APRIL 2025 | VOLUME 36 | ISSUE 3

THERAPY TODAY

bacp | counselling changes lives

When therapy causes harm

The truth behind the headlines

THERAPY TODAY

APRIL 2025 | VOLUME 36 | ISSUE 3

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Contents

←22

'Harm doesn't have to be some headline event. It can happen gradually'

Erin Stevens
('The truth about harm in therapy', pages 22-28)

Highly rated by Counsellors like you

I had done all of the usual promoting, but something was missing. That something was the amazing website WebHealer created for me. And they made it so easy.

★★★★★

Craig Connell

My designer had great communication and worked quickly to help my website come to life. They were so patient and responsive with all of my questions & revisions - 10/10 service for an affordable price!

★★★★★

Quel Paris

Great experience - Tara was extremely helpful and able to develop exactly what I was looking for. I am very happy with the finished result - thank you!

★★★★★

Karen Carroll

I was incredibly impressed with the level of customer service I received from Grace. She was attentive, changes were easily made, there was no difficulty in contacting her, and no question was too difficult. Highly recommended!

★★★★★

Ewen Purcell

Grace and Laura from WebHealer were absolutely phenomenal from start to finish. They were patient, attentive, supportive and above all, kind with everything that was asked of them.

★★★★★

Rahi Popat

My previous website looked old and tired and, although I had some ideas for a new one, I didn't know how to translate these into a fresh, new design. The team at WebHealer were fantastic: they understood my brief perfectly and created a website I am really proud of.

★★★★★

Karen Moyes

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THERAPY TODAY

What I recall from my earliest experiences of therapy is the terror I felt just before I asked for help. Not knowing who to turn to or what to ask for, they had all the power, and in my mind I feared what they'd do with it. My first-ever therapy session left me feeling cold and panicked. Months later, at a point of desperation, I had a completely different experience with a new therapist who I believe saved my life. I often wonder what would have happened if I didn't receive this attunement when I needed it most. Would I even be a therapist now? I considered myself fortunate that I sought help quickly and didn't get lost down a rabbit hole. Since then I've had therapy again at different times in my life, some powerful, some less so.

What strikes me most is that some of the worst experiences I've had in past therapy have come from good intentions. So how do we extrapolate what is meant well and lands messily from what is considered harm? Ellie Broughton (page 22) does a great job of exploring this more nuanced aspect of harm beyond the big media headlines that hone in on the more obviously nefarious cases of therapy. It feels apt that this issue also contains pieces aimed at helping minimise the risk of such harms, such as the update on BACP's *Ethical Framework* review, and Caz Binstead's piece on contracting. We hold great power as therapists to impact our clients.

'What I recall from my earliest experiences of therapy is the terror I felt just before I asked for help'

My hope is that this theme doesn't scare you off but connects you back to who you were when you first sought 'help' – whether through therapy or otherwise – and how you were met.

This is my first issue as the new Editor of *Therapy Today*, and I'd like to say the deepest thanks to Sally Brown from whom I take on this baton.

Katerina Georgiou MBACP (Snr Accred)
Editor

FRONT COVER: NEIL WEBB

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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Empowering

... helped my confidence grow exponential. I feel a lot more prepared and competent working with trauma presenting clients

Wholly recommended

... covers all you will need to have the competence and courage to work in the ever-expanding area of trauma

Noticeboard

Our monthly digest of news, updates and events

NEWS REPORT

METAMORWORKS/SHUTTERSTOCK

AI and mental health

Artificial intelligence (AI) integration is already improving mental healthcare in several ways according to a recent briefing from the Parliamentary Office of Science and Technology (POST). The report found that AI can help improve accessibility to services for clients who find travelling to appointments or spending time in group settings a challenge. AI-enabled chatbots can also de-stigmatise therapy, and provide anonymity. Other advantages identified included incorporating AI tools into in-person services to manage routine tasks such as client bookings and payment.

The past decade has seen considerable development in the scope of AI tools in mental healthcare. However, while more than 20,000 wellbeing apps are now on the market, the report flags how many are not robustly backed by scientific evidence. Some have been specifically produced to be part of NHS treatment, but others such as general wellbeing apps and chatbots lack appropriate professional and ethical regulation.

The UK Government is expanding AI tools within public services including the NHS, having set up a Regulatory Innovation Office to support innovation, and has established an AI Safety Institute. An AI bill is awaiting its third reading in the House of Lords.

Ethical concerns include the risks posed to data privacy and anti-discriminatory practice by deploying AI in mental health support as well as potentially eroding transparency and accountability of services. Digital exclusion could also be a problem for some people such as those who struggle with internet connectivity and literacy.

The report's researchers, including academics and professional stakeholders, emphasise that to reduce disparities in access to support, in-person mental healthcare and services such as counselling must be retained and funded. They also concluded that the initial production of AI mental health support must be rooted in ethical principles to mitigate risks. Research is needed to observe the impacts of these services over a longer-term period to draw conclusions about their efficacy, with some such studies already being undertaken in the UK.

Read the full briefing at **post.parliament.uk/research-briefings/post-pn-0737**

98%

of mothers want to go back to work after having children*

*CAREERS AFTER BABIES: CAREERSAFTERBABIES.ORG

SOCIAL MEDIA UPDATE

Leaving X

We've stopped posting on X (formerly Twitter) and are exploring alternative channels following a review of our social media strategy.

Social media helps us to educate and inform people about counselling and our members' expertise. We also use it to campaign on behalf of our members, share our policy work and highlight our activities. However, we no longer believe that X helps us meet our communications objectives or is the right place for us to be.

We'll remain active on Facebook and LinkedIn and continue to monitor the growth of other social media channels, including Bluesky. We'll also be launching on Instagram soon.

Thank you to those of you who've engaged with us on X over the years. Read our full statement at **bacp.co.uk/news/news-from-bacp/2025/7-february-update-on-our-social-media-channels**

Noticeboard

MIKE SEWELL

FROM THE CEO

Phil James, Chief Executive Officer

I'd like to invite you to help shape the future of BACP. Not only can you get involved, your involvement is *welcome*.

With two Trustees stepping down – including our Chair, Natalie Bailey – we're recruiting for members to join the Board and its delegated committees. You don't have to be a certain type to 'get on Board'. Of course, there's a serious job to be done and skills and personal qualities matter, but you've got those, and you could nominate yourself. If you're interested, look out for our emails in the coming weeks.

There are other ways to help shape BACP, including through our fabulous Divisions. We're also increasing our work with Expert Reference and Advisory Groups on a series of professional and organisational issues, which is a key (but not the only) part of our work on advancing practice and taking action on major issues facing our profession.

Maybe, for you, getting involved means coming along to one of our events, such as those in our Making Connections series. You can just sit and listen, share your ideas with me and my team, or even take up the microphone to the room.

We can do better at creating spaces for views to be shared, and being receptive to what you'd like from BACP. Our AGM doesn't work as well as it could. Our motion and resolution processes remain important vehicles for change, as demonstrated by the two presented motions last year on trauma practice and improving access for marginalised, highly challenged parents. But as I said then, the AGM and surrounding processes are ineffective in creating open and ongoing dialogue about issues central to the profession's efficacy. Therefore, we've revisited how we'll deliver the AGM this year: we'll focus on organising an event that deals with the formalities of BACP as a business. We're open 24/7 to your views and we'll build better opportunities to debate, refine and elevate those ideas.

I don't expect all our existing ways of engagement to resonate with everyone. We must be here for you when the time's right for you, which isn't easy to predict or engineer. Equally, we value hearing voices that might otherwise be lost in traditional and formalised ways of working.

So maybe a fitting way for me to sign off is by hoping you'll see BACP as a place to come and be heard. Let's be creative about how we do that. Don't wait for the formal channels to swing into action. Come forward, and we'll work on the next bit together.

42% of 18- to 34-year-old employees reported experiencing burnout in the past 12 months**

**AVILIO: AVILIOGROUP.COM

BACP NEWS

Children's Mental Health Week 2025

Deputy Head Teacher Sanchita Chaudhary talks about the impact of school counselling

She's witnessed it for herself at her school, Kingsway Primary, in Braunstone Town, Leicestershire. She knows how it can help not only the child who accesses the counselling but that it also has positive consequences for their families and the school as a whole.

During Children's Mental Health Week in February Sanchita joined us on a video to call for Government to invest in a counsellor in every school. She told us how school counselling is 'one of the most crucial things we can invest our time, money and effort in'.

She added: 'The quicker that intervention is put in place, the longer I think the impact will be. It will have an impact on the child, on their current families and on their future families. If the Government was to invest in a counsellor for every school, it would make a massive difference to our school because we are a small school with not enough budget to fund a counsellor.'

Watch the video at **bacp.co.uk/news/news-from-bacp/2025/3-february-school-counselling-is-one-of-the-most-crucial-things-we-can-invest-time-money-and-effort-in**

MONKEY BUSINESS/SHUTTERSTOCK

DIARY DATES

bacp.co.uk/events

29 APRIL
MANCHESTER

Accredited Courses and Services Event
Supporting best practice

RAWPIXEL.COM/SHUTTERSTOCK

8 MAY
ONLINE

Working With Race and Racial Identities to Support Ethical Practice

FIZKES/SHUTTERSTOCK

BACP EVENTS

31st Annual International BACP Research Conference: Impact through collaboration

This year's conference will take place on 16 and 17 May in Manchester in collaboration with our co-host, University of Manchester, with a pre-conference workshop on 15 May.

The conference will showcase cutting-edge research relevant to counselling, psychotherapy, coaching practice and policy development. Presentations will explore research through co-construction or collaboration with participants as people with lived experience. It will also highlight interdisciplinary research where researchers have worked alongside fields outside counselling, psychotherapy or coaching that might support the counselling professions in mental health interventions.

The first keynote on day one is a talk entitled 'Impact through collaboration in trauma-informed and social justice-orientated research: challenges and opportunities in working with marginalised communities', presented by Professor Divine Charura. Kate O'Brien will deliver the second keynote on day two, entitled 'Stories of trauma, healing and harm in carceral settings: reflections on research with women in prison'.

Day one of the conference is in-person only, while day two is available in person with selected presentations livestreamed for online audiences to join. The in-person pre-conference workshop is also available to book for all those participants attending the conference.

To find out more and to book, visit **bacp.co.uk/events/rc2025-31st-annual-international-research-conference**

1/4 of women are negatively impacted by the end of hybrid working***

***DELOITTE GLOBAL REPORT: WOMEN @ WORK: A GLOBAL OUTLOOK: BIT.LY/3XKAVBA

Spreading the word

Promoting our members and our profession through the media

Anthony Davis and **Susie Masterson** provided happiness tips in *iNews*. • **Kate Bufton** discussed the grief parents feel when they realise they'll never be a grandparent in *The Daily Telegraph*. • **Dee Johnson** talked about the mental health benefits of some free-to-play puzzle games in *Pick Me Up!*. • **Rochelle Armstrong** discussed ways to improve your mood and manage stress in *Yahoo! Life*. • *The Independent* featured **Charlotte Monk** and **Ruth Micallef** in articles about open relationships and eating disorders respectively. • **Bhavna Raithatha** commented on cheating partners in the *Mail Online*. • **Natasha-Rae Adams**, **Georgina Sturmer** and **Lindsay George** discussed managing the January blues in *HELLO!*. • **Hilda Burke** explored the rising popularity of 'kindness influencers' on BBC News. • **Mandy Gosling** and **Kemi Omijeh** commented in *The Guardian* about grief and parental concerns about violent online material respectively. • **Dan Mills-Da'Bell** commented on the importance of giving safe spaces to child abuse survivors in *Metro*. • **Sara Mathews** explored some of the positive benefits when adult children leave home in *Good Housekeeping*. • **Ashley Duncan** explored the mental health benefits of friendships on MSN.com.

SUSIE MASTERSON

ROCHELLE ARMSTRONG

DAN MILLS-DA'BELL

ASHLEY DUNCAN

SOUTHWORKS/SHUTTERSTOCK

16-17 MAY

MANCHESTER/ ONLINE

31st International Research Conference

Collaboration in counselling and psychotherapy research

AMIRRAIZAT/SHUTTERSTOCK

25 JUNE

EXETER

Making Connections

Free CPD and networking event for members

Software for people who care about life balance

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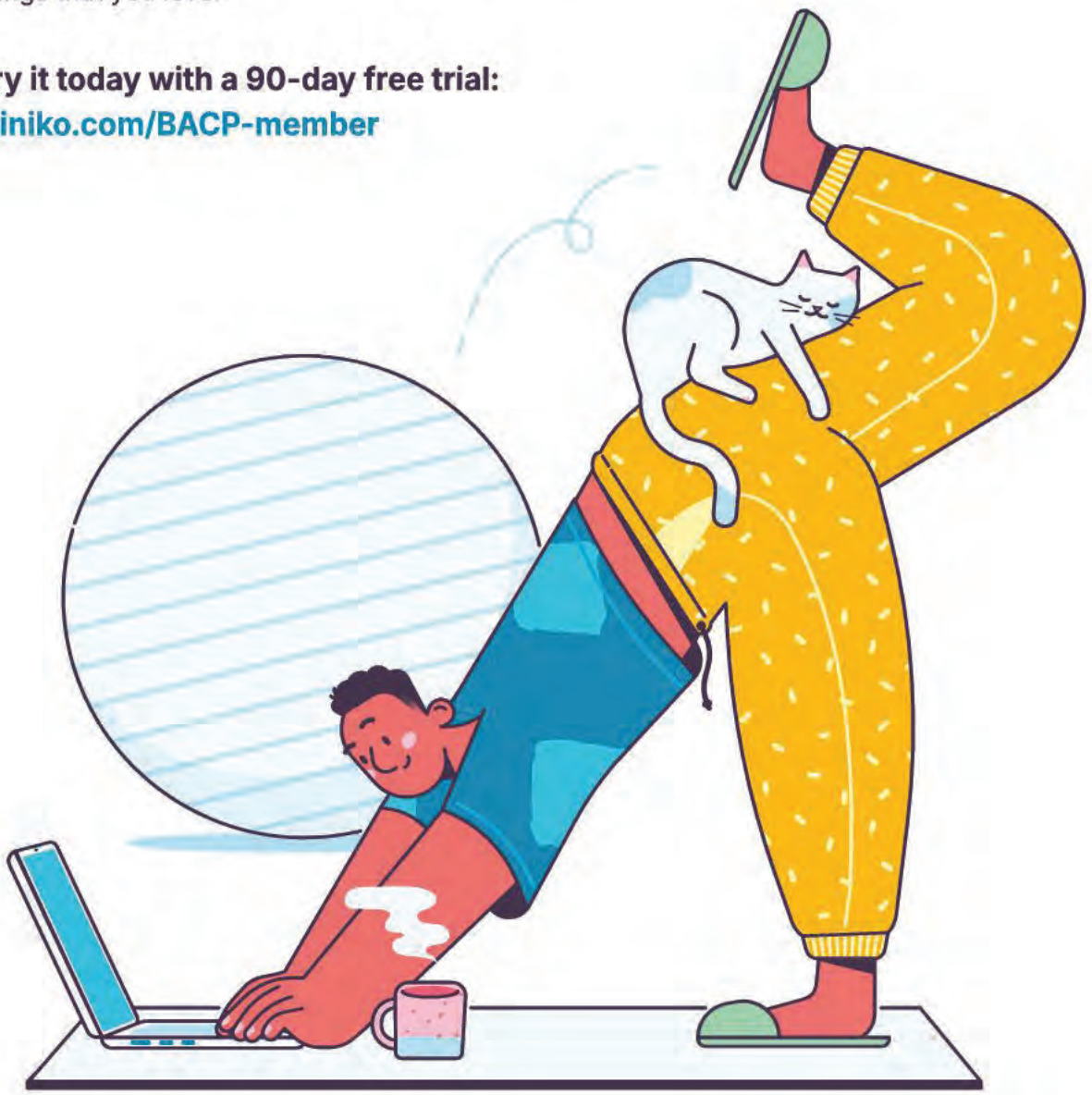

Cliniko
Software for people who care

80% of parents report feeling too stressed to be able to focus fully on their job****

YOUR QUESTIONS ANSWERED

Member resources and CPD

Rebecca Gibson, BACP Member Resources Manager

BACP's Member Resources team develops and delivers all member events in person and online, and hybrid events. The team also produces the BACP podcasts, including monthly episodes for *Therapy Today* and the *Insights* podcasts. To support you, we make sure the CPD hub and Learning Centre are kept up to date with innovative and relevant CPD to support all your learning development needs.

The top questions we get asked:

How do I access the event on-demand service? All our events have a three-month on-demand service with selected presentations from the event. You'll receive a link after the event or you can visit our website directly at **bacp.co.uk/events-and-resources/bacp-events/on-demand-services**

How do I access my CPD certificate? You'll be sent a copy of your CPD certificate after each event. For online and hybrid events your CPD certificate can also be downloaded from the event platform on the day. Certificates for CPD hub or Learning Centre resources will appear in the CPD Certificates area within the Learning Centre once the content is marked as complete.

How do I access the content now I've subscribed to the CPD hub? You can access all CPD hub resources in the Learning Centre, where the content catalogue updates automatically when you next log in after subscribing. New content is added monthly. Visit your member account area to log in.

The easiest way to get more information about the CPD hub is to email us at **cpdhub@bacp.co.uk**

****THE MODERN FAMILIES INDEX: BRIGHTHORIZONS.CO.UK

BACP EVENTS

MAKING CONNECTIONS

Our Making Connections events take place throughout the year across the four nations, offering you chances to network with other members and divisional executive members as well as hear important updates from BACP. Over the next year we'll be visiting Exeter, Belfast, Sheffield, London, Wales and Edinburgh.

What's included?

- Three CPD presentations
- Dedicated live Q&A sessions after each presentation where our host will discuss key themes with presenters
- Selected presentation slides and recordings from the event for a three-month period
- Lunch and refreshments on arrival and during the refreshment breaks
- The opportunity to network with peers, colleagues and BACP staff, where you'll receive key updates from the organisation.

For more information and to book your place, please visit **bacp.co.uk/events**

Places are limited so if you do book and can no longer attend, please let us know so your place can be offered to another member on the waiting list.

AGM 2025

The processes for our 2025 AGM will open in April, so please keep an eye out for emails on how you can get involved. This year you can submit, support and vote on motions and resolutions, and nominate and vote for candidates standing for election to our Board of Governors.

We encourage all members to get involved with our AGM processes – this is your chance to help shape the future of BACP.

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**

ZAMRZNUTI TONOVI/SHUTTERSTOCK

9 JULY

BELFAST

Making Connections

Free CPD and networking event for members

SHUTTERSTOCK

13 SEPTEMBER

LONDON/ ONLINE

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MEMBER SPOTLIGHT

Support for disabled therapists

Emma Cannop MBACP, founder of The Therapeutic Hour

What was your journey like to becoming a therapist? As a disabled woman (I live with fibromyalgia, myasthenia gravis and undiagnosed neurological conditions) from a minority ethnic background, a Christian, a survivor of online childhood sexual abuse and someone from a less privileged socio-economic background, I often felt like an outsider during my training. But my journey was a path of healing and self-discovery. I realised that being a survivor no longer had to define me. Instead I could reclaim the parts of myself that had been buried under the weight of trauma.

What do you see as the challenges facing disabled therapists? A major challenge is balancing client care while managing our own health. Disabled therapists may feel less worthy compared to able-bodied peers, especially when facing discrimination and lack of understanding. Success for us might look different – perhaps supporting a few clients deeply rather than running a large practice – but our work is no less valuable. Our lived experiences bring unique insights and empathy to the field. Universities and training programmes should integrate education on disabilities and chronic illnesses, helping future practitioners better support both clients and colleagues. The same applies to diversity in faith, race and culture – representation matters in making therapy more inclusive and compassionate.

What are the challenges you've found seeking mental health guidance within faith communities, and how were they overcome? Faith communities often struggle with open conversations about mental health. Spiritual bypassing – the idea that 'God will fix everything' – can invalidate struggles and discourage seeking help. As a Christian I believe suffering is part of the human experience, and I developed a mental health awareness course for faith leaders to equip them with the knowledge and tools to create safe, supportive spaces.

Tell us about The Therapeutic Hour and who it's for? The Therapeutic Hour (TTH) is one hour each week dedicated to your mental wellbeing. TTH involves three simple steps: recognise (tune into your emotions); release (find a healthy, creative outlet to express those feelings); and reflect (process and learn from our expert tips or simply your experience). This is offered via weekly in-person group sessions, with one-to-one email support delivered as a monthly subscription plan for weekly personalised, non-crisis support. You can visit **thetherapeutichour.com** or find me on social media (**@TTHFounder**) for more information.

FROM THE PRESIDENT

Professor Lynne Gabriel OBE

This month's big theme in *Therapy Today* is harm in therapy – a huge subject with multiple interpretations of what might be, intentionally or unintentionally, harmful. My own early experiences of therapy were foundational – both as a person and later as a practitioner. The therapist ultimately influenced my move into training; however, that learning and development were seriously undermined, and the previous therapy work negatively impacted, when my therapist became my trainer. Across the period of the training course they had sexual relationships with several students. No surprise then that my interest in relational ethics was piqued. Those formative training experiences led to my research on dual and multiple-role relationships, and my book *Speaking the Unspeakable: the ethics of dual relationships in counselling and psychotherapy*.

Those early experiences of therapy and training led to further work in practice ethics, and ultimately to developing my work and research on relational ethics. Believe me, I'm no vigilante chasing down perpetrators. We *all* are capable of harm. I recognise that I'm a flawed human who could harm others and I see this in other people; yet my commitment and fidelity are constantly flexed, firmed and fixed through multiple relational contexts. My life partner, friendships, respected colleagues and supervisors all play a crucial role in my inclinations and choices in relation to 'do no harm' – intentional or otherwise. However, it is the prospect of unintentional harm that might keep me awake at night. Now that's an aspect of therapy that is under-researched and an essential area for overt exploration in practitioner training and development.

The training and development context is crucial in the ongoing reflexive iteration of personal and professional relational skills. In the never-ending 'testing and refining' of yourself in relation to self and others, being able to navigate a route through relationships that avoids annihilation is essential. Obviously we have ethics codes or frameworks that evolve through professional bodies, and are provided to support ethical practice. Yet truthfully we're on our own in the multiple moments we're relating with our clients, research participants, supervisees or trainees. No code substitutes for authentic and compassionate relational ways of being and relating.

Zanda: Practice Management Made Easy

Running a busy counselling practice is no small feat. From managing appointments to collecting payments, the administrative load can quickly pile up. That's where Zanda, the all-in-one practice management software, steps in. Designed with counsellors in mind, Zanda simplifies daily operations, giving you the tools to focus on care while we handle the busy work.

Keep Your Schedule Productive

Eliminate the stress of unplanned gaps in your calendar. Zanda makes it easy to stay productive with time-saving automations, including appointment reminders that **reduce no-shows** and help clients stay on track.

Need to fill a last-minute opening? Use the **waitlist feature** to reach out to waiting clients seamlessly with SMS messaging.

Your Zanda client portal empowers clients to **book online** at their convenience, ensuring your schedule stays full without the endless back-and-forth of emails and phone calls.

When it's time to recall clients who haven't been in for a while, Zanda **automation tools handle recall communication** with no effort from you.

Get Paid Faster

Efficient billing and payment systems are essential for your success. That's why Zanda built tools to help you get paid faster, with less hassle. **Collect payment** information at the time of booking to streamline your processes while reducing the chance of missed payments.

Use **automation and communication templates** to send appointment follow-ups with invoices, and reminders for outstanding accounts.

Keep Moving, Stay Connected

As a counsellor, your day is packed. Zanda ensures nothing slows you down. It's easy to **switch between desktop and mobile** to access schedules, client records, and billing tools. With Zanda, you stay connected, organized, and focused—so you can keep your practice moving forward.

Your Practice Partner

Zanda is the result of years of hands-on experience in allied health, combined with a passion for making life easier for practitioners like you. Until recently, our Co-Founder and Head of Customer Success, Damien Adler, was a practicing psychologist who faced the same administrative challenges that all allied health practitioners encounter.

Our deep understanding of the day-to-day demands of running a practice is what drives us. We're your trusted partner dedicated to helping your practice thrive.

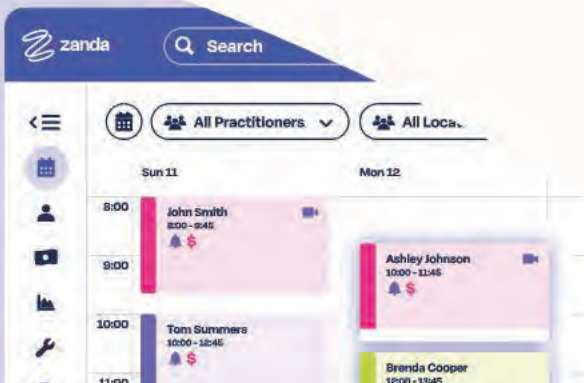
"We're constantly listening to our customers to find ways to make their admin work easier. Our goal is to eliminate the barriers that prevent practitioners from doing what they love. When your practice thrives, so do your clients."

Damien Adler, Co-Founder & Head of Customer Success

Power Diary is now Zanda! With **over 30,000 practitioners** relying on us, we're the same trusted partner committed to supporting physiotherapy practice management. Our mission is to make health practice management easy and enjoyable with features and time-saving automations that help you focus on what matters most.

zanda
formerly Power Diary

zandahealth.com



WORKING FOR YOU

Updates from BACP's Policy team

Government must act now to avoid children and young people's mental health crisis

We've backed calls for urgent Government reform and investment in children and young people's mental health services, as new research shows the cost and long-term impact of the impending crisis.

The research, published as part of a new Future Minds campaign led by major UK mental health charities, says that more than one in five children and young people now experience a common mental health problem such as anxiety or depression.

BACP Child, Young People and Families Lead Jo Holmes said: 'We agree that Government must deliver immediate reform and investment to boost children and young people's mental health services in its forthcoming Spending Review and 10-year NHS Plan.

'Children and young people's mental health services continue to be considerably under-funded relative to demand. Millions of families across the country are experiencing the everyday reality of children living with often extreme distress.'

Chancellor must put counselling at the heart of economic growth

We've called for investment in a wide range of areas where counselling would enhance the Government's objectives while delivering a significant return for the public purse.

Our 12-point response to the Government's Spending Review includes evidence on how expanding access to counselling in schools and reviewing counselling recruitment pathways could deliver on the Government's growth mission as well as provide a sound return for taxpayers.

ZORAN ZEREMSKI/SHUTTERSTOCK

Martin Bell, BACP Head of Policy and Public Affairs, said: 'Too many people are falling through the cracks in current services when they need access to support from trained therapists. This includes young people who don't meet the threshold for Child and Adolescent Mental Health Services (CAMHS), people languishing on NHS waiting lists or those struggling to keep working due to their poor mental health.'

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

FROM THE CHAIR

Natalie Bailey,
Chair, BACP Board of Governors

Philosopher Immanuel Kant, known as the father of modern Western ethics, would probably be considered an influencer in today's terms. Nowadays ethics is shaped by dominant voices, media narratives and shifting societal norms. What may have been considered acceptable a few years ago might now be condemned, and previously marginalised views now accepted. These societal shifts are usually noticeable following dramatic events such as COVID-19, or might be so subtle that change happens right before us.

BACP's *Ethical Framework* (*EF*) provides clarity, fairness and accountability in changing times for an increasingly diverse counselling population. The challenge is upholding ethical integrity when individual perspectives evolve and are sometimes applied inconsistently, which I call 'the hypocrisy of ethics'. This uncertainty can be deeply personal for clients who come to therapy struggling with beliefs and values that may not align with what society says is right – whether that be identity, relationships or political issues. These internal conflicts can sometimes create doubt, shame and anxiety.

While our role as counsellors is to help clients make sense of their own values and not impose ethical judgments, in a world where moral standards are not always applied equally it can also be quite confusing for counsellors. Some counsellors might struggle with feeling unheard, as dominant narratives may not allow for alternative perspectives or opposing views.

Ethical practice is also about critical thinking, fairness and consistency. The rise of digital spaces, cultural changes and global events all contribute to shifts in counselling ethics, with issues ranging from confidentiality in online therapy to boundaries in campaigning.

We may have come a long way since Kant, but ethics is still shaped by power, influence and dominant voices. So who are today's 'influencers'? The *EF* helps ensure our practice is centred around the client and not solely dictated by external forces. That means helping clients explore their own ethical dilemmas with clarity and self-compassion. It also means ensuring that our profession remains thoughtful, reflective and adaptable – engaging in dialogue with our peers and colleagues, both online and in person, with courtesy and respect.

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RESEARCH DIGEST

To mark Stress Awareness Month in April, this issue features research on working with anxiety.

1 Person-centred counselling for depression and anxiety

THE STUDY: The effectiveness of person-centred counselling on depression and anxiety outcomes for 301 adults seen within a charitable, community-based service was explored at three time points.
THE FINDINGS: By the sixth/final session, 48.1% of clients' depression and 50.8% of anxiety scores showed clinically significant improvement, and reliable change was achieved by 47.8% of clients for depression and 60.5% for anxiety. Reliable and clinically significant improvement was shown by 32.6% and 41.2% of clients for depression and anxiety respectively.
THE TAKEAWAY: Person-centred counselling was shown to be as effective as other psychological interventions for reducing depression and anxiety symptoms within community-based settings.
READ MORE: Young J et al. A practice-based exploration of therapeutic change in a charitable, community-based person-centred counselling service using routine outcome measures of anxiety and depression. I: statistical and clinically significant change. **bit.ly/43ejvw8**

2 Working with anxiety and depression following COVID-19

THE STUDY: This study compared the effectiveness of mindfulness-based cognitive therapy (MBCT) and Beck cognitive therapy (BCT) in treating people with symptoms of depression and anxiety following COVID-19. Forty-five COVID-19 survivors were randomly assigned to each therapy and completed pre- and post-intervention measures.
THE FINDINGS: Both approaches resulted in significant improvements in symptoms of depression and anxiety for people in this population. BCT was shown to be more effective than MBCT.
THE TAKEAWAY: These therapies should be integrated into healthcare settings, and training should be provided to support therapists in their use. As BCT appears to be more effective than MBCT, it should be prioritised to address symptoms of anxiety and depression among COVID-19 survivors.
READ MORE: Khajehnezhad M and Veshki SK. A comparison of the efficacy of mindfulness-based cognitive therapy and Beck cognitive therapy on the depression and anxiety of patients recovering from COVID-19: a pilot study. **bit.ly/41A01AX**

3 Collaborative care for depression and anxiety among cancer patients

THE STUDY: This study investigated whether collaborative care would lead to greater reductions in depression and anxiety than psychotherapy alone among people with cancer. Treatment outcomes in 433 adults patients with cancer were analysed, where 252 received psychotherapy alone and 181 received collaborative psychotherapy and psychiatric care.
THE FINDINGS: Collaborative care was more effective than psychotherapy alone for reducing depressive symptoms. However, there were no differences between the two types of care in reducing anxiety symptoms.
THE TAKEAWAY: Mental healthcare for patients with cancer may benefit from collaborative care models that include both psychiatric services and psychotherapy to treat depression.
READ MORE: Spitz D et al. Psychotherapy alone versus collaborative psychotherapy and psychiatric care in the treatment of depression and anxiety in patients with cancer: a naturalistic, observational study. **bit.ly/3DiMMek**

OUR RESEARCH

Fenia and Paul talk about their research on the role of personalised learning pedagogies in the context of counselling training at university.

Dr Fevronia Christodoulidi (Fenia), Senior Lecturer at Metanoia Institute/ Middlesex University, and Dr Paul Galbally, Senior Lecturer at the University of East London. Both are BACP accredited psychotherapists

Our article 'Personalised learning pedagogies and the impact on student progression' (**bit.ly/43ixNMm**) discusses how tailored educational approaches to individual students undertaking a counselling practitioner degree can influence academic success. We focused on personalised learning, which acknowledges a student's unique learning style and differences, and considers their needs and preferences with the aim of engaging them more effectively. We aimed to identify strategies for inclusive, effective education.

We explored concepts such as the lived curriculum, which integrates students' personal experiences into the learning process, and pastoral support, which refers to the guidance provided to support students' wellbeing and academic development. Both were underpinned by an ethos of vulnerability, appropriate self-disclosure and collaboration to reduce traditional academic power imbalances. This approach fostered a more creative learning environment, enriching theoretical teaching with storytelling and personal connection. Our hope was to encourage educators to adopt more flexible, student-centred teaching methods, which could lead to improved student outcomes.

The initial research centred on the student experience. We followed up on key findings with experienced counselling educators, presenting two questions: how staff use pedagogical skills and contemporary research in their teaching, and how institutions can facilitate this. Our analysis showed discrepancies between professional qualifications, demanding workloads, identity conflicts, unwieldy assessment processes and a perceived lack of institutional support. Our recommendations included formal teaching qualifications alongside counselling expertise, flexible teaching practices, use of the self, formal supervision and demystifying academic ability.

If you're interested in training with us as part of your staff development provision or CPD programme for your team, get in touch at **bit.ly/41xfDF4**

What's on

Mental wellbeing in the arts and media

THEATRE

MARC BRENNER

Dear Evan Hansen

Shy and anxious Evan returns to school with a broken arm and a recommendation from his therapist to write himself a letter each day about what he might look forward to. A misunderstanding with one of these letters snowballs after one of Evan's peers at school dies by suicide. This award-winning musical is a fast-moving look at the awkwardness of love and friendship for Generation Z as well as a critical approach to the struggle to cope after the death of a young person. Produced by The Nottingham Playhouse, the UK regional tour includes Wolverhampton, Sheffield, Plymouth, Hull and Cardiff in April, with more UK dates elsewhere until July. **evanontour.com**

TELEVISION

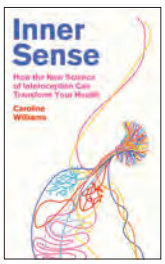
BBC

FINDING HOPE

Charity CEO Marjaneh Halati, a social psychologist and psychotherapist, is working with siblings Zari and Ali, who have settled in the UK after leaving Afghanistan. Filmmaker Sara Nourizadeh is Welsh-Iranian, and turns a keen eye on stories of loss, migration, love and belonging that fill Halati's days. The documentary is a window into her career at the OMID Foundation in London, a charity that provides support and access to women from Persian-speaking countries now living in the UK. The unique challenges of moving from one culture to another provide plenty of insight into what clients like Zari need most, and Nourizadeh observes Halati's warmth with deep appreciation for her work, and those she works with. Available now on **BBC iPlayer**.

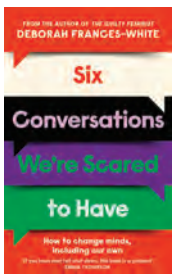
The power within

BOOKS



Interoception is underrated, Caroline Williams tells her audience in her book *Inner Sense: how the new science of interoception can transform your health*, which is a rough guide to the latest research into feelings like hunger, safety and stress (and tools such as meditation that hone them). It feels like a brilliant bank holiday read for any therapist. (Profile, out 3 April)

Disability advocate Tasha Ghouri takes a break from *Strictly* and *Love Island* to take a positive stance on disability. In *Your Superpower: embrace what makes you different* she writes with gusto about how conditions from blindness to alopecia can foster new sources of strength, and the pitfalls of traditional ways of understanding disability. (Piatkus, out 24 April)



After growing up in a cult, Deborah Frances-White became internationally recognised for her intelligent, outspoken approach to free speech and feminism. In this new non-fiction book, *Six Conversations We're Scared to Have*, she turns her attention to the needs, doubts and changes of heart that are hardest to voice. (Virago, out 3 April)

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

PODCASTS

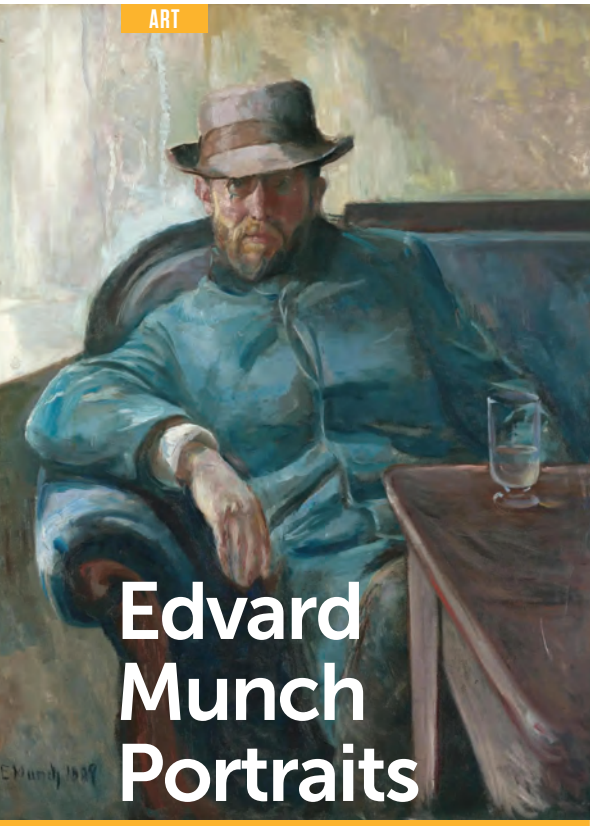
Going deeper

Jon Nelson, along with a reported 2.8 million other US patients, lives with 'treatment-resistant depression' (TRD), and is waiting for novel treatments such as deep brain stimulation to show promise. Leading podcast company PRX teams up with journalist Laura Sanders for a closer look at the diagnosis in the *Science News* series *The Deep End*. **bit.ly/3Elg5x0**

Investigative journalist Carole Cadwalladr hosts *Stalked*, a new 10-part BBC series that looks into what happened when her ex-partner's daughter, Hannah, was cyber-stalked, and why. Shining a light on this case puts a face to this increasingly common crime that uses technology to control, manipulate and threaten, and is so hard to prosecute. On **BBC Sounds**.

In *LeadHERship Journeys*, psychologist and author Leona Deakin talks to women at the top of their professions about what they do, and how sexism has affected their ascent. If you're jumping right in, start with episode two, featuring Siobhan Blake, the national crown prosecution lead for rape and serious sexual offence prosecutions. **bit.ly/3Q5TwiK**

ART



Edvard Munch Portraits

Best known for his work *The Scream,* Munch's painting still haunts the way we see mental illness. The National Portrait Gallery is this year hosting the first-ever UK retrospective that focuses on the experiences that shaped his career. The exhibition begins with his early work, made before and after his sister was hospitalised with a diagnosis of schizophrenia. Munch went on to become one of the most exhibited artists in Europe, but as his fears rose that he had inherited the same mental illness he collapsed from stress. He went on to develop a new phase of his style in his recovery, when a close group of friends (his Lifeguards and Guardians) became his exclusive subjects. The exhibition traces this arc for the details beyond his dark, best-known piece. At London's National Portrait Gallery until 15 June. **npg.org.uk**

HANS JÆGER, 1889 BY EDVARD MUNCH © NASJONALMUSEET FOR KUNST, ARKITEKTUR OG DESIGN. THE FINE ART COLLECTIONS. PHOTO: NASJONALMUSEET/BØRRE HØSTLAND

FILM

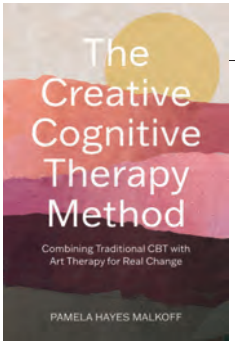
Julie Keeps Quiet

Tennis player Julie is the cream of the crop at her academy until one of her peers takes her own life, and her coach falls under investigation. Players at the academy are encouraged to speak up, but Julie doesn't seem to have anything to say. Friends and family begin to question her silence, and what private thoughts might be roiling inside this strong-willed young woman. This directorial debut premiered at Cannes last year and has been praised by critics for its tense atmosphere and realistic approach to trauma. The film makes original points about the role of silence and withholding after losses, and the risks of speaking as well as how people cope with conflicting pressures at a crossroads in a career. At selected cinemas nationwide.

NEW EUROPE FILM SALES

Bookshelf

Edited by Jeanine Connor. Please note, we do not accept unsolicited reviews.



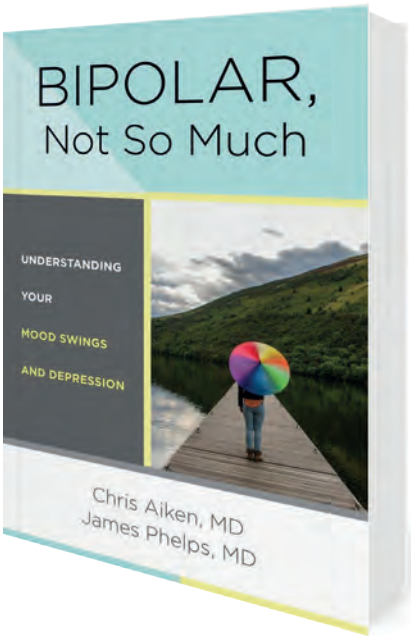
The Creative Cognitive Therapy Method: combining traditional CBT with art therapy for real change
Pamela Hayes Malkoff (Jessica Kingsley Publishers)

Described as a groundbreaking 10-session programme combining art therapy and CBT, this book provides structured self-help for clients, and a therapeutic framework for therapists working with a variety of issues including anxiety, depression and post-traumatic stress disorder (PTSD), without previous experience in art needed: the focus is on the creative process rather than the end results.

The book's tone is light and humorous, and the author's vulnerability shared. Traditional CBT methods are used, such as identifying the link between negative thoughts and psychological distress, and developing alternative perspectives of trigger events. But third-wave interventions are also included, such as gratitude, accepting emotions as uncomfortable rather than harmful, mindfulness and self-compassion. As an integrative practitioner, there were several concepts recognised in the integrative approaches demonstrated.

Malkoff's approach focuses on working with clients in person. The order of the activities may not work with all clients, and therapists may need to move backwards and forwards through the framework, which may take more than 10 sessions. More could have been mentioned about managing client resistance and maintaining good habits after therapy. The author encourages therapists to try the interventions themselves before using them with clients. This book has some fun and insightful art and writing exercises to help clients achieve therapeutic change.

Angelina Archer MBACP, counselling psychologist



Bipolar, Not So Much: understanding your mood swings and depression
Chris Aiken and James Phelps (WW Norton)

This book by two distinguished US psychiatrists encourages readers to develop an understanding of their mood disorders, describing how depression and mania can interact, arguing that these interactions exist on a continuum, counter to the way they're categorised in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM 5-TR*). There are helpful explanations of current research evidence for genetic influences and of how the experience of a mood disorder differs from typical functioning.

The second section discusses lifestyle factors conducive to healing, with a wealth of practical advice covering daily routine, exercise, nutrition, sleep and the impact of substance use and technology. One fascinating chapter presents survey evidence that the most helpful interventions identified by those with lived experience of mood disorders are lifestyle changes, ahead of medication.

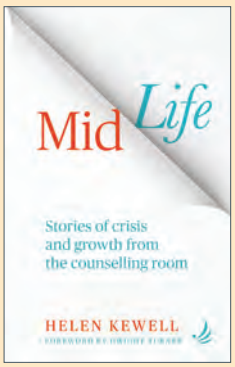
The third section explores treatment options, including recommendations for medications – perhaps less relevant for a UK audience – with the differences in culture and regulations on prescribing. Non-pharmaceutical interventions are included, including 'Good therapy', emphasising the fit of therapist to client and the therapist's understanding of the client's condition.

The fourth section advises on dealing with relationships and work/education, and includes a chapter for friends and family. For me, the book is a useful resource in understanding mood disorders, and a practical reminder of what can help clients.

Kay Hoggett MBACP (Accred), integrative counsellor, coach and supervisor

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

'One fascinating chapter presents survey evidence that the most helpful interventions identified by those with lived experience of mood disorders are lifestyle changes'
Kay Hoggett



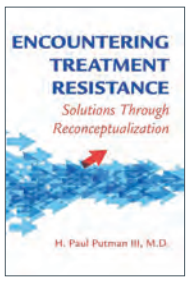
Midlife: stories of crisis and growth from the counselling room
Helen Kewell (PCCS Books)

In this follow up to *Living Well and Dying Well*, in which humanistic counsellor Kewell wrote about counselling older people, the author turns her attention to midlife while also supporting clients experiencing similar transitions. This is a short book (160 pages) comprising nine chapters about work, bodies, relationships, legacies and what we can learn about ageing from the LGBTQIA+ community.

Kewell challenges the concept of 'midlife crisis' – the psychological conflict caused by the realisation that we are no longer young, and that death is approaching. She describes the stereotype of the emotionally volatile menopausal woman and shares vignettes that are amalgamations of her client work to illustrate how she has helped many women, including herself, to reframe their experiences and thrive. Kewell's skill is in accentuating the opportunities of life transitions with genuine compassion and connection.

This book is well researched: Kewell leans heavily on existential theory and the idea that, as therapists, we offer clients the possibility to experience themselves differently, focusing on their potential as well as their actuality. She spoke to many experts and assimilated their insights into her own. Kewell acknowledges the part she plays in exacerbating a lack of diversity, as well as the ways in which she is trying to improve. She owns her 'pink washing' and blind spots for what she calls 'non-typical transitions', ie non-typical to her. This hopeful book ends with a midlife manifesto urging all of us to be the change.

Jeanine Connor MBACP, psychodynamic psychotherapist



Encountering Treatment Resistance: solutions through reconceptualization
H Paul Putman (American Psychiatric Association)

Intended primarily for psychiatrists, this book is a manifesto on the power of remaining curious and hopeful about client work. I found it a difficult read, owing to the amount of unfamiliar technical language from the field of psychiatry, but for those interested in this area of mental health work it may be worth persevering.

Up to 60% of psychiatric diagnoses eventually become labelled 'treatment resistant', a term Putman believes to be unhelpful. I suspect that, like me, many therapists have felt stuck or hopeless in relation to some client work that might mirror this label. As a concept it seems highly relevant to counselling and psychotherapy, even if we might not always use the same language for it. Throughout the book I couldn't help but find the therapeutic equivalents to Putman's arguments, of which there were many. From this perspective it is an interesting exercise in comparing and contrasting our overlapping fields of practice.

However, there are hurdles to this kind of comparison. For example, Putman asserts that the goal for a clinician is to provide solutions to patients. Depending on your modality and therapeutic stance you may well disagree.

The book is an interesting foray into a different perspective on client cases. It is well structured, with lengthy vignettes and questions for reflection, and potentially useful to therapists working in conjunction with psychiatric settings.

Emily Harrison MBACP (Accred), integrative therapist

The Spirit of Psychotherapy: a hidden dimension
Jeremy Holmes (Karnac)

In this slender book psychiatrist Jeremy Holmes contemplates the spiritual aspects of his work as a psychodynamic psychotherapist, offering a definition of secular spirituality. Having written extensively about attachment theory before, Holmes attempts to show here that therapy fosters a secure base, which can lead to a greater sense of psychic cohesion and connectedness to the world. This is a deeply personal book, describing the consulting room as a place of holiness.

Holmes describes himself as an atheistic agnostic. The book is structured as an extended argument that often seems aimed at the antipathy towards religious experience Holmes encountered during his clinical training.

By citing research in neuroscience he suggests that spirituality has a biological foundation in our brain. He naturally turns to Winnicott's work using the term 'transitionality'. The most fertile ground for Holmes' argument for the existence of a secular spirituality may be in his description of the 'infinite silences' in sessions. This description may come closest to the ephemeral quality of the profound moment of spiritual experience that often marks a turning point in an individual's course of therapy. Holmes uses science, literature, philosophy and interviews on the role of religion in believers' lives to illustrate his case. His comprehensiveness is sometimes cumbersome but also rich material for reflection.

Stacey McNutt MBACP, psychodynamic psychotherapist

The truth about harm in therapy

Ellie Broughton looks at the nuance of harm behind the sensationalist headlines

When Jessica Wing* started seeing her new therapist she was just a trainee. 'I'd seen a few therapists by that point, all women,' she says, 'and felt that I knew what to look for and ask.'

But when Wing opened up to the therapist about her experience of sexual violence he undermined her. 'I spoke about a few of the events of rape I experienced,' she recalls. 'He responded by saying, "you feel like you've been raped". This small adjustment in language took me from feeling believed and validated, knowing I had been raped, to questioning and blaming myself. He even asked whether I said "no".'

In a later session the therapist crossed a physical boundary: touching her shoulder as they said goodbye. In the moment, she froze. Afterwards she ruminated on whether she invited the touch, whether he was 'testing' her, and whether he would escalate boundary-crossing as the therapy went on.

Wing discussed what had happened with her supervisor, stopped working with her therapist, and stopped therapy altogether for several years. Wing also wrote her therapist a letter about her experience of harm, but not every client can voice their concerns – some may even struggle to name it. Studies show harm is underreported and remains poorly understood. As long as the profession resists the question of harm, the problem remains corrosive.

Not every client seeks redress for a problem but some do. In 2023 BACP received 511 complaints, in the same period 29 cases were allocated to a practice review hearing (also known as the practice review process track),[1] and 14 were allocated to a disciplinary hearing. Although they involve less than 1% of BACP's almost 75,000 therapist membership, the risk of doing harm – and its consequences – is rightly a serious concern for the profession. Although complaints are still rare, they have risen yearly since 2020, increasing by 26% from 406 in the report for 2022, outpacing growth in BACP membership (up just 6%). Given that not every client harmed by therapy makes a complaint, it may be that the rarity of complaints belies the true prevalence of harm.

Last summer the lack of regulation of counsellors and psychotherapists was in the headlines again when a high-profile therapist was found guilty of sexual assault in a civil claim and his victim was awarded £200,000 in damages.[2] The reports from the courtroom are likely to have disturbed both clients and therapists. But most harm in therapy is far less headline-grabbing than cases that involve sexual conduct or dual relationships – harm can also come from lack of awareness, a gap in knowledge or competence, or lack of attunement to a client's needs. We spoke to key stakeholders to build a true picture of when therapy is most likely to harm clients, and how prevalent it is.

Boundaries

One of the key issues underlying harm in therapy is a lack of knowledge among clients of what 'good' therapy should look like. 'I always felt like it was really hard for me to know whether or not what I was experiencing was OK, or to explain why, when I felt that it wasn't,' says Erin Stevens MBACP, a humanistic, integrative therapist and supervisor whose experience of harm in therapy motivated her to train as a therapist and specialise in working with clients who have also experienced harm.

'It wasn't until two years after termination, when my former therapist began to break boundaries more explicitly, that it became clear. When he did that, I could go, "See, this is what I was talking about the whole time". It took something obvious for everyone to go, "Oh, yeah". All the other stuff was just so hard to articulate,' she says.

During therapy, the practitioner would do things such as use jargon, change session duration and self-disclose. 'At the time I was not a trained therapist myself, and I had no frame of reference for knowing what was OK in therapy and what wasn't,' she explains. 'When I questioned what was happening, my therapist would tell me that he was "congruent" and I was "incongruent", further leading me to doubt my experience. He controlled much of the narrative and context in a way that was confusing and painful for me.

'He would often allow sessions to go on for much more than the designated hour, which was difficult to challenge – it felt good to have more time. However, he completely controlled the terms of the time boundaries, which was ultimately disempowering.

'I felt similar ambivalence about his overdisclosure regarding his personal life, and his expressions of feelings towards me, which would range from awe and admiration to announcing that he felt I had "stabbed him in the heart" by questioning an approach he used. Due to my attachment and love towards him, I felt completely powerless and beholden to his whims, which was frightening.'

Stevens eventually took a break from her therapist to see a second therapist.

'It would have been very difficult for me to walk away without support,' she says. 'Clients can become stuck in harmful dynamics for years due to a sense of isolation and an absence of other options. Ultimately the therapist's refusal to talk about the feelings that were happening in the relationship led me to take a "break" while I worked out what was happening, with a second therapist.'

After two months Stevens made a decision about the first therapist.

'Most harm in therapy is far less headline-grabbing than cases that involve sexual conduct or dual relationships – harm can also come from lack of awareness, a gap in knowledge, or lack of attunement to a client's needs'

NEIL WEBB

'Noticing the sheer difference that a boundaried and calm therapy space made to my nervous system, I decided not to go back. At first there was nothing but grief in this for me, but I then stayed with the second therapist for over nine years. The first year or so was almost completely focused on recovering from the first therapy, and we returned to processing it intermittently throughout the work.'

Betraying trust

Clara** was a trainee therapist when she too experienced harm in therapy as a client. 'I had been working with my therapist for several months and felt we had a good rapport,' she says. 'I trusted her, so it was quite a shock when months in she revealed that she'd spoken to some of her therapy colleagues about an issue I was grappling with and had picked their brains for advice on how to work with it. With complete conviction she proceeded to relay the advice they'd given her: "They told me to tell you... And they told me to ask you..."

'I was in such shock I disassociated. I felt heartbroken and unable to explain to my therapist why this felt like a betrayal. I believe she really thought she was helping, and I believe she did it out of care. But it destroyed me.'

'There is still much to be learned about the nuances of harm in therapy, but one area that has come under the spotlight in recent years is the risk of retraumatisation'

Clara says she wasn't far enough in her training to be able to challenge her therapist, or understand what was happening: 'Looking back I can see my therapist repeated a relational pattern with me that was familiar – having my confidences betrayed – but it's not enough to excuse it. The experience harmed me and I never really recovered.'

Stevens says that the thing that some therapists don't realise is that harm may be caused in incremental degrees. 'Harm doesn't have to be some kind of headline event,' she says. 'It can happen gradually. I think this is why a lot of the time when clients leave a harmful therapeutic relationship, they're asking the question, "Was this harmful?" Sometimes it's difficult to pinpoint and articulate.

'Sexual or financial abuse can sometimes happen in therapy, but they are relatively rare compared to other types of harm. It's easy to think, "Harm is abuse" or "I'm not going to abuse a client, therefore I don't have to worry about harm", to other the "bad" therapists.'

Research

As well as being too little discussed, 'harm' in therapy has long been a struggle to define. The process of every therapy is likely to include difficulties such as missteps, mistakes and distress, but while every harm done in therapy is a mistake, not every mistake is harmful.

A definition may be difficult to come by, but given how common harm can be, clarity is urgently needed. One of the most recent studies into 'lasting negative effects', focusing specifically on therapy for anxiety and depression in NHS trusts, found that 14% of 662 participants, one in seven, reported them.[3] The study authors concluded that, going forward, clients should be prepared for 'negative experiences of treatment', and that progress should be reviewed regularly, both 'to identify and prevent' negative effects.

Experts who have been in the field for some time also warn that lessons have not yet been learned. Professor Glenys Parry was the chief investigator for AdEPT, a landmark study into harm that received funding from the UK's prestigious National Institute for Health and Care Research in 2014.[4] In 2019 she co-authored another paper to develop a model of process factors that might lead to harmful therapy.[5,6] 'I'm amazed at how few people actually have a formal informed consent process telling people what the risks are,' she says.

A decade on from AdEPT, Parry says she remains shocked by the relative scarcity of information that some clients receive before contracting. 'It's so important for clients to be aware that therapy can be distressing. It's a collaborative relationship,

and the client should know that they've got the power to raise a concern or to seek external support. I really don't know how many therapists do that.'

Retraumatisation

There is still much to be learned about the nuances of harm in therapy, but one area that has come under the spotlight in recent years is the risk of retraumatisation. In 2020, in their study on psychotherapy for children, Dr Daniel Hayes and Barbara Castro Batic developed the research on this topic by creating a distinction between clinical deterioration and retraumatisation as two separate types of harm.[7,8] The authors said further research into harm in therapy may benefit from research into specific settings, especially to explore retraumatisation as a new research subject.

They also recommended future studies might be able to identify harmful experiences that are currently 'out of the awareness of particular stakeholder groups', especially since clients and therapists were shown in the 2019 AdEPT paper as having different understandings of 'negative effects'.

Hayes is now working on a project with UCL's Social Biobehavioural Research Group to improve outcomes in CAMHS. 'This study came out about four or five years ago now,' Hayes says, 'and since then there's been a greater focus on trauma-informed care. Things such as therapists having training in trauma-informed care and cultural competence can definitely help mitigate against retraumatisation within therapy for young people.'

Preventing harm

There are simple but effective ways that every therapist can reduce the risk of harming clients, says Sarah Millward, BACP's Client Ethics Manager. 'I strongly believe that therapists should be encouraging regular feedback from their clients, and that when they do receive feedback, that they work with their clients through their concerns in an empathic and non-defensive way,' she says. 'Doing so can often forge a stronger therapeutic relationship with that client.'

It's also important to be familiar with the *Ethical Framework*. 'When you sign up to be a member of BACP, you don't sign up just to have the letters behind your name,' she explains. 'You sign up to adhere to the *Ethical Framework*, to work with it and work to high standards. That's our expectation.'

Part of Millward's role is to run the Get Help with Counselling Concerns service, a free helpline for any client who has questions about their therapy. In 2023 it answered 1,390 public queries. The biggest cause for calls is, as many might guess, boundaries. 'Issues around professional boundaries come up the most, perhaps because it covers so many different aspects of therapy,' says Millward. 'Without professional boundaries it's like the Wild West out there.'

Endings are another common cause for concern for Get Help callers. 'Endings are such an important part of the therapeutic process itself,' she says. 'I talk about

Support for clients

BACP's Get Help with Counselling Concerns service was founded in 2012 at the same time as BACP's public Register, and currently offers support (Mon-Thur, 10am-4pm) to any therapy clients with concerns about their therapist or counsellor – whether or not the practitioner is BACP registered. 'The reason the Get Help service was created was to support the public by providing as much information and guidance as we can in relation to ethical practice in counselling and psychotherapy. If you empower clients with information, they have a better understanding of what good practice should look like. Then if something goes wrong, or doesn't feel right, they can talk to their therapist with that knowledge and education. It helps, I think, to address the power imbalance within the therapeutic relationship,' says Sarah Millward, BACP's Client Ethics Manager.

'Our hope is that the guidance we provide will help clients to make their own decision about how they feel they want to move forward'

Get Help is not an advisory service but if the client's practitioner is a BACP member then the client will be signposted to relevant parts of the *Ethical Framework* that the member has signed up to work by, and also given examples of ways for clients to highlight their concerns to their therapist. Clients can also access the resource, *'What happens when therapy goes wrong?'*.

bacp.co.uk/about-therapy/get-help-with-counselling-concerns-service

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ICEEFT

Emotionally Focused Couples Therapy (EFCT) Externship, Online

8 – 9 and 15 – 16 May 2025

Location: Online

Trainers: Helene Igwebuike and Sarah McConnell, Certified EFT Trainers

The EFT Externship is a four day immersion in the theory and practise of Emotionally Focused Couples Therapy.

The course is the foundation of the training required towards becoming a Certified EFT couples therapist and is endorsed by the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT).

This training includes presentations of theory and clinical techniques, video clips of couple EFT sessions, training exercises, group work, and usually a live couple session.

Date: Thursdays and Fridays: 8 – 9 and 15 – 16 May 2025

Cost: from £700 Early Bird Fee, write randall.lloydh@gmail.com for more information.

Venue: Online

Times: 9:30 a.m. – 4:30 p.m. each day.

Booking: Please visit https://conserarelationshipwellness.com/efct-online-externship/ for booking information.

Information: For any other questions, please write randall.lloydh@gmail.com.

Emotionally Focused Individual Therapy (EFIT) Essentials training – face to face

26 - 27 June 2025 and 3 - 4 July 2025

Location: London

Trainers: Helene Igwebuike and Sarah McConnell, Certified EFT Trainers

The four-day EFIT Essentials workshop is based on the attachment-based humanistic and systemic EFT model developed by Sue Johnson and is the first step to becoming a Certified Emotionally Focused Individual Therapist.

In days 1 &2, participants will learn the theory, key interventions and skills to tune into, order, and use the transformative power of potent emotion and attachment to literally 'move' clients into a new sense of self, a sense of secure connection with self and others, and an increased ability to overcome symptoms of emotional disorders. During days 3 & 4, participants will deepen their understanding of EFIT while discovering effective ways to overcome barriers and obstacles to change and support for working with challenging clients and situations.

Date: Thursdays and Fridays 26 & 27 June and 3 & 4 July 2025

Cost: From £700 Early Bird Fee. Contact randall.lloydh@gmail.com for more information.

Venue: National Council for Voluntary Organisations (NCVO) Society Building, 8 All Saints Street, London N1 9RL

Times: 9:30 a.m. – 4:30 p.m. each day.

Booking: To book, please visit https://forms.gle/wWg5ErgJK1VE3xuz9

Information: For information, write to Randall Horton at randall.lloydh@gmail.com

For information, write to Randall Horton at randall.lloydh@gmail.com

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endings an awful lot with clients, and what good practice around endings looks like. It's important for a therapist to actually be aware of their own competence, being honest about the work rather than just ending the therapy. An abrupt ending can be hugely damaging for a client.'

Another common theme is that clients find it difficult to talk to their therapist about concerns or questions they may have about their work together. 'If it's difficult for clients to talk to their therapist about what's bothering them, I might suggest to a client that they could put something in writing and send it to them before the session to say, "This is something that I would like to talk to you about in the next session", or take something that they've written into the session to read out,' says Millward.

Cultural competence

BACP's Public Protection Committee's annual report in 2023 included a list of common themes in types of concerns and complaints at the Investigation and Assessment Committee; concerns categorised as 'equality, diversity and inclusion' represented just 1% compared with boundary issues (14%) and 'abrupt endings' (10%). Nevertheless, lack of cultural competence is emerging as causing a significant risk of harm in therapy.

Myira Khan, a BACP counsellor, author and founder of the Muslim Counsellor and Psychotherapist Network, warns that a lack of cultural attunement by the therapist runs many risks.

'Working with clients who are culturally distant from the therapist may result in the use of an "outsider" lens by the therapist, which brings into the room their bias, projections and assumptions about the client's lived experience,' Khan says. 'The "distance" creates unfamiliarity and unsafety for the client and/or therapist, and the client feels unseen and unmet by the therapist.'

Khan says that she has worked with clients who have been set directive goals by the therapist that clash with the client's own wishes. 'Trends in harm that I have seen in my clinical practice revolve around the cultural misattunement between an individualistic-cultured counsellor and collectivist-cultured client,' she says. 'The client may be presented with choices or goals in therapy which sit outside their cultural values and context.'

Rotimi Akinsete, BACP counsellor, author and member of the Black, African and Asian Therapy Network leadership team, adds: 'As outlined in the *Ethical Framework*, it is our duty to facilitate a sense of self that is meaningful to the person within their personal and cultural context. In my professional experience as a counsellor, supervisor and course tutor, I have worked with clients and students who have been deeply harmed by a lack of cultural sensitivity in previous therapeutic relationships. For example, I have supported clients who felt their cultural identity was dismissed or pathologised, leading to a breakdown in trust and a sense of being misunderstood. These experiences often compound existing trauma, making the therapeutic journey longer and more complex.'

Complaints

Every client of a BACP registered therapist has a right to make a complaint and have it investigated. Our complaints system is designed to protect both individual clients and the public perception of our profession. Most therapists agree it's important to have a robust complaints system in place, but the fear of a client taking out a complaint can be a constant worry for many.

Susie Jamieson MBACP was subject to a complaint in 2021. She says the process cost her 'a significant amount of money' in lost earnings, despite her insurer funding her solicitor's fees. 'It tore my world apart' and 'I took to my bed for days at a time', she says. 'Sometimes I was able to cope because I have the luxury of working from home, but what if I was hiring a room two days a week, for example, and had clients back to back? Where's the space for falling apart?'

Jamieson first spoke publicly about her experience at the BACP Private Practice Conference last September, and today around a quarter of her caseload now comes from therapists who have received a complaint. 'I haven't come across anybody yet who's come to me and said,

'Most therapists agree it's important to have a robust complaints system in place, but the fear of a client taking out a complaint can be a constant worry for many'

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'There is still reluctance among many professionals to acknowledge that as well as helping clients we have the potential to harm them'

"Look, I've harmed a client. Can you help me?",' she says.

Complaints seem to have a devastating effect on therapists who seek her help, she says, causing many to abandon their work: 'A therapist may decide to wrap up their entire practice after a complaint. Some seek work elsewhere. I remember wanting to work in a supermarket.'

Jamieson says she would like to see more clarity around what constitutes harmful behaviour but says we also need to acknowledge that not all complaints or allegations of harm are justified. 'A client is under no obligation to tell us if they have a mental health diagnosis,' she says. 'We could be working with people with quite severe mental health issues and be somewhat oblivious to it. We don't get access to medical records, and we don't even really know that the client is using their real name. Even if we are doing all the things that we're supposed to be doing, that's no guarantee that a client is not going to be upset about something.'

Interventions

BACP continues to invest in and develop its public protection function, and arguably the low rate of complaints among a growing membership suggests that the profession overall is well-resourced to prevent and address harm directly with clients.

Therapists can also point to specific preventative interventions when discussing overall professional risk of harm: BACP's current review of the *Ethical Framework*, cross-partnership work like the Memorandum of Understanding, which protects clients against homophobia and transphobia, and the introduction of the Get Help service in 2012.

But Stevens says there is still reluctance among many professionals to acknowledge that as well as helping clients we have the potential to harm them, something that became apparent when she started training in 2015. 'I felt shocked. As a trainee I was at a loss as to how somebody who's been harmed in therapy is supposed to re-engage. I had been lucky. My subsequent therapist was very, very open to learning from me about what I needed, and keen for us to work on that collaboratively and figure it out together. Now I think that few people have that experience when they go back into therapy, if they go at all. A lot of people who have been harmed in therapy aren't able to re-engage.'

Interventions rely on the therapist's own willingness to prevent and recognise harm in the therapy room, she says. She now leads independent training on preventing harm in therapy, and says in her experience, the hardest part for therapists is often simply recognising what's happening.

'It's surprising to therapists to learn that a lot of harm, and in my experience the majority of harm, is nuanced and difficult to spot,' she says. 'It's an erosion of boundaries, or a kind of relational enmeshment re-enactment – an enactment that we might not spot readily. [The challenge is] how we can approach it, and how we can use supervision and self-inquiry to prevent that descent, which is often shrouded in denial.' ●

**Jessica Wing wrote about her experience in a member blog, 4 February 2025. bit.ly/3F9hG9v*

***Name has been changed*

● *For information about Erin Stevens' training courses for therapists working with clients harmed by therapy, see* **erinstevens.co.uk**

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Rewinding trauma

Denise Winn describes a simple but effective approach to help a client process the ongoing impact of her child's serious accident

Elena* had experienced every parent's worst nightmare – a call to say that her daughter, 20-year-old Cheryl, was on life support in hospital, having been hit by a speeding car while riding her bike and hurled headlong into a wall. The next few weeks were a tidal wave of emotions, as Elena and her family were told first that Cheryl was unlikely to come out of her coma, then unlikely to survive long if she did, and then that she was likely to be severely brain damaged for life.

Elena refused to give up hope. She brought in the girl-band T-shirt and shorts Cheryl wore as pyjamas and, from Cheryl's bedroom, a big, colourful poster of the same band. She pinned it up where Cheryl would see it immediately she regained consciousness, alongside photos of family and friends, to help reconnect her to her former life. Despite all the gloomy prognoses Elena remained convinced that Cheryl would fully recover from her injuries, and her strong faith supported her in this. Incredibly Cheryl did recover fully and, after months of intensive and challenging rehabilitation, was able to go back to her work as a receptionist. She had no memory of the accident and seemed fine.

It was then, however, that Elena started to feel that she couldn't cope. 'What's wrong with me?' she said on the phone, when she contacted me for help. 'I should feel euphoric. I used to be full of fun and keen on new challenges, but now I'm not interested in anything. Something weird is happening in my body – I suddenly can't breathe and I'm covered in sweat. Why aren't I just grateful to have my beloved daughter back?'

She was highly relieved when I explained to her that, because of the prolonged trauma she had suffered, a part of her brain called the amygdala, whose concern is with survival, had got stuck in a state of alert. Anything that reminded her of the trauma, consciously or not, caused the amygdala to trigger the fight-or-flight alarm, causing the symptoms she was experiencing. Because, in its prolonged state of high emotional arousal, her brain had been unable to process the horrific event as being in the past (thus enabling it to become a normal memory, albeit a highly unpleasant one), each time there was a 'pattern match' it was as if Elena was responding to the traumatic injury all over again.

The good news, I told her, was that when she was guided to re-experience the trauma in a state of calm, her brain would finally be able to put the event in context and code it in narrative form as something that was truly over.

Rewind technique

Enabling the coding of a traumatic memory in this way, using our version of the rewind technique, is something that all human givens (HG) practitioners learn to do in training. The results can be quite spectacular, but it is always made clear that the method is not magic; it does not suit everyone, must be approached judiciously in terms of timing and execution, and be coupled with other therapeutic techniques as appropriate – for instance, building confidence or assertiveness skills when bullying has eroded these, or addressing emotional needs that are no longer being well met, such as for connection or sense of meaning after the traumatic death of a loved one.

The rewind technique originated in the work of Richard Bandler, one of the founders of neuro-linguistic programming (NLP), who created it as a phobia cure and called it the visual-kinaesthetic dissociation protocol.[1] The name 'rewind' comes from Dr David Muss, after the

version he developed and published about back in 1991.[2] Recently the findings of the first randomised controlled trial based on his method were published and showed 'a large effect size in treating symptoms of PTSD' in one-to-three sessions.[3]

The HG version, which most commonly works in one session, has been modified in line with latest understandings from neuroscience about how trauma is processed in the brain, to make it as safe and reliably effective as possible. It requires clients to be put into a state of deep relaxation before it is carried out, preventing any risk of embedding the trauma pattern deeper, and also essential is ensuring that the trauma template is activated, ie that the trauma memory is being re-experienced at an emotional level. This is crucial because sometimes people are so traumatised that they are emotionally cut off from their experience, dissociating from it completely, in which case they are not yet ready for the rewind technique and the priority will be to enable them to feel safe enough to access the related feelings.

We also usually expect to test out clients' response to relaxation and guided imagery before employing the rewind technique. Some clients who are literal-minded do not take to it; for others it may take practice to relax. When carrying out relaxation and guided imagery in my first session with Elena, I was surprised by how quickly she engaged – tell-tale signs are the rapid eye movements, revealing that she could go into trance very speedily, despite her disabling anxiety.

Non-invasive process

In our next session, Elena and I embarked on the rewind. The process itself is fairly straightforward, although it takes practice to become confident with it. In brief, once the template had been activated I guided Elena to imagine herself in a relaxing place and, when the relaxation was sufficiently deep, to see or sense the traumatic event flashing by from before it began to after it had ended, and then running back through it. This is achieved in a specific and gradual way, to keep the client calm, and we continued this process until no emotional arousal was experienced. Throughout I was monitoring Elena closely, guiding and steering in whatever way necessary.

I was again surprised by how very quickly Elena engaged, cycling at speed through the fast-forwards and rewinds of her 'film'. She was so fast that I initially wondered if she was fully processing what she needed to process. When she nodded to signal that she had repeated the process enough times and we had disposed of the film paraphernalia, I invited her to enjoy her special place again and, with the aid of vivid metaphors, reminded her of her powerful innate resource of positive expectation, which she had applied throughout the ordeal, her instincts as a mother and the support of her strong faith, all of which could once again stand her in good stead as she moved on with her life.

If the problematic circumstance had been one which needed or was likely to be encountered again, such as travelling in a car after a car crash or seeing a spider after a spider phobia has been treated, I would have guided her to rehearse experiencing this while remaining calm. When I counted Elena back out of trance, her eyes were sparkling and she couldn't stop saying that a huge weight had been lifted from her.

Techniques such as eye movement desensitisation and reprocessing (EMDR) and emotional freedom technique (EFT) deal with detraumatisation too, of course. However, in HG therapy we favour the rewind technique because it is non-invasive (the client doesn't even have to give details of the incident, an element which appeals to many rape victims) and because our version harnesses the almost limitless power of the imagination. It can thus even be used to rewind years of trauma (such as patterns of domestic abuse extending from childhood through adulthood), very commonly in one session. And it could be used creatively to help Cheryl when she, in turn, started to struggle.

For while Elena didn't need to see me again, several months later she got back in touch to say that Cheryl had started having a strange experience. At times in pubs and parties, when she couldn't hear what people were saying to her over the noise, she went into full-blown panic. Elena wondered whether fragments of memory about her hospital care were coming to consciousness, such as lying helplessly in intensive care with the burble of others talking all around her. She asked me if I could help.

Break-through memories

On arrival Cheryl mentioned a recurring dream she had also started having, of waking up in her bed in a panic. She could clearly see the girl band on the large poster at the end of her bed and the girl-band 'pyjamas' she was wearing, yet,

'In human givens we favour the rewind technique because it is non-invasive and because our version harnesses the almost limitless power of the imagination'

in reality, her bedroom had black-out blinds, preventing her from seeing any such details. Each time, she also became aware of voices she couldn't understand. It was so frightening that she had stopped wearing the top and shorts, took down the poster, and couldn't listen to her favourite band's music.

It certainly seemed that memories were starting to break through to consciousness, so again I employed the rewind technique, but with a difference, as there was a lot that she still didn't remember, yet might later. Our film began before the accident and ran through related traumatic memories up to the present time, including the recent events that had bothered her. I made a point of suggesting that her unconscious mind could include in the process anything else which might surface in relation to her traumatic time in intensive care, and which her amygdala could now safely ignore.

Like her mother, Cheryl relaxed extremely deeply very quickly and went through the rewind process just as fast. Afterwards I invited her to visualise herself putting the poster back up and enjoying listening to her favourite band again. She was actually giggling at this point, and told me after that she had already put the poster back up before I even suggested it. She had no further recurrence of break-through memories.

As might be imagined, successful execution of this technique is very commonly life-changing. And circumstances always alter cases. I remember a chartered surveyor called Adam, who had a powerful enduring resentment of his parents because of what he had experienced as total disregard for his feelings as a child. Unfortunately he and his wife now depended on his parents for childcare because of a lack of facilities close to them, and the result was that his blood pressure had rocketed dangerously high, and his rage felt so out of control that he was even shouting at his wife and two young children.

He believed that his rage against his parents sat deep inside him. I explained that, in fact, it was merely reignited by the 'protective' amygdala, every time he saw or thought of them (which was now very often), and that we could neutralise the emotion and put it in the past if he wanted, which he didn't. He said he wanted payback – although he also insisted he didn't want to hurt his parents. We did a lot of other therapeutic work to help him with his mood swings and anxiety, but I had to tell him that until he decided that he was ready to let his anger go we couldn't move forward on that.

After several weeks he got back in touch, saying he had recognised that, for the sake of his own family, he did need to let his anger go. So we rewound the relevant incidents from his youth and adulthood that related to his parents, then rehearsed his being able to enjoy his family life again, tolerating his parents and appreciating their kind caregiving to his children, even if he had not felt such good effects himself. We had one more session and he was a different man – more at ease, positive about the future and with normal blood pressure levels.

Training

The initial HG rewind training takes place in person over two full days (preceded by our training in guided visualisation, if not already a practised skill) because it is important to absorb the steps thoroughly and have plenty of time to experience and practise the technique under proper guidance.

There is a lot to learn. Practitioners must decide when the technique is appropriate to use; be ready to troubleshoot, as our unconscious minds process things in different ways; vary its execution as needed – for instance, in accordance with whether the trauma happened to the client, someone close to them or is entirely imaginary; and adapt speedily to the unexpected – the 'simple' needle phobia that turns out to mask unexpressed grief for the trauma of a stillbirth, or the real cause of enduring pain, if not readily apparent. HG practitioners never consider the rewind technique an end in itself but one highly valuable component within effective therapy. ●

'It is important to absorb the steps thoroughly and have plenty of time to experience and practise the technique under proper guidance'

**Based on composite examples. Names and identifiable details changed.*

● *Human Givens College runs its accredited two-day CPD workshop, 'The rewind technique: effective treatment for trauma (PTSD) and phobias', in London and Bristol throughout the year (**humangivens.com/college/rewind-technique-training-workshop**).*

BACP advises that it recognises the practice when used psychotherapeutically in a mutually contracted therapeutic relationship and when supervised to the required level. It reminds members that they need to be 'competent' (*Ethical Framework*, Commitment 2) to work with client issues presented and using the technique, and must have the required 1.5 hours of supervision per month.

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ABOUT THE AUTHOR

Denise Winn is a human givens psychotherapist, a fellow of the Human Givens Institute and the former editor of *Human Givens* journal. She is the author of 11 books and co-author of five books in the human givens self-help series *Essential Help in Troubled Times* (Human Givens Publishing).

‘Therapy helped mend my broken heart’

There have been many times in my life when I’ve thought to myself: ‘I should probably start looking for a therapist.’ A troubled childhood, complicated relationships with my narcissistic parents, an ongoing skin-picking obsession and, later, a rocky patch in my marriage were all good enough reasons to seek some kind of counselling. I just didn’t know what kind.

It wasn’t until my mum died by suicide in March 2023 that – aged 57 – I knew I couldn’t use that excuse any more. A friend recommended an online therapy service, and I liked the idea. At my first appointment, after a kind-hearted face on a screen watched me cry for 30 minutes, I realised I did not actually like that idea. It felt impersonal and awkward. It was also too soon after my mum’s death. I felt like I was leading the therapist to counsel my grief, when what I really wanted to do was explore my anger. Towards the end of the session I remember thinking: ‘This can never work, I am way too complicated and broken for therapy.’ I didn’t book a second session.

It was a year later, after I developed stress-induced heart failure, that I realised it was *because* I was complicated and broken that therapy was essential – for both my physical and mental wellbeing. The physical impact of my unresolved emotions literally led to a broken heart (known as takotsubo cardiomyopathy). It was my doctor who suggested somatic therapy, a technique that focuses on a mind-body connection to release trauma from the body.

At my first session my therapist didn’t have the chance to say much as I unleashed a tirade of 50 years of trauma. I think the only thing she might have said is, ‘slow down’. I am joking, of course; she said more than that. I told her that I have a problem with control – I’m a control freak. ‘Don’t use words like that to describe yourself,’ she said. And right there and then I had a light-bulb moment – I *do* use words like that to describe myself, all the time. I am trying not to anymore.

This one realisation alone ensured my continued journey with her. And gradually I started to relax into this new world – one where I was the focus – for an hour every fortnight at least. It was not easy for me. I struggled with the rawness and vulnerability of it all. Somehow it felt wrong to always be talking about me.

In a later session I told her something personal. Staring at my hands – because I find it easier to open up without making eye contact – I recounted a simple, lovely moment between my husband and me that had made me feel loved and cared for (something I struggle to feel). When I looked up she was crying. When I told a friend about the crying she was appalled. ‘Your therapist should not be the one crying,’ she said. But I was not appalled, I was impressed, and grateful. To me this meant that she was empathetic and genuinely caring. It helped me to develop trust in her, an essential component of the therapist-client relationship. It also made me laugh a little – I made my therapist cry! What a great anecdote.

I had a couple of revelations during my journey with her. One was when I had a sudden realisation about my childhood that I had never said out loud before. I even surprised myself when I said it: ‘I was so immersed in my parents’ world that I never really focused on my own. As a result I never even tried to fulfil my potential. I never became what I could have become.’ I don’t think that I would have come to this conclusion on my own. When I did it was truly enlightening for me.

I found the somatic part of the therapy equally as powerful as the talking part. Towards the end of each session my therapist would get me to relax, do some deep breathing and focus on the mind-body connection. She once asked me to lay a hand over my heart and to sit with it. As my whole body relaxed I felt an intense surge of love. I highly recommend you try this. There is an actual science behind it, but I don’t care about that. I just know that it feels good. And that is what it’s all about.

MEMEJ/SHUTTERSTOCK

ABOUT THE AUTHOR

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The paradox of shame in motherhood

Therapy is crucial for helping women deal with the isolation and sense of failure that often comes with motherhood, says **Jaya Chingen**

Anna,* a client at a women's centre, presented with anxiety and symptoms of post-traumatic stress disorder (PTSD) after the recent birth of her first child. Although she had sought counselling for herself, initially she was hesitant to share her feelings and experience. Gradually, over the course of our work together, she began to open up, sharing in anxious whispers snippets of her lived experience and internal world. Her feeling of isolation was palpable, despite having a husband and supportive family; she felt alone in the intensity of her feelings. Guilt, resentment, fear, overwhelming love – as far as I could understand it, the changes in her own experiencing – were what she found most overwhelming and alone in. Much of our work was centred on challenging her belief that she was 'over-emotional' after being told this by her husband and other family members.

Anna offered herself little empathy for the hormonal impact of pregnancy. Like many women she seemed unaware that the placenta pumps out hormones at sometimes 200 or 300 times normal levels. As a result the rises are enormous; oestriol rises by 1,000 fold, testosterone by six and progesterone by 15 times.[1] And when birth happens, the sudden decline due to the expulsion of the placenta can be likened to withdrawal, with severe implications for mental wellbeing.

As well as hormonal changes, Anna was likely experiencing neural changes, described in pioneering research in 2024.[1] The study revealed 'pronounced decreases in grey matter volume and cortical thickness' with 'very few regions untouched by the transition to motherhood'. This transition – referred to as matrescence by anthropologists – is also the name of a book by Lucy Jones published in 2024, which is a radical examination of the transition into motherhood and its effect on the mind, brain and body.[2]

Given that mankind would not exist if it were not for mothers and childbirth, there has been a significant lack of scientific research into the phenomenon until very recently. A common feminist critique of science is that women's health is rarely prioritised as a topic of research, and certainly the historical lack of research into the maternal brain supports such claims.

What is the impact of a society uninformed about the nuances of maternal brain changes? Certainly, comparative to other cultures, there is little ritual, celebration and support available for women who give birth in the UK. New mothers elsewhere in the world benefit from cultural practices that acknowledge women's transition into motherhood and support them during this vulnerable time. Such practices often involve offering nutrient-rich meals, drinks, herbal baths and similar. These are provided by family members, women in the community or hired postnatal assistants who, in some cases, care for mother and baby for around 40 days – widely regarded as the 'fourth trimester'. During this period a mother is looked after so that she may rest while feeding and bonding with her baby. Ceremonies such as 'closing of the bones' are popular in Mexican and Indo-Malay cultures – aiding both the physical and emotional close of a woman's body after the extreme opening of birth. In Western societies the mother is mostly left to her own devices after birth, and little is done to mark the passage into her new stage of existence.

While studies vary widely, perinatal loneliness ranged from 32% to 100% in a review of literature undertaken in 2002.[3] According to the Red Cross, almost half of new mothers feel lonely 'often' or 'always'.[4] Our increasingly insular society has stripped mothers of the communities once available to give and receive support and experience connection with others in similar situations. Current figures suggest that around 38% of new mothers spend more than eight hours alone each day.[4] Women enter a period of intense change and emerge as mothers, described by Jones as 'likely the most drastic endocrine event in human life' and subsequently find themselves isolated and alone. Even with Jones's groundbreaking publication, many women have little idea of the magnitude of neurological changes happening to them throughout pregnancy. Without research to inform healthcare professionals and wider society of how significant the transition to motherhood is for women, their experiences go unexamined and unnoticed. Women are left feeling isolated and shamed.

Shame

Brené Brown defines shame as believing that we are flawed and therefore unworthy of love and belonging.[5] In one study on maternal guilt and shame that analysed 450 qualitative questionnaires completed by both men and women, a recurrent thread that emerged was the idea of the 'ever-present' mother.[6] Mothers expressed concerns about 'being absent, absent-minded, working, studying, having to arrange for day care or enjoying other aspects of their lives more than motherhood and thus feeling guilty or ashamed'. Carl Rogers conceptualised the origin of psychological distress as dissonance occurring between the self-concept and the ideal self. This dissonance is a result of denied and distorted experiences due to conflict between the ideal self and the self-concept. The prevalence of mental health disorders in mothers substantiates the theory that conflict arising between motherhood and modern expectations of women are impacting their ability to achieve fulfilment and progress towards, in Roger's terminology, becoming 'fully functioning' – someone who is in touch

'Without research to inform healthcare professionals and wider society of how significant the transition to motherhood is for women, their experiences go unexamined'

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with their deepest and innermost feelings and desires, and who embraces their own emotions, and places trust in their individual instincts.

This conflict could be viewed through Kelly's theory of personal constructs as the concept of organisation corollary, where the conflict between working and motherhood, or between prioritising themselves or their children, have contradictory solutions leading to anxiety.[7] Through a psychodynamic lens, our understanding of shame can be enhanced by linking it to unconscious phantasies based on internalised object relations, which has its roots in infancy.[8] Klein's object relations theory also demonstrated that the earliest activities of the ego involve various defence mechanisms to exclude particular anxieties from consciousness. In our work together, Anna regularly reflected on her experiences of being a child and being ignored, and feeling misunderstood by her mother, which formed the basis of much of her anxiety around her own parenting.

Digital age

This shame is perpetuated by the digital age of mothering and, inadvertently, by mothers themselves. Technological advances have changed the social and cultural landscape in a myriad of ways. 'Sharenting' (sharing + parenting), which includes sharing experiences, photos and personal information in the digital realm, has become a widespread activity on social media. Women turn to these spaces looking for support and a sense of camaraderie that would have previously been experienced through neighbourhood community and having friends and family in close proximity, something that our mobile and insular modern society does little to accommodate. Unfortunately the negative impact of social media use far outweighs the positives that it offers.[9]

Comparison and idealisation appear to be the most significant factors in the dyad between motherhood and mental health.[10] Humans are innately drawn to comparison as a means of self-evaluation. In some cases upward comparison can be beneficial in inspiring motivation to self-improve. However, the digital nature of the interactions and consumption allow for deliberately idealised versions of motherhood becoming internalised as expectation and the norm. Accounts depicting various mothering ideologies advertise their content with sentiments that are derogatory about their competition. Confessional blogs, for example, using lines such as, 'If you're looking for perfection, you won't find it here'. These sentiments appear to directly undermine intensive mothering accounts, which may be considered the most severe perpetuators of idealisation when it comes to mothering. Kane writes: 'Related to the concept of hidden shame is the expression of contempt as a defence against shame.'[11]

The fact that each sub-sector of motherhood ideology takes a comparative approach to shaming others highlights an inherent insecurity with its own positioning. The opportunities presented by mass and social media to judge and criticise mothers are certainly a negative of mothering in the modern world. As Crittenden writes: 'In the past, a woman might have enjoyed motherhood or not, been good at it or not, but she did not enter into existential dialogues with herself about what it meant to be a mother.'[12]

Justine Roberts, founder of the popular parenting forum Mumsnet, describes a culture of 'having it all' that most women cannot achieve, supporting the idea that this is the reason for defensiveness about how we are seen as mothers. She says the breast versus bottle for feeding contention is one of the most ferocious arguments that happens on the platform, highlighting that discussions tend to get the most heated over areas where women feel the guiltiest.

More general social discourses surrounding women such as the label of 'psycho' and 'crazy' in response to heightened female emotions contribute to the idea that intense feelings and reactions are not acceptable and compromise mothers' credibility in their parental role. One example of this is demonstrated in Suzanne Zaccour's study exploring gendered use of mental health labels in custody disputes.[13,14] The investigation revealed that these labels serve to discredit the mother, attack her parenting abilities and distract from allegations of violence by the father. Much has been written exploring the negative impacts of this degradation of the female character. The judgmental discourses of mothers in society arguably create conditions for perpetuating unrealistic expectations of motherhood, encouraging women to deny their experiences and inspire shame around the hormonal and biological changes that pregnancy and childbearing bring.

Distortion

In my work with Anna and many other mothers I saw that the experience of

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shame can lead to the denial and distortion of experiences, which Rogers describes as the origin of psychological tension. The implication of mothers experiencing the anxiety and depression characteristic of this tension has a serious impact on their mothering experiences and outcomes for their children. A number of studies suggest an established association between maternal mental health problems and negative outcomes for children, such as maternal foetal attachment, temperament, and cognitive emotional and behavioural problems.[15,16] Addressing maternal mental health concerns protects future generations of children, promoting a healthier, better and more resilient collective society.

Fundamental to our therapeutic journey, affirming Anna's experience through offering unconditional positive regard and empathic understanding allowed her space to explore and develop acceptance towards her complex feelings around herself and motherhood, reducing her experiencing of shame. However, in order to tackle combative mothering on a wider scale, and the shame perpetuated by women themselves through collective insecurity around mothering practice and ideology, perinatal women could benefit from group-based therapeutic intervention. This would enable in-person opportunity for peer support, building the essential sense of community that has been lost in the modern day. The benefits of group therapy for reducing isolation have been explored in multiple studies. Other benefits of group-based therapy would be enabling a space for realistic comparison and diffusing idealised ideas of motherhood through sharing challenges in a safe and supported space. If these interventions could enable women to feel supported in an in-person capacity, perhaps social media use could be reduced along with exposure to damaging idealised content that perpetuates unrealistic expectations of motherhood.

Hertfordshire Mind Network offers a facilitated peer support group made up of eight online sessions. The programme has been designed and developed by mums, for mums, with the aim to improve the mental health and wellbeing of new mums by empowering them with knowledge and understanding of perinatal mental health as well as expanding social networks. I have had the honour of co-facilitating some sessions and witnessed a powerful sense of togetherness and communal tackling of myths, assumptions and judgments around motherhood. Meditation and breathing techniques are integrated into the format to encourage grounding and alleviate anxiety in everyday life. Services like these are integral sources of support for women during the perinatal period, and more interventions like this need to be encouraged on a national level to ensure that all women have access to safe spaces such as these.

Further research is needed to explore the neurological and endocrinological changes for women in the process of becoming mothers. Better societal education around the magnitude of these biological changes would enable women to be better understood and be affirmed in their internal experiencing. As therapists working with women who are experiencing perinatal-related mental health issues, we should endeavour to be educated in the plethora of changes women experience during this time. This is inherently valuable to the therapeutic process and our ability as practitioners to offer our clients the qualities of care, diligence and empathy. ●

** Name and identifiable details have been changed.*

'The judgmental discourses of mothers in society arguably create conditions for perpetuating unrealistic expectations of motherhood'

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DO I HAVE A SAFEGUARDING DUTY TO A CLIENT'S CHILDREN?

Q **I am currently working for a low-cost counselling service and seeing a client who struggles with alcohol misuse. She tells me that she frequently blacks out at home and 'comes to' on the sofa in the morning. My concern is that she has two children at home aged seven and nine. She is a single mother who recently split from an abusive partner, and the children have little contact with their birth father. She says she always gets the children to school although sometimes they are late, and they don't always manage to have breakfast. The service supervisor thinks the best thing for the children is to keep the client coming to sessions, and therefore we should protect her confidentiality to ensure this. If I had become aware of this situation in my previous job as a teacher the protocol was clear – we would have alerted social services. But I am unsure of what is expected of me in terms of safeguarding as a counsellor working in this context.**

A

Safeguarding can be a very emotive and distressing area of practice, and views are likely to vary between counselling professionals. Although an expansive and multifaceted topic, the following response can only highlight the most important points, and signpost to further information.

Let's start by acknowledging your client's strength, resilience and courage. She has cared for her children, possibly with little help, and ensures they have a consistent education. She has protected herself and them by leaving an abusive relationship. None of this would have been easy to do.

Your concern for the children may be well founded, but from your description it's a little unclear which are your client's words and which might be ones you use to describe what you think is happening. Might pieces of information have been fitted together to form a picture that isn't wholly accurate?

If the words 'blacks out' were hers, it may be that she is incapable of responding to a night-time emergency – perhaps your major concern. However, if she has not actually used those words, is it possible that after a tiring day and once the children are in bed, she has a moderate amount of alcohol and falls asleep on the sofa until the morning? Arriving late for school without breakfast may not be desirable but might say more about the difficulty in getting two children ready and to school rather than a mother having to recover from excessive alcohol the night before.

It would be helpful to get more information from your client – and you may have been intending to gather this as your work together progresses. This might include the significance of alcohol in her life, more on her relationship with the children, any adverse childhood experiences they've had, any support she has apart from you, and any agencies already involved, including her GP. You may have already explored whether the children's school ever raised any concerns about the children and if the school provides any forms of support that might help.

If alcohol is a significant factor, it may have required courage and strength for your client to tell you about it. You might consider that she told you for a reason and be interested in 'why now?'. You could also ask whether she wishes to do anything about her drinking at the moment (or not), and help her identify other coping strategies and steps to mitigate any risks.

It might become tempting to begin to see this client through a single lens, but it's important not to lose sight of her as a whole person, to respect and encourage her autonomy and trust her capacity for change, where that's possible.

The guidance document *Safeguarding Children: working together under the Children Act 2004*[1] acknowledges that parenting can be 'challenging' and often involves 'juggling with competing priorities to balance work and home life, as well as trying to understand how best to meet children's needs at all stages of their development. Parents themselves require and deserve support. Asking for help should be seen as a sign of responsibility rather than as a parenting failure.' How could counselling make a difference to this

The opening response to this dilemma reflects typical points, questions and issues that may be raised if the dilemma was brought to the BACP Ethics team. This includes highlighting all the potential implications of a dilemma, including those that the practitioner may not have considered or asked for specific advice on. Following this response, *Therapy Today* readers share insights based on their own experiences.

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SAFEGUARDING ESSENTIALS

- Safeguarding involves 'Protecting people's health, safety, wellbeing and human rights to enable them to live free from harm, abuse or neglect' (*Ethical Framework*, Glossary).
- How safeguarding is governed will differ across the four nations (see Good Practice in Action resources 031 and 052).

Under the *Ethical Framework* we agree:

- to make each client the 'primary focus of our attention and our work during our sessions together' (Good Practice, point 7)
- to carefully consider 'how we manage situations when protecting clients or others from serious harm' (Good Practice, point 9)
- that in 'exceptional circumstances the need to safeguard our clients or others from serious harm may require us to override our commitment to making our client's wishes and confidentiality our primary concern' (Good Practice, point 10).

Managing safeguarding challenges requires us to demonstrate most of the Personal Moral Qualities (*Ethical Framework*) but especially courage, resilience and wisdom.

client – what would help her? Does your (or another) agency provide any additional services that might be supportive to her and/or her children?

Holding risk is 'not the same as colluding or turning a blind eye', says Michelle Higgins in her article 'Navigating safeguarding dilemmas'.[2] She states that risk assessment can sometimes be seen as an 'unquestionable following of rules around reporting about a child's or other vulnerable person's welfare' and that 'perhaps this limits the notion of safeguarding, which may be better understood in terms of safety planning and co-ordination'.

To support this client it is important that you feel competent in assessing risk, safeguarding and working with any possible alcohol addiction, and that you keep your skills and knowledge current (*Ethical Framework,* Good Practice, points 13 and 14).

When safeguarding concerns arise it can be a very anxious time for practitioners. I'm sure you've also considered your client's safety, but when the person possibly also at risk is a child, stresses can understandably become particularly high. Your past experiences as a teacher are likely to also play a part in how you'll approach this situation. For more on risk, see the Good Practice in Action resource *Working with risk within the counselling professions.*

Alerting social services

Safeguarding Children: working together under the Children Act 2004 further states that 'research and experience have demonstrated the importance of early identification of children who may have additional needs, in order to prevent problems worsening'. It has been 'shown repeatedly that keeping children safe from harm requires professionals and others to share information'. The report concludes, 'Often, it is only when information from a number of sources has been shared and is then put together and evaluated that it becomes clear that a child is at risk or is suffering harm, or that someone may pose a risk of harm to children.'

The information provided by a client to a therapist is ethically and legally protected by a contract made between them. When exploring with a client disclosure to a third party, discussions held during contracting are useful to refer back to, including information provided about your role and responsibilities and what is and is not negotiable.

Exceptions to confidentiality will have been agreed. In the Good Practice in Action resource *Managing confidentiality within the counselling professions*, Barbara Mitchels and Tim Bond advise that 'a tension may arise between the need to disclose information in the public interest or for the protection of individuals, and guarding the professional contractual and moral duty of confidentiality'. (Good Practice, points 9, 10, 26 and 55d).

You may also be experiencing a tension between holding information about a possible risk posed to your client's children with what you are likely to have seen or heard about in the media regarding other children in society who have died because professionals haven't shared information. Disclosures 'may be justifiable in the public interest where the practitioner is aware of

'It's important not to lose sight of this client as a whole person, to respect and encourage her autonomy and trust her capacity for change, where that's possible'

any serious danger to the client, to another, or to the public health and welfare, provided that the practitioner holds a cogent, reasonably held belief that the information disclosed is accurate, and that the risk is imminent and that the disclosure would help to prevent or reduce the harm'. Does this apply here? You might find Good Practice in Action resource *Managing confidentiality within the counselling professions* (GPiA 014) helpful in considering the question.

The law usually protects someone who discloses confidences in an 'appropriate, ethical and proportionate response to public duty or a statutory requirement' (again, see GPiA 014).

Unless harm is imminent with no time to consult others before acting, it's advisable to refresh your understanding of any statutory or organisational policies/procedures (particularly around safeguarding/breaching confidentiality) and any employment contract. Where possible, discuss the situation again with your supervisor, any agency safeguarding lead, your manager, BACP's Ethics hub and your insurer (who may offer legal advice). The NSPCC can also advise (see **learning.nspcc.org.uk/child-abuse-and-neglect/recognising-and-responding-to-abuse**), as can local child protection services – see the relevant local authority website. Ask yourself:

- What's the likelihood of imminent, serious harm?
- Is there time to prevent or mitigate the risk of serious harm? If so, what steps need to be taken?
- Is this the right time to disclose? Do I need more information from the client?
- Who would this disclosure be designed to protect – the children, the client or both? Might I want to disclose in order to protect myself?
- Would disclosure be in the public interest and does it outweigh the need to maintain confidentiality?
- What has my client given me permission to do? What about her autonomy?
- Could I justify this disclosure to my client, colleagues and possibly a court?

Some practitioners may have data protection concerns about sharing information in relation to child protection. However, NHS England's safeguarding guidance states: 'Remember that the GDPR, Data Protection Act 2018 and human rights laws are not barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriately.'[3]

Decisions around sharing client information should be made on a case-by-case basis and in consultation with colleagues and others.

To support your decision-making process, see:

- Good Practice in Action resources 014, 031, 044 and 052
- BACP's *Decision making for ethical practice* tool (**bacp.co.uk/media/6875/bacp-ethical-decision-making-model.pdf**)
- The safeguarding page of the Ethics hub: **bacp.co.uk/events-and-resources/ethics-and-standards/safeguarding-and-protecting-people**
- The Government guide *Working Together to Safeguard Children 2023: a guide to multi-agency working to help, protect and promote the welfare of children.*[4]

Sharing information

If you plan to share information, assess whether telling your client will cause or increase any risk of harm to her, the children or anyone else. If safe to do so, seek her consent. If she refuses this, how could she be helped to access assistance or understand and accept your proposed actions? Tell her with whom you intend to share information, what you will share and why.

Ask the person/agency to whom you plan to make the disclosure how it will protect and is likely to treat the information. Precede oral communications by a statement that what's about to be disclosed should be regarded as confidential. Mark written or emailed communication as 'Confidential'.

In its resource *Information sharing – advice for practitioners providing safeguarding services for children, young people and carers*, the Department for Education describes 'seven golden rules' for sharing information.[5] Rule six advises that any information shared should be necessary, proportionate, relevant, adequate, accurate, timely, secure and only given to those who need to have it in order to consider safeguarding action.

- See also Good Practice in Action resources 014, 031, 052 and 130.

Note-keeping

Good safeguarding includes diligent note-keeping. Record any identified risks, how each was responded to and outcomes. Document discussions had with your client around risk, including, if possible, any verbatim accounts, consent, plus any decisions made, including rationales. Also record discussions with others. Has your supervisor provided in writing their advice not to currently alert social services and, if not, would you feel comfortable asking them to do so? Remember, your client may ask to see case notes, and courts may require their submission.

Possible risks in alerting social services

In a 'From the Chair' column on safeguarding, Andrew Reeves describes risk as increasingly being viewed 'from a binary perspective – someone is at risk or is not – without acknowledging that while a risk "A" does indeed exist, the risk of an action "B" might be greater to the client's wellbeing'.[6]

He goes on to say: 'There is no doubt that we must always act to safeguard the wellbeing of those experiencing harm.' However, we are 'faced daily with the shifting nature of what "safeguarding" means and how the person we are meant to be safeguarding actually can be left vulnerable and without support – victim of the procedures that are meant to protect them'.

Reeves considers that apart from times when we clearly do need to act to safeguard wellbeing, 'blanket expectations

'Decisions around sharing client information should be made on a case-by-case basis and in consultation with colleagues and others'

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of premature disclosure are a threat to counselling in that we become agents of social control rather than facilitators of social change'.

Your supervisor currently advises against alerting social services so that your client keeps attending sessions. We can't guarantee this but can imagine that acting without due consideration and consultation, and maybe without the client's consent, could leave her feeling like you've severely betrayed her trust and irretrievably damaged the therapeutic alliance (*Ethical Framework*, Principles: being trustworthy, non-maleficence). She may lose faith in therapy altogether. It's early days since she separated from her abusive ex-partner – might she reach out to them for support? This mother may fear her children will be taken from her, potentially worsening any alcohol problem. Risk of self-harm may also increase and, in her desperation, might she even harm her children? Finally, she could decide to take action over what she regards as unethical practice, and be considering the legal situation around breach of contract with you and defamation of character.

Supervision and the agency

In the Good Practice in Action resource *Working with risk within the counselling professions*, Reeves states 'a supervisor's expectations about the response to any given risks will be critically important', with discussions 'best had before risk situations emerge, so that both supervisor and practitioner can be clear about mutual expectations and response processes'. It's important that you, your manager and supervisor share a 'mutual understanding of risk, and what you might expect of them – and them of you – in the day-to-day working with risk, as well as in more crisis situations'.

Have you discussed with your supervisor how your attitudes and beliefs about risk might consciously and unconsciously impact the therapeutic relationship and work with this client? Also important to talk about is any impact on you.

Even though your instincts as an ex-teacher to protect children might remain strong, it's from your current position as a counselling professional that you must now consider how best to act. Discussions in supervision or personal therapy may be appropriate if these roles feel difficult to reconcile.

Are there in place agreed systems, standards and protocols for information sharing within the agency and between agencies (in general and specifically in terms of safeguarding)? Does the agency have regular, frequent meetings to discuss safeguarding and cases that do (or could) include risk? Is there safeguarding training?

Self-care

Don't forget the stresses and strains this area of practice might bring to your life, both professionally and personally.

In *Working with risk within the counselling professions*, Reeves comments that when facing 'situational' risks, 'stakes are very high and, subsequently, so can be the anxiety'. This, accompanied by thinking about how to work within the agreed contract, policy or expectation of the setting and unpredictability of the client's needs, 'can sometimes feel overwhelming'.

Adopting the right self-care approach is key (Principles: self-respect; Good Practice, point 91). Reeves recommends we:

- Talk openly with clients about risk rather than speculate
- Have ongoing discussions around risk with colleagues, managers and supervisors, including expectations and any anxieties this work raises
- Pay attention to how working with risk impacts us personally, particularly when an agency requires us to act in ways that might contradict our values and beliefs
- Regularly assess risk within our caseload – if necessary and possible, reducing our caseload or work with clients who've different needs
- Access relevant, up-to-date resources and continuing professional development opportunities.

Final thoughts

Presumably your supervisor's advice not to alert social services is for now. The situation may rapidly change if you gain further worrying information from the client at a subsequent session or even possibly before then. It's therefore vital to keep in close contact both with your client and supervisor regarding current risk levels.

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

READER RESPONSES

Keeping your client engaged is vital

As an addiction specialist my primary focus would be to address the complexities of your client's alcohol misuse in a way that fosters motivation rather than shame, the key to which would be to maintain a trusting therapeutic alliance.

Alcohol dependence often thrives on shame and self-judgment, which can create a vicious cycle where the client drinks to cope with feelings of failure, guilt and inadequacy. If the client perceives that she is being judged or that her parenting is being scrutinised in a punitive way, she may disengage from therapy entirely. This would not only halt her progress but also remove the one professional support she currently has, leaving both her and her children more vulnerable.

Keeping your client engaged is vital. Concentrate on understanding the function of her drinking, exploring harm reduction strategies and gradually building her readiness for change. A non-confrontational, compassionate approach is crucial. Exploring her motivation – perhaps through motivational interviewing techniques – can help her see how reducing her alcohol intake aligns with her values as a mother.

At the same time practical interventions can be introduced – for example, encouraging small but meaningful steps that can create immediate benefits for her children, such as establishing a structured evening routine, ensuring there is food available for breakfast and identifying supportive figures in her life. Addressing your client's self-care, sleep patterns and emotional regulation may also help reduce her reliance on alcohol over time.

If the children occasionally going without breakfast and missing the start of school are the only impacts so far, it may be more harmful and disruptive for the children as well as the client to alert social services at this stage. But I would mention the children in discussions with the client and remain alert to signs that the situation may be escalating.

I find developing situations like these to be particularly emotionally demanding, so I make good use of supervision, book extra sessions when needed and regularly update my supervisor even when I think I have handled a session well. I also tap into peer support to manage my emotional responses and to ensure that my own anxieties do not lead me to act in ways that might inadvertently push the client away.

Ultimately, the best course of action is to provide a space where the client feels safe enough to address her alcohol use honestly, without fear of shame or immediate punitive action. Only by maintaining engagement can you support the client towards change – benefitting both her and her children in the long run.

ANNA KINGSLEY MBACP is a relationship and psychosexual therapist and supervisor working in private practice who specialises in couples work and substance abuse. **kingsleycounselling.com**

Holding risk is not the same as turning a blind eye

The notion that 'if anything happens, we've covered ourselves' is a worrying sentiment I have heard on numerous occasions. This narrative omits the possibility of 'something' happening because premature action was taken, eradicating the client's autonomy by overriding their personal power and efficacy.

Recent tragic cases of children murdered by their caregivers after suffering sustained and horrific abuse are a reminder that we must confront safeguarding concerns. It's also important to recognise these cases can exacerbate a culture of fear and blame, leading to a climate of reporting and professional 'covering of backs'.

Awareness about the potential impact of the lawful, societal, cultural and organisational contexts of our practice is helpful with regards to safeguarding as a counsellor. It helps us to confront our fears, barriers, dilemmas, decisions and conflicts originating from outside the therapy room so they don't obstruct us and ensure that we make a considered response to safeguarding concerns rather than an impulsive reaction to them. Obstructions can include a permeating culture of fear around holding risk to the client as well as risk to our own professional reputation, or managing our relationships with the wider network, or being held responsible if something goes wrong.

Holding risk is not the same as colluding or turning a blind eye to safeguarding concerns. It's about embracing risk assessment as an ongoing part of our work, evaluating protective factors against risk factors with every client in every session through the natural unfolding of the narrative or expression. Disclosures vary from loud and clear to subtle and hushed. Some come about as a slip-up, some

SUPPORT AND RESOURCES

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

- *Managing confidentiality within the counselling professions* (**GPiA 014**)
- *Safeguarding children and young people within the counselling professions in England and Wales* (**GPiA 031**)
- *Ethical decision making in the context of the counselling professions* (**GPiA 044**)
- *Understanding child protection in Scotland* (**GPiA 052**)
- *Self-care for the counselling professions* (**GPiA 088**)
- *Working with risk within the counselling professions* (**GPiA 120**)
- *Contracting for adults across the counselling professions* (**GPiA 130**)

are intentional and others unravel over time. Carefully considering the nature of the risk and the style of disclosure will help us to respond in a meaningful and empowering way. We can ask ourselves – who is at risk? From whom or what? Is the threat immediate or longer term? We can talk with clients about risk. As counsellors we must expect, accept and tolerate a level of risk in our day-to-day practice, and wherever possible engage clients in collaborative safety planning.

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Shaming the client about their parenting could be counterproductive

In my own practice I have encountered complex ethical and therapeutic dilemmas. In this case, supporting a client who identifies as a single mother of two young children struggling with alcohol misuse, the key challenge would be balancing the client's autonomy with concerns for child welfare. Can a mother who blacks out from alcohol use every night still be a responsible parent? That central question does not have a simple answer.

Many mothers struggling with self-destructive alcohol habits remain deeply committed to their children's welfare, often experiencing immense shame and guilt about their substance use. In my experience, some manage to provide stability despite their addiction, while others may be in denial about the risks they pose. My role as a therapist is to explore these dynamics with compassion rather than judgment, helping the client acknowledge the impact of their drinking while also empowering them to find the motivation to change.

Shaming the client about their parenting could be counterproductive, reinforcing feelings of failure and increasing the likelihood of disengagement. Instead, keeping the client engaged in therapy should be the primary goal, as it represents the best opportunity for both the mother and her children.

In my 2023 study with Mick Cooper we explored helpful and unhelpful psychological processes for women with substance use disorders.[1]

Three key themes were identified as helpful:

1. **Finding another language** – using creative methods to help clients express feelings that are difficult to articulate verbally.
2. **Identification with the therapist** – building a strong therapeutic alliance where clients feel understood and connected.
3. **Getting towards acceptance** – assisting clients in accepting their circumstances as a foundation for change.

Incorporating these findings, I would also focus on strategies to help clients 'de-shame', challenging any resistance from an empathic, accepting standpoint.

While there is a duty to safeguard children, the involvement of social services is often a contentious issue in private practice. Service providers may advise against immediate reporting if engagement in therapy is strong and there is potential for change. This aligns with a therapeutic approach prioritising trust, encouraging the client to take responsibility in a supportive environment rather than retreat into defensiveness. However, if there were clear signs of imminent harm escalation would be necessary.

Ultimately, my focus would be to support the client to recognise her strengths as a parent, addressing her drinking patterns in a way that fosters motivation rather than resistance, and helping her develop healthier coping mechanisms. By maintaining engagement we create the best conditions for long-term change, for both the mother and her children.

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HOW WOULD YOU RESPOND?

We welcome members' responses to this upcoming dilemma. 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 wrong to acknowledge clients in public?

During our first session I recently asked a client how they would like to be acknowledged, if at all, should we meet in public. They responded that I should just say 'Hello', as they were not ashamed to be in therapy. This got me wondering whether asking the question at all contributes to maintaining the stigma attached to mental health provision. I am thinking of reframing the question to clients in future, to imply a default setting of greeting one another in a normal manner, but what are the possible adverse consequences of this that I may not have considered?

Issue: June 2025 **Deadline:** 11 April 2025

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

Contracting as a relational process

ELLY WALTON/IKON IMAGES

Creating or revising your contract can help consolidate the way you work, says Caz Binstead

Over the years there have been discussions and differing opinions about the role of contracting for the therapeutic professions, but for some time it has been seen as a vital part of the working alliance. In 2003 Petrüska Clarkson named the working alliance as one of five components of the therapeutic relationship and described it as comparable to a contractual agreement,[1] with Charlotte Sills emphasising shortly afterwards the need for – at the very least – some kind of agreement/contract with clients around relevant administrative details.[2]

For therapists, contracting has never been simply a tick-box exercise, or one connected only to practicalities. It is a fundamental part of the therapeutic relationship. Specialising in ethical private practice, including the intersection between the business side of private practice and the therapeutic work itself, I have come to believe that a well-thought-out contract underpins the therapeutic relationship, and has a crucial role to play in protecting clients from harm, and therapists from complaints.

Contracting requires much reflection but need not be confusing or scary. In fact, it can be a process of great discovery in terms of cementing who you are as a therapist and how you want to practise. Fundamentally, it is the contract that provides the frame for our clients to feel contained – the importance of which cannot be underestimated.

Relational

Arguably, elements of contracting start the moment we begin to engage with clients. With this in mind, we may think of contracting as a relational process that goes way beyond words on a page. In private practice, for instance, there are explicit agreements being made with potential clients through the first point of contact. These extend from the preliminary information you will have given about your practice through your marketing – a form of communication explaining what type of therapy you are offering; what client groups you work with; your qualifications and experience; where you work; how you work; what you charge; and what you as a practitioner mean by the term 'initial session'. All of these contribute to the client making an informed choice about which therapist they may choose to work with, and are an early set of mutually understood expectations between client and therapist. This is why considerations about ethical practice within our marketing, as well as how we think about engaging with potential clients, are vital.

At some point we need to collate all this information – and more – into a concise 'contract' for use with clients who decide to work with us. Practitioners who work for services and agencies may be provided with *pro forma* client contracts, but

private practitioners have to create their own. The BACP *Ethical Framework for the Counselling Professions* (Good Practice, point 31)[3] recommends we give 'careful consideration' in reaching an agreement with clients about the terms on which 'our services will be provided', and includes some suggestions about what to pay attention to when doing this but not specific examples of what to include. Therefore it can be hard to know what a 'good' contract looks like.

Having immersed myself in the subject while researching and co-writing the BACP resource *Contract discussions: private practitioner's contracting template* (see box on page 46) and, later, the book *Relational Ethics in Psychotherapy and Counselling Private Practice*, it became clear that certain elements are essential for an ethical and effective contract. Here are my recommendations based both on that research and my own experience as a practitioner in private practice, followed by two case studies that show how lack of attention to these elements might impact practice.

Write it down

My first recommendation is that your contract is in written form. Although much of contracting revolves around conversation – including in our initial engagement with clients as well as talking through any points that form the contract – by drawing up set parameters in written form you will be not only employing best ethical practice but also following the safest course of action as a private practitioner.

If we agree that clear boundaries lead to mutually understood expectations, then writing these down for the client allows for a number of things. Having a tangible written contract can be a handy reminder of certain important points, such as your cancellation policy. It's unreasonable to expect our clients to remember such things, especially if we are being mindful about respecting the rich diversity of our client base. A written contract also allows both parties to return to it any time, which in terms of the therapeutic relationship feels important. That's not to say we are necessarily reviewing or changing our contracts but allowing space for any relational discussion to develop should it need to.

Private practitioners run their independent practices in isolation and so, apart from their supportive spaces, such as supervision, it means that they are more vulnerable to complaints. In the eventuality of a dispute or complaint it can help to determine more easily the terms of the working alliance. When a service is being paid for this becomes even more important because clients of course have every right to question any deemed inconsistency or confusion in relation to business boundaries, and what has been mutually agreed, or if in general they do not understand something that has taken place that they feel runs counter to any earlier agreement.

Reflect before writing

There are commonalities that we are going to have in our contracts as private practitioners, which is why a template can be useful in terms of getting started. However, given the importance of the therapeutic relationship and our own business boundaries, the contract is a unique process of reflection and exploration for each private practitioner. Think of it like branches on a tree – we need the fundamentals that cover the most important parts of both ethical and legal requirements, but how we grow from there will be determined by several different factors. And when it comes to ethical practice, understanding this and ensuring you apply an individual and reflexive stance towards your contract is pivotal because it represents who you are and how you practise. That may differ quite a lot from the therapist down the road in terms of modality, philosophy of therapy and thoughts around what is meant by 'the relationship' as well as the way you choose to run your business.

The truer we can be to ourselves in terms of who we are and how we run our practice, the more likely we are to have robust contracts that we will find easier to stick to. This does not mean never updating our contracts; there is much scope for growth and change as we continue our own journeys as private practitioners. However, when we contract with a particular client we do then need to be consistent, unless we are choosing to revisit and look together at changing or updating that initial agreement (which comes with its own ethical considerations and sensitivities). It is a lot harder to stick to our own stated boundaries if we have not thought about how they relate to us and have included them only because we have seen them written in someone else's contract.

Take it to supervision

Transparency, consistency and clarity are often my chosen words when it comes to contracts, and I've created some vignettes to show how we might understand them in relationship to contracting and in the context of private practice. That's not to say that providing we're being transparent and clear 'anything goes'! We may indeed be thinking creatively around what we put in our contracts but we also need to ensure that our considerations are coming from an intentional commitment not to cause harm to a client. In other words, remember there are some restrictions in terms of what is suitable for a therapeutic contract. This is why it's good practice to chat through your contract with your supervisor, who can help you reflect on its intricacies as well as provide potential fresh perspectives.

The reality of lone working brings isolation in many forms, and this includes the enormous responsibility of running our practices on our own. The support we get from supervisors – especially those who have experience specifically in private practice – is invaluable. Given the

'Contracting can be a process of great discovery in terms of cementing who you are as a therapist and how you want to practise'

CREATING YOUR CONTRACT

It can be daunting to start with a blank page when creating your own contract for private practice, which is one of the reasons why I lobbied for a template for members in 2019 as a member of the executive for BACP's Private Practice division. The resulting *Contract Discussions: private practitioner's contracting template* (bacp.co.uk/bacp-divisions/bacp-private-practice/private-practice-toolkit/managing-your-practice-a-quick-guide-to-contract-discussions), co-written with David Lloyd-Brown, is available free for all BACP members. It includes suggested wording for both essential and optional sections that can be added or omitted depending on the way you work, and information to help your thinking process.

ESSENTIALS

- Name
- Contact details
- Professional membership details
- Commitment statement to anti-discriminatory practice
- The way that I work
- Duration and notice of termination
- Holidays
- Fees
- Payment options
- Cancellation policy
- Supervision
- Confidentiality (including when it might be broken)
- Record keeping (including reference to GDPR and/or a link to a separate privacy notice)
- Complaints

OPTIONAL

- Referrals/third-party arrangements
- Contact between sessions
- Reduced fee rate
- Letters and reports
- Keep safe policy
- Attending under the influence

What more might you add to this list?

contract forms an essential part of our overall practice, there is much room for ongoing conversation too in terms of our own development, self-care and how we engage with ethics and best practice.

Talk it through with every client

Given each private practitioner chooses how they run their practice, it feels clear that the majority of elements that make up the contract are decided by the therapist as opposed to a mutual process of contract making. To acknowledge that is also to accept the existence of a slight power imbalance between the therapist and the client, giving us the opportunity to reflect on what it means to hold more power. In terms of ethics, being ever mindful of our ability to hurt clients, and the existence of harm in therapy, allows us to endeavour to be as responsible as we can be with the power we have. Because despite this power imbalance we are still in a therapeutic relationship.

For therapists who put the relationship at the heart of the work, part of this means consciously giving space to enable the client to share their feelings on aspects of the contract, especially being curious about how certain practice boundaries may sit with them, should they decide to work with you – in addition to being open to the possibility that a different therapist may suit them better. It also allows for the client to request potential changes (this might be for a variety of reasons) which, if workable, you *might* choose to accommodate, particularly if you believe it to be in the best interests of the client and the therapeutic relationship. This is why conversations around the contract are so powerful and needed. In fact, many practitioners prefer to use alternative terminology that emphasises the relational aspects of contracting, in comparison to an overly formal and potentially rigid document. Terms such as 'agreement' are commonplace as well as conversations around 'how we will work together'.

Case study 1: Managing expectations

Johnny* has been in supervised private practice for six months and has a written contract. He decided not to run it by his supervisor and feels happy that he has deliberately left it quite open. He doesn't want to appear over-detailed or too prescriptive in his practice. He also sees the process of therapy as a 'two-way' thing. At the beginning of his contract, when talking about what he offers, he shares information about the way he works but does not say how frequently he meets with clients. He assumes that most clients will want to work on a weekly basis, but that by not stipulating, it allows him some wriggle room to help him make decisions as and when they become relevant, ie when an enquiry comes in. He was also particularly mindful of what his business' needs might require. Weekly clients, for instance, gave more continuous income, and he also believed that having a continual base aligned more with his philosophy of therapy, but if he was short on clients he felt that he might be tempted to agree to fortnightly therapy (to ensure he was making enough income from his practice). His client Zahra has been coming on a weekly basis for eight sessions and unexpectedly asks to move to fortnightly. Johnny feels this is not in Zahra's best interests in terms of the work they are doing and so communicates to her that he thinks it would be useful to continue meeting weekly. He doesn't offer any further comment on the possibility of switching to fortnightly sessions in the future. Zahra feels confused. When she began therapy she had enough money to pay for weekly sessions but now does not – she had assumed that she would be able to switch if needed. She doesn't feel that

HYEJIN KANG/SHUTTERSTOCK

'For therapists who put the relationship at the heart of the work, part of this means consciously giving space for the client to share their feelings on aspects of the contract'

she can question Johnny but also feels let down and hurt by what feels like a miscommunication around Johnny's practice boundaries.

Analysis: The key word that I would highlight here is *expectations*. The contract is the one place where there is an understanding and agreement on what the client is signing up for. In private practice this becomes even more crucial because a client is choosing to pay you for services and trusting that the space is what it says it is. As therapists we might not like thinking about money and its role in private practice but it is present in various ways whether we like it or not. In this vignette Johnny was prioritising the business side of things over ethical practice. He may well be shocked to hear my conclusions on that! Effective conversations about ethics in our profession involve bringing some of these taboos to the surface. They are not often talked about because there can be an assumption that we all should just be ethical practitioners. But the reality of running a business that also happens to be a therapy practice brings new levels of complexity. And conflicts between the two elements can, and do, arise. Despite the very distinct possibility that Johnny's reasonings to Zahra were based purely on what he thought was therapeutically best for her (as we already know that in his philosophy of practice he agrees with weekly therapy), that is in fact overshadowed by the lack of detail in his contract, which was connected to his thoughts about the business. This is why transparency is a key feature of contracting.

Case study 2: Being authentic

Katie* is at the beginning stages of setting up in private practice and has not yet decided on her cancellation policy. She has had many conversations with fellow colleagues who are new to private practice themselves, and although these conversations have felt mutually supportive she is still unsure how to proceed. In the end she settles on a 48-hour cancellation policy, which is what her closest friend has decided upon for her own practice. When she starts to see clients, however, she struggles with enforcing this policy. If a client stated that they were sick, she found it difficult to bring herself to charge for the session – her reasoning being that she was empathic to a client becoming suddenly unwell. Being someone who herself had a chronic migraine condition, she found it hard to understand how it was fair to charge if someone was ill, as it clearly wasn't their fault. She doesn't think there would be any benefit in discussing this further in either supervision or with her peers as she has already chatted so much about cancellation policies. She is aware that there have been several cancellations under 48 hours for which she has not charged, and knows logically that in order for the business to be financially viable on an ongoing basis she will need to enforce her cancellation policy. So she decides that she will just need to be firmer going forwards. Given we know Katie has already waived the agreed contractual boundary for an unspecified number of clients though, it poses a question around how any future action that is inconsistent with what has gone before – even if it's in line with the contractual business boundary – would be received.

Analysis: This is an interesting situation because Katie has actually done many things right – she's joined in peer discussion within her own community and, as she sees it, has tried to learn about what might be the 'right cancellation policy'. But this is where her reflection stops. Perhaps she is feeling under pressure to make a decision so she can start working, as there is a notable lack of consideration around what 'right' actually means. Furthermore, her own experiences are suggesting that she does not actually equate her chosen policy with 'fairness'. It feels a shame that she has not taken either her difficulties in sticking to her chosen practice boundaries as stated in her contract or the reflections that have come up for her since deciding on 48 hours to supervision. Those conversations could in fact be very fruitful in terms of thinking more deeply about her chosen policy and potentially developing her contract as time goes on. Inconsistent boundaries lead to confusion for the client, and where money is involved – as it is with a cancellation policy – this can be really shaky ground for a private practitioner. We owe it to our clients to bring a level of safety into the working alliance and that, unless we are intentionally choosing to bend a boundary for *therapeutic reasons* (which would be done in a transparent way), there is clarity and consistency. ●

** Case studies are composite based on typical supervision presentations.*

● Caz Binstead's new book, *Relational Ethics in Psychotherapy and Counselling Private Practice: solidarity, compassion, justice*, co-authored with Nicholas Sarantakis, is published by Routledge.

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ABOUT THE AUTHOR

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Under the influence

Therapists on social media platforms can inadvertently find themselves becoming mental health influencers, says Ella White

'Just shut down all of your social media profiles!' The lecturer issued this blanket statement during a seminar on professional and legal issues during my first term of training as a counsellor. While my fellow students primarily in their 40s and 50s nodded their heads in apparent agreement, aged 23 this instruction seemed unfathomable to me. Perhaps because I grew up with social media as a teenager, or because I had just moved away from my friends and family, I perceived social media as an essential resource to keep in touch with those close to me. Suffice to say, I double-checked my privacy settings and continued posting on Instagram.

Fast-forward two years and I was once again sitting in a professional ethics seminar, now training as a counselling psychologist. I was eager to hear how to manage ethical issues around social media use, having noticed an increase in practitioners sharing mental health information online over the past few years with a further surge during the pandemic. The seminar covered a wide range of ethical dilemmas from the typical risk-related issues through to the more obscure, 'how to respond if a client brings you baby clothes as a gift before you go on maternity leave'. And still there was nothing on social media.

I decided to find my own answers by researching (along with my supervisor, Terry Hanley) the ethical dilemmas experienced by therapists who use social media, resulting in three publications.[1,2,3] The systematic review we published in 2024 found that it is now almost an inevitability to experience an ethical issue on social media as a therapist. Due to the societal normalisation and accessibility of social media, the boundaries around communication between client and therapist have evolved. The growing public interest in mental health and therapy has resulted in a demand for information on these subjects, and increasing numbers of therapeutic practitioners have responded by setting up professional social media accounts. The blurred boundaries between client and therapist increase further if the therapist takes on the role of a mental health influencer.

Definition

Defined by Triplett et al, a mental health influencer is a qualified therapist, trainee therapist, or other mental health professional who uses social media to share psychoeducation and anecdotes from either their professional experience or own personal experience.[4] Mental health influencers increase accessibility to psychoeducation through sharing knowledge that, prior to social media, would only have been accessible through therapy.

Although some therapists may not self-identify as influencers, their motivation to use a social media account to share knowledge fits with the mental health influencer definition. Influencers are categorised into different size brackets, with a following size of 1,000 needed to classify as the smallest type of influencer.

This resonates with one of the findings of our research, that therapists may not be aware that they meet the criteria of an influencer based on following size or content shared, and so may not have considered how to manage ethical issues on social media with a professional presence.[2]

Many therapists either set up in private practice straight after qualifying due to lack of available employed roles, or do so after leaving work in the NHS or another service for reasons such as burnout, feeling undervalued at work and feeling restricted in how they practise.[5] They soon learn that to survive in a competitive marketplace they need to promote their practice. For a growing number that includes posting on a social media platform such as Instagram, and in the process – either intentionally or by accident – becoming a mental health influencer.

This is often new territory for practitioners who have not had previous business experience. One of the themes that came out of our latest research, which explores psychologists' experiences of using Instagram as a mental health influencer, is 'I didn't train as a marketer or social media expert'.[3] We found that practitioners were uncertain of how to maintain therapeutic boundaries while also using their social media presence to market their private practice and related products such as books and online courses. The ethics become particularly murky when practitioners also use their accounts for social justice advocacy to explain the impact of social inequalities on mental health, and yet place some content behind paywalls, which reduces accessibility.

Wild West

Social media and the influencer industry in general have been described as the 'Wild West' due to the apparent 'lawlessness' of what is deemed appropriate behaviour online.[6] In this context, it is no surprise that mental health influencers experience great uncertainty about what constitutes ethical practice online. Although key professional bodies have published ethical guidance for therapists' social media use in recent years, including BACP[7] and the Health and Care Professions Council,[8] most of the guidance focuses on practitioners' personal social media use rather than their professional online presence, covering subjects such as contracting with clients around social media and maintaining client confidentiality. Overall, the emphasis is on the importance of privacy settings, when, conversely, mental health influencers want to increase accessibility to their content. The standard advice to keep personal and professional identities separate online stands at odds with those therapists who want to share their authentic human selves to reduce mental health stigma and increase engagement with their posts.

Boundaries

Another paradox we came across in our latest research is that despite aiming to be wide-reaching with their public profiles to attract potential clients, many mental health influencers still felt surprised if a client knew information about themselves that they had disclosed online but not in sessions, such as if they had children.[3] Some practitioners in the study acknowledged that they probably self-disclosed more on social media than they would in therapy sessions due to the context, albeit with information that they had intentionally chosen to share with the public.

Information shared online is often designed for potential clients to learn about a therapist's values and practice, to decide if they would be a good fit for therapeutic work together. However, this particular form of marketing opens the possibility for new clients to develop a parasocial relationship with the therapist and have expectations of how they will be in sessions, which could impact the therapeutic relationship. Research has found that after viewing their therapist's personal social media profiles, 74.1% of clients held more positive beliefs about their therapist's expertise, and 68.2% had more positive overall feelings about their therapist.[9] Concerningly, some people may develop a parasocial relationship where they perceive the mental health influencer as their own therapist, and so choose not to access individualised therapy, despite posts being generalised and not intended as a replacement for therapy.[10]

While some mental health influencers specifically contract with clients around social media, such as stipulating that the practitioner will not follow any of the client's social media accounts, others do not acknowledge their professional presence at all with clients. It is vital that mental health influencers consider how their clients would feel viewing their content and the impact this may have on the therapeutic relationship.[3] Therapists may need to forewarn a client if they will be posting potentially triggering content, or inversely, light-hearted content while they are having a difficult time. Some therapists described being inspired by their client work to create content, either from a specific client or from across multiple clients. This may create a rupture in the therapeutic relationship if a client feels that their private and personal issues are being shared online, even if they are not identifiable or are in fact composite or fictionalised examples.

Responsibilities

Our most recent research found that practitioners using social media as mental health influencers felt a responsibility to share their professional training and knowledge online.[3] Many were concerned that if qualified health professionals did not share mental health resources, then people may turn to less reliable sources for support during a time of increased

'Mental health influencers increase accessibility to psychoeducation through sharing knowledge that would only have been accessible through therapy'

DANAE DIAZ/IKON IMAGES

demand for mental health services and widening social inequalities following the COVID-19 pandemic and cost of living crisis. However, they also felt pressured to market themselves as 'experts' to promote their accounts, which could risk stepping outside their competences.

Cederberg noted there is competition between different professionals to distinguish themselves online and so they may exaggerate their credentials.[11] The general public are unlikely to check that the practitioner is speaking from an informed position based on their professional training and work experience, and so it is the professional's responsibility to adhere to working within their competences. Smith et al advise mental health influencers to clearly state what training they have and what services they can provide, as many people may not understand the role of a therapist and so make assumptions about their competences.[12] This is particularly important in the context of the titles 'therapist', 'psychotherapist', 'counsellor' and 'psychologist' being unregulated in the UK, and giving no indication of level of training. This means that legally an individual with no mental health training could state they were a therapist on social media, which would create a false credibility and increase the public's trust in their content.

There is uncertainty around how much responsibility mental health influencers hold for the wellbeing of the people they interact with online. If perceived in the same way as clients, this would place great pressure on the therapist about how to respond and what responsibility they held if they saw an individual expressing, for example, suicidal ideation online. The therapist would likely have no knowledge of the context of the individual, what support systems they currently have in place, or even what country they live in, and so have great difficulty in providing support. This has led many mental health influencers to include disclaimers as pinned posts at the top of their profiles stipulating that the boundaries of their role are not to provide individualised support, and for followers to instead access offline support with signposting options provided. Our most recent research also found mental health influencers were unsure of their responsibility to support individuals who become distressed in response to a post they have shared, particularly regarding trauma.[3] Despite inputting boundaries, there can still be a sense of invalidation that the therapist cannot do more to support people online, and there are difficulties in offering empathy without slipping into a therapeutic relationship.

Supervision

The role of a mental health influencer is still perceived as taboo by many practitioners working in more traditional roles, with concerns around earning money from using their therapeutic expertise in different ways from their conventional training. This can lead many mental health influencers to feel judged by other practitioners, and so feel unable to turn to others for support with any issues they experience online.

This lack of support also extends to supervision, as it is not currently mandated to receive supervision specifically for social media work. An additional issue is the mental health influencer themselves may have a greater knowledge of ethical issues experienced on social media than their supervisor, and so not receive knowledgeable support.[2] Appropriate supervision can support therapists with the decision-making process of how to present themselves online and engage with followers while also guarding their personal safety and the representation of their profession. Supervision can also be used to check in on the therapist's wellbeing, as they are at increased risk of burnout from the additional workload and from receiving distressing messages around risk and trauma (see box, 'Red flags').

Positives

Despite the current uncertainties and anxieties around how to use social media as a mental health influencer, those currently working online also report many positives to this role. Many of the mental health influencers we talked to for our research said they greatly valued the online community they had created with both other mental health influencers and the general public. Some also said they found social media a fun way to use their creativity when planning content, and felt they could learn new tools and theories from other professionals that they could use in their practice. They additionally found social media rewarding as it allowed them to work in line with their values, such as by sharing content about social justice, and felt a sense of validation from hearing direct feedback of how they had helped others. The practitioners worked hard to produce social media content in addition to their offline therapeutic work, and so believed they should be financially compensated for this work.

Has the time come for the identity of a therapist to expand from exclusively traditional therapeutic roles to also encompass social media work as a mental health influencer? This reconceptualisation of the therapist identity to include social media work may normalise the use of specialised supervision for this work, and the introduction of more nuanced ethical guidelines for professional social media use as a mental health influencer to protect both the general public and the therapist. As social media platforms continue to develop, the role of a mental health influencer will also evolve, and so ethical guidance will need to be regularly updated as new ethical issues occur.

While interviewing practitioners for my research I was asked by multiple participants if I would set up a professional

'There is uncertainty around how much responsibility mental health influencers hold for the wellbeing of the people they interact with online'

RED FLAGS

Regardless of good intentions, there are ethical risks to consider when working as a mental health influencer. Our research[1,2,3] flagged up several issues that practitioners should be aware of:

- **Misdiagnosis:** You may feel a responsibility for how your posts are received and interpreted, and yet the nature of social media means that who views your content is outside your control. This risks the potential pathologisation of normal experiences, leading people to misdiagnose themselves.
- **Stigmatisation:** Most of the content shared by mental health influencers focuses on 'more palatable' common mental health disorders, such as anxiety and depression, potentially contributing to mental health stigma around more complex and chronic mental health conditions as these are less often discussed.
- **Oversimplification:** Nuance can be lost and the communication of evidence-based accurate information can be hindered by the format of social media where content is oversimplified to fit within a short post or video.
- **Invalidation:** Content shared to validate experiences and reduce mental health stigma could have the unintended opposite effect if an individual feels their experiences do not match a short, oversimplified description on social media. Posts intended to teach coping strategies may also be invalidating and lead to self-blame if they are pitched as a quick fix in order to draw in views, when in reality affected individuals would need a greater level of individualised support.
- **Burnout:** You may struggle with the dilemma of not being able to do more to support people who contact you online, and it may be difficult to offer empathy without slipping into a therapeutic relationship. Receiving personal messages which may describe trauma and risk can place you at increased risk of burnout, particularly if you do not have a supervisor with whom to discuss your mental health influencer work.

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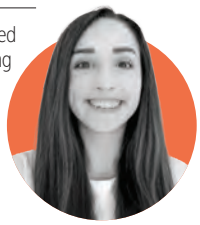
account myself as a mental health influencer. Right now I am still hesitant to give a firm answer. I feel proud of the resourcefulness and hard work shown by my fellow mental health practitioners to utilise social media as a free and accessible platform to provide the general public with psychoeducation and mental health support during a time of growing social inequalities. I am excited by the opportunity to bring social justice advocacy into my practice through social media, either from my own account or through setting up a social media account for the service I work in. I feel hopeful that the future of mental health care will normalise these new ways to support the wider population beyond the therapy room. However, I am also aware of the complexity of the ethics involved, and that the informed support needed to protect both the public and the practitioner around social media work is still not widely available.

ABOUT THE AUTHOR



Dr Ella White is a HCPC registered counselling psychologist working in the NHS. Her doctoral thesis conducted at the University of Manchester explored practitioner psychologists' use of Instagram as mental health influencers.

Question everything

A guided discovery technique helps clients gain new perspective, says **Clare Patterson**

Socrates said that 'the highest form of human excellence is to question oneself and others'.[1] Many of us are familiar with the ancient Greek philosopher, founding figure of Western philosophy and famous for his 'Socratic questioning' method of uncovering the truth, which is often used as a tool in CBT to help guide clients in challenging negative assumption thoughts.

In Socratic philosophy, happiness is said to be a state of being where a person's life is in harmony with their true nature (also known as *eudaimonia*). Socrates believed the key to this was self-knowledge, which is found through a search for objective truth, facilitated, possibly, by a therapist and the famous Socratic questioning. The technique can therefore guide a person closer to this objective truth, giving them the ability to make more choices that will bring true happiness.

BEN MINERS/IKON IMAGES

Socratic questioning is used in CBT to help clients sense-check reality. This raises a number of interesting questions – whose reality is important here? Can 'reality' be changed? How will we know when our clients can 'see things clearly'? With Socratic questioning, we help a client unpick what they *think* they know, coming to see, as Socrates once said, that 'the more I know, the more I realise I know nothing'.[2] This is a good place to be, however, as Socrates also said: 'The only true wisdom is in knowing you know nothing'.[2]

Furthermore, it is only from this place of 'nothingness' that 'reality' can truly be known. How can we say that we are our thoughts when in many cases our thoughts are given to us through societal conditioning? Where do we get our ideas from about ourselves? They are an accumulation of childhood experiences and messages from the culture we live in. Is this really who we are? It is only when we see beyond our thinking (or our conditioned minds) that we truly know ourselves. This is what we might refer to as 'the end of thinking' or, to use a term of the day, enlightenment.

Socratic questioning can fit into any modality when used as a tool for guided discovery – I use it as part of my work as a transpersonal therapist. At its heart, it is the idea of neutral, non-judgmental discussion, which might apply psychodynamically, humanistically, or within a more traditional CBT framework. But what does it look like, and how can it help our clients? Here are some examples:

When we need someone to make us happy *(example 1)*

Client 1: I can't get over my ex-wife. I know she said she doesn't love me anymore, but I can't let go of the idea of her with other men. I feel like I need her. It's like an obsession.
Therapist: *What is it you feel you need from your ex-wife?*
Client 1: I don't know. I just need answers. Why did she leave me? What did I do wrong?
Therapist: *What answers do you need to hear?*
Client 1: I need to know what I did wrong.
Therapist: *So you can put it right and 'win her back'?*
Client 1: Yes.
Therapist: *So what is it you really need from your ex-wife?*

Ironically, in this scenario the client does need answers. But he doesn't need them from his ex-wife, he needs them from himself. Also ironically, the answers come from the silence. The question the therapist asks twice ('What do you need from your ex-wife?') ultimately fades into nothingness as the client realises that what he was 'needing' was something he had projected onto his partner and, through Socratic questioning, can begin to see he had this inside all along. When this process is complete, there are no more questions. There are only answers.

GOOD PRACTICE

- **Be with the unknown.** We cannot ever 'know' the answers for our clients through concentrated effort. The answers most often come in the moment we say 'I don't know'. Simply *being with* is enough, as the client is enough, and we are *with* them. There is an element of trust here. We must trust that the client can find their own answers. We must trust we can for ourselves.

- **Know yourself.** If there are areas in our own psyche we do not want to explore or accept, this can impact our ability to lead clients on their path. It is often said that we are given the clients we need in life, and so if a client is provoking resistance, dissociation or a desire to 'pedal backwards' in this process, we can see this as an opportunity to explore what is going on for us, and if there are any more areas we might explore within ourselves. When we can truly see and accept who we are, we may guide others confidently in their own journeys of self-discovery.

- **Trust.** We need to trust that we and our client are safe in this process. As our client comes closer to their truth, some shadow material may emerge, or emotions surface that have been kept contained, perhaps for many years. We must be fully, totally committed to the truth, and unafraid of this – it is the place of healing (with awareness of possible contraindications, as detailed below).

- **Tread carefully.** This method of guided discovery must be done sensitively and at times very cautiously. A client must be psychologically stable enough to engage in this method of therapy, and if there is significant dissociation or trauma, work must first be done to stabilise and ground before possibly re-exploring at a later date. These methods should not be used with clients who are experiencing psychosis or dissociative disorders – this client group may find such a direct approach too unsettling, as it has the potential to shake the foundations of their personality structure and potentially cause significant distress. Careful consultation in supervision is always required.

'It is only when we see beyond our thinking (or our conditioned minds) that we truly know ourselves. This is what we might refer to as "the end of thinking" or, to use a term of the day, enlightenment'

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When we think there is something wrong with us *(example 2)*

Client 2: I can't ever make relationships work. I always pick the wrong guys and end up disappointed. What's wrong with me?
Therapist: *Tell me about the sort of guys you 'pick'.*
Client 2: 'Peter Pan' types. Safe men who haven't really grown up.
Therapist: *What makes these men feel 'safe' for you?*
Client 2: Well they're not demanding. I don't need to worry about them.
Therapist: *Are there any men you have had reason to worry about in the past?*
Client 2: My father. He was very controlling and demanding.
Therapist: *So you choose men who are the opposite of your father to 'stay safe'. Yet you're not satisfied because you end up disappointed and wanting more. What can you do about this?*

In this scenario, again, the client had the answer. She 'led me' towards inner-child work, healing the frightened part of her that had yet to grow up due to her challenging childhood environment, feeling safe around men with more assertive personalities and taking her place in society as a woman worthy and capable of relating to such men. To answer her original question, there was nothing 'wrong' with her at all. She, like client 1, had the answer. It was within herself.

When we think we are stuck *(example 3)*

Client 3: I feel so stuck. I don't know what to do with my life. I feel like I've always done things for other people and now I'm realising I don't have to, but I don't know what to *do*!
Therapist: *Well, what do you* want *to do?*
Client 3: If I knew that I'd be doing it!
Therapist: *What* don't *you want to do?*
Client 3: I don't want to do the things I was told I ought to do. I don't want to do what's expected of me. I want to do something where I have total freedom.
Therapist: *So who is keeping you stuck?*

'Socratic questioning ultimately "tires itself out". When enough questions have been asked, the client has no more questions to ask themselves. An "objective truth" has been uncovered'

In this example, the client was able to come to the realisation that she *already had* what she sought. She *had* freedom, and it was her mind and the ideas she had about what she *should* be doing that were keeping her stuck. There were no more questions. She had the answers.

As has hopefully been demonstrated by the examples above, this technique of Socratic questioning ultimately 'tires itself out'. When enough questions have been asked, the client has no more questions to ask themselves. An 'objective truth' has been uncovered.

Another philosopher, Descartes, came up with the dictum *cogito ergo sum* or 'I think, therefore I am'.[3] This might be a precursor to another idea on which CBT is founded, which is that our thoughts shape our beliefs, which in turn shape our reality. What we think is what we become. If we think we need someone else to make us happy (example 1), if we think there is something wrong with us (example 2) or if we think we are stuck (example 3), inevitably this is 'true' for us. What Socratic questioning does is challenge our false truths, picking at our thoughts until our faulty conditioning crumbles and leaves in its place the very thing we sought therapy to attain – peace and understanding. ●

**Identifiable details have been changed.*

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A matter of ethics: your questions answered

Marita Morahan summarises the findings of the *Ethical Framework* review so far, and how it was undertaken

As members we are familiar with the *Ethical Framework* as we commit to complying with it when we join BACP or renew our membership. It is essential for acknowledging the high ethical standards we hold in our work. It serves as a guiding frame for all professionals working in the counselling professions, in addition to reassuring the public that practitioners are held accountable to ethical and professional standards.

As a living document it needs to be under constant review to meet changing needs, and in March 2023 the *Ethical Framework* review began. Since publication of the last *Ethical Framework* in 2018 there has been a global change in how people live their lives, work and access support. These changes have taken place at speed.

Q What does the review include?

A The review of the *Ethical Framework* has taken the form of a consultation with all stakeholders and has been as broad ranging as possible in its reach, including using existing historical data within BACP since the publication of the last framework in 2018.

BACP has a commitment to equip our members to be able to work in a fast-changing world, to be able to influence and contribute to the wellbeing of society.

In order to achieve this the review set out to listen to, learn from and work with our members to inform the work of the *Ethical Framework* review.

Q What question is the *Ethical Framework* review hoping to address?

A The main question being asked was, how can the new *Ethical Framework* become more accessible for all members to inform their ethical decision making and to account against it when things do not go well?

Q What is informing the review?

A Data examined included ethical queries coming to the attention of BACP through its various services to members, feedback from the public and data from professional conduct.

Member feedback

- Member feedback was collected through a wide range of consultation activities. These were through more formal routes including a member survey, focus groups, feedback buttons on the Good Practice resources section of the website, a survey for accredited courses and services, a dedicated survey aimed at minoritised groups who were underrepresented in the focus groups, and a survey on the use of technology in therapy, including questions on the use of artificial intelligence (AI) and the use of smart devices. A specific report on AI and the *Ethical Framework* has been commissioned, which will be reported on separately.
- Throughout the consultation period from April 2023 to December 2024, the communications department at BACP maintained active communication to inform members of the *Ethical Framework* review and to enable as much opportunity to participate in feedback as possible, either formally or informally.
- Informal member feedback was collected throughout the consultation period through a dedicated *Ethical Framework* email inbox, which was regularly monitored and responded to where necessary, through feedback on social media, through Making Connections events, and feedback from the webinar chat on a presentation of initial findings of the review in April 2024.
- In addition to the direct routes of accessing member feedback, data from the ethics service were collected in the form of queries to the ethics service, alongside complex ethical queries, which had been escalated within BACP. Examination of these data made up the first phase of evidence gathering for the review.

Surveying members

- A member survey was conducted from May 2023 to April 2024. A key question for the survey was: 'How do you use the current *Ethical Framework* in relation to your practice?' This followed similar themes to the previous survey for the last version of the *Ethical Framework*. Qualitative and quantitative analysis was conducted to identify key themes and data trends in member responses.
- Member data were also collected in the form of member focus groups in November 2023. A key question for the focus groups was: 'What kind of *Ethical Framework* do you need to support your practice?'
- No questions were asked in relation to the informal feedback from members that was provided on the *Ethical Framework* more generally.

Public feedback

An important priority for the *Ethical Framework* is to be able to reassure the public that practitioners are held accountable to ethical and professional standards.

- Data from two Public Perceptions surveys carried out in 2023 and 2024 were analysed as part of the information gathering on public views of using counselling. The main question for this large data set was to try to understand how respondents accessed counselling and psychotherapy. Descriptive analysis was used to identify trends in this data set.
- Additional public data were accessed in the form of client feedback. The 'Get Help with Counselling Concerns' service addresses concerns raised by clients during or after therapy. These concerns formed an additional source of feedback data and informed the wider consultation.

'An important priority for the Ethical Framework is to be able to reassure the public that practitioners are held accountable to ethical and professional standards'

MICHAEL VILLEGAS/IKON IMAGES

Professional conduct data

In order to further develop confidence in and credibility of the profession, the *Ethical Framework* needs to be a document that aids the professional conduct team to develop and uphold professional and ethical standards, informed by an evidence base.

- Data were collected from the professional conduct service on the types of issues that were raised as professional conduct complaints.
- Additionally, professional conduct personnel were consulted about their use of the current *Ethical Framework* and its use during professional conduct processes given the changing nature of ethical challenges for members.

Q What are the findings of the consultation?

A Collection and analysis of this wide-ranging data set involved a number of teams within BACP working collaboratively to inform members, to set up surveys and focus groups, to attend formal and informal events, to access complex data and to be available to respond to questions around their own use of the *Ethical Framework*.

Ongoing analysis of the data was performed throughout 2024 by a small team of researchers within BACP. Data were analysed using mainly descriptive and comparative analysis of quantitative sets and thematic analysis of the qualitative data. Much of the data gathered from members were qualitative data as it was important to be able to listen to members' own words and to learn from their own experiences of using the *Ethical Framework*.

The data fell into three main areas, which focused on:

i) responsibility,
ii) a manageable, usable, accessible document, and
iii) issues around supervision and ethical decision making.

i) Responsibility

Many elements of the analysis could be grouped under the theme of responsibility. What is the responsibility of the *Ethical Framework*, and how are members responsible to others within their professional work and responsible to the *Ethical Framework*?

- **What is the responsibility of the *Ethical Framework*?** Analysis identified some tensions regarding the purpose of the *Ethical Framework*. Members indicated a need for a framework to provide a list of definitive rules and guidelines for practitioners, in order to address public protection needs and to provide greater clarity in complex ethical situations. However, other members indicated that this should not be the sole purpose of the *Ethical Framework* as this would move the framework from its current guiding framework position to one of a code of conduct. Feedback informally through email and social media indicated that online and digital work needed to have better guidelines from BACP in order to keep up with the growing demand in this area. Finally, feedback from professional conduct indicated that the new *Ethical Framework* needs to be clear on the purpose of supervision, as currently many members who reach professional conduct indicate an overreliance on a supervisor's guidance, regarding it as mandatory.
- **How are members responsible to others within their professional work?** Many issues arose in the feedback around professional responsibilities outside the therapy room. Issues around work within organisations, placements and training institutions were cited as instances where members were experiencing behaviour that did not align with ethical behaviour. This might relate to situations of power imbalance, for example. Data indicated that a number of therapists do not recognise power imbalances in boundary issues, dual roles/conflict of interest, supervision and line management. Placement providers were often cited as having both supervisory and line management roles, and training institutions often did not recognise or acknowledge the power dynamic in the assessment of student work alongside the role of modelling ethical good practice. Furthermore, feedback suggested that both supervisors and training institutions needed to embed issues on awareness of race competence, awareness of neurodiversity and awareness of equality, diversity and inclusion (EDI) within training and supervision. A further issue of professional behaviour outside the therapy room concerned the use of social media and the overlapping boundaries of professional and personal media accounts. Social media was cited as being used by members to comment on the professional behaviour of other members or to articulate specific ideological positions, which could cause unintended harm.
- **How are members responsible to the *Ethical Framework*?** Members are responsible to the *Ethical Framework* by working in a professional way, mindful of their ethical responsibilities and demonstrating awareness in attending to these responsibilities. The data indicated many instances that were problematic for clients, including therapist boundary issues, fitness to practise and abrupt endings. These are consistently problematic and may be indicative of a wider issue in ethical decision making, as addressed below. Emerging issues raised with the ethics service include online working, international working, safeguarding issues and issues with digital technology and AI (typically, but not solely, involving data breaches).

'The Ethical Framework needs to be able to account for cultural diversity, neurodiversity and disability much more than is apparent in the current framework'

'Participants regarded this as a rich source of learning for supervisees, not to "agree" with their supervisor or to "find the right answer" within the Ethical Framework*'*

ii) A manageable, usable document, accessible to all members

In order to address the accessibility of the *Ethical Framework*, much of the feedback offered suggestions on its usability, manageability and accessibility.

- **Manageability and usability** Feedback suggested the revised *Ethical Framework* should offer resources to support understanding and implementation into practice. These included signposting to supplementary information, provision of case study examples, and explanations for application of the *Ethical Framework*. Informal feedback from stakeholders echoed issues raised in other parts of the review. Specific comments on the structure reflected how the document could be improved in terms of its accessibility and manageability to speedily access guidance on ethical concerns. In reference to this, summaries, indexes and less complex legalistic language – with fewer abbreviations – were recommended.
- **Accessibility** Other data from multiple formal and informal sources suggested that the *Ethical Framework* was sometimes considered complex, intimidating and difficult to implement. Words used to describe the current *Ethical Framework* were: 'long', 'confusing' and 'simply not accessible'. Accessibility of the framework, including using simpler language and smaller sections, was raised particularly for those who are neurodivergent. It was also felt that it was important to offer the framework in more languages. Another consideration on accessibility was that of making the *Ethical Framework* more accessible to the public, which helps with public protection, and to those new to the profession. Accessibility was also considered necessary in relation to issues of EDI. Member feedback indicated that the *Ethical Framework* needs to be able to account for cultural diversity, neurodiversity and disability much more than is apparent in the current framework. This was felt likely to be in the form of greater attention to EDI and competences within the Good Practice resources but also allowing a space for critical thinking in ethical decision making around EDI competences. This echoed the points raised in the section on professional responsibilities.

iii) Supervision and ethical decision making

- **Supervision** Much of the data from the ethics service, professional conduct, complex ethics and feedback on Good Practice resources indicated that members were not making enough use of supervision or were using supervision at a late stage when problems had already been identified. There were many instances where the joined-up approach of making ethical decisions in collaboration with a supervisor was not evident, leading to problems later for members. Furthermore, some feedback suggested that supervisors might be working beyond their competence, and supervising work which they cannot demonstrate competence in. These included coaching, working with trauma and supervising overseas (either supervisees or client work). Peer supervision was raised as an issue, particularly within closed social media groups where a lack of challenge might facilitate 'group think'.
- **Ethical decision making** Ethics service data indicate that often members are turning to the ethics service to provide definitive answers to ethical dilemmas once they encounter a problem. This indicated a limited use of ethical consideration throughout the counselling work, which might have prevented some of the problems further down the line. It also often reflected a limited use of supervision, or poor (or inconsistent) supervision. Feedback indicated that supervisors need to be drawing their supervisees' attention to the *Ethical Framework*, particularly those who are still in training. Participants regarded this as a rich source of learning for supervisees, not to 'agree' with their supervisor or to 'find the right answer' within the *Ethical Framework* but to be able to hold different interpretations of the framework and be prepared to justify their ethical thinking and decision-making processes.

Next steps

Many other issues were raised within this wide-ranging consultation, and we hope you will appreciate that they cannot all be included within the limits of this article. However, in meeting our aim to be transparent, reports on findings will be accessible in the second consultation phase of the project, which is due to begin in August 2025 and which will be alongside the publication of the draft *Ethical Framework*.

** The contents of this article reflect a summary of the findings of the consultation process by the author, and are drawn from the broader consultation, analysis and findings of the wider* Ethical Framework *review team within BACP.*

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Marita Morahan MBACP is BACP Ethical Framework Review Lead. She has worked for many years as a trainer in counselling and as a lecturer and researcher in psychology, and is also a chartered psychologist with the British Psychological Society.

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Letters

Your feedback on *Therapy Today* articles

Placements

Thank you for shining a light on the 'Wild West' of student placements ('The placement problem', *Therapy Today*, February 2025). The Psychotherapy and Counselling Union (PCU) of which I am a member has long been campaigning on this issue. While it may be understandable that third sector organisations struggling with inadequate funding turn to trainees for support, it is certainly not acceptable. The reliance on unpaid student placements as a core component of service delivery is both exploitative and unsafe – for trainees and clients alike. We have encountered organisations whose entire model depends on student placements, a practice that places unqualified and often unsupported trainees in a vulnerable position while also failing to prioritise client safety. It is clear that students alone cannot repair this broken system. However, concerted action by training institutions and membership bodies could make a significant difference. We believe that good practice standards must be implemented and enforced. Training institutions and placement providers should be required to meet these standards – or risk losing their accreditation by membership bodies. As a minimum we advocate for placement providers to cover essential expenses incurred by trainees, including appropriate supervision at the frequency required by their training body, travel costs and insurance coverage. Beyond financial support we also urge greater care in matching trainees with clients and fostering a placement environment in which trainees feel safe seeking guidance or stating when they do not feel competent to continue working with a client. If we are serious about ethical practice, safeguarding, and the wellbeing of both trainees and clients we must move beyond treating student placements as an unlimited, unpaid resource.

The PCU's Code of Practice calls for a three-way contract between trainee, provider and training organisation; full reimbursement of expenses; safe reporting structures for bullying, misconduct or harassment; proper client matching so trainees aren't put in unsafe situations; inclusion in organisational planning – trainees must have a voice; whistleblower protections for all trainees; and payment of at least the Living Wage whenever possible.

Anne Lee MBACP, member of PCU

Helen Dalley makes some excellent points regarding the problems that many trainees have in securing a placement. I would like to add to the debate by drawing on my own experience as the counselling co-ordinator in an agency that offers trainee placements. There is a trend towards asking trainees to pay for supervision and/or an admin fee; I agree that this is unfair and possibly discriminatory. We know all too well how

Internal conflicts

I appreciated Gill Frost's article ('Understanding our inner tugs of war' *Therapy Today*, February 2025) because I grappled with internal conflicts before, during and after my training. As a childhood trauma survivor the most intense conflict for me has been around the very young part of me that takes care of others to try and stay safe and secure versus the more adult part that is still learning to take care of myself. I imagine many who are interested in therapy training carry unconscious, even dissociated, conflicts because I believe it is the unconscious drive to heal ourselves that takes us towards the listening profession. I contacted Gill as I'm interested in the relationship between self-doubt and resilience. I also wonder if working with internal conflicts might bring greater self-awareness, self-knowledge, self-trust, confidence and optimism to professional life. Gill's article also made me wonder if internal conflicts could be a larger focus of student training because greater understanding of mine only came after the accreditation process.

Louise Smith MBACP (Accred)

> ‘I believe it is the unconscious drive to heal ourselves that takes us towards the listening profession’

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expensive it is to train to become a counsellor, and these additional costs may be the final straw for some trainees, preventing them from completing their training. However, I’m less inclined to agree that it’s unreasonable to ask trainees to stay volunteering with their placement agency beyond the end of their course. As the counselling co-ordinator for a small charity supporting people affected by sexual violence, we rely entirely on volunteers to provide counselling as we have no external funding. We offer placements to trainees and see this very much as a two-way process. Trainees are obviously giving us their time and energy for free; in return we ask them to see two or three clients per week, and to commit to two years with us. I was surprised to read in Helen’s article that many trainees feel they should only be asked to stay with an agency while they’re still training. The truth is, our investment in our trainees is considerable, and requesting they stay for two years is not unreasonable: first, trainees in any agency are given the opportunity to gain valuable experience in working with real clients, usually in a supportive environment. Many agencies, including my own, provide specialised training at the start, group supervision and ongoing CPD, all for free, as well as offering reasonable expenses. Second, the admin involved in taking on a trainee is considerable: lengthy placement forms, liaison with training providers, DBS applications, agency and supervisor reports and inductions all take time, and they impact our budget.

While we deeply value our trainees and recognise the significant contribution they make to clients and the agency as a whole; I don’t think it’s disproportionate to ask them to stay with us for two years for one morning or afternoon a week. After all, we’re just making the request; it’s not a legal obligation. I understand the pressure to find paid employment but I do have concerns about trainees who rush into private practice the moment their training is complete. Staying on as a volunteer enables newly qualified counsellors to gain a greater depth of experience, grow in confidence and develop their skills even further in a supportive and familiar environment.
Laura Smith MBACP (Accred)

I liked the ‘Big issue’ article on placements but I thought it useful to give the ‘other side’ – that of placement provider. It’s not ideal that agencies have to rely on volunteers for the bulk of their work as it creates an unhelpful dynamic. But we must remember that the background to all of this is lack of secure funding for services. I have managed several third sector services in my 25 years, all offering placements to trainees. I personally benefitted hugely from a very well-run placement scheme during my training, and I took those principles with me. First, the agency should be paying supervision costs (which are usually by far the highest outgoing), as well as DBS checks, insurance cover and access to free or subsidised CPD: that’s the very least we can offer. Second, remember that counselling services exist primarily for the clients, but we have also become placement providers, a sometimes complex dynamic. We cannot guarantee hours, and colleges need to do their bit by being more flexible. Third, many organisations are third sector, where funding is precarious to say the least. The cost of rooms, insurance, supervision, clinical managers and admin support is considerable. Some of this is covered by client fees and some by organisational funding. With no core funding it is a constant balancing act.

Some trainees, I’m sorry to say, are just not ready for placement at the point the course dictates. There are too many courses now offering unrealistic expectations and sometimes taking on people who aren’t necessarily suited to the work. I’m sometimes amazed at how little trainees are able to talk about themselves, or their training and learning. As an agency it’s important to follow the guidelines for working with volunteers. This means, upfront information about the placement from application stage, proper administrative processes, clear policies and procedures, full induction (and handbook), an approachable clinical lead, good supervision, supportive development and the ability to say no to a client (and not allocating beyond someone’s competence). You should never be charging for any of this.

From my own experience, trainees should be treated as professionals from the get go, so the application and interview process is that of a paid job. The agencies I worked in were all doing reasonable long-term work, and it was important to find out if a trainee had the inherent skills, with or without experience. In my last post, however, the complexity of clients was such that we had to mostly take on those with experience, albeit not directly as a counsellor. We were looking for those who could manage complexity. With the erosion of NHS therapy, client needs have changed, and there is far more risk now being dealt with at community level. Not all trainees are ready for this: they need support, nurturing and a professional experience.
Claire Moor MBACP (Snr Accred)

‘Let’s shift from opposing sides and work together to find a sustainable solution that benefits everyone involved to ultimately support clients’

Letters

Provider perspective

February’s ‘Big issue’ article, ‘The problem with placements’, raised key points that warrant attention as well as nuances overlooked. As a placement provider, we receive more than 100 applications each year. We wish we could accommodate every student but spaces are limited.

Additional challenges include influxes of applications from students once a student secures a placement, adding to admin workload. We do our best to communicate transparently when declining applications but sometimes it’s a matter of timing. It’s not uncommon for applications to feel like a game of roulette, where a student may be declined one week, only for another to be accepted the next. This may not be due to the student but down to when they email the application, which would be out of the student’s awareness.

To suggest that we recklessly assign clients with complex health issues to trainees is unfair. We have stringent assessment processes in place to ensure that complex cases are handled by experienced and qualified counsellors. Sometimes complexities arise that clients themselves are unaware of until therapy begins.

I was disheartened by the claim that agencies are profiting from trainees. The running costs for a placement service are huge: we pay for premises, insurance, DBS checks, and administrative staff to process applications and manage compliance. There are costs associated with training and supervising students, maintaining case records, and ensuring that all ethical and legal obligations are met. Supervision is one of our largest expenses, costing thousands of pounds each year. Despite providing free supervision for trainees biweekly, the cost to us as an organisation remains high. Many training providers ask for extensive reports, in-depth assessments and additional paperwork that further strain resources. With inflation and increasing requirements for higher-accredited supervisors these costs will only

Placement panic

It did not matter how many times my tutor told me that it would be OK and I would find a placement, that there was no pressure and it would happen – I worried! Before even starting my Level 4 course it was made very clear what the pressures and commitment would be. My tutors described in detail the workload, expectations, time commitments and costs. They arranged for students at the end of the course to come and share their experiences with us, and encouraged us to ask questions. I even heard the course referred to as the ‘divorce course’, due not only to the pressures but also the amount of life-changing internal discovery. It was obviously not for the faint-hearted!

I am still in year one of my training and absolutely loving it. There are many tricky aspects of self-discovery on this very personal journey but even they are welcome as part of my learning process. It’s like I am unpicking myself at the very core of my being and rebuilding it in a way that is full of growth and understanding. But so far the most stressful aspect of my journey has been securing a placement. I reached out to my first choice and was really surprised to receive a reply stating that they only took placement students in their second year. For someone who was normally sought after in a working environment this was an entirely unexpected feeling for me. Other approaches received responses of ‘no placements available’, ‘not taking placements at the moment’, ‘thank you for your interest, but no’. I was finally offered a position on a phone helpline, on the basis that after three months I would be considered for an in-person placement. If I was successful I would be expected to keep the phone line commitment for a year, alongside my placement. This sounded like quite a commitment, but I understood that it was important to support their service to clients. However, the phone shift was 7pm–11pm and I am an early riser and I tend to be in bed by 9pm. I work and I have a family so had to consider how that commitment would impact me. I struggled over the decision and finally turned it down. I actually feel relief now at not taking it: it was not right for me. I have just had an interview at another setting and, from my perspective, it is a great fit and I hope I will be successful, but if I am not I will keep applying and try to hold on for what will be a good fit for me. I will sit in awkward comfort with my placement panic.

Hayley Mills MBACP, student member

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.

continue to rise. Additional operational costs, such as IT systems maintenance, software, safeguarding training and CPD, mean that the misconception that trainees generate profit for placements without any associated costs simply isn't true. We're constantly working to balance financial viability with the ethical responsibility of supporting trainees and clients. There is no spare money to pay for travel for trainees.

From a training perspective I agree that training providers need to play a more active role with helping trainees find placements. The pressure to secure a placement by year two adds significant stress, especially when placements require students to meet certain criteria. This intense anxiety is filtering into the therapeutic space too as trainees are using their personal counselling to talk about the issues around their training.

Placements should be seen as a partnership, providing trainees with a valuable opportunity to learn and grow in a real-world setting. Yes, there are costs, but there's also immense value in the experience offered. Students have personal responsibility in this matter too. Choosing a course that requires hands-on experience means accepting the need to travel for placements. Maybe it is time to reconsider how we approach this – placements are not just a stepping stone but a mutual exchange of value. Our ultimate goal should be the wellbeing of the clients we serve, not just profit margins or completion of hours. Let's shift from opposing sides and work together to find a sustainable solution that benefits everyone involved to ultimately support clients.

Debbie Retfalvy BACP (Accred)

Having read February's 'Big issue' on placements I felt that it was important to respond from a placement perspective. We are a small community counselling service run by volunteers, and we utilise counselling students on placement. This means that we can charge clients £10 per session. We value our trainees: two have stayed with us post-qualification, and another wants to stay on once qualified. This gives us the capacity to accept the more complex clients and consequently be even more selective about the clients allocated to new trainees. Overall we have had some great trainee counsellors who have gone on to find paid counselling work.

However, we've also had trainees disappear after a few months, abandoning their clients; others can behave as if any admin outside the counselling room (such as reporting client attendance and handing over cash payments in a timely manner) is unimportant to the point where it becomes an ethical concern. Despite us raising concerns with educational institutions when something like this happens, we don't always hear anything back. Meanwhile, when students apply for our placements and are asked to supply their CV, many can take weeks to provide this and some don't get back to us at all. Trainees can be slow to provide information and sometimes it is inaccurate, meaning it takes longer to follow it up and allocate clients to them, which impacts our aim to have a new client lined up after one finishes. All of this takes careful planning and co-ordination, which requires input from the trainee. We often end up with huge gaps between clients due to all this, and I suspect that many see this as a failing on our part.

As far as supervision goes, I do understand the financial impact this has on students. We provide monthly group supervision, which as a charity is as much as we can afford. When I did my training supervision was included in the cost and provided by the educational institution, and I'm very grateful for that.

Jeannette Robson MBACP (Accred)

OBITUARY

Marietta Marcus

My mother Marietta Marcus worked as a specialist social worker in Richmond and Kingston-upon-Thames for more than 20 years. She trained as a Jungian psychotherapist in 1981, then obtained her MA in Analytical Psychotherapy from the University of Hertfordshire in 1994, sitting on various committees from the late 1990s.

Marietta arrived in England from Hungary in 1947 having escaped Nazism and Soviet Communism, and she was profoundly grateful for the understated freedoms this country afforded. Her English academic journey started with A-levels in English, German and Hungarian. In 1953 her husband (my father) gave her an inscribed hardback copy of Jung's *Modern Man in Search of a Soul*.

She was remembered as an elegant dresser without being showy. She enjoyed skiing, swimming, tennis, cooking, classical music and walking. She also enjoyed writing, taking a creative writing course in retirement. On 13 February 1997 (the anniversary of the death of her very close friend, George Mikes) she wrote this haiku:

Went to see snowdrops
At Kew, without you; nine years
Of rebirth on view

Her clients will remember her understanding of the power of helpful silence in opening a door of healing. Marietta Marcus died at home, as was her wish, aged 93 in June 2024. She leaves behind two sons, six grandchildren and four great-grandchildren. Her 2021 memoir, *Survival... From the Danube to the Thames – life after death, memories of a life well lived*, is available on Amazon.

Tom Marcus

Sophie Scott

Feelings are the words we give to sensations. According to the University of California, Berkeley, people experience an average of 27 emotions daily.[1] The way into them is through the body. Helping clients notice where they feel sensations – tightness, movement or discomfort – can shift their relationship with emotions. Many of us fear our feelings. But when we breathe into a sensation, observe its impermanence and stop labelling emotions as 'good' or 'bad', we allow energy to move through us rather than remain stuck.

Visualisation can be powerful. When words are exhausted, visualisation is a powerful tool, engaging the brain's creative centre. I often guide clients through imagining safe spaces, setting boundaries, working with their inner child or even picturing their ideal day. This bypasses logical resistance and accesses deeper insights.

Communication is more than words. Connection isn't just verbal. Painting, sharing music or simply sitting in nature can foster deep understanding without words. So can storytelling – everyone loves hearing stories, it's our oldest art form! Communication is about meeting someone where they are. Laughter can also be unifying even in the darkest times, and it often finds its way into my therapy room. My own family has found humour in absurdity when life has felt unbearable. Non-verbal connection takes us beyond words, ushering us from the mind to the heart, allowing something deeper to emerge.

There is an art to sitting with discomfort. As a therapist I frequently have to resist the urge to 'save' clients. Stepping back allows them to find their own answers. This applies to caregivers too – learning to tolerate discomfort helps both them and their loved ones. Sitting with the things we'd rather avoid – helplessness, despair, uncertainty – expands our capacity for resilience. In relationships we are not just supporting others; we are also confronting our own shadow.

A holistic approach is essential. We are often reduced to statistics but we are far more complex. True wellbeing isn't just about mental health; it includes physical, emotional, intellectual, occupational, social, financial, spiritual and environmental factors. In my book I use the eight pillars of holistic health to help caregivers consider these aspects of their own wellbeing, not just that of the person they support.

Authenticity builds connection. The more authentic I am, the stronger the therapeutic relationship becomes. While I don't overshare, I will share when it serves the client. Therapy isn't about perfection; it's about presence. I've stumbled over my words, sometimes breaking through emotional defences without intending to. But these moments – raw, messy, human – become grist for the therapeutic mill and the foundation for transformation. The essence of communication isn't about flawless delivery; it's about the courage to remain engaged, to recalibrate and continue when we veer off course.

The 'forgotten ones' need support too. Mental health issues, similar to any health issue, don't just affect the individual – they impact those around them. Yet resources for people in supportive or caregiving roles are scarce. I call them the 'forgotten ones'. I wrote a book out of a desire to change that, to acknowledge these individuals and let them know they're not alone. For every person struggling, there are two or three others profoundly affected – without any formal support. We know that caregivers themselves face higher rates of depression and anxiety. Many end up in therapy, especially if their loved one isn't receiving the help they need. ●

'Sitting with the things we'd rather avoid – helplessness, despair, uncertainty – expands our capacity for resilience'

ABOUT THE AUTHOR

Sophie Scott MBACP is an integrative psychotherapist, writer and speaker on emotional health, and the founder of BALANCE magazine. Her book, *You Are Not Alone in This: supporting a loved one's mental health without losing your own*, is published by Watkins.

1. Cowen AS, Keltner D. Self-report captures 27 distinct categories of emotion bridged by continuous gradients. Proceedings of the National Academy of Sciences of the United States of America 2017; 114(38): E7900-E7909.

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