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For counsellors and psychotherapists working in healthcare

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Walking and talking 08

Plus

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Features

From the **Editor**

NAOMI CAINE

Regulars

Counselling and psychotherapy are often referred to as talking therapies. Indeed, NHS England has recently rebranded its psychological therapy services. Instead of Improving Access to Psychological Therapies (IAPT), it's now known as NHS Talking Therapies. It's undoubtedly catchier, but it's also a pretty good description of the counselling professions. And we can probably agree that talking therapy is powerful and effective, even if we don't all subscribe to the same modality.

But that's not to say that improvements can't be made. Most talking therapy takes place inside, with practitioner and client sitting opposite each other. It works for many people, but some clients find the traditional counselling setting uncomfortable, even oppressive. Maybe it can also be experienced as hierarchical, however much the practitioner believes in equality and supports a democratic dynamic.

Outdoor therapy is less rigid and formal, so is perhaps less intimidating. If your therapy sessions are outside, you can also enjoy the natural environment and the pleasure of being in a green space. Plus, you are probably doing some physical exercise, which is known to benefit both mind and body.

On p8, Simon Davies describes a walk-and-talk counselling project in the Midlands. It started during the pandemic, when it was difficult, if not impossible, to meet in person, inside. But the pilot was so successful that outdoor counselling is now one of the NHS Talking Therapies options in the area.

All types of therapy deal with emotions. But emotionally focused therapy (EFT) deals with emotions in a particular way. It draws on attachment theory, suggesting our emotions are often expressions of an attachment need. And it works with individuals, couples and families. On p14, Sarah McConnell walks us through the EFT moves, showing how the process helps clients to connect with their vulnerability, and interact with themselves and others in a more authentic way.

Equine therapy can also help us to understand how we interact with ourselves and others. As Tracie Holroyd highlights on p20, horses can offer us unique insights into our emotions and behaviour.

Massage therapy isn't a traditional talking therapy. But it doesn't only offer relief for physical symptoms, such as a tense shoulder or a stiff neck. Massage therapy can also alleviate psychological distress, by promoting calmness and relaxation. It's all about the connection between the mind and the body.

> “Emotions are often expressions of an attachment need”

Trauma-informed massage therapy is an emerging discipline. But its attention to the profound impact of psychological trauma on the body's nervous system is proving effective when working with people who have experienced trauma. Hanna Kemp writes on p24 about the different massage techniques and the importance of creating a safe environment for the client.

Addiction is surely as complex as it is distressing – and it's certainly not easy to treat effectively. And addiction to crack cocaine seems to be particularly virulent. Like many towns in the UK, Great Yarmouth is struggling to deal with the impact of crack cocaine. Richard Wink, a therapist for the People Sleeping Rough Team in the town, writes on p28 about the team's multidisciplinary approach and the ways it supports vulnerable users. ■

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In touch with your BACP

Competence framework supports counsellors working with addictions

We have published a new Addictions Competence Framework, to support practice in addictions counselling. The competence framework acknowledges the specific knowledge, skills and abilities required by counsellors who want to work with clients with addictions.

The competence framework can be used by counsellors already working with clients with addictions, 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.

The framework also provides training institutions, service providers and researchers with an up-to-date resource to inform and enable activities, such as curriculum development and delivery, commissioning, clinical governance, research and continuing professional development (CPD).

You can download the Addictions Competence Framework at: https://tinyurl.com/5csu9yyw

BACP issues statement on investigation into social media claims

Last year, we commissioned an independent investigation into claims made anonymously about BACP on social media. We engaged independent experts to conduct a comprehensive review. In response to the review, we've developed an action plan to address the issues raised.

The report clearly found that there was no evidence of fraud or financial wrong-doing, and no financial loss was identified. The report concluded that multiple social media comments contained information that lacked '... relevant, critical context which typically negates the allegations'.

The analysis did highlight opportunities for us to review and improve some of our internal processes. Specifically, our action plan involves strengthening the signing-off and auditing of expenses, including the process of reviewing any exceptional expenditure that falls outside policy limits.

The report was helpful in pointing out historic issues and routines that were having an impact on a healthy working relationship between the Board and senior staff, highlighting that BACP staff members had left the organisation due to issues relating to organisational culture.

With new Trustees on board, including a Senior Independent Trustee, and a new CEO and Senior Leadership Team in place, we've already seen improvements in the way we work together.

We're now focusing on practical steps to strengthen relationships, improve communications and ensure our procedures support both positive collaboration and constructive challenge. In our plan, we're committing time and space for deliberate and collective reflection, so that we're always challenging ourselves to become a more effective governing body.

Alongside our personal commitments as leaders, we want our colleagues to feel safe in sharing their concerns and ideas. We accept our responsibility to foster a positive and inclusive culture and have established new internal practices to accommodate this, including the introduction of a new whistleblowing service.

We also understand how the work of our Board might not always be clear and transparent. We respect that you want to hear more from us, and more often, and we're committed to sharing more regular updates with you all.

You can read the full statement at: tinyurl.com/43bysdd3

Member writes about her experience as a dyslexic counsellor

In a member blog, Debbie Keenan, an integrative counsellor, writes about her experience as a dyslexic counsellor and how it enhances her relationships with her clients. Debbie found out that she was dyslexic at the age of 41. She explains how her dyslexia has resulted in excellent listening skills, which are crucial when nurturing a therapeutic relationship. You can read Debbie's blog at: tinyurl.com/yhswtm9u

Blog considers the connection between mind and body

Nicola Vanlint is an accredited member of BACP, whose clients include international footballers and elite athletes. In her member blog, *Healing the Brain and Body in Therapy*, Nicola explains how her approach recognises the connection between mental and physical health. She also suggests ways that counsellors can use the brain-body connection to help their clients. You can read Nicola's blog at: tinyurl.com/bd6bztne

How to help clients manage anger

Join us for an online professional development day (PDD) on Wednesday 26 March 2025, to help you work more effectively and confidently with clients who present with anger.

The PDD is not about theory. Instead, it will consider practical ways of working with clients and their anger.

It will be presented by Martin Hogg, who has been a counsellor in private practice since 2005, working exclusively with young people and adults with anger management issues.

The main aims of the PDD are to:

- increase confidence in working with clients who report anger problems
- identify the underlying issues that clients have with anger
- introduce a suite of tools to use with clients
- offer practical examples to demonstrate the use of anger management techniques
- better understand our own relationship with anger.

The workshop is split into three sessions, each followed by a live Q&A session with Martin. The first session will begin at 9.30am and the event will finish at 1.00pm.

The price for BACP members is £35. To book your place online, please visit: https://tinyurl.com/24x43wkc

Workshop explores suicide and self-harm

On Friday 31 January 2025, Katherine Caffrey will present an online professional development day (PDD) on suicide and self-harm.

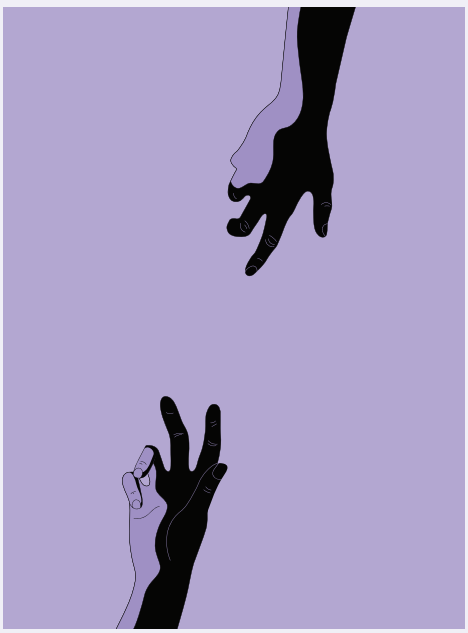
The PDD will provide strategies to manage risk safely and effectively, through presentations and individual exercises. The main aims are to:

- understand our own experience and beliefs around suicide and self-harm, and raise awareness of the law around suicide
- understand risk assessment strategies – the importance of asking the right questions in the right way
- be more confident about when and how to break confidentiality
- look at the benefits and potential pitfalls of safety planning
- recognise the importance of self-care when working with risk.

The workshop is split into three sessions, each followed by a live Q&A session with Kath. The first session will begin at 9.30am and the event will finish at 1.00pm.

The price for BACP members is £35. To book your place online, please visit: https://tinyurl.com/mpew4u4k

Call for investment in early intervention as suicide rates increase to highest level in two decades



We're calling on the Government to urgently invest in suicide prevention, as new figures from the Office for National Statistics (ONS) reveal that suicide rates in England and Wales are at their highest levels in two decades.

The ONS data show 6,069 suicides were registered in England and Wales in 2023 – an increase from 5,642 in 2022, and the highest rate since 1999. Of the recorded deaths, three-quarters were male, but the female suicide rate also reached its highest level since 1994.

We're urging the Government to recognise that access to psychological therapies is a crucial part of suicide prevention, and early intervention can offer people vital support before they reach crisis point.

Our Third Sector Lead, Jeremy Bacon, said: 'It's essential that counselling and psychotherapy are easily accessible and available to anyone who is at risk of suicide or self-harm, as well as those who are affected by these issues. Suicide is the main cause of death in people under 35 in the UK. And for every one of those people, there's a personal tragedy and the grief of loved ones left behind.

'The latest statistics highlight the stark impact of the funding crisis that has caused many community-based services to reduce their delivery, close waiting lists or even shut down in the face of rising demand. We strongly urge the Government to consider investing more in timely and appropriate services for suicide prevention in the next budget.'

BACP is part of the National Suicide Prevention Alliance (NSPA), which works to reduce suicide and help people get access to support when they need it. We've put together a compilation of suicide prevention resources for members, including presentations, articles and good practice resources. Please visit: https://tinyurl.com/bdh4znkw

BACP meets conditions for professional accreditation

We're pleased to announce that the Professional Standards Agency (PSA) has re-accredited BACP, following a review of our work.

The PSA checks in on our processes every year, to make sure we are maintaining high professional standards and protecting the public.

It carried out a targeted review this year, seeking further detail on some specific areas. We were re-accredited in March, with three conditions. The PSA asked us to complete the work on those three conditions within three months.

The first condition was that we should obtain an independent, authoritative review of our Good Practice in Action resource, *Talking about suicide risk with clients in the counselling professions* (GPiA 042).

The second condition was that we should share our updated GPiA 042 and supporting guidance with our members. We've already produced and communicated to members a short video resource, which highlights recent changes to the National Institute for Health and Care Excellence (NICE) guidance on suicide risk, *Self-harm: assessment, management and preventing recurrence* (NG 225).

The third condition was that we must demonstrate we've informed our education and training providers of the need to include the underpinning evidence base (as set out in NG 225) in teaching on suicide risk assessment, and that self-assessment risk assessment tools are unable to accurately predict suicide.

We're committed to improving our resources, to support both the public and our members.

The PSA has now confirmed that we have met all the conditions. You can find out more at: https://tinyurl.com/bp4rusp2

Tune into the Insights podcasts

BACP's *Insights* podcasts feature lively conversations with experts and counsellors across the professions, focusing on topics that aim to expand your expertise and foster collaborative learning. In the latest episode of *Insights*, podcast host Grace Mansah-Owusu is joined by Callum Jones, to discuss how we can better support members and their clients with disabilities.

Grace is a BACP registered counsellor, organisational psychologist, trainer and career coach. She hosts two podcasts of her own, *The Black Business Psychology Podcast* and *The Great Minds for Business Podcast*, highlighting and showcasing the careers of racially minoritised professionals in the fields of psychology, medicine, healthcare, art, research, film and non-profit organisations.

Callum is a BACP accredited therapist and a doctoral student studying Counselling and Psychological Trauma. He is employed by the University of Salford as a lecturer and also works in private practice. Callum aims to raise awareness of the ableism that exists within counselling and psychotherapy by applying the social model of disability.

The learning outcomes for this podcast episode are to:

- identify and bring awareness to disability in counselling courses
- examine possible changes to accredited courses to support disability
- discuss the social model of disability.

You can listen online, download the podcast or read the transcript. If it's your first visit to the Learning centre, you'll be asked to read and agree to the terms and conditions. Once you've listened to a podcast, you can record it on your CPD log and download a CPD certificate.

You can find out more at:
https://tinyurl.com/mwbzcj7u

Campaign trail

MATTHEW SMITH-LILLEY

Following the election of the Labour Government in the summer, we have begun reaching out to relevant ministers, to promote the skills and expertise of counsellors and psychotherapists – and how they can best be brought into the workforce to deliver high-quality public services.

Wes Streeting is the new Secretary of State for Health and Social Care. Ministers in the department include Karin Smyth MP, Stephen Kinnock MP, Andrew Gwynne MP and Baroness Merron, who has responsibility for mental health.

Our priority for working with the new Government will be to continue to argue for an expansion of counselling and psychotherapy, focusing on the importance of choice and waiting times, so that everyone can access high-quality counselling and psychotherapy, which is free at the point of need. We will also continue to champion the importance of employment opportunities for our members.

Autumn budget

We are preparing our submission to the Treasury, ahead of the autumn budget, which is scheduled for October 30. We will put forward the case for continued and further investment in counselling and psychotherapy. We will also reiterate our calls for more opportunities for both qualified and trainee counsellors to take up paid roles within the NHS, both to help meet workforce expansion targets and to widen the choice of therapies on offer to the public.

At the moment, counsellors and psychotherapists are often overlooked, undervalued and underappreciated in the health service, typically encountering pay inequity and barriers to career progression.

We would like our members to be able to enter the NHS as trainees and go on to develop thriving careers, rewarded with promotion, development and leadership opportunities.

Crisis care

NHS England has recently announced that the 111 service will, for the first time, offer support for people experiencing a mental health crisis, 24 hours a day, seven days a week. The service, which is available to people of all ages, can be accessed by selecting the mental health option after calling 111.

BACP welcomes the wider provision of crisis care, as recognition of the vital need to increase access to mental health support in this country. There must be greater capacity in all national mental health services, so there are no gaps in provision.

We also need to see greater investment in interventions to support people before they reach crisis point, including employing more counsellors and psychotherapists in the NHS.

Professional recognition in the NHS

We have been contacted by a small number of members working in the NHS in England, as their NHS Trusts have failed to recognise that BACP membership is sufficient for some roles.

If examples are brought to our attention, we are able to contact NHS Trusts to gather further information about their decision making, and to correct any misunderstandings about the training and competences of our members.

If you have experienced any similar difficulties in your NHS Trust, please email me at: matthew.smith-lilley@bacp.co.uk ■

Matthew Smith-Lilley *is the Policy and Engagement Lead (Mental Health) for BACP. To contact Matthew, please email: matthew.smith-lilley@bacp.co.uk*

Walking and talking

An NHS Talking Therapies service piloted walk-and-talk counselling during the pandemic. It was so successful that it's now permanently available, as ***Simon Davies*** explains

In a city park, two people walk together – one is talking seriously; the other is listening intently. People stroll past, enjoying the autumn sunshine. It's not an image that immediately comes to mind when we think about NHS Talking Therapies. We might more typically picture a neutral room with two chairs, or even a couch and a portrait of Sigmund Freud.

NHS Talking Therapies are many people's first – and often only – encounter with psychological support, in large part because they are free at the point of access and available through primary care services.[1] But some people find the typical therapy setting uncomfortable or even intimidating. The option of outdoor therapy can therefore offer them easier access to the support they need.

> Some people find the typical therapy setting uncomfortable

The decision to take therapy into the outside world is not particularly new. In the spring of 1910, Freud famously analysed the composer Gustav Mahler on a four-hour walk through the streets of Leiden, Holland.[2] Since then, the benefits of access to nature have been widely documented. For example, Roger Ulrich's groundbreaking 1984 study found that physical health outcomes for hospital patients improved when they could see greenery through a window.[3] There is also a body of evidence that confirms the benefits to mental health of exposure to nature, especially while engaging in some kind of physical activity, such as walking.[4,5]

Ecopsychology looks at the relationship between humans and nature – and it has become more popular since the 1980s. It is based on the biophilia hypothesis,[6] which proposes that humans have an innate tendency to seek connections with the natural world. Consequently, psychological distress increases if we become disconnected from our natural environment.[7]

Ecotherapy, a branch of ecopsychology, harnesses the healing power of nature with a range of therapeutic practices that combine traditional forms of talking therapy with time spent in an outdoor environment, such as walk-and-talk counselling.[8] Evidence suggests that such interventions not only improve clients' connections with the natural world but also enhance the experience of therapy. They can support a non-hierarchical relationship between therapist and client, helping clients to talk more freely, especially when they have struggled to engage with talking therapies indoors, online or by phone.[9]

The COVID-19 pandemic prompted therapists to think more creatively and flexibly about clinical settings. Outdoor therapy increased in popularity, in response to pandemic restrictions.[10] Some practitioners, for example, offered walk-and-talk sessions, so they could meet their clients face to face, when indoor working was impossible.[11]

The Living Well Consortium consists of more than 40 voluntary, community, faith and social enterprise organisations. The consortium works collaboratively to improve access to mental health and wellbeing services across Birmingham, Solihull and other areas of the Midlands. A large part of this work includes a contract to deliver NHS Talking Therapies.

In 2021, the Living Well Consortium recruited three qualified counsellors to explore the potential for offering outdoor NHS Talking Therapies sessions. At the time, many clients were requesting face-to-face therapy, but the pandemic restrictions did not always allow for indoor, in-person sessions. The pilot was modelled on the British Psychological Society (BPS) guidance on outdoor therapy.[12] The guidance covers a range of factors, including an assessment of location, practitioner and client suitability, procedures for informed client consent and predictability of sessions, such as a regular meeting place and route.

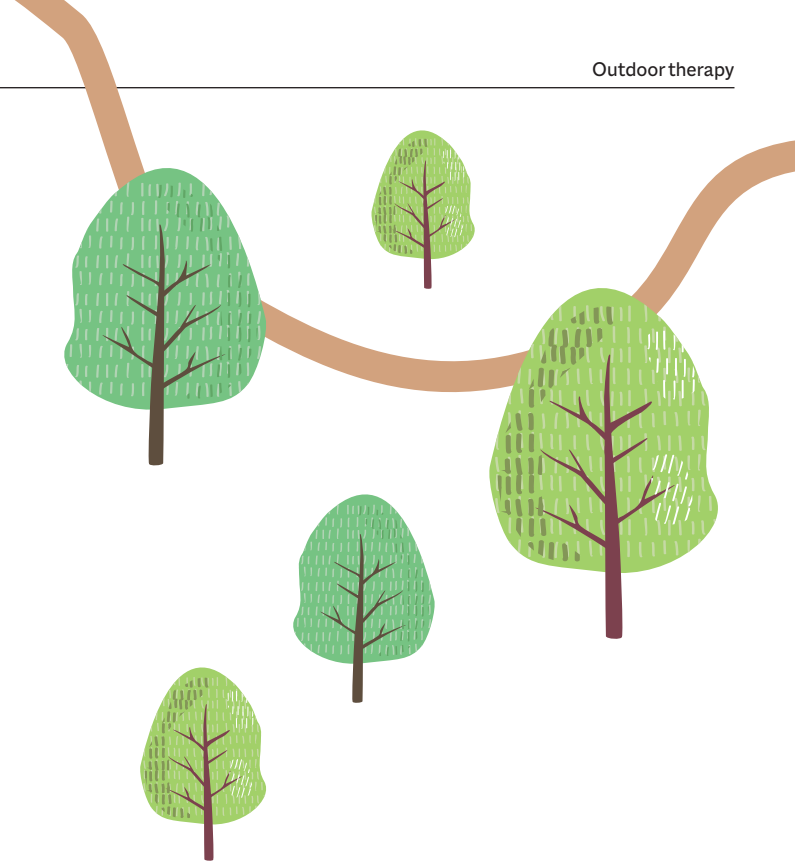
The service was also mapped onto Zone 1 of the Institute for Outdoor Learning (IOL) Statement of Good Practice for mental health interventions outdoors, which emphasises that the service's primary purpose is to provide counselling.[13]

In line with the BPS guidance, the first step was to identify appropriate green spaces to deliver the sessions. The following key features were considered necessary to ensure suitability:

- even, well-paved paths, suitable for walking and wheelchairs
- an area for practitioners to shelter between sessions, with access to toilet facilities
- availability of benches or seating areas for clients with limited mobility
- adequate links to public transport and/or parking spaces.

Larger parks in the centre of the city were deemed the most suitable, as they offered easier access to transport options and greater availability of shelter. They were also more likely to have seating areas, as well as wider, well-maintained paths. Parks in the city centre were busier than parks in outlying areas, minimising any concerns about personal safety. But they were also spacious enough to safeguard confidentiality.

To mitigate the risk of lone working in a public space, the practitioner team created a 'check-in, check-out' system on a private WhatsApp group, which was always monitored by at least one practitioner. Counsellors notified the group when they were meeting a client and when the session had finished.



A new clinical contract was created, based on the BPS guidance for informed consent. The contract:

- informed clients of the limits to confidentiality when working outside in a public space
- explained that sessions would go ahead, whatever the weather, except if the Met Office issued an alert, in which case the practitioner would contact the client as soon as possible to offer a telephone or video appointment, or to reschedule the session.

Clients who expressed an interest in outdoor therapy were then booked in for a one-hour telephone assessment with a walk-and-talk counsellor. The telephone assessment discussed presenting issues, goals and expectations for therapy, as well as the implications of working outdoors. Specifically, this included:

- screening for any health conditions that might impact the client's ability to move through the space
- assessing the client's familiarity with the proposed location for therapy, including any personal connections to the place or whether they anticipated seeing anyone they knew
- assessing the client's positive or negative emotional associations with green spaces outdoors.

The pilot walking therapy service ran for one year, from November 2021. And it was successful enough to be incorporated as a permanent offer within Living Well Consortium's choice of NHS Talking Therapies.

Outcomes were monitored using the PHQ-9 (depression) and GAD-7 (anxiety) questionnaires, which are mandatory for NHS Talking Therapies. We also collected qualitative client feedback – and it continues to inform the ongoing development of the service.

Mandatory data set monitoring shows that 58% of clients moved to recovery after completing eight to 12 sessions of walking therapy, well above the NHS guideline benchmark of 50% for Talking Therapies. The feedback from clients and the reflections of practitioners highlight the distinctive features of the walk-and-talk offer within an NHS setting.

'It was nice compared to being sat in a room for an hour. The experience didn't feel like therapy.'

The outdoor setting was particularly appealing to clients who had previously found it intimidating or uncomfortable to meet in a typical practice room. It was also immediately different and separate from their experiences of other professional services. Clients who might have written off counselling, especially clients with negative experiences of other statutory services, therefore had the opportunity to engage with the therapeutic process in a way that might otherwise have been lost or missed.

> The first step was to identify appropriate green spaces

The practitioners were trained in person-centred experiential counselling for depression (PCE-CfD), as part of the NHS Talking Therapies programme. In their reflections, the counsellors noted that the outdoor setting supported the emphasis on equalising the power dynamic between therapist and client, which is at the core of the Rogerian approach.[14]

'You feel like you're making progress with sorting out the issues that are impacting your life and at the same time you're giving yourself a treat of a lovely walk in a lovely environment.'

By combining talking therapy with walking, clients can attend to their physical as well as their mental health. A recent meta-analysis shows that increasing our daily step count by just 4,000 can significantly decrease the risk of cardiovascular disease.[15] Many clients also indicated that they would continue to take regular walks, after the sessions had finished.

'I often came to the sessions straight from a day of work, and would feel like my mind was at a 100 miles an hour. I found being outside helped me feel a lot calmer by the end of the session, and reduced some of the day's anxiety.'

Research into the Japanese practice of *shinrin-yoku* (forest bathing) documents the psychological benefits of spending time in green spaces, including improvements in depression, anger and anxiety.[16] There are also physiological benefits, such as reduced blood pressure.[17]

Outdoor therapy works at the intersection of physical and mental health, acknowledging the interdependence of these two aspects of wellbeing.[8,9] Walk-and-talk counselling could perhaps be seen as a practical example of the integrated approach, advocated by Doherty and Gaughran, to address co-morbidities in both physical and mental health.[18]

'I felt there wasn't the pressure to talk the whole session. I could have moments in which I could just be present and take in my surroundings.'

Clients often feel the pressure to talk in traditional counselling rooms, as they find silences uncomfortable or a waste of session time.[19] But clients reported feeling less pressure to talk in an outdoor setting. They also felt more present in the moment and their environment. The ability to be present links to Kaplan and Kaplan's 'attention restoration' theory,[20] which proposes that natural environments provide 'soft fascinations', such as the colours of flowers, swaying of trees or sounds of birdsong. The soft fascinations offer gentle stimulation, but don't require focus or attention. In contrast, most working and urban environments demand effortful focus and attention that can lead to stress and fatigue. The natural environment can therefore offer relief and enable us to feel restored.

> The benefits of outdoor therapy extend beyond the pandemic

As practitioners, the encouragement of a form of attention that is relaxed and present, rather than goal-oriented, complemented the non-directive approach of PCE-CfD. It might also have helped to support clients who had struggled to engage with the more outcome-focused cognitive behavioural therapy (CBT), which is more widely available within NHS Talking Therapies services.[21]

'It felt less formal and, in a way, there was less pressure on me … I think perhaps it's because you're not sitting in an office staring at somebody but walking along beside them.'

In an outdoor setting, the therapist walks alongside the client. The lack of eye contact can be helpful for some clients. In the feedback, one client likened the therapeutic encounter to a car journey, when it is easier to talk about difficult feelings because you are not looking directly into someone's eyes. And in a recent study of walk-and-talk counselling, clients appreciated the release from the expectation to make continuous eye contact with the therapist.[10]

Walking together can foster a 'side-by-side' relationship, with client and therapist working collaboratively in attending to both the client's concerns and the shared environment. Brazier writes: 'When we go outside, as we actually walk together or sit next to one another, we both experience the same landscape and respond to it, so we can see similarities and differences in how we perceive things.'[22]

The consortium originally offered walking therapy to accommodate client demand for face-to-face therapy during the pandemic. But the benefits of outdoor therapy extend beyond the pandemic.

Some clients find it difficult to engage with therapy in traditional settings, partly as a result of negative associations with medical, clinical and other statutory services. Taking the process outdoors proved a cost-effective way not only to lower barriers to engagement but also to enrich the service.

During the pilot, we collected quantitative data and qualitative feedback, but no demographic data. Future provision and evaluation of the service would benefit from demographic data, to build a clearer picture of the clients and communities that are best served by the walk-and-talk service, and where it needs to evolve and improve.

Clients who are not white, middle-class and able-bodied often find it harder to access green spaces.[23] The racialised

> Clients can attend to their physical as well as their mental health

narratives of nature and belonging in the UK can result in green spaces being both explicitly and implicitly discriminatory.[24] Yet, as Djossou argues, outdoor spaces also present counselling and psychotherapy with an opportunity to re-envisage their services, without the lens of white hegemony.[23] Djossou has championed hiking groups, led by black people, to empower participants to feel seen and welcomed into outdoor spaces, a model that could translate well to ecotherapy groups. Living Well Consortium's Healing Circles, delivered by Pattigift Therapy,[25] exemplify another supportive space that directly addresses racial inequality.

We could also think about developing an outdoor therapeutic experience that does not involve walking, so we could include people who have mobility issues.

My hope is to encourage further discussion and exploration of outdoor therapy, in order to keep alive the premise of 'improving access' that was originally embedded in the NHS Talking Therapies provision. ■

Simon Davies *is a BACP registered counsellor and NHS Talking Therapies high-intensity therapist, delivering walking therapy for the Living Well Consortium (www.livingwellconsortium.com). Simon and the outdoor therapy team would welcome contact from practitioners and services interested in setting up or expanding an outdoor therapy provision.*

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1 NHS England. NHS talking therapies for anxiety and depression. [Online.] https://tinyurl.com/mpad47wv (accessed July 2024).

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WHAT LIES BENEATH

Sarah McConnell explores how emotionally focused therapy helps clients to understand and express their hidden emotions

Some years ago, my partner and I were out for a walk in Houston, Texas. Suddenly, there was a huge thunderclap. Houston storms are not like British storms: they are intense, loud and often come without much warning. Before my brain knew what I was doing, my body, specifically my hands, reached out for my partner. My nervous system needed contact and comfort in that moment of potential danger and threat.

'Attachment is not a mere connection between two people; it is a bond that involves a desire for proximity to the person we are attached to.'[1]

My experience in the Houston storm is, to my mind, a perfect illustration of attachment theory, which has its roots in the pioneering work of John Bowlby. Attachment theory proposes that the need to connect with a trusted other, to feel safe in the face of threat, to know that you don't have to face life alone, is critical to our survival. Conversely, to feel alone, without connection or safety, can be devastating and damaging to our mental and physical wellbeing. It is not weak to need others.

Sue Johnson and Les Greenberg drew on Bowlby's insights to develop emotionally focused therapy (EFT) in the 1980s.[2] Sue went on to develop EFT for couples (EFCT), emotionally focused individual therapy (EFIT) and emotionally focused family therapy (EFFT). More than 30 outcome and follow-up studies demonstrate the EFT model's effectiveness in creating lasting change.[3]

Working with emotion in EFT

In EFT, we refer to the 'primary' emotions, which are the '... here and now direct responses to situations'; 'secondary' emotions are '... reactions to, and attempts to cope with, these direct responses, often obscuring awareness of the primary response'.[4] For example, we might bury a primary emotion of fear, hurt or shame, protecting ourselves with a secondary emotion or response, such as anger, anxiousness or avoidance.

If we're lucky enough to have learned to express our primary emotions, it's usually because our caregivers have tuned into and mirrored our emotions, helping us to become securely attached. But if our needs have not been met, we learn to cover up our vulnerability. So, we might use reactive, anxious or avoidant coping strategies, as a result of our attachment insecurity. Of course, this process usually happens outside of conscious awareness.

Emotion in EFT is both the target and the agent of change. If our clients can take ownership of vulnerable, primary emotions that have become 'foreign, alien and unacceptable',[5] they can experience and share what they really feel, which can bring about the change they seek.

The work also involves exploring and sharing feelings about previous – and sometimes ongoing – experiences, such as life events, traumas, discrimination and oppression, which impact the way we respond to ourselves and others.

EFT helps clients to feel safe because it validates both their attachment need and the reason they have learned to cover up their vulnerability. Accompanied by the therapist, they can then explore and organise their emotional world, maybe for the first time. They can also share their attachment fears and needs, creating compassion and providing corrective emotional experiences. They become accessible to themselves and in touch with their emotions. In EFT for couples and families, the partner or family member is also accessible and responsive – and the couple or family is now emotionally engaged with each other.

How we intervene

In every EFT session, the therapist uses the 'EFT tango' to explore emotions.[6] The first tango move reflects on the client's present processes – how they deal with emotions and relationships. The following example from an EFIT session demonstrates the first move of the tango, when the therapist tracks the client's experience of himself, and between himself and others.

> The need to connect with a trusted other is critical to our survival

'Therapist: I hear that you are very upset and angry at your boss, Sam. You feel unfairly treated and you see this as leaving you in this dark fog of depression. If I have it right, you get caught in this space and become more and more angry, more and more down, till the spiral takes over your life. You didn't want to come and talk to me about this really – it's hard. It feels safer to shut everyone out – yes?'[6]

The second move draws on the work of Magda Arnold, who described emotion as a process containing several elements – a cue or trigger, an initial appraisal, a 'felt sense' in the body, a cognitive reappraisal or meaning making and an action tendency.[7] In the second tango move, we assemble these elements of emotion, so we can slow down a process that is usually very fast (remember the thunderclap story). Here's an example of the second tango move with a couple.

'Therapist: Can you help me, Dan? You just turned away and shook your head there, as Marnie talked about her hurt. What happened there? What is it that has you shaking your head like this?

Dan: I think it's that voice she uses.'

(Dan identifies the trigger for his habitual withdrawal from his partner.)

'Therapist: Can you help me? What does your body feel like when you turn away? What does it feel like right now?

Dan (looks blank): I just shut down. I don't feel nothing at all. Nothing.

Therapist: So, you want to shut down, something here doesn't feel good?

Dan: Oh, it feels bad, bad, like get me out of here, so I turn away.'

(Dan is giving his initial perception and his action tendency.)

'Therapist: So, you hear her tone, and it feels like something bad is going to happen. What do you hear in her voice?

Dan: She says she is "hurt" all the time, but all I hear is: "You have screwed up again. You are just a screw up, period".'

(Dan is talking about the meaning he makes of his partner's words and voice.)[6]

The third tango move involves the therapist asking the client to turn to their partner or family member with their new understanding of their internal experience. If we are working with individuals, we adapt the third tango move, as there is no partner or family member in the room. Instead, the therapist can act as the sharing partner, or the client can turn to an imagined attachment figure or a part of themself.

In the fourth move, we consider how the exchange impacted the sharer, receiver or the individual client. The final tango move, number five, is where we summarise, integrate and validate what has taken place.

The tango helps the client to find new compassion and understanding for themself, their partner or family member. Also, and this is just as important and useful, it enables us to identify blocks to compassion and understanding, which can be worked through in another tango. We use the tango moves right from the start of therapy and in every session. We can also use the tango multiple times in one session.

EFT for couples

'Emotional availability and responsiveness of caregivers are crucial for establishing secure attachment bonds.'[1]

By viewing tapes of couples in therapy, Sue and her team recognised that a focus on the attachment bond between couples could be helpful. Conflict could then be understood as protests at the absence or unavailability of the attachment figure.

When we meet couples in therapy, we often discover that it's too risky for them to ask each other to be there in times of need

> We might bury a primary emotion of fear, hurt or shame

or if they matter to their partner. A pattern of interaction therefore develops that often involves blame, criticism, avoidance and anger. Sue realised the importance of making sense of the conflict, understanding the emotions as a response to the underlying desperation that clients feel when an important attachment need is not met.

'Tara: When I walk into the room and he is absorbed in his gaming, he barely notices I am there, so I storm out and stew for an hour before returning like this angry monster!

Therapist: You stew at your sense that Kyle is absorbed in something and there's no room for you. He doesn't even know how lonely and upset you are for the entire hour of your stewing. After you can't stand the stewing in your own loneliness without Kyle, you go back to him and erupt in anger, demanding his attention.'[7]

EFT helps couples to step back and see the negative cycle or pattern that they are co-creating – and to start to understand how they get stuck in the pattern. For example, the more Tara pursues with anger, the more Kyle retreats. The more Kyle retreats, the more Tara pursues.

'Attachment is not a fixed trait; it can be influenced and shaped by later experiences and relationships.'[8]

In the first stage of EFT for couples, we identify and de-escalate the cycle. The couples slow down and start to talk to each other through engaged, emotional conversations, called 'encounters'. The encounters are carefully choreographed by the therapist, using the EFT tango moves, enabling the couple to break the negative cycle and talk to each other safely about the emotions that underlie the pattern or cycle. So, we might say something like: 'Tara, I'm hearing that underneath your anger is a longing for Kyle to notice you. Am I getting that? Could you turn to him and tell him that?' Couples can then start to experientially connect the dots and explore those 'foreign, alien and unacceptable emotions'.[5]

> EFT seeks not just to modify behaviour but to re-organise the pattern of interactions, so couples can rediscover their attachment bond and restore a sense of safety and connection. A common negative cycle is the pursue-withdraw pattern: one partner has learned to cope with attachment

desperation by pursuing their partner – pushing, prodding, demanding. The other partner has learned to cope with their attachment desperation by withdrawing – avoiding, going quiet, moving away. The EFT therapist tracks these cycles with the couple.

'Therapist: This is one of those times, Jane, is it, where you start to feel all alone, like Walt is indifferent to you? You feel invisible, and that stirs up indignation in you (invisible and indignation are Jane's words from a previous session), and you protest. You get mad and you "get in his face" as you put it.

Jane: Yes, and then he does his "I'm out of here" thing.

Therapist: Aha.

Walt: There's no point in staying.

Therapist: The way you experience it, there's nothing you can do then. It seems hopeless.

Walt: Right, right, so I run. I go and find my friends.

Therapist: You run to a safer place, where nobody gets mad at you, tells you they are disappointed in you. That's very difficult for you to hear?'[4]

In stage two, restructuring attachment, EFT therapists help couples to explore their primary emotions more deeply. We can then find out what is preventing or blocking the clients from sharing their vulnerable feelings. We work first with the partner who withdraws. We want the withdrawing partner 'on the dance floor' first, because we need them to be engaged before we ask the pursuing partner to reach behind their anger or criticism to something more vulnerable. Otherwise, the pursuer's needs could once again be unmet, risking another attachment injury.

We then focus on the pursuing partner. We try to help them discover why they are unable to vulnerably reach for their partner – and support and encourage them to risk asking for their attachment needs to be met. We then support the other partner to listen and respond in a compassionate way. At this stage, partners are usually ready and able to reassure their loved one, facilitating a corrective emotional experience.

When connection and attachment security have been re-established, we proceed to the third stage – consolidation. By the consolidation stage, clients can address problems with a greater sense of agency and safety, helping them to reinforce the positive attachment cycles developed from their work in stages one and two.

EFT with individuals and families

The basic tenets of EFT remain the same, whether working with couples, individuals or families. The first stage of EFT with individuals – de-escalation of the cycle – helps the client to become aware of their own patterns, as in the example with Sam. We use reflection and validation, as well as the tango, to slow down the process of experiencing, so emotions can be

> Therapists help couples to explore their primary emotions more deeply

assembled into something that makes sense. The first stage prepares the individual client for stage two, restructuring attachment, where we again use the tango moves to evoke and feel primary attachment emotions, so the client begins to interact with themselves and others in a more authentic way. In stage three, we help the client to explore and consolidate their new, authentic ways of being.

'If we value our children, we must cherish their parents.'[9]

With families, the relationships are hierarchical, as parents are responsible for caring for the child. We still focus on connection, but it's about creating a felt sense of belonging, rather than intimacy. We work in dyads (for example, one parent and one child), though other family members are sometimes also in the room. We often see parents alone first, to strengthen the parental system, before working with the child or children.

In the first stage of EFFT, we look at the patterns of interaction between parents and children. But we don't talk about pursuing and withdrawing. Instead, we simply track the triggers for attachment distress and the ensuing patterns. We are looking to identify, access and harness the parent's accessibility, which is often missed, unseen or distrusted by the child.

Once the parent's accessibility is up and running, we move into stage two of EFFT where, with more attachment safety available, we can help the child to let their parent or parents know what they need – needs that are not immediately obvious from the child's secondary responses.

In stage three, we help families solve problems and talk about issues that they were previously unable to manage. We also celebrate and consolidate the changes they have made. The tango is our guiding intervention throughout, helping parents and children initiate different conversations, without the interference of negative cycles.

It's been my privilege to see firsthand how couples, individuals and families have been able to identify and change their negative cycles, allowing them to have secure conversations. Sadly, Sue Johnson died in April 2024, but I offer my grateful thanks and appreciation for her dedication and determination in growing and developing EFT – and to John Bowlby for his vision. ■

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On the couch

WITH NATASHA-RAE ADAMS

What are your current roles and responsibilities?

I'm an integrative therapist, working with adult individuals in private practice, in and around London. My clients are varied, but my areas of specialism are trauma and perinatal therapy. I offer both online and in-person therapy, although I predominantly work face to face. Occasionally, I contribute to articles in the press. I completed an English degree before I became a therapist, so writing about therapy feels like a meeting of my two, core curiosities.

Can you describe a typical working day?

My days tend to differ, and I thrive on the variation. I've evolved into an early riser and feel that I am at my sharpest in the mornings. So, I run an early clinic twice a week, beginning at 7am. I hold some evening clinics, but I try to limit these to one or two a week. Generally speaking, I wake early and head to my private practice, while listening to some morning mood music. I see five or six clients and then complete any admin tasks, reply to emails, write immediate notes or send resources over to clients. Once every two to three days, I schedule in some additional processing time. My brain appreciates time to ponder client sessions, as it allows new thoughts, reflections and directions to arise. It's usually during this time that I also make any notes required for upcoming sessions with my supervisor.

What are the highs and lows of your working life?

The highs are helping people to rediscover their autonomy and power. Endings can be bittersweet, but they mean that clients no longer feel they need me. A particular high of working with perinatal clients is when they break the cycles of their own upbringing, establish a healthy attachment with their child or allow themselves to continue to have their own identity. The lows of my working life are watching challenges such as addiction, eating disorders or suicidal thoughts dim the light of the person in the therapy room.

How did you get to where you are today?

Grit and growth.

How do you look after yourself?

My primary source of self-care is found in the water. I can talk at length about the benefits of swimming, both wild and in the pool. I even wrote an article for the journal about it last year.[1] For me, swimming is a happy moment of solitude, relaxation and immersion in the natural world. Therapists spend a lot of time prioritising the client, putting the client at the centre. Swimming helps me to re-centre myself.

What's the most useful thing you have learned?

Intellectually, I've always believed in the human capacity for good. Embarking on a career as a therapist has enabled me to feel it to my core. It's a privilege to see all the vulnerable parts of others and to watch clients navigate towards compassion and growth. With everything that is going on in the world at the moment, my clients remind me that there is hope.

If you could make one change, either in your professional or personal life, what would it be?

I would like to re-introduce a creative hobby into my personal life. Over the past year, I've really felt that my imagination needs an outlet.

Who or what is your inspiration?

I've been fortunate enough to have many people in my life who are all startlingly different from one another. And they have taught me that life is rich and varied. My ultimate inspiration is life itself – and all it has to offer.

What would you tell your younger self?

You'll be OK, kiddo.

What book would you recommend to other therapists?

My all-time favourite book is Mary Shelley's *Frankenstein*. There are so many themes in the book that are relevant to therapy. But I think, at its heart, it reveals so much about the importance of relationships. The creature desires connection and only becomes the monster when he is shunned by the world. In this way, *Frankenstein* is a cautionary tale about the negative effects of isolation.

Do you have a favourite song?

When I was a child, my dad would take me and my siblings on car journeys – and my taste in music is influenced by the self-burned CDs that my dad would play in the car. Nick Cave's *The Ship Song* evokes joyous memories of my dad screaming the lyrics. New Radical's *You Get What You Give* is my 'up and at 'em' song.

Who is your fantasy client?

Oscar Wilde. We often believe him to be a fearless figure, perhaps because of the famous quote: 'Be yourself; everyone else is already taken.' But I would be interested to learn more about the difference between the public and the private Wilde.

In your dreams, you are...

I wish I could answer with something more poignant. But my mind seems to go haywire during my dreams, so they usually look like the brain dump of a science-fiction writer. ■

Natasha-Rae Adams *is an integrative therapist in private practice. She works with a range of adult clients and presenting issues, with a special interest in perinatal therapy and trauma.*

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Horse POWER

Working with horses can help us gain insights into our own feelings and our relationships with others, leading to the possibility of lasting change. ***Tracie Holroyd*** explains how it works

I have been around horses since I was a child, riding and working on livery yards. I was bullied at school and found comfort in a dapple-grey horse. I would visit the horse every evening and tell him what I was going through. I believed that he could understand – a belief I still hold. So, when I trained as a person-centred counsellor more than 20 years ago, I often wondered how I could incorporate my lifelong passion for horses into my work.

I was working primarily with young people when I heard about equine therapy. I was intrigued and signed up to a three-day training programme with the Equine Assisted Growth and Learning Association (Eagala). My business partner, Sarah Heward, also completed the Eagala training.

So, what is equine assisted psychotherapy (EAP) and how does it work? The Eagala model is collaborative: a mental health professional and an equine specialist work with the clients and horses. There is no riding involved and Eagala's Code of Ethics safeguards the wellbeing and safety of both the clients and the horses.

The sessions are experiential. The way in which the client relates to the horses – and vice versa – enables the client to understand more about themselves, offering them the possibility of lasting change.

Horses have their own individual personalities and can evoke a range of emotions. They also respond to human behaviour, so give instant feedback. The mental health professional and equine specialist observe the interactions between the clients and the horses, as well as between the horses, allowing us to gain insight into how a person, group or family communicates and relates to others.

We might share our observations with the client, but we don't interpret. Instead, at appropriate times during the session, we explore the experience with the client. For example, we might notice how the horses behave with the client. We might also wonder if anything could be done differently. However, we would not direct any changes, as we aim to enhance the problem-solving skills of the client.

People who struggle to articulate their feelings often find EAP useful, as they're able to express their emotions with the horse. In addition, people who find it hard to trust others can create a strong bond with their horse.

> We are there to facilitate and observe

The horses are members of the team. They are assessed each day, and throughout the day, to ensure they are bright, active and responsive. The equine specialist also keeps a close eye on the dynamics between the herd. My horses work in a large space, such as an indoor arena, paddock or field. They also choose whether to interact with the clients. We don't use equipment to hold them in place. They are at liberty, though we are always mindful of everybody's safety.

I offer EAP to individuals, tailoring each session to meet the diverse needs of my clients. I also offer equine assisted learning (EAL) to families, groups and corporate organisations. Some people self-refer. The service also gets referrals from schools, the police and the military.

When I started offering EAP, clients were often referred when traditional talking therapies had not been able to effect changes in their behaviour or support their emotional needs. But that has now changed, as people have become more aware of the benefits of EAP.

Both EAP and EAL are usually short-term interventions. I can often gain the same amount of information about a client from one session of EAP as from 12 room-based sessions. In traditional therapy, a client has to tell the therapist how they experience relationships. In EAP, you can observe how it plays out, in real time.

Client A was a student counsellor who attended a continuing professional development (CPD) day for counsellors and psychotherapists. The aim of the CPD was to raise self-awareness and to consider the impact of the self in the therapy room.

Client A was interested in alternative therapies and was intrigued by EAP, though she was also fearful of horses. The evening before the CPD day, client A was out walking her dog when the footpath took her through a field of horses. The horses approached and followed her. She became anxious and ran out of the field. When she arrived at the CPD day, client A explained that she would not be able to go anywhere near the horses, because she was scared. We acknowledged the fear, but went on to explain the aims and goals of the day.

Client A appeared to enter the arena confidently, which was surprising. We watched as she approached each horse, keeping some distance between herself and the animal. Each time, the horse turned and walked away. Client A eventually returned to us and said: 'I can't do this.' She started to cry. 'They just keep walking away,' she said. I asked the client if she knew that the horses were now behind her, as they had followed her across the arena. But she was unaware of their presence.

We then asked the participants to create a 'life path', using equipment such as cones, poles and

jumping blocks. We also provide 'emotion balls' – balls that represent different emotions. The members of the group also select one horse to join them on their journey through the past, present and future.

When client A was in the present section of her life path, she was holding several emotion balls. She tried to pick up more, but without letting any go. She then put some emotion balls down, but almost immediately picked them up again. We watched as one of the other horses joined her on her journey; client A did not even notice. She picked up and put down one of the emotion balls several times. But then the horse's mouth touched her arm, prompting client A to raise her head, so she was unable to pick the emotion ball back up. When we checked in, we discovered that client A had been considering the emotion ball of rejection. Client A had been afraid of rejection since childhood – and had experienced rejection in the first exercise when the horses had moved away when she approached.

Client A was surprised that her encounter with the horses had so quickly aroused her fear of rejection. She described her experience as '... the most powerful experience I have ever had. I learnt more about myself in one day than in all my counsellor training or in personal therapy'. The impact of the session led client A to train in the Eagala model and become the mental health professional within an Eagala team.

> It can be hard to trust the process

Client B came with what were described as behavioural issues. Initially, client B was anxious with the herd. The horses approached him one by one, and then moved away. Each time this happened, client B turned to look at us. Finally, client B moved towards us and stood for a while, looking in the direction of the horses.

Then client B spoke. 'That's just like what's happened to me. My grandad passed, who was like a father to me, and my best friend died six months ago'. There was nothing on the referral form about loss or bereavement. But working with the horses had enabled client B to acknowledge his thoughts and feelings.

We were then able to focus the sessions on client B's grieving process, using a number of different exercises. For example, in one session, we wrote the 'stages of grief'[1] on blocks around the arena, to support client B in working through his emotions. Client B also identified the horses as different members of his family, past and present. He could then project his feelings onto the horses, enabling him to see himself and others from a different perspective, in a safe, non-judgmental space.

Within seven sessions, client B had gained an understanding of his grief and could begin to process his emotions. He could also understand that other family members were grieving, too. When client B was with the horses, he could find new ways of responding to others, so there was less conflict in his relationships.

It can sometimes be difficult for mental health professionals to adjust to the Eagala model. We are there to facilitate and observe the interactions between the client and the horse. So, sessions prioritise the relationship between the horse and the client, not the therapist and the client.

EAP is sometimes thought of as a non-talking therapy. We can – and do – talk in sessions. But we talk primarily about what is happening in

> Horses have their own individual personalities and can evoke a range of emotions

front of us. The Eagala model teaches us to 'externalise', so we focus on what we see rather than the impact on the person's feelings. It allows clients to reflect on their experience at their own pace, when they are ready. It also creates emotional safety for the client.

There are times when the mental health professional will explore an experience in greater depth and invite an internal response from the client. But it depends on the aims and objectives of the sessions, as well as timing and professional judgment.

It can be hard to trust the process, to take a step back and allow the horses to do their work. But experience has taught me that these amazing creatures can be so much more powerful and effective than mental health professionals.

Client C came to the service because he would often physically attack others, usually people who were bigger than him. If they retaliated, he would complain to his care worker. He was too anxious to go near the horses, so we conducted the sessions from the fence, so he could see the horses, but at a safe distance.

Initially, client C identified one horse as himself, one as his father and a third as his grandmother. The little grey pony was the grandmother – and she kept going up to the bigger horses. The other horses would then kick their back legs, sometimes hitting the pony, who would squeal and run away. Interestingly, this was not the normal dynamic within this group of three horses. They shared a field and were usually good natured with each other. At each session with client C, the three horses displayed the same behaviour. They also reverted to their usual tolerance of each other when client C was not around.

It would have been easy for us to interpret that the horses were re-enacting something of client C's behaviour. But instead of pointing this out, we gave the client the time and space to develop and share his story. Then, on the 12th session, he experienced a lightbulb moment. He identified himself with the little pony, recognising the behaviour and its consequences. When this was named, all three horses came together and ate in close proximity to each other, for the first time since starting the sessions with client C. We then worked on new ways for the client to relate to himself and others, which had a positive impact on his behaviour.

Group work or EAL is slightly different from EAP, as there is a clear goal. For example, we might work on effective communication with a corporate organisation, or bereavement and loss with military personnel or first responders. We do not focus on one person in the group or invite any one member of the group to explore anything in greater depth.

I am grateful to all my clients over the years for teaching me and for keeping me enthused, inspired and committed to providing accessible mental health services. I am also grateful to my herd, who graciously grant us time in their presence, allowing us to grow and gain greater insight into ourselves and others. Over the two decades I have been involved in this work, I have witnessed how EAP and EAL can transform people's lives. ■

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HOW **TOUCH** CAN **HEAL**

Trauma-informed massage helps to regulate the nervous system and has an important role to play in the healing of psychological trauma, writes ***Hanna Kemp***

Imagine a new client nervously entering the massage therapy room. They feel anxious because their previous massage experience was disappointing. The therapist greets them warmly and begins by explaining what will happen during the session, meticulously describing the method and techniques. The client is informed that they can stop the massage at any point, request a pause, change their body position or ask for adaptations. The therapist also discusses undressing preferences, boundaries and physical comfort with the client, as part of a contract that focuses on establishing safety and trust.

The therapist obtains explicit consent for each step, ensuring the client feels in control throughout the session and promoting a supportive, healing environment. The client feels reassured by this level of control and transparency. It also gives them an opportunity to relax before the massage starts. Such a sensitive and informed approach can transform the therapeutic experience for trauma survivors.

Trauma-informed massage therapy is an emerging field that acknowledges and seeks to address the profound impact of psychological trauma on the body. It helps to regulate the nervous system, balancing the body's response to stress. It also works to expand the 'window of tolerance',[1] allowing clients to handle emotional challenges more effectively, without becoming overwhelmed. Trauma-informed massage therapy therefore fosters both physical and emotional resilience, helping to improve overall wellbeing.

Psychological trauma is characterised by exposure to actual or threatened death, serious injury or sexual violence, whether directly, as a witness or through repeated exposure to details of such events.[2] People who have undergone trauma might experience a range of psychological symptoms, including hypervigilance, intrusive thoughts and dissociation. Anxiety, depression, sleep disturbances, emotional numbness, difficulty concentrating, irritability and a heightened startle response are also common.[2] They might also display physical symptoms, such as chronic pain and muscle tension. Studies have documented that people with post-traumatic stress disorder (PTSD) often experience gastrointestinal issues, headaches and heart-related symptoms, such as palpitations and shortness of breath.[3]

Trauma dysregulates the body's stress response system, particularly the hypothalamic-pituitary-adrenal (HPA) axis, leading to an overproduction of stress hormones, such as cortisol and adrenaline. Persistent activation of the HPA axis can cause wear and tear on the body, contributing to the physical and psychological symptoms associated with trauma.[4] The symptoms indicate the body's attempt to manage overwhelming stress, which can result in chronic issues, such as cardiovascular disease, gastrointestinal disorders, metabolic disorders, chronic pain and mental health disorders, which can significantly affect daily functioning, relationships, work performance and overall quality of life.[5]

Non-verbal communication

Touch is arguably the oldest form of communication, predating verbal interaction and facilitating bonding and social cohesion. For infants, the nurturing touch of caregivers is essential for healthy development, promoting secure attachment and emotional regulation.[6] Our fundamental need for touch extends into adulthood, where it continues to play a vital role in emotional and physical wellbeing, fostering social connections, reducing stress and supporting long-term emotional health.[7]

> Trauma dysregulates the body's stress response system

Touch, when applied thoughtfully and with awareness, can be a powerful tool for healing. However, there is evidence that people who have experienced psychological trauma tend to avoid physical touch, due to its potential to reawaken traumatic responses.[8,9] So, as with all trauma-informed therapy, we have to be aware of the potential to retrigger traumatic memories in our clients. The priority is always the client's sense of safety.[10]

Regulation of the nervous system is a fundamental objective of trauma-informed massage therapy. We want to help clients achieve a state of balance and calm, ensuring they remain in their window of tolerance. Massage helps to regulate the nervous system by calming the sympathetic nervous system (SNS), which is responsible for the 'fight or flight' stress response, and engaging the parasympathetic nervous system (PNS), which promotes relaxation.

Research shows that massage reduces cortisol levels (a stress hormone linked to SNS activation), increases serotonin and dopamine (which enhance mood and wellbeing), improves heart rate variability (indicating a shift towards PNS dominance) and reduces muscle tension, all of which contribute to overall stress relief.[11] Regular massage therapy has also been shown to improve sleep patterns and reduce chronic pain, both common issues for people with

histories of trauma. For example, a study by Sherman et al found that massage therapy significantly reduced pain and improved sleep quality in veterans with PTSD.[12]

By providing a safe space and gentle touch, massage can help clients reconnect with their bodies and develop healthier coping mechanisms. The regulation of the nervous system and the greater tolerance of touch can also help clients to once more enjoy social interactions, participate in group activities and feel more confident in social situations. It can therefore improve their relationships and enable deeper connections.[1,13]

What does it mean to be a trauma-informed specialist and what should we expect from a therapist who claims to be trauma informed? To provide effective treatment, the therapist needs to be attuned to the different states and responses of the nervous system — and how they manifest physically and emotionally in themselves and their clients.

> Touch is arguably the oldest form of communication

The nervous system typically operates in three primary states: sympathetic activation (the 'fight or flight' response), parasympathetic dominance (the 'rest and digest' state) and dorsal vagal shutdown (a state of immobility or 'freeze' response). Each state has distinct physical and emotional manifestations, such as increased heart rate and anxiety in sympathetic activation, or lethargy and emotional numbness in dorsal vagal shutdown.[14]

Modern trauma therapy systems, such as Babette Rothschild's somatic trauma therapy,[14] emphasise the importance of understanding these physiological responses, to create a safe and effective therapeutic environment. Therapists need to regulate their own nervous systems to effectively convey tranquillity and stability. They can then create and maintain touch that facilitates a state of relaxation and receptivity. By doing so, therapists not only provide immediate comfort but also help clients to build resilience and improve their capacity to manage stress and emotional responses.

Creating a safe environment

A trauma-informed space is thoughtfully designed to create an environment that supports the healing and wellbeing of people who have experienced trauma. Key elements include ample natural light and proper ventilation, which contribute to a sense of openness. Light and ventilation can also improve mood, by regulating circadian rhythms and ensuring clean air circulation.[15]

The space should be big enough to avoid feelings of confinement and small enough to provide a sense of safety and comfort. The décor should be calm and relaxing. I like to use soothing colours, such as muted greens or neutrals, comfortable furniture, soft textures and natural elements, such as plants and water features.

Blankets, pillows, ergonomic chairs and sensory items, such as stress balls and fidget toys, can enhance personal comfort. It's also important that the space is adaptable to the diverse needs of clients. Additional features, such as soundproofing, calming music, white noise and adjustable temperature settings, further contribute to a safe and supportive sanctuary, aiding recovery.

Techniques and their benefits

I believe that any massage approach can be adapted to suit a trauma-informed practice. I started out as a craniosacral therapist and gradually added tools to my repertoire, as I wanted to master a variety of techniques to meet the diverse needs of my clients.

Thai yoga massage

Thai yoga massage offers a holistic approach to relaxation and healing, through a combination of deep tissue massage, acupressure, assisted yoga postures and energy work. Modern Thai yoga massage includes a variety of styles, from traditional techniques to osteopathic and dynamic approaches. The dynamic approach involves rhythmic rocking, gentle bouncing and wave-like movements, to create a fluid and continuous motion throughout the body. It helps to release deep-seated tension, improve joint mobility and enhance the flow of energy.

The different styles allow practitioners to tailor the massage to each client's specific requirements, without disrupting the flow of the session. The versatility of Thai yoga massage is especially beneficial for clients who find deep tissue manipulation triggering or uncomfortable. By focusing on the body's energy lines and using rhythmic movements, Thai yoga massage can help improve circulation, enhance flexibility, stimulate the vagus nerve and induce a profound sense of wellbeing.[16]

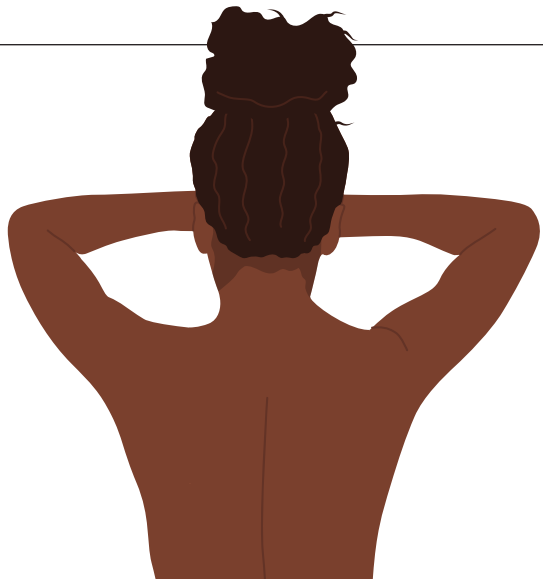
Thai yoga massage can be performed on various surfaces, according to the client's preferences and comfort, including a floor mat, a low, wide couch and a massage table.

Gentle touch therapies

Techniques such as craniosacral therapy and gentle abdominal massage are particularly effective in regulating the vagus nerve, which plays a critical role in the body's parasympathetic nervous system and its ability to relax and reduce anxiety. [17,18]

The vagus nerve extends from the brainstem, through the neck and thorax, down to the abdomen, influencing heart rate, digestion and respiratory rate.[13,19] By applying light, targeted pressure through craniosacral therapy, practitioners can enhance cerebrospinal fluid movement and release tension in the tissues surrounding the central nervous system, which can lead to a profound sense of relaxation and a decrease in anxiety levels.[20]

Similarly, gentle abdominal massage can stimulate the vagus nerve through its connections to the gastrointestinal tract. So, this type of massage can improve digestion, reduce abdominal discomfort and promote a state of calm, by activating the parasympathetic response. It not only offers immediate stress relief but also support for long-term



regulation of the nervous system. Abdominal massage can therefore be invaluable for people who are dealing with the aftermath of trauma.

Non-contact techniques

Non-contact techniques, such as towel massage or herbal compress massage, offer alternatives for clients who are not comfortable with direct touch. Non-contact methods can be particularly useful for trauma-informed massage, where physical touch can sometimes trigger distressing memories or responses.

Towel massage involves using a towel or a scarf to apply pressure and perform various massage techniques, allowing the client to experience the therapeutic benefits of massage, without skin-to-skin contact. Herbal compress massage uses heated compresses filled with therapeutic herbs, which are pressed and rolled over the body. The warmth and the medicinal properties of the herbs help to relax muscles, improve circulation and promote overall wellbeing. It can be a soothing experience that can calm the nervous system and reduce anxiety.

> The priority is always the client's sense of safety

In my experience, clients often find that massage complements their psychological therapy, by providing physical relief from tension and fostering a sense of safety and control. Clients who engage in trauma-informed massage therapy often report improved quality of life, better emotional regulation and a greater sense of overall wellbeing, finding joy in interactions and activities they had previously avoided.[21]

It is always a privilege to hear my clients speak about the changes in their lives since they started their trauma-informed massage therapy. If we, as experts, incorporate a trauma-informed approach into our work, we will help many people to become happier and healthier.

The future of trauma-informed massage therapy looks promising. As awareness of the importance of a holistic approach to trauma grows, more therapists are likely to adopt trauma-informed practices. By focusing on safety, presence, collaboration and flexible techniques, trauma-informed massage not only addresses the immediate physical symptoms but also helps clients develop long-term strategies for managing stress and trauma. ■

Hanna Kemp *is a trauma-informed massage therapist. She began her career working with pregnant and postpartum women, but now supports female health across all stages of life, offering a compassionate, healing touch to those seeking relief from both physical ailments and the deeper wounds of trauma.*

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CRACK COCAINE: WORKING WITH ADDICTION

Crack cocaine is cheap, potent and easy to obtain. ***Richard Wink*** describes a community service that supports vulnerable people in Great Yarmouth

In my work with a rough sleeping team in Great Yarmouth, a Norfolk seaside town, it has become clear that one drug is particularly problematic – crack cocaine. In my experience, people who might be able to resist or reduce their dependency on alcohol and other drugs, find crack cocaine harder to refuse. Crack cocaine, which is classified as a Class A drug, is potent and produces an almost instant high. But the high is short lived, driving users to take more of the drug. Users might also consume more crack to stave off the unpleasant effects of the crash from the high.

There are several health risks associated with frequent cocaine use, including organ damage, respiratory issues, such as chronic obstructive pulmonary disease (COPD), increased blood pressure, cardiac arrest, stroke, cognitive damage, mood changes and psychosis.[1,2] Crack cocaine also causes behavioural change and emotional dysregulation, which can negatively affect interpersonal relationships. For example, when someone is using crack cocaine, they tend to miss appointments with professionals or get involved in conflicts and disputes with friends and family.

Crack cocaine is prevalent in the Great Yarmouth area, largely as a result of county lines drug dealing, where illegal drugs are transported from big cities into smaller towns, often by children or vulnerable people who are exploited by gangs. The county line refers to the mobile phone, which is used to take the drugs order.

> “Crack cocaine is potent and produces an almost instant high”

Crack is easy to obtain. And if the police close down one line, another soon opens. So, temptation is always there. It’s not unusual for people to be approached by a drug dealer in Great Yarmouth when they withdraw money from a cash machine. Some people are even escorted to cash machines to withdraw the money to pay for drugs. People who are struggling with addiction tell me they avoid the area, because someone will always offer them a chance to score.

Most of the people I work with have a limited, yet regular, income – usually a benefit payment. But crack is cheap: a low income doesn’t mean you can’t buy crack. People are particularly vulnerable on pay day. Many struggle to manage their finances and longstanding addiction problems mean they often associate money in their pocket with buying drugs. People can source crack cocaine from other users, as well as dealers. In other words, there’s always a way to get hold of the drug. Even if you are blacklisted by a dealer, you can usually find someone to buy the crack on your behalf, though they will take a cut of the drug as payment.

Users often talk about the positive aspects of crack cocaine. They might be drawn to the drug because it alleviates stress or worry, or reduces the symptoms associated with trauma, such as flashbacks and auditory hallucinations. Others assert that they have no desire to stop taking the drug, because they enjoy it so much. Behavioural change is therefore a challenge. Establishing goals can be helpful, though it is not always easy, as people who are addicted to crack cocaine are not always incentivised by a goal, even if the goal is meaningful to them. For example, I have known people who cannot resist the lure of crack cocaine, even if they must be ‘clean’ before they can access their children.

> A low income doesn't mean you can't buy crack

There is an option to treat crack cocaine addiction with a detox programme – and users are sometimes referred to a detox programme through the criminal justice system. However, the number of live-in drug and alcohol rehabilitation services in England has fallen.[3] Many of the treatment centres are also private, which makes them prohibitively expensive for many people in the local community. In a detox programme, drug withdrawal is managed by medical professionals. The challenge is to maintain abstinence and work towards recovery over the longer term. But many addicts remain vulnerable to using crack cocaine,[4] which adds credence to the theory that addiction is a lifelong problem.[5]

The People Sleeping Rough Team has been running since the summer of 2023. We work with adults who are sleeping rough or at risk of sleeping rough, who also have an identified mental health need, including dual diagnosis (a mental health and a drug or alcohol problem). Our team is made up of two mental health nurses, a nurse prescriber, a clinical support worker and a therapist. The aim of the service is to increase our clients' involvement with mainstream mental and physical healthcare provision, improve engagement with drug and alcohol treatment and reduce the health inequalities of vulnerable people sleeping rough.

We don't have a restrictive cancellation policy, so if people miss appointments they are not automatically discharged. Instead, we proactively try to engage with our clients, giving them time to reconnect with us and resume their treatment.

Many of our service users have previous, negative experiences of mental health services. Our process enables us to build up trust and support the establishment of the therapeutic relationship. We try to offer a psychologically informed approach, adapting to our client's varied needs.

In my opinion, it is important to help clients change their behaviours by targeting their access to the drugs, offering support with money management and helping them to consider the negative impact of crack cocaine use on their self-identity and relationship with others. An agreed relapse prevention plan can also be helpful when dealing with crack cocaine use. For example, I might work with a client to identify triggers to cocaine use, such as low mood or feelings of loneliness. We can then develop coping strategies, including techniques to regulate emotion or tolerate distress.

A range of therapeutic models can support people who are using crack cocaine. Person-centred counselling, with its core conditions of empathy and unconditional positive regard, can help an addict to feel safe, valued and able to access their own resources.

Cocaine users can also benefit from a trauma-informed approach, as they are often dealing with past or current traumas. In addition, dialectical behaviour therapy (DBT) can help to change behavioural patterns and can be useful in the treatment of substance abuse.[6]

Motivational interviewing (MI) aims to assist people to cut down or stop using drugs and alcohol, by working through four main principles: expressing empathy, supporting self-efficacy, rolling with resistance and developing discrepancy.[7]

In the United States, contingency management (CM) is showing positive results in community treatment programmes.[8] CM uses incentives, such as vouchers or prizes, to encourage people to abstain from drugs or to provide drug-free urine tests. Sometimes, the emphasis is on

> People can source crack cocaine from other users

wellbeing incentives, such as gym memberships or food vouchers. People often respond better to incentives than goals, because a tangible reward can be more appealing than an intangible goal.[9]

Cognitive behavioural therapy (CBT) can also be effective when working with substance misuse. It can enable users to develop coping strategies to manage the temptation to take the drug, supporting long-term abstinence. CBT can also be delivered through computerised or app-based programmes, which makes it easily accessible.

Research shows that therapeutic communities, including drug-free residences, can draw on peer support to help people stay motivated to change.[10] Ideally, peer support comes from those with lived experience, who can offer understanding and an example of the possibility of change and recovery. We work alongside a drug and alcohol charity that provides group meetings. We are also in the process of creating our own support groups.

A multidisciplinary approach can work well, as it can support the client to deal with practical as well as psychological issues. For example, the mental health team can work alongside a housing or employment team, to help the client with their living arrangements or to find work as their recovery progresses. There also needs to be a co-ordinated approach that allows for relapses and setbacks, as the recovery process does not follow a linear path.

By building relationships with other workers in the local community, we strive to create a supportive network that meets the needs of our service users, allowing them to feel held. We hope this support enables people to actualise and grow, become the person they want to be and live a life they feel is worth living. ■

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