OCTOBER 2024 | VOLUME 35 | ISSUE 8

THERAPY TODAY

bacp | counselling changes lives

Black women & birth trauma

WHY POSTNATAL PTSD STILL GOES UNRECOGNISED

THERAPY TODAY
OCTOBER 2024 | VOLUME 35 | ISSUE 8

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'Black queer men are particularly vulnerable to discrimination and stigmatisation within some black communities'

Anthony Davis
('Intersections of trauma', pages 27-30)

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IN PROGRESS
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Courses • Practice services

SCAN THE CODE TO SET UP AN APPOINTMENT.

SPEAK TO CIARA, GRACE, RACHEL, LAURA, TARA, YOMNA, DIRCE OR BRITNEY TODAY TO SEE HOW WE CAN HELP.

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THERAPY TODAY

In our Black History Month cover story this month, journalist Micha Frazer-Carroll reports on the race disparities in birth trauma. Among the many shocking issues raised, I was struck by the point that rather than being a joyous time, pregnancy and birth can mean heightened fear and anxiety for many women of colour, who are four times more likely than white women to die in childbirth. Micha talks to key campaigners to explore why black women are at increased risk of postnatal trauma and also less likely to get the support they need. If you're wondering how this impacts you as a therapist, awareness of the risk of PTSD and the impact of trauma long after birth can help to ensure we properly support affected women of all cultural heritages. Don't miss that important report on pages 22-26.

Heightened fear is a daily reality for many people of racially minoritised heritages, as Rhea Gandhi points out in her thought-provoking 'Viewpoint' piece. We started working on this issue of *Therapy Today* while the UK was still reeling from the impact of race-related violence on the streets of many cities. In her piece, Rhea discusses why caricaturing racism as being restricted to such extreme actions overlooks the more insidious discrimination that exists in everyday life. She stresses

'Caricaturing racism overlooks the more insidious discrimination that exists in everyday life'

the importance of brave and honest conversations in raising awareness of the impact of actions driven by innate biases. It's a theme that is also explored by Eugene Ellis in 'Transforming race conversations', an extract from his excellent book of the same name.

Member Helen Dalley meanwhile is hoping to start a brave and honest conversation about student placements in her piece, 'Winning the placement race'. She describes the hoops that she and her fellow trainees are expected to jump through to get the required number of clinical hours to qualify. If you are a student member and want to share your own experiences of securing and completing your placement hours, then look out for our specially commissioned survey in your inbox. We're hoping your responses will help to inform a more in-depth report into placements for an upcoming issue.

Sally Brown Editor

WILL AMLOT

Contributing to *Therapy Today* *Therapy Today* includes submissions from members and other practitioners, and we very much welcome your contributions. For *Therapy Today*-specific guidelines on the types of articles we are looking for, please email **therapytoday@thinkpublishing.co.uk**. Please note, we do not publish poetry, blogs or dissertations.

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FRONT COVER: PAUL WEARING

THINK

Therapy Today is published on behalf of the British Association for Counselling and Psychotherapy by Think, 65 Riding House Street, London W1W 7EH
thinkpublishing.co.uk

Printed by: Warners Midlands Plc
ISSN: 1748-7846

Subscriptions
Annual UK subscription £76; overseas subscription £95 (for 10 issues). Single issues £8.50 (UK) or £13.50 (overseas). All BACP members receive a hard copy free of charge as part of their membership.
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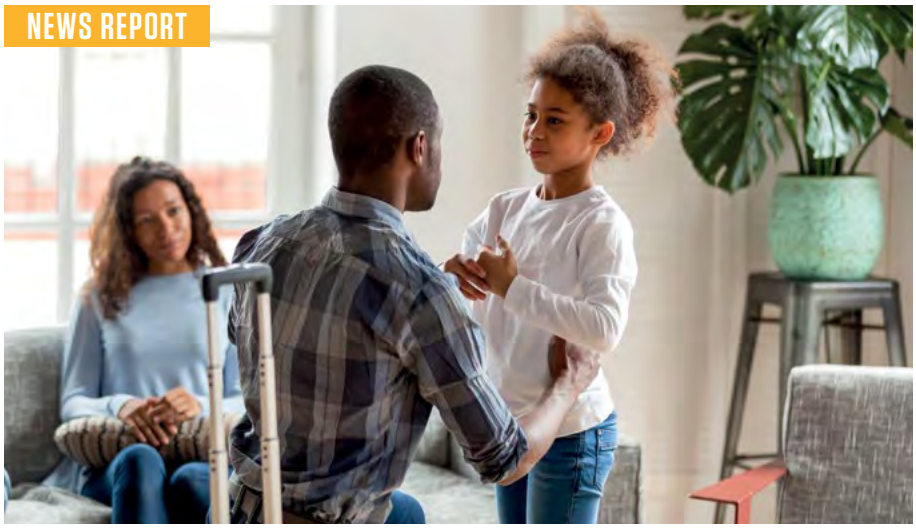
Noticeboard

Our monthly digest of news, updates and events

NEWS REPORT



FIZKES/SHUTTERSTOCK

Supporting separated parents

Counselling is playing a key role in supporting children after parental separation, particularly those affected by conflict or abuse, according to a new report from Action for Children. The report provides insight into specific challenges affecting families in the UK. Although several were highlighted, one in particular stands out – the struggle to co-parent following separation due to ongoing conflict or abuse.

Action for Children also reported an increase in requests for information from parents about co-parenting with a controlling partner. Many parents seeking help are experiencing high levels of stress and low wellbeing, and say their children are struggling with mental health and wellbeing, and behavioural issues.

It's estimated that there are 3.8 million children living in separated families in the UK, and while not all of these families will be struggling to resolve conflict, the potential number of children impacted is high. The findings show the nuances in the types of issues that parents and children are experiencing as a result of conflict or abuse, and how this can impact their overall outcomes.

When families face problems, getting the right support at the right time is essential and should include access to mental health support for both parents and children. Although many parents were in touch with a range of support services, for a whole host of reasons this support wasn't adequate in the moment they were seeking it, or they were experiencing barriers to accessing the right support.

Although many parents reported struggling to manage the conflict without any support, some also reported that their children were receiving help through counselling. You can read the key findings and the full report at **bit.ly/3MdAPaP**

44 days

of productivity lost on average per UK employee due to working through sickness*

* IPPR *HEALTHY INDUSTRY, PROSPEROUS ECONOMY* REPORT 2024

Don't miss out on voting!

All members are able to vote for the member-submitted motions that received the required level of support from Tuesday 1 October until 1pm on the day of our 2024 AGM, Thursday 7 November.

Members are also able to vote via proxy from Tuesday 1 October, but this process will close earlier on Thursday 31 October. Thank you to everyone who's taken part in our 2024 AGM processes so far.

To find out more on how the motions and resolutions process works, along with answers to members' most commonly asked questions about the AGM, see bit.ly/3At8s5P

Noticeboard

MIKE SEWELL

FROM THE CEO

Phil James, Chief Executive Officer

I'm finding our equality, diversity and inclusion (EDI) strategy challenging.

It's good – great, in fact. Clear, imaginative, ambitious and inspiring. Reading it causes me to stop and reflect on the work ahead of us as BACP, and about who I am becoming as a person.

Where I'm struggling is, well, the very idea of having an EDI strategy in the first place. Reading it is an invitation into the rich, imaginative, dissonant conversations that forged its creation. Yet creating the hymn sheet means we're all singing the same tune. So how does diversity fit now?

It's not diversity and inclusion I'm struggling with, it's the idea that we can engineer a more equitable BACP, profession, society, by blueprinting the future and setting about delivering it. Don't get me wrong, there are things that we categorically *must* change. But if we take the idea of diversity seriously we have to recognise that BACP has become what it is today through a complex history of interaction between people. It is only through richer, more diverse and ongoing dialogue that a fairer, more inclusive BACP will emerge. That's a very different prospect to a linear view of change that says, 'Plan, do, review'.

Diversity means not everyone singing from the same hymn sheet, at least not all of the time. It's about expanding our collective capacity for tolerance, being open to others without othering, and struggling with our own shifting sense of identity – as individuals and as a community, both at the same time. It's about becoming familiar with prolonged discomfort, tension and constructive conflict, and viewing the achievement of our strategy not just in terms of what it looks like but what it feels like too.

So here's to achieving our strategy and not achieving it at the same time. Here's to the unending emotional struggle of adjustment as a self among other selves. Here's to deepening our commitment to a more inclusive, diverse and equitable society, and to sustaining our efforts beyond meeting the goals we can see in front of us, towards those not yet fully in view.

57% of UK adults say their mental health is affected by the climate crisis**

PRESSMASTER/SHUTTERSTOCK

Research Conference submissions

Are you a researcher passionate about the power of collaboration? Then tell us about your research – we are now accepting abstract submissions on the theme of collaboration in counselling and psychotherapy research for the 31st Annual International BACP Research Conference.

For 30 years the BACP Research Conference has been a place where researchers and practitioners come together to exchange ideas on important research findings, presented in open discussion with constructive critical debate and helpful dialogue. The conference fosters a climate where all are welcome to share learning and network with other delegates.

The 2025 event, 'Impact through collaboration', is hybrid and will take place in person in Manchester on Friday 16 May and Saturday 17 May, co-hosted by the University of Manchester with selected presentations livestreamed. The deadline for abstract submissions is Sunday 3 November 2024. Find out how to submit at **bacp.co.uk/events-and-resources/research/conference**

**BACP PUBLIC PERCEPTIONS SURVEY 2023

DIARY DATES

bacp.co.uk/events

10 OCTOBER
GLASGOW

Making Connections
Free CPD and networking event for members

7 NOVEMBER
LONDON/ ONLINE

BACP AGM 2024
Get involved and help shape the future of our profession

S.BORISOV/SHUTTERSTOCK

New Addictions Competence Framework

Working with addictions can be one of the most challenging and rewarding areas of practice. To support practitioners and services working with clients affected by addiction, we've published a new *Addictions Competence Framework and Training Curriculum*.

Our competence frameworks set out best practice standards for the benefit and protection of clients, practitioners, services and the overall profession. The addictions framework is designed to support you in considering whether you have the necessary training and skills to work with clients with addictions in the following ways:

- Therapists already working in this area can use the framework to map their existing competence and identify any areas for further development

- Counsellors and trainees interested in learning about addictions counselling can also use the framework to assess their readiness for the role and to identify training needs.

We've also developed a user guide that describes the framework and explains how to apply it in your practice. You can read and download the framework, user guide and other resources at **bit.ly/470Wpc7**

1 in 3 young people (18-25) say stress stops them being more active***

*** MENTAL HEALTH FOUNDATION REPORT MAY 2024

Spreading the word

Promoting our members and our profession through the media

The Daily Telegraph included comments from **Ayo Adesioye** about the rise in men seeking therapy, and **Kemi Omijeh** about helping support a child with gender dysphoria. ● *The Independent* included comments from **Heidi Soholt** on managing back-to-school anxiety, **Cate Campbell** on 'sexsomnia' in sexual assault cases, and **Jenny Warwick** about adult children's relationship with their parents. ● **Susie Masterson** also featured in *The Independent*'s new agony aunt column giving relationship advice on 'sexting'. ● Hits Radio Manchester interviewed **Rachel Vora** for advice on coping with exam results days. ● Planet Radio also featured comments from **Jenny Warwick** and **Susie Pinchin** on exam results days. ● **Tracy Stafford** commented in a *Marie Claire* article on compassion fatigue. ● *HELLO!* featured **Katerina Georgiou** commenting on the impact of celebrity break-ups, and **Susie Masterson** about family estrangement. Susie also appeared in a *Metro* article about people being emotionally attached to their home. ● BBC World Service Outside Resource interviewed **Lina Mookerjee** live to discuss panic attacks. ● **Alison Goolnik** was interviewed by *Stylist* for a feature about 'doom spending'. ● *GoodtoKnow* featured **Natasha Page** on preparing a child for the start of the school term, **Helen Hazell-English** gave advice on mother-daughter relationships, and **Charlotte Monk** commented on introverted parents. ● **Lorraine Collins** featured as an agony aunt in *Pick Me Up!* magazine.


LORRAINE COLLINS


KEMI OMIJEH


AYO ADESIOYE


LINA MOOKERJEE

19 NOVEMBER BRIGHTON

Making Connections

Free CPD and networking event for members


Z. TONOV/SHUTTERSTOCK

6 DECEMBER ONLINE

Working with Spirituality

The relationship between post-traumatic growth and spirituality


ISAEVA ANNA/SHUTTERSTOCK

Discussing RACIAL IDENTITY Respectfully

Sarah Henry

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2% of global healthcare budgets are devoted to mental health****

MEMBERS MAKING A DIFFERENCE

Demystifying therapy

Audrey James MBACP, founder of Restore Black

When I established my private practice, Restore Counselling Service, in 2013, to my surprise only 3% of my clients were black during the first few years. Now, however, approximately 40% of my client base is black.

Despite this shift, a common question remains – how can simply talking to someone make a difference to mental health? To address this, we launched the Restore Black initiative in May 2024, aimed at demystifying therapy through innovative events. The launch featured a live therapy session on stage with singer Sarah Brown, providing insight into the therapeutic process. In addition to our live events, we have also launched our podcast.

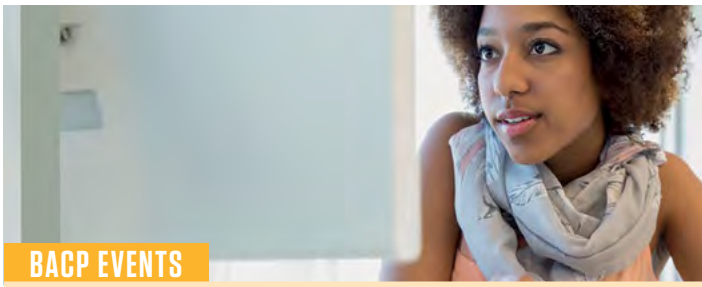
My faith has always been incredibly important to me, and I initially envisioned a career in ministry, though I unexpectedly found myself working in social housing. Eventually I trained as a therapist, and during my training and long after, I engaged in my own therapy. This helped me to navigate various traumas including being left behind in Jamaica by my mother as a baby when she joined my father in England. I moved to live with them aged five, having grown up believing my grandparents were my parents.

I struggled to find a black therapist and although the white male therapist I eventually worked with was excellent, this experience inspired me to become the therapist I had needed for the black community.

My career has come full circle. While I continue to run my private practice, Restore Black has become my ministry in its own right. The name restore is inspired by a line from the 23rd Psalm: 'He restores my soul...' I believe that we all face experiences in life that leave us feeling broken, but we do not have to remain that way – restoration is possible.

- Find out more at **restoreblack.com**

**** THE LANCET PSYCHIATRY COMMISSION ON YOUTH MENTAL HEALTH REPORT 2024



SHUTTERSTOCK

BACP EVENTS

Students Conference

If you're currently in training, don't miss our dedicated student event, 'Bridging the gap'. This ever-popular hybrid event always has a friendly atmosphere, and attendees have described it as inspirational and confidence-building. It's designed to support student members as they transition through learning and experience from trainee to fully qualified practitioner.

Presentations will address the current challenges impacting the profession, equipping you with the knowledge and confidence to approach these in the future. There'll be two keynote presentations in addition to 16 workshops across four strands. The strand themes will focus on career pathways, practitioner experience, personal development and feeling out of your depth. There will also be taster talks providing valuable insights into how BACP can support you throughout your career, and an exhibition of products and services that may be of benefit.

The event takes place on Saturday 8 February 2025 and costs £25 to attend online and £35 to attend in person in London. To book, see **bit.ly/3yUcymX**

PROFESSIONAL CONDUCT

- **BACP's Public Protection Committee holds delegated responsibility for the public protection processes of the Register. You can find out more about the Committee and its work at bacp.co.uk/about-us/protecting-the-public/bacp-register/governance-of-the-bacp-register**
- **BACP's Professional Conduct Notices can be found at bacp.co.uk/professional-conduct-notices**

10 DECEMBER
ONLINE

Working with adult adopted clients

Latest updates on adoption-related issues

21 JANUARY
NEWPORT

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8 FEBRUARY
LONDON/ ONLINE

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BACP EVENTS

Working with adult adopted clients

There is a growing demand for counselling for adopted adults, and a recent change in guidance in England was designed to make it easier for more practitioners to work with this client group. But given that issues related to adoption can be complex, how do we ensure we ethically and effectively support adopted adults?

Our online event, 'Working with adult adopted clients and adoption-related issues', aims to address this by increasing your knowledge and updating you on the latest developments in adoption counselling. It's aimed at counsellors and practitioners who'd like to start working with adult adopted clients now or in the future, or continue the therapeutic relationship if adoption-related issues arise in therapy. As well as addressing what the new guidance changes may mean for clients in the future, the event also aims to offer insights into the lived experience of an adoptive client.

- This member-only event takes place on Tuesday 10 December 2024 and costs £35 to join online. For more information and to book, see **bit.ly/4dQlY1L**

FROM THE PRESIDENT

Professor Lynne Gabriel OBE

Oppressors and oppressed are ever-present features of human life, relationships and systems. Challenging oppression associated with racism is vital. The relational and interactional expertise of the counselling professions means they are well placed to question invidious offensive behavioural and relational cultures. Equally they can engender much needed authentic inclusivity, starting with practitioner training and extending through all therapy theory, practice and research. Most recognise there is no place for 'othering' or any other demeaning or dehumanising behaviours.

Creating facilitative conditions in which difference is valued and celebrated is a complex and contested area. As humans we've been around this seeming conundrum time and time again, yet humankind still struggles with interactions across races and nations. People, because of their differences, whether through colour, age, gender, sexual identity, disability or any other markers, can celebrate rather than censor diversity. UK summer 2024 riots were shocking; yet community responses challenging racism and fascism were heartwarming. Most people do not want to annihilate. Thankfully many pitch and progress work to mitigate tensions and toxicity that exist across divides.

Oppression pervades, playing out in multiple contexts – relationships, groups, communities, workplaces, organisations and systems. We have an ethical responsibility to challenge oppression in the profession. Professional bodies can play a part. Leaning in to work with members, reaching out to work in targeted ways with other organisations, being a visible and active influencer in relation to UK policies and politics; all are essential ways of working in the contemporary landscape. Authentic leaders, like BACP's CEO, can do this, bringing compassion, collaboration and inclusive ways of being and relating to foster innovation and advancement.

Whatever I'm involved in I advocate for BACP and its members as well as the wider counselling professions. We make a vital contribution to mental health and wellbeing workforces and are active change agents in the development of person-centred, co-produced community mental health provision. Putting aside divisiveness and defensiveness to work collectively, collaboratively and creatively makes us stronger together.

15 MARCH — ONLINE/HYBRID

Children, Young People and Families Conference

Our popular biannual event

29 APRIL — ONLINE/HYBRID

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For full course details: www.naos-institute.com/training/ - www.psychosexualtraining.org.uk

The course is accredited by COSRT, level 7

WORKING FOR YOU

Updates from BACP's Policy Team

Promoting healthier workplaces

As part of our long-term campaign to raise awareness of the importance of employee wellbeing for the economy, and the role of counselling in supporting wellbeing at work, BACP Workforce Lead Kris Ambler responded to a new report from the Institute for Public Policy Research. *Healthy Industry, Prosperous Economy* found that UK workers tend to avoid taking sick days and are more inclined than those in other European nations to continue working despite being unwell. Despite this the cost of employee sickness has risen to £103 billion a year, an increase of £30 billion since 2018, mainly due to the UK population's escalating long-term health issues. The report also emphasised that a significant portion of this cost comes from 'hidden' challenges such as presenteeism and reduced productivity among employees. Ambler said, 'These findings show a concerning trend, with the UK workforce facing extreme pressures and burnout. By offering timely access to counselling services, employers can help employees manage their mental health effectively, reduce the need for time off and promote healthier workplace cultures.'

Evidence for school counselling

Having a funded, registered counsellor in all UK schools is one of our long-standing campaigns, and part of this involves collating evidence of the benefits. Our campaign received a recent boost from a Welsh Government review on the impact of school counselling that showed it reduces the need to refer pupils to places like Child and Adolescent Mental Health Services. The review was undertaken by Cardiff University and looked at evaluations of school counselling in 29 UK schools between January 1999 and December 2020. As well as providing evidence that school counselling reduces the number of children and young people being referred to more intensive services, the report also shows a positive impact on their wellbeing and mental health. Currently England is the only country in the UK not to have Government-funded school counselling.

VECTORBUM/SHUTTERSTOCK

- To find out more about how we're working on your behalf, see **bacp.co.uk/news/news-from-bacp**

MIKE SEWELL

FROM THE BOARD

Josephine Bey MBACP (Accred), Trustee, BACP Board of Governors

Joining the Board had a bit of a bumpy start for me as I lost my father just weeks before attending the 2023 BACP AGM where my appointment was announced. You're probably wondering why I chose to still attend and make the journey to Birmingham from where I live in Cornwall. Being a Trustee is a passion and a privilege and it was important to me to be present at my first AGM.

A few months later I attended BACP's 30th Annual Research Conference, and despite enjoying excellent and thought-provoking workshops I was left with a mix of emotions. As a black and neurodivergent therapist who specialises in equality, diversity and inclusion it was good to see a more diverse group of speakers and professionals. I want to acknowledge how far the conversation has shifted in support of the decolonisation of academia. However, it struck me that representation is still very limited and there is more work to be done to make room for and invite more diverse voices in counselling and psychotherapy.

In my own education and training I had no black or brown educators until retraining as a counsellor, my fourth career, when I was taught by two people of colour – attending a college in south London perhaps tipped the balance in that favour.

In terms of seeing people who look like me, this was encouraging. However, the foundations of counselling and psychotherapy are deeply rooted in Western thought, and still taught through a white, male lens. While these contributions are significant they often marginalise non-Western perspectives. Colonial legacies have imposed Western models globally, frequently dismissing the validity of other healing traditions.

As a profession we must be intentional about making room, opening doors and ushering in other voices. If we are to truly embody the ethical principle to do no harm we must open our arms wide and mean no harm to all, not just some.

I hope that my father would have encouraged me to attend the AGM despite my grief. I know he'd be proud of his youngest child working hard and striving to pave the way for our profession.

Make use of your membership benefits

Whether you're new to BACP or you're a current member looking to get the most from your membership, we're here to support and enrich your career.

Your membership subscription includes:

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- Access to our Counselling and Psychotherapy Research Journal
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To find out more about your member benefits, visit our website.

www.bacp.co.uk/membership/member-benefits

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RESEARCH DIGEST

Race and diversity in therapy

1 Cultural topics in therapy

THE STUDY: The researchers examined three types of 'broaching' in therapy – direct, indirect and avoidant – and the impact on client perceptions of microaggressions and therapist multicultural orientation. Direct broaching involves explicitly raising cultural topics, while indirect broaching explores issues without explicitly referencing cultural backgrounds, such as asking about similar experiences in other situations. Avoidant broaching involves ignoring or sidestepping cultural conversations, even if initiated by the client.
THE FINDINGS: An indirect broaching approach to addressing clients' cultural issues, particularly related to ethnicity, gender identity or sexual orientation, was preferred. Avoiding cultural topics was associated with clients experiencing more microaggressions and perceiving their therapists as having lower cultural humility.
THE TAKEAWAY: How therapists approach cultural topics within therapy matters.
READ MORE: Depauw H et al. bit.ly/4diA38p

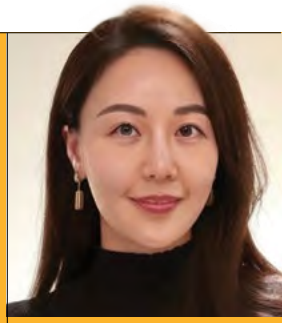
2 EDI in CBT training

THE STUDY: This evaluation study assessed the extent to which a CBT training course had embraced equality, diversity and inclusion (EDI). Eighty-nine graduates of a postgraduate diploma in CBT completed an in-depth survey featuring both Likert-scaled answers and free-text responses.
THE FINDINGS: Only 55.6% of black and minority ethnic participants perceived EDI to be a core value of their training course. Responses also indicated a desire for more teaching by practitioners from diverse backgrounds and experts by experience.
THE TAKEAWAY: Course providers need to develop inclusive recruitment strategies for staff and students; create safe, reflective spaces in which self-awareness of biases is supportively encouraged; and work together with placement providers to develop inclusive working practices.
READ MORE: Presley V. bit.ly/3WZlTmF

3 Black clients' mental health needs

THE STUDY: The mental health needs of black clients were explored from the perspective of black practitioners, addressing a gap in research that has primarily focused on the cultural competence of practitioners.
THE FINDINGS: Semi-structured interviews with eight black mental health professionals resulted in the identification of five areas of need – mental health literacy education; culturally specific family and parenting counselling; advocacy to support navigation of complex systems and reduce mental health stigma; culturally sensitive counselling for transgenerational trauma and grief; and improved self-efficacy.
THE TAKEAWAY: We need evidence-based, affirmative and culturally sensitive approaches to counselling to provide safety for black clients to speak openly about their experiences and develop their sense of self-efficacy.
READ MORE: Summers LM, Lassiter PS. bit.ly/3SJWHhA

MY RESEARCH



Elizabeth Li PhD
Project Manager, Anna Freud Centre

Elizabeth has received multiple awards and grants for her research, including a new researcher award and a secondary data analysis grant from BACP. She currently teaches at University College London, Anna Freud Centre and Birkbeck, University of London.

My journey into this field of research began during my undergraduate studies in social work, where I specialised in counselling and psychotherapy and became aware of a common pattern – people with mental disturbances often had troubled childhoods and adolescences marked by mistreatment. I saw how early negative experiences could manifest in different ways later in life. Many of these individuals felt pain, sadness, self-hatred, helplessness and confusion, living in a social world but not knowing where to turn. Some sought help from others, sometimes showing an overly dependent tendency, some distanced themselves, and others would swing between these two extremes.

My research generally looks at individuals who grow up in abusive or deprived environments and how they cope. For my PhD at UCL, I focused on epistemic mistrust, which leads people to perceive social communication as unreliable, preventing them from fully benefitting from relationships and communities.

After my PhD I began working with the San Francisco Psychotherapy Research Group to understand how psychotherapy can be better tailored to meet individual patients' needs and goals. Overall I want to understand what makes some people vulnerable while others are resilient, and I want to help to empower people who have been mistreated in the past to foster their ability to become full members of the community and regain control over their lives and mental health. My ultimate goal is to contribute to a mental health field where patients are active participants in their recovery and life.

What's on

Mental wellbeing in the arts and media

COMEDY

Duker's sold-out Edinburgh Fringe show *But Daddy I Love Her* tours the UK this month. Out and proud queer woman and *Live at the Apollo* stand-up Duker praises the art of fantasy and delusions – and their intrinsic hopefulness – in her new solo show. Duker recently made headlines by revealing that she went to therapy with her dad, who'd left the UK after her parents separated when she was at primary school. Both parents' behaviour gets a look in, as do her own exploits. If you can't catch her this month, further dates are scheduled round the country in 2025. *But Daddy I Love Her* will be at Norwich Playhouse on 4 October, London Soho Theatre from 7-19 October and Brighton Corn Exchange on 25 October. **sophieduker.com**

HAMISH BROWN

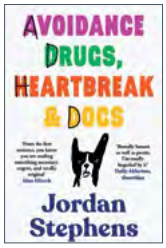
TALKS

LONDON LITERATURE FESTIVAL

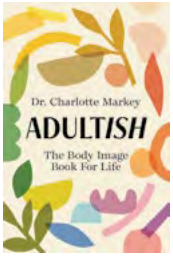
One of the UK's leading book festivals returns to London's Southbank Centre this month with a packed programme of readings, interviews and Q&As that lift bestselling authors off the shelf and onto the stage. On 26 October, reporter Lindsey Hilsum will discuss her new book *I Brought the War With Me* (Chatto & Windus), a collection of poems that sustained her while she covered conflict in Palestine, Kosovo and Rwanda. Later the same day Lemn Sissay (pictured) hosts a night of poetry readings in the Purcell Room curated by a public vote, before kicking off his own UK tour for his latest book *Let the Light Pour In* (Canongate). The festival runs from 23 October to 3 November. **southbankcentre.co.uk/events/london-literature-festival**

Chasing change

BOOKS



Musician, actor, presenter and half of hip-hop duo Rizzle Kicks, Jordan Stephens recounts his own experience of the relationship, identity and mental health issues that face thousands of young men in his new memoir, *Avoidance, Drugs, Heartbreak and Dogs.* After his girlfriend Chloe recommends a therapist, Stephens takes a new approach to his quarter-life crisis. (Canongate, out now)



Adolescence can take its toll on body image so Dr Charlotte Markey's new guide aims to lead young people through this tumultuous time with compassion and wisdom. *Adultish: the body image book for life* takes an interactive approach that could work equally well as a self-help guide or resource for therapists and clients. (Cambridge University Press, out now)

If you're looking for succinct self-help guides to recommend to clients, look no further than The School of Life's stylish 'Secrets' series, edited by Alain de Botton. The newest release, *The Secrets of Successful Relationships,* covers essential communication skills including how to talk about sex and ask for what you need. (The School of Life, out 3 October)

Compiled by Ellie Broughton
Email details of events to
therapytoday@thinkpublishing.co.uk

MUSIC

Soweto Kinch

Celebrate Black History Month with British saxophonist and rapper Soweto Kinch's live performance of his 2022 jazz album *White Juju*, as part of the City of Birmingham Symphony Orchestra's 2024 programme. Kinch's album developed from experiences of walking in London during lockdown, and how its imperial landmarks looked after being abandoned by their usual crowds. Kinch has said that the title *White Juju* describes racism as a psychosis or spell: 'Much like any good spell you don't know you're under it.' This special one-night only performance takes place at Birmingham's Symphony Hall on 20 October. **cbso.co.uk/events/soweto-kinch-white-juju**

PODCASTS

Tough talk, easy listening

In the second series of the successful *Shrink the Box*, therapist and BBC Radio 6 DJ Nemone Metaxas takes over the co-host chair and joins actor-comedian Ben Bailey Smith to put our favourite film and TV characters 'on the couch', from Frasier Crane to Cersei Lannister, *The Bear* to *Slow Horses*. On most podcast platforms.

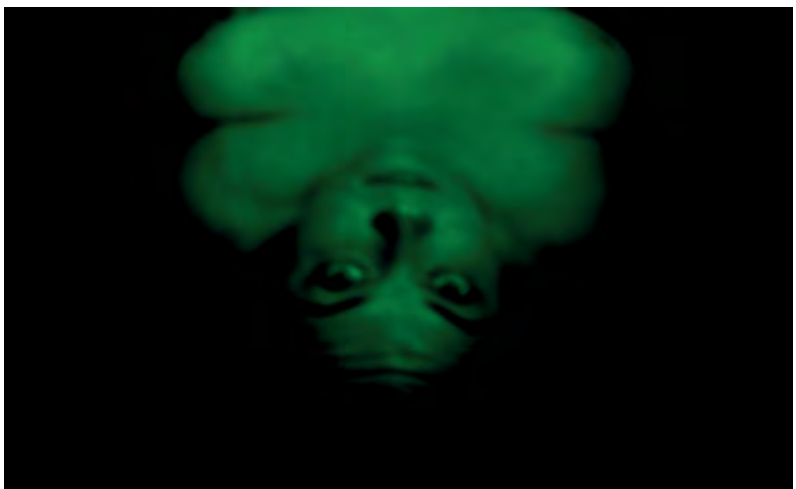
In *Mixedlings: weekly conversations and affirmations on being mixed-race*, therapist Rochelle Armstrong MBACP muses on what is wonderful and challenging about a culturally mixed heritage. Don't miss episode eight when interviewee Christy talks about discovering she was adopted at 29 years old. On most podcast platforms.

Back for a fourth series, the Scottish podcast *Speaking of Suicide* features discussions about experiencing suicidal thoughts with guests as diverse as a paramedic and a deputy first minister. Therapist Shona MacPherson adds a little psychoeducation each episode, and charity Mikeysline supports the work. On most podcast platforms.

ART

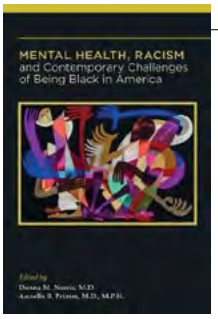
In the Dark: Birth

After her friend's traumatic birth experience photographer Phoebe Wingrove responded the best way she knew how to – with a series of photographic compositions. 'In the Dark: Birth' visualises the emotional experience of birth, the physical transition into motherhood, and how parenthood changes a person's sense of identity. The photographer has previously worked with other lived experience experts with vaginismus and HPV to find ways to talk around the silence and shame these conditions are mired in. The series will form one of the exhibitions of Photo Fringe 2024: Common Ground, a biennial festival that takes place at various venues around Brighton and Hove from 14-20 October. **photofringe.org**



Bookshelf

Edited by Jeanine Connor. To join our panel of book reviewers, please email **therapytoday@thinkpublishing.co.uk**

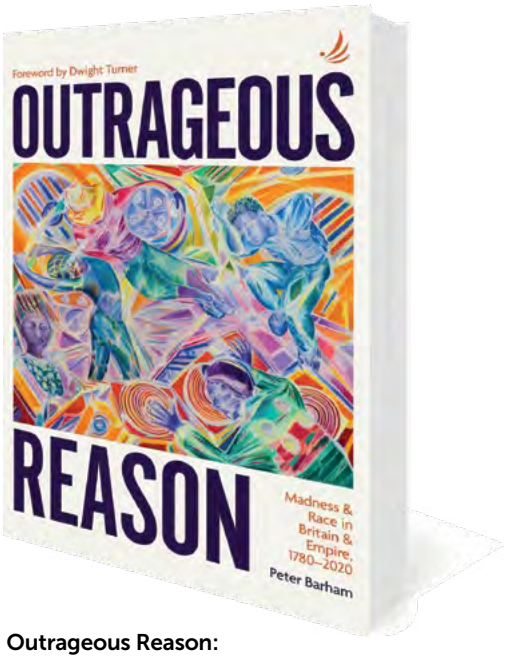


Mental Health, Racism and Contemporary Challenges of Being Black in America
Donna M Norris and Annelle B Primm (eds) (American Psychiatric Association)

The COVID-19 pandemic highlighted that physical and mental healthcare disparities have changed little over the past 50 years, and that black people are still often treated as inferior within those systems. Racism also affects the impact on communities of anthropogenic climate disasters. In this book black psychiatrists reflect on black lives against this context in the US. The first of its four sections focuses on conditions within black communities. Discussions in part two include the importance of comprehensive social and emotional skills in the general population and placing black people at the centre of decision making about their lives. The importance of mentorship for mental health practitioners is emphasised in part three, as well as the need for research into mental health within black communities as black people are often misdiagnosed. The authors argue for including anti-colonialism, anti-racism and mental health equity in global mental health provision.

The final section reflects on the legacy of early black psychiatrists and exhorts the American Psychological Association to 'embrace all its members' regardless of colour. I was struck by the humanity and generosity of the words of Stephen McLeod-Bryant, President of the Black Psychiatrists of America, at the end of the book in mentioning the difficulty of recalling the past without bias. He writes, 'This places me in the same boat as critics and allies alike, imperfect humans struggling to do what is right.' The book contains a wealth of information about the contemporary challenges of being black in the US and beyond.

Dr Els van Ooijen, retired psychotherapist



Outrageous Reason: madness and race in Britain and Empire, 1780-2020
Peter Barham (PCCS Books)

This book demands that the reader fundamentally reconsiders the lens through which they see and understand the world when it comes to mental health and race. Using meticulously researched stories of key figures, the author gradually builds the case that racism exists deeply, systemically and inescapably in the UK's mental health system today, with its roots firmly in Britain's colonial past.

While individual stories of those caught in the cross hairs of 18th-, 19th- and 20th-century colonial oppression exemplify the explicit racism at play at the time, the case studies detailing recent appalling cases of systemic violence amply demonstrate how racism has become deeply ingrained, unacknowledged – and, indeed, flatly denied.

From the horrific story of the slave ship *Zong*, through the Jamaican lunatic asylums and the British Raj, all the way to 21st-century London, the author draws a thread that pulls together how power, race and class intersect to maintain systems of oppression that we, as mental health professionals, are a part of – like it or not.

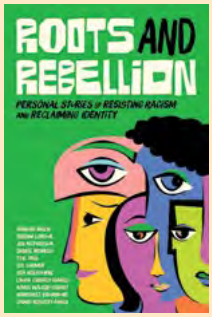
Psychiatric concepts and practice have not only dehumanised racialised people and justified their oppression for hundreds of years but have also been actively weaponised. The individual stories included demonstrate the agonising impossibility of escaping from psychiatric pathologisation that is based on unacknowledged systemic racism – which is as true today as it was 200 years ago.

Nick Campion MBACP, integrative psychotherapist

For exclusive publisher discount codes, see **bacp.co.uk/membership/book-discounts**

'This book demands that the reader reconsiders the lens through which they see and understand the world when it comes to mental health and race'

Nick Campion MBACP



Roots and Rebellion: personal stories of resisting racism and reclaiming identity
Various
(Jessica Kingsley)

In this little book (127 pages), 11 authors tell their personal stories of resisting racism. Stories are described as 'containers of rich knowledge', and this collection is certainly rich and varied, describing each person's experience of being displaced or misplaced, standing out yet not really seen.

Debbie Iromlou speaks of her experience of being taken from her unmarried Kuwaiti mother and placed within a care system that didn't care enough. Adopted in England, she says no one can know 'how it feels to be raised in a home and community of people that don't look like you'. A person of mixed heritage shares their experience of 'men, women and dogs shouting, barking and spitting at us daily' and how a 'step up from lighter to whiter was too hard to achieve' while 'a step down from brown to black' seemed less painful and damaging. Jen McPherson, a woman of mixed Japanese/Scottish heritage, implores us to look at mental illness within the cultural context of the individual, with a reminder that mental health in Japan is taboo. Zoe Lorimer, a black Scottish woman, tells of the daily microaggressions from white people believing they are 'colour-blind' and highlights the 'systemic institution of whiteness'.

The foreword says this book will 'disrupt what you think you know about racism' and states 'resistance is an act of kindness [and] the loving thing to do to be better allies and advocates'. Let's all try to disrupt, resist and be kind.

Jeanine Connor MBACP, psychodynamic psychotherapist

ACT for Burnout: recharge, reconnect, and transform burnout with acceptance and commitment therapy
Debbie Sorensen (Jessica Kingsley)

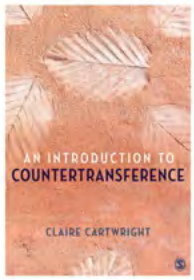
The author of this book has extensive experience of working with clients experiencing burnout. She has used a range of therapeutic modalities to treat burnout but her favourite, discerned through evidence-based practice and research, is acceptance and commitment therapy (ACT – pronounced as 'act'), which she defines as 'a form of contextual behavioural therapy' that can help clients with anxiety, depression and chronic pain, making positive changes in their lives. The method focuses on relating to the client's own internal experiencing with awareness, responding flexibly to life's challenges and engaging wholeheartedly with what matters most. Each of these factors are important in working with burnout.

Topics include the understanding and recognition of burnout, psychologically flexible approaches to personal transformation and steps towards personal growth, systemic change and setting boundaries to create a better future.

This is a readable and well-researched work with a wealth of useful case examples and practice information. The content is supported by exercises and reflection questions to assist practitioners to develop their own personal strategies to address, alleviate or prevent burnout in their own lives, and those of their clients.

This will be a useful resource and self-help book, well referenced and relevant for experienced and trainee practitioners. I found it to be a useful, informative and enjoyable read, and I will certainly be taking into account the principles of the ACT approach in the future.

Dr Barbara Mitchels FBACP (Snr Accred), psychotherapist



An Introduction to Countertransference
Claire Cartwright (Sage)

This is an ideal entry point for those looking for a systematic and plain-speaking introduction to countertransference theory and practice. The author is a clinical psychologist with a core training in both CBT and psychodynamic approaches and 15 years' worth of focused teaching and research on the topic.

Like psychoanalyst Paula Heimann who in 1950 observed that many candidates seemed to regard countertransference as 'nothing but a source of trouble', Cartwright is responding to her trainees' needs. Having defined countertransference as 'the emotional, cognitive and bodily reactions of the therapist to the client or the therapy situation and context', she shares her four-step approach to understanding and managing them. This is anchored in the concept of self and other representations, drawing on object relations, CBT and the parent-adult-child model from transactional analysis. I can imagine these pages piling up on the photocopiers of counselling courses. They're filled with 'pause and reflect' exercises, diagrams and fictional session extracts, as well as facilitative questions and practical tips.

Although there is a chapter on ruptures, I did miss any mention of parallel process, enactments or countertransferential pressures when working with complex presentations. Whether or not it's entirely possible or even preferable, this book aims to keep us from getting mired in the messiness and mystery of countertransference.

Isobel Todd MBACP (Accred), psychotherapeutic counsellor and supervisor

Breaking the birth trauma taboo

Postnatal trauma is still largely unrecognised and untreated ~ particularly in black women, says Micha Frazer-Carroll

Illiyin* had always planned to have a home birth. But, after hours of slow dilation and the realisation that she would like pain relief, the then 25-year-old felt she had no choice but to go into hospital. Knowing that slow dilation progress often results in an emergency C-section, Illiyin knew what was likely to happen when she went into hospital.

But that didn't make the experience any less distressing. Lying on the operating table after five attempts to insert a spinal anaesthetic, Illiyin noticed the smell of burning flesh. 'They had started the surgery without me knowing,' she tells me over a voice note (six years on, she has two children and a busy schedule). The doctors had been operating for a full three minutes before she realised. Illiyin describes the experience of not being consulted or informed during the process as shocking and traumatic: 'This was supposedly happening with me but ended up totally happening *to* me.'

Illiyin's experience of maternal care – which, while not being fatal, ended up leading to lasting trauma following the birth – isn't so anomalous. Earlier this year an All-Party Parliamentary Group (APPG) on Birth Trauma report revealed the extent to which poor medical care during labour results in birth trauma in the UK.[1] The report described 'mistakes and failures' by services as leading to outcomes such as stillbirth, premature birth, babies born with cerebral palsy caused by oxygen deprivation, and life-changing injuries to women as the result of severe tearing.

What the report also highlighted was that women from ethnic minority backgrounds were more likely to experience trauma due to particularly poor care, as well as racism and discrimination from services. Numerous women told the researchers that, like Illiyin, procedures were performed without fully informed consent and awareness, including non-consensual vaginal examinations and breaking of waters. An important life event, which many mothers hope will be a memorable and special experience, is still leaving many feeling violated, disempowered and traumatised.

Although the APPG report found that women from all ethnic groups reported feeling like they were objectified, dismissed and denied autonomy over their birthing experiences in the UK, women from racially minoritised groups were found to be most at risk from birth trauma, both psychologically and physically. Between the years 2019-2021, black women were almost four times

PAUL WEARING

more likely to die during or up to six weeks after pregnancy than white women.[2] The Black Maternity Experiences Survey from the black maternal health organisation Five X More found that 42% of black mothers felt the standard of care they received during childbirth was poor or very poor.[3] The same percentage of respondents felt that their safety had been put at risk by professionals during labour or the recovery period. Illiyin tells me: 'When you are at risk of prejudice, at risk of bias, at risk of racism, at risk of poor care, this means that there is an increased chance that you will suffer trauma.'

Trauma

An inclusive definition of traumatic childbirth experiences developed by Professor in Midwifery Julia Leinweber and colleagues describes it as 'a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short- and/or long-term negative impacts on a woman's health and wellbeing'.[4] Some people also use the term to refer to injuries sustained during birth, or simply the subjective perception of threat during the experience of childbirth.

42% of black mothers felt the standard of care they received during childbirth was poor or very poor[3]

Although awareness of birth trauma is growing, it still largely goes unrecognised and untreated, leading to potentially serious mental health issues – particularly in women from racially minoritised backgrounds. An analysis by *The Guardian* found that black women were more than three times as likely to be admitted to hospital for 'severe instances of perinatal mental illness and behavioural disorders associated with the six weeks immediately after childbirth', when compared to their white counterparts.[5] This includes diagnoses like postpartum psychosis. Black women also experience postpartum depression at higher levels than any other group.[6]

Yet few women are offered post-birth support for trauma, or made aware of the possible lasting impact on their mental wellbeing. Patrice Dantzie, who is a counsellor and works with black communities at the pregnancy and baby loss charity Sands (**sands.org.uk**), tells me that black women are less likely to get the support they need. 'Many women feel pressured to embody the "strong black woman" persona, or are told things such as "it was God's will", which suggests that showing sadness or seeking support indicates a lack of faith,' she says. This can ultimately lead women to feeling isolated and misunderstood, further exacerbating mental distress.

Labour anxiety

Many women feel apprehensive about childbirth, but for black women it can be a time of significant anxiety. Black women are 1.5 times more likely to develop pre-eclampsia, a serious pregnancy complication that left untreated can lead to potentially life-threatening complications for the mother and the baby, and six times more likely to experience some of the most serious birth complications during hospital delivery across England than their white counterparts.[7] Stillbirths are significantly higher for babies of black and Asian ethnicity, regardless of socioeconomic status. These discrepancies led to the revelation this year that black women were twice as likely to have their births investigated for NHS safety failings.[7]

Perhaps most shocking of all is the statistic that black women are six times more likely than white women to die in childbirth.[8] Sandra Igwe, Chief Executive of The Motherhood Group, an organisation that aims to empower black mothers, believes being faced with this 'is one of the many reasons why black mothers are now even more anxious and stressed over their birthing experience and postpartum journey'. US research found that tokophobia, fear of childbirth, which increases the odds of pre-term birth, was most prevalent in women who are black or have lower incomes or less education.[9]

Yet instead of having their anxieties managed during maternity care, many black women encounter cultural barriers in services where staff aren't adequately trained to work with migrant communities

'An important life event, which many mothers hope will be a memorable and special experience, is still leaving many feeling violated, disempowered and traumatised'

23% of women who died in the postnatal period suffered from mental health disorders[10]

and communities of colour. For example, in some cultures, screaming during childbirth is not the norm, which leads mothers to be disbelieved about their progress or pain. 'When you're already feeling vulnerable, the last thing you want is to explain your cultural context to a healthcare provider,' says Igwe. 'The dearth of representation in mental health professions doesn't help either – it's hard to open up when you don't see yourself reflected in those meant to help you.'

Despite glaring issues in treatment, it can be difficult for black women to advocate for themselves, as this can see mothers further stereotyped or discriminated against. This was Mel Green's experience when she attempted to speak to doctors about her treatment during childbirth: 'I was told that I was aggressive.'

A lecturer and researcher, and mother of two, Green was told that she was having 'tetanic' contractions, strong and sustained contractions that last longer than usual, and that her baby was lying 'back-to-back' in the womb, making delivery more prolonged, but was still denied pain relief. 'Instead I was told that unless I calmed down, my baby would die. My husband was advocating for me until I passed out from the pain,' she says.

After being subsequently swept off to emergency surgery, Green also experienced disempowerment when her husband was not allowed to come into the operating room, despite originally being told that he could. 'He was left for over an hour without knowing my status. He said all he could hear were my screams.' After the birth, her baby was put in a crib next to Green's bed, while her husband was shut outside, and Green was unable to pick up her baby. She says: 'My newborn child was left without the important skin-to-skin contact in those crucial early moments.'

Postnatal PTSD

The emotional impact of birth trauma can be long-lasting, Illiyin discovered. 'I really struggled with parenting for the first 12 weeks,' she says. 'I was getting lots of flashbacks to the smell of burning flesh from the section.'

There is growing awareness of the frequency of postnatal PTSD. This affects women from all heritages, but one factor that has been found to increase a mother's chances of PTSD is a negative subjective birth experience, which many black women evidently have. Dantzie tells me: 'There are many symptoms of postnatal stress that can present in the counselling room, such as trauma re-experiencing, heightened threat perception, and avoidance behaviours. Postnatal PTSD is a more severe form, with these symptoms being persistent and significantly impacting daily life.'

There are numerous barriers to mothers accessing support in the postpartum period, says Igwe: 'Many black women also carry a deep-seated fear of judgment or misunderstanding from healthcare providers, which can be paralysing.' This mistrust of state services is often very much grounded in reality, as there can be serious material consequences of speaking out. She tells me a bit about Sarah,* a 'vibrant' member of The Motherhood Group, who found herself struggling with postpartum depression: 'Sarah was terrified that if she expressed her mental health concerns, social services might get involved and take her children away. This fear, deeply rooted in the historical mistrust many in the black community feel towards authorities, kept her from getting the support she so desperately needed.' Similarly, black people continue to be more likely to be pushed into the sharp end of the mental health system, with higher rates of detention under the mental health act. This can also result in avoidance of services, or a fear of being honest with medical professionals.

The result of various forms of silencing means that many black women end up repressing their experiences, with nowhere to take them. Green tells me: 'I don't really think I have dealt with the trauma of my last birth, even though my son is now four. This is actually the most I have described it to anyone other than my husband since the birth.'

Disrupting the system

It is clear that a cultural shift is needed. The APPG report made several recommendations that would improve birth experiences for all mothers, but would particularly ameliorate issues that disproportionately affect black women. For example, it suggested that there should be better training and awareness on birth trauma, and trauma-informed care. It also specifically recommended that the Government commit to tackling inequalities in maternity care among ethnic minorities, particularly black and Asian women.

Last year a University of Bedfordshire report on behalf of Wellbeing of Women flagged up removing barriers to accessing early antenatal care for women from ethnic minorities as a key factor in protecting the health of both women and babies.[10]

The Black Maternity Experiences Survey makes a number of recommendations specific to improving black women's outcomes, including an annual maternity survey targeting the group, training for healthcare professionals on conditions that specifically or disproportionately affect black women, more community-

'The result of various forms of silencing means that many black women end up repressing their experiences, with nowhere to take them'

based approaches, and improved feedback systems. Crucially, it also recommends more training for healthcare professionals on ethnic disparities in maternal outcomes.

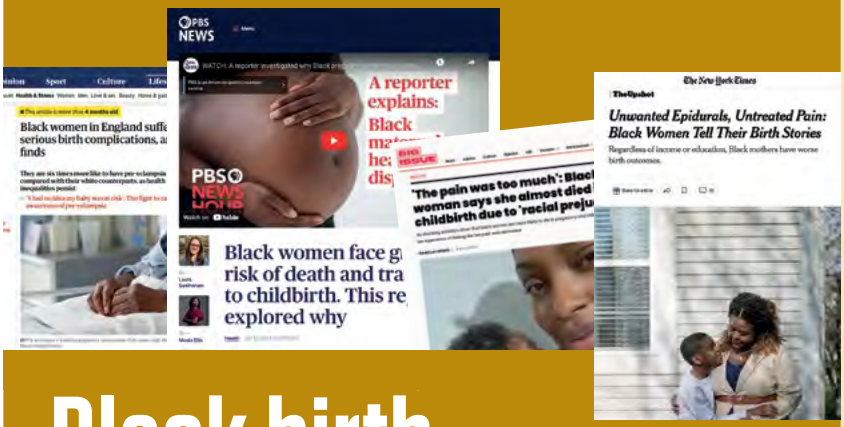
Simultaneously, black women who have experienced birth trauma are increasingly utilising and pioneering interventions from outside the system. Illiyin, for example, is now a midwife and birth debrief facilitator, spending her time supporting other people to have a better birthing experience than she did. Meanwhile, Green employed a doula, which helped prepare her for the birth of her second child. She says: 'Without her aftercare, I don't know if my husband or I would have overcome the experience of our eldest's birth.'

Similarly, Igwe founded The Motherhood Group in order to tackle and address some of these disparities, using what she describes as a 'multi-pronged approach'. This includes a peer support network for black mothers, and campaigns for better maternal care and mental health services for black women. The group also trains healthcare professionals on cultural competence, helping them understand and address the unique needs of black mothers.

Of course, wider cultural attitudes projected onto black women must also be challenged, including ideas that black women internalise about themselves. Illiyin feels that black women are broadly encouraged to unconditionally accept poor treatment: 'People say this is just what we do, it's just how it's done. But in our communities, there needs to be a shift in the narrative around what is actually normal, and a real reinforcement of the fact that we are worthy to feel dissatisfied and complain.'

However, it cannot fall on black women alone to disrupt the complex

13% of women struggle with their mental health after birth[11]



Black birth experiences

There are many factors behind racial discrepancies in care standards that can lead to both trauma and death:

- **Lack of consultation.** Five X More cites a long history of medical professionals making decisions on behalf of black people, a legacy that continues despite the NHS's stated commitment to person-centred care. A substantial number of black women interviewed for the organisation's 2022 report talked about having procedures performed without their full consent or knowledge. This is linked to assumptions about black women's education levels, and ability to understand and direct their own treatment. One black woman describes being treated dismissively by healthcare professionals, only to be taken more seriously when they discovered she was a lawyer.

- **Not being believed.** Tinuke Awe, co-founder of the charity Five X More, told *The Independent* of her experience of medical professionals not believing she was in labour at all, and therefore denying her any pain relief. Sandra Igwe describes these attitudes as a 'pervasive problem', which leads to black women's valid concerns not being taken seriously. 'Many medical professionals hold preconceived notions about black women that cloud their judgment and affect the care they provide,' she says.

- **Stereotyping.** Black women and ethnic minority women more broadly are more likely to be denied adequate pain relief during childbirth, which campaigners have long-argued is linked to the 'strong black woman' stereotype. This concept that black women are inherently stronger (as well as angrier and more assertive) dates back to slavery, and was used to justify brutal experiments on black women throughout 19th-century gynaecology. Many other black mothers in The Black Maternity Experiences Survey said that they did not have pain relief options explained, or were not told why pain relief was denied.

ACTION FOR CHANGE

Sandra Igwe, CEO of The Motherhood Group, is campaigning for:

- Mandatory cultural competency training for all NHS staff, focusing on understanding diverse cultural practices and dismantling stereotypes
- Increased representation of black healthcare providers, especially in maternity services
- Community-led initiatives that bring culturally specific support into mainstream healthcare settings
- Clear guidelines for addressing racial bias in pain management and mental health assessments.

'Therapists can help by educating themselves and being aware that post-birth trauma can impact women's health several years after birth'

interaction between racism and sexism that sees them experience such poor treatment at every stage of the birth process. The dehumanisation of black women, the reduction of their personhood to crude stereotypes, and the dismissal of their desires and pain are all complex issues, many of which can be traced to economic factors, and histories of enslavement and colonialism. These forces cannot be dismantled wholesale within the nation's health systems. But better education and understanding of these issues might better equip professionals with the tools to challenge them.

In the meantime therapists can help by educating themselves and being aware that postnatal trauma can impact women's health several years after birth. The general principle of creating a safe, non-judgmental space is important for supporting women who have experienced birth trauma, says Dantzie. She also emphasises attentiveness: 'It's essential to listen for cues and observe body language and tone without making assumptions. If either changes when discussing their birth, it would be something to explore, asking questions that help you enter the client's frame of reference. An awareness of how post-birth trauma may present itself, as well as ways to work with trauma, will also help.' ●

** Names changed for anonymity*

• Black Maternal Mental Health Week UK 2024, Transforming and Advancing Change, runs from 23–29 September. themotherhoodgroup.org/black-maternal-mental-health-week-uk

REFERENCES

1. Leinweber J et al. Developing a woman-centered, inclusive definition of traumatic childbirth experiences: a discussion paper. Birth 2022; 49(4): 687-696.
2. Thomas K. Listen to mums: ending the postcode lottery on perinatal care. All-Party Parliamentary Group on Birth Trauma UK report; 13 May 2024.
3. Peter M, Wheeler R. The black maternity experiences survey: a nationwide study of black women's experiences of maternity services in the United Kingdom. Five X More; May 2022.
4. Knight M et al. The women who died 2016-18: saving lives, improving mothers' care – lessons to inform maternity care from the UK and Ireland confidential enquiries in maternal death and morbidity 2016-18. MBRRACE UK/National Perinatal Epidemiology Unit, University of Oxford; 2020.
5. Raleigh VS et al. Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. Journal of the Royal Society of Medicine 2010; 103(5): 188-198.
6. Sowemimo A. Divided: racism, medicine and why we need to decolonise healthcare. London: Wellcome Collection; 2023.
7. MBRRACE-UK perinatal mortality surveillance: UK perinatal deaths of babies born in 2022: state of the nation report. timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance
8. Yildiz PD, Ayers S, Phillips L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: a systematic review and meta-analysis. Journal of Affective Disorders 2017; 208: 634-645.
9. Thayer ZM et al. Childbirth fear in the USA during the COVID-19 pandemic: key predictors and associated birth outcomes. Evolution, Medicine, and Public Health 2023; 11(1): 101-111.
10. Sharma E et al. Ethnic minority women's experiences of accessing antenatal care in high income European countries: a systematic review. BMC Health Services Research 2023; 23(1): 612.
11. Knight M et al. Saving lives, improving mothers' care – surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland [on behalf of MBRRACE-UK]. Confidential enquiries into maternal deaths and morbidity 2009-14. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2016.
12. Maternal mental health. [Online.] World Health Organization 2018. who.int/teams/mental-health-and-substance-use/promotion-prevention/maternal-mental-health

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Intersections of trauma

Anthony Davis and **Marita Morahan** explore an intersectional approach to working with black queer men

In the summer of 2020, I (Anthony) experienced a surge in referrals from black clients, especially African and Caribbean men. They were seeking support to process their emotions of fear and sadness triggered by the death of George Floyd on 25 May 2020, and the subsequent resurgence of the Black Lives Matter movement.

For many black queer men this retriggered racialised trauma that was exacerbated by the isolation of lockdown due to the COVID-19 pandemic, and the homophobia they experienced having to return to living in their family home. Such clients sought me out as a black queer male therapist who could understand and relate to their unique challenges. As well as feeling deep compassion and empathy for my clients, I found it genuinely inspiring to see more black male clients accessing therapy to process their experiences, despite past stigma in seeking support for mental health.

One client, Ibrahim,* stands out for me. He sought therapy after a break-up with his boyfriend, feeling anxious and insecure. An investment banker in central London, Ibrahim was one of the few black people in his firm, and he often faced microaggressions and the pressure to code-switch. He was out to his family, but they refused to accept his sexuality, which strained his relationship with his boyfriend. Coming from a deeply religious Nigerian background, Ibrahim had endured homophobic bullying from his cousins and physical abuse from his father, who tried to 'beat the gay out of him'. These experiences left Ibrahim estranged from his father and struggling with his identity. In our sessions we worked to process the trauma of his past abuse and explored the pressure to conform to hypermasculine norms.

Ibrahim's experiences left a lasting impact on me and my therapeutic work. His case encapsulates the mental health needs of black queer men who face intersecting traumas of racism, abuse and homophobia. In recent years reports and research have shed light on the poor mental health outcomes experienced by black and minority ethnic individuals within the LGBTQ+ community. More than 60% of black and minority ethnic LGBTQ+ participants in the UK experienced anxiety and depression, according to a report conducted on behalf of Stonewall.[1] Specifically, queer men within this population face heightened mental health risks, with gay and bisexual men twice as likely to experience depression or anxiety than heterosexual men.[2] Black queer men are particularly vulnerable due to discrimination and stigmatisation within some black communities, contributing to traumatic experiences in their lives that impact their mental health.[3]

'I found it genuinely inspiring to see more black male clients accessing therapy to process their experiences, despite past stigma in seeking support for mental health'

Barriers

Adherence to masculine ideologies can lead to reluctance in black men to seek help for mental health-related issues.[4] The concept of black masculinity influenced by race, gender, social class, sexuality and religion often leads to maladaptive coping and a lack of emotional expression.[5] The conflict between adherence to black masculinity and homosexuality within the black community can create internalised homophobia, contributing to stress and maladaptive coping strategies.[3]

The deterioration of men's mental health and increased suicidality continue to be pressing concerns, and the crucial changes needed in the NHS and third sector services that support men recently gained the attention of Parliament. The UK Government's Health and Social Care Committee conducted a thorough inquiry into men's health from December 2023 to May 2024, gathering evidence from individuals, organisations and charities supporting the health and wellbeing of men in the UK.[6] I had the opportunity to give evidence on behalf of BACP on the mental health of men, highlighting BACP's R.A.I.S.E. campaign, which outlined how to support men to identify and manage depression they may experience.

Research

There has been limited research on trauma-informed integrated counselling and coaching approaches tailored to the intersectional and queer-affirmative needs of black male queer clients. Realising this gap existed, I decided to focus on this area for my master's research in integrative counselling and coaching.[7]

As well as exploring ways of working in therapy with the trauma being presented by black queer male clients, I also hoped to offer a genuine space for therapists to reflect on working with trauma in black queer men. Therapists were likely to be encountering the same lack of guidance on trauma-informed, queer-affirming practice that I encountered, so I was curious about the nuanced ways in which therapists were working with this client group.

Interviews were conducted with therapists who identified primarily as male, black and British, with a range of sexualities including heterosexual, gay and bisexual, and one heterosexual woman who identified as Indian. All the therapists interviewed had developed integrative models of practice, which felt helpful to their clients. Often their core approach was based on person-centred therapy, and different elements of integrative practice were used as appropriate.

Conceptualising trauma

For black queer men, both isolated or repetitive traumatic incidents from childhood can affect their sense of self and often result in post-traumatic stress disorder (PTSD).[7] Anti-gay bullying, childhood abuse and racial discrimination are key sources of trauma in this cohort.

Childhood abuse, primarily emotional and psychological, is often compounded by homophobia within the black community.[8] Anti-gay bullying in childhood can affect self-acceptance and relationship development.[8] Additionally, racial discrimination is a pervasive traumatic experience for black individuals, resulting in anxiety, depression, and PTSD.[9] The intersection of these traumas exacerbates psychological distress among black queer men.

The therapists who took part in the study highlighted the persistent mental health and social challenges faced by black queer men who experienced trauma. As one participant noted, 'With a lot of my clients their experiences are rooted in abuse, rather than just coming to terms with identity. It's usually been quite a challenge.' [7]

The trauma for black queer men extends beyond these direct experiences to include family isolation and a lack of representation in the gay community. Another participant emphasised, 'There are too few social spaces for black queer men to meet and network.' The

60%

of black and minority ethnic LGBTQ+ participants in the UK experienced anxiety and depression

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GOOD PRACTICE

Working well with trauma in queer black men

1 Start slow

Clients need a safe place to feel heard and be curious, so focus on building trust, safety and rapport.

2 Be trauma-aware

Carefully consider the impact of accessing and managing repressed and recurrent traumatic memories.

3 Self-educate

Be curious and empathetic, and learn about the nuanced, intersectional experiences of black queer men – do not expect your client to educate you.

4 Consider self-disclosure

Being open and authentic about your sexuality and gender identity may help establish a strong working alliance.

5 Accept and affirm

Take a queer-affirming approach and fully accept clients' sexual identities.

participants further observed that their clients often felt traumatised by fetishisation within the gay community. One explained, 'I think [it's about] feeling in one sense objectified, fetishised and desired. The trauma has often been in the fact that people have used them and built them up to various levels but then wanted to try to diminish them and disempower them as well.'

Intersectional

Supporting black queer men in recovering from trauma necessitates addressing the profound impact of intersectional differences, such as black masculinity, ethnic identity and sexual orientation, on mental health, traumatic experiences and help-seeking behaviours. Traditional white, Eurocentric therapeutic and coaching frameworks often fall short in addressing the cultural and racial identities of clients from the African diaspora, failing to account for the impact of colonialism on perceptions of mental health and healing.[10]

A decolonised approach to therapy emphasises cultural competence, challenges power and privilege, and explores concepts of 'otherness'.[11] It highlights the significance of healing and recovery from trauma at both individual and collective levels. This approach further adopts an anti-oppressive framework, recognising that many responses to trauma are adaptive and understandable reactions to systemic oppression and historical violence. According to therapist and author Myira Khan, effective work with clients' intersectional differences requires acknowledging their lived experiences of power, privilege and oppression: 'To be blind to structural and systemic inequality is to be blind to our client's truth.'[12]

Queer-affirming approaches also play a crucial role by offering unconditional acceptance, helping therapists dismantle heteronormative ideologies and fully attend to the psychological challenges faced by LGBTQ+ clients.[13] One participant emphasised, 'I accept the diversity in the room. You just focus on the person-to-person relationship.'[7]

Alliance

Establishing a strong working alliance emerged as a pivotal theme in the study to foster effective trauma-informed interventions, echoing the emphasis of previous research on its critical role in effective practice.[14] One participant succinctly captured this sentiment, stating, 'The relationship itself is all. It's the only thing we have to work with.'[7]

To build this alliance participants highlighted the importance of being genuine, sharing their own experiences with sexuality, and valuing their clients through core therapeutic conditions. This authentic approach not only fostered trust but also minimised power dynamics, reinforcing intersectional and anti-oppressive practice. Black male participants in particular emphasised the need to eschew traditional masculine stereotypes and norms of blackness, with one participant noting, 'It's important to be really aware of ourselves in that relationship, not colluding with blackness or black maleness.'[7]

Challenges in establishing a working alliance presented in transference and countertransference – sometimes the therapist experienced transference by being positioned as a family member of the client, particularly one who had victimised them. Equally, therapists acknowledged their own countertransference by seeing their clients as family or friends whom they had wanted to help in the past.

These findings highlight the barriers posed by traditional black masculine gender norms and that a robust, authentic relationship is indispensable for clients to process and heal from their trauma.

African-centred

The practitioners who participated in the study often felt that European and white-centred therapeutic models were less helpful in addressing the trauma needs of black queer men. They suggested using an African-centred therapeutic framework that acknowledges and validates diverse cultural and racial identities. This was reflected by one participant: 'I have not found a great deal that has been helpful in European models of psychology and therapy in helping me engage with or work with black queer men.'[7]

Participants described a lack of knowledge gained during their core

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training of the intersectional differences that might impact this group and other populations. Much of UK core training has traditionally focused on European white models that work with diversity as a single difference from the white European norm. A more helpful approach may be for training to embrace intersectional differences and allow these to be fully explored in an authentic way using self and self-disclosure sensitively, with therapists questioning their own preconceptions or biases.

Action for change

Understanding systemic oppression and the impact of power and privilege enables trainee therapists to be consciously aware of their own knowledge base when working with clients. Training courses should consider working with an anti-oppressive model that acknowledges the systemic injustices of power, privilege and oppression. This enables a recognition of intersectional differences and how these context-based issues around the client also contribute to their distress. This is powerfully explored by Khan who discusses models that work *within* diversity.[11]

Addressing clients' intersectional identities within therapy can be part of practice and can be used therapeutically to repair rupture and transference within the therapeutic space. The therapists who participated in the study felt that simply working in a person-centred way without acknowledging these intersectional differences did not go far enough in opening up the therapeutic space and building the client's trust.[7] Openly addressing intersectional differences and the internal conflicts of their black queer male clients was also vital to progress in trauma recovery.

We also need to hear additional voices within the therapy professions talking about the intersectional differences that contribute to trauma experienced by clients. This study focused on black British queer males – it may be useful to incorporate additional other black queer experiences or ethnic minority queer experiences to contribute to further understanding of these intersectional differences.

A key responsibility as practitioners means working ethically with our clients and considering the context of their distress. The psychological distress experienced by our clients is often part of their experience, and with black male queer clients we need to ensure that we are not making the clients the problem by pathologising their experience but equipping ourselves to understand their struggles and distress.

* Names and identifiable details have been changed for anonymity.

REFERENCES

1. Bachmann CL, Gooch B. LGBT in Britain: health report. London: Stonewall/YouGov; 2018. **2.** Guasp A. Gay and bisexual men's health survey. London: Stonewall/Sigma Research; 2012. **3.** Balaji AB et al. Role flexing: how community, religion, and family shape the experiences of young black men who have sex with men. AIDS Patient Care STDS 2012; 26(12): 730-737. **4.** Booth NR et al. Masculine gender role stress and self-stigma of seeking help: the moderating roles of self-compassion and self-coldness. Journal of Counseling Psychology 2019; 66(6): 755-762. **5.** Young AA. Black men and black masculinity. Annual Review of Sociology 2021; 47: 437-457. **6.** Brine S. Men's health: inquiry progress. London: Health and Social Care Committee/House of Commons; 2024. bit.ly/3YEfn6a **7.** Davis AJ, Morahan M. Decolonising integrative practice with Black queer men who experienced trauma: a thematic analysis. Counselling and Psychotherapy Research 2024; 24(3): 1044-1056. **8.** Hart TA et al. Childhood maltreatment, bullying victimization, and psychological distress among gay and bisexual men. The Journal of Sex Research 2018; 55(4-5): 604-616. **9.** Carter RT et al. Relationships between trauma symptoms and race-based traumatic stress. Traumatology 2020; 26(1): 11-18. **10.** Mullan J. Decolonizing therapy: oppression, historical trauma, and politicizing your practice. New York: Norton; 2023. **11.** Turner D. Intersections of privilege and otherness in counselling and psychotherapy: mockingbird. Abingdon: Routledge; 2021. **12.** Khan M. Working within diversity: a reflective guide to anti-oppressive practice in counselling and therapy. London: Jessica Kingsley; 2023. **13.** Neves S, Davies D (eds). Relationally queer: a pink therapy guide for practitioners. Abingdon: Routledge; 2023. **14.** Flückiger C et al. The alliance in adult psychotherapy: a meta-analytic synthesis. Psychotherapy 2018; 55(4): 316-340.

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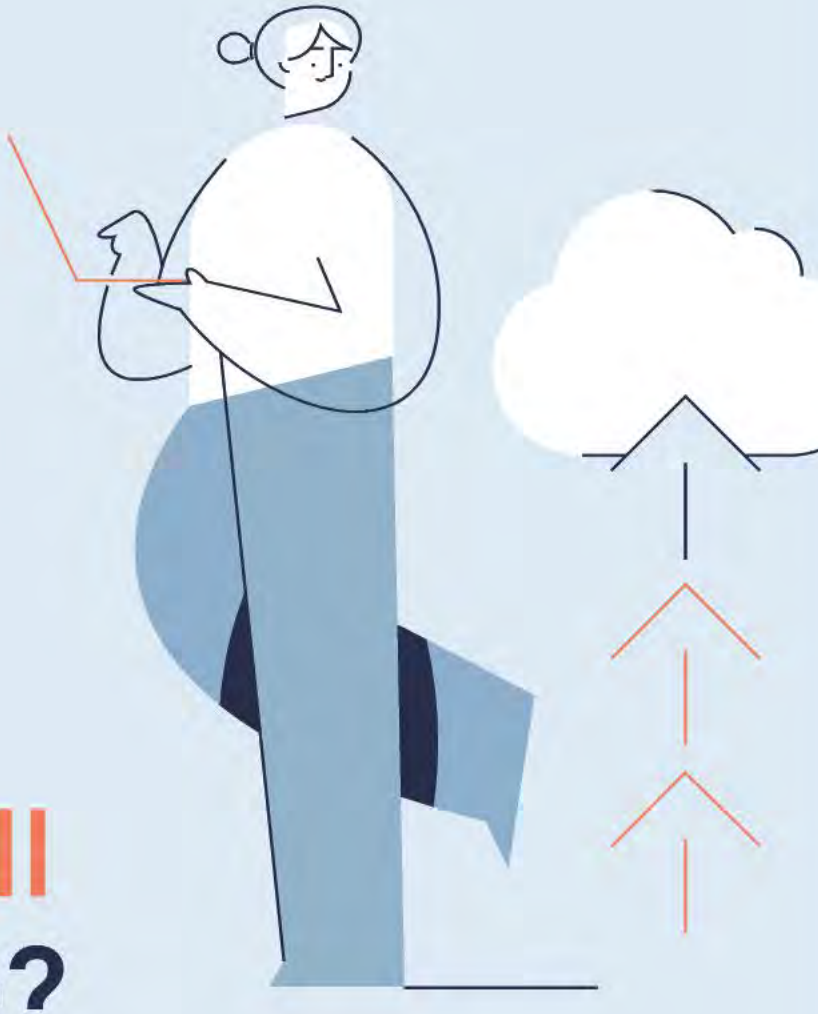

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Letting go with love

Monique Notice and **Felicity de Zulueta** describe a powerful intervention for overcoming attachment trauma in adults

Jean* came to a drug and alcohol unit in her 50s, seeking help after many years of alcoholism, and was assigned as a client to me (Monique). She reported drinking three bottles of wine a night and blacking out. I was becoming disheartened and began to doubt that she would ever give up drinking after many failed attempts at detoxing.

It was around this time that I learned about the traumatic attachment induction procedure (TAIP)[1] and considered whether it could be helpful for Jean, who had talked about how she had been brought up to feel dependent on her mother who had died several years previously. This simple technique has a powerful effect on improving the psychotherapeutic experience and outcomes in adult clients who have suffered childhood abuse and neglect, by helping them become more aware of their traumatic attachment and understand the role it plays in destructive behaviour and fear of change.

Dialogue

The idea was first introduced to Jean by describing a test we could use that might be helpful. Then during another session, when Jean was talking about her mother, I said, 'I think this is an ideal time to do this test.' I invited her adult self into the room by saying: 'You are 58, you have three children, you have achieved so much in your life. Imagine that your mother walks into this room now with you as a 58-year-old woman. I am going to ask you to repeat something after me that you might say to your mother and just note how it feels in your body and where you feel it. In she comes, she sits on that chair, and I want you to say these words out loud to her: "Mum, I am 58 years old, and I don't need you to care for me anymore like I did when I was a child."'

The dialogue between us then went as follows:

Jean: I couldn't, I couldn't say that.

Monique: Why not?

Jean: Well, I wouldn't say it, I wouldn't because I need her, you know as a person not so much as a child, yeah, you know.
Monique: What do you need her for?
Jean: For everything, for moral support, for comfort, for listening, for back-up.

Bearing in mind that her mother was no longer living, I was curious about Jean's need for her. She explained that she had been devastated when her mother moved 100 miles away from her when Jean was 40 years old, and that she needed her to be close so her mother could fight her battles for her and give her advice.

When she finally managed to say the words I had asked her to repeat, she reported a bodily sensation of feeling very empty, a feeling of 'a big empty hole because I really do need her'. Jean later reflected that she now realised that for years it was that 'big empty hole' that she was trying to fill with alcohol.

Origins

While running a year-long group for sexually abused women in the Maudsley Hospital Traumatic Stress Service, I (Felicity) found that the best outcomes were seen in those who overcame their traumatic attachment by grieving the loss of their idealised but unavailable parent. A key part of this process was being able to say with conviction and without fear: 'Mum, I do not need you anymore as I did as a child.' When interviewed after six months, these same women were successfully getting on with their lives and reporting that their relationships with their actual mothers had markedly improved. We measured symptoms and levels of dissociation before and after psychotherapy and noted that both had returned to normal levels. This successful form of group therapy was then taken up by the South London and Maudsley NHS Foundation Trust and used for survivors of sexual abuse in childhood.

These observations led to the development in 2005 of the TAIP, a procedure specifically designed to facilitate this process. Several therapists were trained at the Maudsley Hospital Traumatic Stress Service to use the TAIP with patients suffering from the effects of abuse, neglect and trauma, until my retirement from the NHS in 2011. Now training is available for its use by therapists in private practice.

The aim of using the TAIP is to find out if, underlying many of the adult client's difficulties in progressing in therapy, there is a hitherto implicit or unconscious younger child self who is strongly attached to an idealised caregiver from whom they still hope to finally get the care and love they yearn for by remaining needy and helpless. The TAIP brings this embodied experience to the client's awareness, helping them to let go, make use of therapy and finally start to thrive. This article will describe the theory behind the TAIP and how it can be used in practice.

Roots of trauma

The human infant's utter dependency on its primary caregiver in early development means that, should the caregiver become unavailable or threatening, they can neither fight nor flee but they can freeze and thereby disconnect. It is at this point that the infant brain adopts an alternative developmental mode referred to as traumatic attachment, with the potential to develop different mindsets that ensure its survival in a frightening world where others cannot be trusted. Some of the clients we meet in our therapy rooms may be those for whom the cost of these ways of feeling, thinking and behaving have outweighed their benefits – they suffer from the effects of addiction, prolonged grief, domestic and other forms of violence, borderline personality disorder and developmental or complex trauma.

If we look at research carried out on infants who have suffered from abuse or neglect using the 'strange situation', a structured separation test originally developed by Ainsworth to observe how infants respond to a time-limited separation from their caregiver, there is often a dysregulated and disorganised attachment response towards their terrifying caregiver.[2] These infants find themselves in a state of 'fear without solution' as their secure base, represented by their attachment figure, has also become the source of their terror.[2]

When in a state of fear without solution the infant's autonomic response to danger comes into play involving the fight, flight or freeze responses we share with other mammals.

The fight-flight response, mediated by the sympathetic component of the autonomic nervous system, results in increased heart rate, blood pressure, respiration and muscle tone as well as hypervigilance. The thyroid system is stimulated as is the hypothalamic pituitary axis, releasing high levels of cortisol. As symbolic processing is not possible in such states, these traumatic experiences are stored in sensory, somatic, behavioural and affective states.[3] The terrifying caregiver not only dysregulates the infant but, in addition, they do not attempt to repair the damage, so the child is left at the mercy of these states that interrupt normal development.

However, if the fight-flight reaction is not possible a second reaction takes place, and the infant freezes as other mammals do in similar circumstances – in this way they conserve energy or feign death and thereby foster survival. Numbing of pain occurs through the release of endogenous opiates, and immobility is achieved through detachment dissociation. Cortisol levels are elevated and there is a decrease in blood pressure, metabolic activity and heart rate. Infants who are abused or neglected by a primary caregiver face a situation of fear without solution – this activates both responses and results in the

'The human infant's utter dependency on its primary caregiver in early development means that, should the caregiver become unavailable or threatening, they can neither fight nor flee but can freeze and thereby disconnect'

GOOD PRACTICE

- It can be useful for both therapist and client to record the TAIP sessions (with client consent). A video recording is useful because it allows the client and therapist to revisit the experience in subsequent sessions.
- Prior to conducting the TAIP it is important to ascertain the client's level of dissociation. Clients who score over 40 on the dissociation experiences scale (DES),[10] a 28-item self-rating questionnaire measuring dissociation, need a longer period of preparatory work focusing on emotional stabilisation before carrying out the TAIP. It is contraindicated for use in clients who suffer from high levels of dissociation such as dissociative identity disorder.
- For therapists who work with adults who suffer from the symptoms of complex or developmental post-traumatic stress disorder, it is important to note that we have never triggered a flashback when using the TAIP. One theory is that it may involve a different part of the brain.

human infant experiencing an inward flight from the source of danger. This process results in 'structural dissociation', a splitting of the self that takes place for the infant to survive.

As Schore put it when describing the formation of traumatic attachment, these children (and later adults) will resort to dissociation to maintain their attachment to their desperately needed caregiver: 'They will develop an idealised attachment to their parent by dissociating off their terrifying memories of being abused. The resulting working models are those of an idealised attachment relation and that of a dysregulated self in interaction with a mis-attuning and frightening other'.[4] These internal working models are internal representations of how the attachment figure is likely to respond to the child's attachment behaviour.[5]

Thus, the different dissociated states of the child in relation to the terrifying caregiver will develop around the fulcrum of the idealised attachment to that same caregiver. The result is the creation of 'self-states' or different representations of themselves in relation to their caregiver. These are found in those who suffer from fairly common disorders such as addiction or prolonged grief, or from disorders with higher levels of dissociation resulting in a lack of self-continuity in relation to the other, such as borderline personality disorder and other dissociative disorders.[6,7] All these individuals suffer to a varying degree from an inability to regulate their emotions, to empathise and mentalise.

'To individuals who are traumatically attached to their parent, proclaiming their independence can feel at that moment as devastating as it does for a child who is abandoned by a parent on whom they depend for survival'

Strange situation

The TAIP is based on a simplified version of Ainsworth's strange situation by creating an imaginary separation between the client and their abusive caregiver. It reveals either their idealised or their dysregulated internal working models in relation to their abusive or neglectful caregiver whom they are invited to imagine sitting in the same room as them.

An attuned and trusting relationship must first be established between therapist and client before the TAIP is introduced. At the appropriate moment the therapist explains how helpful this intervention can be in making sense of the client's problems. This usually takes place when the client is ready to explore in depth their relationship with their primary caregiver.

When the client says they feel ready to carry out the TAIP the therapist will start by asking the client to remind them of their age and achievements, to make sure that the adult self is ready to carry out the procedure. The client is then invited to imagine that their mother, or other primary caregiver, is sitting in the room. The therapist then asks the client to say the following words: 'Mum, I don't need you anymore, as I did when I was a child' (or words to that effect), while noticing what bodily sensations come up during this imaginary exercise.

The value of the TAIP experience lies in the fact that the adult self of a traumatically attached individual finds that what they initially thought would be quite easy – telling an imaginary mother or father that they no longer need them as they did as a child – turns out to be

very difficult or seemingly impossible because of the fear it elicits.

Making sense of this discovery is what follows in the session and is achieved with the attuned support of the therapist. If a traumatic attachment is present it means that a child self is also present within the client, and repeating these specific words usually evokes an extreme fear response, as was elicited in infants with a disorganised attachment in the strange situation test.[2] This fear response makes the heart beat faster, and there is a tightening sensation of the stomach and chest. Often speaking becomes difficult as the client feels afraid to say the specific words.

With the gentle encouragement of the therapist the client's adult self finally repeats their choice of words to their caregiver, and the client's body responds as it did all those years ago when interacting with the frightening parent – 'the body holds the score'.[8] The elementary self-system in the brain stem and limbic system is activated when faced with the threat of annihilation, which results in an overwhelming sense of terror. To individuals who are traumatically attached to their parent, proclaiming their independence can feel at that moment as devastating as it does for a child who is abandoned by a parent on whom they depend for survival.

However, it is important to point out that when the TAIP is used for the first time this interaction does not last more than one or two minutes. At this point the therapist will gently invite the client to share what they are feeling and thinking and to report any bodily sensations.

Acknowledging their bodily manifestations can help the client understand the connection between their traumatic attachment and the felt emotions in the body, which may have led in the past to the client trying to overcome these distressing emotions through self-medication, leading to addiction or other symptoms of dissociation. In the process of sharing their very powerful emotions and bodily feelings with their attuned therapist clients become increasingly aware, both cognitively and somatically, of the presence of their extremely needy or terrified younger self. In doing so, the adult and child selves can begin to come together and begin a path to healing the dissociation that is at the root of the problem. The therapeutic journey will then involve letting go and mourning their idealised parent as clients come to recognise that they can now survive and develop as competent adults.

Unresolved grief

Over the next 12 sessions, Jean was able to mourn the loss of her mother, overcoming her unresolved grief. The integration of her dissociated self, triggered by the experience of the TAIP, meant that her addiction could finally end. I recently heard that nearly 10 years later she is still not drinking alcohol.

The use of the TAIP in this case revealed that Jean's previous inability to make use of therapy was the result of the unconscious traumatically attached internal working model of her child self. Her recovery from her addiction and from her unresolved grief illustrates just how effective the TAIP can be for clients who suffer from an apparent resistance to therapeutic change.

Wider applications

The TAIP has also proved to be a powerful tool in revealing and healing some of the psychopathology underpinning borderline personality disorders and dysfunctional violent behaviour in individuals with a history of childhood abuse and neglect.[9]

It has the additional merit of making people aware of their traumatic attachments in a very concrete way through their yearning and/or fear response. It has also become increasingly evident to us that it facilitates the integration of the childhood self-state and thereby heals the underlying structural dissociation – in so doing, the TAIP promotes healing of the self and wellbeing. Perhaps most importantly it provides us with an alternative explanation for clients labelled as 'resistant' to therapy, or the therapy as having failed. ●

* Name and identifiable details have been changed.

• TAIP training enquiries can be made via **newmeanings.co.uk**

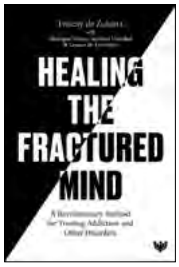
REFERENCES

1. de Zulueta F. Inducing traumatic attachment in adults with a history of child abuse: forensic applications. The British Journal of Forensic Practice 2006; 8(3): 4-15. **2.** Hesse E, Main M. Disorganized infant, child, and adult attachment: collapse in behavioral and attentional strategies. Journal of the American Psychoanalytic Association 2000; 48(4): 1097-1127. **3.** Perry BD et al. Childhood trauma, the neurobiology of adaptation, and 'use-dependent' development of the brain: how 'states' become 'traits'. Infant Mental Health Journal 1995; 16(4): 271-291. **4.** Schore AN. The effects of early relational trauma on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal 2001; 22(1-2): 201-269. **5.** Bowlby J. A Secure Base: clinical applications of attachment theory. London: Routledge; 1988. **6.** Ryle A. The structure and development of borderline personality disorder: a proposed model. British Journal of Psychiatry 1997; 170: 82-87. **7.** Ogawa JR et al. Development and the fragmented self: longitudinal study of dissociative symptomatology in a nonclinical sample. Development and Psychopathology 1997; 9(4): 855-879. **8.** van der Kolk B. The body keeps the score. London: Penguin; 2015. **9.** de Zulueta F. Post-traumatic stress disorder and attachment: possible links with borderline personality disorder. Advances in Psychiatric Treatment 2009; 15(3): 172-180. **10.** Bernstein EM, Putnam FW. Development, reliability, and validity of a dissociation scale. The Journal of Nervous and Mental Disease 1986; 174(12): 727-735.

ABOUT THE AUTHORS

Monique Notice MBACP (Accred) is a psychotherapist in private practice. She is one of three co-authors alongside Felicity de Zulueta of *Healing the Fractured Mind: a revolutionary method for treating addiction and other disorders*, recently published by Karnac.

Dr Felicity de Zulueta is an emeritus consultant psychiatrist in psychotherapy at the South London and Maudsley NHS Foundation Trust.



It changed my life

‘Seeking help is a courageous act of self-care’

My journey to therapy began in 2018 when, after years of battling depression and anxiety, I found myself in a mental health crisis. I had been living and working abroad for almost 20 years, enjoying a fulfilled life. What I didn’t realise until it was almost too late was that focusing on my career and burning the candle at both ends would eventually take its toll. I had replaced my real needs with money, trinkets, flash holidays and an expensive lifestyle, never thinking my life would come crashing down. But it did, and losing my last job was the traumatic tipping point.

The weight of my experiences and the stigma surrounding mental health made me hesitant to seek help. The real wake-up call came with my first suicide attempt, and the realisation that I could no longer navigate these turbulent waters alone. Despite my reservations I decided to seek professional help. It turned out to be one of the most transformative choices of my life, but finding the right therapy was anything but straightforward.

At every assessment I was told that finding a black therapist would either take too long or wasn’t possible. Every time I attended therapy in person or online I was seen by a white, middle-aged woman. Although some were great it gave me insight into why so many black men either don’t engage with therapy in the first place or drop out soon after.

I ended up experimenting with various forms of therapy, which at times felt like wandering through a maze, encountering confusion, dead ends and frustration. I went to The Listening Place charity, which was brilliant, particularly for someone facing chronic loneliness and social isolation. I also attended several men’s peer support groups, which was a humbling experience, listening to the stories.

I decided to use my previous networking skills to find the help I needed, and scoured the internet to find anything that might help. But the language on many mental health websites didn’t resonate with me, and I rarely saw content that fully represented ethnic diversity. I often wouldn’t hear back when I filled in their self-referral forms.

When I eventually found a black therapist it was a game changer. The shared cultural understanding not only made it easier to discuss issues related to race and identity, it fostered a sense of safety and trust in ways I had not experienced before in a therapeutic setting. With the right therapist I could begin the hard work of unravelling the complex layers of my experiences, exploring the interplay of past traumas and more recent stressors. Each session felt like a step closer to self-awareness and healing, which was a huge sense of relief.

As the US Navy SEALs say: ‘Work the problem.’ This mindset helped me identify different approaches to tackle difficult issues. Don’t be mistaken; I’m no Navy SEAL– far from it. But I do love military shows, my favourite being *SEAL Team*.

As my most recent therapy journey neared its conclusion I felt a mix of gratitude and apprehension. Although I left with helpful tools and insights I still have setbacks that can bring back feelings of guilt and inadequacy. However, one significant breakthrough has been understanding the importance of self-compassion. I had always been my harshest critic, but therapy has taught me to treat myself with the same kindness I would offer a friend. This shift in perspective has liberated me and paved the way for deeper emotional healing.

Therapy helped me purge the mental and emotional burdens that weighed me down, allowing me to emerge stronger and more resilient. It also gave me the courage to share my story and advocate for mental health awareness.

Entering therapy was a daunting but necessary step, the start of a journey of self-exploration and healing that transformed my life. I encourage anyone considering therapy to take that first step. Despite the challenges the journey is worth it. Therapy is not a place of judgment but a space for healing and growth. Your mental health matters, and seeking help is a courageous act of self-care.

USTYNA SHEVCHUK/SHUTTERSTOCK

ABOUT THE AUTHOR

Chris Frederick is an expert by experience who works with charities and other organisations to support better mental health for the black community, after surviving his own breakdown. A passionate *Star Wars* fan, Chris proudly considers himself a ‘mental health Jedi’.

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SHOULD I DISCLOSE MY ADHD DIAGNOSIS TO CLIENTS?

Q I was recently diagnosed with ADHD and have been going through a reassessment of my life and identity, which has felt very significant. So far I have said nothing to clients but at some point I would like to include this in the biographical details on my website as I feel it is important to embrace the diagnosis and not hide. But how do I let existing clients know about this in a way that doesn't affect the work?

A

Karen Stainsby replies:
A major life event, this diagnosis may still seem quite new, perhaps even raw. You may be feeling shock, relief, validation, anger and grief, or maybe something else. Reflecting on how it might affect your work is important. But might it be useful to take a broader view, starting with its impact on you?

Here are some initial thoughts...

While some people regard ADHD as causing difficulties in their life, others see themselves as experiencing positive aspects or having strengths. These may include an enhanced ability to think flexibly, notice patterns easily or respond well in a crisis. ADHD may well have contributed to shape who you are today, and your experience of it is unique to you.

However, this diagnosis has led to an existential reappraisal making you consider your past, present and future identities (*Ethical Framework*, personal moral qualities: identity). Perhaps you sought it in response to emotional, reasoning and behavioural challenges that may have impacted your mental health and wellbeing.

While it's early days, medication may have been offered, which could involve trying different treatments and dosages in order to find the best fit. You might also have to manage medication side effects.

Now, turning to you as a practitioner:
For a diagnosis, symptoms must have caused significant difficulties in at least two areas of your daily life – for example, at home, in education or employment, relationships or housing.[1] So it's important to ensure that despite these difficulties, you are still working to professional standards (Our commitment to clients, 1b and 2d).

You may have lived alongside your ADHD and been managing symptoms for some time, but having now got your diagnosis, could it be helpful to think about putting in more support for running your practice, for example, an appointment reminder system if forgetfulness is a problem for you? Is it appropriate to revisit your contract or talk about any additional practicalities with your clients? It's important we know how clients see our work, so does your review process still feel adequate?

Occasionally we realise we're looking through the lens of our experience rather than that of our client. Has this happened in regard to ADHD? Similarly, if a client with ADHD brings an unconnected presenting issue, might there be a danger that unhelpful links are made (Commitment 3a, Good Practice, point 22h)?

Some clients will have lived successfully with ADHD for some time. Might you feel tempted to actively learn some tips (Good Practice, point 22g)? Could your diagnosis be seen as granting you 'permission' to delve into uninvited areas that compromise your client's privacy and dignity (Good Practice, point 21)?

Finally, you want to 'embrace' your diagnosis and 'not hide'. Might you unintentionally communicate this in a way that pressurises clients to do likewise?

Self-disclosure

Moving on to disclosing your diagnosis, I wonder about a few things:

- Therapist personality and therapeutic style will influence thinking around disclosures as much as client-related or contextual factors. Modality will also play a part. Remember that disclosure should only be made for the benefit of the client ('put clients first'). Disclosures should be brief, with the focus brought back to the client.

VELVESTUDIO/SHUTTERSTOCK

- It is vital for both our clients and us that we remember that once known, a fact can never become unknown. You don't want your disclosure to affect the work but I think that's unavoidable. Its impact may be felt immediately or surface later in the work.
- However, well-judged and timed disclosures can help create authentic relationships, convey similarity, humanise therapists and address power imbalances. Working with transparency and candour are important, but this doesn't mean clients have the right to know everything about us (Principles: being trustworthy; personal moral qualities: integrity).

And that raises questions in my mind:

- It's wise to disclose only about issues we've come to terms with. Are you, understandably, still in a period of adjustment and adaptation?
- Who benefits from telling clients you have ADHD? Is it clinically relevant? Might it hinder the therapeutic relationship and work? Might it help the work in some way (Principles: beneficence)? Could it harm any of your clients (Principles: non-maleficence)?
- What information might you tell them? Would you limit this solely to a statement of your diagnosis, or tell them about other aspects of your experience? Would this vary between clients?

'Working with transparency and candour are important, but this doesn't mean clients have the right to know everything about us'

- While we can't anticipate every question a client might ask about us, there may be some regarding your ADHD that you don't want to answer. It may be best to be prepared. Are there any no-go areas?
- Is it possible that a client could question your resilience, feel burdened by the information or confused about the relevance of your disclosure to them? If they want to end therapy with you now, how might you handle that?
- Often when a self-disclosure is discussed in supervision it's already happened. Have you spoken with your supervisor about making a disclosure?

Guidance on self-disclosure can be found in the *Ethical Framework* (Good Practice, points 43-45) and the Good Practice in Action resource *Practitioner self-disclosure in the counselling professions* (GPiA 117).

Updating your website

This is another area that might benefit from some further thinking through. This diagnosis is very sensitive personal/medical information. Once published on the internet you've little control over it, even if you later delete it.

You want to embrace the diagnosis but what does that mean? You say you don't want to hide – I wonder, is there unprocessed shame? Might telling the world, which is what we do when we publish information online, be addressing a personal as well as professional need?

While it could offer prospective clients more information to help them choose a therapist (Principle: autonomy) it may also influence the neurological profile of people contacting you and could suggest an expertise in ADHD (Commitment 2a, Good Practice, point 13). If in the future you decided to work with ADHD as an expertise, while lived experience could be hugely informative, having some specialist training would be appropriate. If however you do not intend to specialise or get training in working with clients with ADHD, then you need to think about how you make it clear on your website that this is not a specialism,

although you have lived experience of neurodivergence.

If you go ahead with updating your website, do ensure you tell current clients beforehand. But what about past clients? There's nothing to stop them looking at your website. How might your disclosure impact that past work? Will you mention your ADHD to future clients or are you relying on them having seen it on your website?

Self-care

Self-care is an ethical responsibility (Good Practice, point 91) and perhaps now even more relevant for you. Might personal therapy be appropriate at the moment (Good Practice, point 91c)? Your work-life balance and energy levels may need more careful management as symptoms could be more challenging if you're tired or stressed. Part of looking after yourself might be to think about time, diary and financial management.

How might you respond if a client behaves in a challenging or discriminatory way towards you? How would you balance your right to safety and dignity with putting the client's interests first? Have you considered how you might protect yourself from psychological or even physical harm?

Supervision

Supervision is essential to safe and effective work, and several key questions stand out for me. Does your supervisor know about your diagnosis and any difficulties you might have been having? Have you discussed disclosing your diagnosis with them? What part can supervision play in helping you to address how you manage your client work, fitness to practise and self-care?

A final thought

You are going through a significant life change and period of adaptation. At the moment I think staying 'closer to home' and thinking more about how this diagnosis affects you as a person would be helpful. With this perhaps more anchored viewpoint you can then think further about your practice, including whether and how you make any disclosures.

KAREN STAINSBY MBACP is senior accredited as both counsellor and supervisor and practises in Surrey. She also provides various professional services to BACP.

This column is reviewed by an ethics panel of experienced practitioners.

REFERENCE

1. Royal College of Psychiatrists. ADHD in adults. [Online.] June 2023. bit.ly/4dJf929

READER RESPONSES

Self-disclosure can deepen relationships

After years of slowly recognising the various challenges I face in life, I was diagnosed this year with combined type ADHD. For me this was a powerful, affirming and liberating experience, a journey of understanding that I am still undertaking. I wanted to share my diagnosis with friends and colleagues to help me unmask, begin to feel better understood and be more authentic. As so many responded by indicating they already knew I was neurodivergent, I realised how unwittingly unauthentic I have been all my life. Being authentic with clients has always been extremely important in creating a safe, trusting space for them. I questioned how many of my neurodivergent clients and supervisees over the years had recognised my neurodivergence and wondered why I did not acknowledge it as we explored their own.

I began by sharing my diagnosis with my supervisees, as many of them are neurodivergent. Their responses affirmed the importance of being fully authentic with clients, and encouraged me to consider how I would share my neurodivergence with them. I started by sharing with existing clients who were already exploring their neurodivergence. This deepened the relationships and shifted how we explore neurodivergence as they could see I understand more fully their struggles.

With neurotypical and new clients I simply mentioned that I am using a fidget toy as I have ADHD. I have had entirely positive responses and curiosity about their own neurodivergence. My use of fidget toys has also enabled clients to feel comfortable bringing their own. I want to mentor, support and encourage other neurodivergent counsellors to feel safe and comfortable in sharing who they are.

SARAH WORLEY-JAMES MBACP (SNR ACCRED) is a humanistic-existential counsellor and supervisor and author of *Online Counselling: an essential guide* (PCCS Books). sarahworleyjames.life

SUPPORT AND RESOURCES

You can find more information in the following BACP Good Practice in Action resources, available online at bacp.co.uk/gpia

- *Making the contract in the counselling professions* (**GPiA 055**)
- *Fitness to practise in the counselling professions* (**GPiA 078** Fact sheet; **GPiA 094** Clinical reflections for practice)
- *Self-care for the counselling professions* (**GPiA 088**)
- *Practitioner self-disclosure in the counselling professions* (**GPiA 117**)
- *Contracting for adults across the counselling professions* (**GPiA 130**)

It may not always feel necessary to share a diagnosis

As with any self-disclosure it can be helpful to ask why and for whose benefit we are sharing a particular aspect of ourselves. This was a question I considered with participants in my recent research about counsellors with ADHD. For them, and indeed in my own experience, disclosing their neurodivergence had been significant in creating a shared understanding with clients. This was particularly true for those clients who were also neurodivergent or from other minority groups. These disclosures were not universal, however, and it may not always feel necessary to share a late diagnosis with your existing caseload.

You may like to consider whether doing so would help to explain a particular dynamic or barrier you've experienced in your work, or benefit the relationship in some other way. For me disclosing is always with the awareness that my experience is my own, and of what aspects of that experience I choose to keep for myself. The latter may be an important consideration as you describe your diagnosis as recent and of having gone through a significant reassessment of identity.

I am mindful that you are keen to embrace and not hide from your diagnosis, and I too am passionate about making space for neurodivergent voices within the profession. At times this can be about sharing our experiences, though at others an awareness and acceptance of ourselves can be demonstrative enough of congruence and authenticity, and an important first step.

MEGAN LEWIS MBACP is a person-centred counsellor and published researcher in the areas of ADHD, neurodiversity and grief.
meganlewiscounselling.co.uk

VELVESTUDIO/SHUTTERSTOCK

'As with any self-disclosure it can be helpful to ask why and for whose benefit we are sharing a particular aspect of ourselves'

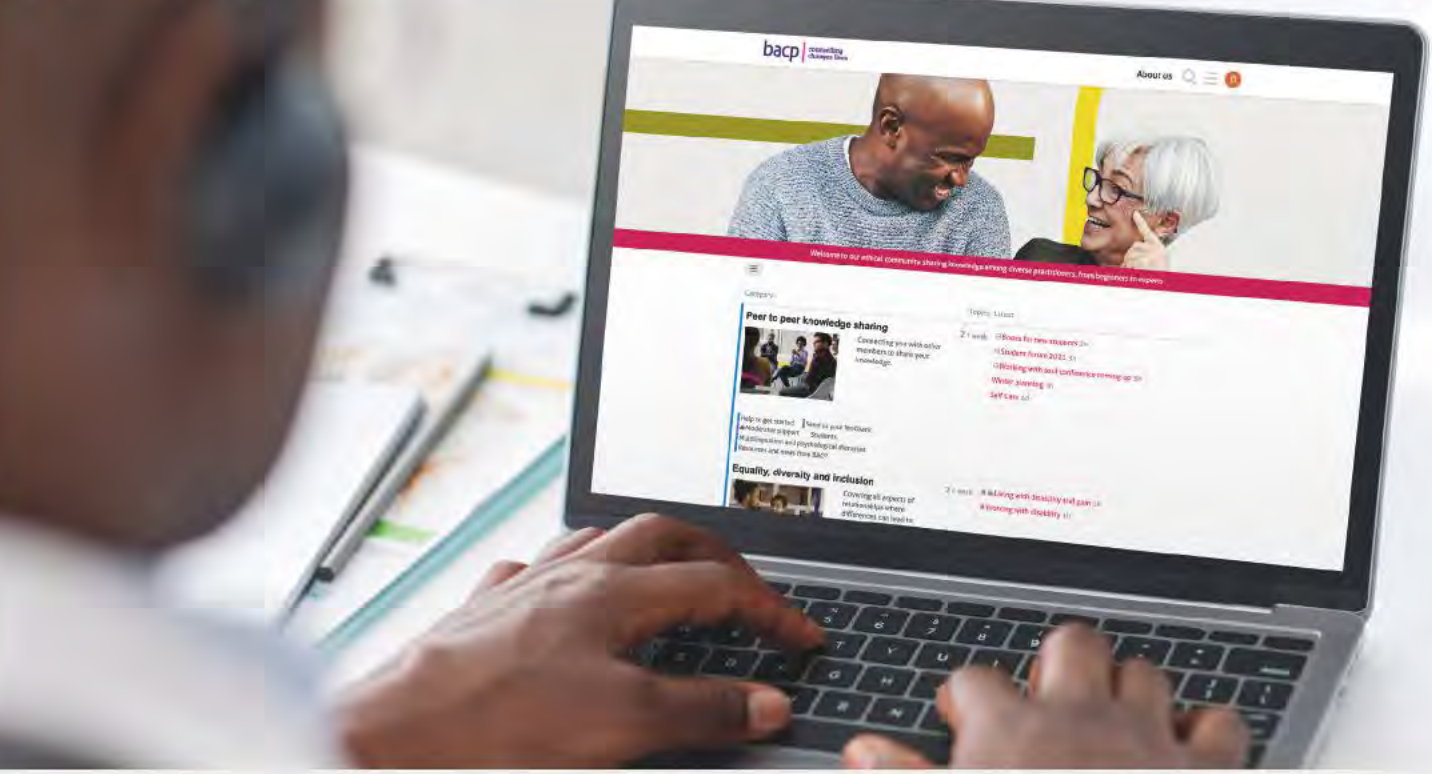
Self-disclosure can help clients move forward

Personally, I don't see bringing up my ADHD as an issue. I find self-disclosure can help clients move forward if lived experience is important for them. At times clients may deviate from an issue and I unconsciously go along with it, as two people with ADHD together who ping off each other and go down rabbit holes while eventually coming back to the original point. Noticing this together can lighten the mood and make clients feel less judged.

However, I've worked with many organisations who frown on self-disclosure, and while self-disclosure can help build rapport, therapists are able to build it without disclosure. So it really should be considered on a case-by-case basis. I like to keep it simple by reflecting on the motive for disclosing. Are we making this about ourself in some way? Is it to make us feel better, or to help our client?

I have worked with charitable organisations as well as in the NHS, prison and private sector for 15 years. Many clients I have worked with have stated that previous therapists appeared 'cold' by giving nothing away – that's not to suggest the therapists were wrong, it's a matter of perspective. However, the 'blank slate' approach can make therapists appear out of touch in today's world. You are asking somebody to get vulnerable, and if they find it hard to trust this can be difficult.

TANER HASSAN MBACP is an integrative counsellor, psychotherapist and clinical supervisor.
taner-hassan.com



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A

Pause and give it some consideration

I am a clinical psychologist with ADHD supporting clients with ADHD in my private practice, many of whom come to me because of my personal and professional experience in the area. So my own diagnosis is relevant and clients often tell me that it's helpful for them as they wanted someone who truly understands the challenges of ADHD and who can adapt their therapy accordingly.

However, I also have another area of specialism – infertility and baby loss. I don't disclose my ADHD to clients seeking this support and it doesn't feature in my profile on my infertility and baby loss website because these clients are unlikely to benefit from knowing about it.

I understand the desire to unmask and be who you are as someone with late-diagnosed ADHD, and it is important. However, when it comes to publicising a personal diagnosis on a website bio, it makes sense to pause and give it some consideration. Is your aim to help clients embrace their own neurodivergence? If not, would it be better to embrace your diagnosis personally, and only disclose to clients on a one-to-one basis, when there is a clear rationale for it being helpful for that client?

DR KARA DAVEY HCPC is a senior clinical psychologist, speaker and consultant.
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HOW WOULD YOU RESPOND?

We welcome members' responses to these upcoming dilemmas. You don't have to be an expert – if a question resonates with you, do share your experiences or reflections with your peers. We welcome brief or longer responses (up to 350 words) by the deadline below. Email your response or any questions to therapytoday@thinkpublishing.co.uk

Is it OK to work from home with children in the house?

December 2024/January 2025

I would like to run my private practice from home to save money and could use our family living room as a counselling room as it is right next to the front door. I have invested in a white noise machine to sit outside the room for confidentiality but it's likely that early evening and Saturday morning clients may hear the sounds of family life as they enter and leave (my two school-age children and partner). I will ask them to keep the noise down but I don't think I can expect them to be completely silent. I wonder what the implications of this may be? **Deadline:** 10 October

Can I supervise a former therapy client?

February 2025

A therapy client I worked with for around 10 sessions came back to me three years later for therapy as a student as he had decided to train as a therapist. I discussed the boundary issues in supervision but as the original work had been short term and ended some time previously we decided it was OK. I saw him for around two years during his training and he qualified 18 months ago. He recently approached me about supervision – I would like to take him on but wondered how I ensure I am his supervisor rather than therapist given our history? **Deadline:** 10 November

The dilemmas reported here are typical of those worked with by BACP's Ethics Services. BACP members are entitled to access this consultation service free of charge. Appointments can be booked via the Ethics hub on the BACP website.

VELVESTUDIO/SHUTTERSTOCK

Keeping clients safe

Susan Dale explores how ethical concerns for both clients and members are informing the *Ethical Framework* review

As a practitioner I am passionate about ethics and see it as being at the heart of everything I do. For me ethics is not just about using an *Ethical Framework* to determine what to do in a crisis – it is part of every aspect of the relationships I have with clients, supervisees, trainees and colleagues. The decisions and choices I make within my work, however small, are all underpinned by my internalised ethical principles, values and the models that shape who I am as a therapist, trainer, supervisor and BACP staff member. I see the *Ethical Framework* as important in that it aims to articulate an agreed stance on what ethics mean in respect of the counselling professions, and how we can embed ethical thinking within practice. It is also how I am held accountable to working to acceptable professional standards.

I was part of the review team for the 2016 and 2018 frameworks, so I am delighted to be supporting the current review. Following a period of consultation with members, accredited courses and services, we are now analysing the data collected so far. Thank you to all those who took time to give us your feedback – this helps us understand how members use the framework in their practice, and what they feel they need in the future.

Alongside the consultation feedback we are also looking at data collated on themes from the Professional Conduct team on client complaints, as well as member and client queries about ethical issues and dilemmas. These insights into what members and clients are finding challenging help give us an understanding of what we need to work on to ensure members have an *Ethical Framework* and Good Practice in Action resources that support their practice.

To understand more about the stories behind the statistics, I talked to Sarah Millward, BACP Client Ethics Manager, who runs the Get Help With Counselling Concerns service, and Patrick Cawley,

ALEX WILLIAMSON/IKON IMAGES

BACP Ethics Services Manager, who manages the team who respond to members' ethics enquiries.

I started by asking them for some background information, before moving on to the themes raised by clients and members.

Susan: Tell us a bit about your roles at BACP.

***Sarah*:** I've worked at BACP for more than 16 years now, and I've been working on the Get Help With Counselling Concerns service since its inception in September 2012, so nearly 12 years. We offer members of the public confidential telephone and email guidance on what to do if they have any concerns about their therapy or therapist. I currently run the service by myself since a colleague retired in March of this year. However, we have successfully recruited someone to help me run the service, and they'll start working with me from January 2025.

***Patrick*:** I've worked as the Ethics Services Manager for three-and-a-half years, overseeing the services and resources that support members with ethical concerns. I work alongside five Ethics Officers (most working part time) who have a wide mixture of experience and expertise in many aspects of counselling and psychotherapy, including working with children and young people, trauma, organisations and supervision, as well as expertise in ethical decision making.

Susan: Roughly how many people contact the services each month?

***Sarah*:** I currently respond to around 150-170 enquiries to the Get Help service a month, via both email and phone. This may not sound like a huge number, but the enquiries are often very complex and can take some time to respond to – the thinking time is also important! However, as we don't limit the number of times a person can access the service, this number doesn't necessarily relate to new enquiries.

***Patrick*:** We respond to around 900 queries to the Ethics service each month from members via email or phone appointments, plus every month we answer about 250 queries from members that are passed on to us by different BACP departments. We also support

'We offer members of the public confidential telephone and email guidance on what to do if they have concerns about their therapy or therapist'

Sarah Millward, BACP Client Ethics Manager

ETHICAL FRAMEWORK REVIEW: NEXT STEPS

1. The data and feedback collected so far will continue to be analysed.
2. Summaries of the data will be shared on the BACP website.
3. Recommendations will be made.
4. A draft for an updated *Ethical Framework* will be produced.
5. A consultation process on this draft will open in 2025.

'People can be under the impression that BACP is a regulator rather than a membership body, meaning they will get a "yes" or "no" answer to their dilemma and there will be specific rules' **Patrick Cawley, BACP Ethics Services Manager**

members through the Ethics hub, and through our latest updates on topics such as international working and online platforms.

Susan: What are the most common themes and have these changed over the years?
***Sarah*:** I would say that themes in client concerns have remained fairly consistent over the years, and enquiries regarding professional boundaries certainly continue to remain at the top of the leader board. Other themes may fluctuate but I'd say that endings, contracting, record keeping and confidentiality are in the top five.

***Patrick*:** The most common themes in ethical concerns from members coming through the service at the moment are around international working, working online and artificial intelligence (AI). These sit alongside the regular queries we get on supervision, working with children and young people, and confidentiality – particularly access to notes. Since I've been in post, the queries we receive have become much more complex in nature. For example, we often get queries relating to when an organisation updates their processes and how this links to the *Ethical Framework*. We also get a lot of complex queries from training institutes about students' suitability or competence to practise.

Susan: Are safeguarding concerns common and how do you deal with them?
***Sarah*:** If you mean safeguarding concerns regarding the members of the public contacting the service then thankfully these are very few and far between. However, the service does occasionally deal with safeguarding concerns about a member, perhaps from a Local Authority Designated Officer, whose role is to co-ordinate the safeguarding and investigative process in response to allegations made against people working with children. In these cases I'm able to explain BACP's remit and how we can look at the concerns on a more formal basis via our complaints process. We have an amazing Safeguarding Lead too, Jo Holmes, who is also BACP's Children, Young People and Families Lead, and who heads up a small safeguarding team within BACP, which is invaluable.

***Patrick*:** Out of the 120 safeguarding concerns logged by BACP over the past year, 75% of these had come into the Ethics service. If we have a safeguarding concern, the Ethics Officer will formally log the safeguarding concern with BACP's Safeguarding Lead who then manages the process. We always support the member and advise them to contact the Designated Safeguarding Lead within their local authority, or follow the policies and procedures within the organisation they work for.

Susan: Thinking about the kinds of situations you hear about, what do you think counsellors struggle with the most in their practice?
***Sarah*:** From what members of the public are bringing to the service, it feels that clients can often feel not listened to or heard about their concerns. Their therapists may struggle to hear negative feedback (in cases where a client even feels able to voice their concerns). There can sometimes be a defensiveness to their response to clients, which is such a shame because I'm sure that client concerns could often be resolved within sessions. Resolving issues is something that the service encourages if this is possible and appropriate.

***Patrick*:** Emerging technology can cause concerns – for most of the members we talk to, online working, AI and digital technology have not been included in their training. Some struggle to utilise clinical supervision to assist them in their clinical practice on these and other issues.

Susan: Are the people who call or email you aware that counselling is not regulated?
***Sarah*:** Not typically. I find that I often need to explain the non-statutory status of counselling to clients, and while some express concern, it opens up an important conversation about regulation and BACP's membership of the Professional Standards Authority Accredited Register programme. I also make sure to inform them about the work that BACP's Policy team does to ensure stakeholders are informed of the robust standards our members uphold, and I mention that if they feel strongly about the issue they might consider discussing it with their local MPs.

***Patrick*:** People can be under the impression that BACP is a regulator rather than a membership body, meaning they will get a 'yes' or 'no' answer from the team to their ethical dilemma and there will be specific rules to follow. We have to explain that counselling and psychotherapy are not regulated, and then support them to make an ethical decision based on the *Ethical Framework*.

Susan: What do people say they find most helpful about talking to your team?
***Sarah*:** Gosh, where do I begin? I think it's having an impartial, safe space for members of the public to discuss their concerns that is so important to them. They may have supportive family and friends but they often don't want to talk to them about their therapy. There can be many reasons for this – the dynamics of these relationships, or the client may think family and friends will just tell them what they want to hear, or that they lack ethical knowledge. They may not even know the client is in therapy, or it may be that the client's concerns are so personal they don't want people to know what they've been discussing in sessions.

ROMAN SAMBORSKYI/SHUTTERSTOCK

The service isn't there to tell clients what they should or shouldn't do, but I'll talk through their concerns, acting as a sounding board and providing ethical information and guidance, often informed by the myriad of Good Practice in Action resources written for our members.

The positive feedback received from members of the public is incredible and holds a mirror up to the service, which I believe is the only one of its kind currently in the UK. It's so important that clients have somewhere to go to about their concerns, and they really do find the service invaluable.

***Patrick*:** In terms of feedback, we get 'excellent' satisfaction ratings from 84% of BACP members who use us. They say that we are good at helping them with their ethical thinking, and that this assists them to come to their own understanding of the dilemma or situation they find themselves in. We're also able to signpost them to other BACP information or to external organisations that can help them.

Susan: Is there anything that surprises you in your work?

***Sarah*:** Yes, every day! Themes may have remained fairly similar over the years but every client's story is unique to them, so you think you've heard them all but you really haven't. I think this is what I love about my work – every day is completely different, and the sense of purpose I get from speaking to members of the public is priceless.

***Patrick*:** Many things, including the volume and complexity of the ethical dilemmas that are presented to us by BACP members, and the difficulty of navigating the ethical implications of using novel or new techniques that may lack a strong evidence base or clear ethical guidelines. These dilemmas often need careful consideration, consultation with colleagues and a nuanced approach to ensure that the decisions made are ethically sound and in the best interest of the client.

Members don't consciously work unethically but often members come to us after they have got into difficulty, rather than seeking advice earlier.

Susan: Is there anything else you would like to share with members about ethics and what you see as important?

***Sarah*:** This is such a huge question I'm not sure where to begin! But I'd say that ethics should inform every part of a member's practice, every day, with every client. Without ethics it would be like the Wild West out there! Ethics inform every single conversation I have with clients. The lack of regulation of counsellors and psychotherapists is scary, not least to clients, and it goes such a long way to be able to inform members of the public how important ethics and good practice are to BACP and our members. I would say that knowing how absolutely essential we feel ethics are to our profession and our members provides members of the public with some level of comfort.

***Patrick*:** What I see as important is members upskilling themselves in the rapid advance of AI and digital technology, as I believe that it is going to be part of everyday practice in the near future. From an ethical point of view, what does that mean in relation to data protection and safeguarding?

Also, thinking about newly qualified counsellors entering into private practice, we would recommend that they seek extra clinical supervision, establish a strong support network and engage with ongoing professional development to support their practice.

Susan: It always interests me that there is often a marked difference between what clients report as ethical issues and how these are often not the issues that members bring. Lack of regulation of the profession is something that comes as a surprise to many clients, which makes ethics and our *Ethical Framework* all the more important in holding safe working. Thank you both for your insights. ●

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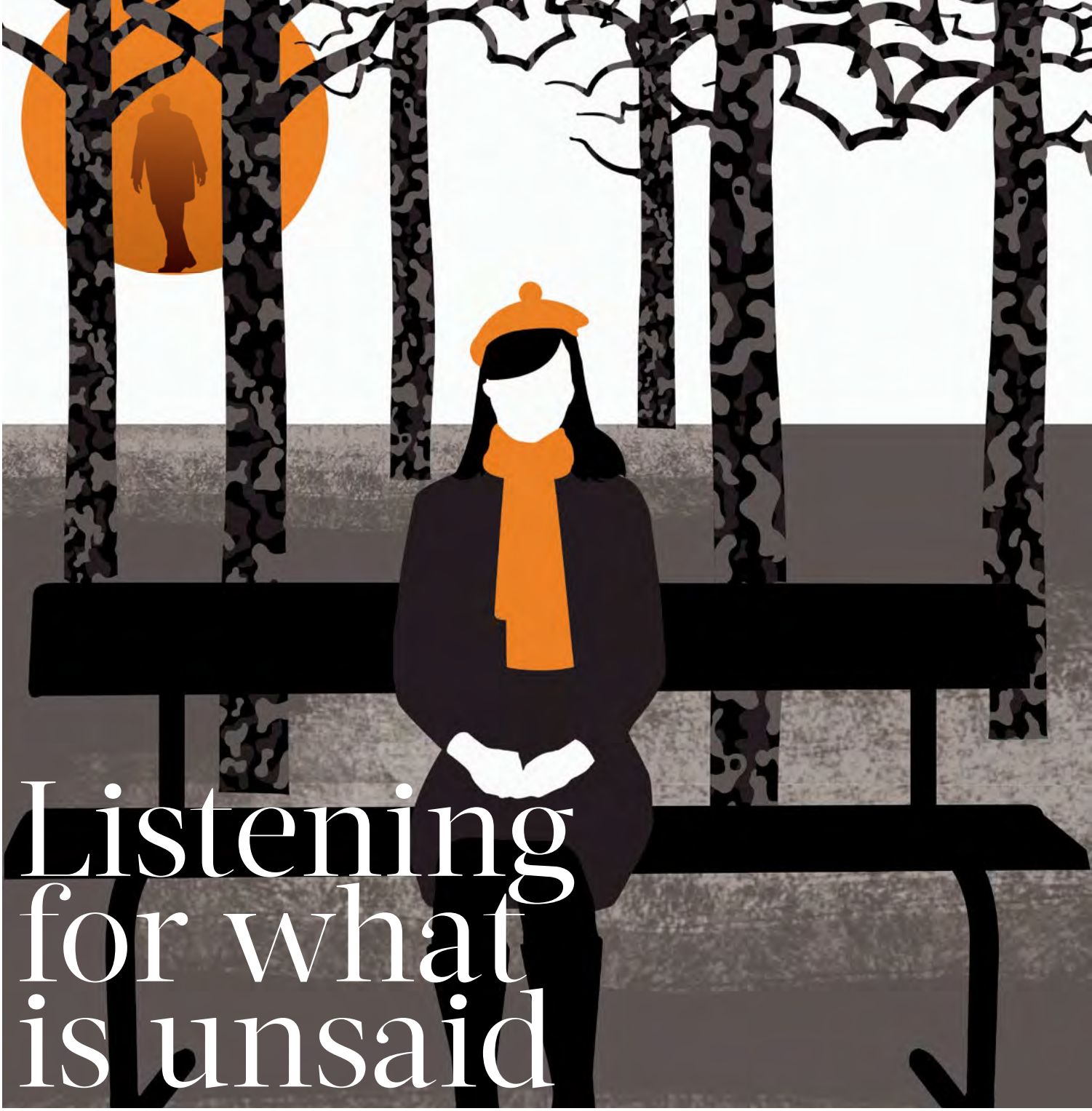

NEIL WEBB/IKON IMAGES

Listening for what is unsaid

A trauma-informed storytelling approach could help young adult clients process the effects of childhood domestic abuse, says Tanya Frances

Around one in five people aged 16 and over (9.8 million) in England and Wales have experienced domestic abuse since the age of 16,[1] with emotional abuse and controlling behaviour being the most reported, followed by physical abuse.[2] Yet these statistics don't capture the full extent of the issue, and

they overlook the ongoing nature and impact of abuse.

For children who've experienced domestic abuse, these distressing experiences can significantly shape early life and have a lasting effect on health and wellbeing into adulthood. It can lead to challenges with emotional regulation, forming relationships and achieving academic or career success.

While adversity can shape your life, everyone's experiences are unique, and it's important to question deterministic views that might label childhood adversity as a lifelong deficit. Experiencing domestic abuse as a child presents significant challenges, yet stories of resilience, hope and resistance can coexist alongside stories of struggle.

As therapists we may encounter clients affected by childhood domestic abuse, especially with the rise of social justice movements like #MeToo and #WhyIStayed encouraging more people to speak out. While there are some excellent resources for therapists working with domestic abuse experiences, such as *Working with Client Experiences of Domestic Abuse*, edited by Jeannette Roddy,[3] which I recommend for its practical and theoretical insights, there's a lack of research into how therapists can help young adults addressing their childhood experiences in therapy.

While we recognise the profound impact on children, there's a need to further understand how to better support these clients as they navigate the complexities of young adulthood. Drawing from my research as an academic at The Open University, and practice as a therapist and psychologist, I hope to shine a light on working with young adults who have experienced domestic abuse in childhood. I aim to share insights and trauma-informed practices to help therapy be a space where clients feel safe to explore parts of their experiences that might be difficult to voice or have been previously unheard or unseen.

In this article I aim to offer a summary of the key foundations for safe and effective working with these clients, gained from my research and practice experience. There are of course a multitude of possibilities for trauma work, underpinned by a range of theoretical lenses, modalities and approaches to working with trauma. My thinking is informed by a humanistic integrative framework, dialogical narrative theory and my use of feminist narrative research methods with young adult women who have experienced childhood domestic abuse.

1 in 5

people aged 16 and over (9.8 million) in England and Wales have experienced domestic abuse, including emotional abuse and controlling behaviour

1 UNDERSTAND THE IMPACT

The term domestic abuse encompasses a broad range of behaviours and relational dynamics, including controlling, coercive, threatening, degrading and violent actions typically perpetrated by a partner, ex-partner or family member.[4] This can include coercive control, psychological and emotional abuse, physical or sexual abuse, financial or economic abuse, harassment and stalking as well as online or digital abuse.[4] It is characterised by ongoing relational dynamics and a pattern of behaviour rather than isolated incidents.

Contrary to outdated beliefs that children are passive witnesses or secondary victims, we know that children aren't 'just watching' – they are directly impacted by domestic abuse. In England and Wales, significant legal changes were enacted by the Domestic Abuse Act 2021. The legislation introduced a new statutory definition of domestic abuse, explicitly recognising children as victims in their own right.

Children may attempt to protect family members by intervening to prevent violence from escalating. Sometimes they are directly involved in how a perpetrator maintains control, such as through manipulation or using family courts and contact agreements to exert power even after separation. In any case, living in a controlling and threatening environment is inherently harmful to children. They *experience* domestic abuse rather than simply being 'exposed' or 'witnesses' to it. Recognising this helps us understand the long-term impact of domestic abuse on children. Even as adults the abuse may not have stopped. They may still be in contact with the perpetrator, or continue to support family members experiencing abuse.

2 RECOGNISE ABUSE

Not recognising or naming abuse in therapy can have harmful consequences for clients and the therapy process. It may result in a client's experiences remaining unacknowledged, mirroring past experiences of feeling unseen or invisible, despite violence and trauma at home, and for some, efforts to seek help. It may also mean a client terminates therapy early, or is less likely to disclose further or seek help from someone else. But recognising domestic abuse can be complex as experiences vary considerably.

Some individuals may not recognise their experiences as domestic abuse because they don't fit the stereotype of extreme violence. Behaviours like controlling actions, threats, shouting, door slamming or furniture smashing may be

'Living in a controlling and threatening environment is inherently harmful to children. They experience domestic abuse rather than simply being "exposed" or "witnesses" to it'

'It's important that therapists, regardless of speciality or expertise, can bear in mind the complexities of domestic abuse, so they can help clients acknowledge and process their experiences'

dismissed as not being 'real' abuse if they don't involve direct physical harm. Yet these behaviours can still deeply affect children and young adults.

Others may struggle to name their experiences as domestic abuse because labels like 'victim' or 'survivor' don't resonate or fit their view of themselves. They may also avoid identifying solely with their past experiences of how they have survived or been victimised in childhood. Moreover, conflicting feelings towards parents, such as both anger and love, can further complicate the recognition and acknowledgment of abuse.

While most cases of domestic abuse involve men's violence against women, it's important to deconstruct some socially held assumptions about gender and power dynamics. Domestic abuse can happen in any relationship, including LGBTQ+ ones, and can involve any gender. It's important to recognise this, as some may have a hard time naming experiences as domestic abuse if they don't align with stereotypical ideas about domestic abuse in intimate partner relationships. For example, a child raised by parents in a lesbian relationship may not identify their experiences as domestic abuse because it doesn't fit the male-to-female violence commonly associated with domestic abuse. As a result they may downplay or discount the violence they experienced.

Whether working directly with this client group in the domestic abuse or trauma field or not, it's highly likely you will work with clients who have experienced domestic abuse in childhood who want to address these experiences in therapy. So it's important that therapists, regardless of speciality or expertise, can bear in mind the complexities of domestic abuse, so they can help clients acknowledge and process their experiences.

3 BE TRAUMA-INFORMED

'Trauma-informed practice' has become increasingly prominent in popular discourse, reflecting a growing awareness among counselling, psychotherapy and other practitioners of the importance of being sensitive to trauma. It is encouraging that practitioners want to become (and indeed are becoming) more trauma-aware, and are actively seeking to work effectively and safely with individuals who have experienced trauma. However, research in this area is still developing, and there isn't yet a recognised consensus about what it means to be 'trauma-informed' in practice.

There are six main ideas of trauma-informed practice: safety, trust, choice, collaboration, empowerment and cultural consideration.[5] In principle, taking a trauma-informed approach means that services, organisations and practitioners aim to support safety and reduce the risk that the act of seeking help could end up causing more distress and retraumatising clients, known as iatrogenic harm.

Broadly, being trauma-informed means acknowledging that trauma can impact all parts of an individual's being, including their body, mind, spirit and emotions. It involves recognising that trauma can be experienced at individual, community and systemic levels, affecting both individuals and communities. Additionally, it means appreciating that safety within relationships can be a crucial part of trauma recovery, and that those who've experienced trauma may find it difficult to feel safe and trust professionals, organisations or services they seek help from.

At the same time, fostering safety within relationships – including cultural sensitivity, cultural equity, and humility – is one of the key factors that can support trauma recovery, therefore this is important to build. Importantly, a trauma-informed approach means avoiding a deficit lens. Instead of focusing on what is wrong with the client, practitioners can ask guiding questions such as, 'What happened, and what does my client need?'

When we apply trauma-informed principles to working with clients who have experienced childhood domestic abuse, it means we focus on co-creating a therapeutic relationship where the power is shared. By fostering a 'power with' relationship rather than a 'power over' relationship, we work towards collaboration and a sense of choice and agency within the therapy process. In my research I explored the role of power, in particular, how societal systems of power shape individual experiences and young women's sense of self after childhood domestic abuse.[6] Given that trauma-informed practice is, in part, about empowerment, understanding how power has operated in clients' lives is crucial.

4 LISTEN FOR WHAT IS UNSAID

Women's voices have often been discredited or devalued when giving accounts of violence and abuse, otherwise known as 'epistemic injustice'. This can lead to self-silencing and shame, complicating how young women narrate and present their own stories and selves in therapy. My research with young adult women who experienced childhood domestic abuse,[6] and recent research by others, such as Jade Levell's work with men's experiences of childhood domestic abuse,[7] show how power dynamics can operate in particular ways when people make sense of their experiences of domestic abuse.

For example, societal ideas about gender can influence people's stories and self-perception.[6] Masculinity norms, for instance, may shape men's difficulty in expressing vulnerability alongside masculinity, sometimes manifesting through violence.[7] In my research, young women shared accounts of navigating early adulthood that were heavily shaped by societal ideas about femininity, and what 'successful femininity' looks like, in the face of recovering from adversity and telling a story of survival. What I found is

CASE STUDY: NOVA

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Nova, a 22-year-old woman, sought counselling after experiencing domestic abuse as a child. Her father was violent towards her mother, and subsequent partners were also abusive. This left Nova feeling resentful towards her mother for not protecting her, and guilty for the distress she felt she caused her mother.

The first focus when Nova began therapy was to create a welcoming space where she felt safe enough to share her story at her own pace. Initially hesitant, Nova gradually opened up about her experiences. Early sessions involved careful listening, validating Nova's feelings and offering psychoeducation about trauma's impact, helping Nova to soothe her nervous system when overwhelmed.

In the storytelling approach, close attention is paid to how experiences are narrated. Nova often presented a story of resilience, claiming she had 'moved on', but her stories sometimes included silence or 'I don't know', suggesting the presence of something important that needed attending to. Acknowledging this and inviting Nova to explore what was happening in the silence revealed a coexisting voice of fear and doubt about the future.

Therapy provided a space for Nova to explore these contradictory stories, helping her understand the function and limitations of each. By staying with these contradictions and tensions, Nova could examine the parts of her that felt resilient and those that were fearful and struggled. This exploration allowed Nova to express and understand her fear and doubts, which were related to feeling 'marked' by her childhood and carrying shame.

Through this process Nova could see how her story of resilience empowered her, but it also sometimes limited her ability to express vulnerability. Therapy helped Nova to understand both her resilience and her vulnerability and to find more compassionate ways of relating to parts of herself that she had felt ashamed of.

- *This is a fictional case study informed by interviews with young women and my work in practice.*

that while these stories can be useful, they may also significantly limit what is voiced. They do not always hold space for voicing struggle too.

In short, voice is important. I use the example of gender here to demonstrate how clients may voice their stories in therapy, heavily shaped and influenced by socially structured forces and environmental factors. Therapists need to pay close attention to how clients voice their stories – what is voiced, what is not voiced, and what is voiced in less obvious ways such as through the body, through self-silencing or quieter voices that may exist in dialogue with a critical or shamed voice. By acknowledging these influences, and taking a curious and exploratory line of thinking with clients, therapists can create space for them to examine and understand their own stories without judgment.

5 CONSIDER INTERSECTIONALITY

While gender norms play a significant role, they are only one aspect of a person's identity, intertwined with other socially located identities such as race and class. Moreover, other forms of privilege, marginalisation and oppression, such as poverty, racism and LGBTQ+ discrimination, can further compound these experiences. When considering power dynamics within the therapeutic relationship and a client's life, it is important to understand that systems of power are interlocking and do not operate in isolation. Intersectionality theory offers a framework for understanding how, for instance, both gendered ideologies and race-related privilege or oppression simultaneously shape a person's identity and sense-making following experiences of domestic abuse.[8]

This approach can lead to fruitful and generative lines of inquiry in therapy, as it recognises a client's problems relating to trauma are not due to an inherent individual deficit.

6 MAKE SPACE FOR STORYTELLING

Voice is an important aspect of identity and meaning-making, and power and empowerment are central to trauma-informed work. Storytelling is not new to therapy. Narrative therapy, for example, emphasises re-authoring stories in creative and empowering ways that foster healing and change. Also, culturally sensitive anti-racist approaches in counselling highlight the role of storytelling in amplifying marginalised voices.[9] Storytelling can be a way of challenging dominant discourses and accepted 'truths'. Lastly, and importantly, storytelling is relational. It depends on the specific exchange of stories, the specific relational dynamic and the particular socially located experiences of marginalisation and privilege, such as experiences of racism, sexism or ableism, between the teller (the client) and the listener (the therapist). Paying attention to how stories are voiced can provide grounds for counter-storytelling, attending to less-voiced stories or voices that have been silenced in the past.

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To do this, a spirit of openness, humility and curiosity is needed, with an interest in listening to *all* voices, not just the loudest or most dominant ones that enter the therapy room. By actively engaging with clients' stories, therapists can help clients challenge dominant narratives or stories that have become, in part, limiting, so clients can begin to be open to alternative possibilities in terms of how they see themselves and understand their life and their trauma experiences.

As well as listening for what is unsaid or more silenced, therapists can also tune into when stories have ambiguities, uncertainties or tensions. Therapists can become curious and attentive listeners, gently bringing these ambiguities or tensions to clients' awareness in a non-judgmental way. As described earlier, it can be common for people navigating young adulthood after childhood domestic abuse to feel conflicted about one or both parents or caregivers, such as love for a parent and coexisting anger or resentment that they did not feel protected by their parent. It can be hard to voice both as equally valid experiences. This can help clients recognise and create space for parts of their experience that may have remained less voiced or less heard and, as such, foster space for change.

7 BE SELF-AWARE

Critical reflexivity and mindful self-awareness, as highlighted by Babette Rothschild in *Help for the Helper*, are valuable tools for thinking about how we work safely alongside clients, allowing us to engage thoughtfully with the nuances of trauma therapy.[10] By intentionally examining our own values, biases and life experiences, including any personal trauma histories, we are more likely to see how they affect how we work with clients and when our own material is being touched on in this work.

Given that relational safety is a key aspect of trauma-informed practice, this commitment to understanding the self and how we respond to stories, bodies and experiences of clients is crucial. Equally important is recognising how power dynamics affect the therapeutic relationship, acknowledging and, if relevant, working with how our own socially located identities such as race, heritage, disability and gender intersect with our clients' identities. Exploring these dynamics, if relevant to the client, may be part of the work of facilitating safety and trust.

Importantly, trauma work can be rewarding and challenging. Prioritising self-care and recognising our own needs are important for working safely with clients and minimising the risk of vicarious trauma, compassion fatigue or burnout.

I invite other therapists to look into the challenges faced by young adults dealing with trauma from childhood domestic abuse, and continue to reflect on our role in their recovery processes as we listen and engage with clients' stories. ●

FURTHER LEARNING

Trauma-informed Counselling is a 25-hour CPD Open University course co-authored by Dr Tanya Frances and Dr Kerry Hughes, which aims to help learners apply a trauma-informed approach in therapeutic work, and gain a better understanding of the impact trauma can have on individuals. For more information, see **openuniversity.co.uk/counselling-cpd**

REFERENCES

1. Office for National Statistics. Domestic abuse in England and Wales overview: November 2023.
2. Women's Aid. The domestic abuse report 2023: the annual audit. Bristol: Women's Aid; 2023.
3. Roddy J (ed). Working with client experiences of domestic abuse: a handbook for counsellors, psychotherapists, and other mental health professionals. Abingdon: Routledge; 2023.
4. Women's Aid. What is domestic abuse? [Online.] womensaid.org.uk/information-support/what-is-domestic-abuse
5. Office for Health Improvement & Disparities. Guidance: working definition of trauma-informed practice. [Online.] Gov.co.uk: 2 November 2022.
6. Frances T. A dialogical narrative approach to transitions and change in young women's lives after domestic abuse in childhood: considerations for counselling and psychotherapy. British Journal of Guidance & Counselling 2024; 52(1): 19-35.
7. Levell J. Boys, childhood domestic abuse and gang involvement: violence at home, violence on-road. Bristol: Bristol University Press; 2022.
8. Crenshaw K. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum 1989; 1(8).
9. Haskins NH, Singh A. Critical race theory and counselor education pedagogy: creating equitable training. Counselor Education and Supervision 2015; 54(4): 288-301.
10. Rothschild B. Help for the helper: preventing compassion fatigue and vicarious trauma in an ever-changing world. New York: WW Norton; 2023.

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Transforming race conversations

Eugene Ellis explores how bravery and honesty are the essence of life-changing dialogue

Imagine you have shares in a multinational company. These shares have been handed down to you and, though you don't give it much thought, they are part of your inheritance. The income from these shares is small but it allows you to work four days a week instead of five, which gives you time to gather your thoughts and enjoy the finer things in life, and allows you space to think about things other than what is directly in front of you.

Every once in a while, you think about the company you own shares in, and what the company does. Occasionally the company is highlighted in the news, and you don't like what you hear, but the shares are so much a part of your life that it's difficult to give them up. You feel a bit embarrassed at times and maybe even ashamed, but the feelings soon pass, and it's business as usual.

You meet someone on your travels and they start talking to you about the company you are associated with. They don't know you own shares but of course you know. You feel uncomfortable but what can you do? You would much rather talk about another subject and tactfully move the conversation to safer ground. In a candid moment you might speak to someone about the position you are in, and about how, when you think about the company, you feel bad and you don't know what to do. You think perhaps you can give up the shares, but then you hear, through a shareholder's letter, that the company is trying really hard to be a good company, an ethical company, although you are doubtful. You say to yourself that if unethical companies around the world were to lose their shareholders, the whole economic system would collapse and then where would we be? You hear from an economic analyst on the news that the capitalist economy is not a perfect system but what are the alternatives? The company itself says that it wants to do better but is beholden to its shareholders, who expect more profits every year.

Those arguments make you feel a little bit better, but you are still uncomfortable. After a while that uncomfortable feeling goes away, but you know that at some point it's going to come back, unannounced and unwelcome, out of the blue. To avoid these unwelcome intrusions into your mind you place yourself in spaces that give you the comfortable arguments you are used to about why things should remain the same, how you are only one person and you couldn't possibly make a difference. You wonder, even if you did take your shares out of this unethical company and put them in a more ethical one, this wouldn't change anything on the big scale would it?

You wake up one morning to find that the company you own shares in is on the news again for grossly unethical behaviour. The uncomfortable feelings that you were grappling with before come back to the fore and take over your world as the news story plays out. You start to read about other companies that do the same things as the company that you have investments with. Your horror at what you find brings up the type of fear that leads you to feel that the world is somehow infected by evil, and you despair. As you continue to explore and speak to other people you discover that rather than there being evil in the world, there are only decisions that look evil. You decide to put yourself into the types of arenas that allow those uncomfortable, complicit feelings to be seen and responded to because you feel in your bones that there's something, other than denial, that can be done. It's a massive leap of faith but you're on a journey now. The genie is out of its bottle and there is no putting it back.

'A decision to not perpetuate racism is more often than not a non-verbal sense of "getting it". It's akin to lifting a veil to reveal a previously explored aspect of the world as if seen for the first time'

The moment of change

This imagined story illustrates a lifting of the veil and the shift that I feel is possible when we are relationally resourced. A decision to not perpetuate racism is more often than not a non-verbal sense of 'getting it'. It's akin to lifting a veil to reveal a previously explored aspect of the world as if seen for the first time. Temporarily set aside is the daunting weight of racism with its unforgiving history, to be replaced by an internal sense of something more compelling, more purposeful. This crucial part of the process then allows other aspects of you to become more fully energised. With coherent narratives 'in the mind' alongside what is essentially a body/heart decision not to perpetuate racism, the journey towards a sense of healing can begin – healing not just for personal gain but also for the communities we live in, and especially for our young people.

On the following pages are extracts from two race conversations that I hope will bring to life what the process of making a decision in your gut looks like and feels like, at least as it does for these two individuals. The first is a conversation I had with a white male psychotherapist, Andy,* and the second a Sikh male psychotherapist, Raj.*

MELITAS/SHUTTERSTOCK

NADIA SNOPEK/SHUTTERSTOCK

ANDY is a white psychotherapist who is passionate about psychotherapy and politics

'Within the backdrop of the race construct, healing takes place through the coming together of like-minded individuals'

Prior to this part of our conversation I guided Andy through a mindfulness exercise that encouraged him to explore his cognition, emotions and sensations at the thought of having a conversation about race. I was interested in bringing to his awareness the initial moments of discomfort, which are usually the optimal place to catch ourselves in the moments before we become dysregulated.

Eugene: What was uppermost [in your mind during the mindfulness exercise], and what were you aware of?
Andy: I have been sitting on something from the forum [a forum for therapists that invites a deepening of the race conversation] which took me by surprise. It was a moment where I changed. Someone mentioned something to me, and it changed my world view, it was just a comment. I don't really know where I am with it yet; I haven't settled and since then other little things have happened that I might have noticed but not 'felt'. I'm left with some unknowns that impact how I see the world and myself in it.
Eugene: It feels important, perhaps we need to just get straight to it?
Andy: Well, I might go a bit red. I thought and felt that I was really quite comfortable with that [the race conversation]. At times in therapy I could bring up the topic. I might often introduce it. I might ask what it's like working with a middle-class white guy from Surrey for somebody who's from Africa who's got a very different world outlook and probably comes from a country that my ancestors might have colonised. I could encapsulate that. I had some kind of minimal awareness of these issues, but I've been wondering for some years now... It's not a bad reaction I get, or a non-reaction. The conversation quite often doesn't go anywhere. So that has been sitting in the background.
Eugene: So, you bring it up, you're curious, but it doesn't take you into places where you might want to go.
Andy: Ah, well, I thought I did! So here's the rub – here is the body thing, I can feel it, the little hairs on the back of my neck; be careful what you wish for.
Eugene: So, what was the overall experience about the comment that was made to you in the forum?
Andy: I was speaking to one of the facilitators. I mentioned the race conversation, or somehow that was in the room, and he said something along the lines of, 'But if someone really brought that topic to you, their experience, could you cope?'
Eugene: Hmmm.
Andy: And I think not. Because actually until that moment I thought 'yes', I believed yes, I mean I really believed. And in that moment it started to dawn on me. Could I?

The moment that Andy describes, of the world suddenly changing, is something that I have heard on many occasions. It often comes after an initial, sometimes extensive process of curiosity and exploration. This exploration is typically driven by a particular personal hurt and through communion with other hurt souls. This journey then transforms into a decision to work towards no longer perpetuating race hurt.

MELITAS/SHUTTERSTOCK

RAJ is a psychotherapist of Sikh heritage

Our conversation began with Raj talking about his explorations of his culture and his culture's relationship to him as a Sikh man in the UK. It was shortly after he attended a Black, African and Asian Therapy Network conference.

Raj: I think there's something, I want to call it special or different, about Sikhs. I've gone back in my family history. We were branded the 'martial race' by the British. We were recruited to fight; a big proportion of the Indian army were Sikhs. So, we were special, or maybe more aggressive, I'm not sure. It's all been put into me, at some level. I'm supposed to be a certain way. Now I feel like...
Eugene: Now you're a counsellor!
Raj: I'm vulnerable... Someone called me a traitor, someone in my family. Being a Sikh and Sikhism is very important to me, so I felt disappointed by that. If I go anywhere or challenge anything in my culture it will be seen as anarchic rather than adding something. It's a sadness when I speak about that as well.
Eugene: It's like many journeys of healing. It sounds like you've done a lot of reading, a lot of research, a lot of thinking, a lot of trying to process and trying to make sense.
Raj: Healing is a good word.
Eugene: What was it like to have done all of that?
Raj: [Exhalation of breath]. Like I said, I was doing something different, away from the culture, it's threatening – for me internally, and I guess for others. People always say 'an Asian male counsellor'. What? It's like, what?
Eugene: Oh right, yeah.
Raj: They wanna know what you're about, what you are doing. 'Do you still deal with Asians?' There are presumptions and assumptions, I find. The healing journey has been difficult.
Eugene: How did you come to this healing journey? I know you're a counsellor, so that might have given you a little professional impetus.
Raj: I think it was more than that; it was a redirection. I didn't have therapy until I started my training [as a counsellor], so there was something else going on. Maybe it was personal history, family, collective culture. It felt enlightening actually while I was doing it, and still there's never an end, I don't think. Still learning things about myself all the time but the cultural part I think needed to be addressed first. One of the first layers I think.
Eugene: Say more about that?
Raj: Yeah, the caste thing, Sikhism and where we stand, where we're supposed to stand.
Eugene: You were trying to work out your place in relation to where you were supposed to be?
Raj: In the family business, arranged marriage – it was all for somebody else. I never realised why. It's almost for an ideal that didn't exist, the norm. Break the mould comes to mind. The actual process, I will be honest with you, has been very difficult at times. I almost felt like I was giving up and conforming but no, I didn't think that was useful. I feel I've been honest culturally. I feel I'm near the end of the cultural stuff. Not at the end of it, but I understand a lot of it.
Eugene: And what did you gain from this painful process of exploration?
Raj: I feel much more solid. I went to the conference, I found a few Asian guys that could talk to me about this. It was really important actually. I can empathise with it and be willing to talk about this stuff. I needed to be understood, and I needed to understand myself. The rational part is understanding the history. The 'actual' part is understanding how all this affects me on a basic level, what bits do I need to keep. I will mention my daughters. They had a huge impact on me when they were born. And some of the practices towards them were quite... I found quite oppressive. So, there is that gender thing as well that goes on.
Eugene: Hmmm.
Raj: One word I'm looking for is liberation – that's what comes up.
Eugene: It's a word that often comes up for people.
Raj: Yeah, it makes me emotional, that makes me feel something when I say that.
Eugene: Yeah.
Raj: It's an ongoing process, me feeling stuff. I name it now – in safe places. There is a bit of me thinking; I hope this helps.
Eugene: Oh no, it all helps, absolutely.

For Raj, it seems making a decision not to perpetuate racism and other oppressions was very much tied up with being a victim within his own culture. Trying to live a more authentic and ethical life can often make people within your own race and culture experience a sense of betrayal for 'crossing over to the white side', as it is sometimes seen. The rejection for that betrayal is extremely painful. Raj also demonstrates having the kind of support that is needed, from like-minded individuals, in order to go through a journey of 'being yourself' and 'being your culture' at the same time.

It's almost impossible to attend to race harm as an individual. Race trauma is formed through relationship and must be healed in relationship. Within the backdrop of the race construct, healing takes place through the coming together of like-minded individuals – together they can orient their efforts towards attending to the hurt with positive regard, curiosity and compassion. ●

* The stories are included with permission but names and identifiable details have been changed.

Extracted and edited with permission from *Transforming Race Conversations: a healing guide for us all* by Eugene Ellis, recently republished by Norton. Use code WN149 to order a copy at 30% discount from **wwnorton.co.uk/norton-mental-health**

ABOUT THE AUTHOR

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Winning the placement race

Is it right that students are forced to accept increasingly stringent demands from placement providers to get their hours? asks Helen Dalley

Linking academic theory with practical, real-world application, placements are a prerequisite of advanced level counselling courses, giving students valuable time with clients before they qualify. But with demand for counselling services increasing – nearly a third of UK adults have sought help from a counsellor or psychotherapist in the past 12 months according to BACP's latest Public Perceptions survey – so too is the number of student counsellors. As a result the demand for placements has also soared, and finding one is becoming increasingly difficult for many therapists in training.

As a trainee counsellor in the first year of a Level 4 Diploma in Therapeutic Counselling I can testify that the struggle to find a placement is real, as is tracking down an agency with reasonable demands on your time. I'm not the only one who's stressed out – during every drop-in session before class the anxiety in the room is palpable as talk turns to gaining those non-negotiable client hours. But as one fellow student puts it, 'There are just not enough placements out there.' Indeed, students from our diploma class are competing for places with other institutions offering the same qualification alongside university students on degree and master's courses.

Conscious that placements are oversubscribed and trainees need to clock up 100 hours to qualify, agencies can place stringent demands on students, with some expecting trainees to give up two or three evenings a week, and many asking for a minimum commitment of a year of voluntary placement. If you commit to four hours a week this amounts to 192 hours, almost double the required hours – all unpaid.

Then there are costs – increasingly trainees are being asked to pay to secure their placement spot. A fellow trainee was asked for £110 a month to cover 'training costs', while others say they have been asked to cover an 'admin charge' of £50-£60 a month. Due to funding cutbacks within the charity sector many agencies are no longer able to offer supervision, meaning that counselling

students also need to pay for 45 minutes of supervision every two weeks on top of their personal therapy, personal indemnity insurance and yearly membership fees to professional bodies. Then there are travelling costs to and from the placement, with no or minimal expenses given. One student on my course shared they were reimbursed 20p per mile for a journey that took them more than an hour each way. Given these financial demands it's not hard to see why our profession still struggles to attract a fully diverse workforce.

Competition

With the benefit of hindsight I should have started applying for placements as soon as my training place was confirmed last summer, as many placement opportunities had been snapped up when I began emailing agencies in September. A fellow Level 4 student on a different course has sent in 13 applications and heard nothing so far. 'At the moment I feel like I have to take anything just so I don't fail the course,' they told me. 'I don't feel like I have the option to be picky as competition is so fierce.'

I began my journey to find a placement by approaching the mental health charity I'd completed a case study on during the Level 3 course, but they called back to say they no longer had the time or capacity to accept placement students. Still, I was grateful that they responded as many agencies don't reply. I remained hopeful of securing a placement relatively easily.

While I appreciate the importance of placement hours, like most of my cohort I'm working full time while training and already losing a day to college, so time is precious. With placements scarce students may need to attend several recruitment events interviews before procuring that elusive spot. After an intensive, hour-long interview I was offered a placement with a children's mental health charity but turned it down as they wanted me to volunteer one day a week for 12 months. Doing six hours a day every week would have worked out at 936 hours in total after factoring in 13 weeks of school holidays – more than nine times the course requirement. While training was offered they admitted the children I'd be working with may have complex issues, and that felt like a big responsibility.

I was then offered another placement with a mental health charity for young adults but it was online only and required a minimum commitment of four hours a week for 12 months. That would be 192 hours and only 49 of those would count towards my placement quota (because of current requirements for in-person work). However, that may seem reasonable compared to the experience of a fellow trainee who told me the agency she's doing her placement with now expects students to volunteer for two years instead of one.

A student I spoke to on an MA in Integrative Counselling says they now feel compelled to apply to agencies that have working practices they don't agree with, including charging clients for services but not paying the trainees delivering them, and not making clients aware they are being seen by a trainee. 'My university has a long list of providers but it's obviously not updated – so many people I've rang or emailed said that the person I contacted has retired, or that they don't do placements any more (and sometimes haven't for years), or that they are full. Or I leave a voicemail and there's no response.'

Rejections

As I settled into the Level 4 course my list of rejections was getting longer. I started to become more rattled about securing a placement as opposed to actually dealing with clients. I never expected to be more concerned with practicalities like finding an agency that would take me on rather than the counselling work itself.

I contacted a local university counselling service but was told it preferred to take students on who had already completed a minimum of 100 placement hours. I attended a recruitment event online for another placement where around 30 to 40 others were in competition for a handful of places. It was disheartening to receive an email saying I hadn't been selected for interview, especially as the organisation's head of counselling seemed so supportive.

Asking for feedback on why you haven't been successful seems reasonable but it can be dispiriting. After attending a group interview at a local hospice I got an email to tell me I'd been unsuccessful. I emailed to find out why they'd rejected my application and they responded by saying they didn't think I was the right person to join them. This not only dampened my confidence but was also maddeningly vague – how exactly had I failed to meet their expectations? If they'd been more specific about my lack of experience with bereavement, for example, it would have felt more understandable. I also felt like the group interview had gone well, I'd completed the tasks competently and the interviewers seemed to like me, so it left me questioning where I'd gone wrong.

Unsafe

Eventually I was offered a placement with an agency that could offer me weekly in-person sessions, and I was relieved and happy – until I realised what was expected of me. Like many agencies they offered me evening work and initially requested that I do nine to 12 hours a week, but after I said that would be too difficult with a young family they came back with two hours one evening a week. Then it was back to four hours, two of which would be on either a Saturday or Sunday. I didn't mind doing evenings but when I learned I'd be in the building on my own – there was no panic button, and I was advised to have emergency services on speed dial – things started

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'While I appreciate the importance of placement hours, like most of my cohort I'm working full time while training and already losing a day to college, so time is precious'

EAMESBOT/SHUTTERSTOCK

to feel uncomfortable. I was also asked to lock the building up and set the alarms. My tutors were concerned for my safety and asked if I could negotiate so that someone was in the building with me, but a growing sense of unease led me to turn down the opportunity.

Many emails later I finally landed an online placement where there was no need to commit to any time frame and I could pick up clients as and when needed. While I appreciate the flexibility there is also no training on offer and it can feel lonely. The first session felt particularly tough – I was conscious of repeating myself and running out of things to say. When my second client cancelled without warning after three sessions I couldn't help but take it personally. The agency sent me a friendly voice note saying this is a common occurrence and not to blame myself. While I appreciate their support I'm grateful when it's time for personal supervision and I can discuss how I'm feeling.

Despite sending out several queries each week I still hadn't secured an in-person placement by May. In desperation I ended up searching for 'counselling placements near me', and to my surprise three options I hadn't contacted came up. I emailed them all and one called me straightaway to say they're no longer offering placements. Another never replied, while the third, a charity, said they couldn't offer student placements as they no longer had a counselling supervisor on site. I was surprised that they didn't know that students can arrange their own supervision, and once they realised they were interested to meet. I breathed a sigh of relief and arranged a time to visit.

My placement hours finally began this summer. They haven't asked me to sign up for a year, and I'll be doing four hours one morning a week, which fits in well around my family. If all goes well I'll have 100 hours under my belt by around February 2025.

Employment

My concern now is whether as a newly qualified counsellor I will be able to get a job, given that so many agencies rely on student counsellors to volunteer for free. I asked a recent Level 4 graduate how they're doing. With their placement set to end they're feeling guilty about letting their clients down – as they put it, 'The most salient point for me now is trying to leave my placement without feeling terrible.' But they added that they feel lucky as someone on their course still hasn't managed to get any placement hours even though they've finished the second year. While students are given another 12 months to fulfil their hours they can't accept paid work until the 100 hours are completed, so there is pressure to complete placement hours within the two years of the diploma course.

Placements will and always should be a crucial part of a counsellor's training. But with such unprecedented demand for places almost everyone I spoke to has faced difficulty in securing one. Once placements begin demands from agencies can feel overwhelming, but many students feel they have no choice but to do what's asked of them, even if that involves paying for training or agreeing to work several nights a week. Even my course tutors say that trying to find a placement is the worst thing about being a trainee counsellor.

So what can be done? With many mental health charities in desperate need of cash – the charity where I'll be working recently lost funding for its only counsellor – more funding would mean agencies could provide training and supervision for student counsellors. In the meantime the only way to secure a placement, it seems, is through forward planning, persistence and an acceptance of the need to compromise. ●

SHARE YOUR EXPERIENCES

We want to know about your placement experiences, so if you are a BACP student member look out for an email that includes a link to a short survey. We are hoping to use the data to inform a more in-depth report, as well as our Student Event in February, and the course accreditation process.

ABOUT THE AUTHOR

Helen Dalley is a freelance journalist and trainee on a Level 4 Diploma in Therapeutic Counselling. She is founder of The Wellness Journal, a service that hosts journalling workshops (**thewellnessjournal.co.uk**).

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Caricature of a racist

What does 'a racist' really look like? asks **Rhea Gandhi**

It is important to note that I wrote this article before the violent, xenophobic riots were sparked in England, amending the introduction afterwards. I say this to contextualise this anti-racist work as ongoing, and not just a topic raised when violent acts of racism are seen by the general public – in other words by people who don't experience everyday racism.

As a brown woman these riots are not surprising – they are just making the implicit, explicit. As a woman of colour in the UK I have consistently had to assert my humanness and my right to exist. Every day, I know there may be a risk of being attacked or harmed. It can be subtle or violent, verbal or physical and, especially, institutional. But this fear is not new, and it is not imagined.

This is not the first time I have had a discussion with my brown partner about whether he feels safe enough to have a beard – an aesthetic choice in his case – just in case he is attacked. The everyday conversations in our home as people of colour have not changed. The anxiety held in our bodies hasn't shifted. The systems in the UK are built in a way that makes us need to 'prove our innocence' and 'value' at every level, for visas, jobs and even relationships. Little has changed in our reality – these riots have only made our truths more visible and racism less deniable.

Good versus bad

Not all forms of racism will make it to the news, and most of us won't believe we contribute to this racist system. These riots further reinforce the split of the 'racist' being outside us, not within us – of ourselves being 'good' and 'these rioters' as being 'bad'. But let's explore this idea further.

We've made so many unconscious associations with the word 'racist'. Here are some crowdsourced from my Instagram followers:

A bad, hateful person. Slave owners. Archaic. Conservative. White. Frustrated. Evil. Problematic. Unempathetic. Unkind. Ignorant. Wilful. Cold. Unfair. Prejudiced. Intolerant. Indifferent. Oppressive. Dominant. Egotistical. Someone who actively treats others as less than or beneath them. Someone who believes they belong to a superior race.

But what does a 'racist' really look like? Time for real talk.

The Black Lives Matter (BLM) movement brought conversations about race to the forefront. It made people reflect on their own beliefs and behaviours – or so we are told. In this article I speak directly to you, the reader, to ask you to listen not just cognitively but to observe your visceral response to my words. The lived reality of the post-BLM years is that most educated, aware people are afraid of being 'called out' as racist, of being cancelled, shamed on social media – but really of being caught. Revealed. Exposed.

The overwhelming fear of being called racist is also a fear of being associated with the fantasy of a person who is racist. When someone tunes into the racism we've been concealing from ourselves it is these associations, along with shame and guilt, that get activated. It is this portrait of an imaginal racist that distances us from the reality of lived racism and microaggressions in the way that they exist today. This caricature maintains a distance from the idea of racism as something that is outside ourselves instead of within us. It is flawed and outdated (for the most part) and does not reflect the way this plays out in the real world today – internally, relationally and institutionally. It is so much more nuanced and complex to unpack.

Internalised

It is this archetype that restricts us from seeing our own prejudices, acknowledging them, unpacking them and recognising the capacity within ourselves to be harmful – not just to others but also to ourselves as internalised racism.

Our racism is tightly bound to our chest by invisible ropes. These are deeply internalised ideas about the world we learned from our upbringing, society, the media and social groups. These ropes stretch and grow, take different shapes and forms, strengthening their hold on us over the years. But what happens when these ropes begin to unravel? We fall at the expense of others, and slowly come to realise that these ropes have been invisible only to us. We stay blissfully ignorant and benefit from denial. Our blindness has not been challenged by self-reflexivity. This blindness, however, is our responsibility as we mature and enter a relational world. Others have to bear the brunt of our blindness while we're tripping over these ropes. But do we listen when the person who has tripped up on our prejudice or discrimination brings it to our notice? How do we respond to this?

'Our racism is tightly bound to our chest by invisible ropes. These are deeply internalised ideas about the world'

LIGHTSPRING/SHUTTERSTOCK

The deeper psychological work around unpacking our racism is not always an individual journey but a relational one. When we are called out for a microaggression it can be an opportunity to connect, not disconnect, as it is often experienced. You are being invited into a conversation by someone implying, 'Hey, I'm hurt by you. I might want to stay in a relationship with you. But in order to do so I need you to look at these aspects of yourself that hurt/harm me.' Simple enough, right? But what happens in real life? What makes something so simple exceptionally heavy on our hearts?

Spiral

Our racism is in us – most often unshakable and hidden below splendid ideas of ourselves being good people, of being kind, generous, intelligent, empathetic or understanding. Our racism is buried deep underneath these layers of wonderful, and probably true, qualities we hold on to so preciously. And being called out as being racist doesn't actually negate them – it calls attention to the ways in which we might not always be wonderful, equally, to everyone.

Yet we spiral. Our whole identity and sense of self feels under attack. Our actions being called out as racist have the capacity to annihilate our whole being. The threat of being exposed – most often to ourselves – tends to feel more real than the harm perpetuated. We are engulfed by the storm of vulnerability within, having to defend our goodness, and it has the capacity to consume us. We are preoccupied by our own dissonance and are unable to identify with or correct the harm we caused. This is not 'doing the work' around racial trauma and the role we play in it but plays into the narcissism of goodness and is not rooted in relationality.

The disconnection we experience by being called out – being invited to investigate our unconsciously defended, learned beliefs – is really a disconnection from ourselves, of wanting to push these associations of the caricature far, far away. It's not being able to contain the guilt and shame while we see ourselves. Someone just untied those invisible ropes – they are no longer invisible or harmless. We can see them in their complexity and ugliness, and we don't like to think that we have been bound or conditioned.

We become defensive, we attack, we cry. We feel silenced, and while that is projected on the messenger it is our own shame that is truly silencing. But our racism exists. We know deep inside that our racism has the potential to cause harm – in whatever degree – or our defensive reaction wouldn't exist.

Colourism

The interesting part is that this doesn't apply just to whiteness but also to communities of colour. We all grow up in a racialised world and absorb similar messages, and this reaction plays out intra-psychically too. For people of colour there are so many messages about our ethnicities and skin being 'bad' that we learn to devalue it very deeply. We degrade ourselves for our skin colour and features, and try to fix our feelings of inadequacy by bleaching our skin or modelling whiteness in whichever form is possible. But as we do this we miss how we have become the caricature ourselves.

As people of colour we assume that racism is something that happens to us, not within us. We don't think it is the socialised voice in our head or the inadequacy that plagues our being. In our imagination this caricature is outside us and not embodied. But let's think about this for a few minutes. How would we feel if white folks spoke to us the way we speak to ourselves? I physically cringe at the idea. And we do this inside us and to our own, unconsciously, all the time. We become this caricature but not in the way that we ever imagined. The terminology is 'internalised racism' or 'colourism' (not used interchangeably). It is tough to deeply explore these lived realities of the racist voices in our head every day, and the deep ways in which they impact our relationship with our skin and our features, always feeling not good enough or making our own community feel that way by holding ourselves to the 'acceptable' idealisations of whiteness.

In India, where I'm from, some of my loved ones refuse to dance in the sun or enjoy the saltiness of the ocean waves splash against their skin in the daytime for fear of becoming too 'tanned' or darker skinned and therefore ugly in their own eyes. They tell their children not to run free for the same fear. And race goes beyond skin of course. We cannot accept our blissful, full bodies as our own because we have internalised the colonial project's version of what 'ideal' (white) bodies must look like. In India a woman's body is never her own. It is owned by the other, it is encroached on by the patriarchy and colonialism every day, and it shows itself when people freely comment on its size, shape and shade. It is often the first thing people say to each other when they meet after a while, 'Oh, you've put on so much weight', or 'Your daughter's skin has become quite dark *na*?' It is a culture of internalised colonisation, blatant and clear, but we are so immersed in it, we cannot see the ways in which we are harming ourselves and our loved ones so deeply.

We embody racism – all of us. We live in a racialised world but all of us contribute to this system, and dismantling is as much a personal responsibility as a community one. And so to this end, when I ask the question, 'What does a racist really look like?' the answer more realistically is 'Like me'.

ABOUT THE AUTHOR

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Letters

Your feedback on *Therapy Today* articles

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**Views expressed here are views of contributors, not necessarily those of BACP or* Therapy Today's *editorial team*

EAP work

I empathise with the problem about limited sessions offered by employee assistance programmes in 'Dilemmas' (*Therapy Today*, September 2024). I felt similarly when entering my current position as a child and adolescent counsellor within the NHS, and previously in my role as a statutory social worker, where often the support I could offer was limited.

Engaging in time-limited work limits what is possible, but so do many factors – not all those in need can afford private practice, particularly during a cost of living crisis. Working in statutory and voluntary agencies often involves timescales being dictated to us. Ideally this would be evidence led, but budgets and responsibilities to wider groups must be balanced too. Saying no to clients due to our individual limitations is one thing, but the limitations of the service are often beyond our control. If we choose not to take a client, often another will, or clients may have to wait longer.

Sometimes it's less what we do *for* clients than what we do *with* them I feel

that counts. We can sit with them in their experience of seeking help. Listen, understand and allow them to have an experience that perhaps was not as shaming or judgmental as they may have feared it would be.

We cannot always choose how much to offer a client, but we can be clear about what our limits are, and maybe more importantly we can choose to offer something. Sometimes being willing to listen is enough, even if it's only for right now.
James Mackenzie MBACP

I'd like to reassure the writer of September's 'dilemma' that much can be achieved in four sessions, not least providing a positive experience that may encourage clients to seeking further support, empowering and embedding hope. However, a plan agreeing on what can realistically be achieved is essential where complex issues are brought within a time-limited framework, along with transparency about issue(s) that may require further work. It's also important to identify and encourage engagement for the client to consider beyond the EAP contract, such as specialist charity provision, which can assist the client in continuing with the work.

If the four sessions consist of active listening and reflecting, along with psychoeducation to help the client self-soothe and emotionally regulate, a firm foundation of safety is being put in place for the client now and for future work. The most powerful part for clients in my experience is when they begin to realise they are not a prisoner of their past and subsequent triggers. Once they are able to calm and tolerate distress their courage grows and the real work can

A fair slice?

While I welcome the election promises made by the new Government discussed in the 'Big issue' article, 'A fair slice' (*Therapy Today*, September 2024), I wonder where the workforce is going to come from to provide clinical services in schools, hubs and an expanded NHS. The latter is particularly problematic as many mental health trusts refuse to recognise BACP or UKCP accreditation as appropriate qualifications equivalent to nursing or social work. Practitioners with no therapy training are employed to deliver evidence-based interventions, leaving qualified, accredited psychotherapists out of the NHS Agenda for Change framework. Until our qualifications are recognised and appropriately rewarded across NHS, third sector and education settings, mental health provision will remain patchy at best.
Rupert Smith MBACP (Accred)

> ‘A plan agreeing on what can realistically be achieved is essential where complex issues are brought within a time-limited framework, along with transparency about issue(s) that may require further work’

We very much welcome your letters – the maximum word count is 350 and letters may need to be edited. NB these pages are dedicated to responses to recent *Therapy Today* articles only.

begin. This may not be with you but with another therapist when the client is ready.
Julia Berrington MBACP (Snr Accred)

Experience

As soon as I saw the ‘Experience’ article, ‘The tragedy you try to leave at the door will at some point follow you into the therapy room’ (*Therapy Today*, July/August 2024), I knew something was wrong. It took me a few seconds of scanning the feature to realise what it was – the author’s name was missing. Usually, the author’s name is proudly announced in bold type, purposefully designed to stand out and be seen, usually repeated at the end with a photograph. But this time nothing except a footnote of anonymity tucked away at the end – ‘The author is a BACP member working in the north of England’. And then I realised what the article was about and why this innocent, non-descript epithet was there, ironically screaming out the author’s fear of being named, tracked down and persecuted for being a Jew. It hit me hard, a sad indictment of the fear many Jews feel and hide from every day of their lives.
Name withheld on request

I am writing in response to the ‘Experience’ piece in the July/August issue. As a therapist I had to ask myself the place of my political or any other views in the therapy room, and the anonymous writer expresses theirs eloquently. As a Jewish therapist who is distraught by Israel’s 76-plus years of violent oppression of the Palestinian people and by the 7 October attacks, I have also met the highly charged feelings in my therapy room in ways I don’t necessarily agree with. Might it have been useful for the therapist to have entered into the heat of the feeling in the room brought out in that encounter by, for example, enquiring into the client’s identification with an oppressed people, and asking if their own shocked response belonged to them or their client? As therapists we can contribute to justice and peace rather than sidestepping deep divisions in the world around us, which seems inadequate to me. Much is written about our social responsibility as therapists, and our duty to see and respond to our clients in their social and political context. We need to make this a reality in our therapy rooms.
Charlotte Williams MBACP (Accred)

My British father was a member of the Reform Synagogue and for one like myself, born Zera Yisrael – in other words, Jewish only through the paternal line – I have on occasion been reminded that I am not properly Jewish. It’s a distinction that does not trouble me but it does highlight that certain assumptions underpin certain labels. Not all Jews are considered properly Jewish, nor are all Jews Israeli and not all Jews are Zionists.

In the shadow of the murderous Hamas attack, the author has good countertransferential reason to react to opinion perceived as hostile but professionally has a responsibility to understand their client – were they being anti-semitic or only inadvertently insensitive?
Name withheld on request

I am Palestinian and my parents were expelled from their homes in 1948, and so my views come from that position. I am against all racial prejudices, including anti-semitism, and find it heartwarming that people who are not directly involved in the conflict are concerned about it as a humanitarian issue.

As a therapist I would be considering the client’s history and her experience with oppression. People who have experienced oppression will usually have empathy for others who are oppressed. Furthermore, the client seemed to be expressing anger at the state of Israel and ‘all oppressors’ rather than those of the Jewish faith. Perhaps the client’s feelings can be better understood in the context of them being seen as anti-colonial rather than anti-semitic?
Salwa Jayyusi MACP

As controversial topics are often evaded on grounds of protecting professional ‘neutrality’, it was interesting to read the Jewish therapist’s experience. The contributor is of the opinion that ‘there should be little interest in that country unless you are Jewish, Israeli or Palestinian’. Would they extend this view, and argue that expressions of international solidarity with the struggle against apartheid in South Africa were misplaced?

We were privileged to have contributed a piece in *Therapy Today* in 2009,[1] reporting on a visit made by a group of health professionals to Palestine/Israel, hosted by two Israeli human rights organisations. In it we described our visit to Yad Vashem, the Holocaust Museum in West Jerusalem: ‘High on the wall, just inside the museum, is the statement: “In the 1930s the rest of the world considered the persecution of the Jews to be an internal German matter”.’

We understand this as a justified rebuke to those who had looked the other way as the Nazi regime dispossessed and terrorised German Jews. It implies that the world ought then, as we believe it ought now, to speak out against such atrocities, whoever the perpetrators might be.
Martin Kemp and Eliana Pinto

REFERENCE

1. Kemp M, Pinto E. To resist is to exist: notes on the psychological impact of military occupation in Palestine. Therapy Today 2009; 20:2.

Kemi Omijeh

LIGHTFIELD STUDIOS/SHUTTERSTOCK

We don't value young therapists. I wanted to go into training straight after college as I instinctively knew what I wanted to do. At the interview I was initially told to reapply in a year. I felt assumptions were made about my age, so I fought to take the course at 19. In hindsight I understood why they suggested I reapply, but I also felt ready.

Learning has a different depth after you qualify. I am psychodynamically trained and the theory informs my work, but the learning never stops. I have invested in additional training to deepen my understanding of an intercultural approach, broaden my skill set in working creatively with young people, and connect with research and work that speaks to the experiences of black therapists.

Therapists are not 'blank slates'. Developing my cultural competence, which is an ongoing learning process with no final destination, has taught me that how clients perceive and respond to our intersectional identity as therapists matters. We need to be aware of what we may be bringing into the room, consciously or unconsciously.

Being a therapist changes you. I don't think I would be the kind of parent or partner I am today if I hadn't become a therapist. Particularly with parenting – my motto is you parent the child you have, not the child in your mind, and not by following a parent model.

We don't always need a career plan. It has been a surprise that my career path has led me to working in the media, such as being asked to be a resident therapist for the BBC TV reality series *Mimi on a Mission*, and a mental health consultant and writer for BBC Bitesize. The career I had in mind is not the career I have now – thankfully! I just follow my instincts and stay open to what might come my way.

We do need purpose and meaning. The underpinning of any work I do is ensuring I am highlighting an intercultural approach and supporting members of my community.

'I learned to swim as an adult originally for my children but the joy I experienced when I swam a full length was for myself'

Being a therapist can be lonely. It's only thanks to lockdown and connecting on social media that I made therapist friends. I spent much of my early career being marginalised, not finding other therapists who I felt I could connect with or who could relate to my experiences as a black therapist.

Laughter is medicine. Anyone who knows me knows I don't take myself too seriously. I love to spend time with friends who I can just be myself with, and balance that with time alone, walking the dog. I also find joy in learning and achieving new things, like learning to swim as an adult. I originally did it for my children so I could get in the pool with them, but the joy I experienced when I swam a full length of the pool unaided was for myself!

ABOUT THE AUTHOR

Kemi Omijeh MBACP is a London-based therapist who has more than 15 years of experience working with children, young people and their families. **kemiomijeh.com**

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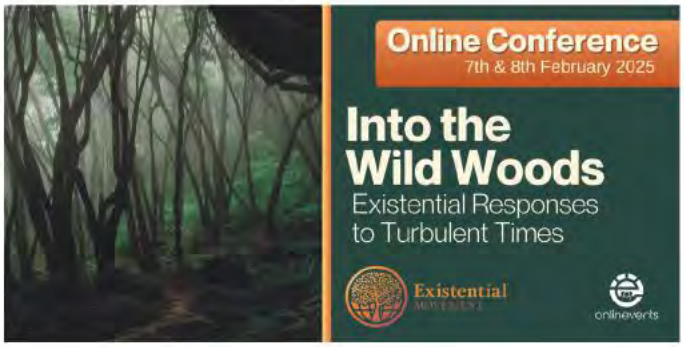

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