Healthcare

Counselling and Psychotherapy Journal

For counsellors and psychotherapists working in healthcare

April 2025

My mental health 08

Plus

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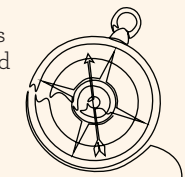


From the **Editor**

NAOMI CAINE

Regulars

Counsellors and psychotherapists deal daily with people's pain and distress. On any given day, we might be sitting with someone who is struggling with addiction, abuse, self-harm or thoughts of ending their own life. They might also be struggling within a context of physical illness, poverty or unemployment.

Donna Taylor knows a lot about growing up in difficult circumstances. Her father walked out of the family home when she was a toddler, leaving her mother to bring up four children. Donna's early life was marked by instability and hardship: her mother tried to take her own life, and her brother became a drug addict. On p8, Donna talks to *Healthcare Counselling and Psychotherapy Journal* about the impact of her experiences on her own mental health and how she now monitors and manages her psychological wellbeing.

On p11, we run an extract from Donna's memoir, a searingly honest account of her mental fragility and fracture, which eventually led to her admission to a psychiatric hospital. It's not an easy read. But it's an important account, not only of a personal struggle but also of the professional response to mental ill health.

It is also a story of hope. Lost in pain, it can be easy for clients – and clinicians – to lose hope. But Donna's memoir is a reminder that there is hope – and that it can help us to heal.

Breathing – we all do it. But for millions of people with a respiratory disease, breathing is as difficult as it is necessary. Chronic respiratory diseases, such as asthma, tuberculosis, pneumonia and chronic obstructive pulmonary disease (COPD), are the third biggest cause of death in England and the most common cause of emergency hospital admissions.

On p16, Devi Sundar describes how respiratory diseases can affect your mental as well as your physical health. But most treatment plans focus on the physical symptoms, compromising the effectiveness of pulmonary rehabilitation. Devi argues the case for a more holistic approach, which would integrate psychological support, including cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT), into care plans for people with respiratory diseases.

Like breathing, sleep is essential for our physical and mental health. We all know that poor sleep can limit our capacity to function. But have we thought about the impact on our clients? Do we, for example, consider that some symptoms of poor mental health are also symptoms of sleep deprivation? Ruth Webb works with sleep problems at the forefront of her therapeutic practice: she gathers information about her clients' sleep patterns in the initial assessment, which helps her to identify issues that are caused or exacerbated by sleep deprivation. Ruth writes on p20 how recent research into the effect of technology on our sleep has challenged some of her previous assumptions and prompted a subtle shift in the focus of her work.

> We all know that poor sleep can limit our capacity to function

Men are sometimes reluctant to seek counselling or psychotherapy, but that's not because they don't have mental health difficulties. Allegiance to a socially prescribed model of masculinity might prevent some men from seeking psychological support. Ironically, it might also be the root cause of their mental health problems. Gareth Palmer explains on p24 the concept of the 'expected self', how it is developed and how it can subdue and subjugate thoughts and feelings. Gareth uses the image of a compass to help men understand and navigate their mental health, opening up a space in therapy where they can be free from the tyranny of the expected self. ■

hcpj.editorial@bacp.co.uk

In touch with your BACP

Call for Government to recognise value of counselling

In our 12-point response to the Government's Spending Review, BACP proposes ways to increase access to counselling and make better use of the existing counselling and psychotherapeutic workforce. We also recommend tax incentives for employers, to encourage greater uptake of accessible mental health support.

We know there are significant challenges. Lord Darzi's recent NHS analysis shows that more than one million people are waiting for mental health services and long waits have become the norm. Some 345,000 people have been waiting more than a year for a first appointment with mental health services, about one third of whom are children and young people.

We also cite the growing evidence that mental health issues are having a serious impact on business productivity and are a significant barrier for many people who want to work. The economic cost of mental ill health in England is estimated to be more than £110 billion a year.

Our submission recommends making better use of counsellors and psychotherapists to help the Government meet its commitments to enhance mental health support in schools and youth hubs, to expand the mental health workforce in the NHS and to help more people find and stay in work.

Martin Bell, BACP's Head of Policy and Public Affairs, said: 'Too many people are falling through the cracks in current services, including young people who don't meet the threshold for Child and Adolescent Mental Health Services (CAMHS), people languishing on NHS waiting lists and those struggling to keep working due to poor mental health. Many of our 72,000 members could help meet rising demand through their life-changing work.'

BACP's key recommendations for the Spending Review are:

- make the NHS Psychotherapeutic Counselling Core Training pathway permanent
- invest in the NHS mental health workforce pipeline, tapping into the vast pool of underused talent, skill and experience within the existing counselling and psychotherapy workforce
- increase the capacity of NHS Talking Therapies and expand the counselling and psychotherapy interventions currently recommended by NHS England through the NHS Talking Therapies manual
- develop a national specification that reduces the deficit of service provision between the upper clinical thresholds of NHS Talking Therapies and the clinical entry thresholds for Community Mental Health Teams
- resource integrated care systems, so they can fulfil their potential as drivers of change and improvement
- tackle the mental health crisis facing our children and young people, through universal counselling interventions across all England's primary schools, secondary schools, further education colleges and sixth-form settings.
- use the counselling workforce within the Government's commitment to implement Young Futures Hubs
- ensure vulnerable people are supported into the right kind of work or work-related activity, without fear of sanctions
- learn from previous employment support programmes, to ensure services provide ongoing, accessible, flexible and inclusive support
- extend tax incentives to employers, to facilitate greater uptake of accessible mental health support, including workplace counselling
- invest in third-sector services that provide vital psychological support and additional capacity to statutory provision of NHS Talking Therapies
- remove VAT on counselling and psychotherapy services that are provided by counsellors and psychotherapists who are on a Professional Standards Authority Accredited Register.

How to develop a fair, diverse and inclusive profession

Aseia Rafique, BACP's Senior Equality, Diversity and Inclusion (EDI) Lead, discusses in her blog the importance of EDI in the counselling professions. Aseia explains how power imbalances, perhaps as a result of ethnicity, socioeconomic background, disability, sexual orientation and/or religion or belief, can hinder therapy, if they are left unacknowledged or simply set aside.

Aseia recognises that EDI can pose multiple challenges to us all. She therefore encourages therapists to:

- recognise and understand historical inequality, which continues to impact people today, often resulting in unequal access to resources, opportunities and power
- reduce our implicit bias, where people hold biases that affect their decisions and actions
- better understand structural barriers, where existing systems and policies might be designed in ways that unintentionally or intentionally disadvantage certain groups
- support changes that would redistribute resources more equally
- learn more about how some societal norms and cultural values can reinforce exclusion or discrimination.

You can read Aseia's blog at: https://tinyurl.com/2hz8wf3x

BACP no longer posting on X

Following a review of our social media strategy, we've stopped posting on X and are exploring alternative channels.

Social media is an important communications channel that 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 what we're doing to support our members and the wider profession. We directly engage with our members through our social media platforms, celebrating their successes and answering a range of customer service queries.

However, we no longer believe X helps us meet our communications objectives. We've seen a large drop in engagement on X and we're concerned about the overall direction of the platform. We've therefore decided that we no longer want to proactively use or engage with the channel. So, we won't be posting or responding to any messages from now on.

We'll remain active on Facebook and LinkedIn. We're also continuing to monitor the growth of other social media channels, including BlueSky. And we'll be launching on Instagram in the coming months. Members regularly ask us about Instagram and we're aware that it's popular among our members – and we want to be part of the channel's mental health and wellbeing conversation.

Social media is a fast-paced world, and we'll continue to make sure that our channels serve us, our members, the profession, clients and the public in the best possible way.

Free access to online divisional journals

Reading journal articles counts towards your annual continuing professional development (CPD) requirements – and the online versions of all seven BACP divisional journals are now free of charge for members, giving you access to hundreds of articles on all aspects of counselling and psychotherapy.

You'll still need to sign up, but just follow the links from the individual journals and add the free subscription to your member account.

The online version includes the full journal content, as well as access to archived articles back to 2016. You can browse the content by issue or use the journal search to find articles on specific topics. If you want to access an article that was published before 2016, you can download a pdf of the relevant issue from the archive.

If you prefer, you can still choose to join a division for a small annual subscription. Divisional members receive a printed journal, discounts on divisional events and other benefits.

If you are not a BACP member, you can still buy a subscription to our journals. You'll find prices and full details on the individual journal pages. https://tinyurl.com/htju47z3

Working with race and racial identities to support ethical practice

An online 'Working with' event on Thursday 8 May 2025 aims to support therapists to further develop knowledge and skills in working with racial difference in their practice.

Presentations will offer opportunities to explore racial identity and difference, to gain understanding of the concept of 'cultural attunement' and of the role of white allyship in supporting ethically grounded anti-oppressive practice.

The main aims of this event are to:

- further develop abilities to engage with, and relate to, racial differences in counselling practice
- introduce Myira Khan's concept of 'cultural attunement' and its application to practice, as a progression from cultural competence
- understand the ethical value of cultural attunement as an enabler of anti-oppressive counselling practice
- gain insights from research exploring the impact of whiteness within anti-racist counselling practice
- encourage further exploration of race, racism and anti-racism in the context of counselling practice.

The event will begin at 9:30am and finish around 1:00pm.

The price for BACP members is £35.
To book your place online, please visit:
https://tinyurl.com/2ef2xdfy

Blog discusses link between hormones and mental health

In her member blog, *Menopause and anxiety*, Donna Morgan, who specialises in women's health, discusses the hormonal link to emotional wellbeing. Donna explains that women frequently seek therapy for anxiety or panic attacks, often without realising the effect of the menopause on their mental health.

Donna writes: 'The hormonal changes of menopause can cause a cascade of psychological symptoms, including heightened anxiety, irritability and difficulty coping with everyday stress. Women who have previously managed their emotions well can suddenly find themselves overwhelmed by worry, experiencing racing thoughts or struggling with self-doubt. For some, these symptoms mimic clinical anxiety, leading to unnecessary prescriptions for antidepressants when hormonal treatment or lifestyle adjustments could be more effective.'

Donna believes that therapists have a crucial role in helping women recognise and validate their experiences. 'Therapy provides a safe space for women to express fears about ageing, identity and body image, which often surface during menopause. By normalising these concerns and offering support tailored to their unique experiences, we can help them navigate this transition with greater confidence and resilience.'

You can read Donna's blog at:
https://tinyurl.com/yc886rz5

Artificial intelligence and the human connection

Join us for an online Professional Development Day (PDD) on Wednesday 7 May 2025 to explore artificial intelligence (AI) and the human connection.

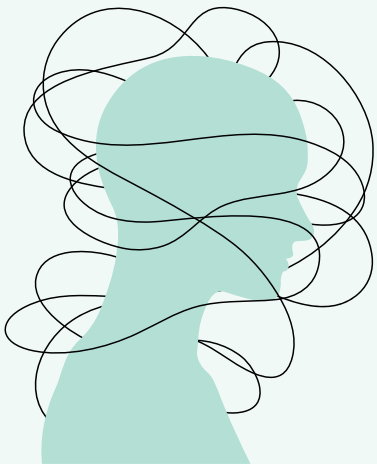
The PDD aims to give you a basic understanding of AI and its potential effects in counselling practice. We will also look at how to ethically and effectively integrate AI tools into your work, while maintaining precious human connection.

The main aims of the PDD are to:

- explain fundamental AI concepts in simple terms
- develop strategies to maintain meaningful empathy and connection when using AI in your practice
- consider ethical dilemmas that can arise from using AI in counselling contexts
- raise awareness of basic data security measures to protect client confidentiality
- explore what to do if you have concerns about how AI is being used.

The PDD will be split into three presentations, each followed by a live Q&A session. The first session will begin at 9:30am and the event will finish at around 1pm.

The price for BACP members is £35.
To book your place online, please visit:
https://tinyurl.com/yv7z4bra



Workshop explores suicide and self-harm

On Friday 13 June 2025, Katherine Caffrey will present an online Professional Development Day (PDD) on suicide and self-harm. The workshop will provide strategies to manage risk safely and effectively, through presentations and individual exercises.

The main aims of the PDD are to:

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

The workshop is split into three sessions, each followed by a live Q&A session with Kath. The first session will begin at 9:30am and the event will finish at 1:00pm.

The price for members is £35.
To book your place online, please visit:https://tinyurl.com/2p9spe7x

BOOK REVIEW

GENDER-AFFIRMING PSYCHIATRIC CARE

Teddy G Goetz MD, MS and Alex S Keuroghlian MD, MPH (eds)
American Psychiatric Association Publishing
ISBN 978-161537472-4

If you are seeking to improve the sharpness of your intersectional lens, *Gender-Affirming Psychiatric Care* is a rich and varied resource for any practitioner working alongside transgender, non-binary and/or gender-expansive (TNG) people.

The book is made up of 26 chapters that span a wide range of experiences of structural oppression, including neurodivergence, Asian American and Pacific Islander communities, two-spirit people, Black TNG people in North America, disability, working with older adults and perinatal psychiatry. The book mixes cutting-edge neuroscience, clinical research, best practices and mental health policy and systems design, making it useful for a wide range of readers.

The strength of this book is not only the breadth of client identities and experiences that are afforded attention, but also the fact that each chapter includes contributions from at least one TNG writer. The authors demonstrate a profound and nuanced understanding of TNG communities, stemming from lived experience as well as clinical expertise.

The book espouses a clinical approach that affirms gender-expansive experiences, as opposed to a clinical approach that is simply tolerant, curious or objectifying. The authors' care and passion for TNG communities shine through the writing, making this book an especially vital and powerful resource in the current UK climate, where standards of best practice are being debated, often without the input of TNG clients or clinicians. As a transgender man of colour, this book felt like a breath of fresh air – and a return to a more empathic engagement with the question of how best to meet the needs of TNG clients, in the consulting room and beyond.

The book addresses a wide range of experiences in a North American context, but this does not limit its usefulness to clinicians in the UK. I found the chapter, 'How cis?', by Tobias Wiggins, of particular interest. Wiggins discusses the importance of recognising and managing transphobic countertransference – the ways in which a clinician's unconscious prejudice can be felt, and potentially acted out, in the consulting room.

For anyone interested in improving their work with this embattled community, *Gender-Affirming Psychiatric Care* is a comprehensive and timely resource that will guide you through the current trans-hostile discourse, towards internationally accepted standards of gender-affirming best practice. ■

Ellis J Johnson *MBACP is a psychodynamic psychotherapeutic counsellor.*

MY MENTAL HEALTH

Donna Taylor knows what it's like to suffer a mental breakdown and spend time in a psychiatric hospital. She talks to the journal about her experience

When Donna Taylor was three years old, her life changed. Her father disappeared from the family home, leaving Donna's pregnant mum to care for Donna and her three older brothers. Shortly after her father left, Donna's mum attempted to take her own life and was admitted to a psychiatric hospital. The four children were placed in care.

When Donna's mum came out of hospital, the family struggled to find a suitable place to live and even spent several nights in the car. Eventually, they found a permanent home and Donna's mum settled into a job.

But the stability didn't last long. Donna's mum started seeing Ray, who was an alcoholic. The relationship was volatile and Ray was sometimes violent. Ray also had an uneasy relationship with Kevin, Donna's brother. Kevin struggled with the situation at home and developed a drug habit. The arguments and Kevin's descent into addiction attracted the attention of the police – and the family earned a reputation that was difficult to shift.

Donna's teenage years were blighted by melancholy, which made it difficult for her to leave the house. Her attendance at school was patchy, but she found the strength and determination to get a job. She also met Tony. When they moved into a new home together, Donna felt as though she could leave behind the poverty and disappointment of the past.

When Donna found out she was pregnant, Tony reasoned that they were not ready to have a baby, which resulted in the decision to terminate the pregnancy. Donna suppressed her own doubts but was later filled with regret. The relationship with Tony began to buckle under the strain of grief and ended when Donna discovered his infidelity. Donna retreated from the world, seeking solace in isolation and darkness.

The intervention of Donna's family prompted a visit to the GP, who prescribed Prozac. The support of her employer enabled Donna to continue, and progress, at work. Then, one day, her Mum arranged a date for Donna. Hassan offered the promise of a future and the couple were married in 2003. But Donna soon noticed a change in Hassan; he became forgetful, losing track of time and place. Hassan was diagnosed with early onset Alzheimer's – a diagnosis that was later withdrawn.

The diagnosis was a shock. Donna put all her time and energy into researching the condition. But the sleepless nights took their toll on her mental health, and she became convinced that she was being spoken to by a higher power. Unable to distinguish between reality and delusion, Donna was admitted to a psychiatric hospital. After a brief stay, she discharged herself and went back to the family home, where she tried to take her own life.

With the support of medication and mental health services, Donna returned to work. But the stability was threatened by

Kevin's continuing struggles and the death of Ray. Donna experienced manic episodes, followed by intense depressions, and was eventually diagnosed with bipolar affective disorder.

Donna's condition was monitored and managed, and there was a period of relative calm. But when she decided to stop taking her medication, partly because of its impact on her physical appearance, things started to unravel. An intense period at work seemed to trigger another episode of hallucinations and paranoia. Donna ended up back in the psychiatric hospital, where she was detained under the Mental Health Act.

When she came out of hospital, Donna made changes to her life. Acknowledging that her mental health must take priority, she drew up a comprehensive plan to manage stress and learned to recognise the early warning signs of her deteriorating mental health. She also changed her job, finding employment at the psychiatric hospital where she was once an inpatient. Donna is still working at the hospital, and hopes her story can remind others that there is hope after despair. Donna talks to *Healthcare Counselling and Psychotherapy Journal* (HCPJ) about her experience.

HCPJ: You experienced trauma in your early life – your father's departure from the family home and your mother's suicide attempt. How much do you think those traumatic experiences affected your mental health?

DT: I think early-life trauma can have significant and lasting impacts on mental health, possibly affecting brain development. I also believe it can increase the risk of developing conditions such as depression, post-traumatic stress disorder (PTSD) and anxiety, particularly if the trauma is not addressed.

HCPJ: Do you believe that the environment has an impact on mental health? I am thinking about the financial hardship and the period of homelessness.

DT: Yes, I believe the environment has a significant impact on mental health. I experienced overcrowded living conditions and poor quality housing. I would also cite family dynamics and relationships as major influencing factors on my mental wellbeing.

HCPJ: You have lived with addicts: your brother developed a drug addiction and your mother's partner was an alcoholic. How do you think addiction affects mental health?

DT: There is no doubt in my mind that addiction affects mental health – not only the mental health of the addict but also of family and friends. Addiction can both cause and worsen mental health problems; mental health conditions can also increase vulnerability to addiction.

HCPJ: Do you think society does enough to support people who struggle with addiction?

DT: No. There is a shortage of treatment facilities and qualified providers. In my opinion, the criminal justice system also prioritises punishment over rehabilitation. But there is growing recognition that addiction is a health issue that requires medical intervention.

HCPJ: You write in the book that you feared becoming a 'revolving door' patient. Could you say a little bit more about your fear?

DT: It's scary to think that you could be caught in a cycle of psychiatric hospitalisations. I work in a psychiatric hospital and I see patients who are admitted, stabilised and discharged, only to return a short time later.

HCPJ: Several times in the book you talk about the purpose and structure that regular employment can offer. Is that still important to you?

DT: I believe that daily routine and structure contribute to psychological stability. My job also gives me purpose and keeps me grounded.

HCPJ: Human connection also seems important to recovery. Would you agree?

DT: Yes, human connection plays a vital role in mental health recovery. Emotional support and validation can reduce the feelings of shame and isolation that often accompany mental health challenges. Friends, family or support groups can also help with daily tasks and offer different perspectives, which can challenge distorted thinking.

HCPJ: You take medication for your bipolar affective disorder. How important is the medication to your mental wellbeing?

DT: My medication helps to keep me well and able to live a reasonably normal life. I dislike the side effects of some psychiatric medication, particularly the weight gain. But in the end, my mental stability is more important than my weight.

HCPJ: You don't really mention therapy in the book. Have you been to therapy? If so, did you find it helpful?

DT: Yes, I have attended cognitive behavioural therapy (CBT) and counselling sessions. I found therapy helpful, as it gave me the opportunity to offload, understand my condition and learn different coping strategies.

HCPJ: Do you think there is still a stigma around mental health?

DT: Yes, despite significant progress in recent years. Many people still feel uncomfortable disclosing mental health challenges to employers, fearful that it could affect their career prospects or how they are perceived by colleagues. People can also struggle to open up about their mental health in personal relationships, perhaps because they are worried they will be seen as 'weak' or 'unstable', particularly in cultures where mental health discussions have traditionally been taboo. I think it can be particularly challenging for men to seek help with their mental health.

HCPJ: Are there any ways you think that mental health services could be improved?

DT: I think more funds should be allocated to mental health — and that mental and physical health should be treated equally. I would also review 'revolving door' patients, to determine why some patients keep coming back, so we can come up with ways to prevent re-admission to hospital.

HCPJ: What would you say to others who are experiencing mental health difficulties or suicidal thoughts?

DT: Don't act upon suicidal thoughts; time passes and circumstances change.

HCPJ: Is there anything you would say to therapists who are dealing with clients who are suicidal or severely mentally unwell?

DT: I would suggest that every therapist should have in place clear safety protocols and crisis plans, including a rigorous risk assessment and up-to-date record keeping. I would also ensure the client has access to crisis hotlines and emergency resources.

MY STORY

In an extract from her memoir, ***Donna Taylor*** writes about the events that led to her admission to a psychiatric hospital

As the nights wore on and sleep continued to elude me, the boundaries between reality and delusion blurred. On the fifth night, my behaviour took a turn for the bizarre, a testament to my fractured psyche. In the dead of night, I moved with an almost frenetic energy, fuelled by a desperate need to cleanse the world around me of its perceived evils.

With trembling hands, I wielded a bottle of water as if it were holy, its droplets a sacrament to cleanse the tainted air of our home. With each invocation of the Lord's Prayer, I sought to banish the darkness that clung to the walls, my mind consumed by the memory of past traumas.

In my distorted reality, the misery and violence that had once plagued our home now manifested as an evil presence that lurked within the shadows. Driven by a firm belief in the righteousness of my cause, I reached for the battered gold crucifix that had once belonged to Nan. Faith illuminated the path forward.

When Mum returned home, I was crouched on the floor like a wild beast, my eyes ablaze with a primal fury that seemed to defy all reason. 'Oh my God, Donna,' she exclaimed, her voice trembling with fear and desperation. 'We need to get you help, now.'

Journey to hospital

As we embarked on the journey to Prospect Park Psychiatric Hospital, the world outside seemed to warp and contort, its familiar contours twisted into grotesque shapes. But I clung to a conviction that our destination held the promise of salvation. With each passing mile, I felt the hand of God guiding us forward.

At the hospital, I was filled with a sense of euphoria at the anticipation of meeting my maker. When we were ushered into a room, I was met by a psychiatrist. 'Are you God?' I asked her, my voice trembling with awe. 'I am Jesus,' I proclaimed. 'I am here to save the world.'

As we made our way to the ward, I sensed a malevolent presence lurking in the shadows. In that moment, it felt as though the demon that had haunted me in the living room had returned, its grip tightening around my soul. The urge to purge myself of its influence consumed me, a desperate desire to rid myself of the darkness that threatened to engulf me entirely. 'Come on, love,' my mother's voice cut through my terror, pulling me back from the brink. 'We've got to go to the ward now.'

I followed her down the corridor, my movements disjointed and animalistic, like a creature possessed. As we approached the waiting doctor, I felt the weight of impending doom pressing down upon me. The door to the ward loomed ominously in the distance, like a gateway to the abyss. 'Mum, please don't leave me,' I pleaded, my grip on her sleeve tightening. Despite my trembling limbs and racing heart, she pressed forward, her reassuring presence the only anchor in the swirling chaos of my mind.

> The door to the ward loomed ominously in the distance

As we entered the room, a new wave of terror washed over me; the walls closed in on me like the jaws of some unseen predator. In a crazy outburst, the words spilled from my lips, a twisted confession torn from the depths of my fractured psyche. 'I've been raped by the devil,' I cried out, my voice echoing off the sterile walls of the room, each syllable laced with raw anguish and despair. Before I knew it, I was surrounded by hospital staff. Needles pierced my skin, drugs coursed through my veins, and the world faded into darkness, as unconsciousness claimed me at last.

In my manic highs, I became convinced of my divine purpose, certain that I had been chosen to bear a child, who was destined to save humanity. My longing for motherhood morphed into a delusional belief that I carried the offspring of God within me. At other times, I found myself consumed by the belief that I was the Messiah, my hands bearing the

phantom wounds of stigmata, a testament to my divine nature. As I grappled with the chasm between reality and fantasy, I clung to the fragile threads of sanity, praying for deliverance from the darkness.

Venturing out into the communal areas, I encountered my fellow patients, each grappling with their own demons. A middle-aged woman approached me, her eyes filled with a mixture of confusion and concern. 'Oh hello,' she said. 'You really frightened me when you came in. You kissed me on the cheek and told me you loved me.' I couldn't recall the encounter she described, but I remembered that I was here for a reason. God had chosen me to save the world from an impending catastrophe. In the crucible of my delusions, I found purpose.

I noticed a nurse, slipping into the staff room. I darted after her, my hand catching the door. 'You can't come in here; it's staff only,' she declared. 'I am staff!' I retorted. Didn't they understand? I was on a divine assignment, an emissary of a higher calling. I was working for God, tasked with a mission of utmost importance. I attempted to shoulder past her. 'You must let me through!' I insisted, my voice edging into desperation. My plea seemed to summon a force against me. Staff members materialised, as if mobilised by an unseen alarm. They converged on me with a practised efficiency, their hands firm and unyielding. I twisted and turned, a wild tempest of limbs, fuelled by a blend of panic and an unshakeable belief in my cause.

> I became convinced of my divine purpose

Then, a sharp pinch in my thigh; the cold kiss of a needle. As the liquid fire spread through my veins, the world began to dim and my struggles faded away. The last thing I felt was the embrace of oblivion, as everything went to black. In the ensuing days, I discovered a sanctuary within the hospital's walls: the chapel. It became my refuge, a place where I could lay bare my soul and seek solace in prayer.

Derek was one of the patients at the hospital. A frail, elderly gentleman, perpetually in an anorak, despite the controlled temperature. Wherever I went, Derek was my shadow. Our friendship became not just a comfort but a lifeline, affirming that, even in the most unlikely places, companionship and understanding can flourish. I found solace in tending to Derek, a tangible way to anchor myself against the pull of my own disarray.

I took it upon myself to cut Derek's food and to prepare for him a peculiar concoction that was his favourite – a blend of tea and coffee. Within the walls of our temporary home, this odd mixture became a symbol of our shared defiance against convention, a small act of rebellion that made sense only to us. It wasn't long before I, too, found comfort in this unique brew, a testament to the ways in which Derek had influenced my life.

Ward transfer

The news of my impending transfer to another ward struck with the force of an unexpected blow. The doctors' explanation did little to ease the pain of separation from Derek; an administrative oversight had placed me in a different ward. The thought of navigating the days ahead without Derek filled me with a sense of desolation. The hospital, with its endless corridors and sterile rooms, seemed all the more daunting, a labyrinth from which the path to healing had become uncertain.

I sought out the doctor and asserted my status as a voluntary patient, clinging to the sliver of autonomy it afforded me. The doctors, perhaps sensing my resolve, underscored the importance of continuing my medication regimen. They laid bare the diagnosis: a hypomanic episode with acute polymorphic psychosis. The term 'revolving-door patient' echoed in my mind, a future I was determined to avoid. The home care team, a group of diligent guardians, ensured I remained tethered to this newfound stability. Yet, my psyche remained a fragile construct, teetering on the brink of disarray.

The presence of Ray and Kevin at home became a source of constant agitation. No corner of my world offered solace or respite; I was adrift, longing for a haven that seemed ever elusive. Witnessing the detrimental effect on my fragile state, Mum took a stand. Her directive for Ray and Kevin to leave was a declaration of her priorities, a clear assertion that my wellbeing was paramount. 'Why should we go?' Ray

> My psyche remained a fragile construct

shouted, drunkenly. 'Because Donna's been really unwell, and she can't cope with this anymore,' Mum replied. 'Well then, she's the one who should go,' Ray said. 'Lock her up!'

His words highlighted the stark contrast between those who truly understood the nature of my struggle and those who, either through ignorance or indifference, refused to acknowledge the gravity of my condition. The suggestion to exile me, to send me back to an institution, was a chilling reminder of the stigma and misunderstanding that still surrounds mental health. In that moment, the battle lines were drawn, not just within the confines of our home but within the broader context of my journey towards healing – a journey fraught with challenges but also illuminated by the possibility of finding a true sense of belonging and peace.

Uncertain future

Mum's unwavering stance eventually led to the departure of Ray and Kevin. But their absence did little to alleviate my own internal battles. As I languished in my bed, the echoes of the past mingled with the dread of an uncertain future, drawing me deeper into despair. The future, once a horizon teeming with possibilities, now appeared barren and devoid of hope.

In a moment of sheer desperation, overwhelmed by the bleakness of our situation, I found myself voicing a thought that had taken root in the darkest corners of my mind. 'Hassan,' I begged him. 'Let's just end it now. We can gas ourselves in the car.' The suggestion to end our suffering, to seek an escape from the pain and uncertainty, was born from profound despair. Yet Hassan's response, a silent but firm refusal, was a testament to a will to endure that I had struggled to find within myself.

Hassan's decision to share my proposition with the care worker was a pivotal moment. It was an act of intervention, a plea for help on my behalf that I couldn't voice myself. It was a crucial step towards seeking the support necessary to navigate the treacherous waters of mental illness. But it felt like a betrayal at the time, and I decided I would have to find a way to end my suffering without Hassan.

The note I penned to Hassan was both a farewell and an apology, a final attempt to articulate a pain that had grown too immense to bear. With each word, I hoped to convey a love that remained untarnished by the darkness that had enveloped my mind.

The concoction of psychiatric medication seemed to offer the promise of release. As I settled into the bath, the warmth of the water enveloping me, a calm took hold. The act was a resigned acceptance of defeat – an overwhelming desire to escape a world that had become unbearable.

The doorbell was the inadvertent saviour that pulled me back from the precipice. It was the home treatment team. If they discovered the note I had left on the side table, they would likely decide to readmit me to Prospect Park Psychiatric Hospital. With every ounce of willpower I could muster, I dragged myself out from the water's embrace, destroying the tangible evidence of my intent, before succumbing to the overwhelming lethargy that had begun to claim me.

> The future...appeared barren and devoid of hope

I woke in an unfamiliar environment, with the concerned face of a stranger hovering into view. The question: 'Am I in heaven?', reflected my longing for peace, for an end to the relentless turmoil that had characterised my existence. His reply, though gentle, anchored me to a reality I had sought to escape: 'No, you're in the Royal Berkshire Hospital.'

The disappointment that welled up within me was not just because my plan had failed, but because I had returned to a life that seemed devoid of solace or understanding. Yet, this moment also represented an opportunity to confront the pain and despair. It was a chance to recognise the presence of individuals who were invested in my wellbeing, even when I had felt most alone. The care worker's timely arrival, the medical staff's efforts to stabilise me – all were testaments to a network of support that existed, even in moments when it felt like all was lost.

Reaching out for help

My experience served as a catalyst for initiating crucial conversations about mental health, shedding light on the profound importance of reaching out for help and addressing the underlying causes of despair. This period highlighted the intricate and complex nature of the journey towards mental healing – a path often marked by numerous setbacks, yet also highlighted by significant moments of intervention, understanding and compassionate care.

This pivotal event in my life brought to the forefront the reality that mental wellbeing is not a destination, but a continuous process that demands patience, resilience and the courage to confront your deepest fears and vulnerabilities. It emphasised the need to dismantle the stigma surrounding mental health issues and create an environment where seeking help is not seen as a sign of weakness but as a step towards recovery and self-discovery.

The aftermath of this challenging time was filled with uncertainty, yet it was also imbued with the potential for profound personal transformation and a renewed hope for the future. It opened up avenues for deeper introspection and a better understanding of the intrinsic value of life, highlighting the possibilities for positive change and growth.

This phase taught me the importance of nurturing your own mental health, of being kind and patient with yourself, and of the power of supportive relationships and open communication in facilitating healing and fostering a stronger, more resilient self.

Each step forward, no matter how small, represented progress and a commitment to a healthier, more hopeful future. It was a journey of rediscovering joy, of opening up to love and possibility, and of stepping boldly into a future where mental wellbeing is prioritised and cherished.

Extracted with permission from *Show Me Heaven*, published by Arkbound. ■

Donna Taylor *works at a psychiatric hospital in Berkshire, where she was once an inpatient. She has a diagnosis of bipolar affective disorder.*

On the couch

WITH PHIL McEVOY

What are your current roles and responsibilities?

I am semi-retired, but I combine a part-time private practice as an adult psychodynamic psychotherapist with work for Age UK Salford.

Can you describe a typical working day?

In my private psychotherapy practice, I have appointments scheduled throughout the week, with a mix of online and face-to-face sessions. But no two days are the same. In my work with Age UK, I have a small caseload of family carers of people living with dementia. I also supervise the counselling team.

What are the highs and lows of your working life?

The highs and lows of psychotherapy can be extreme. The highs: I'm constantly gobsmacked by people's resilience, given some of their life experiences. Their ability to overcome adversity is hugely underestimated. The lows: the emotional weight of dealing with negative transference can sap your energy, especially when people are trapped in dark emotional places.

How did you get to where you are today?

I trained as a mental health nurse at Prestwich Hospital in Manchester. A few years later, I obtained a PhD Fellowship Award, which opened up new opportunities for me, academically and in clinical practice, where I managed a social enterprise that ran an Improving Access to Psychology Therapies (IAPT) service, now known as NHS Talking Therapies. My interest in psychotherapy was prompted by reading Robert Hobson's book, *Forms of Feeling: the heart of psychotherapy*,[1] which spoke of the importance of emotional engagement in therapy in a way that was new to me. The book encouraged me to pursue training in psychodynamic psychotherapy with the Tavistock Clinic.

How do you look after yourself?

I'm not sure that I do look after myself. But I like to read, write, play the guitar and walk the dogs with my wife. I'm also a member of a rock choir.

What's the most useful thing you have learned?

The most useful thing that I've learned varies all the time, as I'm always learning new things. There's a lot that I wish I'd learned but haven't, such as how to overcome my fear of public speaking. I'm still working on that one.

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

If I could change my professional life, I would extend it so I could work longer before I retire. I wouldn't change anything in my personal life, which has been truly blessed.

Who or what is your inspiration?

I'm inspired by the work of psychoanalysts such as Ron Britton, Thomas Ogden and Lynne Layton, an eclectic mix of psychoanalytic thinkers who have helped me to accept that sometimes we can be our own worst enemies.

What would you tell your younger self?

Try to read more literature and poetry.

What book would you recommend to other therapists?

I'd recommend a non-therapy book, *What You Have Heard is True: a memoir of witness and resistance*,[2] written by the poet and human-rights advocate Carolyn Forché. The book bears witness to the atrocities that were committed in El Salvador in the late-1970s, giving a deep insight into the roots of the culture of fear, without ever descending into gratuitous violence. Forché has also edited a tremendous poetry anthology, *Against Forgetting: twentieth century poetry of witness*,[3] which contains work by poets from around the world, who have suffered political oppression and persecution for their political beliefs. For me, it has been a gateway into poetry; before I read the anthology, I was only familiar with the poetry I'd learned at school.

Do you have a favourite song?

I don't really have a favourite song. I like listening to instrumental jazz music, perhaps Fergus McCreadie, Bill Evans or Keith Jarrett. But if I have to pick one, I'll pluck for an old one, *Romeo and Juliet*, by Dire Straits. I love the opening lyrics.

Who is your fantasy client?

My fantasy client, that's one I'd prefer to dodge. Our work takes us to places beyond our wildest phantasies.

In your dreams, you are...

I'm trying to get things done, but making huge gaffes along the way, so I never quite get there. I'm a bit of a blunderbuss really. ■

Phil McEvoy *is a psychodynamic psychotherapist, who works in private practice and for Age UK Salford.*

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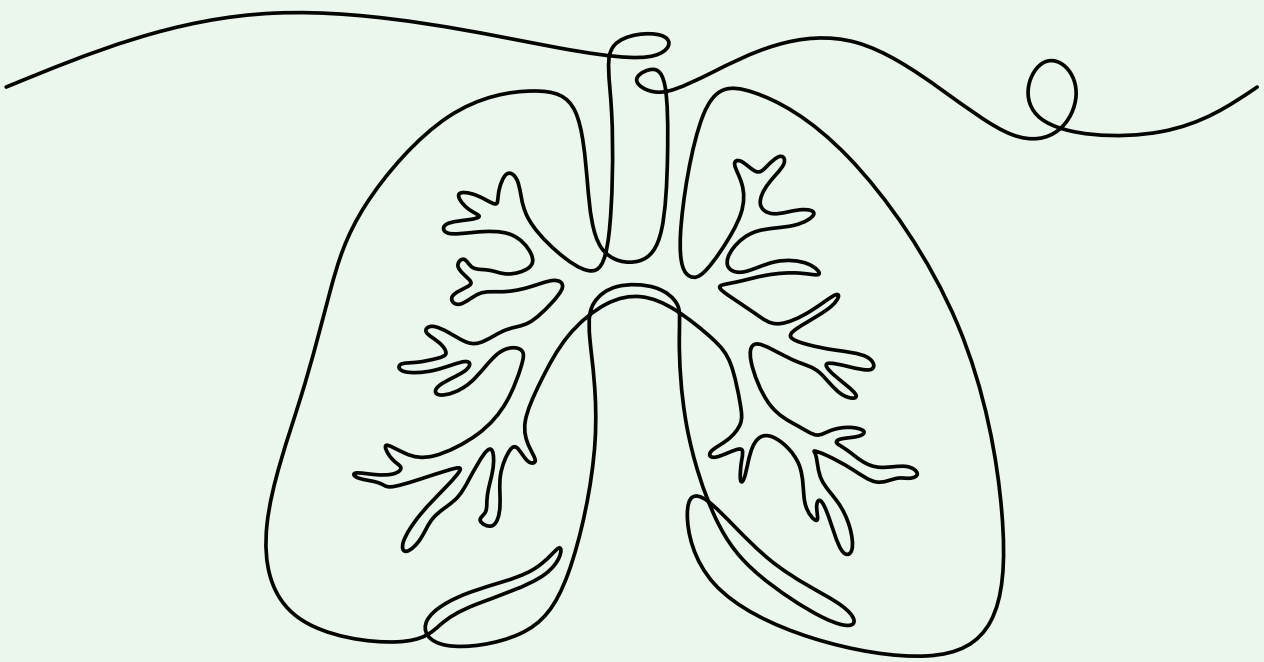
HOW **BREATHING** AFFECTS OUR **MINDS**



Anxiety and depression are more common in people who have respiratory diseases. But psychological support is often missing from care plans, writes ***Devi Sundar***

Breathing is important not only for our physical health but also for our mental wellbeing. There is a direct connection between breathing and mood regulation.[1] The nasal cycle – the spontaneous congestion and decongestion of nasal mucosa that switches every 60 to 80 minutes – also affects our emotional state.[2]

So, what happens if you have difficulty breathing? Chronic respiratory disease (CRD), which includes asthma, tuberculosis, pneumonia and chronic obstructive pulmonary disease (COPD), affects one in five people and is the third biggest cause of death in England.[3] Respiratory conditions are also the most common cause of emergency hospital admissions in England, accounting for 1.7 million admissions in 2023.[4] The Government estimates that lung conditions cost the NHS in the UK £1.9 billion a year.[5]

COPD is one of the most common respiratory diseases. About three million people in the UK have a COPD diagnosis, but a further two million people are thought to be undiagnosed.[6] COPD accounted for 108,891 emergency hospital admissions in 2022–2023.[7]

Physical symptoms

Treatment of respiratory diseases tends to focus on the physical symptoms, but we know that anxiety and depression are more common in people who have respiratory diseases than in the general population.

Anxiety or depression is present in 10% to 25% of COPD patients, rising to 50% when the disease is severe.[8,9] Depression occurs in 21% to 26% and anxiety in 16% to 22% of patients with obstructive sleep apnoea syndrome (OSAS).[10] Around 40% of patients with asthma have anxiety and 25% to 30% have depression; again, the rates are higher for people with severe asthma.[11]

In 2008, research strongly advocated for the inclusion of psychological and behavioural therapies in the management of COPD. However, comprehensive psychological support is still largely absent from integrated care plans for patients with CRDs.[12] Lung treatments focus on alleviating symptoms, such as inflammation and breathlessness, often neglecting psychological factors.[13] Moreover, medications, such as corticosteroids administered via inhalers, worsen anxiety and depression symptoms.[14]

> “Around 40% of patients with asthma have anxiety”

I have been working therapeutically for more than two decades with people who have respiratory diseases. I have observed how stress, anxiety, depression, burnout and low self-esteem affect their quality of life.[15] I therefore believe it is important to incorporate psychotherapy into the management of CRDs, recognising the complex relationship between the mind and lungs.

Respiratory conditions, such as COPD, compromise airflow, often resulting in weariness and breathlessness. For many patients, the disease is not only a physical but also a psychological challenge. It is not uncommon for patients to feel anxious, helpless and exhausted. The result is often social isolation, as the physical and mental struggles can make it difficult for the patient to go out of the house.

Lung rehabilitation (pulmonary rehab) is the gold-standard, non-pharmacological treatment for COPD. Lung rehabilitation is based on the biopsychosocial model of care and focuses on physical improvement through exercise, breathing techniques and education.[16] Lung rehabilitation can improve physical endurance and reduce symptoms, such as breathlessness. But it does little to address psychological problems. And a failure to address mental health issues can limit the overall effectiveness of pulmonary rehab.[15]

Let me take you through a fictitious case study. A 47-year-old woman with COPD was referred for pulmonary rehab. She achieved reasonably stable lung function, but her anxiety levels increased, exacerbating the breathlessness. She started smoking, in an attempt to relieve her anxiety. But the smoking aggravated her symptoms. As a result, she restricted her activities, so her health continued to decline. Ultimately, she lost her job because of the deterioration in her physical and emotional health.

The case study illustrates the interplay between mental and physical illness. The woman's anxiety amplified her physical symptoms. To alleviate her anxiety, she took up smoking. But smoking compounds respiratory symptoms, which can aggravate anxiety and, in turn, lead to heavier smoking, perpetuating a cycle of poor health outcomes.[17]

Anxiety and depression can also impair cognitive functioning, which can make it difficult for patients to adhere to prescribed treatment plans,[18] leading to a downward spiral in physical and mental health.[19]

It's important also to consider the relationship between stress, immune function and disease progression in conditions such as COPD. Chronic stress can enhance lung inflammation through the disruption of immune function.

GUIDELINES FOR GOOD PRACTICE

Drawing on my experience, both as a respiratory physiotherapist and psychotherapist, I propose some recommendations on good practice.

Primary care collaboration
GPs should collaborate with psychotherapists trained in chronic disease management. Collaboration could involve referring patients for psychological support and integrating psychotherapy into GP practices for a holistic treatment approach.

Multidisciplinary teams
A basic multidisciplinary care team should include respiratory specialists, psychologists, psychotherapists and behavioural analysts, to ensure that all physical and emotional challenges are addressed.

Patient education
Healthcare professionals, such as respiratory physiotherapists or nurses, could be trained to provide psychoeducation about the mind-lung connection, normalising psychological care in CRD management. They could also offer low-intensity counselling support in underfunded centres.

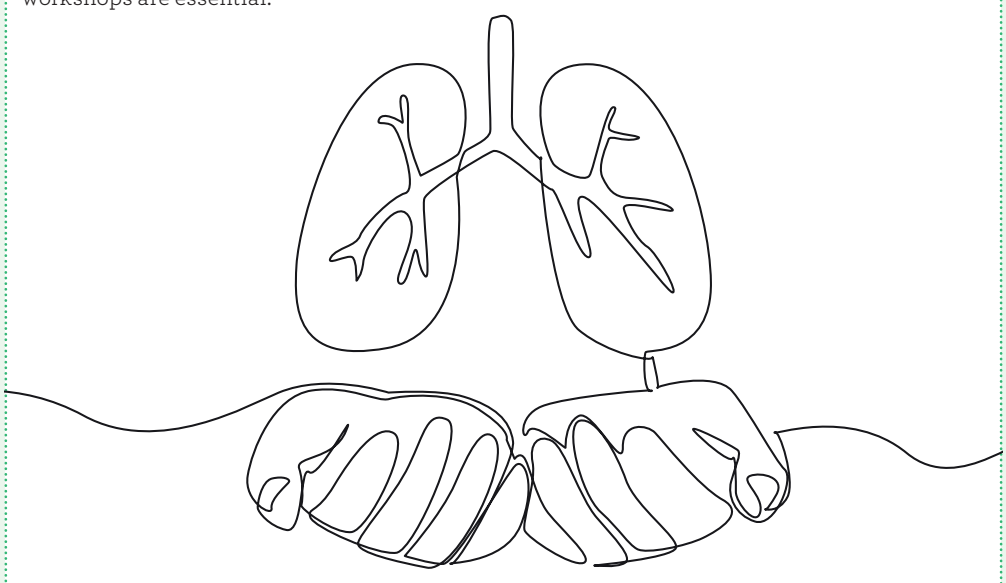
Community support programmes
Community programmes could provide physical rehabilitation and psychological support to reduce social isolation. Group therapy, support groups and stress-reduction workshops are essential.

Therapeutic techniques
Incorporate techniques, such as mindfulness, diaphragmatic breathing and relaxation exercises, to help manage anxiety, stress and breathlessness, promoting self-management.

Undergraduate education
Integrate psychotherapy training into the undergraduate curriculum for healthcare professionals, particularly for respiratory care and physiotherapy students, to ensure early exposure to the psychological aspects of chronic respiratory management.

Pre-screening
Psychological trauma, past injury and genetic/environmental predispositions, such as air pollution and smoking, play a role in CRD management. Early identification enables tailored treatment plans, improving patient care by addressing both physical and emotional aspects.

Duration of psychological intervention
Incorporating six to eight sessions of psychological interventions helps patients develop coping strategies, improve emotional regulation and build resilience, enhancing overall management alongside traditional respiratory treatments.



Stress hormones, such as cortisol, further increase inflammation and accelerate disease progression.[20] High markers of stress, such as C-reactive protein and interleukin-6, have been consistently associated with poor outcomes in COPD.[21] Additionally, depression has been shown to increase the production of pro-inflammatory cytokines, worsening inflammation and complicating COPD management.[22]

Integrated care
In my view, effective management of CRD is possible only when patient care integrates psychological therapies with physical interventions. I would suggest incorporating at least six to eight sessions of psychological therapy into CRD care management for maximum effectiveness. The following therapeutic interventions have all been shown to be effective.

Cognitive behavioural therapy (CBT)
CBT helps the patient to identify and alter any negative thoughts and behaviour, reducing anxiety and alleviating pain.[23]

Mindfulness-based stress reduction (MBSR)
MBSR is a mix of mindfulness, meditation and yoga that helps to regulate the emotions and thereby lower stress levels. Studies indicate that MBSR reduces fatigue, breathlessness and stress, while enhancing the overall quality of life for CRD patients.[24]

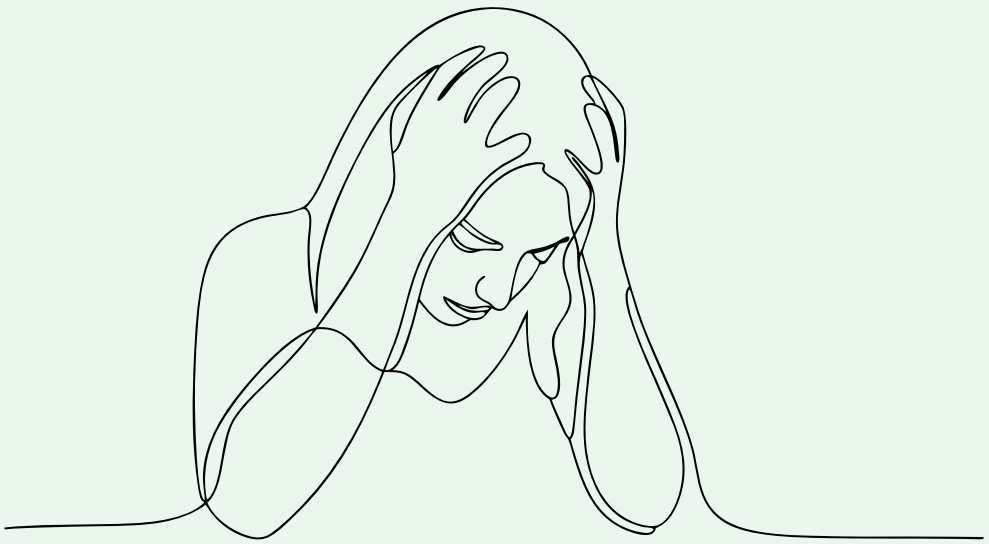
Acceptance and commitment therapy (ACT)
ACT aims to foster emotional resilience and enables patients to live a rewarding life, despite their chronic disease. Recent research concluded that ACT can improve mental health and daily functioning, although it's not effective for everyone.[25]

Breathing retraining
Therapeutic breathing exercises, including diaphragmatic and paced breathing, can reduce fatigue and relax the patient with COPD,[26] aiding the management of physical symptoms.

Hypnotherapy
Hypnotherapy is increasingly used in the management of chronic conditions, including CRDs.

Hypnotherapy has been shown to reduce breathlessness and anxiety, while lightening the psychological burden of chronic illness.[27] It is also effective in dealing with addiction, particularly smoking or substance use, that can worsen respiratory conditions.

I believe the integration of psychotherapy into CRD treatment will result in better outcomes for patients and a reduced healthcare burden. As healthcare professionals, we must be conscious of the strong connection between the lungs and the mind, and approach patient care from a holistic perspective. ■



***Devi Sundar**, founder of Tele-Therapies and Mind-Body Consultant, specialises in respiratory physiotherapy, integrative psychotherapy, neuroscience coaching and hypnotherapy. She offers holistic care for lung and mental health, advocating for the integration of psychological therapies in healthcare.*

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WAKE UP TO THE BENEFITS OF SLEEP!

Poor sleep can affect our mental wellbeing, which is why ***Ruth Webb*** puts sleep problems at the forefront of her work with clients

We all know that poor sleep affects our ability to function, which is why it's important to prioritise our sleep needs. But how many of us consider sleep when we are working with clients?

As a qualified sleep practitioner, I believe that many client issues are exacerbated by sleep deprivation. Poor sleep can also inhibit the motivation to change. So, I work with sleep problems at the forefront of my therapeutic practice.

What is sleep and why do we need it? We still don't fully understand sleep, despite a wealth of research. However, we do know that sleep is an essential biological function: we can last far longer without food and water than without sleep.[1]

When we are asleep, we are in a state of reduced consciousness and our muscles are paralysed. However, there is a great deal going on when we are asleep. We don't just crash out; sleep is a restorative and rejuvenating process.

Growth hormones are emitted during sleep, which is why sleep is particularly important for children. Leptin and ghrelin are two other hormones that are both linked to sleep. Leptin is an appetite suppressant, which is released while we sleep. Ghrelin is an appetite stimulant, which is discharged when we are awake. The longer we are awake, the more ghrelin is released. Hence the link between sleep deprivation and the increased risk of obesity.[2]

Circadian rhythm

We all have our own, unique circadian rhythm, a cycle of approximately 24 hours, which influences our sleep pattern. It is governed by the hypothalamus area of the brain, which is responsible for the release of melatonin, the sleep-inducing hormone, and cortisol, which keeps you alert.[3]

The homeostatic sleep drive also shapes our sleep pattern. Essentially, the longer you have been awake, the greater the urge to sleep. Our sleep need is lowest in the morning and highest in the evening, apart from a 'siesta' time at about 2pm, when a natural peak in our sleep drive is triggered and melatonin is released, making us feel sleepy.

The hypnogram shows we fall quickly into 'stage three sleep', the deepest of the sleep stages, when we are unresponsive to stimuli. So, we would not be aware if someone broke into our house. The second part of the night is characterised by periods of shallower sleep and rapid eye movement (REM) sleep. During REM sleep, information and emotions from the day are processed and either discarded or put into long-term or short-term memory. We also naturally wake up twice in the night. The awakenings should be brief and we should quickly resettle. We might not even remember we have been awake.

Every stage of sleep is important. For example, a reduction in our REM sleep can affect our memory consolidation and processing of daily information. We know, for example, that studying into the early hours is counterproductive, because it reduces the capacity to retain and process information.[4] Research has also shown that an hour's extra sleep a night can result in a 50% increase in grades.[5]

Sleep debt

Everyone has their own unique sleep need, which cannot be changed. We can alter the timings of when we sleep, but if we don't get enough sleep, we incur a sleep debt – and this is when the problems can begin.[3]

The implications of sleep deprivation are serious and far reaching, but they are often overlooked. For example, symptoms attributed to attention deficit hyperactivity disorder (ADHD), such as poor concentration and hyperactivity, can be present with sleep deprivation. We can also appear overstimulated, rather than drowsy, when we are deprived of sleep.

'Brain fog' is a term often used by clients whose ability to think rationally and clearly is compromised. Brain fog can be the result of sleep deprivation, as the frontal lobe of our brain, which controls our executive functions, is affected by lack of sleep.

> "Poor sleep can inhibit the motivation to change"

Accidents, such as the Selby train crash, have been attributed to human error due to sleep deprivation.[6] Police statistics also show that fatigue contributes to about 4% of fatal road crashes and 2% of all collisions in the UK.[7] However, the true figures are likely to be higher because fatigue is hard to spot. Worldwide, it is estimated that between 10% and 20% of all road crashes are fatigue related.[8]

If we follow our body's sleep cues and rhythms, a standard sleep cycle might be between 11pm and 7am. But our lives do not necessarily conform to the standard. Shift work, for example, has a huge impact on our body clock, forcing us to fall asleep in the day and stay awake at night, when the biological signals are priming our bodies to sleep.

Late nights at weekends also push our circadian rhythm out of sync, making it more difficult to return to a normal pattern in the week. We also overrule our cues to sleep. For example, stimulants, such as sugary foods, caffeine and alcohol, override the release of melatonin, making it harder to sleep.[9]

Our sleep is often affected if we are stressed or anxious. Stress and anxiety can make it difficult to fall asleep; we might also struggle to get back to sleep, if we wake up in the night. We can then develop an anxiety about sleep and a dread of going to bed, which only exacerbates the problem.[10]

Research from the early 2000s suggested that blue light from computers, phones and TVs suppresses melatonin levels, which interferes with the body's natural sleep cycles. The research also suggested that it takes at least an hour for the effect of blue-light stimulation to wear off. Sleep plans therefore advise abstaining from the use of technology at least an hour before bedtime, to give the body time to wind down and relax.[11] But the study only measured the time it took people to fall asleep when they had been using blue-light devices. It did not compare the times with people who had not been exposed to blue light.

Recent research into the influence of light on sleep onset has produced some surprising results. The brightness of the screen, which was previously thought to be one of the greatest sleep disrupters, was found to have very little impact.[12] The content of the material was also explored in the research. Logic would predict that someone who played a violent video game before bed would find it harder to fall asleep than someone who watched a nature programme. Surprisingly, the results showed that content had little impact on the ability to fall asleep.[12]

> Sleep is a restorative and rejuvenating process

The way we use technology can also affect our sleep, as the amount of time we spend on our screens can lead to sleep deprivation. Research therefore suggests that personality is a contributory factor to sleep problems. People who can acknowledge the importance of turning off technology to maintain a consistent bedtime are more likely to be successful. People who are prone to risk-taking behaviours struggle with this self-imposed boundary and are therefore more likely to run up a sleep debt.[12]

Rapid eye movement (REM) and dream sleep
- Light sleep but busy brain
- Heart rate and blood pressure increase
- Breathing is fast and shallow
- Processing emotions
- Relieving stress
- Learning takes place, memory consolidation
- Muscle paralyses
- Nightmares occur

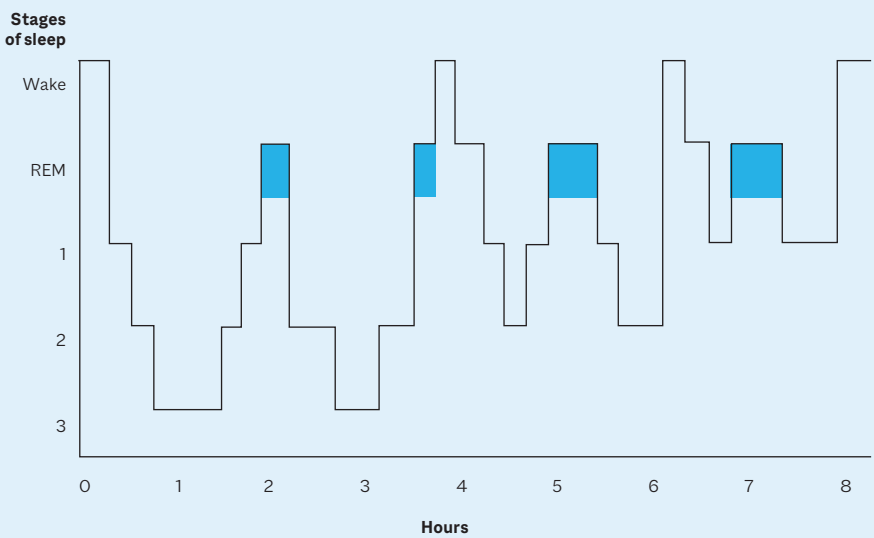
Stage 1 sleep
- Drowsy but easily woken
- 10–15 minutes to fall asleep

Stage 2 sleep
- Body temperature decreases
- Heart rate slows
- Fairly light sleep, not woken easily

Stage 3 sleep
- Muscle paralyses, hard to wake
- Biologically important – tissue repair, hormone production, growth and cortisol
- Sleep disorders in stage 3 – bedwetting, night terrors, sleepwalking and sleep apnoea

Hypnogram

Babies spend half of their sleep in REM
Three year olds spend a third of their sleep in REM
Children over 10 and adults spend a quarter of their sleep in REM



Source: Sleep Action, 2010. https://tinyurl.com/4pu4du6y

The latest research has prompted a subtle shift in the focus of my work. In the initial assessment, I gather information, such as sleep time, wake time, number and time of night wakings. I also ask the client to keep a sleep diary for a week. But I now aim to quickly identify if the client is able to stick to a regular bedtime and a regular wake time, or if there are any difficulties in setting and maintaining sleep boundaries.

After an initial assessment, I draw up a sleep plan with the client. The sleep plan emphasises the importance of sleep hygiene and a sleep routine. But it also takes into account the client's personality. I can then tailor the plan to their specific needs.

Tackling sleep problems at the outset of the therapeutic process helps to identify issues that were caused or exacerbated by poor sleep. I often find that some or all of the client's presenting issues improve or disappear when sleep improves. The sessions can then prioritise the issues that remain or that are still problematic. The client is also in a better place to deal with any remaining difficulties, as they are not sleep deprived. ■

Ruth Webb *is an integrative counsellor working in private practice, with a special interest in looked-after children.*

The following, fictitious case study demonstrates how I might incorporate into client work the recent research on how blue light, the content of technology and the role of individual personality can affect sleep onset.

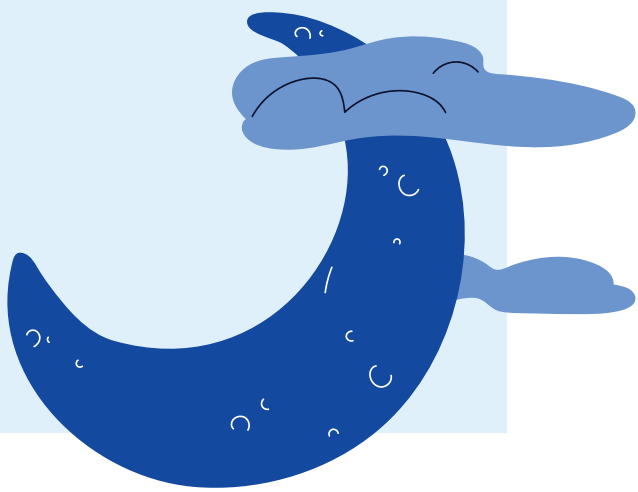
Sam is a 22-year-old man who works full time and lives with his partner. He came to counselling because he was struggling with anxiety, low mood, exhaustion, delayed sleep onset, overeating and relationship issues due to gaming. My starting point would be to improve Sam's sleep, as sleep deprivation could be contributing to his low mood, anxiety, day-to-day functioning and eating issues.

I ask about Sam's typical bedtime routine. I also find out about the bedroom environment. Is it a clutter-free space? Is the bed comfortable? Does the room have blackout curtains? What is the temperature? I also discuss with Sam when and what he eats. In addition, Sam keeps a sleep diary for a week, so that I can assess his sleep pattern, including time in bed, time asleep, any night wakings and time he wakes in the morning.

I use all the information to help devise a sleep plan. The sleep plan advises Sam to dim lights on devices and switch them off an hour before bedtime. I also recommend that Sam tries calming techniques and considers pre-bedtime alternatives to gaming, such as reading or podcasts. In addition, the plan includes advice on sleep hygiene, anxiety management and psychoeducation on eating patterns and the impact of hormones. I also recommend Matt Walker's book, *Why We Sleep: the new science of sleep and dreams*.[13]

The sleep plan makes a big difference to Sam, as he is able to fall asleep quicker and stay asleep longer. Consequently, his mood and energy levels improve. Sam's relationship also improves, as he is not staying up alone to play computer games.

The sleep plan has a positive effect on his eating, too. Sam is asleep for longer – and he isn't reaching for sugary snacks and drinks to maintain his energy levels to continue gaming. The residual issues of anxiety and work/life balance can then be worked on.



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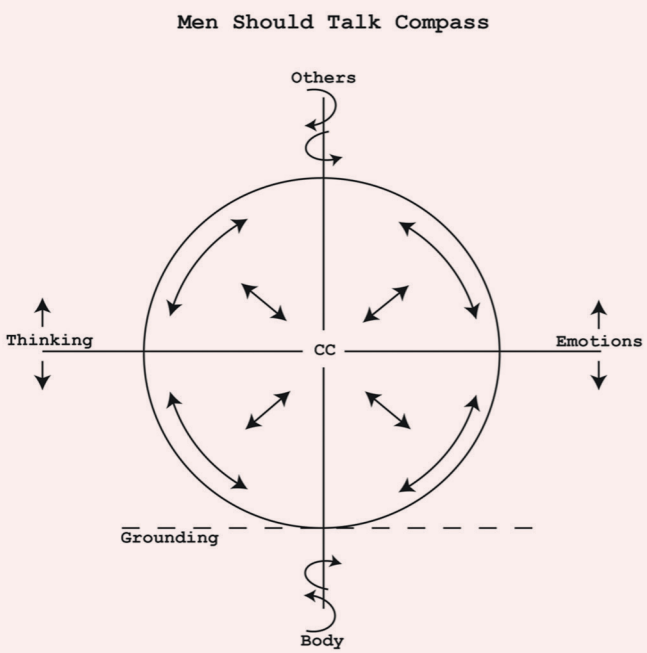
COMPASS POINTS

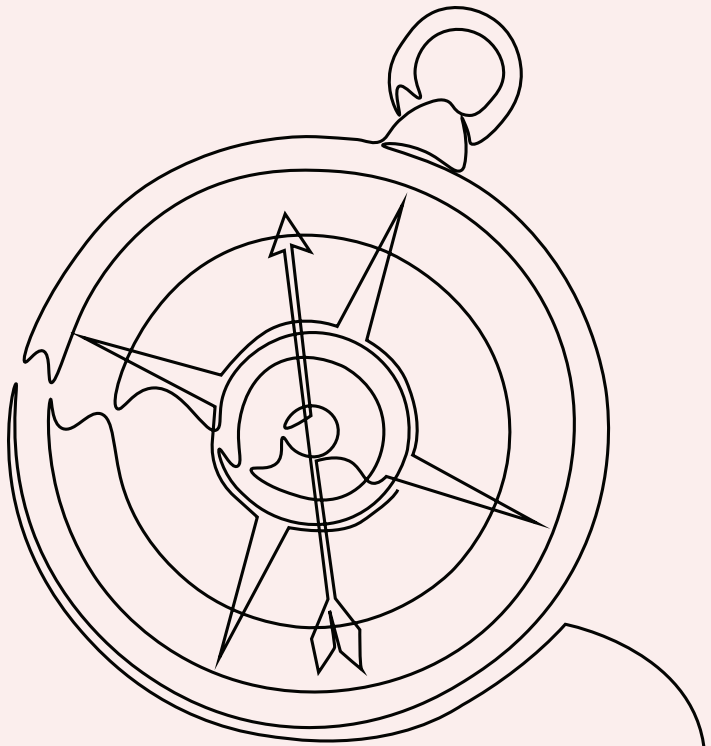
Gareth Palmer uses the model of a compass to help men understand themselves and navigate their mental health

Men often come to therapy because they want to find a solution to a problem. My method is to help them understand their situation by thinking of their lives as determined by a powerful, if unarticulated, compass. It is a non-gendered model, but my working experience is with men.

As we can see from the diagram, the body is 'south' on the compass. At Men Should Talk, we explore how the physical body was developed in relation to the needs and demands of others, who are 'north' on the compass. If we can understand how this vertical axis operates, we can understand why we feel compelled to respond to others in a particular way.

At west and east on the horizontal axis are thinking and emotions. The interaction between thinking and emotions helps shape our decision making. The long-term aim of the therapy is to open up a mindful space at the centre of the compass, so the client can make choices that are free from compulsion and habit.





We are a tribal people, whose principal drive is to survive. If we don't follow cultural norms, obey social conventions and fit in, we run the risk of exclusion from the tribe, which would threaten our survival.

The expected self

So, we develop an 'expected self', through our interactions with others. As we grow up, other people come to know our expected self – and their expectations reinforce our identity.

Some people are comfortable with their expected self, perhaps if they have been allowed freedom to explore and express their thoughts and feelings, to experiment with their identity. But others are less at ease. As the expected self requires dedication to the public face of their identity, they are constantly fearful that they will do or say the wrong thing.

The four points of the compass help the client to understand the way in which the self develops and how it navigates the world.

In many cultures, the male body is expected to be 'fit for purpose'. The man fulfils duties and carries responsibilities, so his physicality must reflect his role. It's a mechanical understanding of the body; the body is a machine. Consequently, men are conditioned to downplay their aches and pains and adopt an 'accident and emergency' relationship to the body: if it's serving its function, there is no need to pay it much attention.

> Some people are comfortable with their expected self

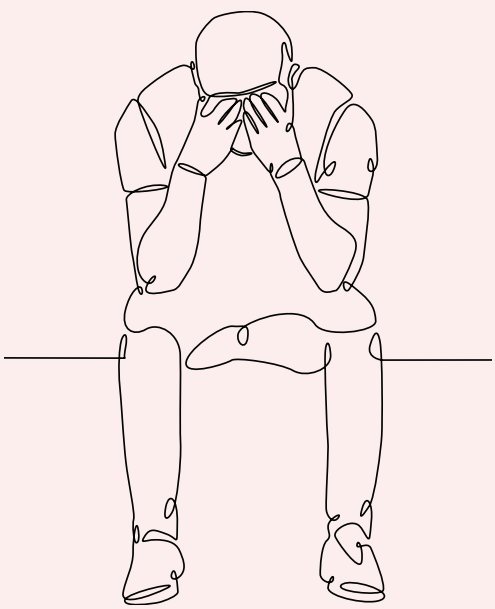
When I ask men about self-care, they typically talk about nutrition, exercise, grooming – ways to maintain the machine. Popular culture and online advice also suggest that good health is visible: glowing skin, a six-pack or a well-fitting suit. What's missing is a form of self-care that requires men to be caring and compassionate, to listen to their bodies.

The idea of the masculine physique – and the visibility of good health – perhaps explain why many men regularly go to the gym. The gym is the ideal forum for the public display of allegiance to the expected self. Similarly, we can think of tattoos as markings that publicly identify the male body as signed up for service, whether it be to the family, an army regiment or a football team. Tattoos are visible signs of the man's dedication to established norms. They could even be seen as the ritual sacrifice of the body to the expected self.

I encourage men to reflect on how their bodies have developed. Did they experience nurture? How does the body nurture itself? How is intimacy expressed? Is the body used in the service of others? How does the body find its boundaries? How did his father treat his own body?

If boys have been raised in families in which men were not warm and affectionate with their partners, intimacy can be problematic. When a father is dedicated to an expected self that rules out intimacy, the children might feel

> I encourage men to reflect on how their bodies have developed



anxious about their own bodies. They might also focus on performance or conquest rather than authenticity and mutuality. Therapy is a space where the client can, for example, uncover the extent to which his body has grown strong and muscular in order to meet the needs of others in his family or peer group.

Expectations of others

Others are due north on the compass. The mother is often the first other, but both mothers and fathers are fundamental in developing the expected self of the growing child. We consider in therapy the ways in which children are shaped by the expectations of others, by the need to fit into their tribe. We also think about the different tribes that emerge and influence our identity. For example, in adolescence, the peer group can become dominant, and sometimes in conflict with the family.

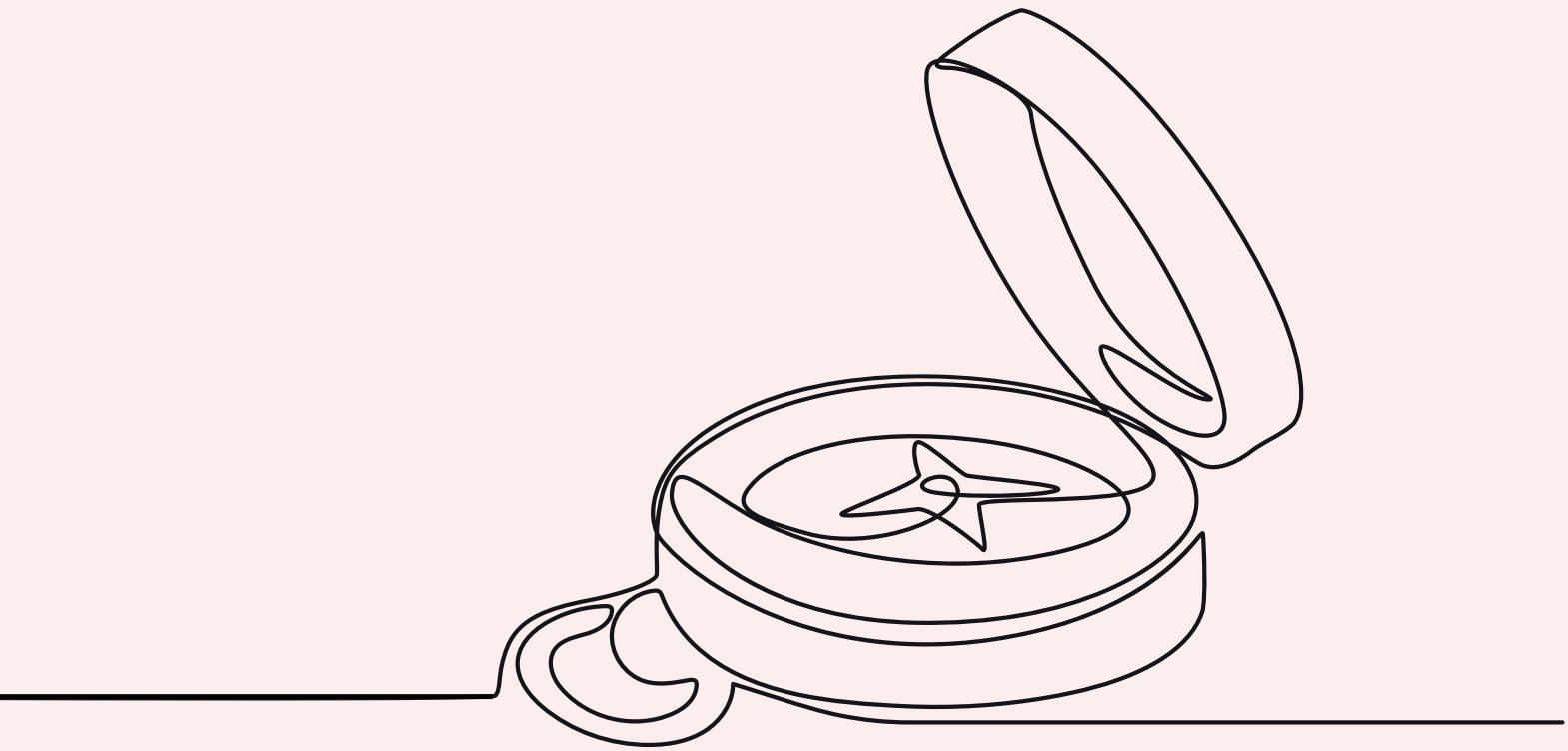
We have to understand how the vertical axis – the relationship between the body and others – has operated in the construction of the expected self, before we can consider thinking and emotions on the horizontal axis.

For many men, thoughts often represent 'calls to action' – the need to respond, to act, to do something. For example, many men would take on an extra shift at work rather than take time for self-care. Consequently, men often feel bullied by their thoughts.

We begin this part of the therapeutic enquiry by considering thoughts – and actions – in relation to cultural convention, the duty and responsibility of the expected self. If we can understand how we practise obedience to the expected self, we can also understand why our thoughts and actions feel 'automatic' and unquestionable. We can also gain some distance and perspective, which can liberate us from the dominance of the expected self.

Social status

For example, we might explore thinking patterns that suggest a sensitivity to social status. Or we might look at binary thinking patterns (yes/no; good/bad). Exploration of thinking can cause anxiety, but anxiety can give way to relief, as the client recognises that their thinking was shaped by their culture and its conventions, which in turn played a role in building their expected selves.



In our society, men's emotional expression is often muted by the expected self and its allegiance to social convention. Except in certain 'authorised' areas, such as sport, many men equate emotions with weakness. The 'strong, silent' type might be a cliché, but it's a powerful cliché that is celebrated in many cultures. The result is often a struggle for dominance between the emotions and the expected self. The tension can lead to anxiety: the man fears that his emotions will be revealed and his weakness exposed. He must therefore remain vigilant.

> In adolescence, the peer group can become dominant

And that can make relationships difficult, as relationships usually depend on emotional expression and commitment. If a man's expected self has limited access to his emotions, he will be slow or even unable to enter into a relationship, because it's too risky. In my experience, relationships often break down because the man withdraws from his partner, taking refuge in the 'safety' of the expected self.

Pressure to serve

The pressure to serve the expected self, to subdue private thoughts and feelings, perhaps explains why some men find relief or solace in alcohol, drugs and pornography. In such spaces, they might be able to express themselves to other men, with less fear of censure. They might also feel able to reveal pain or trauma, which is usually subjugated by the expected self.

Men feel impelled towards certain thoughts, emotions and behaviours, in order to meet expectations, conform to convention and obey the expected self. Therapy can open up a space in which the individual can learn how he developed his expected self, hopefully enabling him to make choices rather than following compulsions. To sit at the centre of the compass is to acknowledge, accept and explore the value of emotions, which can lead to a more balanced and easeful way of being. ■

Gareth Palmer *set up Men Should Talk in 2013. He is trained in hypnotherapy with psychotherapy. He is also a member of the Western Chan Fellowship, which runs Buddhist meditation retreats. Gareth's book,* The Expected Self: alignment, balance, choice, *is available now.*

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