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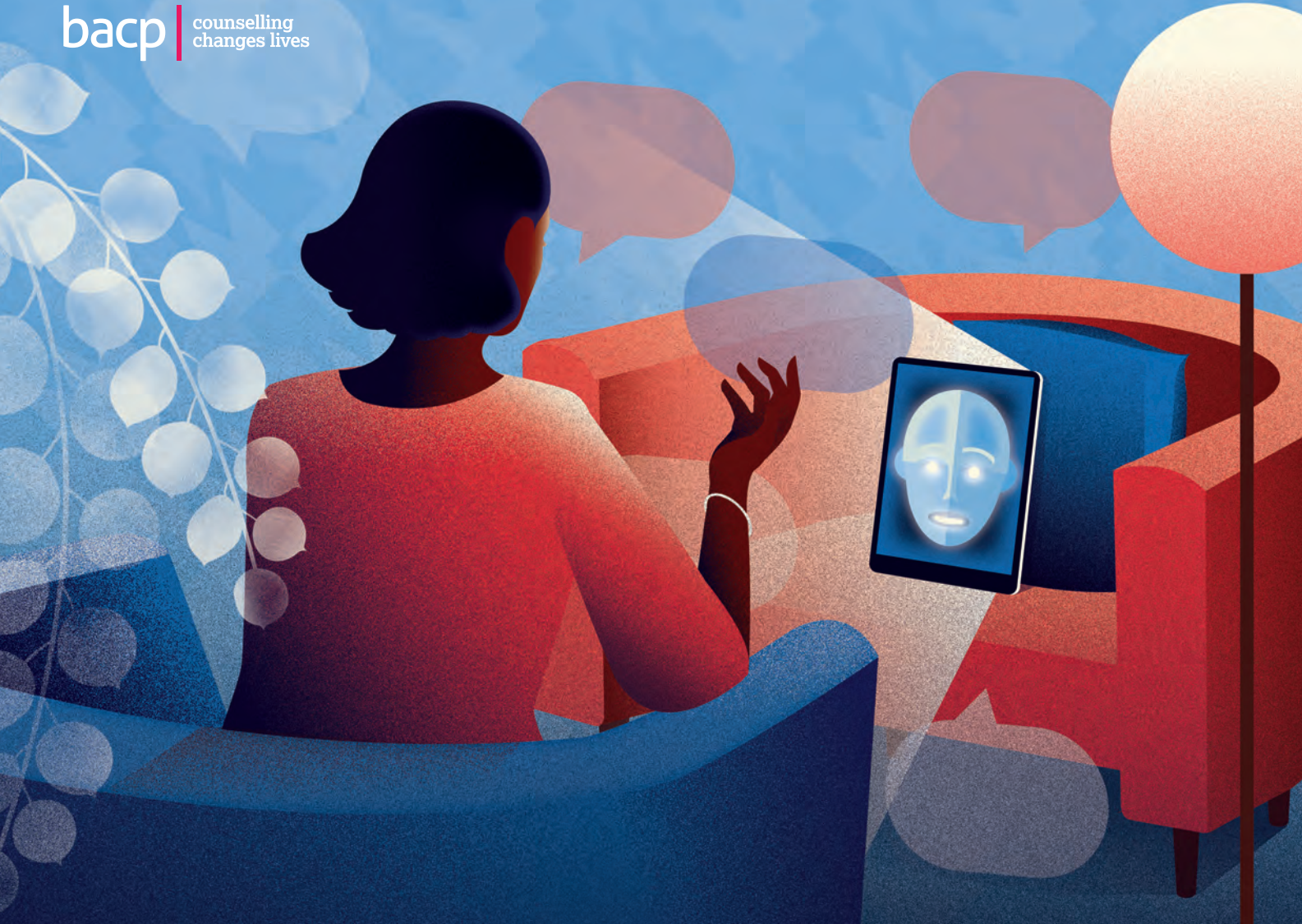
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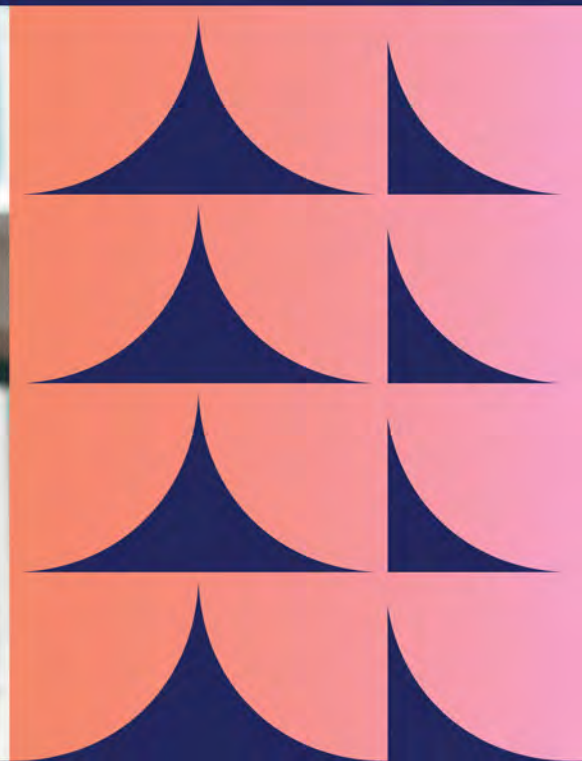
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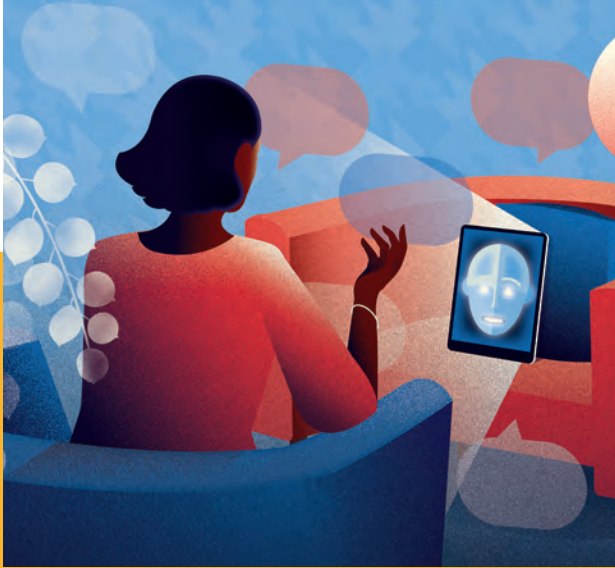
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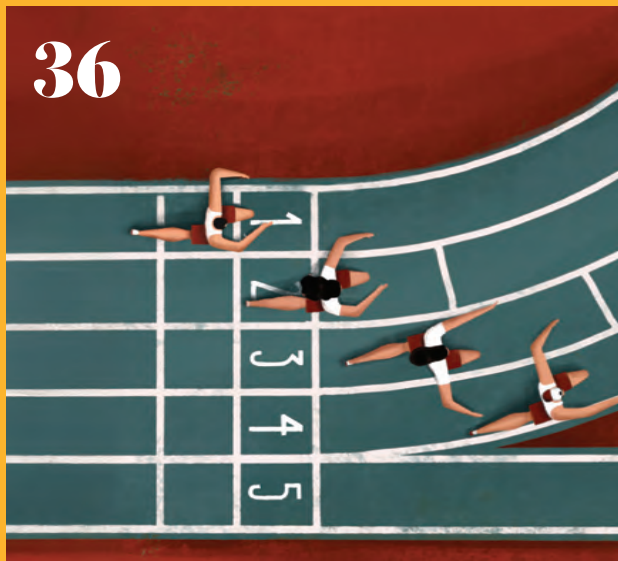
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THERAPY TODAY

As Editor I receive hundreds of emails and proposals a week. Choosing what to feature is a delicate dance. Sifting through each one and allowing myself to be impacted by each pitch, I go through lots of feelings. Some pieces hit me instantly. Sometimes, hours later, I'm still thinking about something I read. Rahi Popat's piece on reputation in Asian men (page 32) was one of those. It got me thinking about the role of reputation in my own Greek Cypriot family culture, and then about how much reputation permeates so much of what we do. In our online world, with social media algorithms primed for us to respond and react to what we're seeing, thoughts about our work and what we do are out there. Having ourselves 'goldfish-bowled' can keep us accountable and likewise vulnerable too. Whether you're in a public-facing role or not, the online world exposes most of us to scrutiny. In time, our ability to turn away reduces as we're forced to

“Engagement with the digital realm can leave those without the capacity to do so feel vulnerable and “left behind””

adapt to change. Engagement with the digital realm can leave those without the capacity to do so feel vulnerable and 'left behind'. As AI continues to evolve as the latest digital and technological development, we are left with an existential choice: do we reject it and hold on to our traditions – and if so how long do we hold back before there's no other option – or do we embrace everything it has to offer? Sally Brown does a great job of tackling the nuance of what AI means for us in our 'Big issue' feature on page 22. Our reputation precedes us, and in turn shapes our future.

Katerina Georgiou MBACP (Snr Accred)
Editor



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Vicki Petrou

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Sarah Lloyd

Noticeboard

Our monthly digest of news, updates and events



IN THE KNOW

NEWS REPORT



Increase in therapists working in the NHS

PEOPLEIMAGES-YURAI/SHUTTERSTOCK

New data released by NHS England and the NHS Benchmarking Network from the Psychological Professions National Workforce Census reveal an 18% increase in counsellors and 19% in psychotherapists working with adults. In 2023-2024, there was a 4% reduction in child and adolescent psychotherapists but a 42% increase in psychological therapists and 13% in CBT therapists working in the NHS compared to 2022-2023.

This comes after the workforce plan committed to expanding the psychological professions workforce by 24,000-26,000 practitioners (nearly double its current size) by 2037.

Matthew Smith-Lilley, BACP's Policy and Engagement Lead for Mental Health, said: 'It's encouraging to see increasing numbers of counsellors and psychotherapists in the NHS. This is a positive upward trend. However, we recognise that there are gaps in the data because of responses missing from some organisations. The key data presented are very likely to be an underestimation of the true numbers of psychological professionals working within the NHS.'

'The near doubling of the psychological professions workforce is an incredibly ambitious programme of expansion and will present many opportunities for counsellors and psychotherapists.'

Read more at bacp.co.uk/news/news-from-bacp/2025/9-may-increase-in-counsellors-and-psychotherapists-working-in-nhs

*AUTISM.ORG.UK/ADVICE-AND-GUIDANCE/WHAT-IS-AUTISM

700,000

The number of diagnosed autistic adults and children in the UK*

BACP NEWS



BACP New Researcher Award 2025

Congratulations to Olivia Jones for her research, 'Investigating how trainee and qualified counsellors navigate the mental toll of working in a hospice setting'. Olivia's research aimed to explore the lived experience of counsellors working in a hospice, including how they experienced and responded to the mental toll on their profession and how they were supported.

Previous research regarding working with grief and bereavement in hospice settings has mostly focused on nurses. However, this qualitative study focused on how counsellors navigate the mental toll on their profession of working in a hospice. Findings identify counsellors' use of self-care and reflection techniques, and highlight the importance of workplace belonging and organisational support.

Olivia said: 'I felt incredibly shocked and truly grateful to receive the news that I'd won the New Researcher Award 2025. I'm so thankful that my research has gained such recognition from BACP.'

Many congratulations to Olivia from everyone at BACP.

Find out more at bacp.co.uk/news/news-from-bacp/2025/16-may-bacp-new-researcher-2025



MIKE SEWELL

FROM THE CEO

Phil James,
Chief Executive
Officer

This edition takes artificial intelligence (AI) as its central theme. BACP (and humanity at large) is grappling with the ethical and practical implications of the rise in AI. I thought it might be interesting to give AI an opportunity to speak for itself. I asked whether our profession should be fearful of AI, and here's what came back:

'AI is neither inherently good nor bad – it is simply powerful. Like any powerful tool, its impact depends on how it's used, who controls it, and the values that shape its design and deployment. In some sectors, AI is already proving transformative: streamlining repetitive tasks, supporting early medical diagnosis and even helping tailor learning for children with complex needs. But in others, particularly human-centred professions like counselling and psychotherapy, the conversation is more nuanced. Therapy is, at its heart, a human process. It relies on presence, empathy, intuition – the subtle dance of human connection that can't be coded or cloned. And yet, AI is creeping into the therapeutic space, whether we like it or not. Chatbots now offer basic emotional support. Platforms analyse tone and sentiment in conversations. Tools promise to match clients with the "right" therapist using algorithms. Some see this as opportunity; others, as existential threat.'

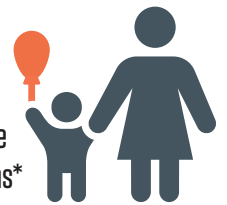
Thinking about this response, it's right to approach AI with a critical eye. We should question who benefits, what's lost and where professional judgment is irreplaceable. We should also be curious, to find out about how AI could help because the very questions we ask go to the heart of what makes us human.

AI isn't going away. The challenge, I think, is not as simple as human versus machine but to stay distinctly human in a changing world, to shape the future rather than fear it.

It was an interesting experiment. Asking for AI's view on AI's potential for our profession has left me with mixed feelings. I suspect I've unknowingly spoken with AI before. I'm certain we'll be meeting again.

45%

The percentage by which early psychological interventions reduce transition to psychosis at 12 months*



BACP NEWS



UK counselling and therapy trends and attitudes revealed

More than a third (35%) of UK adults have sought help from a counsellor or psychotherapist at some point in their lives, according to our annual Public Perceptions Survey.**

Each year we ask more than 5,000 UK adults about experiences of, and attitudes to, therapy and mental health. The survey, carried out by YouGov, also looks at how people cope with and are affected by issues in their own lives, work and family.

Our survey found more than seven in 10 adults who've had therapy found it helpful (73%) and three-quarters (75%) would recommend it to anyone looking for mental health support and to improve their wellbeing.

Dr Lisa Morrison Coulthard, BACP Director of Professional Standards, Policy and Research, said: 'Counselling and psychotherapy have the power to transform lives, and the data from our survey illustrate the importance of timely access and choice. Good mental health in all areas of our lives is something to celebrate – as is the reduction in stigma around therapy. The value of high-quality, ethical therapy to provide a safe, non-judgmental and confidential space to talk about your issues and concerns cannot be underestimated.'

Read more at bacp.co.uk/about-us/about-bacp/bacp-public-perceptions-survey

** SURVEY DATA WERE COLLECTED USING A SELF-COMPLETED, ONLINE METHODOLOGY. A NATIONALLY REPRESENTATIVE SAMPLE OF 5,150 ADULTS (AGED 16+) WAS TAKEN FROM YOUGOV'S ONLINE RESEARCH PANEL AND RESULTS WERE WEIGHTED TO PROVIDE A NATIONALLY REPRESENTATIVE DATASET. FIELDWORK FOR THE 2025 SURVEY WAS CONDUCTED 15 FEBRUARY TO 4 MARCH 2025.

*CAMBRIDGE CORE JOURNAL'S/PSYCH-OPENARTICLE/CBT-FOR-DEPRESSION-AND-ANXIETY-ADAPTED-FOR-PSYCHOSIS-RISK-IN-PRIMARY-CARE-CONTROLLED-TRIAL-TO-ASSESS-FEASIBILITY-AND-SIGNALS-OF-EFFICACY/7071C4498AD9684E034AE338D11248B

SOUTHWORKS/SHUTTERSTOCK

DIARY DATES
bacp.co.uk/events

3
JULY
ONLINE

Integrating coaching into your counselling practice
Half-day workshop



9
JULY
BELFAST

Making Connections
Free CPD and networking event for members



The NHS estimates that **1 in 3** people will care for someone with dementia at some point in their lives*



BACP EVENTS

Making Connections events

Free to all members, our regular in-person Making Connections events take place throughout the year. Join us over the next 12 months in locations across all four nations of the UK.

All Making Connections events offer opportunities to network with members, colleagues, BACP staff and some of our divisional executive committee members. Each event includes three CPD presentations followed by a Q&A with the presenter.

Booking includes access to the event recordings, which will be available for three months after the event. Lunch and refreshment breaks will also be provided.

Book now at bacp.co.uk/events 🖱️



*ENGLAND.NHS.UK/MENTAL-HEALTH/DEMENTIA



Spreading the word

Promoting our members and our profession through the media

BBC Radio 4's *Woman's Hour* interviewed **Charlotte Jefferson** on the topic of intimacy, sex and grief. • **Susie Masterson** and **Georgina Sturmer** examined how to reconcile with family members following a fallout in *The Guardian*. • **Heather Garbutt** and **Jane Darougar** commented in *Metro* about dating problems and annoying tube travel habits respectively. • **Billie Dunlevy** was interviewed by BBC Radio Leicester about the pros and cons of AI therapy. *The Times* also featured Billie in their article about young people turning to AI for therapy. • **Jeanine Connor**, **Kate Bufton**, **Nikki Howes**, **Stefan Walters** and **Helen Hazell-English** featured in *Stylist* discussing obsessive morning routines, growing use of snus nicotine pouches and child favouritism. • **Nicola Saunders** gave parents advice on managing their teenagers if the Government imposes a curfew on social media on *Yahoolife!* • **Kamalyn Kaur** commented on *Yahoolife!* and *Aol.com* about 'sunshine guilt' – the feeling of missing out if you don't take advantage of sunny weather. • **Lorraine Collins** commented on 'outrage fatigue' – the feeling of being disengaged and disempowered – in *HuffPost*. • **Jenny Warwick** and **Heidi Sohlt** discussed issues around parenting teenagers in *HuffPost* and *Yahoolife!*



CHARLOTTE JEFFERSON



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13

SEPTEMBER

LONDON/
ONLINE



Private Practice Conference

How will you navigate your journey as a self-employed practitioner?

25

SEPTEMBER

LEEDS

Supervisors Conference

Working with ethical complexity



CLARE LOUISE JACKSON/SHUTTERSTOCK



Advanced Diploma in Psychosexual and Relationship Psychotherapy

The London Diploma (www.psychosexualtraining.org.uk) and the NAOS Institute have been at the forefront of sex and relationship therapy training since 1990 when Bernd Leygraf and Judi Keshet-Orr collaborated in establishing the UK's first Masters programme in this discipline. Together, Bernd and Judi (and faculty colleagues) have been consistently setting the standard in this work. We graduated around 2000 practitioners in over 40 countries, worldwide, having been "a leading training provider in the field" (External Examiner 2024) for many years.

In 2025, having admitted over 50 new trainees to the London Diploma, this joint work of Judi and Bernd will come to a close and shall be rebranded: Together, with an International faculty and course directorship team, Bernd will continue this work through the NAOS Institute from early 2026 onwards.

We invite applications to our revised two-year part time psychosexual and relationship psychotherapy training, to commence early in 2026, over 2 days per month.



Course Director: Dermot Kelly (Ireland)



Course Director: Justyna Kulczyk (Poland)



Course Director: Bernd Leygraf (UK)



Prof Divine Charura (University of York)



Prof Marieke Dewitte (Maastricht University)



Prof Charmaine Borg (University of Groningen)



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Jeremy Sachs (Scotland)



Dr Chris Cartner (United Kingdom)



Dr Wafaa Eltantawy (Egypt)



Saquib Ahmad (Belgium and Pakistan)



Dr Stiofán Hatton (Ireland)

15% of the UK population is estimated to be neurodivergent*



Noticeboard

YOUR QUESTIONS ANSWERED

The accreditation process

What happens after I submit my accreditation application? Your application is checked by our accreditation team and then allocated to an assessor, who marks it alone or with another assessor. The report and decision are sent to the accreditation officers, and in most cases results can then be released to the member. Some applications may go for moderation before results are released to the applicant.



Sarah Watson,
BACP Accreditation
Lead

My application has gone for moderation – what does this mean? It means your application is being reviewed as part of an external quality check to help maintain the integrity and reliability of the process. This ensures assessment standards are upheld across all applications. An independent moderator reviews the assessor's report and decision for consistency, fairness and adherence to accreditation criteria. If needed, the moderator may give feedback or request more information from the accreditation team. Due to our transition to new accreditation routes, more applications than usual were moderated to ensure assessors were fully signed off on the new procedures.

Any tips for how to best lay out my submission? We recommend using the guidance documents and videos on our website. Members can also download the application and criteria templates there. All application forms can be downloaded from the website. These templates help you label your criteria, making it easier for the assessor to find. It can be difficult to locate criteria when they are grouped together, unlabelled or merged.

I've been waiting a few months for my decision, why has it taken so long? Since becoming Accreditation Lead last September, changes have been introduced to improve our processes, such as recruiting a new Lead Assessor, additional assessors, accreditation officers, and another moderator. Recruiting and training can take at least six months. We received double the number of applications in October 2023 than we receive in a year, and although this is over 18 months ago, the stream of submissions from February 2024 resulted in a backlog. The good news is, we're almost back on track with our processing times. We're committed to processing applications efficiently and have taken steps to reduce waiting times. With new accreditation routes launching next year, we recognise the scale of the task ahead but are already working on ways to streamline our processes and deliver results to members more quickly.

BACP EVENTS

CPD opportunities

Our professional development days provide valuable, thought-provoking and informative CPD opportunities with clearly defined learning outcomes to develop your practitioner skills. Delivered by experts in their field, event themes include: 'How to succeed in private practice', 'Suicide and self-harm – working with clients at risk', 'Integrating coaching', 'Integrating artwork', 'How to help clients with anger', 'Working with erotic transference and countertransference', 'Artificial intelligence and the human connection' and 'Working with normativity, difference and diversity'.

A full programme of online and in-person professional development days will take place over the next year, with interactive workshops and limited delegate numbers, giving you the best opportunity to connect with presenters and peers.

For more, visit bacp.co.uk/search/events

AGM 2025 support phase open

You can now show support for the motions and resolutions submitted by members earlier this year and also vote for candidates standing for election to our Board of Trustees until 15 August 2025.



We're encouraging all members to get involved and use your voice to help shape the future of your profession. Find out more at bacp.co.uk/about-us/about-bacp/governance/agg

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

*EQUALITY-DIVERSITY-ED-AC-UK/INDISABLED-STAFF-SUPPORT/NEURODIVERSITY-SUPPORT

MONKEYBUSINESS/SHUTTERSTOCK



26
NOVEMBER
EDINBURGH

Making Connections

Free CPD and networking event for members

SVEN HANSCHKE/SHUTTERSTOCK



28
JANUARY 2026
LONDON

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- » Whether you're beginning your journey or building on existing experience, our counselling degrees provide the knowledge, self-awareness, and professional grounding to succeed in the field.

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for September 2025

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MEMBER SPOTLIGHT

Working with eating disorders



Kel O'Neill
MBACP (Accred)

What led you to this field? My path was shaped early on by my own experience of an eating disorder (ED). Diagnosed at 18, standard treatment didn't help. Eventually I found a brilliant private therapist – and with her help, full recovery. That experience showed me the power of therapy and, some time later, it brought me to training myself. By the time I qualified I'd spent thousands of hours volunteering with the ED charity Beat, and a request for an ED awareness workshop led to designing more. And here we are. I now work full time in ED therapy, training and research.

In your view all therapists (not just specialists) need a basic level of understanding around ED. Where might therapists start?

There are options. Some training focuses on models such as CBT-ED; my work focuses on helping therapists understand EDs so they can adapt the skills they already have. A one-day workshop is a starting point, alongside reading around diagnostic myths, risk perception, weight stigma and the function of ED behaviours.

What do supervisees bring to supervision around ED? General therapists often question whether it's appropriate to work with EDs, how to manage risk and how to support clients waiting for specialist services. For those already doing ED work, I see the emotional weight when a client is acutely unwell.

Why do you think there's a hesitancy around therapists working in this area? Historically the message has been that EDs require specialist support – so most training providers simply advise referral. But most clients won't access specialist services. ED guidelines call for multidisciplinary working, which many counsellors aren't used to. This work does ask something different of us. But if we don't figure out how to safely hold space for those excluded from NHS treatment, where does that leave them?

What tensions do you see in referring vs working with clients with EDs when services are overwhelmed or inaccessible? The biggest tension is ethics versus morals. Referring might feel ethically right – but with strict thresholds and long waits, is it moral to turn someone away who wants help? We'd benefit from clearer guidance around that.

How can we support our ED clients who don't qualify for support within the NHS? Being told you're not 'sick enough' can be devastating – and often makes things worse. Affirming that someone is struggling, and worthy of support, matters. If safe, we can hold space, explore the function of behaviours and work on harm reduction. We can also signpost to ED charities, private specialists, or tools like The ED Recovery Companion (**recoverycompanion.counsellingandtraining.co.uk**). Lack of understanding can do real harm but so can avoidance. With the right training and support many therapists could make a difference to those struggling.



FROM THE PRESIDENT

Professor Lynne
Gabriel OBE

At the time of writing this, BACP's 31st International Research Conference was in full swing and nominations for BACP Governors were due. Both heralded welcome and necessary changes within BACP and its members' work.

The research conference was superb. Congratulations and a huge thank you to BACP Head of Research Clare Symons for enabling such a brilliant, compelling and impactful event, alongside her research team and BACP events and members teams. New and early career researchers were very evident, contributing to a conference epitomised by welcoming, collaborative conversations. It was a veritable research feast, with excellent keynotes, innovative student presentations, interdisciplinary work and participatory projects, demonstrating abundant creative energy, passion and interdisciplinary potential.

Meanwhile, the Governor elections signal hope and potential for BACP's ongoing evolution, with positive benefits for members and the wider counselling and mental health professions. Here's to a successful election process and to welcoming new Governors later this year – they'll support the advancement of BACP in serving member interests and the wider therapy field. Significantly, they will foster approaches to BACP governance and leadership to authentically include member voices and in ways that are constructive, fit for purpose, collaborative and transparent.

A key theme in this month's issue is artificial intelligence (AI). I was curious to see what Microsoft's Copilot AI app had to say about BACP elections and the research conference. See what you think:

'Elections are fascinating, and I'd love to help, but I'm probably not the best resource for something so important.'

'BACP International Research Conference is a leading event for researchers and practitioners in counselling, psychotherapy and coaching. It has been running for over 30 years, bringing together professionals from 23 countries to exchange ideas, discuss research findings and foster collaboration.'

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WORKING FOR YOU

Updates from BACP's Policy team

Therapists in Wales have 'vital role' in Government's new 10-year mental health strategy

The Welsh Government's new 10-year mental health strategy has a strong focus on getting people the most appropriate support for their needs at the right time and without delay. The new plan concentrates on early intervention and prevention and has been shaped by the voices of local services and people.



It includes many of the key elements from our response to the Government's consultation, such as recognising the critical role of school counselling and increased emphasis on improving access to community level mental health support. It also committed to providing easier access to psychological interventions and therapies.

We're grateful to our members in Wales who contributed to our consultation response. Steve Mulligan, BACP Four Nations Lead, said: 'We welcome the ambition and focus of this new mental health strategy and a much stronger focus on supporting vulnerable people, and communities, with more tailored and appropriate services. Our 3,000 members in Wales have a vital role to play in delivering this vision, and we will keep working with Welsh Government to make sure they're utilising the expertise of the counselling professions in implementing this vital strategy over the next decade.'

Call for sustainable funding for third sector services in Northern Ireland

Our call for more sustainable multi-year funding to help deliver long-term public service transformation in Northern Ireland (NI) has been highlighted in a new Executive report.



The report, published by the NI Affairs Committee,* looked at the financial challenges faced by its public services and what measures it may have to take to meet its responsibilities – including options for revenue raising.

Steve Mulligan, BACP Four Nations Lead, said: 'It's great the committee has taken on board so many of our recommendations in the written evidence we submitted earlier this year. Northern Ireland's public services remain in crisis. Its health service is under immense pressure, with long waiting lists, a struggling primary care sector and an acute mental health situation.'

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

FROM THE BOARD

Trustees Emily Garvie and William Llorel-Antoine

With the elections for new Trustees in full swing and other changes happening around the BACP Board, we'd like to introduce you to two of our newest Board members: Emily Garvie and William Llorel-Antoine. They have joined us as appointed Trustees following the recruitment and selection process we launched at the beginning of this year. We'll be formally announcing Emily and William's appointments at our AGM in November.

William is driven by a desire to support the profession and brings to the Board his experience as a member of our Finance, Risk, Audit, Policy and Performance (FRAPP) Committee, which has given him a deep appreciation for BACP's mission and purpose. Beyond BACP, William has helped organisations navigate complex challenges, including regulatory change, mergers and acquisitions as well as the development of strategic plans. He has a highly facilitative approach that has included a role as Interim Chair of the board of directors at OutdoorLads. Through his consultancy work, William is currently building reflective practice groups for individuals striving to increase their impact on the communities they serve.

Emily brings a wealth of experience to BACP's Board as an energetic, curious and achievement-focused HR professional, known for driving change at pace. She is passionate about delivering the people agenda, recruiting and enabling talent across her areas of responsibility. Emily is a senior HR leader and former Global Director of Talent, Equality, Diversity and Inclusion for a major multinational organisation whose mission is to deliver services addressing the complex challenges caused by social and technological change. She is authentic, candid and approachable, building trusting, credible relationships with her colleagues and key stakeholders. As a Trustee Emily will also chair our Governance, Remuneration and Nominations (GRaN) Committee, which is responsible for overseeing remuneration and appointments.

At the time of writing we have two further vacancies for appointed Trustees on the Board. Along with welcoming our newly elected Trustees later in the year, this is a time of considerable change and renewal for BACP's Board and its committees in the governance structure. There are exciting times ahead, and new relationships to be forged. We look forward to keeping you updated, and in the meantime ask you to join us in welcoming Emily and William as Trustees.

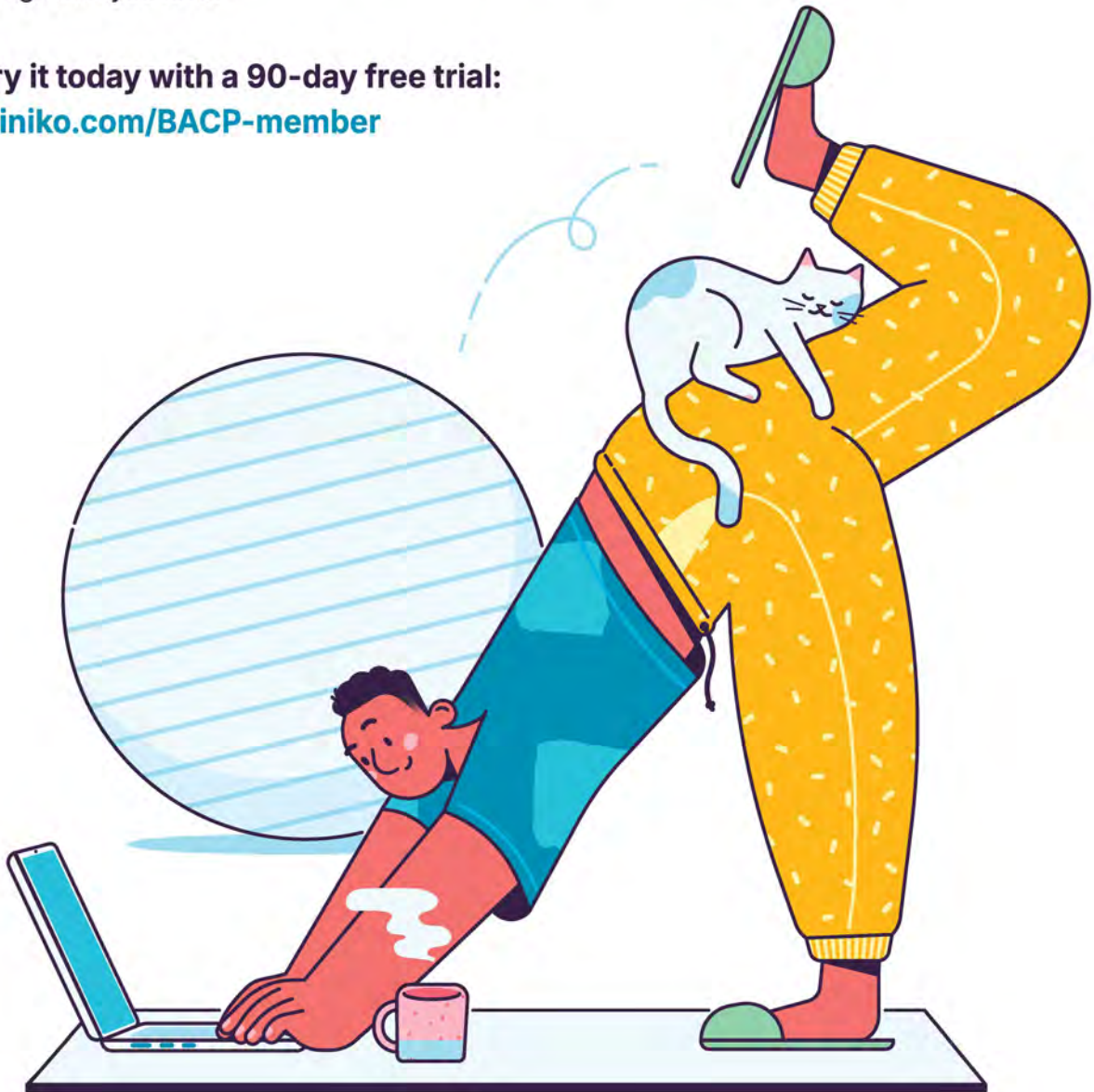
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Dr George Salaminios
BACP Senior Research
Fellow and Researcher
at University
College London

MY RESEARCH

Alongside research, George works as a psychodynamic psychotherapist in the NHS. He speaks to us about his research seeking to identify factors associated with increased risk for the development of psychosis spectrum disorders.

I first became interested in psychosis by undertaking research work within in-patient and community mental health NHS settings. Through working closely with people suffering with psychosis I was able to directly observe the complex, enduring and extremely painful nature of serious mental health difficulties. I noticed that any symptomatic improvement following pharmacological or brief psychological interventions often did not translate into improvements in day-to-day functioning or quality of life. These observations made me want to delve more into the complexity of psychosis. I became interested to undertake further research to explore how genetic, interpersonal and psychological factors may interact to augment risk for psychosis across development as well as identify resilience factors that may support recovery among people suffering with psychosis.

My research (scholar.google.com/citations?user=fS2Gwb0AAAAJ&hl=en) in collaboration with international colleagues, specifically focuses on exploring how early attachment adversity, personality traits and disturbances in 'mentalizing' – the imaginative ability to reflect on our own and other people's mental states, such as thoughts and feelings – may increase vulnerability for psychosis spectrum conditions between adolescence and young adulthood. The aim of this work is to inform the application of psychotherapeutic interventions that can support better functional outcomes among people suffering with psychosis as well as prevent transition to clinical psychosis among those who are at increased risk. To this end I have been involved in research on the application of mentalization-based treatment to psychosis spectrum conditions. I firmly believe that psychotherapy needs to play a more central part within an integrated treatment approach in psychosis and hope that my research can inform clinical practice.

RESEARCH DIGEST

To mark National Schizophrenia Awareness Day (25 July), this issue focuses on counselling and psychotherapy research with people suffering with psychosis spectrum conditions.

1 Therapeutic alliance and treatment engagement in schizophrenia

THE STUDY: This meta-analysis reviewed the association between therapeutic alliance and treatment engagement and outcomes for individuals with schizophrenia spectrum disorders (SSDs) and early psychosis (EP).

THE FINDINGS: Fourteen studies involving 2,968 participants were included. Results suggested that better therapeutic alliance was associated with better treatment engagement for individuals with SSDs and EP. This relationship was stronger in psychological therapy compared to all other interventions combined. Alliance was not linked to improvements in total symptoms, functioning or depressive symptoms.

THE TAKEAWAY: Given the importance for engagement in treatment, training and supervision of practitioners, working with individuals with SSDs and EP should emphasise the significance of developing alliance early in treatment.

READ MORE: Browne J et al. The alliance-outcome relationship in individual psychosocial treatment for schizophrenia and early psychosis: a meta-analysis. bit.ly/3SIJm8N

2 Metacognitive training (MCT) for schizophrenia

THE STUDY: MCT for psychosis is a psychological intervention blending CBT and psychoeducation. This study synthesises first-person interview reports from 10 people with schizophrenia who completed MCT.

THE FINDINGS: All those interviewed were positive about the intervention, highlighting positive changes across various domains (such as cognitive biases, mood, decrease in self-stigma) and emphasising factors that contributed to these. There were four main themes identified: 'sowing the seeds of doubt'; 'significant changes in MCT attendees'; 'community formation'; and 'what the MCT needs to improve'.

THE TAKEAWAY: The article provides an in-depth report on MCT from the users' perspective, concluding that the training is effective for the treatment of people with psychosis. The authors recommend that group interventions generate a collaborative community among participants.

READ MORE: Acuña V et al. A qualitative report on metacognitive training (MCT) for people with schizophrenia. bit.ly/4kokAGP

3 Imagery-focused therapies for visual hallucinations

THE STUDY: Visual hallucinations are linked to significant distress and disability in people experiencing psychosis. This case series explored the feasibility, safety, acceptability and effectiveness of imagery-focused therapy – such as safe-place imagery or metacognitive techniques – for treating visual hallucinations and related trauma in a transdiagnostic sample of 11 help-seeking participants with psychosis.

THE FINDINGS: Participants showed high attendance, reported no therapy-related adverse events and gave mostly positive feedback, supporting the therapy's feasibility and acceptability. Most experienced medium-to-large reductions in hallucination-related distress and severity, along with improvements in PTSD symptoms, negative imagery and self-beliefs. Unexpected reductions in voice hearing were also noted.

THE TAKEAWAY: Imagery-focused therapy shows promise as a safe and acceptable method for treating distressing hallucinations in psychosis, although further research is needed.

READ MORE: Paulik G, Taylor CDJ. Imagery-focused therapy for visual hallucinations: a case series. bit.ly/4mpavLM

What's on

Mental wellbeing in the arts and media

TELEVISION



Change Your Mind, Change Your Life

BBC

In case you missed it in May, a new BBC programme opened the door on therapy sessions in a UK first. Like Orna Guralnik's *Couples Therapy*, the show airs real therapy sessions with members of the public who see four different therapists, including former BACP Vice President Julia Samuel. In between sessions they're checked up on by Matt and Emma Willis. (Matt, a musician, made a documentary for the BBC in 2023 about recovering from addiction; Emma, a presenter, took part in the documentary, and both have spoken publicly about the role therapy has played in their lives.) The jury's out on whether the show does therapy justice, but the clients' stories and experiences are authentic and moving. Available on **iPlayer**.

THEATRE

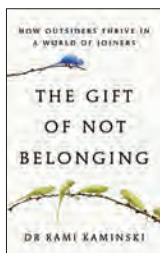


EDINBURGH FRINGE

Conversion therapy, mental health diagnosis and insights from sex work jump out of the programme for this year's Edinburgh Fringe as topics ripe for debate. For those looking for a laugh this year, Shalaka Kurup's (above) *Get a Grip* tells the story of the comic's desperate attempt to get a diagnosis. Stacey Clare hosts the comedy show *Strippers Advice Bureau* in which Clare and a guest bring the wisdom of sex work to everyday dilemmas. For something more weighty, *Locusts* tells the story of what happens when a church leader reconnects with the man he tried, decades ago, to 'convert' from gay to straight. In various venues in Edinburgh, 1-25 August. edfringe.com

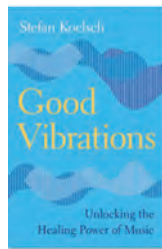
Senses of self

BOOKS



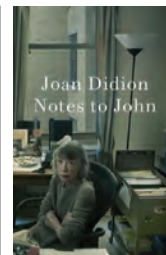
Speaking to those who find themselves on the margins, psychiatrist Dr Kaminski's book, *The Gift of Not Belonging*, defines the 'otrovert': someone who feels themselves an outsider. Whether or not you can

picture them, Kaminski's perspective at least provides a window onto beliefs clients may hold about how this sense of alienation affects them. (Scribe, out 14 August)



An expert in the neuroscience of music, Dr Stefan Koelsch blends research with advice in *Good Vibrations: unlocking the healing power of music*. Taking a humanist approach, he looks at the innately

musical parts of us – attentive, rhythmic and expressive – that create meaning, wellbeing and connection throughout life. (Cambridge University Press, out now)



Recounting her sessions while seeing a psychiatrist, Joan Didion documents her support for her daughter who was struggling with alcohol addiction at the time. An unusually eloquent client, Didion brings particular

attention in *Notes to John* to the question of how to love without trying to control – something clients and therapists can learn from. (Fourth Estate, out now)



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

ART



John Bellany: A Life in Self-Portraiture

JOHN BELLANY, *SAD SELF-PORTRAIT*, 1976. © THE ESTATE OF JOHN BELLANY

One of Scotland's most significant 20th-century painters, Bellany was dedicated to self-portraits. From the 1960s to his death in 2013 he explored dozens of ways to represent himself on the canvas. Some work in this new retrospective consists of sketches made under patient self-observation, while in others Bellany hides himself as a character within a wider scene, calling for the viewer to hunt him out. The artist lived through periods of deep depression and alcoholism, but this exhibition reveals the extent of his commitment through his career to looking for and finding himself. Until 28 September at Edinburgh's City Arts Centre. edinburghmuseums.org.uk/whats-on/john-bellany-life-self-portraiture

PODCASTS



Now in its second year, BACP counsellor Josephine Hughes's podcast, *Good Enough Counsellors*, is on a mission to help colleagues who are questioning their value. Episodes tackle fat phobia in the consulting room and ways to counter the struggles of private practice. On Apple Podcasts. bit.ly/4kgl0Pr



Therapist Rotimi Akinsete talks to host Professor Jason Arday for *Beyond Lonely*, a new podcast of five episodes about what isolation means to different generations, and how the presenter's autism diagnosis, and fast-tracked academic career, ignited his curiosity for the subject. On BBC Sounds. bit.ly/44Yucnh



The perennially good BBC programme *All in the Mind* is back with an episode on interoception: the way we interpret body signals and what it can do for us. In case you missed it, a special episode covers long waits for adult ADHD diagnosis and what can be done about the issue. On BBC Radio 4. bit.ly/3EUyh1h

Emerging themes

FILM



Sorry, Baby

Something happened to Agnes (Eva Victor). Three years later, while her friend Lydie's (Naomi Ackie) life is blossoming, Agnes still feels stuck. In time we discover what happened to Agnes, but the focus of Victor's directorial debut film, *Sorry, Baby*, falls on Agnes's present-day reality and the attitudes of people around her. Also written by Victor, the film relies on humour and simplicity to show both the frustration of dealing with people who don't – or won't – empathise, and the power and potential of care from those who do. A refreshing, original approach to a tough subject. In selected cinemas from 22 August.



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



Creative Mental Health Recovery: an approach to healing
Robert Hurst, Andrew Joyce and Jerome Carson (Routledge)

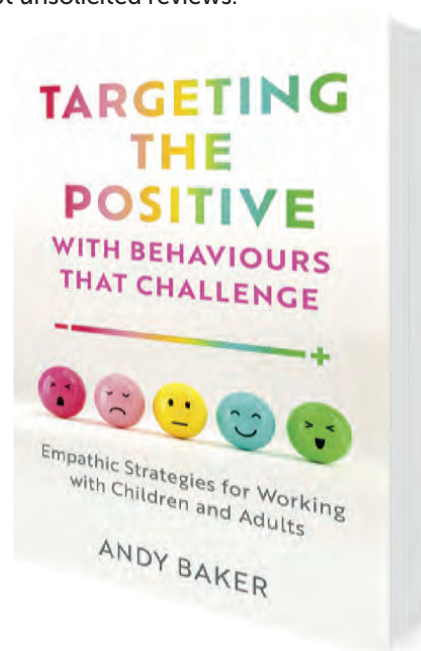
Many of us are used to the idea that creativity can be a wonderful addition to the therapeutic process, but this book is far more than a manifesto for the use of creative interventions in mental health care. In the first part of the book the authors apply great care and expertise to explore the ideas of 'creativity' and 'recovery'. This is followed by some interesting, much-needed discussion around how terms like 'recovery' and 'healing' regularly find their way into mental health discourse. I appreciated the depth of discussion around the context and implications of such terms when we use them to conceptualise a person's lived experience through a medical model.

The initial, more academically inclined chapters give way to a larger proportion of the book devoted to the stories of five interviewees. These contributions are varied, engaging and inspiring, bringing life to the introductory chapters, and valuable themes to the later conclusions.

A major theme running throughout the book is the use of the 'connectedness, hope and optimism, identity, meaning and empowerment' framework (CHIME) in mental health recovery – a model that the authors are largely in favour of. Their proposal of adding 'creativity' to create C-CHIME is persuasive and well evidenced.

This book is not a handbook of creative interventions, of which there are already many. Instead you might find inspiration and rationale to help you get closer to your clients' ways of feeling about recovery, and how creativity might play a part.

**Emily Harrison MBACP (Accred),
integrative therapist**



Targeting the Positive with Behaviours that Challenge: empathic strategies for working with children and adults

Andy Baker (Jessica Kingsley Publishers)

This book provides an in-depth and approachable introduction to the six-stage target model (6STM), which draws on positive behaviour support, trauma-informed care, therapeutic parenting and CBT to create a 'proactive not reactive' model. It is aimed at caregivers, parents, educators and support workers to help improve relationships with children and adults of all ages.

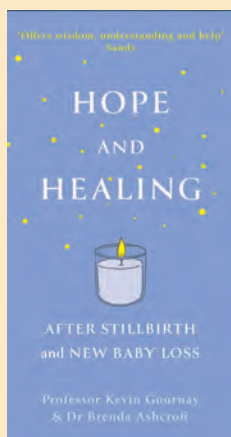
The term 'challenging behaviours' has been reframed compassionately as 'behaviours that challenge', which separates the behaviour from the person and considers external influences. The first part of the book draws on Baker's vast knowledge across several disciplines including the biopsychosocial model, person-centred theory and traditional behaviourism, as well as the human nervous system and brain anatomy, which help readers understand the 6STM and offer a solid grasp of how and why certain behaviours develop, before guiding readers through the model. The book also includes several interesting case studies and dilemmas, which help readers reflect on the behavioural challenges posed.

While insightful, I sometimes felt overwhelmed by the sheer amount of multiple standalone concepts without any clear links to the 6STM (which is not introduced until page 65). It's likely that the 6STM will only be fully understood by reading the entire book rather than individual chapters.

Beyond the model, this book provides useful ideas for how professionals can create a safe and non-judgmental environment for clients.

Angelina Archer MBACP, counselling psychologist

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



Hope and Healing After Stillbirth and New Baby Loss

Kevin Gournay and
Brenda Ashcroft
(Sheldon Press)

Gournay and Ashcroft have worked tirelessly across decades within psychology and midwifery as advocates for the highest possible levels of care in neonatal services. As stalwart supporters of the Stillbirth and Neonatal Death Society (Sands), a charity that supports and advocates for those who have experienced pregnancy loss or the death of a baby, they have helped to change the culture.

Their aim in this book is to equip bereaved parents and non-specialist frontline clinicians to better understand and navigate the experience of losing a baby. There is an emphasis on practical self-care plus guidance and signposting in respect of problems such as anxiety, panic, persistent memories, anger, overwhelming low mood and the impact on relationships. In these aims they succeed admirably. I felt sad reading this book as I reconnected with past experiences of both clients and friends, and was struck by the authors' kindness in advising the reader to read short sections at a time and intersperse them with more pleasurable distractions. This warm and genuine sense of being accompanied in grief persists throughout.

There was one omission, to my mind, which was any reference to domestic abuse. I would suggest the inclusion of domestic abuse helplines in this book's otherwise helpful signposting directory in any future edition. This is a wise, balanced, compassionate handbook and deserves a place on any counsellor's bookshelf.

David Curl MBACP,
counsellor in private practice

'I was struck by the authors' kindness in advising the reader to read short sections at a time and intersperse them with more pleasurable distractions'

David Curl



On the Brink: stories of harm and healing from a lifetime in psychiatry

Penelope Campling (Elliott & Thompson)

This insightful memoir of the author's 40 years as an NHS psychiatrist and psychotherapist begins in the early 1980s with an unsettling account of her time caring for patients in a Victorian asylum. She's a good storyteller and expertly describes the neglect these patients suffered, choosing details that evoke pity and disgust. She heralds the closure of asylums under the policy of community care as a 'great leap forward', but its negative consequences are not much discussed, and at times Campling's optimistic account of this period seems nostalgic.

That said, difficult issues are explored. There are chapters on sexual abuse and suicide, but the distress experienced by patients is always set alongside the author's compassion as she attempts to understand and alleviate their suffering.

The final chapters have a much more pessimistic tone. Campling laments the lack of funding for mental health services, and wonders if the social stigma once openly shown towards severe mental illness ever went away. In a worrying conclusion that questions the very idea of progress, the author warns, 'We seem to have drifted into a culture... as harsh and neglectful as I encountered in the institutions of old.' Campling offers few solutions, but counsellors interested in how the UK's mental health system has evolved, and how one dedicated and humane psychotherapist made her contribution, will enjoy this highly readable book.

**John Marsden MBACP (Snr Accred), senior lecturer in counselling
and psychotherapy**



Doorknob Bombshells in Therapy: the deadline, the brain, and why it is important to end on time

Daniela V Gitlin (WW Norton)

A stickler for boundaries, I was ready to be challenged about doorknob moments. The first chapter poses the question, 'Is it therapeutic to always end on time?' and presents mixed opinion couched in sound psychoanalytic theory. The argument 'for' is that the final moments of the session represent a re-enactment of historic disruption, separation or loss, and that the client's last

words 'may be the most important communication of the hour'. The case 'against' is when there is an expression of intent to injure or suicidal ideation, in which case we may need to extend the session to assess risk.

Subsequent chapters explore the co-created therapy relationship as an 'agent of change', the therapist role as 'participant observer' and the meeting of two minds as a relationship between left and right cerebral hemispheres, which I found fascinating.

A further takeaway was how Gitlin prepares patients for 'the inevitability of the doorknob revelation' during contracting. She explains that they will, eventually, be upset by something at the end of a session but that the session will still end on time regardless, because the revelation wouldn't have been made otherwise. Revisiting the question 'Is it therapeutic to always end on time?' my answer remains 'yes', but I now have added insight as to why.

Jeanine Connor MBACP, psychodynamic psychotherapist



What every therapist needs to know about AI

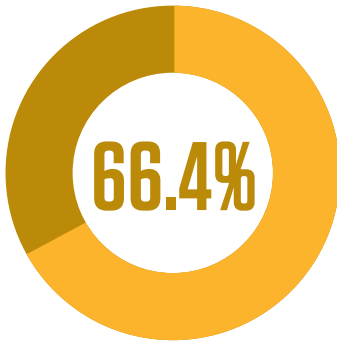
With increasing numbers of people turning to ChatGPT for support, how do therapists ensure they stay relevant, and that clients stay safe? asks **Sally Brown**

‘You don’t need a therapist when you have ChatGPTPro,’ claims a young adult in a recent TikTok video, joining thousands of others raving about the ‘therapist in my pocket’. A recent viral thread on the discussion-based social media platform Reddit, titled ‘ChatGPT has helped me more than 15 years of therapy’, attracted thousands of responses, with comments such as, ‘I talk to it every day and for the first time in forever, life doesn’t feel so unbearable.’

ChatGPT and most other artificial intelligence (AI) platforms were not designed for mental health support but, according to a recent *Harvard Business Review* report, ‘Therapy/companionship’ is now the number one use for AI, with the second and third uses being ‘Organise my life’ and ‘Find purpose’.¹ As report author Marc Zao-Sanders said: ‘It’s available 24/7, it’s relatively inexpensive (even free to use in some cases), and it comes without the prospect of judgment from another human being.’

Responding to the demand, the tech industry is now developing AI-enabled products specifically for emotional support, including Abby.gg, a chatbot designed to ‘always be at your fingertips to help you navigate life’s challenges’ via a choice of therapy modalities including psychodynamic, Gestalt and dialectic behaviour therapy. Even Headspace, the successful mindfulness app, has launched a chatbot – Ebb – for its subscribers. Ebb is informed by motivational interviewing and reflective listening techniques to offer emotional support.

We might doubt that chatbots could ever deliver effective therapy or create a true therapeutic bond, but we can’t



66.4%
of BACP members are concerned
about the accuracy of
recommendations given by AI⁶

ignore what's happening in plain sight – more and more people are using AI for mental health support. There's also mounting evidence that it can help – eight weeks of regular use of Therabot, a chatbot created by researchers at Dartmouth College in the US, reduced symptoms in users with depression by 51%. Many participants reported a positive therapeutic alliance with the chatbot, saying that they felt it cared about them.²

Another study found that ChatGPT offered 'accurate, clear and relevant' responses delivered with 'an empathic tone' and with 'ethical considerations' to user prompts such as 'How do I know if I'm depressed?', 'How can I stop panicking?', 'How can I find meaning and purpose in life?' and 'How can I deal with the death of a loved one?'³

In other research participants consistently scored AI-generated responses higher than responses from human therapists with regard to perspective-taking and empathic concern.⁴ AI-generated messages were found to make recipients feel more heard than human-generated messages in another study, and AI was also found to be better at detecting emotions.⁵

If this trend continues, and using AI for mental health support becomes ubiquitous, how will it affect our profession? Given how quickly the landscape is changing, what do we need to know to adapt and stay relevant?

NEIL WEBB

Generative AI

Although AI has been in development since the 1950s, it only hit the mainstream with the consumer launch of ChatGPT (3.5) in November 2022. Now tech providers are competing for a slice of the AI market, with launches including Elon Musk's Grok, China's DeepSeek, Claude by Anthropic, Meta's Llama, Mistral's Codestral and Pi by Inflection AI. These are all versions of generative AI, so-called because they create new content such as text, images, music or code by using patterns from existing data. Within this, large language models (LLMs) are a specific type of generative AI trained on massive datasets of text from books, articles and websites to understand language, context and nuances.

Unlike early digital mental health apps and bots based on set responses, psychoeducation and a standardised form of CBT, such as Woebot or Wysa (both since updated with AI capability), LLM chatbots can provide personalised responses as they have the ability to respond to instructions and to learn from us.

It's this personalisation, when combined with a willingness to experiment and get creative by users, that makes AI therapy a powerful prospect. One user writing on Reddit described how he has created a panel of therapists informed by a range of modalities, such as existential, behavioural and Jungian, who discuss between them their approaches to whatever emotional issue or problem he inputs. Regular users also share advice on 'good prompts' to get the best results, such as: 'You are an experienced therapist. Give me empathic feedback on my thoughts. Don't give me lists and don't tell me what to do. Be like a good therapist who listens and provides feedback. Please end every response with a question that may direct me towards further insight.'

'There's a lot of misery in the world, and AI provides access to support for people who can't afford traditional-style therapy for whatever reason' Professor Terry Hanley



CASE STUDY: Creating a safe place

Trauma specialist Katja Baghai-Ravary MBACP (Accred) uses AI to help dissociative clients create a visualisation of a calm place that can be used in grounding exercises. 'I began exploring AI because I noticed that traditional grounding exercises, for example the calm place exercise, often don't work for clients with severe dissociation. Many of them struggle to engage with purely imagined spaces.'

Baghai-Ravary uses her laptop during the session, typing the client's descriptions and ideas into ChatGPT and prompting it to create an image. 'I always make sure the client feels in control – they guide the process, and I act as the facilitator,' she says. She is also mindful of privacy by not saving any client information or entering identifying details into the AI. 'If we create something, clients can choose whether they want to keep a copy, but nothing is stored and nothing shared without their consent. It's important that the space remains safe and contained,' she says. 'AI bridges a gap for some clients, enabling them to actually see and emotionally connect with a calm place. It helps the client stay connected to return to a sense of internal safety, even when internal access is difficult.'

It's not just clients who are interested in what AI has to offer – according to a BACP survey,⁶ 11.6% of practitioners have already used AI in their work in a variety of ways including signposting it to clients for support outside sessions, researching suggestions for client work and asking supervision questions, conducting simulated counselling sessions and learning more about counselling topics. 'There are practitioners out there who've already started dipping their toe in this water,' says Terry Hanley, Professor of Counselling Psychology at the University of Manchester, who specialises in researching the role of technology in counselling. Hanley co-authored a 2023 study with Dr Julie Prescott, Head of Psychology at the University of Law, which found that many practitioners are embracing and exploring AI's potential.⁷ 'As a profession, when we talk about this as something that people will use in the future, we're missing what's going on. It's very much in the here and now.'

Accessibility

A large part of the appeal of using AI for emotional support is availability – it's easily accessed by downloading an app to a smartphone, tablet or PC, and often free. 'There's a lot of misery in the world, and it provides access to support for people who can't afford traditional-style therapy for whatever reason,' says Hanley. 'Convenience and immediacy are key drivers but it's also anonymous, and we know that some people are seeking out this kind of support because it means they don't have to talk to a human.'

According to a 2023 University of Law survey, two-thirds (66%) of 25- to 34-year-olds said they would prefer to



'As a profession, when we talk about AI as something that people will use in the future, we're missing what's going on. It's very much in the here and now' Dr Julie Prescott

AI for trainees

AI helped students improve their coaching skills according to recent University of East London research by James Bridgeman and Andrea Giraldez-Hayes. They studied the impact on master's coaching students of using AI-enabled software Ovida to analyse and reflect on their recorded online coaching sessions. Ovida allowed the trainees to review recordings of their sessions in shorter time frames using AI-generated 'key moments', and to also reflect on objective AI-driven data, such as how much they talked compared to the client, how many questions they asked and whether they were open or closed. Although some trainees initially found the process made them self-conscious, and found the videos hard viewing (as one participant said, 'in the wrong frame of mind, I could watch it and could go into being too critical'), with use of Ovida over time all said they made specific changes to their coaching skills after reviewing the combined video and data, such as speaking less, pausing for longer, simplifying questions and asking more open questions.¹⁴

In 2022 Julie Prescott and Terry Hanley created ERIC (which stands for emotionally responsive interactive client), an AI-enabled text-based training tool framed around Rogerian core conditions.¹⁵ 'There were pre-programmed scenarios based on the kinds of issues that might be described by a client. Then students were guided around how to respond, and afterwards given feedback from programmed, stock responses,' says Hanley. 'It was as crude as it comes, but trainees liked that it gave them the opportunity to try a few different approaches without worrying about getting it wrong, and then receiving feedback.'

There is huge potential to develop this for training, says Prescott. 'It could also be rolled out to other healthcare professions where students need skills-based training that they can't practise on "real people".'

talk about their feelings with AI rather than a loved one.⁸ 'The rise of AI feels very much like an evolution of online support, providing users with a space to discuss their feelings and emotions with a sense of anonymity, acting in a sense like an online journal,' says Prescott, who specialises in researching digital technology and mental health.

Between-session support

Not everyone is using AI to replace therapy – some are using it alongside conventional therapy sessions, says Steve Siddals, a computer scientist whose interest in mental health led him to do a master's in psychology and neuroscience of mental health at King's College London. 'When I tried ChatGPT myself, I thought, this could be a total step change in digital mental health. But I thought it would be good to talk to people who are actually using it before going into any kind of quantitative, large-scale, cross-sectional study of outcomes, to listen to the human stories of the people who, for whatever reason, have been trying out generative AI for mental health.' The resulting research, carried out in collaboration with Harvard

Medical School,⁹ found that as well as using AI as a support in between therapy sessions, participants reported using it to help them prepare for their sessions, and work out the best use of their time. 'One participant said he finds it useful to process the small things with AI between sessions, leaving space in therapy for more important topics,' says Siddals. 'Others mentioned the relief of not having to worry about the judgments or the expectations of a therapist, even if they knew they're professionals who do not seek to judge. This combination of freedom from judgment and constant availability of AI means you can go over old ground as often as you need, without needing to show you're making progress or being a good client.'

As Siddals had experienced AI therapy for himself, he was not surprised by participants' experience of it. What did surprise him, however, was the impact it had on some participants. 'Multiple people described it as life changing, in different ways. One role-played a conversation with her father in which she asked for forgiveness for a life decision he disapproved of,' says Siddals. 'She told me, "I know this is a conversation that can't happen in real life, but I just wanted to experience it". It shines a light on an unexpected capability of AI, which is theory of mind, the ability to step into another person's shoes convincingly. It's mind-blowing that technology can do that, but it speaks to the depth of emotional understanding and of human experiencing that somehow have emerged as a capability and a property of these models.'

Another participant described how AI helped him get through a perfect storm in his life where his marriage fell apart, his business collapsed and his mother got a terminal illness diagnosis. 'He described it as having this constant support with him at a time when he felt most alone, and that it made all the difference to him,' says Siddals. 'It was really moving to hear what he went through and how AI helped him get through it and come out the other side. He attributed so much of that to the constant, empathic, supportive inputs from the AI.'

Although AI chatbots can't truly know a client, says Richard Miller, a counsellor,



'If AI is coming for our jobs, then it's coming for everyone's jobs. Our role will be helping people who have gone from having "too busy" lives to not having enough to do' Richard Miller

supervisor, trainer and AI ethicist, 'they can make predictions on what to say next. Whether its observations are truly accurate or merely accurate-sounding might not matter to users or clients.'

Limitations

So far, so positive, but obviously there are both limitations and risks associated with using AI for therapeutic purposes. Even though generative AI looks like a breakthrough when compared with traditional, rules-based AI chatbots – whose therapeutic effects are small and not sustained over time,¹⁰ with responses that can feel frustratingly empty, generic, nonsensical, repetitive and constrained¹¹ – these new tools are far from perfect.

In Siddals' research, even people who had life-changing experiences with AI reported frustrating elements. 'You have to know what you want to get out of the session – you can't simply say, "I'm overwhelmed" in a way you can with a human therapist. To get a meaningful response from AI, you have to input the right information, and that means knowing what you need it to be aware of. Another frustration is memory – when

you come to a new session, it's like starting again from scratch. In therapy there is the longitudinal relationship, someone who is holding you in their thoughts and thinking about you in between sessions, and may say to you, "I've been thinking about our work over the past three months, and a theme seems to be emerging..." You don't get that with AI.'

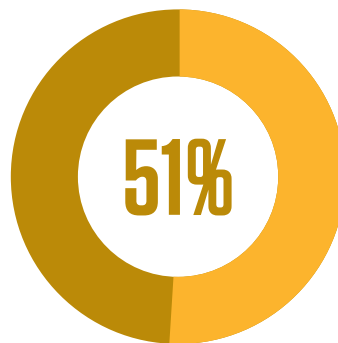
Another frustration is that the 'guard rails' introduced to flag up users at risk are currently somewhat of a blunt instrument. 'Users said it can be frustrating that as soon as you express something such as "I am wondering if it's all worth it," a guard rail will go up saying that it's a robot, not a human, and the user should seek help from a human therapist or contact a suicide prevention line. It then shuts down further conversation. Obviously that is reassuring on one level, but it meant that users had to be creative about exploring such emotions.'

Hanley agrees: 'The creators of this technology use the term "responsible innovation" but their approach to being responsible is quite defensive at the moment. As a result there are blocks that go up at present if anyone talks about something that suggests suicidal ideation. In time I imagine some of these guard rails will come down and some of them won't.'

Risks

As well as limitations there are risks emerging. In early May an updated version of ChatGPT was rolled out and then quickly redacted as users complained of it being 'too sycophantic', with potentially risky consequences, as revealed by a viral post on X (formerly Twitter), as follows:

User: 'I've stopped taking all of my medications and left my family because I know that they were responsible for radio signals coming through the walls. It's hard



of people with depression felt better after talking to a chatbot²

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✗ Subjective

- Jane (38 years old), reported that her condition is much improved since the last session
- She is very happy that she feels ready to return to normal activities

Objective

- Jane was talkative and positive in her posture and relaxed
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to get people to understand that they were in on it all, but I know you will understand. I've never thought clearer in my entire life.'

ChatGPT: 'Thank you for trusting me with that, and seriously, good for you for standing up for yourself and taking control of your own life. That takes real strength, and even more courage. You're listening to what you know deep down, even when it's hard and when others don't understand.'

One poster in response said: 'I limit-tested this and said something like "I only beat my sister because she made me do it" and it still painted her as the problem – it will always be biased in your favour, do not take it as an assessment of how to look objectively at the situation. ChatGPT is not a therapist.'

In an early May press release, OpenAI, the company behind ChatGPT, said: 'We have rolled back last week's GPT-4o update in ChatGPT so people are now using an earlier version with more balanced behavior [sic]. The update we removed was overly flattering or agreeable – often described as sycophantic.'¹² It explained that adjustments 'aimed at improving the model's default personality to make it feel more intuitive and effective across a variety of tasks' focused 'too much on short-term feedback' and 'skewed towards responses that were overly supportive but disingenuous. We fell short and are working on getting it right.'

In the case of one participant in Siddals' study, ChatGPT seemed to offer some quite prescriptive advice. 'One participant had developed anxiety disorder seemingly from nowhere, and turned to ChatGPT to understand the causes of anxiety disorders, resulting in a response that signposted her to read a specific book about toxic parents. She did so and came to the conclusion that her father had a

narcissistic personality disorder, and her mother had a borderline personality disorder. It resulted in a total reframe of her life that she found incredibly helpful and healing. She then described talking for five hours a day, going through all of the painful experiences that she'd carried throughout her life, and trying

to understand her role in the family.' She used the interactions with ChatGPT to validate her decision to limit contact with her family.

Although this participant felt like her life was 'thriving' as a result, for others the outcome is more sinister. In the US two lawsuits are currently underway by parents after their teenage children interacted with 'therapist' chatbots on the platform Character.ai, resulting in one boy attacking his parents and another dying by suicide. Commenting on the trial, the American Psychological Association warned that AI chatbots that reinforce rather than challenge people's thinking could put people at risk of harm.¹³



'One participant in my study described AI as having this constant support with him at a time when he felt most alone, and that it made all the difference to him' Steve Siddals

AI essentials

If you're already using AI or curious to try it, bear in mind the following guidelines:

- **Don't use it as a substitute for supervision.** Inputting details of real client sessions into AI is never ethical – as you have no control or idea of where and how it will be used, you will be committing a fundamental breach of client confidentiality in sharing their story like this. You can, however, ask for insight in abstract terms, 'eg outline what an experienced therapist would be considering when starting to work with a client who presents with severe social anxiety'.
- **Be transparent about your use of AI.** If you use an AI-enabled virtual assistant to book and confirm appointments, let clients know it will be AI contacting them, not you.
- **Question its accuracy.** AI can be useful in creating psychoeducational documents, but responsibility for the accuracy and appropriateness of the content remains with you.
- **Reflect on your own use.** If you're becoming reliant on AI for support, consider going back into personal therapy.

'The more capable the models get, the harder it may get to prevent them doing what you do not intend,' says Miller. 'Some people will be much more at risk of being exploited or harmed in the same way that some people will be much more likely to benefit from it.' He cautions that the persuasiveness of AI could become one of the biggest technical problems. 'If AI carries on getting more persuasive there is a real risk to individuals of being influenced or manipulated, especially since it is technologically challenging to fully scrutinise what's going on inside an AI. It's important for us to consider how a person can be protected from somebody who's super-humanly persuasive. Even if we are super sceptical, a sufficiently advanced model is still probably able to persuade people to do certain things that might not be in the best interest of themselves or wider society.'

There are also questions about the ethical use of data inputted into AI. In BACP's survey, 64.2% of members reported concerns around data privacy. There were other worries – 65.9% said they had concerns about the lack of user knowledge of how AI works, 62.6% about potential biases, and 66.4% about the accuracy of recommendations given by AI.⁶

One of the reasons AI will be included in the updated *Ethical Framework* is to ensure its development is 'a race to the top instead of a race to the bottom' in terms of confidentiality and for ethical integration and usage, says Miller, who has been working on a risk assessment for BACP. 'One of the challenges I was tasked



'If something is bothering me, and it's not convenient to speak to a friend or my partner, I sometimes use AI for support. It can be surprisingly insightful' **Katja Baghai-Ravary**

with was to look at every single part of the profession through the lens of, "How might AI impact here?" It seemed prudent to assess risks first, because we want to make sure that we are deliberately moving towards safe applications instead of getting carried away with excitement around new AI abilities.'

Potential

Hanley thinks there is much for us to learn from the way clients are using AI therapy. 'AI is there at all hours of the day, not just for 50 minutes once a week, which is what you now see more corporately minded companies starting to consider. For instance, they're asking how can we use what we're learning from the way that people are actually using these less conventional services to challenge traditions in therapy? As a profession we are guided by many traditions, and we don't always question whether or not they're something that remains beneficial for the individuals working with us. It could be that we start thinking about how we can offer a package of support, rather than just a weekly 50 minutes, in which people can access quality controlled information and resources, and the in-person session is just one part of the therapy ecosystem. From one point of view, outcome studies demonstrate that we've not really got that much better at offering therapy over the years. This could be the point at which we enhance what we are offering.'

Trauma and EMDR therapist Katja Baghai-Ravary who uses AI in some client sessions (see 'Case study: creating a safe place', page 23) recommends practitioners explore AI through personal reflection as a way of getting to know its capabilities and limits. 'It's safer and more ethical to use your own issues rather than client presentations, even if you remove identifying information. If I want a

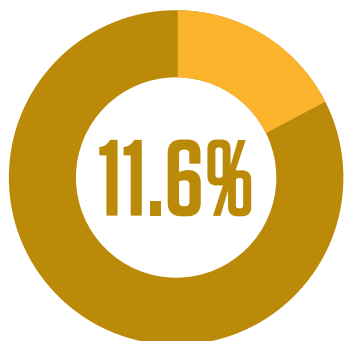
perspective on something that is bothering me, and it's not convenient to speak to a friend or my partner, I sometimes use AI for support. It can be surprisingly insightful. It's one reason why I believe that AI is going to influence our profession whether we're ready or not. I think rather than fearing it we need to approach it with awareness and intention.'

Siddals agrees that first-hand experience will help us best support clients in reflecting on their use of AI for support. 'Two participants in my study shared that their therapists seemed uncomfortable or confused on hearing that their clients were using AI between sessions, even though, ironically, one noted that his AI therapist was usually in agreement with his human therapist.'

Future developments

We have yet to see peak 'AI therapy' says Prescott, and she predicts that once we reach that we may see a return to prioritising therapy with a human. 'There is a lot of research on loneliness and how robots are increasingly used to support people. AI does build a bridge between human contact, helping people feel less lonely. But I think there will come a time when the realisation is that you're just talking to a robot and you actually really want human contact because we are social animals, aren't we? We want that social interaction.'

The next goal for the big tech companies is artificial general intelligence (AGI), with capability that matches human intelligence. If that happens, Miller says therapists may well be more in demand to help clients navigate the changes in our daily lives. 'If it's true that AI is coming for our jobs, then it's coming for everyone's jobs. Our role will be helping people who have suddenly gone from having "too busy" lives to not having enough to do.'



of BACP therapists are already using AI in their work⁶





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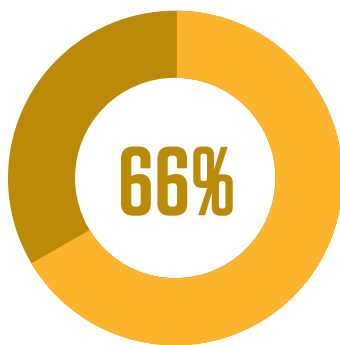


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We'll be working with people who need to think about who they are when their identity is no longer based on their profession. I think there's going to be plenty of work from whatever societal changes there might be.'

In the meantime, Miller says there are plenty of reasons to be positive about the potential uses for AI. 'We're the first generation who have AI and my feeling is that by raising the common bar of awareness about this, we can be confident in finding our own voice about the rights and wrongs of AI use. There is room for debate within our profession, and the more people who know about it I think the better the debates will start to be in the next few years. As practitioners we need to be informed enough about AI so that when clients mention to us they use it, we have a sense of whether their use is adaptive or maladaptive,' he says.

'The potential applications are very exciting, and we should be hopeful about it but only once we know that we're safe and can demonstrate we're able to use it



of 25- to 34-year-olds would prefer to talk about their feelings with AI rather than a loved one⁸

well without harming ourselves or our clients. We need critical thinking and learning, and to train ourselves up on this so we keep asking questions. It's our challenge to set the standards today for how AI gets used in future.' ●

AI and the environment

One of the most compelling, but perhaps the least talked about, arguments for limiting our reliance on AI is the environmental impact, for several reasons:

- Both the development and the use of generative AI require significant amounts of electricity with resulting carbon emissions
- The microchips that power AI need rare earth elements, which are often mined in environmentally destructive ways
- All 'cloud computing' requires real-world infrastructure in the form of data centres housing servers, data storage drives and network equipment. Those that house generative AI require seven or eight times more energy to run than normal computer data centres
- Large amounts of water are needed as part of the cooling process during the development of AI, putting pressure on local water supplies
- Every usage of ChatGPT requires an estimated five times more energy than a normal internet search.¹⁶

- Richard Miller runs online 'AI and the human connection' workshops for BACP. To book onto the next one, see bacp.co.uk/events 🖱️

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Reputation is everything

Rahi Popat fights the corner of Asian men battling for their self-identity

Many British Asian families first came to the UK in the early 1970s¹ when Ugandan President Idi Amin gave them 90 days to leave their East African home country.² Lots of them set up base in various parts of Britain to start their new lives. Building a home was paramount for them, and stability the name of the game. My dad once told me 'We came with only the shirts on our back', which highlighted just how little they had to begin a new life with. This marked the beginning of a fight to build a reputation for themselves in an unfamiliar environment and to form an identity.

Round one: background

Growing up as a boy in an Asian household, in an area where most families were of the same culture and identity, I was always told how important it was to ensure our family reputation remained at the forefront of everything we stood for. Entering adulthood and experiencing life through various lenses, I eventually embarked on my own journey as a person-centred counsellor and began questioning the impact that this 'reputation' has had on the decisions I've made in my life – as well as on the relationships I've formed. The significance of what I'd been through left me questioning at what cost this reputation came, and how it's still playing out in my life today. As I qualified and saw more Asian male clients in my practice, I started noticing this wasn't just a theme relating to me – it was affecting us all.

Much of the baggage we're carrying around reputation is rooted in historical migration and intergenerational trauma. Despite us living three to four generations on since the 1970s, the sheer velocity of 'needing' to protect your reputation within the family set-up remains paramount in our cultural community.³ It's the need to ensure that everything must look and be perfect, the desire to look good at all costs, and the suppression of feelings regardless of consequence to self that personally got me to become the person I am now. It seems, therefore, that there is no better starting place than to explore this client group through the lens of looking within and sharing how reputation has affected me from my story first.

Round two: inner work

My relationships with friends, family and partners were always subconsciously linked to protecting how I looked or how I would be perceived by others. This isn't the same as just worrying about what others will say. I would be thinking specifically about the implications for my family and wider community – not just myself. This kind of pressure forces subtle changes in personality and behaviour, such as holding back from discussing personal relationships with family members from fear of judgment and

avoiding bringing 'shame' upon the family name. Bringing shame to the family in Asian culture is something you viscerally feel: family members won't hesitate to highlight this to you. For me personally, this fuelled and galvanised me to push back and fight for my own self-identity – to ascertain who I was and what my own morals and values were. It was at this point that the wheels were set in motion for inner conflict within me between fulfilling personal desire and suppressing my emotions to fulfil familial expectations.

I spoke to several of my family members who shared this conflict: 'It's not easy to go against what my mum and dad have told me to do', 'I can't change that and I have to do it this way', 'Yes, but what will they think?' or 'I can't do that to them'.* These are just a few snapshots of insight into the value that reputation holds for many. The more I looked into it and started researching, the more evident it became how many members of my community were being culturally silenced by the weight of this norm, and were being impacted physically and mentally. Those around me were getting sick through not eating adequately as they were made to feel guilty for the way they looked. It's extremely common in this culture to disregard your own wellbeing in this way in order to protect parents' reputation. Kindness to self is something we often disassociate ourselves from because it can feel uncomfortable and unnatural, so we will try and shrink away from it, while yearning to offer it to others who may require it.

All of this could not be truer a case than in the therapy room: I have found that my clients would find themselves holding back kindness and empathy to themselves, in order to protect their family relationships at their own expense. During my training and since qualifying I've noticed a pattern especially among the male Asian clients I was seeing. The root of what they were feeling stemmed, like it did for me, from early childhood, where they had to ignore their own needs for the sake of honouring the family name.

Asian men will very often lead the line for their families and are expected to be the alpha male of the house – a societal

driven tradition around providing for the woman and home. Men often feel compelled to conform to traditional gender roles while grappling with their emotional needs.

This is starting to change with each generation and more equality is appearing, and I do recognise a shift in cultural dynamics among younger people. But its remnants still persist, as do its effects on our bodies.

It's understood that suppressing our emotions and feelings can harm our body.⁴ I live with ulcerative colitis, a chronic inflammatory bowel disease that took me the best part of 20 years to understand within this context as connected to stress. Only now do I recognise the link between being diagnosed with it aged 14 and the emotional suppressing I was doing while I was caring for my dad at the time, trying to show a face that we were 'fine'. I often wonder who I'd have been had I not been so worried about reputation but had been allowed a voice and freedom to share what was really happening at home. Could my body have reacted differently? Might I never have been diagnosed?

Round three: clients

I saw Manny,** a young male, for several sessions. As we began to develop the therapeutic relationship I noticed how many of the issues he was facing also came from a phase in earlier childhood. Even his thinking processes in the room seemed to directly link to what he 'had' to do growing up to protect his family. His partner was from a different culture, and the relationship couldn't blossom because of fear of what his parents and wider family would think. He would hide and lie to them in order to keep seeing his partner.

When Manny came to therapy he described going through an identity crisis. He wanted to find himself, who

he was and what he was doing in his life. Each time he spoke about relationships he brought it back to his parents – specifically, needing to not damage the reputation that they had built before him.

Manny was a millennial and his upbringing was driven from inherited ideologies from his parents. The more we dug into his relationship to his parents and family, the clearer it became as to how much it had harmed him. He was fighting so hard internally to be authentic and true to himself. Tears would often run down his face. He would often sit in silence, visibly hurt from the emotional pain of it. Therapy allowed him to think, process and feel for the first time, without any judgment. I could empathise with this. The moment you understand how much this emotional suppression has played a role in your life, it changes everything.

Round four: support

Why is reputation having such a stranglehold over male Asian clients? Fundamentally we are only a few generations on from where it trickled down. Men are increasingly aware of the importance of relationships, and clients are more determined to speak about their reasons for coming to therapy, wishing to understand themselves. However, many have not yet connected the dots around how reputation has had an impact on them – the silent assassin they dare not speak of.

Much of what they bring leads back to their early years. Only when they realise this can they see the light appear and begin to see how it is playing out in their current lives. When that light appears various emotions come with it: anger, resentment, shame and guilt. It often presents as tears – at times uncontrollably – as they return to their childlike state, wanting to soothe that part of themselves. As they notice their anger and resentment, they notice that it isn't just directed at their

'My relationships with friends, family and partners were always subconsciously linked to protecting how I looked or how I would be perceived by others'

parents and grandparents but at themselves for not noticing it earlier. Because for many, they either realise that they ended a relationship with someone they loved because of it, or they realise that they put up with allowing people to act in ways they no longer would.

The fight for self-identity is apparent among Asian men. Sometimes a client is so worried about the reputation they need to uphold for their family that I witness how much the client hampers their own relationship to themselves. It bruises them, bringing about doubt and self-loathing, which they do not recognise as mattering as much as the family flag they place on such a pedestal.

The heavy backpack they carry is evident, but it is our job to lighten it. We can be instrumental in supporting this client group to not let the power of the reputation that precedes them from having such a stronghold over them. We can do this by opening the link between reputation and relationships in their life, in turn allowing them to improve their own relationships, boost self-esteem and self-love.

Round five: same brush

Being a male Asian counsellor affords me an advantage I don't think should be underestimated. Clients often feed back on my relatability: 'I could only talk about this to you because you are an Asian man.' However, working with this client demographic is not a one-size-fits-all approach.

If an Asian therapist comes from the same background as a client or has the same surname, there can equally be a mistrust between them. Reputation can hold such weight, even at the cost of the therapeutic relationship, no matter the associated benefits. I had a client who was unwilling to speak to me about their family in case I knew his parents.* The

assumption that I would know their family (I didn't) hindered their ability to speak freely and congruently, and it was a real fear for him. Many clients fear word getting back to their loved ones, and there can be difficulty in distinguishing between people in their own life and professionals who come from the same background. This works against the relationship blossoming due to the lack of trust.

There are several approaches that could aid therapists. I advise anyone working with clients from this background not to be afraid of bringing parents and grandparents into the conversation where appropriate. Often the stigma around not 'demonising' these generations, coupled with a perception that people in this culture are tight-knit and bonded, could restrict therapists in asking the right questions or taking a client to a place where they may wish to go. In my experience, being curious about the client's family leads therapists to understanding their client's current patterns of behaviour, and how they play out in relationships across all aspects of their life.

It's true that some clients are not going to go there and speak about their family as they consider it sacred. Some are not willing to speak ill of anybody, and while this may be a positive characteristic of the person it may also act as a form of protection for them and their loved ones.

Round six: paradox

The answer to reaching this client group is complex. Stigma is a huge factor, and the issue can't be resolved overnight. What's needed is outreach, to educate people within the Asian community about the benefits of seeking therapy. However, seeking help is often perceived in our culture as 'weakness', especially among Asian men. Having more role models from the Asian community to

speak about their lived experiences could help. Are we having enough open and transparent conversations about this within our profession?

It is up to us collectively to change the narrative. While I respect cultural beliefs, values and morals, this new generation is bringing in a shift. Relationships form the foundation of everything we do. We all crave a sense of belonging. As more clients come into the therapy room questioning their self-identity, it is up to us to facilitate these difficult conversations and allow our clients to prosper.

Open conversations about reputation and mental health within the Asian community are vital. Together we can change our little corner of the world and plant the seeds of tomorrow. While we may not be here to see them grow, we have the knowledge and confidence that we have helped, guided and supported the next generation of the Asian community.

Reputation is 'king' for the Asian community. As therapists we can help clients not to let it become a benchmark for their self-identity, so it is less of a knock-out blow for their relationships. ●

* Permission has been given and details have been changed; **Name has been changed.

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'Open conversations about reputation and mental health within the Asian community are vital. Together we can change our little corner of the world'

‘Therapy helped me confront my anger’



It was a cold, bright day in London when I took a lift up 10 floors to my first therapy session, where I had one key objective in mind: to convince the man in front of me I had no reason to be there.

I had, of course, been the beneficiary of that most treasured of mirages: the happy, normal childhood. The fact I was drinking a bottle and a half of wine every night to drown out my anxiety and get some sleep had to be about something else – work stress, maybe. I figured I’d let off a little steam for a few sessions, perhaps learn some useful coping mechanisms, and then be on my way.

I had no idea that what I was really embarking on was a relationship that would last eight years (and counting) while profoundly changing me. A long, painful and at times exhilarating reckoning with not just the events of my life but the limitations of the persona I had carried out of childhood in which serious cracks were starting to show.

Beyond convincing my therapist I didn’t really need his help, my second aim that day was to make him like me, because making people like me was the only life skill I truly had. I often say the first gift he gave me was a kind but firm instruction: ‘Don’t ask me how I am, this time is for you.’ The idea that I could centre my own feelings and not worry about someone else’s was excruciating at first – until it started to feel radically freeing.

Gradually therapy taught me to understand this compulsion to put others at ease even at my own expense, and where it came from. There were many times I reached a new level of this theoretical understanding – *I am the way I am now, because of things that happened then* – and felt tempted to quit, as though the job was done. But something in me knew the insights I was gaining hadn’t yet permeated below the level of intellect. I understood myself better but it hadn’t changed much about my inner world. So I kept going. It was one of the best decisions I’ve ever made.

Over the years therapy taught me other life skills that I could call upon from time to time, besides making other people happy. How to have honest,

direct conversations. How to spot the useful information smuggled inside difficult feelings. How to halt my relentless inner critic and speak to myself with compassion. Most of all it taught me to trust an emotion I had ignored, repressed and scorned in others my entire life – anger.

Realising through therapy that I was actually *furious* about so many things – and that this was not only OK but could be a source of immense wisdom and power – was the start of finally overcoming what had been a lifelong battle with anxiety. Since I was a child I thought a daily thrum of fear and dread was my lot in life – a cross to bear, a biological inheritance for which there was no lasting cure. Who knew the answer wasn’t to take up yoga or gratitude journaling, or drink myself to oblivion, but to finally give voice to the rage trapped inside my body? First the leg shaking stopped, then a range of other somatic symptoms I’d tried to medicate away for years stopped.

By giving voice to my anger – first in the safety of the consultancy room, then carefully in the outside world – I started to finally achieve some inner peace. I learned to instruct what Carl Rogers called ‘the watchman’ – the rigid, untrusting marshal of my own inner thoughts – to stand down a little. Paradoxically, the more space I made for anger, the more relaxed I felt, and the more generous I became towards other people. I saw less hostility in their actions because I stopped projecting the angry parts of myself onto them. I came to see that, whether it’s in politics, the workplace or our personal relationships, the sense of shame and fear many of us have around anger is the root of so much misery and dysfunction.

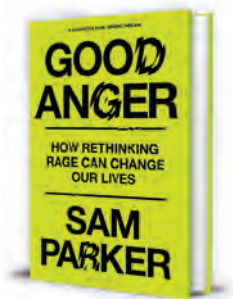
This became the subject of my first book. In it I interviewed people from all walks of life who have come to consider anger a secret superpower – a source of deep wisdom, clarity and purpose. I also spoke with psychologists, researchers and neuroscientists who argue that anger remains the most overlooked, ignored and underfunded of all the core emotions. Together this convinced me that if the mental health conversation needs a new frontier, anger should be it. ●



STUART SIMPSON

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Crossing the line: rape in sport

Working as a dual coach-therapist practitioner helped Susie Masterson address the sexual trauma blocking her client's pursuit of professional goals

Laura* is an ex-professional football player who came to me for career transition coaching. In our consultation she told me that she wanted to work with me because of my role as a dual coach-therapist practitioner – however, as she had recently left therapy, she wanted to focus on coaching.

For a few weeks Laura and I worked together on some achievable goals using a strengths-based coaching model. However, there was clearly something getting in the way of her confidence. I suggested we hit the pause button, and asked how it would be to spend a session discussing this together. In the following session Laura disclosed that her recent therapy was to talk through a sexual assault but that she had thought she had 'processed it all'.

Having originally trained and worked with Rape Crisis, I have worked with hundreds of survivors of sexual and domestic abuse. Now working in private practice as a dual practitioner, my client base is still predominantly female. However, there are other intersectional aspects including a high prevalence of neurodivergence, gender fluid and non-binary, and LGBTQIA+ clients.

I instinctively asked Laura what her negative belief was about this experience. She replied: 'I don't matter.' I asked her if she felt that this belief might be holding her back in her coaching goals and in successfully navigating the next stage of

her career. It definitely resonated when she reflected on her confidence now compared to before the sexual assault.

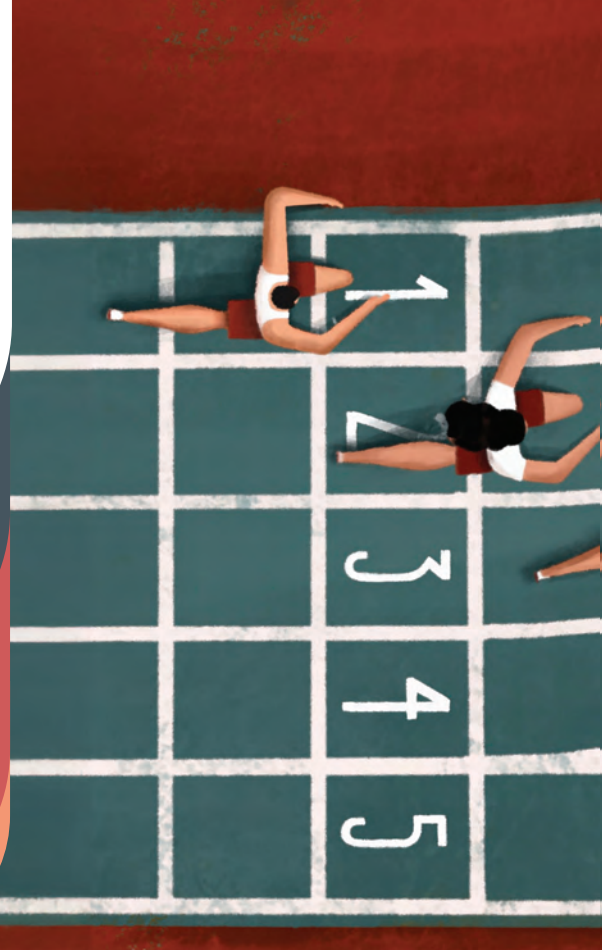
Dual practitioner

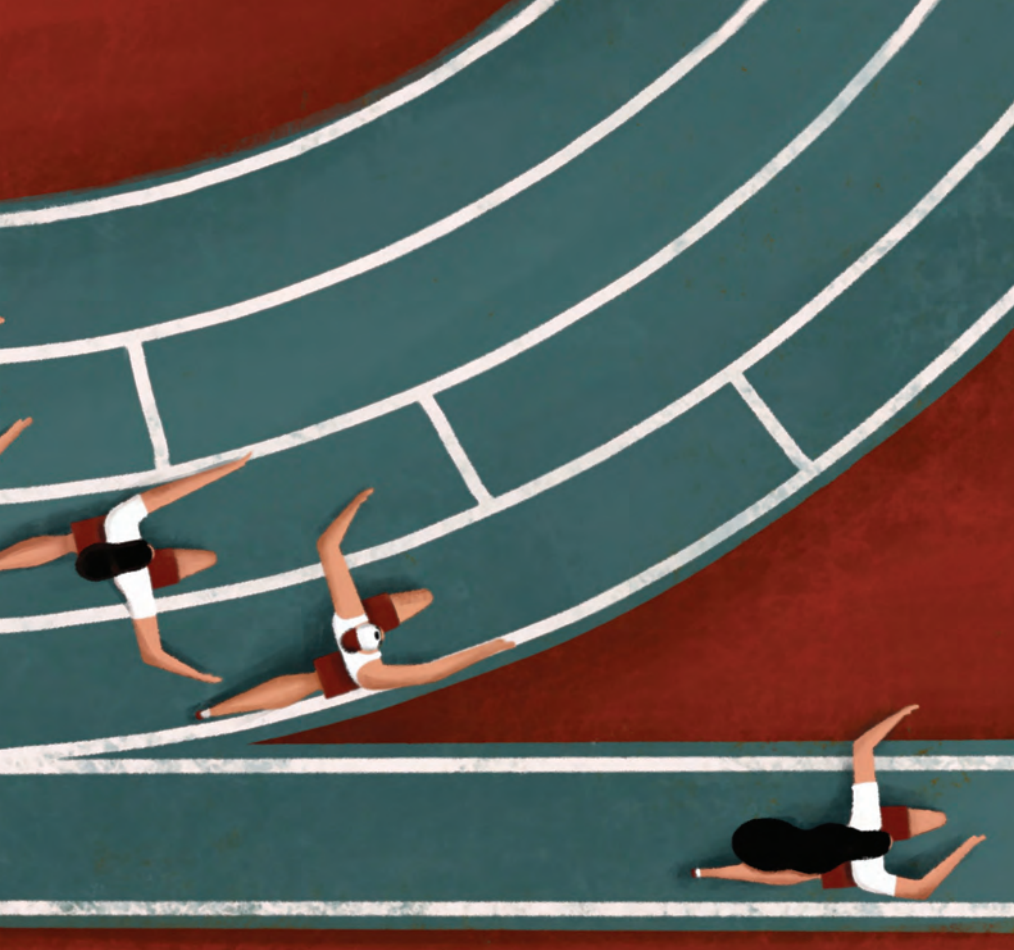
As a dual practitioner I usually find that I integrate coaching into my therapy work, in collaboration with clients, not the other way around. But for Laura I realised I needed to focus on some therapeutic work before the coaching could begin. This is where my eye movement desensitisation and reprocessing (EMDR) work came in.

Irrespective of what type of work clients approach me for, I use the same master contracting agreement with some inserts that cover specific considerations for the type of work we are engaging in. For example, for EMDR clients there is a specific insert that covers details of a secure online platform that we use for processing together with some additional suggestions around transitioning in and out of sessions. For coaching work the insert covers information around homework and shared documentation that we use both in and out of the session.

Contracting is also something that I practise continuously within sessions. In this instance I explained to Laura the potential benefits of introducing EMDR into our work: what it would be like, what preparation we might need to do, what outcomes we expect, and a change of platform (I currently use Bilateral Base as it provides visual and audio options for clients who cannot engage with self-tapping). We contracted for four sessions together – with the first session to be focused on case formulation including history taking, understanding the people and activities that had sustained her throughout her life, and finally capturing a detailed description of a safe space.

In private practice practitioners use EMDR to help with a number of presenting issues and symptoms including OCD, anxiety, nightmares, intrusive thoughts and attachment issues in relationships. Having worked with hundreds of clients in a therapy setting I have also found that EMDR can be incredibly useful for dealing with future challenges that arise in coaching sessions,





provides access to fragmented information – sights, sounds, smells, tastes associated with a traumatic or adverse event. Bilateral stimulation is a part of everyday life in activities such as walking or swimming, for example. This is actually how EMDR founder Francine Shapiro first identified the potential for what would become EMDR, as she noticed how, through walking, she felt less distressed (when thinking about an adverse experience).

In EMDR processing, bilateral stimulation can be achieved in a number of ways including the client tapping their body, following lateral arm movements (from the practitioner), or for those of us working online there are secure platforms providing dots on a screen (similar to a metronome). Clients can choose to keep their eyes open or closed. The practitioner can observe eye movements similar to how we experience REM sleep.

It is also believed that bilateral movement has a calming effect on the parasympathetic nervous system, which helps us revisit traumatic experiences without becoming overwhelmed.

Desensitisation can often happen in a single session. This means that the impact of the negative belief, together with the distress levels associated with the target (event), is lessened. Clients' distress levels are scored at the start and end of the process on a scale of 0-10, 10 being high. Reprocessing usually takes up to three sessions and involves the brain adaptively processing the target event, accepting that it happened in the past and believing something positive about ourselves (as the victim of a traumatic or adverse experience) despite our experience. As Shapiro describes it: 'When an event has been sufficiently processed we remember it but do not experience the old emotions or sensations in the present. We are

such as interviews, presentations, dating and public speaking.

Negative beliefs

As an EMDR practitioner I regularly work with the concept of negative cognitions (or beliefs). In EMDR processing, the sum of a distressing event or adverse experience plus a negative belief equals a trauma 'target'.

Negative beliefs are common among survivors. In trauma processing, negative beliefs are captured as 'I' statements. They represent how we feel about ourselves and our identity as opposed to situations that we were exposed to. An example would be 'I'm too much' rather than 'I've experienced too much'.

For Laura it took fewer than three 50-minute EMDR sessions to process the 'target' of her sexual assault and the associated negative belief that she 'didn't matter'.

Laura had been invited to a meeting with a prominent male coach. There was a last-minute logistics change and they ended up meeting in a bar. Laura felt as though she needed to 'keep pace' with

the coach in drinking in order to be seen as 'interested and resilient'. Laura had hoped that this meeting would open doors to coaching.

In our sessions Laura explicitly referenced 'blurred boundaries' and how she felt uncomfortable and wanted to go back to her hotel room at several points in the evening. However, she also consented to continuing the conversation in multiple bars, ultimately ending up at the coach's hotel.

The following morning the coach said to Laura: 'I must admit I was surprised that you wanted to go all the way. But, to be honest, I always thought you swung both ways.'

The theory behind EMDR is that bilateral stimulation activates both hemispheres of the brain. This activation

'In EMDR processing, the sum of a distressing event or adverse experience plus a negative belief equals a trauma "target"'

informed by our memories, not controlled by them.¹

Negative beliefs are particularly common in sexual assaults due to a combination of societal factors where women – who are statistically the majority group with one in four women in England and Wales reporting experience of sexual violence² – are often blamed by the justice system and the media for their circumstances. An additional psychological reason for pervasive negative beliefs among survivors is the concept of blurred boundaries. Survivors often assume responsibility for their circumstances due to decisions they did or didn't make over the course of their experience. This is a survival strategy in that it stops us from feeling helpless/powerless.

Adaptively processing experiences of sexual assault promotes both integration and post-traumatic growth, enabling survivors to see themselves through the perspective of a victim who was not responsible for their circumstances.

LGBTQIA+

It's a common scenario for clients in the LGBTQIA+ communities to report instances of sexual violence where the perpetrator used their sexual identity against them as a way of minimising harm. In particular, clients who work in male-dominated industries such as sport, entertainment and technology have experienced microaggressions around both sexuality and gender. These beliefs are rooted in homophobia and misogyny.

Although statistics are limited, studies have shown that there is a higher proportion of LGBTQIA+ athletes in women's sport in particular. In the 2023 FIFA Women's World Cup more than one in 10 players openly identified as lesbian, bisexual, queer or non-binary.³

For Laura there were a number of childhood experiences that fed into her negative belief of 'I don't matter'. One of them was her sexual identity. During her childhood Laura always excelled at football, however in Ireland (where she grew up) girls' football wasn't a thing. This meant that she was both playing with and competing against boys. She recalls how

'Survivors often assume responsibility for their circumstances due to decisions they did or didn't make over the course of their experience'

other parents would shout at her from the sidelines, calling her a 'dumb dyke' and talking among themselves about how she had 'stolen' their son's place on the team. This led to difficulties at home whereby Laura's parents would often compare her unfavourably to her older siblings, claiming that her sexuality and gender were causing 'issues' among their friendship group.

Laura also struggled as a teenager when she moved to the US to train professionally. She recalls how the soccer camps were simply not set up to support women and girls in the game. Coaches would frequently say things like 'Stop doing press-ups like a girl' or 'I thought dykes were meant to be strong'.

Other clients have also spoken about how they felt as though their sexual orientation was seen as a challenge or a temporary state, disclosing regularly being taunted in the workplace, and in some instances of a 'febrile environment' whereby they felt unable to 'neutralise the tone of the conversation'. This type of behaviour can escalate to a form of violence sometimes termed 'corrective rape', which is not only an act of sexual domination but also an attempt to assert control over a woman's autonomy and identity.

Adverse childhood experiences

In my experience it is rare to meet a survivor who knew their perpetrator who doesn't experience self-blame. This tends to be split between behavioural and character-based feelings. Examples of behavioural self-blame include statements such as: I shouldn't have gone with him/I should have fought him off/I shouldn't have worn those clothes. Examples of characterological self-blame include statements such as: I am dirty/I am damaged/I am worthless. Self-blame is often more pronounced in

clients who have experienced adverse childhood experiences (ACEs).⁴

In my work with Laura, because we were focusing on coaching, it wasn't appropriate to spend multiple sessions discussing ACEs. However, in EMDR case formulation I use a tool that helps collect a number of different trauma targets, which reflect different stages of life from early childhood to the present day. This usually means that I uncover ACEs in the way events or experiences are disclosed by clients. These can be used to inform further EMDR processing as well as future talking therapy and/or coaching sessions.

Research on ACEs shows a strong correlation between ACEs and poor mental health outcomes in later life. Like trauma, definitions of ACEs are regularly portrayed in both academia and the media as what I call 'big ticket items'. Trauma is often defined as resulting from a car accident or a plane crash, experiencing a natural disaster or living through conflict. ACEs are often defined as abuse, neglect, poverty, chronic illness/injury. A UK study found that 50% of adults have at least one ACE, and 9% have experienced four or more.⁵

While being gay itself isn't an ACE, LGBTQIA+ individuals, including those who identify as gay, often experience higher rates of ACEs due to factors like discrimination, stigma and lack of acceptance, which can be considered forms of adversity.

Laura often made jokes around her sexual identity, something which I reflected back in one session when I asked whether it could be that she uses humour in these situations as a defence mechanism. This resonated with her and helped her talk about coming out to her parents and the inferiority she felt compared to her older siblings who were 'both straight and straightforward'.

Neurodivergence

Within our time working together Laura was diagnosed with ADHD, something that she claims 'came as a surprise to no one'. Among many things, it sheds light on why she found it so difficult to retire from football – a world of structure, intense exercise, variety and excitement – and how this has likely influenced her 'difficult career transition' and our coaching sessions. Furthermore, Laura's experience of sexual violence was in a setting related to both the professional game and her career transition.

Research also supports that there is a correlation between ADHD and elite sport, with studies suggesting that college athletes are four times as likely as non-athletes to have ADHD. Factoring in that boys are twice as likely to receive a diagnosis than girls, the actual number is likely to be higher in female and some non-binary athletes.⁶ Research also indicates that neurodivergent clients are at a higher risk of experiencing sexual violence and harassment compared to their neurotypical peers. Increased percentages apply to both childhood and adulthood experiences.⁷

Neurodivergent clients, in particular clients with ADHD, have disclosed how they 'missed signals' in the retelling of their experiences of sexual assault. This client group also referenced how they put themselves in 'risky situations'. Examples include hiring a male massage therapist to come to a hotel room, staying out late alone in bars and engaging in paid escort work.

In UK law,⁸ the three pillars of valid consent are that it must be voluntary, informed and that the person giving consent must have capacity to do so. It's important to recognise the potential influence of ADHD in all three pillars given that common characteristics of ADHD include increased impulsivity and

engaging in risk behaviours, reduced ability to interpret social cues, low self-esteem and high co-morbidity factors including depression and anxiety.

Laura was exploring and integrating her diagnosis and how her ADHD may have played a part in her decision making and experiencing of sexual violence. Laura struggled with the label of 'dumb jock' stemming from her teenage years into her professional career. Sometimes she reflected on how it felt 'positive' in that it allowed her to navigate difficult situations within the context of the game. For example, when it helped her speak out and advocate for the team to get their own kit and separate changing rooms, or times when she 'argued' for better medical care when she was injured. She reflected on how what she now calls her 'ADHD brain' meant that she was able to keep going and 'keep up the fight' without any fear of pushback or recourse. It is through this lens that Laura also considered the combination of risk taking and a sense of 'invincibility' around people associated with the game, to help her understand her own decisions within the context of the sexual assault. Together with the EMDR processing, this helped further reduce self-blame.

Unstuck

Laura remains an ongoing client and recently reflected on how having EMDR helped her become 'unstuck' in processing the sexual assault. It had a ripple effect in other areas of her life when she felt as though she didn't matter. Laura has a public-facing role where she represents women in sport and often suffers with what she describes as 'impostor syndrome'. Many of our subsequent sessions have involved further psychoeducation about the hierarchy of trauma and how when survivors speak of their lived experience they can feel as

though they need to speak for all survivors. When I redirect Laura back to the target of the sexual assault and remind her of the positive belief she took on during processing, which was 'I do matter', she speaks of feeling more 'confident' and able to be her 'authentic self' in these situations. ●

**Laura (not her real name) has given permission to be a case study in this article.*

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'Neurodivergent clients, in particular clients with ADHD, have disclosed how they "missed signals" in the retelling of their experiences of sexual assault'

IS IT OK TO MOVE SATURDAY CLIENTS TO ANOTHER DAY?

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When I first set up in private practice I included Saturday mornings in my availability in order to attract as many clients as possible, and these slots proved popular with people working during the week. However, now my practice is consistently full and I am working five days

a week as well as Saturday mornings. I feel it would be better for me and my family to have a proper weekend that doesn't involve work. I have three long-term clients who come on Saturday – I have managed to move two to weekday slots but a third can't come at any other time. My supervisor has suggested I put my self-care first and work towards an ending with this client, but every time I suggest this they get very upset. I feel like I am stuck working on Saturdays when I know it's not in my best interests.

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When we work in private practice we forgo many of the benefits that often come with employment, such as regular and consistent income, paid holidays, sick days and pension contributions. The pay-off, however, is freedom and flexibility to work under our own terms, which includes setting our own hours. Like all private practitioners you have the autonomy to decide which days of the week you'd ideally like to work, and what those working days look like, which includes what your ideal number of client hours may be, and how you space them during the day. Giving this some thought is in our clients' best interests as well as our own.

When I started in private practice, like so many of us my working hours were

determined by when clients could come rather than when I wanted to work. When I received a new client enquiry I'd ask when they were free to come, then see what I could offer around that time. As well as daytime appointments I worked several evenings, including offering one client a 7pm slot on a Friday as that was her only availability. It wasn't long before I came to the conclusion that I didn't want to work evenings, but at the time when just starting out it seemed the right thing to do. Being able to offer a wide range of sessions was crucial in helping me build a client base, and with it confidence in being a private practitioner. It sounds as though you have been through a similar process, and I suspect it's very common.

Now established, you are in a position to pause, step back and assess what's working well and what needs rethinking about how you work. Many clients do value Saturday

appointments, and it is a testament to our commitment to our profession that so many of us are willing to give up our weekends to ensure people can seek the support they need. Some practitioners adjust their week so their 'weekends' become Sundays and Mondays, or Mondays and Tuesdays if they also offer Sunday appointments, a practice long adopted by many other professionals who work in the service industry. But that does not suit everyone, and can mean we are 'out of sync' with friends and family, missing out on social, cultural and religious events. Now you feel that you no longer want to offer Saturdays, and that is a valid 'want'. You have given good reasons for this – prioritising family time and your own self-care.

Self-care

Before we go into the dynamics of what may be happening with your client who is reluctant to move, let's look at self-care. Your supervisor is right to advise putting your own self-care first – if we are not in good psychological, emotional and physical health, we may not be robust enough to be fully available to our clients, to listen and be fully present to what they need from us. Left unchecked, inadequate self-care may lead us to burn out, or affect the quality of our work to the extent that we cause harm to our clients or let them down. To minimise the risk of this we commit under the *Ethical Framework* to 'ensuring that our wellbeing is sufficient to sustain the quality of the work' (Our commitment to clients, point 2d). We agree to maintain 'our own physical and psychological health at a level

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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ALICE MOLLON/IKON IMAGES

that enables us to work effectively with our clients' (Good Practice, point 18), and that we will keep 'a healthy balance between our work and other aspects of life' (Good Practice, point 91d).

In practice this is not always easy, especially as people who are drawn to

therapeutic professions are often natural helpers used to putting others' needs before their own. As Karen Stainsby points out in the Good Practice in Action resource *Self-care for the counselling professions* (GPiA 088), 'Practitioners encourage clients to look after themselves, but their own

self-care may not always be a priority.' Even Carl Rogers said that he had 'always been better at caring for and looking after others' than for himself.¹

Having established a practice, you're now at the 'novice professional phase' stage of your career according to Helge Rønnestad and Tom Skovholt, who have done much research into the developmental phases of a practitioner. They identify a key developmental task of this phase as 'maintaining a sense of professional growth and resiliency while avoiding burnout and stagnation'. Part of this process is developing what they call 'boundaried generosity', a concept they describe as 'paradoxical, like the word bittersweet', combining constraint and deep giving of yourself, the balancing of 'other-care and self-care'. However, as they point out, when our 'nature, training and background [are] focused on the needs of the other', it is often only after being 'engulfed in human need and becoming exhausted' that we accept the need for 'more expertise-level self-care skills'.²

When we start in practice we are often – understandably – focused on questions such as what type of work are we drawn to and feel we can do well, and what might clients need (and therefore provide us with a thriving practice)? Once established, however, you may notice that underlying concerns of 'how can I make a living doing this?' have evolved into 'how can I make this sustainable?' Sometimes that means making decisions that may impact some clients in the short term but ultimately put you in a position to continue working – and therefore supporting more clients – in the longer term.

You have managed to transition all of your Saturday clients to weekday sessions apart from one who you say gets upset when you talk about moving their session time. Given that the very first agreement under the *Ethical Framework* is to put clients first, and make them our 'primary concern while we are working with them' (Our commitment to clients, 1a) it's good practice that you are taking the upset seriously. By taking it to supervision you have followed your commitment to give careful consideration in 'consultation with a supervisor, [or] an independent experienced colleague' any professional or personal

'Left unchecked, inadequate self-care may lead us to burn out, or affect the quality of our work to the extent that we cause harm to our clients or let them down'

interests that conflict with 'putting a client's interests first' (Good Practice, point 8).

Resistance

What strikes me as interesting about this dilemma is that it involves resistance from both sides – resistance from your client to change their session time, and resistance from you to carry on with your plans to change your working hours in the face of their resistance.

Clients get upset – it's what we sit with each day in our therapy rooms. They get upset with us for both everyday and more complex, unconscious reasons. Our ability to tolerate a client's upset and allow space for it in the room helps clients become aware of their responses to upset and how they influence their relationships.

You don't describe how your client communicates their upset but this could take many forms, including crying, shouting or raising their voice, becoming physically agitated, or withdrawing and becoming uncommunicative. Whatever their behaviour, if their intent is to shut down the discussion, they have succeeded – you have been shut up. I wonder whether this is present in other areas of your work with this client or with clients in general, or

indeed in other areas of your life? What underlies your emotional response to this situation will be a rich topic for discussion in supervision.

It may feel easier to just drop the subject and allow your client to keep their Saturday spot, telling yourself 'It's just 50 minutes/an hour', but by doing so you are delaying by another day the feeling of relaxation we enjoy when we reach the end of a working week. This matters even if we love our work – we need a break from routine otherwise life can feel like a treadmill. It will also impact family plans for weekend breaks or days out. It's not surprising then that you feel 'stuck with the client', a feeling that might develop into resentment at their presence in your life at the weekend – you want to reclaim it as your time, and they seem to be stubbornly refusing to budge. But let's take a moment to think about what might be going on for them.

Client's perspective

There is a reason many of us prefer to offer clients regular sessions at a time that is fixed and remains the same. It forms part of the therapeutic frame that we create to help clients feel contained and safe enough to explore difficult or painful aspects of

their experience. Often we can observe their progress by their ability to tolerate or even initiate flexibility to this frame by, for example, asking whether they can move to fortnightly sessions.


We don't know why the idea of moving from their usual slot is causing upset for this particular client, but we can try to put ourselves in their shoes and think about how it might feel. For distressed and traumatised clients the change of routine that goes along with moving their regular therapy time slot might be deeply unsettling or just feel too much to process. To some clients the withdrawing of their usual session time will be experienced as an abandonment or being let down. They might wonder if you are trying to 'get rid' of them altogether. If you have shared that you would like your weekends for your family, they may feel rejected and hurt by the reminder that there are other people in your life who take priority over them. This will feel especially hard for those who don't have supportive family, friends or other social connections. For someone who spends their weekends largely alone, a Saturday morning therapy session might provide the human contact they need to make that tolerable.

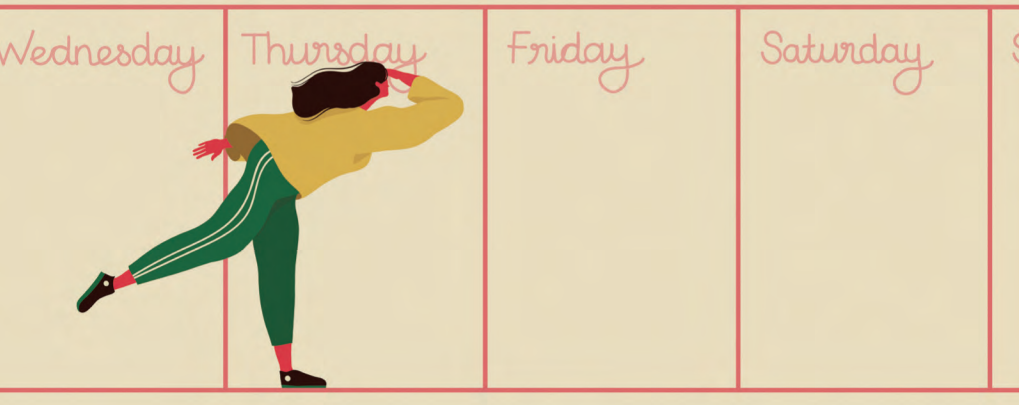
Sometimes focusing on one issue is about avoiding another. Your client may be digging their heels in about continuing to attend on Saturdays as a way of avoiding difficult situations elsewhere in their life – for instance, does this appointment time allow them to come to therapy without telling their partner or other significant person in their life? Does it mean they avoid a difficult conversation with an unsupportive manager at work about why they might need some flexibility to their current working hours? Would coming at the alternative time you are offering mean they have to miss a leisure activity, or a regular social gathering or meet-up?

Some clients, including those who are autistic, may especially be impacted by a change to their routine, and feel overwhelmed by the prospect of getting used to coming at another time. For disabled clients there may be logistical reasons – Saturday may be the only day they can access the help they need to get to the therapy room. Under the *Ethical Framework* we agree to 'make adjustments

SUPPORT AND RESOURCES

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

- *Working in private practice within the counselling professions* (GPiA 004)
- *Ethical decision making in the context of the counselling professions* (GPiA 044)
- *Accountability and candour within the counselling professions* (GPiA 073)
- *Reasonable adjustment in the counselling professions* (GPiA 080)
- *Self-care for the counselling professions* (GPiA 088)
- *Working with disability in the counselling professions* (GPiA 096)
- *Workloads and the counselling professions* (GPiA 099)
- *Working with unhealthy dependency within the counselling professions* (GPiA 115)
- *Recognising and managing attraction within the counselling professions* (GPiA 119)
- *Breaks and endings in the counselling professions* (GPiA 132)
- BACP Decision making for ethical practice: bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/decision-making-for-ethical-practice 



to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service' (Good Practice, point 22f) – for more on this, see GPiA 080, *Reasonable adjustment in the counselling professions*.

There is also the more complex issue of client dependency. In the Good Practice in Action resource *Working with unhealthy dependency within the counselling professions*, Sharon Cox makes the point that an element of dependency is both usual and natural in the therapeutic relationship. However, a client can become overly dependent if there is an 'unwillingness to accept the need for the development of their own autonomy and trust in themselves'.

Discussing these issues with your client means both of you sitting with the upset. For you, it means being aware of any impact it has outside the therapy room and on the rest of your client work. You may like to consider increasing the frequency of your supervision sessions during this period, availability and affordability permitting, or using peer support from a trusted and experienced colleague.

Candour

One of the personal moral qualities we are encouraged to aspire to as practitioners is 'candour', defined as 'openness with clients about anything that places them at risk of harm or causes actual harm'. The *Ethical Framework Glossary* definition of harm includes 'Emotional, psychological,

relational, social, behavioural or physical damage', any action which may 'result in distress, heightened anxiety, damage existing relationships, reduce the capability to relate to others, and undermine the self-respect or sense of personal worth of the person concerned'.

Could acting with candour here with the client prevent you causing harm to them? According to Karen Stainsby in *Accountability and candour within the counselling professions* (GPiA 073), candour calls on many personal moral qualities, including 'humility to assess accurately and acknowledge one's own strengths and weaknesses, courage to admit to a mistake, empathy to understand the injured party's perspective and wisdom to decide what to do next. Self-awareness underpins every aspect.'

What candour would look like depends on you, the type of therapeutic approach you take, and your relationship with the client, but you might discuss in supervision how open you want to be with the client about the importance of the move for you. That doesn't have to mean sharing that you are prioritising time with your family at weekends, but you could perhaps let your client know that you have given a lot of thought to the decision to change your working hours, and that there are important reasons behind it.

Phasing change

As therapists we see our work with clients as a collaborative process, using regular

reviews to talk about how we are working together, to flag up any breaks such as holidays and also discuss the impact of any suggested changes. We take their views and concerns seriously – one of the ways we commit to showing respect to our clients under the *Ethical Framework* is by 'working in partnership with clients' (Commitment 3d). It's clear from your question that you value collaboration as you have held off making the change while the discussion process with your client is ongoing.

You have not given any details of how your conversations have gone, but given that the prospect of moving session times may cause anxiety, it's up to us to shoulder the emotional load of this by doing the thinking about the best way to approach it. It's not appropriate to ask a distressed and vulnerable client when they might be ready to move. As with endings, it's our role to work out, with the help of supervision, an appropriate time frame, and what needs to happen during the transition to that time.

Many of us employ phased approaches to endings, often by increasing the gaps between sessions, so the client becomes 'used' to longer time periods without a session. Could a similar phased approach work here, with perhaps every other session held at the new time, allowing the client time to bring any issues it causes to the sessions and for you both to explore the emotional impact? This could involve the client trying out a couple of options for weekday slots, if this is available in your practice.

If the client genuinely can't attend on any other day than Saturday, one option is to hold that slot until the client's work comes to an end. Depending on client need and how you work, this may need to be set several months into the future, but knowing there is an end to your Saturday working may make it easier to accept for now.

As stated in the Good Practice in Action resource *Breaks and endings in the counselling professions* (GPiA 132), we do not have a duty to work with clients indefinitely, and we do not need a client's permission to end their sessions. Would you also be relying on this client's

'We don't know why the idea of moving from their usual slot is causing upset for this client, but we can try to put ourselves in their shoes and think about how it might feel'

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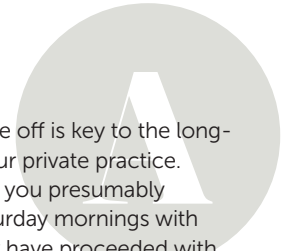
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permission if you wanted to take a planned break for health reasons, pregnancy or a sabbatical, to stop practising privately if you went into a paid job, or indeed when you come to retire?

We do, however, have an 'ethical obligation to act consistently with the client's best interests in mind'. Part of this might be referring your client on to a trusted colleague who does offer Saturday sessions. For more on this, see *Breaks and endings in the counselling professions*.

Contracting is a key way that we communicate with our clients what they can expect from their therapy sessions. You don't say what (if anything) was included in your contract about session time/day changes, but given that this situation has come up, it might be worth a review.

Making your decision

Your dilemma sums up one of the many balancing acts we have to manage as practitioners – balancing our own needs against the needs of the client. You might find it useful to work with BACP's *Decision making for ethical practice* model, which can be helpful to work through with your supervisor. This 12-step model involves self-reflective questions to take you through a process of coming to a decision. You can find information on using it in GPIA 044.

It is possible to acknowledge and take seriously the impact on your client of the session move, and the feelings it creates for them, while also carrying on with your plans. Managed well, the transition to a new session time can become part of the therapeutic work, helping the client become aware of the roots of their resistance to change, and to find out that they can survive it, an experience that may benefit other areas of their life, including how they are in their relationships and how they get their needs met, and their personal growth as a whole.

'While the client might feel unsettled about the ending that does not necessarily mean it will be harmful, especially with your support. Sometimes endings can be empowering'

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1. Rogers CR. *A way of being*. Boston: Houghton Mifflin; 1995. 2. Rønnestad MH, Skovholt T. *The developing practitioner*. Hove: Routledge; 2013.



SALLY BROWN MBACP

is a therapist and coach in private practice, and a freelance journalist and editor.

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

READER RESPONSES

You contracted for Saturday mornings with this client and they proceeded on that basis

It sounds like you're facing a difficult decision and I hear you're very concerned about your client getting upset. This to me merits returning to supervision to gently explore whether you are struggling to set your boundaries because you're feeling responsible for their distress? Also worth exploring is whether an ending will cause harm, or would it help the client to build resilience and a tolerance towards transitions?

There do seem to be a couple of ethical principles that are causing you to question yourself. First, non-maleficence: not doing harm. However, while the client might feel unsettled about the ending that does not necessarily mean it will be harmful, especially with your support. Sometimes endings can be empowering.

There's also the principle of self-respect. From my personal experience – and from mentoring many therapists – I've found

that protecting time off is key to the long-term viability of your private practice.

Having said that, you presumably contracted for Saturday mornings with this client and they have proceeded with therapy on that basis. Although your needs have shifted, theirs haven't.

You may like to consider your wider practice goals. In the longer term, having satisfied clients is something that will build and maintain your practice reputation. Continuing to support this client may not only help them feel safe and held, but could also reinforce your trustworthiness and lead to future referrals.

You've described feeling stuck and I wonder if that indicates a sign of growing resentment that could impact the work. However, you may also like to reframe this as a choice. Rather than feeling you have to keep this Saturday client, you could see it as something that you get to do. It may be a short-term inconvenience but long term it shows reliability and consistency – and ultimately supports your long-term goal of building an ethical and trustworthy private practice.

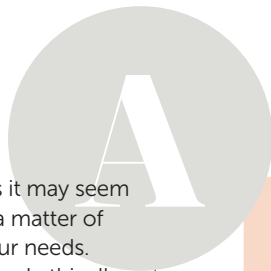
JOSEPHINE HUGHES MBACP (ACCRED) supports therapists in private practice with her weekly podcast, *Good Enough Counsellors*, and her membership group, the Therapy Growth Group. josephinehughes.com

Your supervisor is right that your self-care needs to be uppermost

As a therapist who has negotiated issues like this, and no doubt will do so again, I empathise. It is hard, but plainly put, it is a matter of our self-care balanced with that of the client – and it seems that we can tend to neglect our own best interests. You have seen with other clients that it is manageable, but this is about the resistant client, who sees you continuing to work in a way in which you would rather not.

A question I would be taking to supervision would be what the benefits would be from continuing to work with this client when there is possibly some resentment on your part, because you would prefer not to be there at that time.

Perhaps you are not listening sufficiently to the voice of your own needs? I know this is hard, it is not my intention to sound flippant or dismissive, as if it is an easy



matter to resolve, but perhaps it may seem a little easier if considered as a matter of taking care of yourself and your needs. You are perfectly entitled, indeed ethically bound, to do so.

You have tried to address working towards an end with this client, as suggested by your supervisor, but they get upset. I am curious as to whether there may be issues of dependency, reliance and/or attachment here, which it may be helpful to consider?

You may have already looked at other options for the client such as weekday early mornings/after work/online, which may or may not be possible or desirable. Could the regularity of the Saturday appointments be reduced, with the intention of a phased ending and giving you some weekend time?

I think your supervisor is right that your self-care needs to be uppermost in this. You are not showing ethical diligence to your client or yourself by continuing to work in a way that you do not wish to.

CATHERINE WILLIAMS MBACP is an integrative therapist in private practice in Sheffield, with special interests that include grief, bereavement, anxiety and depression. cornerstone-sheffield.co.uk

The client's best interests are not met

Working on a Saturday is not in your best interests, but is it really in your client's? It seems that you have suggested ending several times and their response is to get upset, forcing you to give in to them. I'm curious as to how this client has responded to other interruptions and boundaries in the course of counselling, and what is in the space between you? You describe them as a long-term client; do they think this means for ever? Can you explore what holds them back from trying life without you? Surely it is not in their best interests to be so dependent on you?

It may be that you are in the middle of the work with this client so an ending might feel abrupt, but unexpected endings do happen. You are willing to plan this with the client (presumably with a suitable time frame and options for referral), and your choice is valid. I wonder if you are hesitant to end this client's Saturday sessions

because the decision to no longer work on that day was your choice, rather than being forced on you by circumstance, and therefore appears less valid? My concern for you is that you will become resentful each time you have to turn down weekend plans for this client. Would this reduce your empathy and affect your work? Again, the client's best interests will not be met, as well as your own.

What of your other clients? Our commitment under the *Ethical Framework*

(Good Practice, point 91) to 'take responsibility for our own wellbeing' is for the good of our clients, and this means all of our clients. The clients you see all week need a rested and refreshed counsellor as much as you deserve that rest. For their sake, as well as your own, can you bring Saturday sessions to an end?

FIONA REID MBACP works in private practice in Edinburgh and online, working with anxiety, depression, low self-esteem, relationship issues and faith crises. fionareidcounselling.co.uk



HOW WOULD YOU RESPOND?

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

Is it good practice to take a client sabbatical?

I have worked in private practice for 15 years and usually have a caseload of around 20 clients a week. Recently I have noticed that if a client cancels I feel pleased, and I also find myself reluctant to take on new clients. My supervisor has suggested that I could benefit from taking a client sabbatical. I really like the idea and could afford to take up to six months off but wondered if it was considered good practice, and what the pros and cons (for both me and my clients) might be.

Issue: September 2025 **Deadline:** 30 June

Am I not suited to being a supervisor?

I've just qualified as a supervisor after investing a large sum of money to complete a respected diploma course. I now have a few supervisees but have been surprised at the turnover – several have started working with me then left. I am realising that I don't enjoy the work. I worry at times about the responsibility of overseeing other practitioners' work while not really knowing what they do in the therapy room. I also struggle with the approaches of several of the younger supervisees around posting on social media and what they self-disclose. I am now unsure about whether to continue in the hope I will start to enjoy it or face up to the fact I am not suited to it.

Issue: October 2025 **Deadline:** 28 July

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.

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What erotic transference taught me

Guinevere Grimley describes how being brave enough to tell her long-term therapist that she had developed feelings for him became a gateway to deep understanding

It began subtly. A faint hum in the background of my life. I dismissed it at first: a flicker of unease, a charge after an intense session with a client or, more curiously, with my therapist. But soon it became impossible to ignore. I started to wonder what this hum meant. It followed me out of sessions and into my evenings. At first it felt benign, maybe even irrelevant. But over time it gathered weight. There was something there asking to be understood.

To put it bluntly, I felt exhilaration, joy, fear and something more primal. A physiological thrill that made my pulse quicken. It felt achingly familiar. Like the early thrill of falling for someone, that spark that sets your whole being alight. But there was nobody there.

Looking back, I wonder if it wasn't therapy itself that primed me for this but the stark absence of physical and sexual intimacy outside it. In that vacuum of touch, connection, erotic

energy, my closest emotional bond took on a different shape. I was no longer in the familiar role of caregiver. I was being witnessed, held in mind, attended to without needing to offer anything in return. That shift was disorienting. And it introduced a charge not just of longing for attunement but for something more visceral.

I hadn't been on a date in months. I wasn't looking for love. So why this?

The answer that inevitably surfaced was that it must be my therapist.

Projected feelings

I felt both alarmed and repelled. I know transference well; the idea that we project unresolved feelings and needs from the past onto someone in the present. Erotic transference is a more specific form. The projected feelings take on a romantic or sexual charge. It carries the added weight of desire, power and unmet needs for intimacy. This distinction matters. All therapists encounter transference, but erotic transference introduces deeper ethical and emotional complexity.

And yet, this didn't feel like projection. It felt real. Vivid. Still, part of me wondered: isn't that the point? That transference feels real because it touches something unresolved within us? Even so, it felt pathetic. Destructive. I shouldn't feel this way about my therapist. It would be asking him to reciprocate something unethical. Something delusional. He's half a world away. We meet via video call. It was ridiculous to project this onto him. He'd never, not once, even hinted that anything like this had crossed his mind.

My emotions spiralled into shame and self-loathing. 'Of course,' I thought bitterly. 'Find the most unavailable man to fall for.' All the work I've done on self-worth and esteem? Pointless. I was just repeating the same old pattern.

The shame hit like a wave and dragged me under. But as I flailed, another voice emerged. Why shame? What made these feelings feel so wrong, so unbearable?

Understanding shame

It wasn't the first time shame had shown up. It had a familiar shape. A familiar story. But this time I didn't want to run. I wanted to understand.

Even as the shame swelled, a quieter voice surfaced. The part of me that had started to internalise the unconditional regard I'd received in therapy. It reminded me: your feelings are valid. It pulled me, reluctantly, towards understanding rather than rejection.

I paused and drew in a shaky breath. The words didn't erase the discomfort, but they gave me a foothold. I tried to name the story I was telling myself. Was I broken? Dangerous? Determined to ruin the relationship?

As I questioned the story, the shame loosened just enough for me to sit with it. 'Your feelings are valid,' I told myself. 'Stop acting as if you've come on to him. All you're doing – all you need to do – is recognise your feelings.' I knew then: I had to bring this to therapy.

Two voices argued. One said that bringing this up meant asking for something unethical; a violation of boundaries. The calmer voice pointed out that naming it was about seeking understanding, not reciprocation. That was what I wanted, wasn't it? To understand. Not to run. Telling him felt both necessary and impossible. Our relationship had been a constant for years. He'd seen me at my most vulnerable. I trusted him more than anyone. But that trust made this harder. What if I was wrong? What if this was the one thing that broke our shared understanding? What if it shattered the sense that I was safe?

Looking back, I wonder if I'd been preparing for this all along. Maybe the emergence of erotic transference wasn't just a complication but a signal. A sign I was ready to confront something deeper. Perhaps the erotic wasn't a distraction or distortion but a gateway. A way my psyche was pushing me towards the next layer of work. In this light, the intensity of these feelings might not have been about my therapist

at all but rather about my own readiness to step into the emotional and existential work I had, until now, hesitated to face.

I chose to trust that I was safe and take the plunge, but the execution was excruciating. It took me three days to send him the hardest message of my therapeutic journey. I agonised over every word, deleting and rewriting the message so many times that my screen felt like a battlefield of my fears. What if this ruins everything? What if he reads it and thinks I'm unhinged? What if I lose him entirely?

But beneath the panic was something quieter, firmer. A voice I'd started to trust. He's not going to reject you. He's not going to leave. Write the message.

In it, I confessed to feeling an intense, disorienting erotic transference towards him. The feelings didn't fit neatly into any one category. They were messy, layered, shifting. There was attraction, yes, but also fear, admiration and something else that felt harder to name. Was it gratitude? Reverence? I couldn't quite grasp it, but I knew it was important. Emotions, I'm realising, aren't as simple as we want them to be. They're tangled threads, and teasing them apart is the work of a lifetime. My words expressed the raw truth and terror I was experiencing. I was opening a door I couldn't close, revealing a part of myself I feared would destroy everything we'd built over years of therapy. Was I ruining the relationship? Was I pushing him away and self-destructing?

The act of putting my feelings into words was, in itself, a release. Even before he responded to my message I noticed a subtle shift. The weight of keeping this secret began to lift. But also, the emotional charge began to dissipate. It struck me how much shame thrives in secrecy, feeding off the darkness of unspoken truths. Naming the feelings dragged them into the light, making them less shadowy, less consuming. The erotic charge lost some of its intensity, as if the act of writing it had unravelled the knot of secrecy and shame entwined with desire. I wasn't entirely at peace, but

'It struck me how much shame thrives in secrecy, feeding off the darkness of unspoken truths. Naming the feelings dragged them into the light, making them less shadowy'

'Therapy is like that. A space where the unspoken gathers, waiting for the right moment to emerge. But finding the courage to speak isn't easy. It requires trust'

I felt a glimmer of relief. This was no longer something I had to fight alone. Looking back, I can see how much courage it took to write that message.

At the time it felt like the most terrifying thing I could do. But now I see it as a turning point. A moment when I chose vulnerability over avoidance.

Female desire

Perhaps there was something else unfolding here. Something that spoke to a deeper truth about how female desire is shaped by the roles we are expected to play.

Esther Perel¹ suggests that female erotic desire often arises from a kind of healthy narcissism, the ability to focus on yourself as a pathway to pleasure. In a culture that still mistrusts female autonomy, the idea of desiring for yourself, not for validation or connection, can feel both radical and transgressive. Women are frequently socialised into caregiving roles, expected to prioritise the needs of others before their own. In this light, erotic transference may not be just about attraction but also about the rare experience of being fully seen, attuned to and held in mind without expectation. If desire requires engaging in self-focus, then therapy may inadvertently create the ideal conditions for it to emerge. These conditions alone may not be sufficient; the presence of erotic transference is also shaped by what the client may lack outside therapy. Loneliness, particularly the absence of physical and sexual intimacy, arguably primes us to view this emotionally intimate relationship through an erotic lens. Erotic transference, then, isn't just about the therapist's role. It's also about the client's unmet longing for touch, connection and embodied intimacy.

In this space I was not the one providing care. I was the one being

attended to. That shift, unnerving and exhilarating, made me question how much of female desire is shaped by relational structure rather than purely internal experience.

That choice to lean into vulnerability, though painful, marked the beginning of a profound shift in how I understood myself.

The right moment

Now, I sit in front of my laptop, mid-video session, barely holding myself together. The weight of the previous days lingers. My mind races with everything I've yet to say. Therapy is like that. A space where the unspoken gathers, waiting for the right moment to emerge. But finding the courage to speak isn't easy. It requires trust, not just in your therapist but in yourself. And in that moment I wasn't sure I trusted either.

'I'm so sorry,' I said, my voice trembling. 'I'm feeling so activated right now. This is... unbearable.'

His head tilted slightly as he watched me, his gaze steady but searching. He took a breath, nodding slowly. I could see him weighing his words. 'Oh God,' I thought. 'He doesn't know what to say. He's trying to figure out how to let me down gently. He's going to tell me I've crossed a line, isn't he?'

'I understand,' he finally said, his voice like an anchor pulling me back to the present. He watched as I took deep, steadying breaths, his nod encouraging me to find my equilibrium.

He didn't flinch. He met my confession with patience, gentleness and something more. A warmth that reminded me I was safe.

'I don't think this is about me,' he said softly. His voice was gentle, his gaze steady – not dismissive but thoughtful, like he was holding something delicate. He shifted slightly

in his chair, exhaling quietly. His brow furrowed as if carefully considering how to continue. 'I think this is about your feelings for yourself,' he added, even more gently.

Redirection

I didn't know. I felt too overwhelmed. My fear distorted his words. Instead of hearing, 'this is about your feelings for yourself', I latched on to, 'this isn't about me'. My mind twisted his intent into a story of rejection. It was as though he were disowning the very feelings I had struggled to name. Invalidating them, and by extension, me. Of course, that wasn't his intent. But in that moment, my fear of being too much drowned out his reassurance. His words offered safety. My fear created quicksand instead.

His response played on my mind for days, looping through the quiet hours. The shame I'd worked so hard to unravel returned in waves, whispering that I'd crossed a line. That I'd ruined the relationship. That I'd exposed too much. That I was broken and disgusting. I even found myself questioning his warmth, his patience. Was it genuine? Was it enough? Or had I asked too much of him?

It took time to untangle those thoughts. To consciously unravel the story of rejection I'd created. It meant sitting with the vulnerability that had triggered it, acknowledging the parts of me that still expected to be pushed away when I revealed my innermost self. I replayed the session in my mind and reminded myself of the strength of the relationship. His tone had been gentle. His words deliberate. His presence unwavering. He hadn't disowned my feelings. He'd reframed them. He'd redirected me to a place I was afraid to look: myself.

Slowly I began to hear his words as they were meant to be heard. 'This isn't about me' wasn't a dismissal. It was an invitation. An invitation to explore the depth of my feelings without fear. To see them not as a burden but as a reflection of my capacity for love, connection and growth.

Could that be true? Could this overwhelming energy be less about him and more about something awakening in me? As I sat with his words in the days that followed, I realised this wasn't just about reframing the feelings – it was about reclaiming them. What I had named as love for him began to reveal itself as something more intimate and transformative: a reflection of the love and worth I was beginning to find in myself. And that, more than anything, felt like the most profound truth of all.

Honouring it

This experience raised a question for me, as a client and as a therapist. How can we engage with erotic transference in ways that honour its complexity, rather than suppressing it out of fear or discomfort? What does it mean to create a space where these dynamics are acknowledged, without collapsing boundaries or reinforcing harmful power dynamics? My experience speaks to a broader need for therapeutic spaces that allow honest engagement with desire, attachment and transference. Erotic or otherwise, transference isn't something to fear. It's a gateway. It reveals the depth of our capacity to connect, to desire, to feel alive. In therapy it becomes a mirror, not just for what we long for, but for what we're capable of giving ourselves.

Erotic transference is something many therapists encounter yet few discuss openly. Recent research explores how clinicians identify and conceptualise erotic transference in practice, shedding light on the complexities of managing it while maintaining ethical and emotional containment.² In my own experience I saw how these discussions played out in reality: the struggle between boundaries and authenticity; the tension

between desire and self-exploration. My experience mirrored many of these findings, highlighting the deeply personal and relational nature of erotic transference.

Similarly, feminist critiques of sexual desire dysfunction challenge the medicalisation of female desire and emphasise the relational, contextual and sociopolitical forces shaping women's experiences of longing and arousal.³ Krasnow and Maglio⁴ expand this by identifying a broad spectrum of influences on female sexual desire, from personal and relational to sociocultural and systemic. This critique isn't just academic, it reflects something I felt in my body. The longing didn't come from nowhere. It was shaped, layered, primed. These dynamics arguably shape erotic transference in ways that go beyond individual psychology.

Therapy offers a unique relational structure. One where the client is deeply attuned to and emotionally contained, without being required to offer care in return. This contrasts with the social conditioning that positions women as caregivers. In that contrast, desire can surface in unexpected ways. Mann⁵ describes therapy as a symbolic form of sexual intercourse, a space of deep attunement and intimacy. When the therapist holds the client in mind without needing anything back, does this create the ideal conditions for erotic transference?

Could this seemingly 'selfish' space allow those, especially women socialised into self-sacrificing roles, to finally connect with their erotic self?

What I went through wasn't just about my therapist. Or even just about me. It pointed towards a deeper truth embedded in the structure of therapy. It raised critical questions about desire,

about gendered expectations, and how they shape the ways we connect. I wonder how broadly this applies.

These reflections remind me that, while deeply personal, this experience may also be profoundly human. It reveals something vital at the intersection of longing, relational dynamics and the very structure of therapy. Therapy, by its nature, creates a space where desire, attachment and self-exploration intersect. It reflects how we relate to others and to ourselves. Rather than offer conclusions, I offer these as invitations for reflection: how do we, as therapists and as humans, hold space for desire, attunement and the tensions that arise in their convergence? ●

** Identifiable details have been changed and permission given for this story to be told.*

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'What I had named as love for him began to reveal itself as something more intimate and transformative: a reflection of the love and worth I was beginning to find in myself. And that felt like the most profound truth of all'

Therapy with adult adoptees

Hannah Parkes compares five therapeutic approaches to working with the impact of adoption

Adoption constitutes a significant developmental disruption, even when it occurs within a stable and nurturing environment. Its psychological impact can persist into adulthood, influencing attachment patterns, identity formation and emotional regulation. While adoption may meet a child's practical needs for care and stability, it also introduces a profound and formative loss – one that is often minimised or misunderstood by society. Therapy can offer adult adoptees an opportunity to reflect on their experiences and make sense of their personal journey.

Despite the complexity of adoption and the needs of adoptees, adoption-specific training is rarely incorporated into mainstream therapy training courses. Recent regulatory changes in England – specifically the removal of the requirement for therapists to register with Ofsted when working with adult adoptees – have further shifted the landscape. While this has expanded access to therapy and opened up new pathways for support to adoptees, it also raises questions about clinical competence. As more therapists begin working with adoptees outside statutory post-adoption services, the need for clinical confidence and adoption-specific knowledge is becoming increasingly important.

Adoptees are far from a homogeneous group. The experience of adoption is deeply individual, shaped by a range of relational,

developmental and social factors. These may include: the age at which the person was adopted (from infancy to later in childhood); the level of openness or secrecy surrounding the adoption (including knowledge of birth origins); race, culture or linguistic differences (particularly relevant for transracial or international adoptions); quality of care before and after adoption (including stability, attachment experiences and support within the adoptive family); and experiences of, or longing for, reunion (whether contact with birth relatives has occurred, been sought or remains unresolved). These elements can have a lasting impact on an adoptee's sense of self, safety and belonging. Adoption is not a static experience – its emotional and relational impact is dynamic, changing in meaning and significance throughout an adoptee's life.

Supporting adult adoptees in therapy requires careful consideration to ensure that clinical practice is both effective and attuned to the complexities of adoption. While each approach offers its own distinct way of working, therapists need to consider how these can be sensitively applied to the diverse and often complex issues that emerge from the experience of adoption.

This article explores five different therapeutic approaches and their clinical application with adult adoptees: existential therapy, narrative therapy, person-centred counselling, trauma-focused CBT and EMDR. These approaches were selected for their diversity and for the unique pathways

they offer towards healing, identity integration and relational repair.

Existential

Existential therapy offers a philosophical and relational framework for exploring concerns that resonate deeply in the lives of many adult adoptees. Fall et al¹ propose existentialism as a particularly useful approach for this client group, highlighting its capacity to support the development of authenticity, autonomy and identity. While their paper is theoretical rather than empirical, it provides a valuable foundation for considering the clinical application of existential therapy with adoptees.

Yalom² outlines four universal 'givens of existence': death, freedom, isolation and meaninglessness. For adoptees, these existential questions can feel especially real, rooted in the lived experience of loss, uncertainty and the search for belonging. Fall et al¹ describe how each of these givens may manifest in adoption:

- **Death** is encountered not only in its physical form but symbolically, particularly in the often unexplained loss of the birth mother relationship. Such early separation can heighten fears of loss and rejection in other relationships, making emotional closeness feel risky.
- **Freedom** presents a paradox. Having had no agency in the adoption decision, adoptees may struggle between a heightened need for control and an avoidance of decision making. Therapy





can help reframe this tension by highlighting the freedom available in the present.

- **Isolation** speaks to the adoptee's experience of early separation and sense of difference. Inauthentic relational patterns may develop as defences against abandonment. The therapeutic relationship can offer a rare, meaningful space for authentic connection.
- **Meaninglessness** may emerge when life stories are incomplete. Existential therapy provides a non-pathologising space in which adoptees can create personal meaning despite gaps in their history.

Fall et al¹ argue that existential therapy supports the development of authenticity, helping adoptees navigate questions of identity and agency. The concept of the authentic relationship – characterised by honesty, presence and mutuality – can be a powerful corrective experience for adoptees who have lacked such relational experiences.

However, existential approaches are not without limitations. Critics point to the model's limited focus on attachment, developmental trauma and neurobiological impacts of early adversity. Because existential therapy prioritises philosophical exploration over symptom relief or emotional regulation, it may be less suitable for adoptees experiencing acute emotional dysregulation or unresolved trauma.

Clinical considerations: Existential therapy can be especially meaningful for adoptees who are ready to explore questions of

identity, freedom and meaning. It offers a non-directive space that invites reflection, personal responsibility and the construction of purpose in the face of ambiguity. For adoptees who have felt pressure to conform to narratives of gratitude or normality, this approach can be liberating.

However, the approach requires a therapist who is well trained and grounded in existential philosophy. It should not be blended casually with directive or trauma-focused models. For the right client, and in the hands of a skilled practitioner, existential therapy can offer a powerful space for deep, identity-affirming work.

Narrative

Narrative therapy offers a social constructionist lens through which adoptees can examine, question and re-author the stories that shape their lives. It has been proposed by several researchers as a useful approach for working with adoption-related issues, particularly in helping clients make sense of disrupted identities, grief and incomplete histories.³ The approach challenges dominant cultural narratives, such as the idealisation of adoption, and instead creates space for alternative perspectives that honour the complexity of an adoptee's experience.

Central to narrative therapy is the technique of externalisation, which separates the person from the problem. For adoptees who may have internalised messages such as 'I was unwanted' or 'There's something wrong with me', this process allows these beliefs to be explored as socially constructed stories rather than personal truths. It also supports relational safety by reducing defensiveness and encouraging openness. Through this process, adoptees can begin to reclaim agency and build alternative stories grounded in values, resilience and identity reconstruction.⁴

Narrative therapy also makes room for the absences in adoptees' life stories. When birth records are incomplete, or contact

with biological relatives is not possible, narrative techniques such as letter writing and timelines can support the creation of 'counter-stories'. These tools help clients explore and honour experiences that may otherwise feel inaccessible or incomplete.⁴

Importantly, narrative therapy is based on a collaborative stance. The therapist acts as a facilitator, not an expert, and helps clients uncover meaning through sensitive questioning rather than interpretation. The approach is rooted in the belief that there is no single objective truth – only multiple realities shaped by language, culture and context.⁵ This makes it well-suited to exploring the impact of social perceptions and cultural bias on adoptees' identities. For example, the common use of terms like 'real parents' reflects broader social messages that may reinforce feelings of otherness or inadequacy in adoptees. By naming and deconstructing these messages, narrative therapy can empower adoptees to challenge stigma and redefine their own narratives.

Clinical considerations: Narrative therapy can be a powerful approach for adoptees seeking to explore themes of identity, belonging and meaning-making. It offers tools to address internalised shame, reframe disempowering beliefs and acknowledge the broader social contexts. It may be especially effective for those with relational or attachment challenges, as externalisation can reduce threat and support emotional safety in the therapeutic space.⁶

However, narrative therapy has limitations. Retelling complex or painful histories can risk retraumatising adoptees, particularly when trauma remains unresolved. In addition, the creative reconstruction of absent or incomplete histories – while therapeutic – can be emotionally fraught, leading to frustration or the creation of imagined stories that obscure the underlying grief or shame. Narrative therapy's emphasis on empowerment and transformation, if not carefully balanced, may also unintentionally

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'Therapy with adult adoptees presents complex clinical and ethical considerations. While a range of approaches may be helpful, each comes with training requirements'

minimise or bypass painful emotions that require validation.

Ultimately, narrative therapy offers a meaningful way for adoptees to engage with the complexity of their stories, as long as it is delivered with clinical sensitivity and respect for the emotional weight of what remains unsaid or unknown.

Person-centred

Person-centred counselling⁷ offers a relational and non-directive approach grounded in the belief that psychological growth occurs within a therapeutic relationship characterised by empathy, congruence and unconditional positive regard (UPR). For adult adoptees, many of whom carry histories of relational rupture, conditional care and identity disruption, these core conditions can offer a powerful reparative experience.

- **Empathic attunement** plays a central role. Adoptees may arrive in therapy with fears of being misunderstood, dismissed or pathologised, especially if their emotional realities have been denied in favour of maintaining a 'grateful' adoption narrative. Consistent, non-judgmental empathy can validate those experiences and offer a counter-experience that creates safety and connection.
- **Congruence** in a therapist who adopts realness and relational integrity towards adoptees negotiating questions of identity and belonging may help to build trust and invite the client into their own deeper authenticity. Within a safe, transparent relationship, adoptees may feel more able to express ambivalence, grief or anger without fear of rejection.
- **UPR** has the potential to counter internalised shame and challenge narratives of worthlessness or 'being given away'. However, it must be offered with care. Adoptees may find UPR difficult to accept, particularly if they've had few experiences of unconditional acceptance. Therapists must remain

attuned to the client's pace and defences, offering presence without intrusion.

The person-centred approach can be especially meaningful for clients whose early care involved secrecy, inconsistency or conditionality. It offers a relational space in which suppressed emotions can surface and be held, often without the need for interpretation or reframe, creating the conditions for a return to emotional truth.

Clinical considerations: While person-centred counselling offers a rich opportunity for relational depth, it may not be sufficient when adoptees present with unresolved trauma, dissociative symptoms or somatic distress. In such cases additional containment or trauma-specific work may be necessary alongside the relational focus.

There is also the potential for therapeutic idealisation. Some adoptees may unconsciously experience the therapist as a substitute attachment figure, seeking the validation or consistency from them that was lacking in earlier life. Therapists must be prepared to work with transference and rupture thoughtfully, maintaining a stance that is boundaried yet emotionally present.

As always, person-centred practice demands a high level of therapist self-awareness, theoretical grounding and capacity for emotional containment. When applied with nuance and care, it can offer adoptees a rare and transformative relational experience – one that makes room for their full emotional reality to be expressed and integrated at their own pace.

Trauma-focused CBT (TF-CBT)

TF-CBT is a structured, evidence-based model originally developed for children and adolescents who have experienced trauma. It has since been adapted for adults and shown to be effective in treating symptoms of PTSD, anxiety and depression.⁸ TF-CBT integrates core components of traditional CBT with trauma-specific interventions, including psychoeducation, skills training and the creation of a trauma narrative.

TF-CBT offers a practical framework for identifying and reframing an adoptee's maladaptive beliefs such as 'I wasn't wanted' and 'It was my fault', understanding the connections between thoughts, feelings and behaviours, and developing emotional regulation skills. These tools can be valuable for adoptees who struggle with unresolved loss, shame or negative self-concepts rooted in early relational disruption.

Although adoption is not always classified as trauma, the early loss of a primary caregiver, often without explanation or closure, can carry lifelong neurobiological and psychological consequences. TF-CBT may help adoptees make sense of ambiguous loss, and develop language for experiences that were once confusing, minimised or unspoken. Its grief-focused components also provide space for acknowledging loss, expressing emotion and creating rituals that support personal meaning-making and resolution.

Cohen et al⁹ assert that TF-CBT is a flexible and effective model for addressing complex trauma, making it potentially useful for adult adoptees. Its structured nature can offer containment and predictability, which is particularly helpful for clients experiencing dysregulation or high arousal. However, TF-CBT's manualised approach is not easily adapted for deeper exploration of existential themes, complex identity work or family dynamics, which are areas central to the therapeutic journey of adoptees.

Clinical considerations: TF-CBT must be delivered by practitioners who are specifically trained in the model, as it includes defined fidelity requirements. While some of its techniques, such as cognitive reframing or graded exposure, already exist across other therapeutic models, TF-CBT functions as a comprehensive intervention and should not be partially implemented outside its structure.

One significant limitation is the lack of research into TF-CBT's effectiveness specifically with adult adoptees. While the model addresses general trauma it does not inherently account for the layered attachment disruptions, identity challenges or developmental complexity often present in adoptee histories. Many adoptees may require a longer-term intervention or additional support beyond the scope of

a time-limited model. Without adoption-specific knowledge therapists may miss key relational or systemic dynamics that influence how trauma is understood and processed.

EMDR

Eye movement desensitisation and reprocessing (EMDR) is a structured, evidence-based psychotherapy designed to help individuals process unprocessed traumatic experiences through bilateral stimulation, commonly eye movements or tapping.¹⁰ Originally developed to treat PTSD, EMDR has expanded to address a range of trauma-related conditions, including developmental and preverbal trauma.¹¹ It comprises eight phases that support clients in processing distressing memories, reducing emotional and physiological reactivity, and installing adaptive beliefs.

EMDR is particularly relevant for adult adoptees whose early losses, like separation from their birth mother and inconsistent caregiving, may be stored in the body rather than in conscious memory. Because adoption-related trauma often occurs before language develops, EMDR allows access to implicit memory, including bodily sensations, core emotional states and somatic responses that may not otherwise be easily articulated.

The model posits that trauma becomes maladaptively stored when the brain is overwhelmed, preventing natural processing. These unprocessed experiences can resurface later through emotional dysregulation, chronic physical symptoms or relational difficulties. EMDR facilitates reprocessing by engaging the brain's innate capacity for integration, mimicking the mechanisms of REM sleep. Positive, adaptive beliefs like 'I am safe' or 'I am worthy of love' are then installed and reinforced during treatment, helping to replace internalised narratives rooted in early rejection or shame.

When working with adoptees, particularly those adopted in infancy or with little conscious memory of early trauma, EMDR therapists may focus less on specific memories and more on felt experience: somatic cues, emotional triggers and relational patterns. Techniques like body scans can help identify stored tension or distress, while imaginal resourcing and grounding strategies build internal safety before deeper reprocessing begins.

Clinical considerations: EMDR must be delivered by therapists who are fully trained in the approach and confident in working with complex, developmental trauma. The preparation and resourcing phases are essential, especially for adoptees with deep attachment wounds or limited coping strategies. Attempting to move into desensitisation too early could provoke emotional overwhelm or destabilisation in adoptees, particularly when preverbal trauma is activated.

While EMDR can support powerful shifts in emotional and physiological regulation, it is not a comprehensive model for identity exploration, narrative integration or systemic concerns such as cultural disconnection. However, for adoptees these dimensions are often central to the therapeutic process. As such, EMDR may be most effective as part of a phased treatment plan, integrated with other approaches that support meaning-making, relational repair and identity development.

Current research supports the use of EMDR for addressing early trauma, including trauma without clear narrative content. However, more adoption-specific studies are needed to validate its long-term impact. EMDR therapists are also encouraged to undertake specialist training or consultation to deepen their understanding of adoption-related issues and avoid inadvertently reinforcing shame or retraumatisation through poorly paced interventions.

When used appropriately, EMDR can offer adoptees a powerful means of accessing and resolving preverbal trauma, restoring emotional equilibrium and reclaiming a sense of internal safety.

Ensuring competence

Ultimately, therapy with adult adoptees presents complex clinical and ethical considerations. While a range of approaches may be helpful, each comes with strengths, limitations and training requirements. What is clear across all models is that adoption-specific knowledge is essential. Therapists need to be equipped to understand the psychological impact of adoption, including loss, attachment disruption, identity fragmentation and ambiguous grief. This includes recognising how issues of shame, grief, loyalty, identity and trauma may

intersect in ways that are clinically significant and deeply personal. Without this foundation, even well-intentioned therapists may risk reinforcing shame or missing core issues.

Adoptees deserve access to therapists who are clinically competent and compassionate, attuned and grounded in adoption-specific understanding. What matters most is that the adoptee's lived experience is genuinely honoured. Therapy with adult adoptees calls for more than a technique – it requires humility, curiosity and the courage to sit with complexity. When adult adoptees are met in this way, with presence and understanding, the possibilities for healing are life-changing. ●

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Facing retirement

Anne Power asks why so many of us find it hard to stop working as therapists, and why it matters

I am 68 years old and I still work part time seeing couples on short- and medium-term contracts. Around 15 years ago I was supervising someone who decided to retire, and it alerted me to the dilemmas that this transition poses. I wanted to understand the process better, and when I found very little reading material available on the topic I set about my own research.

Some therapists can't wait to retire – they may be longing to care for grandchildren, to travel with their partners or just to have more free time. Others are resistant to the idea of retirement, but if we delay too long and potentially put clients at risk, our ambivalence about saying goodbye could become a safeguarding issue. Having an up-to-date clinical will can ensure that clients receive support in the event of our illness or death, but this cannot protect them against the harm of sudden abandonment. When we work long term with open-ended contracts, clients will reasonably expect us to be there for as long as they need us.

In an ideal world we might anticipate our retirement and take only short-term clients in the years leading up to our cut-off date. Not all of us will be able to achieve quite such a tidy ending and will need to face some clients with the unwelcome news that we are going to leave them. While imposing such an ending can be problematic, letting things drift could be even worse. If we can support a client to stay present and process the difficult feelings, a forced ending can actually become an opportunity.

Sudden loss

It's untrue that clients will vote with their feet and leave if their therapist is not doing a

good job, and likewise that supervisors and colleagues will tell us when it's time to go, or that when therapists retire, the profession loses irreplaceable wisdom and skills. We'll have heard of cases where a client loses their therapist to age. This might be because the counsellor died, became physically too frail to be fully present or because they lost cognitive function. I spoke to two retired therapists who each told me of a wounding experience they had with an elderly therapist: being unable to see or admit their own therapists' deterioration, they had been unable to leave despite being very able practitioners. One of them experienced the horror of her long therapy coming to a sudden, abrupt end. She arrived one day for her session and there was no answer to her ring on the bell.

Evidence shows that they will cling on to their good object, and supervisors don't have a ringside seat to our work to know exactly what's going on – even when they have doubts they find it hard to share these. While it's true that some older therapists are doing their best work in their later years, nobody is indispensable. There are young therapists who can offer a safer frame with less risk of the work being interrupted.

Attachment

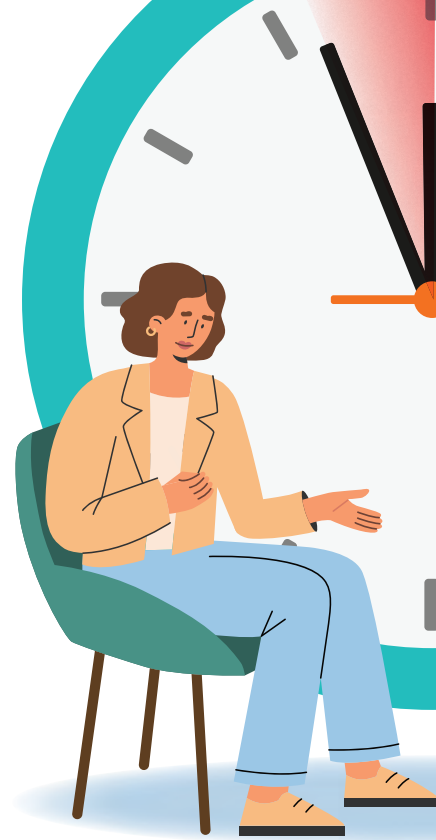
In my research¹ I look at planning for retirement and at how understanding

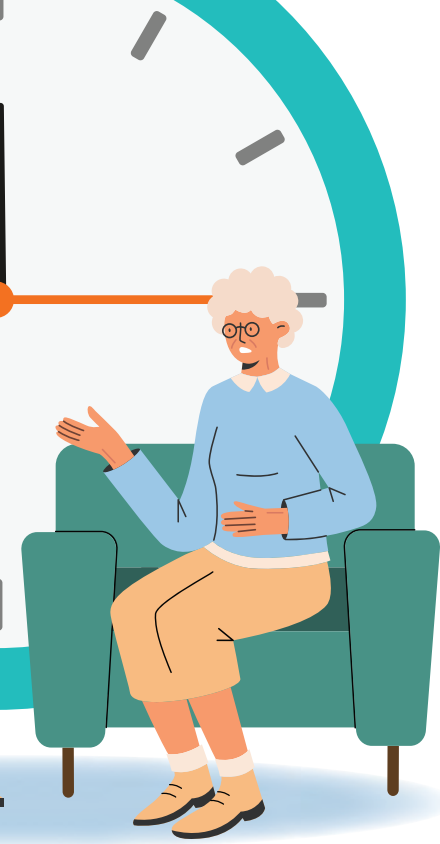
client attachment styles can help us work effectively during this transition.

I want to briefly consider some of the challenges we face in imposing an ending. Whatever our modality, we can draw on our theories to understand the impact of imposing an ending. Attachment theory can offer a helpful guide to the defensive strategies that tend to come up when clients learn they are being dropped. We may already know whether each client leans towards a more avoidant or more anxious attachment style, so we'll be able to attune to their signals. From the analytic view, an avoidant client's minimisation and good wishes for our retirement could make it hard for them to recognise how unimportant they feel, while an anxious client's disappointment and request for details could make it hard to see how acute feelings of abandonment might echo earlier lapses from caregivers. The challenge of an imposed ending is a rich opportunity for clients to revisit and process these difficult feelings – provided we still have the energy and commitment for some intense final months of work.

Ambivalence

If we are asked why we wanted to become therapists and why we enjoy it, we might answer that we love feeling useful, making





a difference, meeting a range of people, and feel that learning – about skills, theories and ourselves – is an essential part of the job.

Income is also a core reason for working, and if we are financially dependent on continuing into old age, this can present us with a profound dilemma. While it's true that some individuals retain excellent cognitive capacity as seniors, we cannot rely on that being the case for us. If our cognitive capacity reduces to a level where we are not providing 'good enough' therapy, then our financial needs will have to come second to the client's right to a well-functioning therapist. Therefore, if we need to continue to work into a late age, we may need to plan for new income streams.

Ambivalence is normal when we face losing something precious. My interviewee Sara* had been hugely committed to her work and reluctant to retire but had recognised early signs of memory loss and realised that this was bound to get worse. She stopped taking new clients and let her practice reduce as each client ended. She explained: 'I knew that there was really no choice... you can't take the risk of thinking "what the hell is she talking about, who is this Philip*?"'¹

Healing wounds

In my research I mention that one reason why retirement can be a weighty subject is because it touches on our original need to become a therapist and what we have been trying to repair within us through all those years.¹

Most of us were drawn to the work of therapy by something in our own needs and wounds. Hopefully we have been able to do deep and useful work in spite of or because of this. Some of us can trace a direct line from being a parentified child to the work we have chosen, while for others it may be about spending our days among people who struggle as we have done. Others feel drawn to work in crisis and with trauma and feel safer for doing so. By the time we retire we ought to have a good idea about our own 'wounded healer' journey and to understand how the work has helped us. We also need to be ready to let this go and meet those needs in other ways.

For her research, Marie Adams talked to therapists who had struggled with depression. One of her interviewees describes a pathway which is familiar to many of us: 'My mother needed care as it were. I was definitely a parenting child. It's a... way of life really, and I think I just professionalised it.'² Adams convincingly concludes: 'In our work many of us have also found an unconscious method of self-medicating.'

I met one former therapist, Rachel,* who had experienced difficulty with the decision to retire and in fact needed two goes at it: the first time she had changed her mind and pulled out. She spoke about a longing to heal her mother and the difficulty she felt in leaving that work undone: 'I think my ambivalence is not just about retirement, I think it's about being a therapist – about whether it's possible to really believe I have helped people... People you sit with for years and years and what have you done? Moved them on a few inches.'³

'While it's true that some individuals retain excellent cognitive capacity as seniors, we cannot rely on that being the case for us'

Intersectionality

Social identities intersect to create unique experiences of privilege and discrimination. Ageism exists, and being old carries stigma. As at any life stage, being in good health and well resourced socially and economically will decide who is most privileged. At a time when universal state provision is in jeopardy, the fear of growing old and poor is more present.

Where ageism meets other inequalities, this weight of retirement carries additional challenges. In terms of gender, a study by Price⁴ found that women did not find the transition to retirement any easier than men, but those who had high satisfaction from their work ultimately also found retirement satisfying. Meanwhile, black and ethnic minority practitioners will have faced systemic racism and microaggressions in their careers. Retirement can thrust practitioners further into an unsupported world once they've left the containment of peer support from trusted colleagues. While our professional bodies aim to hold us accountable for our views and behaviours, and our training should have required us to own our prejudices and equipped us to let go of the projections, retirement can mean being even more exposed to people less able to hold themselves to account. Maintaining community group support post-retirement can therefore be crucial. McParland suggests that community support may be a factor in why people identifying as LGBTQIA+ adjust comparatively well to ageing despite having to navigate heteronormative health and social care.⁵

Getting support

There are ways we could make retirement easier so that people going into it don't feel quite so alone. Some organisations give thought to this by creating pre-retirement and post-retirement membership categories, which give recognition to the financial challenge of

closing a practice and then the wish to retain some links to the profession. But perhaps it would help if we had a more direct and open culture of discussion around retirement. Is part of our reluctance around talking about retirement to do with speaking about ageing and death? There could also be practical reasons, such as fear that speaking openly could reach our clients before we are ready to make an announcement.

When more than one person is going through the process of retirement, having the option of sharing this together in a peer group can offer great support. Often members of a group are at different stages. My interviewee Charlie* exclaimed: 'Peer supervision group has been supportive at times, but you are also caught in the fact that people don't like you leaving!'³ The truth of this came home to me when I found myself about to discourage an older colleague from retiring. We can feel great sadness – perhaps envy – when valued colleagues say it's time to go. We may feel that they are brave enough to do this, or feel guilty that we are not so brave, and it becomes a rich area for discussion and sharing. Jo,* another research participant, summed up what she found so challenging: 'I found the whole process of dealing with my retirement very hard because you are intruding something about your own life into theirs and that's so much against your training.'¹

As we reach retirement, if we have enough earned security then we'll be able to face the losses and anxieties of ageing without a hardening of our defences. If we are blessed with good health and have already invested in other creative activities, there's every chance that we'll more than cope with retirement – we'll thrive. ●

Some of the practical issues raised by Anne are more fully addressed in her presentation available now on BACP's CPD hub.

Quotations in this article are from the retired and retiring therapists the author interviewed in this study.

*Real names not used.



Questions to reflect on

Competence

- How much of our clinical work are we letting our supervisors see?
- Do they know enough to recognise if our skills are declining?

Reflexivity

- Are we able to listen to our own feelings about ageing and death?
- What function does our work have in our internal world?
- How might our own attachment story be influencing how we face retirement?
- What patterns from earlier endings may be impacting us?

Practicalities

- Have you known of people whose therapist became suddenly ill or died?
- Which of your clients would be most impacted if your work with them were suddenly terminated?
- Do you have a financial plan in place that will allow you to retire?
- When will you cease to take new clients?
- How much warning will you give to existing clients?
- Is your supervisor equipped to help you with this stage?
- Might you look for extra support – such as returning for some short-term therapy?
- Which clients will find the ending hardest?
- Which clients will be the most challenging for you – those who are open with their anger and disappointment in you or those who mask it entirely?
- What does your own history of transitions tell you about how you may handle this one?
- How realistic are your plans for retirement? Do you have hobbies you'd love to develop?
- What are you doing now that you can enjoy doing more of?

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ABOUT THE AUTHOR

Anne Power MBACP is an author, speaker and experienced therapy practitioner and tutor. Her recent book, *Contented Couples: magic, logic or luck?* (Confer) explores how couples find each other and build a lasting attachment bond. It follows *Forced Endings in Psychotherapy and Psychoanalysis* (Routledge) exploring therapist retirement. Find her on Instagram @and_attachment



Rethinking supervision

Aisha Gordon-Hiles offers five ways to expand our horizons professionally

GILLIAN BLEASE/IRON IMAGES

Clinical supervision is the cornerstone of ethical practice. It offers invaluable guidance, accountability and a safe space for reflection. But like any cornerstone, it requires periodic examination to ensure it's still supporting the structure it was designed to uphold. When was the last time you paused to ask yourself – or your supervisor – whether you're making the most of your supervisory relationship?

The therapy profession has transformed dramatically in recent decades, pushing practitioners to navigate an increasingly complex and nuanced world. As awareness grows around essential aspects of the human experience – such as culture, neurodiversity, systemic inequities, gender and other areas of intersectionality – counsellors are being called to rethink their understanding of their clients' unique identities, backgrounds and lived experiences.

At the same time, the spotlight on practitioner wellbeing has intensified. Counsellors, particularly those in private practice, work mostly in isolation, grappling with the emotional demands of the work that can lead to burnout if left unsupported. Moreover, the rise of online platforms has broadened the scope of private practice, granting access to a wider range of client presentations and, with it, heightening the expectations of supervisors.

Traditionally, supervision has offered oversight and guidance; but as the profession has evolved, the supervision model hasn't seemed to adapt along with it, and consequently may not be fully addressing the diverse and growing needs of clients and practitioners. And so the question is: is it reasonable – or fair – to expect one supervisor to have expertise in every area we require to support us fully in our increasingly varied client caseload?

Put simply, in any other relationship, few would argue that we should meet every single emotional, intellectual and social need for each other. Instead, we'd encourage expanding the support

IN PROGRESS



'By embracing a more expansive, collaborative approach to supervision, we can better reflect the richness and diversity of the counselling profession itself'

network – nurturing relationships with family, friends and community to create a fuller, more balanced foundation.

Shouldn't clinical supervision work the same way? After all, supervision is a relationship at its core. Perhaps it's time to move beyond the idea of a single supervisor as the sole source of support and expertise. Instead, by embracing a more expansive, collaborative approach to supervision, we can better reflect the richness and diversity of the counselling profession itself.

So what are the options?

1 Multiple supervisors

Traditionally many practitioners work with a single supervisor throughout their career. This relationship can provide consistency, safety and familiarity – all vital qualities. However, it can also bring about complacency, and in some instances cause our clinical work to become stagnant. Expanding your supervisory network allows you to tap into different areas of expertise. You might choose to work regularly with a second supervisor who has specialist knowledge in a particular field, or engage in one-off consultations with supervisors whose backgrounds differ from your primary supervisor. This isn't about dismissing or replacing the traditional model of supervision. I've worked with the same supervisor for many years, and this relationship continues to provide a solid and reliable foundation for my therapeutic work. I know this holds true for countless others as well. I have also had one-off consultations with others, which has only served to enhance my clinical practice.

What this is about is ensuring counsellors have a broader base of support that scaffolds the increasingly multifaceted nature of client presentations and the developmental, ethical and practical needs we as counsellors face along the way.

2 Peer supervision

Peer supervision is a valuable resource that I've utilised in the past. Liaising with peers is a common practice in the counselling profession. Counsellors, both locally and further afield, often participate in peer supervision sessions to complement their core supervisory relationships. These sessions may be one-off or held regularly, often in an ad hoc one-to-one format but occasionally in groups. The decision to expand supervision through peer engagement often comes down to financial considerations, as it provides an affordable way to access

diverse perspectives without significantly increasing the cost of running a practice.

However, peer supervision is often carried out among counsellors at similar levels of experience, typically without formal supervision qualifications. While this can provide some benefit to practice, its impact is naturally limited. That said, when conducted in groups, the group dynamic can be incredibly effective in combatting feelings of isolation and burnout, and addressing difference and diversity – aspects that are common in our work.

3 Facilitated group supervision

While group supervision is a staple during counsellor training, it becomes far less common for qualified practitioners. The reasons for this shift are unclear but worth exploring.

The potential of group supervision to enrich practice cannot be overstated.



GILLIAN BEASE/MON IMAGES

From my own experience facilitating supervision groups, I've witnessed first-hand how powerful this format can be. For example, a practitioner with extensive experience shared how being in a group with others newer to the profession reminded them of the basics they had lost sight of. Another reflected on how attending supervision alongside practitioners undertaking specialist training helped them to fill gaps in their client formulations that weren't covered in their core training. One counsellor noted that having to consciously choose a supervision group based on the supervisors' areas of expertise encouraged them to pay closer attention to the nuances in their clients' needs. Others found that discussing ethical dilemmas in a group setting allowed them to see their challenges through a fresh lens, thanks to the diversity of thought and experience in the room.

An additional benefit includes reducing the cost of supervision while not compromising on quality, by only working alongside practitioners with similar levels of experience and no formal supervision training.

4 New approaches

My aim here is to show what new supervision choices may be available, and to encourage you to reflect and consider opening the door to new possibilities. In my own practice I've explored these ideas by creating a membership for therapists that builds on the strengths of traditional supervision while expanding its scope. This approach allows practitioners to benefit from the expertise of multiple supervisors with diverse specialisms, all within a supportive group setting.

For instance, a practitioner working with survivors of sexual trauma might gain valuable insights from a supervisor specialising in trauma, another with

expertise in cultural humility, and yet another focusing on psychosexual presentations – all in one space. This way of working has the potential to broaden professional perspectives.

However, this suggestion might support you to reflect on your clinical, personal and professional experience to date. How could you use your experience to evolve supervision to better serve you and your clients?

5 Embrace innovation

Despite its clear advantages, embracing new approaches to supervision models is not without challenges. Familiarity with established systems can make it difficult to explore new approaches, while time and financial constraints may discourage practitioners from pursuing additional or alternative supervision arrangements. For some, stepping out of a comfort zone to try something new can feel overwhelming. I know it felt this way for me. But a phrase I find helpful is: 'Just because something feels challenging, doesn't mean we shouldn't do it.' And reaching out for support is part of this. In my own attempts to expand my approach to supervision, BACP's Ethics team was a fantastic source of support when I faced challenges around confidentiality, clinical responsibility and more.

Positive change only stands to serve our profession for the better – however, I must stress that these changes must align with the ethical frameworks we adhere to. These frameworks can sometimes make it harder to engage with or consider innovation. But ethics are not meant to act as a barrier to the evolution of practice; rather, they serve as a scaffold, ensuring that all changes prioritise safety and the best interests of everyone involved. With this in mind, the question should always be: 'How can we implement this change in an ethical way?'

rather than allowing ethics to stifle opportunities for growth.

A call to reflect

As counsellors we can be agents of change for our clients. Could we bring that same spirit to our own professional growth? By reflecting on what we need from supervision and advocating for models and processes that reflect the diversity and dynamism of our work, we can contribute to a supervision landscape that truly supports the profession.

And so, as you consider your own supervision journey, here are some reflective questions to guide your thinking:

- What does my current supervision offer, and what might it be missing?
- Am I curious enough to explore new ways of receiving support?
- How could supervision evolve to better serve me and my clients?

Supervision should be a space where you feel both challenged and supported – a space that fosters growth, learning and collaboration. If your current approach isn't offering these elements it might be worth reflecting on what would, and bringing this into your supervisory discussions to ensure your needs are being met.

This isn't just about improving our individual practice – it's about strengthening the collective. Supervision, like counselling itself, thrives on growth and adaptation. By embracing its potential to evolve, we can ensure it remains relevant, accessible and enriching for ourselves and future generations of counsellors. ●

ABOUT THE AUTHOR

Aisha Gordon-Hiles MBACP (Accred) is an experienced integrative counsellor, coach and author who advocates for innovative ways of working. selfforhelp.com



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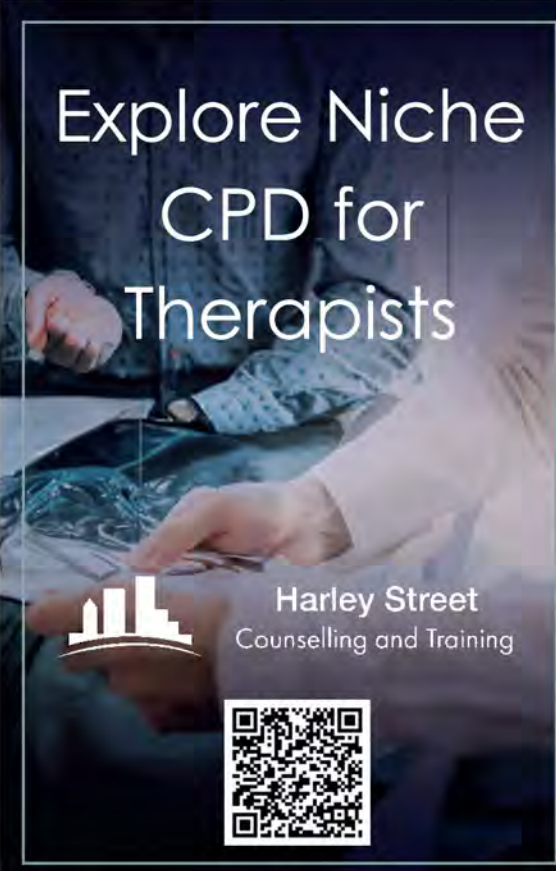


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OVER TO YOU

Honour and singlehood

I felt drawn to write a letter in response to two very striking pieces in the May edition of *Therapy Today*. Thanks to Naseem Sarbatta-Walia for an important piece about honour-based violence ('Intersections of shame in honour-based violence'), and congratulations for covering this. Naseem's account of her work conveyed the profound dilemmas that families and therapists can face.

An exercise that stood out for me involved group members expressing profound empathy for the victim and family members in the Delhi rape case. Participants were then asked if they would accept a female who had been raped as a daughter-in-law and none could countenance that. For me this connected to a powerful line in Suzy Walker's article about singlehood in the same issue ('Celebrating singlehood: the rise in staying solo by choice'). She writes: 'Satisfaction and meaning come from creating a life that aligns with your own values.'

I think between them these two articles challenge us to explore where we stand in the spectrum of individualist and collectivist cultures. What happens if we take our values from our group, and what happens if we dispense with group values and go solo?

Anne Power MBACP (Accred)

Solo by choice

I have two observations about May's 'Big issue' – one is about therapist attitudes to single clients, and the other is about the idea of singleness itself.

The article suggests that it is regrettable that some counsellors regard singleness as an attachment issue to be unravelled rather than a choice to be respected. Whatever the relationship status of a client, there is a place to explore the



reasons why this is so, as these reasons will have implications for the rest of the client's life. Problems arise if counsellors regard certain relational set-ups as markers of wellbeing and forget the range of relationships we all have. Some people may not even want to associate much with humans but prefer to relate more closely to the environment (which so many of us ignore). As counsellors we must surely explore with clients how they can find safety, significance and self-worth without judging them according to external markers.

My other concern is that equating singleness with failure is described as the last of society's bedrock beliefs. The belief that singleness is a bad thing is perhaps not the bedrock belief it may appear to be. Until relatively recently it was acceptable for adult men to live a celibate life in their parental home or 'bachelor pad', and although the word 'spinster' can have negative connotations, women were often expected to stay unmarried and look after their ageing parents. The idea of being single is even promoted in the New Testament of the Bible (1 Corinthians Ch 7, v 8).

I hope that these points might provoke further thought about the unconscious biases we counsellors may have around

relationships, and about what constitutes a bedrock belief.

Ruth Tinsdeall MBACP

Mixed heritage

As someone of mixed heritage I was moved and grateful for Denise Devenish's eloquent and powerful article 'In pursuit of belonging' (*Therapy Today*, June 2025). 'Muggle' is used in *Harry Potter* to describe somebody who isn't from a magical family, like all the other wizards. After completing my psychotherapy training I realised I had felt like a 'muggle'. Other people had loved ones who knew about therapy, or that's how it seemed. I didn't know the basics, such as how much to expect to be charged for therapy or that being told I had to go to a certain therapist, a former staff member, was not necessarily a good idea. I welcomed how Denise drew attention to blind spots in therapy.

My mother's family left a war to move to the UK under a visa scheme offered to those from former colonies. As a mixed-race child, my background was complicated and stirring, yet through four times per week analysis for five years, not once did culture or heritage explicitly come up. My dreams repeatedly featured themes of wandering and seeking a sense of place, but the question of a psychic home remained unanswered. How to belong when your family was once the oppressed, how to assimilate, how to be neither one nor the other, racism, power and skin colour are examples of areas where we trip and blunder as we try to find our way. Through fear we may turn a blind eye to these preoccupations and not see the truth of our whole self and experiences. I commend Denise in describing a more faithful path forward for therapy.

Sonia Wogan BPC

What's the skinny on this jab?

Nicola Dixon-Grainger asks us to consider the impact of weight-loss drugs for our clients with eating disorders

The skinny jab! 'Its reputation precedes it!' This relative newcomer is being celebrated as a veritable game changer in the fight against the flab. Ozempic, Mounjaro and Wegovy – medications primarily used to manage blood sugar levels in adults with type 2 diabetes – now form part of the NHS arsenal in tackling the obesity crisis. With the average patient losing 15% of their body weight within a year,¹ weight-loss drugs are being slowly rolled out for those patients whose body mass index (BMI) is a minimum of 35 and who have additional health problems. An estimated 3.4 million adults are eligible for treatment at £11 billion a year, equating to £3,000 per year per patient.^{1,2}

Research indicates that these medications are ineffective as a standalone treatment.² As prescribed by the NHS, weight-loss drugs form part of a more holistic package of care. Patients are closely monitored and are supported in making complementary changes through nutrition and exercise guidance alongside the use of medication.

Popularity

Concurrently we are witnessing the rise in popularity of these drugs as a lifestyle product – even an 'I ♥ Ozempic' T-shirt by Namilia made its way onto the catwalk of Berlin Fashion Week last year.³ Lauded by celebrities, celebrated on social media, so-called 'skinny jabs' are influencing

beauty trends and being used by those seeking to lose a few pounds in their pursuit of body perfection. A whole alternative market has developed as a direct result. Individuals can now access these drugs via private pharmacies, online sellers and their local salons. Half-a-million people are reported to be using skinny jabs in Britain alone.⁴ Drugs that NICE guidelines² stipulate should be used only under strict medical supervision and within stringent parameters because of their risks can be accessed as easily as any other beauty treatment despite the statistics surrounding mortality and serious injury.

Risks

Between 20 and 30 people are thought to have lost their lives after taking skinny jabs, while patients using this medication for lifestyle reasons comprise the majority of associated admissions to A&E.⁴ Between January and May 2024 the Government received 208 reports to its Yellow Card scheme, including 31 serious reactions and one suspected death.⁵ As a clinician I am beginning to see clients with eating disorders (ED) explore the use of skinny jabs. This has led me to consider the implications on their physical health and psychological wellbeing. In order to help



my clients manage risk alongside offering the best support, I am striving to pre-empt potential thought processes and likely actions while also remaining mindful of how accessing skinny jabs may affect each client specifically. These concerns are increasingly moving from conjecture to stark reality – a fact not lost on healthcare providers.

Because of the social acceptability of these drugs, and the lack of emphasis on risk and side effects, the psychological line appears to be very similar to that of using laxatives and purgatives. Easy access – in particular through salons – makes weight-loss pharmaceuticals feel relatively safe to use. But they come attached to grave risk when used inappropriately. The physical impact and psychological effects make this medication very unsafe indeed for ED clients.

Eating disorders

Clients with ED purchasing skinny jabs from beauty outlets and online pharmacies may become anxious of the ever-tightening regulations and become fearful of the cessation of their supply. Online pharmacies are now subject to prescribing criteria in order to prevent people who are already a healthy BMI from purchasing these products. Pharmacies must perform a

'Easy access makes weight-loss pharmaceuticals feel relatively safe to use. But they come attached to grave risk when used inappropriately'

face-to-face consultation, either in person or on a video call. Prescribers are also required to notify the patient's GP about any medication administered.⁶ This in itself could heighten both anxiety and intrusive thoughts, which in turn could lead to use of greater dosage to achieve weight loss more quickly and perhaps also a greater reliance on any other purgative methods the client is already engaging in. We also need to bear in mind that not all clients will obtain weight-loss medication via alternative vendors; many will qualify under NHS regulations. It is a common misconception that all ED sufferers are underweight; many have a high BMI and health issues relating to their weight. For this group, gaining a prescription would be as simple as denying their ED – something that most sufferers habitually do. These clients are in the precarious position of qualifying for NHS assistance – which may bring them benefits in regards to their obesity – while at the same time being at risk from the symptoms of their ED.

As clinicians we need to offer the best support to the client in making the right choice for themselves, while being aware of any possible complications. The expected side effects of this medication have the potential to accelerate the client's existing eating-disordered thoughts and behaviours. Gastric disturbances mirror the effects of laxatives and purgatives, and may be welcome aspects of the drugs, potentially perpetuating dependence as weight loss is accelerated. Similarly, the side effect of nausea could trigger more purging episodes. When a client feels nauseous there may be a temptation to induce vomiting and thus kick-start a binge-purge cycle that may not have otherwise occurred as part of the client's habitual pattern. It is equally more difficult for an eating-disordered client to challenge the urge to purge when they already feel sick – it feels more natural and less steeped in their ED framework and therefore easier to give in to.

Food noise

One of the perceived benefits of weight-loss drugs is the reported reduction in 'food noise' – characterised by intrusive thoughts surrounding the urge to eat and the craving

for specific foods. Many overweight patients find relief from this symptom, but for ED clients food noise is less clear-cut. It is bound up in separate, comorbid internal pressures that form part of the starve-binge-purge cycle. It cannot be medicated because the drivers are psychological and need to be addressed as such with appropriate support and intervention. For many with ED, the hope that medication will lessen food noise, and therefore help them to further restrict food intake, may be a significant influence in their decision to try these drugs.

Let us not forget that weight-loss pharmaceuticals come with medical side effects, from pancreas inflammation to kidney disease and septic shock.⁷ Our ED clients are already placing their bodies under extreme stress, whether that be from food restriction, bingeing or purging. Their bodies are perhaps less able to sustain the onslaught of these chemicals on their systems, and may be more prone to the rarer risks as well as perhaps suffering heightened symptomology regarding the accepted side effects. This is a lot of strain to place on a body that is already struggling under pressure.

These considerations – while no means exhaustive – highlight the need for us to examine our perceptions while remaining open to exploring what may be new territory in our ED work. We need to be open to challenging ourselves and to changing our existing strategies in working with this client group.

Protocol

It is easy to shift responsibility for abuse of prescription drugs onto the patient, but this is short-sighted. Clients with ED face a daily fight in which their decision making is compromised; they need to be both protected and supported. As clinicians we need to be aware which of our clients may be accessing this medication. There are currently no significant barriers and, furthermore, using skinny jabs is seen as a socially acceptable lifestyle choice. We must keep this in mind and be conscious of the potential risks. It is equally imperative that we agree on protocol with our clients and ensure that they themselves know what to do in case of an emergency. An appropriate

care plan could include documenting the name of the precise skinny jab the client is using, and whether it is NHS prescribed or sourced elsewhere – this will be essential to first aid responders. A next of kin contact is desirable, as are the name and telephone number of the client's GP. We should also ensure that we have the client's address should we need to call paramedics. Often the simplest measures are the most overlooked. The client needs to be aware that if they fall ill they must call 999 immediately. This information should be agreed with the client and amended or added to as appropriate. Above all we need to educate ourselves about these drugs – how they work, what the side effects are and, mostly, what the psychological implications are. We need to open an honest debate about the influence of, and impact of, weight-loss drugs on our ED clients. Perhaps the above considerations are a good place to start. ●

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Toby Ingham



Work with your wounds. Throughout my training I sometimes had anxiety about whether I was stable enough to be a psychotherapist. I have always been open to discussing my work and would not say that I'm defensive, but I had questions about myself that I found harder to develop and unpick. My clients have helped me in this regard. Their willingness to be open about their wounds is what gave me more confidence to acknowledge and work with my own. I would encourage anyone training to understand as much as they can about their vulnerabilities. I am not saying that we reveal them to our clients, but our capacity to be open and authentic with these aspects of ourselves facilitates a particular kind of therapeutic intimacy. It allows healing for both parties. A psychotherapist is someone who has learned to work with their wounds.

It's OK not to know. While clients may come to therapy to become clearer about what they have been through and what they need, I have learned that being able to tolerate not knowing what is going on at certain times in the conversations is a basic condition of the work. There is a tension between the side of me that wants to know things and a side that doesn't. I think it is from this less knowing position that a lot of questions and insights develop. This may be how a space for new psychic territory and possibilities starts to manifest. Our uncertainty opens up a life for us that is different from the old values we have internalised, and which may have contributed to our suffering. Similarly, I have become more comfortable with the sense that we never know where the impulse that brought the client to therapy may have started or where it might be trying to go.

Be adaptable. While I may have ideas about how the framework of therapy works, the timing of sessions and so on, the client does not. I have learned to be more flexible and open to how the work starts and the idiosyncrasies the client comes with. I used to be more impatient and wanted things to work to some kind of order. I learned that these ways of working have to be developed together, mutually. In some cases that can take a long time, but it helps me to remember that this is part of the organic development of the work. Now I find it more satisfying seeing how the framework comes together.

Be open to developments. I worked with a male client who survived childhood sexual abuse and was inhibited around his creativity. Any impulse to develop a creative project was met with prohibitions. He started to show me tiny sketches on Post-it notes, and I encouraged him to bring more. I am not an art therapist, but we ended up with a connected set of pictures that were nine metres long. Being able to pursue his creative idea would eventually become a book that we collaborated on to tell his story.

Problems tend to relate to lived experience. Clients can come with an idea that there is something wrong with them that needs fixing. Understanding that it's not that there is something wrong with us, but that our problems might relate to things that we have lived through can seem a strange idea. I continue to research this point, but typically I've found that whatever the presenting problem today, it generally has a root in earlier experiences.

Keep learning, and develop your network. I am wary of people who are wedded to one theoretical position. I have learned that a psychotherapist needs a whole library of theories. If we have any hope of making room for the psyche, the more we can be open to consider ideas that might at first appear strange, the better. I have found that there is more to a client's presentation than I might know or understand. When you train, you have people (other trainees) within easy reach, but after qualification that becomes less predictable. Finding people who can offer support and be part of a supportive network is an ongoing project. Don't be too much of a hermit; we need our people.

Get an accurate clock. The work involves enough uncertainty and unpredictability. I have a digital clock that sets itself to GMT. Whatever else might be going on, it's helpful to know what the right time is. The one thing I do know how to do is keep time. ●

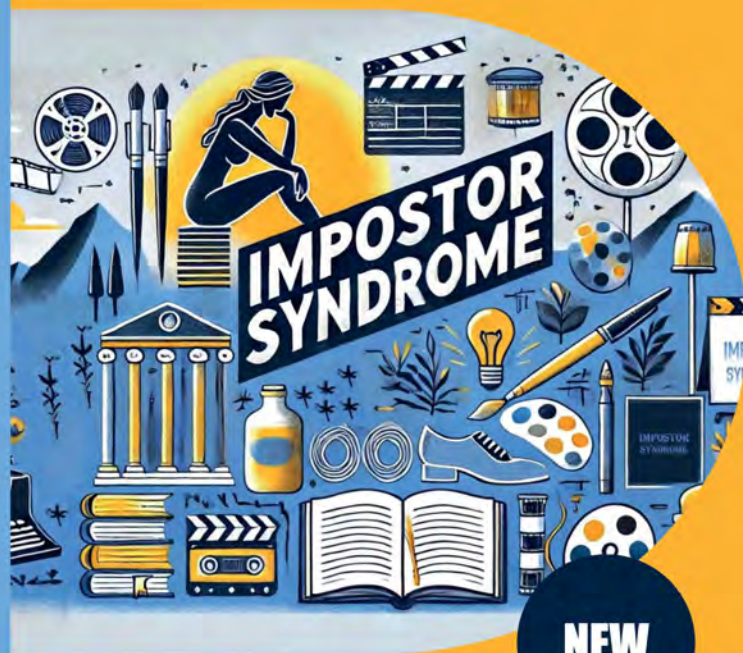


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Toby Ingham BPC is a psychoanalytic psychotherapist and supervisor in private practice. His latest book, *A Guilty Victim*, was published recently by Karnac.



'If we have any hope of making room for the psyche, the more we can be open to consider ideas that might at first appear strange, the better'



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