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THERAPY TODAY

bacp | counselling changes lives

SPECIAL ISSUE WITH happiful



Switching off

HOW NEWS ANXIETY IS SHOWING UP IN THERAPY

THERAPY TODAY
NOVEMBER 2026 | VOLUME 37 | ISSUE 9

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The course is accredited by COSRT, level 7 and in part fulfilment, via NCPS, of the Accredited Register (PSA)



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'The bad news is endless, and it comes to us in an unstoppable digital tide. It makes sense that we might believe that if we stay on top of the issue, understand the ins and outs of it, we might be able to control the way it affects us'

Kathryn Wheeler ('News anxiety: living in an uncertain world', pages 22-27)

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THERAPY TODAY

For this special edition we've teamed up with *Happiful* magazine to explore the impact of the news on our wellbeing. The publication's recent reader survey revealed news anxiety as the biggest source of distress for subscribers, who report feeling caught between moral duty to engage with troubling world events and the desire to switch off entirely. To understand this trend, *Happiful* magazine and *Therapy Today* are tackling it from a 360° lens. Our cover design by Anna Parini forms one half of a bigger scene continued on *Happiful* magazine's cover. The phenomenon is explored by *Happiful* magazine editor Kathryn Wheeler in our 'Big issue' (pages 22-27), while I offer a clinical perspective for *Happiful* magazine's main story this month.

Clearly, therapists and clients are both impacted. The last time this seemed to happen was during lockdown; therapists and clients were navigating new, traumatic terrain together in real time. Its ripple effects still permeate, but the changes it brought – online homeworking, smarter phones and social media feeds that switched from family photos to 24/7 news reels with ever sophisticated clickbait curated by algorithms – have placed many of us in a purgatory, at once trying to stay aware and disengage.

'Happiful magazine subscribers report feeling caught between moral duty to engage with troubling world events and the desire to switch off entirely'

Perhaps connected is Kim Loliya's 'Viewpoint' as she unpacks how we might find solutions out of despair through activism (page 71).

This landscape hugely impacts how we work ethically. More people are training as therapists in response to growing mental health awareness, while demand for therapy grows. This month's 'Dilemmas' explores the option of taking on trainees in private practice to help with workload and placement demand. As the new BACP *Ethical Framework* becomes mandatory from November, we take a look at what's been changed (page 55).

A final hopeful note: *Therapy Today* won 'highly commended' recognition in the Memcom Excellence Awards for 'Best Magazine' for its quality design and content. Thanks to all of you who make it what it is.

Katerina Georgiou MBACP (Snr Accred) Editor



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

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FRONT COVER: ANNA PARINI

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– Beverley Hanley, Dip.Couns, CCS Counsellor and Clinical Supervisor

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– Ellie Finch, MA, MBACP (Accred)

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– Claire Kennaby, MSc, MBACP

Noticeboard

Our monthly digest of news, updates and events



1 in 50

people in the UK have body dysmorphic disorder*

NEWS REPORT



ANTIQUARY/SHUTTERSTOCK

NHS referral patterns are changing

More people are struggling to access, complete or recover in NHS Talking Therapies this year compared with last year, NHS data show.

Data released in September show a year-on-year fall from 108,004 in July 2025 to 105,849 in July 2026 in the number of referrals where people accessed treatment.**

Quarterly results also show that the proportion of referrals that lead to people accessing services, completing treatment or recovering are all falling.

In Q1 2025/26, the proportion of referrals accessing services fell from 69% to 67% in Q1 2026/27. For the same period, the proportion of referrals completing treatment fell from 40% to 37% and the proportion that moved to recovery fell from 19.5% to 17.8%.

The average number of sessions of treatment stayed stable at 8.6, briefly rising in the time between these two quarters.

Matthew Smith-Lilley, BACP's Policy and Engagement Lead for Mental Health, said: 'We should be cautious about drawing conclusions about the reasons for these changes from the published data alone, but the figures underline the pressure NHS Talking Therapies services are facing.

'People are spending longer in treatment, with the average number of sessions rising from around 7.8 to 8.5 in recent years.

'At the same time, services are dealing with high demand, workforce pressures and increasingly complex needs, which can limit the capacity available for new referrals.

'The interim report from the Independent Review of Mental Health, ADHD and Autism suggests the prevalence of mental ill health may have increased, while providers are reporting more people presenting with complex and overlapping needs, including neurodevelopmental conditions such as ADHD and autism.

'We don't yet have a complete picture of how these trends are affecting demand for NHS Talking Therapies or the workforce needed to meet it. That makes the forthcoming NHS workforce strategy and new Mental Health Strategy particularly important. We need a clear plan for how services will meet demand over the next three to five years.'

NHS England was contacted and as of going to press has declined to comment.

Read more at **bit.ly/4hcmUkb**

Words by Ellie Broughton

BACP UPDATE

BACP survey explores emotional reality of becoming a parent

Our latest campaign, The Parenting Grind, encourages new parents to consider therapy if they're struggling with the emotional transition of parenthood. It follows a survey we ran that revealed parents are nearly twice as likely to feel unprepared for the emotional transition (39%) as they are for the practical side (21%).

We took the conversation into communities through a coffee van tour across London, Brighton, Manchester and Glasgow. Members including Natasha Nyeke, Natasha-Rae Adams, Sarah Wheatley and Sanam Iqbal joined us, speaking to parents about the emotional realities of parenthood and how therapy can help.

Member and parenting author Kate Silverton was also involved in the wider campaign, helping to highlight the emotional challenges of becoming a parent and the value of seeking support. The campaign generated national media coverage, including on *Good Morning Britain*.

The Parenting Grind campaign highlights how professional support from a trained therapist can help prevent escalation to crisis, and offers something different from talking to friends and family. Read more at **bit.ly/4dnlDpq**

*BODY DYSMORPHIC DISORDER FOUNDATION. BODY DYSMORPHIC DISORDER AWARENESS DAY: 3 SEPTEMBER. PRESS RELEASE AUGUST 2026. BDDFOUNDATION.ORG/BDD-AWARENESS-DAY

**'TREATMENT' REFERS TO NICE-APPROVED NHS TALKING THERAPIES IN THIS CONTEXT.

Noticeboard



6% rise in young people contacting a teacher about mental health between 2022 and 2025*



MIKE SEWELL

FROM THE CEO

Dr Phil James, Chief Executive Officer

This month sees the publication of the report of the Commission for the Future of Counselling and Psychotherapy, arguably the most significant independent review of our profession for a generation.

Commissioned by the Partnership of Counselling and Psychotherapy Bodies (PCPB) and led by an independent panel of commissioners and co-chairs, the report has drawn on evidence from more than 4,000 contributors, including practitioners, researchers, commissioners, educators, policy makers and people with lived experience.

At its heart lies the question: how can counselling and psychotherapy make an even greater contribution to the nation's mental health at a time of rising need? The Commission's answer is clear. Across the UK mental health demands are growing while health, social care and community services remain under pressure. Yet alongside this challenge exists a highly skilled counselling and psychotherapy workforce whose potential is not being fully utilised. The Commission concludes that our profession could help close treatment gaps and improve access to timely, effective support.

The report explores the changing mental health landscape, the contribution counsellors and psychotherapists already make across the NHS, education, workplaces, community settings and private practice, and the barriers that continue to limit the profession's impact. It addresses some of the most important issues facing our sector: public understanding of counselling and psychotherapy, workforce sustainability, diversity and inclusion, research and evidence, regulation, commissioning, professional fragmentation and artificial intelligence.

Importantly this is not simply a report about the profession. It is a report about the people and communities we serve. Its recommendations focus on improving access to support, strengthening public protection, making better use of existing workforce capacity and ensuring that counselling and psychotherapy are recognised as essential components of a modern mental health system.

For BACP the Commission represents a significant milestone. I would like to recognise the outstanding leadership of BACP's Chief Regulation and Standards Officer, Dr Lisa Morrison, who has led this complex and ambitious programme of work on behalf of PCPB. Her commitment, alongside the truly exceptional work of Martin Bell, Steve Mulligan, Jenny Smith and others in our Policy and Public Affairs and Research teams, together with the contributions of partner organisations, commissioners and countless witnesses, has helped create a report that provides both challenge and opportunity for our profession.

Publication will not be the end of this conversation; it will be the beginning of action. The test now is for all of us to work together to realise a future in which counselling and psychotherapy play their full role in improving the mental health and wellbeing of our society.

*BEEWELLPROGRAMME.ORG/WP-CONTENT/UPLOADS/2026/06/HF-REPORT-2026.PDF

BACP NEWS

Celebrate 50 years of changing lives together



Next year will mark BACP's 50th anniversary. Our '50 years of changing lives together' campaign recognises the collective impact that BACP staff, members and volunteers have made.

'Together' is an important word for this campaign, as together everyone has played their part in contributing to improving mental health across the four nations.

We're looking to celebrate:

- **Our impact** – the difference counselling and psychotherapy have made to individuals, communities and society
- **Our profession** – reflecting on the profession's evolution, influence and future direction
- **Our Association** – demonstrating how BACP has supported, connected and championed members throughout their professional journey.

We want to know what you think are important and inspiring moments, significant achievements and personal highlights from throughout our specialisms, and right across our four nations over the past 50 years.

We're also looking forward so we'd be interested to hear your hopes and aspirations for your work, the Association and the profession for the next 50 years.

Send your pictures, videos and stories to **50yearsofbacp.co.uk**. Tell us what's important and meaningful to you and we can share it once the campaign launches in January 2027. You can also email us with any questions at **50years@bacp.co.uk**

DIARY DATES

bacp.co.uk/events

3 NOVEMBER
ONLINE

Working with context, identity, diversity and universal equity

Professional development day



SEVENTYFOUR/SHUTTERSTOCK

10 NOVEMBER
NEWCASTLE

Making Connections

Networking event



DRAZEN DIGIC/SHUTTERSTOCK



A major new study of more than **115,000** young people suggests teenage wellbeing may finally be recovering from the long-term impact of the COVID-19 pandemic*

Children, Young People and Families Conference 2027: Who Am I? Identity, belonging and mental health in children and young people

Join us on Saturday 6 March 2027 for an event that will explore how identity develops and shapes the mental health and wellbeing of children and young people.

Through an intersectional lens, delegates will consider how different aspects of identity can influence experiences of belonging, discrimination, resilience, relationships and psychological wellbeing. The event aims to support practitioners to think critically, compassionately and reflexively about the experiences of diverse children and young people, and to develop more inclusive, culturally responsive and evidence-informed therapeutic practice.

Delegates will learn:

- how identity develops across childhood and adolescence and its relationship to mental health and wellbeing
- how intersecting identities including race, disability, neurodivergence, gender, sexuality, faith and socio-economic status can shape young people's experiences
- increased confidence in supporting children and young people who are exploring identity, belonging and self-concept
- the impact of discrimination, marginalisation and social exclusion on psychological wellbeing
- practical, evidence-informed approaches for working in culturally responsive, inclusive and anti-oppressive ways with diverse young people and families
- relevant ethical, safeguarding and practice considerations when working with identity-related issues in therapeutic settings.

This hybrid event will take place in Manchester and online. Book your place at **bacp.co.uk/events**

Spreading the word

Promoting our members and our profession through the media

In *Stylist* **Bhavna Raithatha** and **Georgina Sturmer** explored how social media comparison can affect wellbeing, while **Hannah Jackson-McCamley, Brieanne Doyle** and **Kamalyn Kaur** discussed PMDD and relationships. • *Metro* featured **Debbie Keenan** discussing communication around sex and what surprise proposals can reveal about relationships. • In *The Independent* **Georgina Sturmer** shared advice on managing climate anxiety. • *Cosmopolitan* spoke to **Stephen Westcott** about the challenges therapists can face when working with clients in unhealthy relationships. • The Press Association featured **Nicola Vanlint** and **Debbie Keenan** offering advice on coping with the emotional impact of a major sporting defeat, while **Roya Royle** discussed recognising and managing childcare burnout among grandparents. • Apple News looked at the benefits of optimism for mental health and wellbeing, with comments from **Timothy Wright**.


BHAVNA RAITHATHA


STEPHEN WESTCOTT


TIMOTHY WRIGHT

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12 NOVEMBER
ONLINE

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Professional development day


JACOB LUND/SHUTTERSTOCK

17 NOVEMBER
NOTTINGHAM

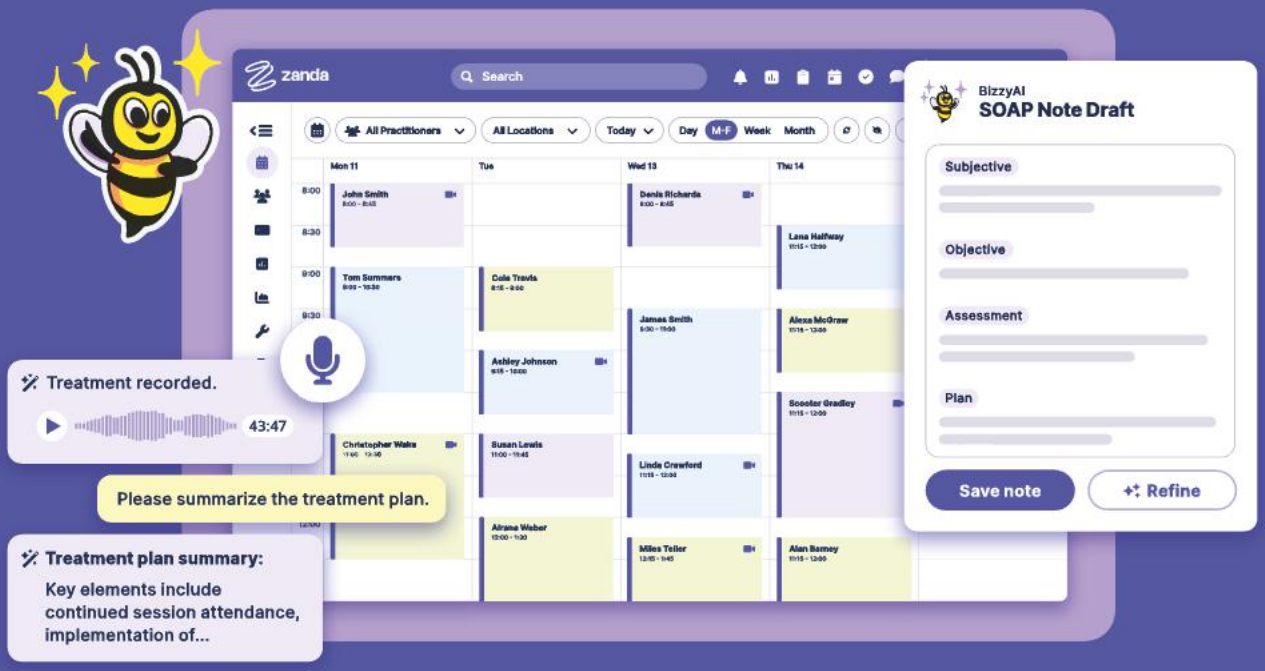
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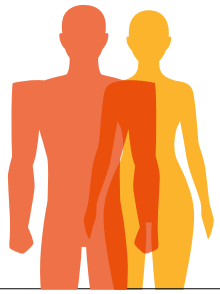
— **Mark L.** Private Practice Owner



zanda

*New customers only

1 in 3 people with body dysmorphic disorder attempt suicide*



YOUR QUESTIONS ANSWERED

Understanding BACP's research



Lydia Knight, BACP Admin Co-ordinator for Research

BACP's Research team supports research across the counselling, psychotherapy and coaching professions. We provide information, resources and guidance to help members, students and researchers find, conduct, share and publish research. Here are some of the questions we're most frequently asked...

How can I find information or research resources on the BACP website? We have a dedicated research resources section under 'Events and resources' online at **bacp.co.uk/events-and-resources/research**. Members are able to access good research practice, ethical guidelines, academic databases through EBSCO, and the *Counselling and Psychotherapy Research* journal. Further guidance on finding research can also be found at **bacp.co.uk/events-and-resources/ethics-and-standards/good-practice-in-action/publications/gpia015-how-to-do-a-literature-search-fs**

The Cochrane Library is also useful for locating research reviews: **cochranelibrary.com**

Can BACP support me in publishing my research in a peer-reviewed journal? Yes, our CPD hub offers a 'Writing for publication – learning path'. You may also wish to submit your research or a paper based on your dissertation to BACP's *Counselling and Psychotherapy Research* journal. You can find submission guidelines at **bacp.co.uk/bacp-journals/counselling-and-psychotherapy-research-journal** or contact the editor directly at **cpr.editor@bacp.co.uk**

Can BACP circulate my research survey or participant recruitment poster to all of its members? BACP can't circulate research surveys or posters directly to members, but studies can be promoted via our research noticeboard at **bacp.co.uk/events-and-resources/research/research-noticeboard**. To submit a survey you would need to provide a research summary, details of your data collection methods and evidence of ethical approval.

Where can I find more information about the next BACP Research Conference? BACP's International Research Conference brings researchers and practitioners together to share research findings and exchange ideas and network. You can find out more about our May 2027 Research Conference at **bacp.co.uk/events-and-resources/research/conference**

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PROFESSIONAL CONDUCT

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- **BACP's Professional Conduct Notices can be found at bacp.co.uk/professional-conduct-notices**

20 NOVEMBER ONLINE

BACP Annual General Meeting

Our yearly gathering for BACP leaders and members



FRAME STOCK/SHUTTERSTOCK

25 NOVEMBER ONLINE

Ethics in action

CPD event for members



PEOPLEIMAGES/SHUTTERSTOCK

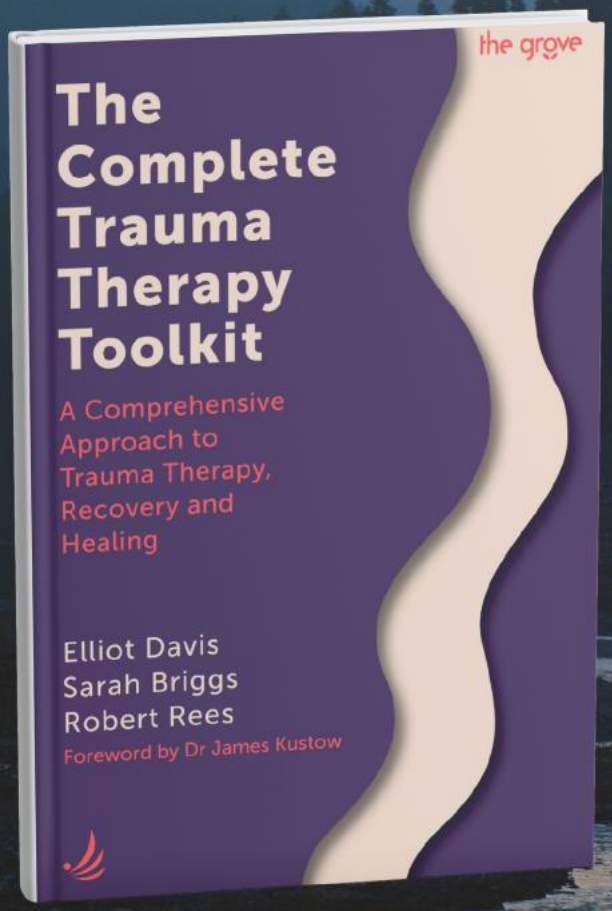
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Dr Graham Music, Tavistock Consultant Psychotherapist & Trauma and Attachment Specialist, Author and Trainer

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PCCS BOOKS

MEMBER SPOTLIGHT

Setting up practice



William Njoki MBACP student member

Before training as a therapist, you spent 20 years working with young people in referral units and SEN education. What were the greatest joys and disappointments?
The joy was relationships – watching someone who'd experienced repeated exclusion and alienation begin to trust, to recognise an ability in themselves and to simply feel heard. The disappointments were systemic – young people reduced to labels and behaviours when there were far deeper stories underneath. The hardest part was losing young people to knife violence and attending their funerals. I still can't make sense of the sheer unfairness of it. What sustains me now is bumping into former students across London, hearing about the careers and families they're building, and still debating who was better at lunchtime ping-pong.

What led you to train as a therapist, specifically in the person-centred pluralistic approach? It grew out of watching what happens when someone is genuinely listened to and given room to make sense of their own experience. Person-centred work matched my belief in people's capacity to grow; pluralism appealed because it refuses to assume one approach fits everyone. My own therapist, who moved as easily between sketching and tarot as between modalities, first suggested the course having seen how I responded to being treated as the expert in the room and in my own experience. That's exactly what my peers and I had consistently found missing from mental health support generally.

What barriers do you face as a relatively newly trained therapist? I think the greatest barrier is adjusting to life after study, eventually finding faith in myself professionally. Building clinical hours, finding openings, becoming financially sustainable, all while working out who you are as a clinician, to yourself and to your clients. Supervisors, peers and mentors help shape that emerging identity, but holding onto my own integrity and purpose through it is its own challenge.

Looking back on your training, what would you change for those coming after you? I'd want deeper engagement with race, class, neurodiversity and culture alongside greater equity and real support for trainees developing their own therapeutic voice. That includes naming things like internalised racism and the pressure of impossible perfection, which can paralyse students, sometimes to the point that they can't submit (or even start) an assignment, and asking what support should be built in, not offered as an afterthought.

What's next for you? Attaining more clinical hours and more importantly clinical experience in placement. Building a practice rooted in liberation, creativity and decolonisation, alongside further writing and research. I would also like to create and engage in support networks – for example, group supervision for therapists from diverse backgrounds. No rigid five-year plan, just courage, curiosity and seeing where the work takes me.



FROM THE PRESIDENT

Professor Lynne Gabriel OBE

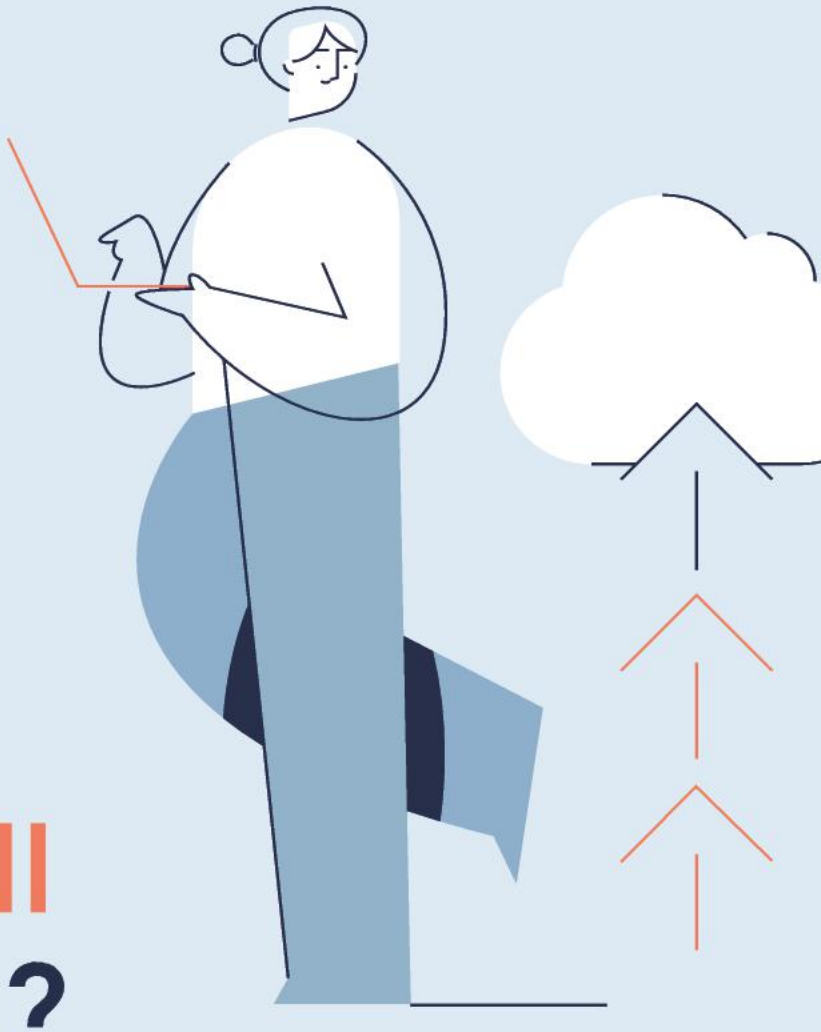
News. It comes at us 24/7 from multiple sources. Through social media, the press, TV channels, online and hard copy newspapers, the news is a relentless churn; one that seems impossible to avoid. Hardly surprising then that we might experience news fatigue or, more disturbing, trauma and associated anxiety from ongoing witnessing of horrific global tragedies, conflicts and losses. What is the human cost of all this? For counsellors, psychotherapists and coaches this could matter. Not only for ourselves but also our clients who may be experiencing information overload while some may show distress that echoes trauma exposure itself.

News arrives as a constant drip-feed of threat; war, disasters, national and international political turmoil, and climate crises. Headlines can appear to compete for our emotional and behavioural response, or more like, reactions. Mirror neuron activation, highlighted in a 2021 study,* suggests that witnessing suffering, even via screens, could generate empathic distress. For clients with prior trauma histories this might compound existing vulnerabilities, creating a cumulative load that clinicians increasingly see in presentations of hypervigilance, sleep disturbance and emotional overload. Mirror neuron research is in its infancy so further studies are required. However, early inferences could be made that human observation of news reporting national or global crises events could impact in ways that evoke stress or trauma responses.

Additionally studies from the COVID-19 pandemic period indicate that heavy news engagement can incur higher PTSD symptomatology, even when individuals are not directly exposed to threat.** People's reactions during the pandemic included anticipatory anxiety, diminished sense of control and blurring of boundaries between personal life and global crises.

For practitioners the clinical implications are clear. News fatigue is not apathy. It is a human protective response to being overwhelmed by news. The likely human cost of relentless news exposure is erosion of emotional capacity. Our task as practitioners is to help clients cultivate ways of managing media engagement, hold boundaries of access that are appropriate to them and to engage with national and global events reflectively and reflexively rather than reactively. Staying informed matters, but not at the expense of our mental health and wellbeing.

*Dreyer AM, Rieger JW. High-gamma mirror activity patterns in the human brain during reach-to-grasp movement observation, retention, and execution-An MEG study. PLoS One 2021 2 December; 16(12). doi: 10.1371/journal.pone.0260304
**Solomon Z, Ginzburg K, Ohry A, Mikulincer M. Overwhelmed by the news: a longitudinal study of prior trauma, posttraumatic stress disorder trajectories, and news watching during the COVID-19 pandemic. Soc Sci Med 2021 Jun;278:113956. doi: 10.1016/j.socscimed.2021.113956



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WORKING FOR YOU

Updates from BACP's Policy team

Mental health expansion cannot come at the cost of existing services

We're deeply concerned by reports of planned cuts and closures across NHS mental health services in England, particularly at a time when demand for mental health support remains high. The reports came just days after the Government announced a £343 million investment to expand community mental health support.

The latest reports raise serious questions about whether the Government's expansion plans are deliverable if existing services are being cut at the same time. Cutting services and clinical staff risks reducing access to support and putting further pressure on an already stretched system.

Dr Lisa Morrison, BACP Chief Regulation and Standards Officer, said: 'The new Minister for Mental Health, Alison McGovern, must urgently address these reported cuts and closures. Coming so soon after the Government's announcement of new community mental health centres and emergency mental health departments, they raise serious questions about whether its expansion plans are deliverable. We need both – not one at the expense of the other.'

Read more at **bacp.co.uk/news/news-from-bacp/2026/13-august-mental-health-expansion-cannot-come-at-the-cost-of-existing-services**

Research highlights the value of school counselling

A pilot study has found that young people who set and reviewed personal goals during school-based counselling may attend significantly more sessions.

Published in *Psychology and Psychotherapy: theory, research and practice*, the study explored whether introducing and regularly reviewing personal goals during school-based humanistic counselling were practical and acceptable for young people aged 13 to 16 experiencing moderate to severe psychological distress.

While there were no significant differences in psychological distress or life functioning between young people who received counselling with or without structured goal setting, those who took part in the goal-setting approach missed significantly fewer counselling sessions.

Charlie Duncan, Senior Research Fellow at BACP and lead author of the study, said: 'School counselling provides an important opportunity for young people to access support in a familiar and accessible environment. Our findings suggest that incorporating goal setting into counselling may help young people stay engaged with counselling, although further research is needed to understand whether this also leads to improved mental health outcomes.'

Read more at **bacp.co.uk/news/news-from-bacp/2026/11-august-research-highlights-the-value-of-school-counselling**

Update from BACP's Ethics team

Ethical Framework for the Counselling Professions 2026

The *Ethical Framework for the Counselling Professions* 2026 is now in effect and mandatory from midday Tuesday 3 November 2026. All members should then be working in accordance with the new framework.

The framework is structured around three key sections: A. Working ethically within relationships, B. Ethical principles and C. Core responsibilities, which should be used together to support ethical decision-making and safe, effective practice.

Alongside the framework we've produced a range of resources to support you in using the *Ethical Framework* 2026 and working ethically within your professional practice. These resources are available in three new categories:

- Ethics Essentials
- Ethics in Practice
- Legal Resources

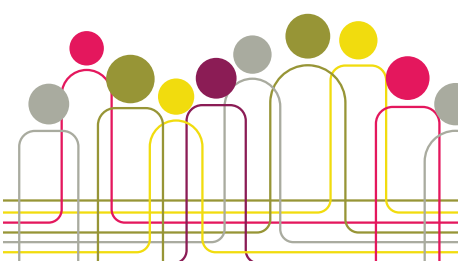
They now replace the former Good Practice in Action (GPiAs) resources, which will no longer be available from Tuesday 3 November 2026.

We're also developing further resources to support you in implementing the new framework, including a range of short and more detailed resources such as e-learning modules, text-based resources and videos. These are being informed by the feedback from you within our second consultation.

We want to make sure you're supported and have what you need to embed the new framework into your practice and ways of working.

To access the new framework, supporting resources and further guidance, please visit the *Ethical Framework* webpage.

Read our detailed update on the new *Ethical Framework* on page 55.



Accredited Counselling and Psychotherapy Courses in Sussex and Online



UPCOMING CPD COURSES (ONLINE):

MENTAL HEALTH FAMILIARISATION WORKSHOP
- 30 October 2026 – 5 February 2027

A four-part series helping trainee and qualified counsellors and psychotherapists deepen their understanding of mental health care systems while meeting UKCP Mental Health Familiarisation Placement requirements. All workshops: Fridays, 9.30am–4.15pm.

30 October 2026 - Counsellors and psychotherapists in the wider mental health care system.

4 December 2026 - A socially responsible understanding of mental health.

8 January 2027 - Diagnosing and treating mental 'ill-health'.

5 February 2027 - Models of assessment: understanding clients with 'mental illness'.

CERTIFICATE IN WORKING WITH FAMILY DYNAMICS
- 9 November – 14 December 2026

Develop confidence and practical skills in working therapeutically with families. Suitable for trainees and qualified counsellors.

CERTIFICATE IN WORKING WITH ADDICTION
- 8 January – 20 February 2027

Develop practical skills and a deeper understanding of the psychological, social and neurobiological aspects of addiction to support clients with confidence and compassion.

CERTIFICATE IN WORKING WITH TRAUMA – EMERGING FROM EMERGENCY
- 12 February – 11 June 2027

Explore how to work effectively with different types of trauma, both in the therapy room and on site at critical incidents. For practising counsellors and psychotherapists.

CERTIFICATE IN NEUROAFFIRMING PRACTICE
- 20 February – 17 April 2027

For counsellors, psychotherapists, coaches and mental health practitioners committed to creating inclusive, respectful and empowering therapeutic spaces for neurodivergent clients.

CORE TRAINING PROGRAMMES:

DIPLOMA IN SUPERVISION (ONLINE)
- 2 April – 2 October 2027

Could supervision be the next step in your professional practice?

Now in its 20th year, our online Diploma in Supervision is designed for experienced practitioners looking to add supervision to their portfolio.

With a strong experiential focus, the course offers opportunities to practise your skills, receive feedback and develop your own supervisory style. You'll explore ethical, group and creative approaches, alongside other key aspects of effective practice.

FREE ONLINE TALKS

HOW TO BECOME A SUPERVISOR
- 25 January 2027

Discover the knowledge, skills and practical considerations involved in becoming an effective clinical supervisor.

OPEN EVENING
- See our website for upcoming dates

Meet the team, ask questions and explore our training and CPD opportunities.

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RESEARCH DIGEST

To mark Men's Health Awareness Month this issue presents research focusing on counselling and psychotherapy with male clients.

1 Therapy experiences of post-suicidal men

THE STUDY: The study explored the lived experience of long-term (at least 20 sessions) individual psychotherapy among six men with a previous unsuccessful or arrested suicide attempt. Semi-structured interviews were analysed using reflexive thematic analysis.
THE FINDINGS: Three core themes were identified: creating a safe space in therapy; the push and pull of gender proximity; and iatrogenic harm in institutional care. Participants emphasised the importance of safety, trust and sustained therapeutic relationships as well as a preference for experienced female therapists. Participants also described institutional care as inaccessible and, at times, harmful, with all eventually accessing private therapy.
THE TAKEAWAY: Long-term relational psychotherapy may provide important recovery opportunities for post-suicidal men. Greater consideration of safety, gender and access to sustained psychological support is needed within services.
READ MORE: Coomes A, Vos J, Roberts R. Long-term therapy experiences in post-suicidal men: safety, gender and iatrogenic harm. **onlinelibrary.wiley.com/doi/10.1002/mps2.70009**

2 Existential isolation and the therapeutic relationship

THE STUDY: Survey responses of 204 men who had previously received therapy were analysed to explore associations between measures of depression/anxiety, suicidal ideation, the therapeutic relationship and existential isolation.
THE FINDINGS: A very strong correlation was found between symptoms of anxiety/depression and existential isolation. A positive therapeutic relationship was associated with lower depression/anxiety symptoms through (ie mediated by) reduced existential isolation. A stronger therapeutic relationship was also associated with lower suicidality, again through less existential isolation.
THE TAKEAWAY: The study draws attention to existential isolation as a vital component associated with men's experience of wellbeing. It also suggests that a strong therapeutic relationship may support better therapy outcomes for men by attenuating the negative effects of existential isolation.
READ MORE: Storey QK et al. Connecting and healing: the role of existential isolation in mediating the impact of the therapeutic relationship on Canadian men's mental health outcomes. **journals.sagepub.com/doi/10.1177/15579883221136980**

3 Engaging adolescent male clients in therapy

THE STUDY: Thirteen Australian therapists were interviewed about the challenges they face engaging young male clients in therapy. Data were analysed using reflexive thematic analysis.
THE FINDINGS: Three main themes emerged: therapists' lack of confidence when working with young men; therapists' feelings of ineffectiveness when young men were referred by a third party; men were sometimes reluctant to be vulnerable and had difficulty expressing complex emotions in therapy.
THE TAKEAWAY: Training in male-specific issues may increase therapists' confidence when working with this client group. The authors highlight the need for clear communication around expectations, use of non-clinical language and adopting a strengths-based approach.
READ MORE: Sadiqi S, Boerma M. '...I felt I was failing': Australian therapists' experiences on the challenges of engaging adolescent males in counselling and psychotherapy. **onlinelibrary.wiley.com/doi/10.1002/capr.70112**

MY RESEARCH



Dr Gary Shepherd
Senior Lecturer in Counselling and Mental Health at York St John University

Dr Shepherd speaks to us about his research focusing on the barriers men face in accessing therapy and on community-based approaches to men's mental health and suicide prevention.

My research asks two simple but urgent questions: why do so few men reach out for counselling before a crisis, and what kind of support actually works for those who won't walk through a clinic door? Male suicide remains the leading cause of death for men under 50 in the UK, yet men consistently engage with mental health services less than women. My work looks at the barriers keeping men from formal therapy, and at community-based alternatives, peer support, activity-based groups and other non-clinical spaces that are proving better at reaching them early.

My interest in this goes back further than my career. Growing up I noticed some boys my age were far more aggressive and bullying than others, and I remember wondering why they seemed unable to control their anger. As a therapist I now understand this is a complex, multifaceted issue, but that early drive to understand and help never left me. It resurfaced in my early career, when I ran a psychoeducational anger management programme for men. Watching men who would never have booked a counselling appointment open up in that space taught me that the problem is that traditional services aren't built with them in mind.

That practice work led to exploring the barriers men face in seeking therapy, and an evaluation of Menfulness, a York-based men's mental health charity. That evidence has already informed real change, contributing to England's first Men's Health Strategy and helping Menfulness secure more than £150,000 to expand its services. I'm now running a national research project exploring what works in community-based men's mental health support, carrying out 28 research sessions, interviews, focus groups and site visits with a range of grassroots organisations, building a national picture of what makes these approaches succeed.

Contact Gary at **g.shepherd@yorksj.ac.uk**

What's on

Mental wellbeing in the arts and media

MUSIC

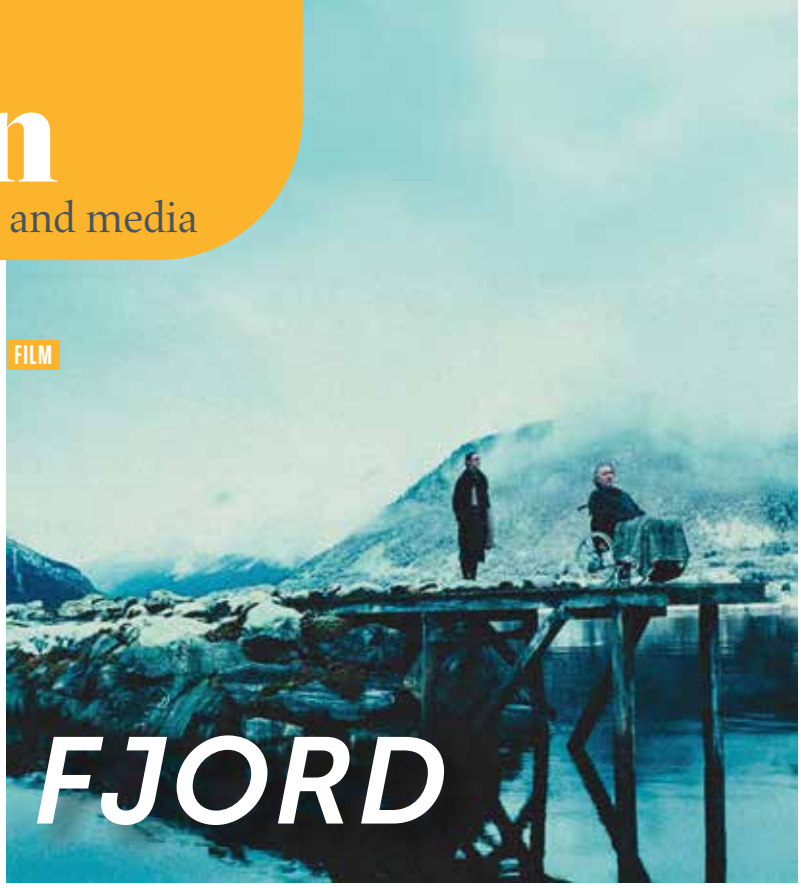


CIRCUIT3

Metanoia: music from therapy

Music about therapy is often a lyrical storytelling about a bared-soul journey to recovery: not so for Peter Fitzpatrick's music project Circuit3. His new album *Metanoia: music from therapy* is a minimal and spacious album that mixes analogue synths and drones with stripped-back piano. He worked with Vince Clarke, a songwriter for Depeche Mode and Yazoo, to find a way to create a personal album that drew on his experience of therapy. The album doesn't aim to get past trauma; instead the music makes room for it, so even the most melodic sections are bittersweet. Available now on Bandcamp.

FILM

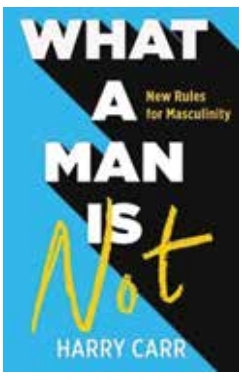


MOBRA FILMS

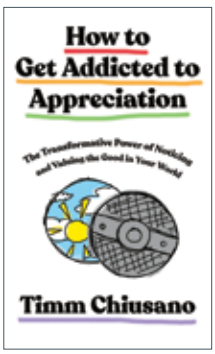
In Norway an immigrant family is investigated by social and legal services. Lisbet (Renate Reinsve) is Norwegian but her partner is Romanian – a difference that the Romanian director, Cristian Mungiu, turns over again and again during this tense drama. Fans of courtroom thrillers such as *Anatomy of a Fall* will appreciate the tightening of the tension, inch by inch, as we get to know the domestic dynamic as well as the pressure of the culture around the family. Inspired by real events, the film recreates aspects of the story of the Bodnariu family whose five children were removed by Norwegian child welfare services in 2015. Themes of family, immigration and the rights of children will make for rich pickings in peer supervision groups this month. *Fjord* is on limited release from 13 November.

Courage inside

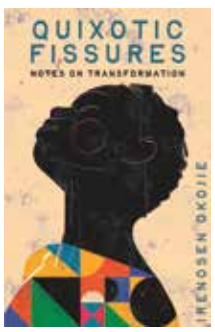
BOOKS



In *What a Man is Not*, Harry Carr's 'new rules for masculinity' define an expansive version of manliness by shouldering out the parts that don't work for the majority of us. (Out now, Icon)



In *How to Get Addicted to Appreciation*, Timm Chiusano's fun approach to work puts gratitude and observation in the driving seat as he engages on a road trip to find more joy in the nine-to-five job. (Out 12 November, John Murray One)



Master storyteller Irenosen Okojie turns her hand to essays in this new collection called *Quixotic Fissures* about race and depression. Her imaginative approach finds a new entry into conversations about intergenerational trauma. (Out 5 November, Dialogue)

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

PODCASTS







Getting it right

From Gary Lineker's Goalhanger network, Katty Kay's show *Doing It Anyway* interviews experts such as Professor Dr Kristin Neff and psychologist Adam Grant about the role of confidence – and how to fake it. On Apple Podcasts. **bit.ly/DoingItAnyway**

Peer-led charity CAPITAL has launched a podcast – *CAPITAL Connections* – about lived experience. Start with the interview with consultant Fiona Palmer on the importance of trauma-informed services. On YouTube. **bit.ly/capitalconnectionspodcast**

For a new BBC series *Confessions of a Performative Male*, Orwell Prize-winning author Darren McGarvey lifts the lid on modern masculinity dilemmas: accountability, privilege and fear. On BBC Sounds. **bit.ly/PerformativeMale**



DOCUMENTARY

Traumality

After years of personal struggle Ton Mazzone collected experts from mental health and psychiatry to discuss the link between mental health diagnoses and childhood trauma. The result is this feature-length production that mixes commentary with animation to bring the subject to life. The aim of the film is clear: forging systemic change so that services public and private are informed by growing evidence that adverse childhood experiences put adults at higher risk of physical and mental health problems. For those interested in de-medicalised models of mental health care, the documentary offers a starting place to develop your stance on mental health care reform. Watch on demand at **traumality.com**

PHOTOGRAPHY

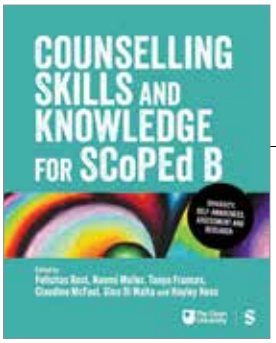


PHOTOGRAPH: MAGGIE'S

Cancer is on the rise in the UK, with its prevalence growing as we live longer. That makes Tabitha Jussa's portraits of women in cancer care feel all the more vital: humanising a disease that is still a taboo subject in 2026. The exhibition 'Just Come in': 30 years of Maggie's centres, in partnership with the Royal Institute of British Architects, celebrates Maggie's centres – places for treatment that emphasise the importance of good settings for care. Until 15 November at Tate Liverpool at RIBA North, Mann Island.

Bookshelf

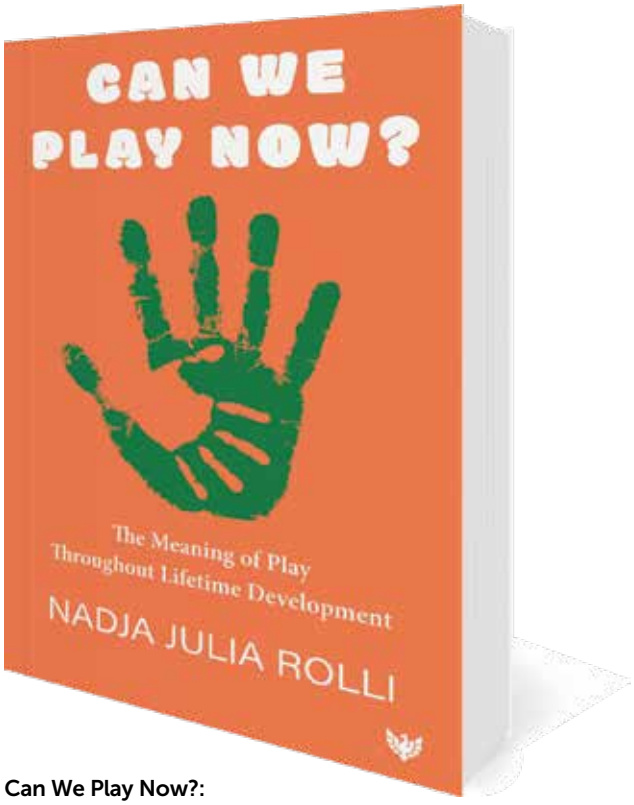
Edited by Jeanine Connor.
Please note, we do not accept unsolicited reviews.



Counselling Skills and Knowledge for SCoPEd B: diversity, self-awareness, assessment and research
Felicitas Rost, Naomi Moller, Tanya Frances, Claudine McFaul, Gina Di Malta and Hayley Ness (eds) (Sage)

Across 20 chapters grouped into themes of diversity, reflectivity, assessment, research and developing as a practitioner, this book deftly aligns counselling competences to column B of the Scope of Practice and Education (SCoPEd) framework. While not without its critics, the framework aims to offer greater clarity about the skills and knowledge of qualified therapists. As an experienced academic psychologist who was a trainee during the consultation and early implementation period, this book prompted me to revisit the framework. Psychodynamic language of the 'unconscious' – although framed as being 'as inclusive as possible' – permeates the framework beyond level A, alongside evaluation, research and heightened reflexivity.

In practical terms this book equips the reader to apply for BACP accreditation, which aligns with column B, should they wish to do so. Closely mapped to each competency element, the book walks the reader through each column B requirement, appropriately foregrounding diversity and reflexivity. It is a thoughtful, engaging and practically grounded guide, peppered with 'pause for thought' boxes, case examples and suggestions for further reading and reflection. I highly recommend this book as a comprehensive support for counsellors of all modalities taking this developmental step.
Professor Elizabeth Peel MBACP, person-centred psychotherapist



Can We Play Now?: the meaning of play throughout lifetime development
Nadja Julia Rolli (Karnac)

This book is simultaneously imaginative, lively, thorough and well-grounded. In one chapter's epigraph the author, quoting Jung, names imagination as 'a concentrated extract of all forces of life'.

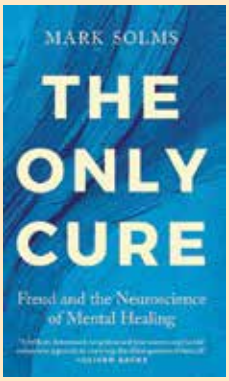
After an introduction offering an autobiographical 'origin story' for her eventual interest in child psychotherapy, Rolli grounds her exploration of the therapeutic role of play in theoretical frameworks that, in her view, can best help us understand the different processes that play embodies during each successive phase of early life. These include Erikson's life-stage model as well as those of Klein, Bowlby, Winnicott and others.

Alongside topics such as sensory play, attachment play and constructive play, Rolli investigates topics that might not immediately spring to mind when thinking of 'play therapy', including the meaning and value of organised team sports (which come to the fore, for some, from later childhood onwards) and the role of play in the lives of adults. There is a strong commitment to lived experience and inclusivity, with detailed case studies encouraging us to think more deeply about, for example, internet addiction among teenagers and intergenerational trauma in minoritised communities.

Another chapter epigraph, from Winnicott, reads: 'It is joy to be hidden but disaster not to be found.' I sincerely hope that this wise, generous book finds a wide readership.
David Curl MBACP, counsellor in private practice

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

'The clinical stories are the book's heart: they humanise theory and reminded me why patience and curiosity matter in practice' **Lizzie Stone**



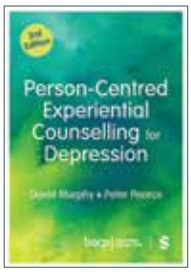
The Only Cure: Freud and the neuroscience of mental healing
Mark Solms (Pegasus)

From my perspective as a trainee psychotherapist this book is a refreshing and sometimes frustrating defence of psychoanalysis. Solms writes with conviction, linking neuroscience with philosophical reflection to argue that, unlike medication, depth work addresses cause rather than simply suppressing symptoms. The clinical stories are the book's heart: they humanise theory and reminded me why patience and curiosity matter in practice. As a student I found the author's insistence on listening to symptoms as meaningful signals both liberating and challenging.

Writing boldly Solms at times seems to downplay evidence, which is contrary to his theme, making the book anecdotal rather than a practical handbook. Some neuroscience sections are complex, and I needed to read slowly and consult other reading materials to clarify meaning. Indeed the book reinforced my commitment to slow, exploratory work with clients but also reminded me to hold claims lightly and check the wider evidence base.

This is a stimulating, compassionate book for those who want to think deeply about why therapy works. I found it moving and inspiring. At times it's rather complex and perhaps not suited to someone starting out on their journey in this field, but I'm glad I persevered. A thought-provoking and touching read.

Lizzie Stone, BACP student member, student psychotherapist



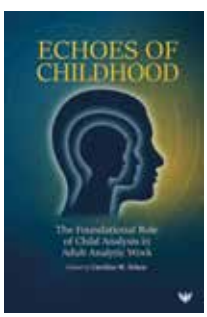
Person-Centred Experiential Counselling for Depression (3rd edition) David Murphy and Peter Pearce (Sage)

The opening chapters of this excellent book provide a clear overview of the theoretical foundations underpinning person-centred experiential (PCE) therapy and an illuminating account of depression through a PCE lens. Murphy and Pearce introduce key experiential concepts with clarity and demonstrate how the person-centred tradition has evolved in response to contemporary understandings of depression and emotional process. While some of the terminology may feel unfamiliar to readers new to experiential approaches, the authors helpfully relate theory back to clinical practice.

The central chapters build effectively on this theoretical foundation by showing how PCE works in practice with depressed clients. The case material and therapeutic transcripts give readers a strong sense of the relational depth and process sensitivity required in this work. As with many therapeutic approaches, these skills are difficult to acquire solely through reading, and the book will therefore be especially valuable for those training on person-centred courses where the approach can be explored experientially in the classroom.

The closing chapters address training, supervision and research, and include thoughtful reflections from the authors on the future of PCE approaches to depression. Challenging issues such as suicide risk, outcome measures, brief work and tensions with the medical model are handled carefully throughout. This is a superb and highly recommended text for trainees, practitioners and counselling educators alike.

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



Echoes of Childhood: the foundational role of child analysis in adult analytic work
Caroline M Sehon (ed) (Karnac)

This is a clinically comprehensive book that presents insights from real-world child analysis, following the developmental arc of early and middle childhood, adolescence and adulthood. Contributions from clinicians around the world reflect how differences in theoretical traditions and clinical cultures do not detract from a central theme that childhood analysis is fundamental to understanding personality and relationships throughout life.

The structure of case presentations followed by commentary was interesting, providing complementary and sometimes alternative perspectives and interpretations. However, at times I found the book heavy going in style and substance. It assumes a sound grounding in psychoanalysis and a theoretical understanding of child analysis. It is a book to dip into rather than read cover to cover. The earlier chapters contain some general statements without sufficient context or clarification of how child development informs work with adults. Later chapters explain these connections more clearly.

This book will primarily be of interest to psychoanalysts working with children as this is its starting point. However, those seeking theoretical case studies to inform their understanding and practice when working with adults may also value the discussions presented.

Anna Perkins, BACP student member

News anxiety: *living in an uncertain world*

Kathryn Wheeler unpacks the growing trend of clients wanting to switch off the news



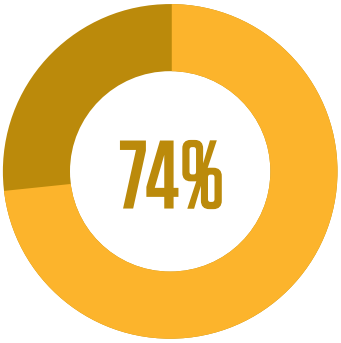
ANNA PARINI

The world is getting scarier. At least it can feel that way. You sit down at the end of a long day and open your phone. You scroll through your feed: there's a photo of your friend on holiday, another of someone's house renovation, and then there's the news that an unfathomable number of people have lost their lives to a global conflict. You wake up in the morning and ask your smart speaker to give you an update: it tells you the temperature, gives an estimation of the likelihood of rain, then moves into the top stories where the first one is of frightening new climate figures. Today bad news feels almost unavoidable. It's not just in newspapers but in our hands at all hours of the day in the form of smartphones. And it's taking a toll.

In a September 2026 survey of 600 Counselling Directory professionals, part of the Happiful network of wellbeing platforms, 74% said that they had noticed news-related anxiety coming up more often with clients. When asked what feelings and behaviours they had noticed in clients in relation to news or current events, 67% reported seeing 'fear about the future', 66% said 'increased anxiety or worry', and 58% saw 'doomscrolling or compulsive news checking'.

As Editor of *Happiful* magazine I recently surveyed readers on the question, 'What element of modern life affects you the most?' 'Anxiety-inducing', 'horrifying', 'depressing', 'existential dread', 'doom' – over and over again readers shared how the news was impacting them, many going on to say that for the sake of their wellbeing they had to turn it off completely.

'Top of list: the bombardment of bad news, a constant reminder that man is doing damage to others and the environment. I pray, worry, write and donate,' says Karen from the Isle of Wight. 'I avoid the news and traditional media at all costs. Knowing that unpleasant things have happened far away just makes my day worse,' says Clare from the West Midlands. Another reader, Nicola from Yorkshire, wrote:



of Counselling Directory professionals said that they had noticed news-related anxiety coming up more often with clients

'I only listen to the news once a day at most; it can be too depressing and affects my mood.'

These are just a snapshot of the messages we received. As I scrolled through the responses I felt sad and sympathetic, but I didn't feel surprised. Beyond what my own relationship with the news could tell me, the things that I was seeing were in line with the national picture.

Negative press

In 2025 the Reuters Institute's *Digital News Report*[1] found that 46% of people in the UK said they sometimes or often actively avoid the news compared with 24% in 2017. Of those people who avoided it the most common reason for doing so was that the news had 'a negative effect on their mood' (39%), followed by feeling 'worn out by the amount of news' (31%).

'People are fed up with political news in particular. They feel overloaded and bombarded by the amount of coverage, much of it negative,' says Dr Craig T Robertson at the Reuters Institute, considering the findings of the *Digital News Report*. 'The overall trend we have tracked over the past 10 years has not been a positive one: consumption of online news appears to be in decline, interest in news has fallen sharply, and more people are avoiding news or choosing not to consume it at all.'

A pattern of feeling anxious or overwhelmed in response to consuming negative news, news anxiety can impact our lives in many ways. But what's happening psychologically when we're repeatedly exposed to distressing news?

'What we see becomes our world, and the more we see it, the more of our reality it becomes,' says Dr Arash Javanbakht, a psychiatrist and Founding Director of the Stress, Trauma, and Anxiety Research Clinic at Wayne State University in the US, who has written extensively on the topic. 'Especially on social media, when the algorithms decide that is what we are interested in, and we will see more and more related news and images. As a result we develop a very grim, sad and scary perception of the world.'

As Dr Javanbakht explains, this leads to frustration, anxiety, overestimation of danger, anger and desensitisation – which could border on a traumatic response. 'An example is how an American would perceive another mass shooting versus someone in a country without a history of repeated mass shootings,' he adds. 'We lose our empathy for others' suffering.'

When asked whether news anxiety is something that she sees coming up with clients in the therapy room more often, counsellor and clinical supervisor Abigail Holman has a firm answer: 'Yes, definitely,' she says. 'I'm coming across it in a couple of different ways. One is people actively seeking out the news and



'What we see becomes our world, and the more we see it, the more of our reality it becomes. We develop a very grim, sad and scary perception of the world' **Dr Arash Javanbakht, psychiatrist**



'Clients often feel that because they are in a more fortunate position they have a responsibility to keep witnessing what is happening' **Abigail Holman, counsellor and clinical supervisor**

feeling compelled to keep up with what is happening. The other is people unexpectedly coming across distressing content when they weren't looking for it.

'Someone might be casually scrolling, watching something light-hearted, and then suddenly be confronted with a live stream of a traumatic event or graphic imagery. That can really catch the nervous system off guard because they haven't had much opportunity to prepare for what they are about to see.'

Holman also points to the conflict people feel around having a 'moral duty to stay informed'. 'Clients often feel that turning away means turning a blind eye, or that because they are in a more fortunate position they have a responsibility to keep witnessing what is happening,' she explains. 'That can lead to guilt about switching off, difficulty sleeping and even guilt about enjoying their own life when they know other people are suffering.'

This tension was something that was explicitly explored in a 2022 paper.[2] Researchers saw that there was a conflict between two key things: the social ideal that being a 'good citizen' involves staying informed, and the participant's experience that consuming news leaves them 'anxious and disempowered'.

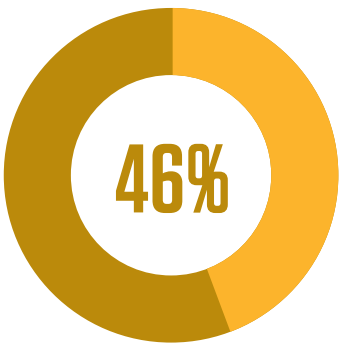
It's a sentiment I recognised in reader Barrie's message in our survey, where he wrote: 'I've become hypervigilant about reading the news as it happens, and can feel that it has an effect on my nervous system. Walking and music help.'

Considering what's happening psychologically when we continue to check the news, even though it's making us feel worse, Holman points to the human need to *know*. 'For some people I think there can also be a search for certainty,' she explains. 'When we feel unsettled or powerless, checking for more information can give us a brief sense that we're doing something or getting some kind of control over the situation, even if what we find actually leaves us feeling worse.'

Shared emotions

From conflict in the Middle East and Ukraine to escalating global tensions, climate disasters and injustice, the bad news is endless, and it comes to us in an unstoppable digital tide. It makes sense that we might believe that if we stay on top of the issue, understand the ins and outs of it, we might be able to control the way it affects us. This feels particularly poignant when it comes to human tragedy – and for integrative counsellor Rav Sekhon our reaction points to something inherent to us as connected, social people.

'We all inevitably feel news anxiety in some capacity as we are connected as human beings through shared emotions we universally experience,' he explains. 'This is very true and real, and it's important for us to acknowledge that the feeling exists. There is no shame in being impacted by world events; it is a natural part of our experience, and often it is such emotion that has the power to create positive change or influence – big and small. As therapists we need to hold the emotion with the client and explore what it brings up for them, guiding them through the process with the aim of having greater awareness of it and potentially creating meaning from it.'



of people in the UK said they sometimes or often actively avoid the news

When it comes to discussing news anxiety in the therapy room, psychotherapist Hannah Jackson-McCamley says that it's as relevant to ask clients about their news consumption as it is to enquire about their relationship with their body, food, sex, family and friends.

'Like all the aspects of a client's life that I am curious about, how our clients engage with the news and the subsequent feelings associated with it gives us data on their perspective, values and outlook and how they participate in the world,' she explains. 'It's important to me to get a strong sense of who they are outside the therapy space as well as being curious about potential stressors that could worsen their mental health.'

But as Jackson-McCamley sees it, news anxiety isn't usually an isolated experience. 'Some of my clients do explicitly state that the news causes them anxiety, but this is often when the themes presented in the news cause them consternation or are directly impactful to them personally,' she explains. The news then emerges as a factor in the client's emotional dysregulation or outlook, sitting alongside other areas such as relationship difficulties or housing and financial insecurity.

Sekhon reports a similar trend with the clients he works with, sharing how the impact they feel often correlates to how they are feeling about life more broadly. 'People's personal feelings about a localised event can sometimes be linked to global events, and this reinforces the feeling,' he says. 'For example, "I am feeling hopeless about the relationship with my mother and, wow, the way the world is going – it makes me feel even worse."

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'As part of the process it's our duty to explore all elements of what may be causing the client to feel a certain way, to understand what is happening,' he adds. 'This is not always obvious and can be very complex, but if news is a clear indicator then there will be value in exploring it further.'

In July 2026 Mind published a dedicated guide called *How to Cope with Upsetting Events in the News*.[3] It advises people to acknowledge their emotional response, set boundaries and seek support where needed. Similarly the Mental Health Foundation[4] shares specific guidance on doomscrolling and healthy news consumption as well as advice on coping with 'global news overwhelm'.[5] And the American Psychological Association's (APA) trauma guidance also highlights how studies have shown that prolonged exposure to upsetting news coverage can significantly affect observers' mental health and wellbeing, even when they are geographically removed from the event.[6]

That said, at present there appears to be little specific clinical guidance on addressing news anxiety in the therapy room, so what are practitioners currently doing?

Finding a balance

'I've found it helpful to explore what's driving the need to keep checking and what they feel might happen if they step away from it for a while,' shares Holman. 'That can open up quite a lot around responsibility, guilt or even conditions of worth – for instance, around what it means to them to be a "good person" and whether staying informed has become tied up with that.

'When I'm working in a more solution-focused way I've also found it useful to look at how and when they're engaging with the news, and whether there are times when it affects them more. For instance, if they're checking first thing in the morning, when cortisol levels are naturally higher, could they experiment with starting the day a bit more calmly and checking later when they feel more resilient?'



'We all inevitably feel news anxiety in some capacity as we are connected as human beings through shared emotions we universally experience' **Rav Sekhon, integrative counsellor**

Addressing the core concerns of news anxiety can present specific challenges as they are often triggered by real rather than imagined threats. This leaves therapists with the task of validating those concerns while also helping clients with their engagement with the news.

'I encourage an emotional as well as a practical approach. By this I mean that it is vital that the client's worries are acknowledged and heard, and that the associated emotions are held, respected and honoured through thoughtful exploration and confirmation,' says Jackson-McCamley. 'I share many of their anxieties and so can understand their concerns while also being cautious not to lean into doom talk but rather validate and hold hope, for them and myself.

'I find that exploring themes of power can be helpful in identifying where and how the client experiences their own agency and, through countering passive behaviours, encourage them to think about practical ways that they can feel more in control. This approach has led to clients taking proactive steps to challenge the hopelessness that their news anxiety has bestowed upon them, be that by managing media consumption through muting notifications, time limits or full disengagement to becoming activists in various personal ways.'



Finding balance when it comes to news, rather than cutting it out completely, is an approach that has a sound foundation. A 2023 study from the APA, which examined the mental health effects of following daily political news, found that disengaging could protect wellbeing, but it could also reduce people's motivation to act on political causes.[7] There are still many benefits to staying informed about world events and engaging in action that could lead to change – but there has to be a balance. And that's something that therapists should consider for their own wellbeing too.

'I can remember certain world events really hitting me hard, triggering deep emotions within me that sometimes I didn't expect to feel,' shares Sekhon. 'For me this emotion can be a source of connection in the therapy room, allowing depth of experience with the client.

'Of course there is a requirement to not make it about "us" in the therapy room, but the source of shared emotion can often help deepen the therapeutic relationship, leading to better outcomes and trust. This requires the skill to be able to bring it back to the client's experience and create meaningful therapeutic engagement from the emotions. Equally if we are deeply impacted it's responsible to explore this in supervision, to allow space and time to work through how the emotion is present.'

In a way that is perhaps unique to this sort of anxiety, therapists aren't observing the events from the outside; they're inhabiting the same news environments as their clients.

Jackson-McCamley shares a similar experience to Sekhon: 'As someone who is very politically

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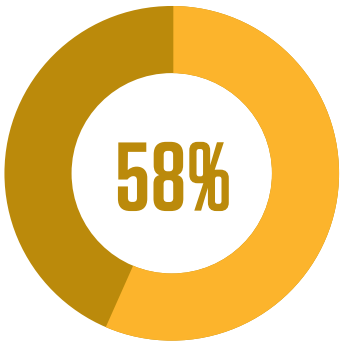
'How our clients engage with the news and the subsequent feelings associated with it gives us data on their perspective, values and outlook' Hannah Jackson-McCamley, psychotherapist

engaged I am very aware of the impact of my countertransference when clients bring in themes related to news anxiety. At times it can feel akin to silently sharing their trauma across the room, and I notice my own emotional responses to their words and the reality of what they speak.

'Sometimes, when their hopelessness and disengagement reflects dissociation or numbness, I wonder if my active, agitated feelings are evidence of projective identification or whether we simply reflect on the world differently and my emotional experience is wholly my own. Over time I have had to step back and reframe my news consumption for the benefit of my work.'

As an example Jackson-McCamley shares how she was working with sexual assault survivors during the high-profile trial of former police officer David Carrick. 'I was incredibly dysregulated throughout,' she says. 'I was grateful for supervisors and peers who challenged my internalised 'cultural parent', who believed it was my duty as an engaged citizen to watch the news, and found their tacit permission to take a break from doomscrolling, from reading every article, and protesting when it wasn't making me a better therapist, a relief.'

News anxiety is inarguably on a lot of people's minds at the moment. But despite the uncertainty and fear that comes with it, it appears that hope hasn't disappeared. In April 2026 the latest Office for National Statistics analysis, *UK Measures of National Well-being*, found that 64.4% of UK adults reported feeling hopeful about their future.[8] Yes, they may be struggling with the scale of challenges we feel we may face as humanity, but there's still something worth fighting for.



of Counselling Directory professionals saw 'doomscrolling or compulsive news checking' in clients

It's a sentiment that I see among the readers of *Happiful* magazine. While many of them shared their anxieties, others spoke of how they deliberately seek out good news stories – not feel-good clips about rehomed puppies (though those certainly have their place) but stories of real progress, innovation and change. 'I want to stay informed about news and politics but there's so much bad news all the time. It helps to follow good news outlets and get outside daily,' says Meera from Cardiff.

Managing our news consumption is not only good for our wellbeing but it also allows us to be open to the good and drive for change that is out there. And Jackson-McCamley has an important reminder: 'Activist Audre Lorde spoke of self-care being an act of resistance. Self-care, for her, was not about bubble baths and massages but an act of survival against oppression. Self-care for Lorde was about sustenance and nourishment of the self to be able to countenance outside forces that aimed to keep people down. To me this can be extended to encourage us to engage with ourselves closely, and know our emotional selves intimately and expressly so that we have the strength and resources to remain resilient in a tumultuous world. We are not any closer to saving the planet by doomscrolling.' ●

The companion piece to this article, written by Therapy Today *editor Katerina Georgiou, is published in issue 116 of* Happiful *magazine, out 1 November.*

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Soulfully potent



In an edited extract from *Black Men, Trauma and Therapy*, Joel Simpson describes the experiences of rape and sexual violations in African diasporan men

Jerome*

I'm a 32-year-old, HIV-positive, Trinidadian-Irish, proud trans man who was once so comfortable in my skin. Yet he took away the one privilege that I had – being seen and treated for exactly who I am. I hate him for putting me years back to deal with the dysphoria I had healed. Yeah, yeah, I know healing isn't a one-time event. I should have been able to defend myself, but I just froze and watched him rape me and take away my pride and dignity. My dad is a boxer from Cork. He taught me that men stand up for themselves. I should've been able to do that for myself, especially against another man, right?

The legal definition of rape in England and Wales is gendered; it only recognises men as assailants. Rape describes unwanted penetration of an individual's mouth, anus or vagina with a penis.[1] This definition does not recognise as intimate partner violence many men's reality, where their girlfriends, wives and partners force them to penetrate them against their own wishes.[2] While cases of men being forced to penetrate are rarely documented and believed, this does not discount the reality. I do not deny the contrasting ways in which men and women are raped. I am challenging the perpetuation in law of 'presumed sexual scripts' between men and their wives, girlfriends and partners that fails to recognise men being forced to penetrate without their consent as a 'real crime'.[3,4] Legal reform could change what constitutes a crime and challenge generalised, culturally constructed beliefs such as, 'He must have wanted it or he wouldn't have been hard; my d**k couldn't get hard if I was pressured, so there's no way I'm believing a woman can rape a man.' Education about erection and ejaculation is needed to update public consciousness. Erections and ejaculations are not necessarily indications of pleasure. Biologically, erections are often involuntary. Erections can be sustained and ejaculations can occur in non-consensual situations, in response to stress, violence, humiliation, terror and shame.[5,6] It is stimulation, rather than sexual arousal and enjoyment, that engages erections. Erections and ejaculations can be understood as protective mechanisms 'against the trauma and crises that the body seeks to survive'.[7] Confusion and distress abound for men who struggle to make sense of complex feelings around sex, rape and sexual violations when there is a dissonance between physiological responses and psychological realities.[8] These states often need to be explored sensitively, particularly when men's inner critics judge their own actions and disallow their own more compassionate retellings of what happened to them. Some assailants are 'turned on' by the power to manipulate men to have erections and ejaculate; it amplifies their control and decreases the likelihood of being reported to the police.[9] It is commonplace for men to seek to appease assailants afterwards – in an attempt to restore a sense of normality or reduce the risk of being raped again, or as a form of denial, to block out what occurred.[5] Hugging an assailant and even seeking to stay in contact with them are primitive survival strategies, which include 'not just fight or flight, but flop, freeze or befriend'.[5]

The assumed dominance of a man's phallus is often symbolically constructed as representing dominance of patriarchal power, whereby in forced-to-penetrate cases the penis is the weapon used against women. In forced-to-penetrate cases, although men penetrate, 'the penis is being used as a weapon against, rather than by, the man himself'.[10] In this context power and subordination in relation to men and women is reconsidered and transformed from patriarchal norms. Power resides in the *vagina dentata* – 'the vagina with teeth' – in dangerous and abusive sexual encounters. The power that can be exerted in these contexts should not be underestimated; it often resides in manipulative scenarios where there is 'verbal pressure/persuasion/coercion'.[10] Power can also be misused in situations where a man is intoxicated and women, and other men, can exercise dominance over them. Moreover, due to social scripts, many men struggle to reject women's approaches, even when unwanted, for fear of being viewed as not 'man enough' or gay. Legitimising wives and girlfriends' power to force penetration disrupts binary notions of femininity by foregrounding female assertiveness, contrary to more usual social scripts of meekness and passivity.

'The distress and pain associated with rape is no worse for a heterosexual man than it is for a queer man – there is no "hierarchy of suffering"'

Debunking myths

Many myths need to be debunked to allow men's voices to be treated as legitimate. It is a myth that only gay men get raped. It is a myth that it is only gay men who rape men. It is a myth that all/most queer men are promiscuous; this infers their consent is assumed and is of less value. A client's supposed promiscuity needs sensitive exploration by the practitioner, rather than condemnation and judgment. What if promiscuity wasn't wrong and it was an aspect of life that could be explored and made meaning of, beyond a moral lens? Hooking up and/or attending sex parties or taking part in chemsex does not mean a man asked to be raped or violated. Not all gay, bi, trans and queer men like or want anal sex. Anal sex is engaged with by people of all genders and sexualities. Many heterosexual men enjoy anal sex and fantasise about it. It is a barbaric fantasy that raping trans men to 'correct' their sexuality and gender/gender non-conformity will cure them. Trans men do not need to be cured because they are not ill. The distress and pain associated with rape is no worse for a heterosexual man than it is for a queer man – there is no 'hierarchy of suffering'.[4]

'Rape is not part of sex work – it is a crime.'[9] Consent is still needed for sex with sex workers. Prostitutes/sex workers have the same rights under the law as anyone else: the transactions they negotiate with clients are for consensual activities, not rape.[5] Men are not only raped in prisons[11] – they are raped in all sorts of settings, including their own homes, by their wives, girlfriends, partners, husbands, people known and unknown. Men are not always overpowered and raped in dark alleys. Men who are stereotyped as feminine are not 'asking for it', just as a 'devoted dad', journeying home to his wife and kids, isn't asking to be raped if he goes for a hook-up.[12]

Consent

Rape is not always blatantly violent, which is part of what makes it confusing. During love-making, a man might remove a condom without consent. The law recognises this as a crime: 'stealthing'. The assailant can continue to present as loving and kind. Due to the ways 'violence' is typically constructed, men can feel disoriented, wondering whether they were actually raped. There can be a collusion and gross misconception about what is kinky and/or rough sex and what is a crime. As some men do not always recognise a crime has been committed against them (and even if they do, they might still remain silent), it goes unreported, and many rapists are not even conscious of being an assailant.

Education about consent is still desperately needed. Consent is conditional and occasion specific. Consent can be withdrawn and renegotiated. Men do not need to say they do not consent.[5] Some assailants do not perceive themselves to have committed any crime; many deny that they dehumanise the 'other' when raping and sexually violating someone. Regardless of the denial, the work of wholing recognises how 'the body keeps the score'.[11] Wholing interrupts the silence to invite men to explore the extent to which they can redeem what has been disconnected through sexual trauma.

Wholing

In wholing, practitioners are invited to consider the symptoms as soulful messengers to be curious about, rather than to diagnose and pathologise – a sense of seeing through and making meaning of what ails, in collaboration with the client. When clients experience flashbacks, practitioners may support them by providing safe-enough spaces in the therapeutic setting, in their bodies and in their imaginations, to resource and enable them not to relive the trauma and to make soulful meaning of it. These symptoms can be reframed from problems to be solved to voices of soul calling to be heard and attended to. Listening deeply, through the body, can enable attunement to the unfolding story that African diasporan men might present through these symptoms. The invitation for practitioners is to hold the tension between the client's desperate demands to be 'fixed' and their own compulsion and impulse to do something to relieve them of their suffering. Practitioners are invited to recognise that there is value and meaning in the client's symptoms that need time to be explored rather than prematurely transcended, avoided and misunderstood. Feeling/experiencing the symptom might be what the client needs to soulfully make meaning of their suffering. ●

**Real name not used. Vignette is fictionalised.*

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Employing meaning

Jules Sander highlights the experiences of unemployment among autistic people



I first started seeing counselling clients while doing a placement with an autism charity and quickly noticed patterns of either long-term unemployment or periods of employment marked by communication breakdowns, burnout and frequent job changes. This tied in with the Office for National Statistics 2021 survey that showed just 29% of autistic people were in work.[1] And while a more recent Department for Work and Pensions (DWP) report revealed a slight improvement to 31.4%, this still means that less than one-third of working-age autistic people are employed.[2]

As a parent to two autistic young people this is an area of both interest and concern. I wanted to understand why staying in employment might be of particular difficulty for this group and to uncover the best way of working with it.

My choice of training in how to work with clients was based on my understanding of autism. While recognising that every presentation is different I had seen how my own children had found a person-centred approach to therapy difficult at the start. They found the silences and not knowing what was expected of them particularly confusing.

I do believe there is a place for silence in therapy and for allowing people time to articulate their thoughts. But for some autistic people already struggling to understand expectations in social situations, it can aggravate anxiety and feel uncomfortable.

> *'For some autistic people silence in therapy can aggravate anxiety and feel uncomfortable'*

I had previously spent over five years volunteering at The Mix, a crisis helpline for under-25s, and had heard the same from many of the autistic young people who called. They wanted support that acknowledged their neurodiversity and included coping mechanisms.

This insight along with a desire to develop therapeutic relationships beyond signposting led me to qualify in an approach to psychotherapy that integrates coaching and to ensure that I gained both academic and hands-on experience with neurodiversity and employment.

My initial understanding of working with autistic individuals was that CBT, a modality offering structure and goals, was considered the most effective therapeutic approach. However, the NICE update to guidelines acknowledge that adaptations to CBT are needed for autistic clients.[3]

Adapting CBT

This need for adapted CBT became clear through discussing a case at the autism charity where I first gained a placement. A CBT therapist who wasn't autism-informed had encouraged their client to spend more time in busy environments as part of exposure work, without recognising that their difficulties were rooted in sensory sensitivity. Rather than full immersion, they needed strategies to support regulation through tools such as headphones, and limiting the time spent in busy or noisy places.

The client described how these accommodations were more effective in preventing workplace burnout. This led me to explore how autistic people experienced integrative coaching and counselling approaches with therapists who were autism-informed, and how this influenced their experiences of employment.

As part of my academic research for my master's I conducted an interpretative phenomenological analysis,[4] later published in the journal *Counselling and Psychotherapy*

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Research. This looks in depth at the experiences of a small number of people to understand their lived experience. I spoke to four autistic women who, while in employment, had experienced therapy that integrated more traditional psychotherapy with solution-focused methods and coaching to provide an individualised approach. All of their therapists had specific training and experience in supporting autistic clients. While aware that my own background and training in this approach might create bias, my role was to present and understand their experiences, identifying themes and recommendations for policy and practice.

The first theme to emerge was how important the work environment itself was. While therapy and coaching enabled the participants to understand their workplace needs and advocate for themselves, if the work environment felt hostile then this wasn't possible to implement. For example, Amber,* reflecting on working in a high-pressure environment, described the feeling of hanging on by her fingertips. She discussed a noticeable shift after 2019 when she observed an increased understanding of neurodiversity and willingness to accommodate it. This enabled her to bring in some of the adjustments she'd discussed with her therapist and to advocate more effectively for her needs.

For others there were challenges. While Alena* had been able to talk about her needs with her boss, a subsequent change meant hot-desking would be required. If she wished to remain at the desk where she felt comfortable and which met her need for familiarity, she would have to disclose her diagnosis to other members of her team. This put her in a position where she felt pressured to disclose before she was ready.

For Hannah,* the inability of her workplace to accommodate her needs contributed to her eventually leaving the role. Hannah, who had a diagnosis of both autism and ADHD (AuDHD) gained enough confidence to disclose her ADHD diagnosis but perceived autism to carry greater stigma. Despite long-term therapy she felt the risks associated with disclosing her autism diagnosis were still too high.

Hannah's AuDHD links to another theme of complexities faced by those with co-occurring conditions alongside their autism. This is the case for a large number of autistic people, with Bonti et al recognising potentially high rates of co-occurrence, and the aforementioned DWP update focusing on the difficulties for disabled people where there is more than one diagnosis.[5] One way of understanding the complexity is through the strengths and challenges model drawn from positive psychology.

This approach is often used in neurodiversity coaching. Doyle and McDowell, who I went on to train with, talk about it in terms of the 'spiky profile'.[6] A neurodivergent person is likely to have a more diverse profile with greater variation between the strengths and challenges than typically seen in a more consistent neurotypical profile. And there are likely to be more overlaps with traits seen across dyslexia, dyspraxia, ADHD and other neurodivergent conditions Their approach emphasises identifying the individual challenges rather than assuming all autistic people face the same difficulties or have the same strengths. For workplace situations this means using the strengths to find the strategies that will work for them in managing the areas that present challenges.

Making sense of the self

These approaches link directly with the next theme of how a practitioner who is autism-informed can support an autistic person to come to their own understanding of themselves. The diagnosis itself wasn't enough to give them this, but the therapy gave them a space to process and understand what was happening. For Alena it was understanding that some of her challenges had been due to sensory issues. This enabled her to ask for things like being able to leave and arrive early at an away day, or to have a quiet space.

For Rhiannon,* who had also had an eating disorder, she was able to link this to her masking, which had led to exhaustion and burnout in her previous workplace. She said, 'It did help me

'A neurodivergent person is likely to have a more diverse profile with greater variation between the strengths and challenges than typically seen in a more consistent neurotypical profile'

slowly start to rebuild a sense of identity. I had heavily masked for a long time. And that last experience of employment... in that kind of an environment that was just overwhelming... We started to rebuild from the ground.'

What became clear was how individual each autistic person was in terms of their needs. Participants described how having the space to process and understand their own neurodiversity strengthened their sense of identity. And there was an awareness of how this would not be uniform. Hannah pointed out that her AuDHD meant that what she experienced could be very different to the experiences of another neurodivergent person. And Alena expressed concern that the study didn't involve anyone who had a co-occurring learning disability, suggesting the findings may not fully capture the diversity of workplace challenges among autistic people.

Support in the workplace

In examining the theme of counselling and coaching as effective support for workplace wellbeing, one thing that emerged was that it was the validating relationship and room to process, whether through counselling and/or coaching, that felt valuable and enabled the necessary exploration.

As well as the integrative approach some of the participants had also experienced specific workplace coaching, and there was a sense that shorter-term this was useful to work out tailored goals and strategies that could be returned to, while counselling was viewed as something that might be needed longer-term for emotional processing.

For Amber who had PTSD alongside her autism, she would have liked to have had support for longer with her chosen integrative therapist but was only able to access a limited number of sessions. On the other hand Alena, who had been in her job for many years and had experienced support through both workplace health insurance and an EAP, felt that this was what was keeping her there. In fact one of her biggest fears was that the support that she found necessary to cope would be gone should she leave her role: 'If I lost my job... all of that support would be taken away... that's one thing that really is quite frightening.'

'It's been interesting to see how finding joy in work can help to keep a person in that role, or to become a motivator in finding more appropriate or fulfilling roles'

Rhiannon and Hannah both felt that longer-term support was necessary for continued processing, with Hannah saying that, 'Therapy is definitely beneficial... I still struggle to grasp things and I'm still kind of building it. The kind of person I am.'

This is something I see in my own practice with many clients who talk to me about masking. For them it isn't as simple as just being themselves in social or work situations. They describe it seeming as though other people know automatically how to be, but for autistic people it's often a case of trying to work out what's expected of them and altering themselves to fit what they feel is required. This in itself can be exhausting. It leads both to burnout and to the feeling that under the layers they may not really know who they are – something we are able to start to unpick in therapy.



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A final theme that emerged in my research, and an area where many of my autistic clients do feel able to be themselves, was around a special interest. Some autistic people develop particularly deep interests, and Wharmby noticed that this can be really useful in helping autistic people to self-regulate.[7] It's something I've noticed in my own clients – for example, where we can build an initial connection through talking about their interest, when they appear to come alive and no longer feel the need to mask.

I've also seen how having a passion for something can be of use when incorporating elements of dialectical behaviour therapy (DBT) to help with negative thought spirals. Here, focusing on a genuine interest can support in redirecting those negative thoughts to an area of true engagement and provide a helpful distraction.

For work purposes it's been interesting to see how finding joy in work can help to keep a person in that role, or to become a motivator in finding more appropriate or fulfilling roles. For Amber her enthusiasm for her area of work brought a huge amount of satisfaction: 'My boss said, "We employed you because you knew the stuff inside out, back to front." My confidence is at the highest at the moment.'

But for others like Hannah, in a workplace that didn't feel conducive to her way of working and where the values felt misaligned, this actually led to a more stressful situation that needed to be explored. 'There's not really a feel-good moment that's worth all the pressure and hard work,' she said.

This ties in with a study by Goldfarb et al who noted that the benefits of a special interest can be reversed if there is workplace stress.[8] I've seen how this workplace stress can be heightened where the fit between their interests and values and those of their employer don't align. Sometimes this may mean working with a client towards leaving a role and finding an environment that is a better fit, but this must always be client led and with the recognition that another workplace may come with its own challenges.

One factor that seems to contribute to workplace stress is what many of my autistic clients describe as a strong drive to perform well. I often see perfectionist tendencies, possibly caught up in the idea of masking, where it feels of particular importance both to please people and to meet and understand expectations. I've seen how this can lead to anxiety and self-doubt in workplace environments.

Tailored approach

A technique that I like to use with my clients when it comes to helping them to understand expectations and feedback is an approach using elements of CBT and clean language. This involves four columns where clients look first at the fact of a situation, and then their often negative understanding of it. This is followed by a third column looking at some alternative framings to consider what might be going on. The final column is an action – what they'd like to have happen, whether it's tearing up the piece of paper itself for some closure, or having a particular clarifying conversation with someone.

Clean language itself has developed from Grove and Panzer's original use in psychotherapy to be used in coaching too.[9] It's a way of using certain words and phrases to illicit metaphors from clients. This helps them to understand their situation in new ways, giving a fresh perspective and the ability to understand the landscape and what needs to happen next. So for Amber, who talked about that mountain where she was hanging on by her fingertips, we might use clean language to explore. It's like what? What is there above and below, and when you're on that mountain what needs to happen next? In looking at what the fears are below and what needs to happen next – perhaps finding a foothold or an alternative route – the client often gains an understanding of themselves and what they need to be at their best.

While using these techniques it's always with the understanding that this may not work for every client. For certain co-occurring conditions the idea of visualising or a metaphor just wouldn't work. Some autistic clients do just need a bit more guidance than traditional coaching and counselling might consider appropriate. So in brainstorming it might be that I suggest some strategies that are known to work. This can encourage them to come up with their own ideas, remember techniques that have worked in the past or find a way to adapt a strategy to suit them. For example, someone struggling to start work might not want to do the 'eat the frog' technique of doing the difficult jobs first, but on hearing of the approach they might decide that they'd like to do one small, easy thing beforehand. The metaphorical equivalent of eating a chocolate before digesting the frog.

Finding what works to support autistic clients and help them to navigate their workplace experiences is about having a toolkit and tailoring things for each client to find their own route to insights and understanding. I'm always open with my clients about what we're trying and what we're hoping for, and that we'll try something else if it doesn't work. And for some clients while they take their time to process and find the right words, silence can also turn out to be what they need. ●

'Finding what works to support autistic clients and help them to navigate their workplace experiences is about having a toolkit and tailoring things for each client to find their own route to insights and understanding'

**Real names not used. Case histories are taken, with consent, from the author's interpretative phenomenological analysis.*

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Mind the menstrual gap

Jenny Prescott explores how to integrate cycle awareness into therapeutic practice

When Claire* first came to therapy she described herself as 'unreliable'. She arrived apologetically, as though her very presence required justification. She was 29 and had been experiencing 'waves of anxiety' and low mood for the better part of three years. She had seen her GP, tried antidepressants and completed a course of CBT, none of which had helped.

I took a thorough history. I asked about her relationships, her work, her family and her sense of self. I attended to her posture and breath, noticing where she held tension. I tracked the quality of our contact. What I did not ask about – and what none of her previous practitioners had asked about – was her menstrual cycle.

This omission is not unusual. Despite the fact that approximately half the world's population will menstruate for an average of 38 years, the psychological and emotional dimensions of the menstrual cycle remain largely absent from therapeutic training and practice.

A 2025 survey of Australian mental health professionals found that while many reported confidence in discussing the menstrual cycle it is not consistently part of clinical practice, suggesting this gap is widespread and systemic rather than individual, and so normalised it has become invisible.[1]

Emerging pattern

One week Claire arrived visibly distressed. The previous week she had seemed settled, hopeful, but now described feeling 'like a different person': irritable, tearful, convinced that her relationship was failing and that her career was meaningless. She was frightened by the intensity of these feelings and ashamed of her inability to hold things together.

Drawing on the Gestalt and somatic influences I had integrated into my practice over the years, I had been attending not just to Claire's words but to the embodied quality of her presence since we started working together. I recognised that I had sat with this version of her before; not necessarily her level of distress but the quality of collapse: the way her energy contracted, the flatness in her voice and the return of her shame. I noticed it before I had words for it.

As she went on to describe her week she added in passing: 'Sorry, I'm always mental before my period.'

The self-deprecation was instant and practised – a throwaway line she had clearly said before to herself and to others. She had no framework for her cycle and no language for its phases. What she had was a label: 'flaw'. Something wrong with her or with it.

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Rather than move on I began gently by asking: 'Have you noticed that some days you feel more energised and other days things are harder to manage?' She paused. 'All the time. I just thought that was me being unstable.'

This was more than a gap in knowledge. Without a framework for the cycle women are cut off from a recurring source of self-knowledge, receiving information from their bodies every month with no means to interpret it. What could be inner guidance becomes noise, or is taken as evidence of defectiveness.

I asked whether she had ever considered that there might be wisdom in her cyclical emotional states – that they might be signals worth listening to rather than symptoms to be managed.

'The inner seasons concept is that the menstrual cycle moves through four distinct phases, each with its own psychological character, energetic quality and relational needs'

Inner seasons

The inner seasons concept, developed by Alexandra Pope and Sjanie Hugo Wurlitzer of Red School, is that the menstrual cycle moves through four distinct phases, each with its own psychological character, energetic quality and relational needs. The premenstrual phase, 'inner autumn', can feel like a time when things are falling apart but might equally be understood as a moment when things are becoming clearer. Menstruation, 'inner winter' phase, invites rest and reflection: not a disruption to daily life but an expression of it.

I saw the shift in her body before she found words for it. Her posture changed. 'Oh,' she said. 'Yes, of course. That makes complete sense.' I watched her frustration find a voice. 'Why isn't this taught at school?' It is a question I have heard many times since. I asked where she was in her cycle and she told me she was on day 26: 'inner autumn'. The framework she had received suddenly had a living, present-tense application. From here I invited her to begin tracking.

What emerged over the following months was striking in its consistency: her most acute episodes of anxiety and self-criticism clustered almost without exception in the premenstrual phase and continued into the first days of menstruation. Her 'good' weeks coincided with the follicular and ovulatory phases. The pattern had been there all along. It simply had no name.

Understanding

Menstrual cycle awareness draws on both endocrinological research and lived experience to map the psychological landscape of the cycle. In the premenstrual phase oestrogen and progesterone drop sharply, and research has demonstrated that these fluctuations directly affect serotonin and dopamine activity, with significant implications for mood, cognition and stress response.[2] For many this shift is accompanied by heightened emotional sensitivity, reduced capacity for self-regulation and an intensified unresolved feeling.

Through a polyvagal lens this phase can represent a window of reduced physiological buffering: the nervous system more reactive, the window of tolerance narrower.[3] For clients who have not been supported to understand this rhythm the result is often shame and self-pathologising: a desperate search for external explanations for what is in fact a predictable, embodied experience.

'Inner autumn' is not pathology. It is, as Pope and Hugo Wurlitzer describe, a time of truth-telling, and a phase in which what has been suppressed or denied becomes harder to overlook.[4] From a humanistic perspective we might understand this as the actualising tendency asserting itself: the organism's drive towards authenticity pressing against the adaptations that have kept difficult truths at bay.

'Inner winter' carries a different but equally significant quality. Many describe a natural withdrawal of energy, a turning inward and a need for rest and reduced stimulation. For clients who have not been given permission to honour this, menstruation can feel like failure. The cultural demand for consistent productivity leaves no room for cyclical rhythms, and clients who cannot maintain their usual pace during 'inner winter' often continue to blame themselves rather than the culture that refuses to accommodate them.

Integrative approach

Once our framework was formed and tracking began something shifted in our work together. Premenstrual distress stopped feeling like proof something was wrong and instead became something useful. Rather than approaching these episodes as crises to be managed we began to approach them as windows. The heightened emotional sensitivity of 'inner autumn' gave Claire access to material that was harder to reach at other points in the cycle. Her defences were lower, her felt sense more immediate and her capacity for authentic contact with her own experience more available.

Over time we identified through this phase a relational pattern she had been minimising for years; a boundary she had been unable to name and a grief she had not yet allowed herself to feel. Her 'inner autumn', reframed, became not a problem to be endured but a messenger to be listened to.

I was careful to pace this attentively. The premenstrual phase can represent a narrowed window of tolerance, and I engaged in 'mini-contracting' at the start of each session — checking where Claire was in her cycle, how she was feeling and what kind of contact felt workable that day. In more inward phases I slowed the pace and offered gentler reflection: 'This is possibly a time when everything feels closer to the surface — perhaps it's OK to take things more slowly just now.' In more energised phases I supported her to take relational risks and explore new possibilities.

Reclaiming 'inner winter'

The work around 'inner winter' was slower and in some ways more culturally challenging. Claire carried an internalised belief that her need for rest was an imposition and that slowing down during menstruation was a failure of discipline. Drawing on Adlerian encouragement I worked to affirm the legitimacy of her body's rhythms and to support her in making conscious choices about how she moved through her cycle rather than being unconsciously driven by shame.

Gradually Claire began to experience herself differently. In 'inner winter' she gave herself permission to rest, reducing commitments, protecting sleep, allowing more stillness. In 'inner autumn' she began to say no more readily, trusting the discernment of that phase even when she felt herself resisting it. Meanwhile in the expansive space of 'inner summer' she found she had more to offer — relationally, creatively, professionally — than before. The cycle became something she could use to navigate her life.

After years of working with this framework I have noticed that this shift is cumulative: each 'inner winter' honoured, rather than overridden, appears to create a deeper settledness and a growing trust in the body's rhythms. Many clients report arriving at their 'inner spring' with more energy and creative capacity, and over time many describe a nervous system that feels less chronically activated.

There is also a dimension that goes beyond the psychological. The more deeply you rest in 'inner winter', the more deeply connected you become with your intuition and sense of what life is asking of you. In a culture that treats a woman's need for rest, especially, as an inconvenience, learning to honour 'inner winter' is for many clients one of the most radical things they do in therapy.

Blind spots

When I trained as a counsellor the menstrual cycle was never mentioned. Not once. I sat in seminar rooms learning about attachment, transference, the actualising tendency, the nervous system – all of it valuable, all of it shaping the practitioner I became. But the cycle? The most consistent biological rhythm in the lives of half the population that I would undoubtedly go on to work with? Entirely absent.

I came to menstrual cycle awareness not through my training but despite it. I read *Wild Power* by Pope and Hugo Wurlitzer[4] some years into practice, and something happened that I find difficult to describe except to say it was simultaneous: my mind was blown and my body already knew. The knowledge felt new and ancient all at once: I recognised something I had been living for years without language for.

The experience of knowledge arriving late, from outside the profession, for something so fundamental is not incidental. It is structural. Western

'When the cycle has no place in a client's self-understanding they lose access to a significant and reliable dimension of their inner life'

therapeutic training has been built on frameworks developed primarily by men. The menstrual cycle, with its rhythms of expansion and contraction, productivity and rest, clarity and dissolution, was not so much forgotten as never considered.

Research supports what many clients already know in their bodies. Ussher and Perz have documented how women especially internalise profoundly negative constructions of premenstrual experience, learning through cultural messaging to experience their cyclical selves through shame, self-objectification and pathologising self-talk.[5] As such, the woman who arrives in the therapy room calling herself 'mental', such as Claire did before her period, has not simply developed a negative cognitive pattern; she has absorbed a cultural narrative handed down to her.

The consequences of this are psychological as well as social. When the cycle has no place in a client's self-understanding they lose access to a significant and reliable dimension of their inner life. The disconnection is the predictable result of a culture that has offered no language for menstrual cyclical experience, and a profession that has largely followed suit.

The addition of premenstrual dysphoric disorder (PMDD) to *ICD-11* in 2022 remains contested because it risks pathologising what may be a natural, if intensified, cyclical process.[6] The Royal College of Obstetricians and Gynaecologists has itself urged caution, calling for approaches that do not unintentionally pathologise the menstrual cycle.

Redressing balance

Claire's question, 'Why isn't this taught at school?' was one I found myself asking. Many clients arrive in the therapy room having already internalised this suppression — over-apologising for their cyclical experience, pathologising their own rhythms, calling themselves unreliable, or laughing themselves off as 'mental'. When a therapist does not ask about the cycle they inadvertently confirm that silence. Once they do ask they can begin to disrupt it.

Implications

Not every therapist needs specialist training in menstrual cycle awareness, and nor should the cycle be the only lens through which experience is understood. For clients who menstruate the cycle is always a context, and ignoring it is a clinical choice whether conscious or not.

In practice, with relevant clients, I introduce the cycle early and lightly. In an initial or early assessment session I will ask simply whether the client has a regular cycle, whether it's tracked and whether fluctuations in mood or energy are notable across the month. The question is gentle and open, signalling that this is a space where cyclical experience is considered relevant, establishing a baseline awareness that I can return to later in the work.

Often the client brings up their own cycle, mentioning in passing how they're always more sensitive before a period, or tearful, angry or withdrawn. I take this as an invitation to slow down and ask: what needs might this sensitivity be signalling? What would it mean to lean into it rather than override it? For example, to say no more, rest more, or ask for more? In the case of Claire, depending on her receptiveness, I would go on to explore what other phases of her cycle looked and felt like, and use the language of the inner seasons as a continued framework for understanding the full arc of her cyclical experience.

As with all integrative work the key is responsiveness. The framework is offered as a lens – one that the client is free to pick up, set down or return to in their own time. But underpinning the approach is one principle of menstruation: the client's own experience is the ultimate authority because the body, as ever, is the most reliable teacher.

Full cycle

By the time Claire ended therapy she no longer described herself as unreliable but cyclical. This was a significant shift. In naming this pattern she had recovered something that years of pathologising had obscured: trust in her body's intelligence and a capacity to take meaning from her inner experience rather than be frightened by it.

Rogers described the actualising tendency as the organism's inherent drive towards growth, fulfilment and authenticity.[7] When it comes to menstruation that movement towards wholeness cannot be fully understood without attending to the cycle through which embodied life unfolds. The therapy room is one of the few spaces in contemporary life where the full complexity of a person's experience can be held. Let's include all of it. ●

**Real name not used. All identifying details changed and drawn from composite examples from practitioner's clinical work over many years. Any resemblance to a specific individual is coincidental.*

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‘Therapy helped me become a better therapist’

In July 1992 I was heading home after spending two incredible post-university years living in Asia, travelling and teaching English in Japan. On the way back to the UK I was due to spend a month in Thailand and, in those pre-mobile phone days, called home from an international payphone in Bangkok’s central post office. I called my dad first but the phone just rang and rang, which was unusual because he usually picked up. I then spoke to my mum and she burst into tears before telling me my father had died of a heart attack the day before. He was just 62.

I vividly remember standing there in shock, tears streaming down my face in the middle of that busy post office. In a daze I hailed a tuk-tuk, and it weaved through the stifling heat and traffic chaos of Bangkok back to my hostel. I packed my bags and arrived back in chilly England, numb with grief and culture-shocked, in my tie-dye T-shirt and sandals. I was only 24 and, over the coming months, had no tools to cope with the hard ball of anger and pain that was lodged in my chest.

I eventually saw a wise, kind counsellor who helped me express all that sadness and hurt as the grief flowed through me. The only silver lining of losing my dad was that this transformative experience of counselling led me to train as a counsellor myself.

In the three-and-a-half decades following the loss of my beloved dad I experienced many kinds of therapy – transpersonal, humanistic, psychoanalytic psychotherapy, CBT and EMDR – but the therapy that had the most profound impact on me was internal family systems (IFS). IFS now forms a central part of my integrative approach to trauma healing along with schema therapy, compassion-focused therapy, Janina Fisher’s trauma-informed stabilisation treatment, mindful self-compassion and Buddhist psychology.

IFS was such a warm, compassionate, non-pathologising approach to healing the hurt young parts of me. At the heart of my inner system is Little Dan, the sweet young boy who lives in my heart and mind. And he is deeply hurt not only by my father’s death but by a fractious divorce between my parents, which reverberated throughout my childhood. I grew up in a Jewish family shaped by generational trauma, which profoundly affected me – as did a savage year of bullying in primary school, which eroded my sense of self.

I also had to navigate various family members struggling with alcoholism and mental health problems including schizophrenia. I remember being summoned back to London to meet one of them at the psychiatric unit where they’d been forcibly sectioned, and to try to manage this highly distressed person until my dad returned from a work trip.

I was lucky enough to have found a therapist who embodied the qualities of ‘Self-energy’ (the warm, compassionate inner resource we all possess) that lie at the heart of this approach – kindness, compassion, tenderness and a skilful holding of every part of my inner system, especially the traumatised young ones. We have worked steadily through the many traumatic events of my childhood, adolescence and adulthood together.

I recovered from losing my dad and the buried childhood trauma this event triggered, which led to many years of crippling depression. It inspired me to specialise in helping people heal from the trauma that blighted my childhood. I hope my painful experiences give me a deep emotional empathy with my clients – ‘I have been there and felt that too,’ I often tell them.

Of course, I wish I had not lost my dad. He was a complicated, difficult man but also warm, funny and loving. I miss him every day. And I wish my childhood had been easier, but if I hadn’t struggled through all those complex family dynamics I don’t think I would be a therapist today. My heart and mind were shaped by trauma so they could understand and help people like me. And that is a wonderful gift.

MYTEAMART/SHUTTERSTOCK



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Dan Roberts MBACP is a psychotherapist and author. His first book, *Heal Your Trauma: how to overcome a painful childhood to become happy and whole again*, is published by Leaping Hare Press, sharing everything he used to help himself and those he’s worked with. Dan specialises in helping clients heal from childhood trauma using an integrative, parts-based approach.
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CAN I TAKE ON A TRAINEE TO SHARE MY CASELOAD AS A PRIVATE PRACTITIONER?

Q **I run a full-time practice and always have a lot of client enquiries but would like to cut down my hours. I am considering taking on a student counsellor to whom I could refer the less complex cases that come in. This way I could retain a full caseload and protect my income while also providing a placement for a student. I am an experienced practitioner and supervisor so in return would offer a trainee supervision and mentorship, and cover their expenses. Is this OK to do and what do I need to consider before doing it?**

A

A 2024 BACP Student Member Survey found that 42.7% of respondents said they had difficulty in securing a placement.[1] Given that it's not possible to qualify without the required practice hours, trainees often reach desperation point and feel forced to take on whatever placement is available, even if the conditions are not ideal. Respondents described placement providers who offered no expenses or financial support towards supervision while charging session fees of £60 and more to the clients the trainees were seeing. Some trainees were even asked to pay 'admin fees' at the start of their placement.

On paper, your offer to cover the trainee's supervision and expenses while also supporting them through mentorship could by comparison seem like a good deal. Such a placement could also provide experience of what is involved in running a private practice. However, this seemingly straightforward idea presents a range of complex ethical concerns and practical challenges.

First, let's look at your first question: 'Is this OK to do?' Like so many areas of our profession there is no black and white, yes/no answer. There is no 'rule' that this shouldn't be done. However, there is a requirement for all practitioners working to the new *Ethical Framework* (*EF 26*), which becomes mandatory on 3 November 2026, to use an ethical decision-making process to think through such practice dilemmas and be able to 'show their workings' behind whatever decision they make. We'll come to what that might look like, but now let's look at your second question, which asks what you should consider before taking on a trainee, to ensure it's a good decision for you, your clients, your practice and any potential trainees. Here are some questions to consider as part of your decision-making process:

What do you hope to achieve?

You give your reasons for considering this as being able to cut down your hours while retaining a full caseload and protecting your income, and also providing a placement for a student. Let's look at these in turn.

Cutting down your hours. You don't go into your reasons for wanting to do this but it's good to notice that this thought is here. Sometimes (although not always) wanting to reduce client hours may suggest the beginning of burnout. If this is the case, taking on a student to manage and supervise may not support your commitment to maintaining your health and wellbeing (*EF 26*, section C, 'Core responsibilities', point 2.3). However, there may be other reasons – perhaps you want to create space to explore other income streams, or to introduce a new challenge or area of learning and development to your working life. Perhaps there is a logistical reason such as freeing up more time for caring duties, or you just want more time to relax or pursue hobbies.

It may help to spend time in supervision to think through exactly how you want to change your working life and how many hours you want to free up. Then compare this with the hours you and your supervisor estimate it will take to manage a student on placement – including time spent on recruitment, liaising with a training provider, initial training/guidance, supervision, mentoring/general support, plus extra support for a trainee who

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.

UNDREY/SHUTTERSTOCK



may be struggling, client assessment sessions and placement paperwork. Once this is factored in, and you get a realistic idea of how many hours it would free up, would taking on a student still meet your needs? Have you considered other ways to allow you to reduce your caseload, such as assessing your outgoings and economising?

Protecting your income. As well as this you say you want to 'retain a full caseload and protect your income'. You may have financial obligations that require a minimum income. However, given that potential placement clients must be informed they will be working with a trainee, will they be happy to pay your full rate in these circumstances? You may need to consider a reduced rate. There is also the question of how the fee arrangement will impact your working relationship and the power dynamic between you and the trainee. Trainees often report feeling resentment at their trainee provider for 'profiting' from their unpaid work. In this scenario the resentment will be felt towards you – how will you manage that?

Providing a placement. Do you have up-to-date training in volunteer management, and the differentiation in terms of rights and acceptable expectations of volunteers, contractors and employees? You may have a genuine interest in mentorship and/or training, and if so have you explored other ways to add this to your practice, such as getting involved with a local counselling service? This might give you an idea of whether you are suited to it or enjoy it.

If you still feel like this is an avenue you want to explore let's look at the implications and considerations for all the potential stakeholders involved in this arrangement.

Your clients. You propose assigning the less complex clients to a trainee, presumably after some sort of initial conversation. But consider how clients will feel at having talked to you about their issues or struggles and they are then offered sessions with someone else? Will this feel like a true choice – for example, if they respond by saying they would rather not work with a trainee and only want to work with you, will you honour that and take them on as a client? While that is an ethical stance, it also could mean you end up expanding rather than reducing your caseload.

What's important is that clients are fully informed that this is how you work, in line with the 'Ethical principle' of transparency (*EF 26*, section B), ensuring 'people are fully aware of what services are being offered, the qualification of those offering the service, any changes to the service provision and any risks, benefits and alternatives that may be available'. We also have a 'Core responsibility' to 'give people the information they need to make choices about their work with us', by providing 'clear, accurate information about services offered, our level of qualification, experience and our competence to undertake that work' ('Core responsibilities', point 1.2a).

This means informing clients from the earliest point of contact that your personal caseload is full but that you are supervising a therapist in training and that they may be assigned to them after an assessment. Ideally this should be added to your website and directory profile/s if you have them ('Core responsibilities', point 4.5a). You may find that a number of clients don't wish to proceed with an assessment on this basis, and that you don't have as many clients available to fulfil a trainee's placement hours as you imagined. It may however be more appealing to clients if the sessions are offered at a reduced rate.

There is also the question of how you assess who is 'less complex'. As discussed in a recent 'Dilemmas' section (*Therapy Today*, October 2026), clients often don't feel comfortable revealing the full picture of why they are seeking help until the therapeutic relationship is established. A seemingly straightforward client, for example, may go on to reveal suicidal ideation or a serious mental health condition. Many students do work with complex cases in placements but they often do this in an agency environment where they have support from multiple team members. Ensuring a trainee is properly supported if the work gets complex may mean offering extra supervision – something to factor in when you're calculating the potential hours you may free up.

The trainee. There are questions to consider in several main areas:

Finding trainees: How will you advertise your placement? Most training providers have approved lists of placements, so you will need to research how you get on those lists. Most specifically prohibit trainees from taking on private clients to gain placement hours – will your placement be prohibited on these grounds?

Selection process: How will you assess a trainee's suitability? Rather than relying on 'gut instinct', what criteria are

you looking for? How will you demonstrate you applied equality and diversity criteria? It might be good to discuss this in supervision and have a checklist to work through in your interviews. For instance, will you feel competent to supervise a trainee working in a different modality to yours? Would they need to be a member of the same professional body as you (and therefore working to the same ethical framework)? How will you check their right to work in the UK? Will you expect them to have a Disclosure and Barring Service (DBS) check or pay for them to take one? Are you happy for this to be the trainee's first placement or would you rather they had already had some client experience? Are you taking on Level 4 trainees or restricting the placement to those on a more advanced training programme (Level 5 and above)? Will you ask them to do a role-play exercise with you as part of the interview?

Commitment: You also need to think about the minimum level of commitment you expect, both in number of weekly sessions provided by the trainee and the minimum length of time to which they commit. Will you expect them to fulfil this term even after they have got their placement hours? How much flexibility will you offer in terms of session hours (given they will need to fit them around preparing for and attending their training course, completing assignments and any existing paid work)? Bear in mind the training organisation might also have requirements/restrictions on the hours a trainee works.

Working environment: This needs some consideration, bearing in mind that most awarding bodies have restrictions on the number of online hours that count towards qualification, and many training providers specify that trainees should not be in a position of lone working on placement. If the trainee will use your therapy room will this be in line with the terms of your lease if you are renting?

Record keeping and data protection: How will you ensure the trainee makes and stores appropriate client records, and stores them in line with your data protection policy (as you will remain data controller)? ('Core responsibilities', points 3.1, 3.2). Will you give them access to your client management software if you use it?

'As well as the time commitment, other concerns to consider in supervision include managing the three-way relationship between you, the student and the placement provider'

Safeguarding: If your client base includes adults at risk, children and young people you will need a written safeguarding policy and procedure in place for your trainee to refer to ('Core responsibilities', point 2.4).

Contracting: As well as creating a three-way contract between you, the trainee and the placement provider, you will need to think about your contract with the clients – will they contract with you or directly with the trainee?

Insurance: Trainees will need to have their own professional liability insurance.

Supervision: Trainees require more frequent supervision than qualified practitioners so be clear on how much supervision the trainee and their placement provider will expect. Is fortnightly OK or will it need to be weekly? This may depend on whether the trainee has other supervision. Will the trainee feel able to be fully open with you in supervision given that you will be responsible for sending progress reports to their training provider? Not taking on the supervision role eliminates the dual relationship and means the trainee has supervision with someone who is not part of their assessment process. This of course means trainees will need to pay for external supervision, but this could be covered by you as part of their expenses. It also frees up your time.

Mentorship: You say you will also be offering mentorship. How will you differentiate it from supervision? Do you have any previous experience? Do you see this as happening on an informal basis or a more structured process involving set check-ins?

Dual relationship: Avoiding 'any dual or dual or multiple relationships that could cause harm' is an ethical commitment ('Core responsibilities', point 1.3a) so proper consideration needs to be given to how you will manage the dual relationship of being the trainee's

SUPPORT AND RESOURCES

The following Ethics essentials videos, created as part of the new *Ethical Framework* review, are available at: bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/ethics-essentials

- *How to use the Ethical Framework*
- *Forming a rationale for ethical decision-making*
- *Keeping ourselves and our colleagues safe*
- *Delivering services to high professional standards*

Ethical Framework for the Counselling Professions 2026 (mandatory from November 2026): **bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/preparing-for-the-2026-ethical-framework**

supervisor and their placement manager. Will the training provider approve of this arrangement? If the student is struggling with their relationship with you or with how they are being impacted by the placement, who could they turn to?

The training provider. A training provider will be an ongoing stakeholder in this arrangement, so it's important to ensure you establish a professional working relationship. Initial discussions should cover what they will expect from you in terms of being a placement manager to their trainee, and whether they will be OK with the dual relationship you are proposing – being the trainee's placement manager and also their supervisor. How involved will they be in selecting trainees to apply for your placement? Will they suggest suitable candidates or leave it up to trainees to apply and you to select the best fit?

Performance management: Part of the placement educator's role is to assess and support trainee competence and fitness to practise – and ultimately to judge if they pass the placement and clinical learning outcomes for their course. What is your policy around trainee responsibility to notify you of any personal or professional circumstance that may impede their fitness to practise? How will you attempt to remedy trainee clinical or administrative performance that falls below the standard expected for their level of training? At what stage would you be prepared to report below-par trainee performance to their training provider? At what point would you end the placement to protect your clients (and your professional reputation)? What happens to the trainee's clients if this should happen – will you take them on?

You. As well as thinking about the time commitment, other concerns to consider in supervision include managing the three-way relationship between you, the student and the placement provider. As a private practitioner you may be used to being your own boss – how will it feel to have someone else tell you how to operate an aspect of your practice? Do you have management experience? What extra support will you factor into your practice to help you transition to this way of working? Presumably you can take your supervision of the trainee to whoever currently supervises your supervision, but will they also be happy for you to bring wider issues such as problems with the training provider? How will this impact the supervision of your own clients/other supervisees? Does your supervisor have the right experience to be able to offer you the support you need? If not, it may be worth finding a mentor/additional supervisor who does (although this will add to your costs).

Recording a rationale for your decision

Having done this thinking, you can now complete the ethical decision-making rationale (*EF 26*, section A) by making notes of your responses to the following questions:

1. What are the ethical issues?
These might include client choice and informed consent; trainee competence; appropriate allocation of clients; safeguarding and clinical responsibility; the power imbalance between you and the trainee; and the possible conflicts of interest created by combining the roles of placement provider, mentor, referrer and supervisor.

2. Who is affected, and how will they be involved in the decision?
That includes prospective clients, the trainee and the training provider and awarding body. How will you ensure all are fully informed?

3. What are the relevant internal factors?
These include your motivation for setting up the arrangement; the drivers for your desire to free up time; your financial interest in maintaining the caseload; and your experience and motivation to act as a placement manager, supervisor and mentor.

4. What external factors need to be considered?
These would include the requirements of the trainee's training provider; your commitments under the *Ethical Framework*, confidentiality and data protection; potential safeguarding incidents; clinical record keeping and your professional indemnity and public liability insurance.

5. What decision is being made, and is it consistent with the Ethical principles and Core responsibilities?
Having considered all of this, if you decide that the arrangement can go ahead, what modifications/structure will you put in place to ensure it is ethical and safe for all stakeholders? (See 'Reframing your plan' below.)

6. How will the decision be reviewed?
How will you build in regular reviews with the trainee, their training provider and your own supervisor, including consideration of whether the arrangement continues to serve clients well?

Reframing your plan

If you are serious about offering an ethical and safe placement one option is to expand your practice to become a service by collaborating with colleagues. Setting up a service and developing working relationships with training providers will allow you to offer a properly structured environment for trainees on placement, which will also help to protect clients. It is a bigger task than simply taking on a trainee but it might also provide a solution to a common challenge faced by established therapists – how do we develop our business once established, and create growth and a sense of progression? It may also provide a sense of purpose as you will be contributing to the mental health support of your local community, and helping to uphold high professional standards in the training and development of new practitioners.



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.

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READER RESPONSES

Placements can be offered that genuinely help counsellors develop into highly effective practitioners

The placement problem goes to the very heart of counsellor training. Many students begin their training without knowing they have to find suitable clients themselves and that they will need to pay for regular supervision (unless it is provided). However, it is unlikely that a sole practitioner could provide a placement that is ethical and also safe for both clients and trainees.

I speak from experience. In 2019, while I was a trainee looking for a supervised placement, I joined Affordable Talk in Bristol, a local low-cost counselling service. When it was due to close in 2020, a number of us involved with the service arranged to take it over and renamed it King Square Counselling (KSC). We wanted to ensure that local trainee counsellors continued to have access to the supervised client placement hours required for qualification, and clients still had access to a low-cost service.

Our model was straightforward – no free counselling. The clients paid an affordable fee, which enabled us to cover the costs of marketing and pay for the services of a clinical manager and ensure the clients were properly assessed as suitable for trainees. We also made a contribution to the trainees towards the cost of supervision. When the COVID-19 pandemic arrived we moved entirely online and over the following years supported dozens of trainee counsellors across the UK to complete their required practice hours while providing valuable, affordable-rate counselling to clients.

There were several important considerations: the clients should understand that they would be working with a trainee; the trainee should be in regular supervision; and they remain responsible for practising within the limits of their competence. The trainee should also be working towards a recognised qualification, be appropriately insured, registered with the ICO, have an Enhanced DBS, and access to support (ideally from their training provider) should any unexpected risks emerge during the work.

The service concluded earlier this year, and I look back with pride at what KSC achieved. It demonstrated that, when undertaken ethically, with careful assessment, appropriate supervision and clear client consent, placements can be offered that genuinely help counsellors develop into highly effective practitioners prepared for future practice.

MICHAEL LLOYD MBACP (ACCRED) is an integrative psychotherapist in private practice specialising in relationship counselling in Bath and online.

I am not sure what the advantages are to either party

This is an interesting question. If I have understood correctly, the therapist wants to subcontract some of their caseload to a trainee. The trainee would not be paid but would be offered supervision and expenses. The clients pay the therapist the normal rate but would be seeing a trainee. I wonder whether having arranged to see one therapist the clients may be surprised to be offered a trainee for the same price?

I also wonder about the workplace location. If the trainee works from home, would the practitioner provide a mobile and computer as would be available in an organisation? If the practitioner is going to provide accommodation, such as a rented room, that is another extra cost.

Another issue is around supervision. It sounds as if the practitioner is suggesting taking on the roles of mentor, supervisor and manager all in one. That is neither desirable, ethical or sensible as the three roles need to be kept separate, especially in this case where the practitioner has the additional roles of employer and practice manager. As the offer is to cover expenses that means they would also have to pay the supervision costs of the trainee.

In conclusion I am not sure what the advantages are to either party. The therapist will have to spend unpaid-for time mentoring the student, assessing clients and deciding which are suitable, as well as paying costs, including supervision. The trainee meanwhile will lack the benefits that come with being in an organisation or service where there may be other trainees, and where they can be offered immediate support, particularly around safeguarding, when necessary.

HEATHER DALE MBACP (SNR ACCRED), FELLOW BACP is a therapist, supervisor, writer and lecturer.

There is a conflict of interest when a supervisor's income is linked to a trainee's caseload

This dilemma resonated with me because it echoes a recent decision I made. I chose not to supervise a trainee on placement because it did not involve the usual three-way relationship between me, the trainee's placement and training institute.

Without that shared accountability I felt I would be working in isolation, and I had no established communication pathway with either the placement or training institute, and therefore no straightforward way of sharing or receiving concerns about the trainee's practice, development or fitness to practise. I would be reliant largely on what the trainee brought to supervision, without access to the other perspectives that form part of their training and clinical work. For me supervision of a trainee needs to sit within a wider system of shared accountability where placement, training institute, supervisor

'It is unlikely that a sole practitioner could provide a placement that is ethical and also safe for both clients and trainees'

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'What feels most difficult is the conflict of interest when a supervisor's income is linked to the trainee's caseload'

and trainee each have a distinct role and clear routes of communication.

My recent experience has led me to notice how variable these arrangements can be, and how much clinical and ethical responsibility can fall on an individual supervisor without the infrastructure needed to support them.

What feels most difficult here is the conflict of interest when a supervisor's income is linked to the trainee's caseload. That makes true independence in judgment much harder, regardless of integrity.

It is not about bad faith – it is about how livelihoods and duties can become entangled. As training grows and demand for placements rises, the educational and financial pieces do not always move in step, which can blur boundaries.

It's important we consider the conditions that keep clients, trainees and supervisors safe. For me that means holding onto clear structures and multiple perspectives so that no single role carries too much power.

AMANDA BARRY MBACP (SNR ACCRED) is a Gestalt psychotherapist and supervisor.

HOW WOULD YOU RESPOND?

If you have experience or a view on the issues raised in any of the following dilemmas we would love to hear from you. The 'Reader responses' section is for peer-to-peer sharing – you don't have to discuss all the ethical implications as these are covered in the main response. The maximum word count is 350 but responses can also be shorter.

Please email your response or any questions to therapytoday@thinkpublishing.co.uk. All emails will be answered and we will let you know if your response will be published.

Is it OK for me to support a client's workplace grievance?

A current client coming for support with workplace stress describes working in what sounds like a highly dysfunctional department within a large organisation and reports behaviour from their line manager that they experience as bullying. Their mental and physical wellbeing appears to have deteriorated significantly during this period. In our last session they told me they intend to raise a formal grievance against their manager and asked whether I would write a letter supporting their case. From what the client has told me I can understand why they want to take action, but I'm conscious that I have heard only their account and that my role is as their therapist, not as an investigator or expert witness. What do I need to consider before agreeing to write anything? Can I appropriately confirm the impact the situation appears to have had on my client without offering an opinion on whether bullying has occurred? I also wonder whether becoming involved in the grievance procedure may compromise the therapeutic relationship.

Issue: February 2027 **Deadline:** 7 December 2026

Do I need training to work short-term?

I work in private practice, mainly with young adults, and an increasing number tell me they only want to come for a few sessions. My training and usual way of working are longer term, and I don't see myself as a short-term therapist. I'm reluctant to turn away clients I feel I could help, and I also know that people sometimes begin therapy expecting to come for only a few sessions and then decide they want to continue. But is it ethical to take on someone hoping they may stay longer when they have clearly asked for brief therapy? Should I undertake specific training in short-term work, or is it enough to be transparent about how I usually practise and agree together what might realistically be achieved in a limited number of sessions?

Issue: March 2027 **Deadline:** 11 January 2027

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.



ABOUT A BOY

John Wilson and **Kenny Mammarella-D'Cruz** explore the cultural forces shaping men today

What do men need from each other – and from therapy – at a time when many are struggling with loneliness, identity, belonging and competing ideas about what masculinity should look like? Here John Wilson, co-founder of Onlinevents, and Kenny Mammarella-D'Cruz, founder of MenSpeak, who has held daily online men's groups with facilitators since lockdown, draw on their own experiences of community, men's groups and therapeutic work to explore vulnerability, power and male friendship.



Kenny: I used to have OCD, body dysmorphia, Tourette's. I needed to not have these little secrets anymore but be present with a healthy life. After five years abroad I returned to the UK having missed my male friends more than anything. But they were all a bit distracted with being Western 'blokes': drink, drugs, sex, money, power. I got my male friends in a room and said: 'I don't know what a men's group is but I'm starting one now, I need to be met at depth and if you can't meet me here then you're chucked. But I'll still come raving with you.' That was almost 30 years ago. I'm 62 now and I just want to pass my tools on to others.

John: When I was two my parents became Jehovah's Witnesses, which turned out to be disastrous. That's in my past now. But what it gave me was a sense of what I really want from community. One of the things my sister Sandra and I built, having both left that community, was to set out to create spaces that are truly welcoming and open. This differs from high-control groups in that it is easy to get in and easy to get out. We do 700 events a year. Hopefully they feel welcoming but a huge part of them is that it's also fine not to come. Which is tricky as a business model but that's also part of the welcome: great to have you, great to have you back again if you want to but no pressure to. We have built something at scale that also aims to take good care of people.

Kenny: I didn't realise that you and your sister left Jehovah Witnesses together and that you were public with it. I am pleased you had each other.

John: The publicity feels important. When you get that knock on the door it can feel like there are nice people at the door and often the people on the doorstep are warm, compassionate people, but the system is toxic and dangerous, and it's important that people know that. Having a companion on these journeys is important.

'Men are not having great experiences in therapy. That feels like the emergency: not to critique what's unhelpful but to be on the job of creating alternative spaces that help'

Kenny: It's an individual, solitary, lonely pathway. Some of my clients were brought up on the idea of superheroes. For some men being a lone superhero is the only option they have. Not 'Who am I?' in relation to the world but 'Who do I need to be in order to be good enough?' So much of the marketing machine is that if you fix certain things then you'll be good enough. It seems like what you and I choose to do instead, John, is invite people to hang out and share their journey. It doesn't matter who you are or what you've got. You don't need to be 'ripped, rich and relentless' – that's boy survival stuff, it's misuse of power.

John: When I was watching the Louis Theroux *Inside the Manosphere* documentary it was frightening what young men were being invited into. The men being interviewed were deeply vulnerable with no place to be looked after. There were repetitions of vulnerability and pain being expressed in the world as violence. A sadness I took away was that we live in a world where it's easy to critique what is not being done well, but there is equally a dearth of something helpful. What are the alternatives we can offer to men of different generations? That feels lacking in our culture. Men are not having great experiences in therapy. That feels like the emergency: not to critique what's unhelpful but to be on the job of creating alternative spaces that help. Something that was so present for me in the high-control environment I grew up in was the idea of grooming people for recruitment. I'm cautious at the idea of a place that has all the answers. As men we have that solution-focused hunter gatherer thing going on. I also identify as neurodivergent. I have that need to codify and catalogue, and if someone says I'll do that for you and here are the answers it's so compelling. But high-control environments are set up so that when you challenge the psychological architecture within then the person expects it and is driven deeper into the arms of that environment by the challenge. So the importance is in showing an example of an alternative rather than screaming 'you're wrong'. That would be counterintuitive in those quite violent environments where you are drawn to war and to battle.

Kenny: The tragedy for me is how many men have had to betray themselves to belong. The greatest fear for men is humiliation and abandonment. Living doesn't even seem to come into it. It is as if life is owned externally. But the only thing any man can be is their own authentic self. The men we attract in our groups are across the board – not just the 'good' guys or the 'rough' guys: they might come from or go into various organisations and cults who will relieve them of their money or power. If that is their journey then that is their journey – it is not for me to fix or save. My job is

'The tragedy for me is how many men have had to betray themselves to belong. The greatest fear for men is humiliation and abandonment. Living doesn't even seem to come into it'

MARIE MONTOCCHIO/IKON IMAGES

to live my life in a way that is true to me. It's the opposite to how I used to be, which was the king of the victim club where nobody leaves, everyone is nice, there is no passion or intimacy, there is no violence, apart from passive aggression, and I wasn't going to leave unless everyone left with me. This wasn't doing anyone a favour. My biggest gift to myself and the rest of the victim club was to move on myself, and for anyone who wants to move on too I can be there for them rather than feeding where they're stuck.

John: I think about it as a full-contact sport. I come out of the person-centred humanistic tradition where there is massive emphasis on unconditional positive regard. Those values have been core to my practice and can come with a real holding. But that can also show up as having so much space to the point of abandonment. I have seen that with some of my male clients. The evolution for me is to be all in. Lots of contact, a space where there is lots of holding, interaction and high challenge. There could be pushing, shoving, elbows – even in ways that may feel bruising – but it's about contact and being able to feel each other and inviting each other into that. Gentleness is needed but so is fluidity and not letting someone drown in their desperation. I certainly needed people to grab me by the scruff of the neck, shake me and be in full contact. That male energy for contact can be quite physical at times. We have a lot of skills in the therapy field, and space is important, but if that is all that we are doing it feels pejorative.

Kenny: Physicality is fundamental. I know enough men who would go to get drunk and fight in order to be intimate with other men because that was the only physicality they'd get. I'm astounded by how many men in their 20s, 30s, older do martial arts because of the physicality aspect. I had a best friend and we would always be play-fighting and tripping each other up. He would say to me: 'I love when we do this because it means everything is OK.'



MARIE MONTOCCHIO/IKON IMAGES

It brought safety. Or it spoke louder than words could speak. There's a certain trust, meeting at the edge. It's a masculine holding. The same with clients. There is all this stuff about 'men don't speak' – well really it's about the way we listen. The way to enquire, the way to tune into language, to know the pace and tone and how to speak so that they will speak. They're invited in their own time without performance. Men in my experience are desperate to speak and be heard. It's just that people don't set the conditions for it. It's tragic, the loneliness and isolation that this brings.

John: The question for us is are we up for that deep psychological and physical contact? If we are not we shouldn't be in those spaces. We need to be available for it. It's somewhere between a very delicate holding and kicking the f***ing door down! We can only do that more challenging work if we really care about the people we are with. We don't transform unless the person we are with loves us deeply. To do that appropriately, in a way that sits within the ethics that we're signed up to, it needs that level of energy and engagement.

Kenny: What I also find uncomfortable and scary is that in the moments when men need to be met there are so many people willing to steal their lessons. They'll say, 'Here are all the answers, be like me.' It's like, wait a minute, what are you doing stealing this person's lessons, power, journey and unfoldment? This is parasitic! There can't be anything good about this.

John: It's so important to hold those boundaries. It's also about welcoming whatever response we get back to how we respond to them too. When that gets in a mess there is so much shame in that.

Kenny: The shame and blame keeps people in limbo for so long. A line in our groups is that we name it rather than blame it or shame it. As we embody that it becomes normal, liberating, for things to be spoken out.

John: We've not done hierarchy well in the counselling world. I've needed male role models in my life. Being available to other younger men coming into the field needing to feel someone there welcoming them with more experience is important. But to appreciate that and not exploit it. We have so few models of this across the global culture. One of the next pieces of evolution for humans is finding a way to be together that matches our evolutionary state, which is hierarchical but not exploitative.

Kenny: I've just had a memory of a client who turned his back to me, but

'We can stand on the shoulders of giants and learn from each others' experiences and talk about failures, not just successes. We move into bigger and better lives not by being a smart a**e but by sharing the journey'

that was an important test. There are times when I've been tested, pushed, abused and punished for the sins of other men. It is so healthy for them to purge it, for me to not take it personally and let it pass so that they can then show up. Some men need to punch the leader in order to rank higher in the pecking order. Over lockdown I would sometimes be scared to go into the groups because members were out to get me because they saw me as the founder, the leader, the head – they had that issue that needed to play out. For it to play out publicly with men in the room and everyone to be aware of their own reactions is worth its weight in gold. This is being in the vulnerability, in the raw, in the lost for words, unsafe, to want to run away, for this to be spoken out and for us to be in it together.

John: This is an important conversation about power. I'm a fan of Peggy Natiello's idea that power is not a zero-sum game. Personal power is not finite. I can make mistakes but I'm not going to give up my power. We are inviting other men to live into their real personal power as well as keeping the space safe, because if there is no power holding the container that's a very dangerous space. I'm on board with the humanistic idea that humans are deeply prosocial. Men have been in difficult relationships for thousands of years; we've lived in oppressive systems for a long time and been oppressive as men, so there is a lot coming down through the generations and in the digital space as well. As much as people are in these environments like the manosphere and the high-control group I was in, as much as it can feel right in the moment, something feels off, and something in the organism is unsettled. There is an incongruence in the organism that it knows. When we hear or experience someone else that matches that prosocial experience it calls up something else. That's the hopeful bit. Lots of this behaviour is symptomatic of something, and when we get to the core of who we are all that begins to change.

Kenny: The term 'showing up' rather than 'showing off' is screaming in my head. Increasingly men are around other men telling the truth about their difficulties rather than showing off about conquests and other nonsense like that.

Who are these blokes that you're trying to be accepted in the boys' club with? I'd say so much of this is the difference between boy behaviour, lost boys and men who are growing into self-awareness. This is little to do with age and all to do with stage in life and where people are lost. They can be big burly men in their 40s, 50s, 60s who are still at the gates of the boarding school figuring life out. It is why I feel we need to be in it together; all of it can be welcome and none of it has to be wrong. As soon as there is information, we all get to learn how to navigate an authentic life with a quiet mind. So many men cannot sit still for a minute without scrolling for information or distraction.

One of the biggest tragedies and causes of addiction and poor behaviour is the lack of an 'off' button. What do I need to do to make it stop? People can get suicidal or addicted to drugs or money or power or sex just to make it stop. These conversations can be groundbreaking because they are beyond survival into conscious living.

In our daily online men's groups we can stand on the shoulders of giants and learn from each others' experiences and talk about failures, not just successes. We move into bigger and better lives not by being a smart a**e but by sharing the journey.

John: It's a fairly recent thing for some humans to have the privilege of not worrying about where the next meal is coming from. It therefore brings us face to face with this question: how are we going to live if we aren't just surviving every day? We are leaning into new questions about being human. That power to push forward is a big part of testosterone, building things, changing things, bringing good things into the world. Doing this is not about giving up one for the other but about not becoming so internal that there isn't an external voice and vice versa.

'I've needed male role models in my life. Being available to other younger men coming into the field needing to feel someone there welcoming them with more experience is important'

Kenny: As you talk about those who don't know where the next meal is coming from, what we have so much in common is community. The whole 'man up' thing for me becomes 'man up and talk about it'. These are spaces from which we can share and grow. People can get to know about them and then know that if they come they will be met, safe and have life open up. We are in it together. ●

Some details of group member experiences have been changed for confidentiality.

John and Kenny are holding a group event on International Men's Day, 19 November, open to all genders. They will also hold a training on how to hold groups and communicate with men. ***bit.ly/4yfqwJH***

ABOUT THE AUTHORS



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What our walls say

Liam Hawkins explores the unseen language of therapy room artwork

Before I trained as a psychotherapist, I spent much of my childhood drawing. I often struggled to express my emotions, instead turning inward and destructive when I was overwhelmed. Drawing gave me a way to put something of that inner experience outside myself. It offered some relief from feelings that otherwise felt entirely consuming. When my drawing fell away during adolescence so did one of the few ways I had to make sense of what I was feeling.

Years later, sitting in my own therapy, I found myself drawn to the artwork in the room. At times I would drift into it when the relational intensity felt too much. Looking back there were moments when I was likely avoiding the work, using the image to step away from something difficult between myself and my therapist. There was something safer about directing my attention elsewhere – somewhere that didn't demand a response. At other times it offered a space to process. It helped me reflect, or brought me closer to feelings that felt hard to name directly. It gave me somewhere to go when words weren't available. I was not particularly aware of this at the time, but with hindsight it was significant. The artwork seemed to meet me at a different level to the relationship; less immediate, less exposing. The artwork didn't respond, misunderstand or interrupt. It held whatever I brought to it without complication, which at that stage of my life felt important.

Now, sitting on both sides of the room, I have had the fortune of working in a range of different therapeutic spaces. While I have seen the same IKEA rug countless times I have never seen the same piece of artwork. Each room carries something distinct on its walls, something that subtly shapes its feel. It led me to a question that stayed with me: why do we display artwork in our therapy rooms?

First impressions

During training we are often reminded that everything within the therapeutic frame matters. When we meet a client for the first time the room usually speaks before we do. Clients form impressions quickly, often before we have said anything of substance.

Creating a comfortable, inviting space is not a new idea. There is a substantial body of work evidencing how lighting, colour and spatial layout, to name just a few factors, can shape mood, behaviour and perception.[1] We are encouraged to create spaces that feel safe, warm and containing, often with an emphasis on neutrality and comfort. What is less often spoken about is the personal imprint we inevitably leave on those spaces. Our rooms are never entirely neutral, even when we try to make them so, as something of us is always present. One of the ways this shows is through the artwork we choose.

Artwork evokes feeling; it can soften a space or introduce something slightly harder to define. Unlike other furnishings it brings a profound expression into the room. Clients may take it in immediately or only become aware of it over time, but it rarely sits entirely outside experience.

Notably surrealist art and psychoanalysis have a long, intertwined and fascinating history,[2] both striving to access and explore unconscious material. More generally, viewing art has been shown to increase empathic ability, alter social views and promote introspection.[3] Some renowned

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medical studies even show that patient recovery times improved when they were able to view artwork from their bed.[4] This sparked curiosity in me. Here there is an intentional use of artwork to improve patient outcomes, but given the nature of the therapy relationship what are we hoping to do for our clients? Now these are two distinct fields with an entirely different purpose, but much of the existing therapy research on this topic comes from medical settings, so its relevance to our field is not always clear. Artwork inevitably brings an emotional tone to an already emotional space, yet clients don't bring their favourite art with them to hang in sight; we choose it for them. Sometimes we don't have a choice, as I found working in various shared NHS rooms, often having to manoeuvre the sessions around medical equipment and the odd sharps bin. However, for those in private practice or holding the ability to decorate their rooms, the artwork is rarely a silent participant.

This curiosity led me to explore what is behind therapists' artwork choices within their practice rooms.

Intention and instinct

I recently published some qualitative research on this topic[5] through which I had the privilege of speaking to several experienced practitioners about what influenced their decisions. I found what emerged to be intriguing: some choices were intentional. Therapists described selecting artwork to support client comfort, help regulate affect, or reflect their therapeutic approach. There was often a preference for calm, nature-based imagery, with softer tones that might feel grounding. Some participants spoke about working with trauma and the usefulness of having a visual anchor within the room – an image that could be returned to in difficult moments. In these cases artwork was chosen with a clear, relational purpose. The image was not only for the client but for the therapist also. It offered a shared point of reference, something mutually accessible in the room. In that sense it did not sit outside the therapeutic relationship but became part of how it was negotiated, particularly when words were inaccessible.

At the same time many decisions were more intuitive. Artwork had been chosen because it felt right, or because it had simply followed therapists from one room to another. It had become part of the setting without being actively considered. Yet when we explored these pieces more closely they all, without exception, carried personal meaning, often tied to memory, identity and experience. A few held associations that were not immediately obvious to the therapists themselves. This reflected the idea that the artwork on our therapy walls is a 'hanging autobiography',[6] which is an idea that resonated with me. Even where selection felt intuitive it still told a story. Sometimes quietly but often powerfully.

As we talked the therapists found themselves looking around their rooms as if for the first time. Pieces that had long faded into the background suddenly came back into view. I sensed curiosity, joy and hesitancy as they scanned their surroundings. There was intrigue but also a sense that these choices had not been examined before. It raises a question that feels difficult to ignore. If our artwork carries so much of us, what might it be communicating to clients?

Neutrality

Can a therapy room ever really be neutral? In some ways yes. We can aim for simplicity and avoid anything that feels overly intrusive. Despite this the space reflects our preferences, our taste and our sense of what feels appropriate. There is often an implicit idea that the room belongs to the client, but in practice it also belongs to us. It is our workspace, shaped by our choices and available resources. Particularly in shared spaces we may be adapting to what is already present rather than starting from scratch. Trying to remove ourselves entirely can leave the space feeling somewhat empty, cold and clinical. While Yalom encourages our verbal self-disclosure to be in service of the client,[7] artwork choice can communicate something about ourselves before any words are spoken.

As one therapist told me, 'self-disclosure is everywhere'. From the way we dress to what's in the room, it's inevitable. Perhaps the more relevant question is not whether we disclose but how aware we are of it. What are we communicating through our space? What assumptions sit behind what we include or exclude? There is a balance to be found. Too much expression could feel intrusive. Too little may feel distant. Most therapists seem to find themselves somewhere in the middle, perhaps without fully reflecting on how that position came about.

A doorway

So how do clients engage with artwork once they are in the room? In my own experience it was always present but rarely acknowledged. I remember one painting in particular that I felt a deep connection to. It was a mesmerising, maze-like image reminiscent of Leonora Carrington's *Labyrinth*, and it seemed to mirror how I experienced my internal world. We never spoke about it. It stayed where it was, quietly influencing the space between us.

Looking back I wonder what might have emerged if I had brought it into the conversation. Artwork can offer a different way into the work, particularly when feelings are difficult to articulate. It can act as something to project onto or as a shared reference point. Clients may be relating to it silently, forming associations or using it to regulate themselves. Some therapists described using artwork more actively, perhaps referring to it during moments of distress, or inviting clients to reflect on what an image brings up. In these moments the artwork may transform the relationship from a dyad into a triad. While many of us will not be trained in art therapy there is still a possibility of

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recognising the sensations and visceral feelings that art evokes in us. If, as Freud says, dreams provide a 'royal road' to the unconscious, perhaps exploring artwork offers an alternative, quieter route.

Culture, identity, inclusion

Artwork choice also reflects our culture, whether we intend it to or not. What we perceive as calm or neutral is shaped by our own experiences. Some images described in my research followed a similar pattern. Nature scenes, softer tones, a sense of tranquillity. These choices often feel safe but they are not without influence. What feels soothing in one context may not feel that way in another. For instance, the Eurocentric preference for 'blue and green' nature rather than 'red' nature is often overlooked.[8] For clients entering the room these signals may contribute to a sense of comfort or feel exclusionary. This may not always be consciously recognised but it can shape how the space is experienced. As therapists we have a responsibility to acknowledge our own positions of privilege, power and otherness, so we must also make a conscious effort to recognise how this is communicated within the spaces we create. By developing reflexivity around these decisions I believe we learn more about ourselves and our own positionality. Only when we are aware of our motivations and influences can we hold responsible, transparent and non-defensive conversations around our points of difference.

Evidently it is not feasible or realistic to create a room that is loved by everyone. The environment will inevitably reflect something of ourselves. However, it is possible to reflect on what is being communicated and consider how that might be received – for example, by considering whose preferences are being centred. These are not questions with fixed answers, although they may encourage a deeper level of awareness.

Unseeing

We are habitual creatures. A recent study found that 65% of our daily actions are triggered by habit.[9] As one might expect we also become habituated to our practice rooms. Things that were once chosen deliberately begin to fade into the background. Similarly artwork becomes ingrained in the room. For clients, however, the space is new. They notice details we may have stopped seeing. Sometimes it takes something small to bring this back into awareness – a comment from a client, moving to a new room, or simply a clumsy cat knocking something off the shelf and disrupting the sense of familiarity. These moments can prompt us to look again. Not to change everything but to reconnect with what is already there. To notice what still feels intentional and what has remained out of habit.

Implications

I am writing this as someone early in my career, currently working in spaces that are not my own. It is something I think about often; what artwork I might choose if I owned my practice room and how those choices might be shaped. Rather than offering guidance my invitation is to be curious. Artwork provides a way to think about our therapy spaces and how those environments in turn shape the work. Some questions to think about include: why have I chosen this artwork? How do I feel when I look at it? How might different clients experience it? What does it communicate about me? What feels present and what feels absent?

Engaging with these questions can bring greater awareness to something that is often taken for granted. It may also bring us back to a broader question about intentionality. Much of what we do becomes familiar over time, and familiarity can reduce reflection. Returning to the artwork on our wall can be a way of reconnecting with the rationale behind our work.

Looking again

Artwork is subjective. What feels meaningful to one person may not resonate with another. There is no single right way to choose what goes on our walls. What feels more important is whether we notice it. For some clients, including my younger self, images may offer a way of connecting when words feel difficult. For others they may remain in the background. Perhaps the question is about how attentively we choose to notice what it is already doing. ●

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IN PROGRESS

A framework renewed: working with the new BACP *Ethical Framework*



Andrew Reeves, Myira Khan and Marita Morahan explain how the new framework responds to recent societal shifts

The BACP *Ethical Framework for the Counselling Professions 2026* comes into effect this November, replacing the version that has guided our practice since 2018. It arrives at a significant moment: online and hybrid working are now firmly established features of practice; artificial intelligence (AI) is increasingly present in clinical, administrative and supervisory contexts; and questions of power, diversity and anti-oppression have rightly assumed greater prominence in professional discourse. The new framework responds to each of these shifts with clarity and purpose.

Sections

The framework is structured around three sections: the first, 'Working ethically within relationships', sets out the relational and philosophical foundation of the document, explaining what it means to engage with ethics as an embedded feature of professional relationships rather than as an external standard applied to them. The second identifies 11 ethical principles including confidentiality, transparency, fairness and trust as well as three principles new to the framework: anti-oppression, collaboration and compassion. The third section, 'Core responsibilities', sets out the fundamental obligations that underpin safe and trustworthy practice, organised under four headings: building appropriate relationships; keeping people safe; understanding legal responsibilities, and delivering services to high professional standards. The three sections are designed to be read and used together; the framework is explicit that ethical decision-making requires all three to be considered in relation to one another.

Leaner framework

The renewal of the framework has drawn on the comprehensive review process with practitioners to inform its development and final creation. At approximately 19 pages, it is considerably shorter than its predecessor. This brevity reflects a deliberate shift in approach: rather than providing an extensive set of prescriptive statements the framework places greater emphasis on ethical reasoning, including on the practitioner's capacity to identify ethical issues, engage collaboratively in addressing them and articulate a clear rationale for the decisions made. In this sense it asks more of us, not less, inviting practitioners to develop their ethical thinking rather than locate the relevant rule.

Incorporating a decision-making rationale within the framework has been positively welcomed as it encourages practitioners to reflect on their own practice, inform discussions with others and provide coherent boundaries for their work. This allows practitioners to demonstrate process while working in what may be grey areas.

One visible expression of the shift in approach is a change in the language of obligation. Where the 2018 framework frequently used 'should', the new framework employs 'must' in its 'Core responsibilities' section. This is not a semantic incidence but rather signals that certain aspects of practice are non-negotiable foundations: the minimum below which professional conduct cannot credibly fall. Building appropriate relationships, maintaining safety,

'Rather than providing an extensive set of prescriptive statements the framework places greater emphasis on ethical reasoning'

understanding legal responsibilities and delivering to high professional standards are not aspirational ideals but binding commitments. It is important to reflect on the 'Core responsibilities' section with this in mind. At this significant moment in the profession the changes to the language of obligation were acknowledged during the review process as necessary for providing greater clarity for practice.

Relational practice

The organising principle of the new framework, captured in the statement that 'working ethically is working within relationships' represents a meaningful development in how BACP understands professional ethics. Ethics, in this conception, is not a quality assurance mechanism applied retrospectively to our work. It is inherent in every professional relationship: every therapeutic encounter, every supervision conversation, every training relationship. To engage ethically is, by definition, to engage relationally.

This has concrete implications for how we work. The framework asks us to approach ethical decision-making collaboratively wherever possible and appropriate, to include clients, supervisees and trainees in the process of identifying and addressing ethical issues rather than reaching separate conclusions and presenting them in a final and decided state. When a boundary question arises, when a dilemma around disclosure presents itself, when a concern about risk emerges, the framework encourages an exploratory, co-operative stance. This aligns well with the pluralistic and person-centred values that inform much contemporary practice.

The framework is also clear about the boundaries of collaborative practice. There are circumstances, such as safeguarding responsibilities, legal duties and questions of capacity, where collaborative decision-making may not be as possible or appropriate. In these situations practitioners are expected to act in accordance with the relevant legal or contractual obligations and to document their reasoning clearly. Collaborative working is a professional orientation, not an absolute principle that overrides duty.

Three principles

The 11 ethical principles in the new framework include three that represent significant additions: anti-oppression, collaboration and compassion.

Anti-oppression is perhaps the most far-reaching of the three in its practice implications. It asks practitioners to remain actively alert to power dynamics within professional relationships; to the ways in which intersectional identities and the inherent asymmetry between practitioner and client can, if unexamined, inadvertently marginalise or 'other' the very people we are working to support. Many practitioners will already hold this awareness as central to their therapeutic stance; its formal inclusion as a named ethical principle confirms that it is now an expectation of all BACP members, irrespective of modality or setting.

Collaboration as a named principle extends and reinforces the relational emphasis discussed above. It is significant that the framework positions this not merely as a process preference but as an ethical commitment; one that applies across client work, supervision, training and our professional relationships more broadly.

Compassion, while implicit in therapeutic practice, gains new weight through its explicit inclusion. The framework frames it as a commitment to kindness and genuine care, not merely technical competence at the heart of all professional work. Notably the framework does not confine compassion to our work with clients; it is a principle that encompasses how we relate to colleagues, supervisees and importantly ourselves, and in all contexts including online and when using social media. At a time when practitioner wellbeing and professional sustainability are matters of increasing concern across the profession, this is an important emphasis.

Digital practice

The new framework addresses digital and AI-related practice with a specificity that reflects the degree to which technology has become integrated into therapeutic work. Practitioners are expected to assess the risks associated with any AI tool or digital platform before using it, to demonstrate competence in its use, to understand how client data are handled and stored, and to be transparent with clients about any AI involvement in their care.

This invites a careful audit of current practice. AI tools are increasingly present not only in direct therapeutic work but in the peripheral aspects of practice: transcription services, administrative platforms, AI-assisted note generation and scheduling software. Each of these carries implications for client confidentiality and data governance. The framework does not prohibit the use of such tools but rather requires that their use be considered, competent and transparent.

Digital and AI tools bring many benefits and challenges, and these will be constantly changing. Maintaining good practice in auditing the risks and transparency of process while using these tools will assist practitioners to manage any consequences or impact. The ability to work online using digital technology allows the freedom to provide services to those who might not otherwise have access, including those with limited provision geographically or those with specific needs that limit access to physical counselling spaces. However, having the ability to work across country or state borders brings with it the possibility of legal, safeguarding and other ethical considerations. The implications of working across different jurisdictions needs to be carefully considered if making the decision to work online across borders.

More broadly the framework affirms that the full range of ethical expectations

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applies equally to online and remote working contexts. The relational ethics of therapeutic practice do not vary with the medium through which that practice is delivered. Practitioners working in hybrid or fully remote contexts should satisfy themselves that their working arrangements reflect this in terms of privacy, boundary management and professional conduct.

Ethical reasoning

Perhaps the most significant practical emphasis of the new framework is the expectation that practitioners can articulate a clear rationale for their ethical decisions. The framework does not simply ask us to make sound judgments; it asks us to be able to explain and document how and why those judgments were reached. To support this the framework offers a structured set of questions for developing an ethical rationale:

1. What are the ethical issues?
2. How has the person impacted by the decision been involved in the decision-making process, and if they have not, why not?
3. What internal factors – identity, context, the nature of the working relationship – have informed the decision?
4. What external factors – legal duties, organisational requirements, the involvement of third parties – are relevant?
5. What decisions were made, and were they consistent with the framework's principles and responsibilities?
6. How was the process reviewed, and with whom?

This is not administrative expectation but rather it aims to formalise what good reflective practice already looks like: systematic thinking, careful documentation and genuine engagement with supervision. Practitioners who use supervision well will recognise much of this process; the framework is asking that it becomes visible and accountable as a matter of routine professional practice, not only when difficulties arise.

Supervision occupies a central position in this regard. The framework is clear that practitioners should bring ethical dilemmas to supervision promptly and that supervisory discussions form part of the evidence of ethical reasoning. This places a corresponding responsibility on supervisors to create the conditions in which genuine ethical reflection can take place rather than supervision functioning primarily as an administrative or caseload management exercise.

Getting prepared

The new framework comes into effect in November 2026, and to support this BACP has committed to providing supplementary resources, updated and new good practice information – Ethics in Practice and Ethics Essentials etc – and training opportunities to support practitioners through the transition. There is, however, much that can usefully be undertaken now. Reading the framework attentively is the obvious starting point. At 19 pages it is accessible; an hour spent with it will almost certainly surface questions and reflections relevant to your own practice. Those questions are worth bringing to supervision. Practitioners would also benefit from reviewing their contracts, consent forms and privacy notices in light of the framework's expectations around transparency, technology use and collaborative working. Consider too how the principle of collaboration is reflected in the way you introduce and review the working agreement with clients at the outset and throughout the therapeutic relationship.

For those working as supervisors, trainers and within organisations the implications are equally significant. The framework applies not only to direct client work but to supervisory and training relationships in their own right. The expectations around collaboration, ethical reasoning, anti-oppression and accountability extend across all professional roles and relationships. It is worth considering how the framework's principles are already reflected in supervisory practice and where there is scope for development.

Beyond compliance

Any new professional framework carries the risk of being approached primarily as a compliance requirement: something to be understood to a sufficient degree to satisfy a regulatory process should that ever become necessary. The new BACP *Ethical Framework* merits a more engaged response than that. At its most productive an ethical framework gives shared language to the values that inform our work and brings them into clearer focus. The new framework asks practitioners to reason carefully, to work relationally, to engage collaboratively, to hold an awareness of power and to account for their decisions with transparency and integrity. These are not new demands; they are, for most practitioners, the values that drew them to this work in the first instance. The framework articulates and confirms them as professional expectations rather than personal preferences.

The shift from 'should' to 'must', the emphasis on ethical reasoning, the introduction of anti-oppression, collaboration and compassion as named principles, the explicit attention to digital and AI practice – each of these reflects a genuine attempt to articulate what ethical practice looks like in the contemporary landscape of counselling and psychotherapy. Engaging with the framework as an opportunity for professional development rather than as a regulatory obligation is likely to yield considerably more for both practitioners and the clients they serve. ●

BACP will no longer produce Good Practice in Action (GPiA) resources. They will be replaced by Ethics in Practice, Ethics Essentials and Legal Resources. For more, visit ***bacp.co.uk/eip***



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The GOOD ENOUGH MONSTER



Jeremy Sachs unpacks how horror films carry rich material for our practice

'Monsters are real, and ghosts are real too. They live inside us, and sometimes, they win,' says Stephen King. Welcome to spooky season.

The Celtic festival of Samhain, celebrated from sunset on 31 October to 1 November, is considered the root of modern Halloween. It marks the boundary between the harvest season and the dark of winter – a liminal time when the veil between our world and the world of the dead and the fae thins, allowing them to cross over into ours.

I cannot imagine a better time then for us therapists to invite these ghosts and fae in and explore the darkness, both outside and within.

It's alive!

In an age where it can seem high-street cinemas are filled with escapist and numbing superhero franchises and Disney CGI and live action remakes – like a capitalist serpent eating its own tail – one genre continually draws on originality by inviting us to confront what is uncomfortable, shadowy and hard to look at – that is horror. Rather than being a genre we use to numb and escape our anxieties, horror actively takes those anxieties and presents them back to us. It reflects back our fears and asks, 'What do you think?'

And because horror films don't exist in a vacuum but are products of the times they are made in, they often can be interpreted as a litmus test for societies' collective unconscious and anxieties. Carl Jung described the collective unconscious as a shared layer of the human psyche containing universal archetypes and symbolic patterns that appear across cultures in myths, dreams and religion.[1]

From a sociological perspective, Émile Durkheim similarly described the collective conscience, arguing that individuals are shaped by shared beliefs, values and symbols that exist beyond the self.[2] Horror, perhaps more than any other genre, gives these collective shared beliefs, and shared fears, symbolic form. I believe that the horror genre has an essential role to play in society by showing us what we are collectively and perhaps unconsciously afraid of.

Of course other genres also capture aspects of the collective unconscious and consciousness, but horror feels uniquely suited to this because, across all the diversity in human experience, we all know what it is to encounter horror in our lives – horror is individual and collective, it is integral to being human. It is in surviving horror that psychotherapy and horror films begin to meet. As Jordan Peele, director of *Get Out* and *Us*, said in his BAFTA acceptance speech: 'We need to face our nightmares, and it is best to do that together.' Peele meant this in the context of cinema, but how easily might that sentiment translate to the therapy room?

> 'It is in surviving horror that psychotherapy and horror films begin to meet'

History: 1950s to 1980s

Each generation reflects the anxieties of the collective unconscious through the horror genre. During the 1950s and 1960s horror was shaped by the threat of nuclear and Cold War tensions, where the fear of annihilation loomed large. *Godzilla* (1954) emerged as a response to the nuclear devastation and atomic anxiety experienced in post-war Japan, while *Invasion of the Body Snatchers* (1956) reflected American fears surrounding invasion and the loss of individual identity during a period of intense political paranoia.

Both films transform post-war collective fear into physical and psychological horror. Rather than simply presenting monsters as external threats they embody anxieties about helplessness, identity and human fragility. In *Godzilla* the monster symbolises the catastrophic consequences of nuclear technology and humanity's inability to control what it has created.



Do you like SCARY movies?

Exploring the human condition through horror

As well as the films mentioned in the main text, below are 13 (unlucky for some) recommendations for this Halloween. I have included very short thematic introductions to them. If you decide to watch them, ask yourself, how do you feel, beyond fear? Do they elicit shame, arousal, laughter, anger, helplessness, catharsis or resistance?

Night of the Living Dead *(1968)* A pioneering zombie film that ends with a Black protagonist surviving the night only to be mistaken for a zombie and shot by a white posse. Themes of racial violence in America during the civil rights era.

Carrie *(1976)* Themes of repression, shame and abusive motherhood. Carrie's religious mother embodies the 'bad mother' archetype through control while school bullying turns years of familial trauma into violence.

The Shining *(1980)* Reverses the 'bad mother' trope into a threatening father figure, exploring domestic violence, psychological breakdown and extreme isolation.

The Thing *(1982)* Themes of paranoia, isolation and the breakdown of social cohesion. A shape-shifting monster that can imitate anyone – making fear and suspicion more dangerous than the creature itself.

Jennifer's Body *(2009)* The only horror/comedy on this list. Explores sexualisation and male violence by turning the trope of the 'sex comedy' (think *American Pie* (1999)) on its head and subverts it with female rage and queerness.

The Babadook *(2014)* A mother physically manifests postnatal depression and confronts the shame of not emotionally connecting with her child in among grief and loss.

It Follows *(2014)* Themes of fear of adolescent sexuality and the destructive power of the teenage sexual self. The monster becomes a metaphor for slut shaming, shame, STIs and fear of your own sexual awakening.

The Witch *(2015)* Explores religious patriarchy, bodily autonomy and repression, where attempts to shame push desire towards rebellion.

Annihilation *(2018)* A cosmic sci-fi horror about avoidance, the human drive towards self-destruction and the potential for transformation through the breakdown of self.

Hereditary *(2018)* Focuses on inherited trauma, grief and family breakdown, where legacy becomes a force of possession and generational trauma.

Relic *(2020)* Explores dementia and intergenerational trauma through a haunted house metaphor for memory and identity loss.

I Saw the TV Glow *(2024)* Themes of gender dysphoria, disconnection from family and yourself. It uses metaphor and visuals to show the horror of never truly living an authentic life – the horror is reality itself, because the characters are forced to live inside a reality that does not fit them.

Sinners *(2025)* Themes of Black identity, race and how the world is already horror to Black people – the scariest things in the film are not vampires but the white counterparts.

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In *Invasion of the Body Snatchers* the horror lies in the fear that individuality and authentic human connection can quietly disappear without a visible enemy to fight. Unlike traditional conflict, such as World War II, the threat is invisible and gradual, creating an atmosphere of constant suspicion and paranoia where no one can be fully trusted and resistance feels futile.

By the 1970s and 1980s horror becomes increasingly moralistic, perhaps as a reaction against the 1960s, which had been defined by free love, anti-establishment protest and alternative culture. Many films seemed to scare audiences towards a more conservative moral compass. *The Exorcist* (1973) explores fears surrounding faith, morality and the decline of religion. Pazuzu, the demon in the film, is frightening yet ultimately defeatable through virtue, sacrifice and renewed faith. But spiritual morality was not the only concern of the decade.

Later we get *Halloween* (1978). The film helped establish the 'final girl' trope, where a studious, academic girl with self-restraint defeats the brutish monster Michael Myers, who is coded as working class through his overalls. Together these films reflect collective anxieties surrounding the breakdown of conventional morality, working hard and traditional values.

If these films reveal a collective unconscious that values morality and traditional values in the face of anxiety around moral decline, they also reveal collective prejudice. Filmmakers and audiences often wanted to see themselves reflected in the survivor. I would argue this may be where the trope of Black characters being killed off first originates. Filmmakers and audiences, who would have been overwhelmingly white, may not have seen themselves reflected in Black characters and therefore had little issue disposing of them early in the story, often alongside the 'slutty' teenage girl who is morally judged for liking sex 'too much'. In *Jaws* (1975), for example, the shark's first victim is a young, sexually liberal woman skinny-dipping at night. Characters perceived as less virtuous, less relatable or outside dominant social norms were often treated as disposable, particularly at a time when civil rights and



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feminism were challenging established cultural norms and society.

History: 1990s to 2025

In the 1990s audiences moved towards comedy and irony. *Scream* (1996) satirises the horror genre as much as it aims to scare, but then 9/11 happens, followed by the Iraq War, and dark horror returns. For Millennials shaped by repeated crisis, war, housing insecurity and financial instability, horror became increasingly nihilistic. The monster was no longer something that could be understood or defeated. Instead characters became trapped in endless suffering, pursued by forces with no clear motive or meaning.

The *Saw* films illustrate this shift. The horror is not simply the antagonist Jigsaw but the horrific and hopeless environments the characters wake up imprisoned within. Survival no longer depends on virtue or morality; suffering feels random, unavoidable and psychologically inescapable. In this way *Get Out* (2017) explores the constant psychological strain of minority stress within a supposedly progressive society, particularly through the lens of an interracial relationship. The film suggests that when the world is genuinely more dangerous for minority groups, paranoia is not irrational simply because others refuse to acknowledge the threat. In *Get Out* the horror is the real world itself, because for Black people it is not paranoia if the world is genuinely out to get you.

Horror today increasingly reflects anxieties surrounding technology, disconnection and the collapse of shared reality. *Talk To Me* (2022) uses possession as a metaphor for addiction and the fear of losing Gen Z and Alpha to technology and social media. The possession can be read as symbolic of giving your child a smartphone or tablet, knowing they may disappear into it and become exposed to anonymous forces we cannot fully see or control online. *Bring Her Back* (2025) similarly explores attachment and the desperate lengths a mother will go to in order to reconnect with her lost daughter. *Backrooms* (2026) shows us the danger of staying stuck in our trauma cycles rather than reaching for connection.

Human condition

I wonder what insights might emerge for us as therapists when we sit down to watch horror films? What can we learn by embracing these stories from a non-therapeutic interpretation of these familiar themes and archetypes? As the audience and as therapists we might be tempted to see ourselves in the victim/protagonist of these films – but can we also see ourselves in the monster? As Carl Rogers said: 'Therapy is about exploring every hidden nook and frightening cranny.'[3]

With this in mind, we can watch horror as Gestalt therapists might work with dreams, acknowledging that every part of the dream is an aspect of the self – not just the first person. What is it to use these horror stories as a way of integrating all parts of ourselves, even the shadow – or indeed the monstrous? ●

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ABOUT THE AUTHOR



Jeremy Sachs MBACP is a therapist and award-winning author of *An Intersectional Guide for Male Survivors of Sexual Abuse and Their Allies* (Routledge), and editor and contributor to *Clinical Perspectives on Working with Men and Shame*, published by Routledge in early 2027.

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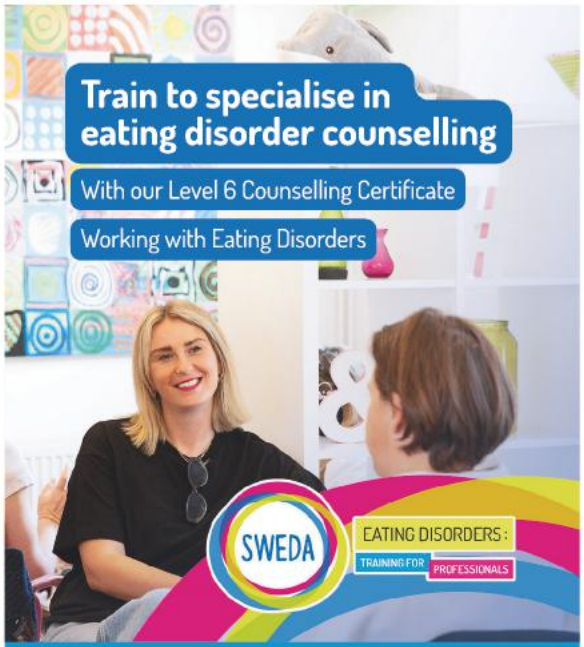


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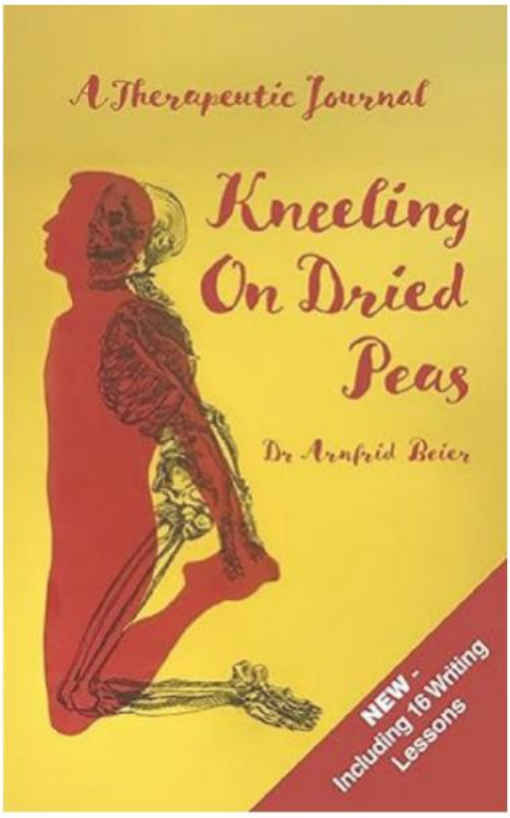
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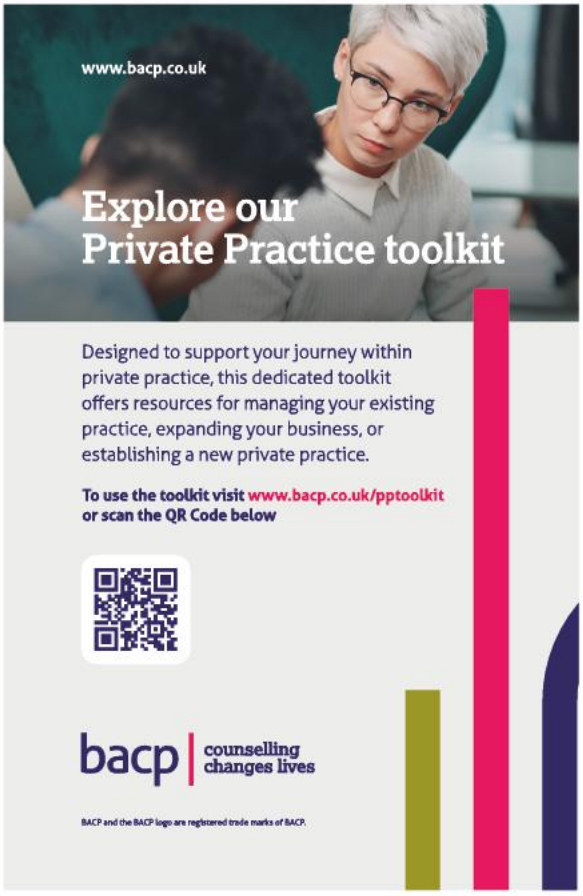
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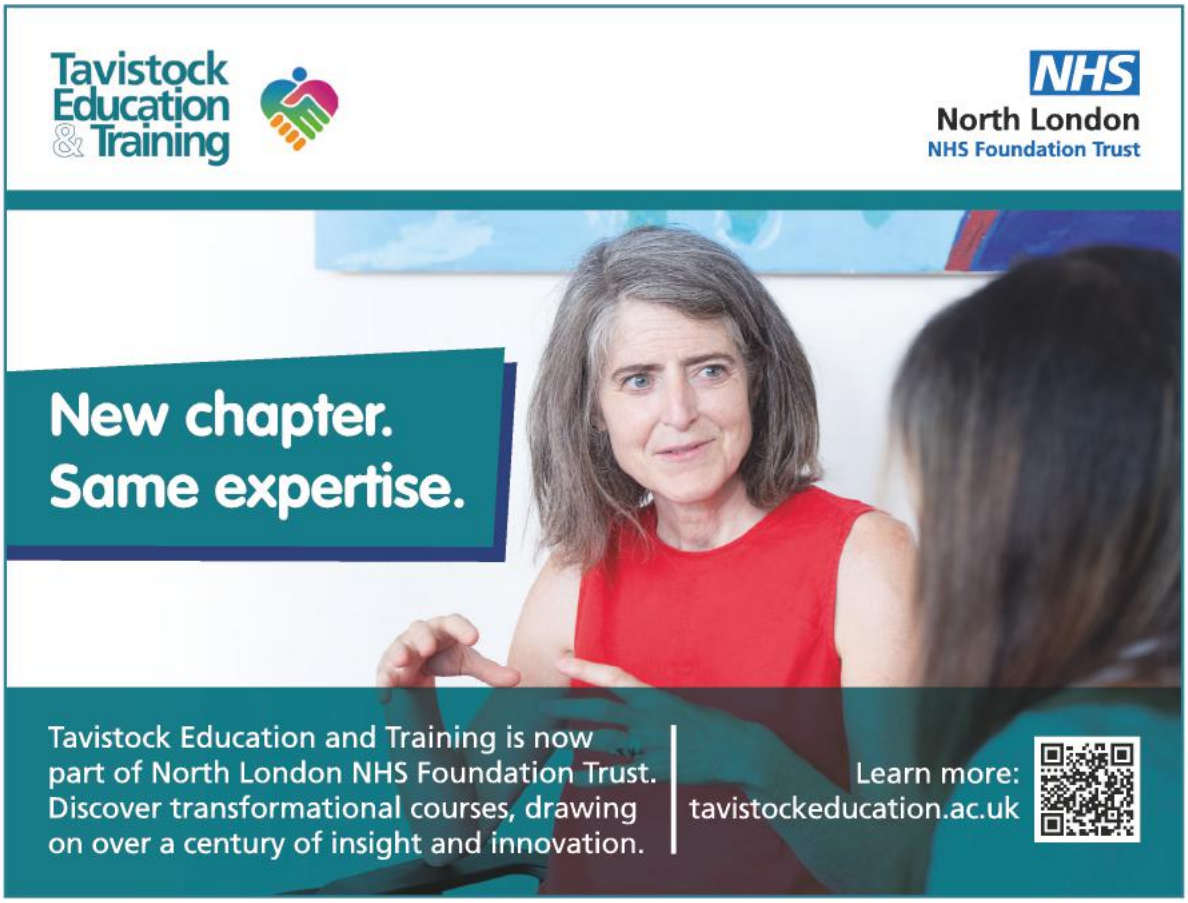


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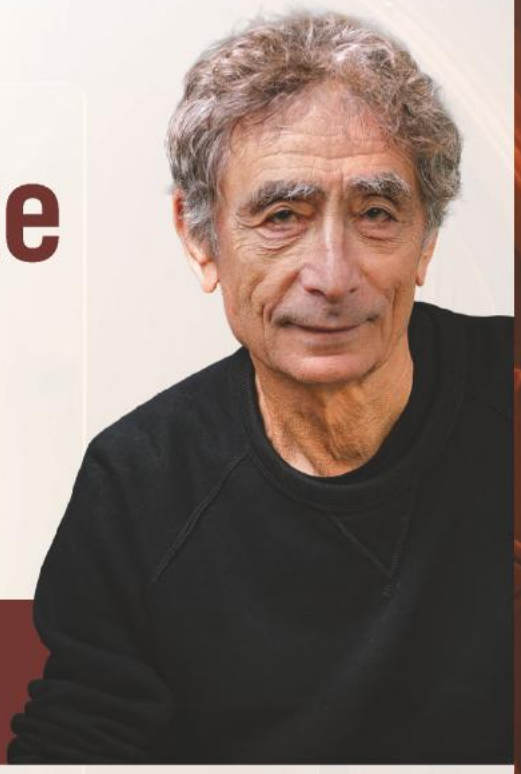
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Therapy and activism

Kim Loliya explores what activism in therapy can look like during times that demand it

It was late on a Friday evening in August when I found out that Professor Jason Arday had died. Like many, I spent much of that weekend reading articles and heartbroken reflections online. By Monday morning I had a knot in my throat, a stone on my chest and I was exhausted. Opening my laptop and starting my working day felt impossible, but I knew I had to take action to avoid descending into hopelessness.

For me activism is the practice of taking values-led action to refuse and resist present conditions, as imperfect or inconsequential as this may seem. This meant that I prioritised reaching out to colleagues and my wider community and expressing words of care, solidarity and rage while at the same time letting them know that I was available to offer practical support. I continued to take action over the coming weeks and months, using the limited resources I had, to organise community-wide grief gatherings and fundraising to offer ongoing therapeutic groups and to deliver one-to-one crisis counselling.



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While I recognised that my actions would never be enough to meet the overwhelming need of the moment, being silent and doing nothing would have felt like being complicit in the tragedy. Despite feeling unsure and afraid, I took incremental steps and mobilised with others, reconciling myself to the grief of not being able to do more. This work took place alongside seeing my clients and supervisees, many of whom wanted to explore their own heartbreak concerning what had happened. While I centred their experiences and their individual responses to the death of Professor Arday, it was also important to acknowledge that I was not standing outside these events as a neutral or unaffected observer. Some clients and supervisees offered me words of support and encouragement, and I received them as a recognition of our common humanity and as an acknowledgment of the impact of navigating a shared world.

Understanding activism

Activists are often stereotyped as those who organise strikes, attend rallies or participate in civil acts of disobedience. While these can be important and effective forms of activism they are reductive interpretations of what is a wide and complex field. When definitions of activism become narrow or policed, and hierarchies define what is politically meaningful work, this undermines the justice that activism is striving to achieve.

In social contexts where there are multiple forms of oppression, activism is often more effective when it can take on many forms to counteract inequality. Everyone holds intersecting identities and dimensions of power and privilege, which shape the kind of activism that is possible. Some cannot protest because they experience chronic pain, while others risk deportation if they are arrested. Others may be more likely to encounter police brutality because they inhabit darker-skinned Black bodies.[1] As activist work can carry consequences, assessing personal capacity and working in complementary ways with others, to distribute the risk, support change work to move forward with greater power and momentum.

Therapists can become activists at any stage of their training or practice and many enter the profession with a history of activism behind them. Some therapists have organised within their communities, participated in trade unions, challenged discrimination in workplaces or campaigned around issues that have affected their own lives. For marginalised trainees, experiencing racism, ableism, homophobia and other forms of oppression during their training can at times lead to engaging in unforeseen activism to resist the unjust conditions that threaten both their learning and wellbeing.

While therapists are often depicted as apolitical and neutral, having the ability to hold the suffering of others is a uniquely transferable skill that underscores both activism and therapeutic work. Supporting others with their mental health, whether in private practice or within services, can also lead to confronting the realities of health inequalities caused by systemic oppression, and becoming politicised may be a natural response to doing therapeutic work.

Understanding lineage

Connecting psychological life with political action is not a novel idea, and there is a long lineage of practitioner-activists, both past and present, working in the UK and internationally. While this

lineage is often missed from counselling and psychotherapy curricula, it can be helpful to find others doing this work, to reduce feelings of isolation and to locate therapeutic activism within a broader historical context.

Contemporary examples of activists include Professor Gail Lewis, who trained as a psychodynamic and psychoanalytic psychotherapist and is now Reader Emerita in the Department of Psychosocial Studies at Birkbeck, University of London, and Visiting Senior Research Fellow at the Department of Gender Studies at the London School of Economics. Professor Lewis describes being 'schooled by activism' as a past member of Brixton Black Women's Group and a founding member of the Organisation of Women of African and Asian Descent. With a political lens, situated within the Black feminist, socialist and anti-imperialist struggle, Professor Lewis describes this education as generating a 'practice against the grain'.[2]

Psychotherapist and Jungian analyst Andrew Samuels is another contemporary activist who has spent much of his career challenging the division between psychotherapy and politics. His concept of the 'political psyche' connects the internal therapeutic process with politics and the conditions of the external world. Samuels believes that psychological ideas can deepen our understanding of political life, and his work asks therapists to consider themselves as citizens whose professional practice and values influence wider social structures.[3]

Helen Bamber's dual role as psychotherapist and activist, specialising in human rights, left behind a significant legacy. Since her death in 2014 the Helen Bamber Foundation has continued to support and advocate for survivors of trafficking, torture and extreme human cruelty. Bamber's work was based on the premise that psychological recovery could not be separated from safety, housing, legal protection and fundamental human rights. She built organisations that combined therapeutic care with medical evidence, legal advocacy, welfare support and community building.

Ethical considerations

When considering activism and therapy as relational encounters, power dynamics need to be understood and deconstructed to reduce the possibility of harm. When activism feels personal, urgent and all-encompassing, care needs to be taken to avoid pressuring clients either to share the same commitment to activism or to expect that their politicised action will look the same. In addition, having shared identities does not necessarily equate to shared politics. Even when values might be aligned initially there may be differences of opinion that emerge over time. Part of ethical practice includes assessing where practice boundaries lie, holding in mind the dimensions of self-care, client care and community care.

In this digital age politically engaged practitioners might need to consider how their public activism affects their therapeutic relationships, as writing, social media activity, campaigning or participation in public events could become information that is easily accessible and in the public domain. Exploring the implications of visibility and communicating candidly about them can be helpful to support clients to make informed choices. Working to cultivate trust and safety within the therapeutic relationship also matters to be able to meaningfully navigate these conversations. Even with awareness and the implementation of the necessary precautions, visible activism may inadvertently lead clients to compare themselves or fear that they are not doing enough. Therapists have a responsibility to find appropriate and supportive ways to address this.

'While I centred their experiences and their individual responses to the death of Professor Arday, it was important to acknowledge that I was not a neutral or unaffected observer'

On a macro level activism unsettles unjust systems by questioning and resisting dominant culture. In an interpersonal context relational activism behaves in similar ways, resisting the silencing and violence that can take place when uncomfortable topics are not addressed. This kind of activism requires therapists to develop a capacity for discomfort and, where appropriate, to support our clients to do the same. It takes courage to engage in system change, and these relational aspects are an integral part of building a new world. When harm or mistakes have taken place, being willing to acknowledge and address them, and to meet any feelings of shame or fear that might arise, sustain and fortify client relationships as well as any relationships within activist movements.

Politicised practice can bring additional layers of complexity that may be less common in those who practise with a more neutral stance, yet the lineage of activist-therapists illustrates that working in this way is not only possible, it can positively impact the lives of many.

Getting support

Supervision is vital for activist-therapists who might be facing specific challenges due to the personal, relational and ethical tensions of therapy, activism and the places where they intersect. While supervisors, like clients, don't need to be engaged in activism themselves, or be involved in the same kind of activism as their supervisee, a supervisory space where politicised perspectives are welcome can still be supportive and affirming.

When supervisors understand the lived reality of activism and are willing to interrogate power (both systemically and interpersonally), including within the supervisory context, the supervisory relationship is better able to respond to the social context within which it is situated. Without this, supervision may reproduce the silencing or marginalisation the therapist is attempting to challenge. Supervisors might also need to attune and respond to fluctuating levels of risk and safeguarding complexities, especially in cases where the supervisee and the client are both experiencing systemic harm because of their marginalised identities.

'Considering lessons from Black feminist activists, self-preservation is a political act and finding ways to rest and access collective care is an act of resistance in itself'

Navigating the supervisory relationship shares many parallels with client work, such as leaning into courage and having uncomfortable conversations. As activism can be integral to someone's identity, compassionate and non-judgmental supervision can be reparative, supporting a therapist to reflect critically, sustain their activism and practise ethically.

Sustaining work

There is extensive evidence that therapists are vulnerable to burnout and compassion fatigue, characterised by emotional exhaustion, reduced empathy, intrusive thoughts, depersonalisation, psychological distress and sleep disturbances.[4] A growing body of research has documented burnout among activists, where these symptoms overlap with feelings of intense guilt and loss of purpose, which can make stepping away from this meaningful work difficult.[5]

There are relatively few studies of the experiences of those in both activist and therapist roles, but research on therapists engaged in social justice work suggests that resistance and advocacy can be both energising and emotionally and physically demanding. These practitioners may therefore experience both the sustaining and depleting effects of politicised practice alongside the cumulative emotional, political and relational demands associated with therapeutic work and social justice.[6] As stopping either therapeutic or activist work might not be feasible or desirable in times of financial and social precarity, politicised practitioners, and those in their communities, need to develop ways to sustain these workstreams. Considering lessons from Black feminist activists, self-preservation is a political act and finding ways to rest and access collective care is an act of resistance in itself.

Understanding risk

Therapists who are also activists work within a complex landscape of risk. Political action may lead to a practitioner being arrested, injured, publicly identified or required to attend court, and they may be unable to see clients, protect continuity of care or maintain their income. These possibilities require ongoing reflection and contingency planning, including clear arrangements for unexpected absence, secure communication, appropriate clinical cover and honest discussions in supervision. However, avoiding activism is not an entirely risk-free position either because for some practitioners remaining silent in the face of injustice may create moral distress, erode their sense of integrity and produce a painful separation between their professional identity and values. Concealing an understanding of power, suffering and injustice may also leave some feeling inauthentic and affect the quality of their work.

There are community-wide risks as well. When therapists present their work as neutral or detached from social conditions they may inadvertently individualise distress and deny the effects of racism, poverty, displacement, state violence or other forms of oppression on mental health. Managing and making sense of these tensions invites practitioners to increase risk-awareness without avoiding or minimising the effect of their actions. This means identifying the possible harm of acting, not acting and acting without adequate preparation.

In politically unstable times therapists may need to increase their tolerance for uncertainty and calculated risk while remaining accountable to clients, colleagues and communities. Risk tolerance does not mean recklessness, martyrdom or assuming that everyone should participate in a visible protest. Activism takes many forms, including teaching, mutual aid, advocacy, writing, funding, witnessing, institutional challenges and beyond. Considering whether activism is nourishing or depleting, and whether politicised work preserves clients' autonomy, privacy, trust and emotional safety, remain key questions.

The weeks following the death of Professor Arday continued to be full of grief for me and those around me. I had many more encounters with hopelessness and exhaustion, and moments where I worried that my work wasn't even scratching the surface. Feeling the magnitude of this loss was overwhelming at times, along with the global anti-Blackness within which this loss was situated. The risks and reprisals in response to this activism continued as internet trolls stormed our virtual grief gatherings, causing additional trauma to those who had attended to mourn and to be heard by others. Among all of this is the memory of all the practitioner-activists who have dedicated their lives to their community, and on whose shoulders we stand, with appreciation for everything they have done and continue to do for our collective freedoms.

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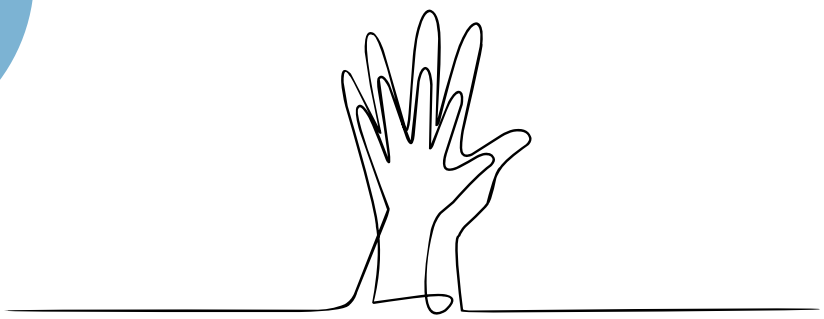
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ABOUT THE AUTHOR



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Indu Khurana



I did not initially have any sense of what my calling was. My first career in IT when the internet did not exist was stressful because I found that work boring and knew I did not want to be doing it longer-term. Starting voluntary work was exciting because through that I found my niche, by accident, which led to training in counselling at Metanoia. It was hugely challenging as it involved a steep learning curve of connecting with emotions that had not seen the light of day for many years, learning and employing the person-centred theory and experiencing weird physical symptoms. Every step I have taken since the day I started voluntary work at Childline has been filled with learning. Learning about the world, about how to be a counsellor and then a psychotherapist; how to be a supervisor, a trainer, a facilitator; about other people, about children, about adults; and about systems – but most of all a journey of coming home to myself.

The world of therapy was as foreign to me at the time as the world of multiple sclerosis (MS) was in 2017. Getting my first MS symptom on my 31st birthday was the start of getting to know the medical world, the world of health and the world of long-term and chronic health conditions.

I would have been quite different without MS. Since 2017 I have been learning about it and about me *with* it. So when I started my business about four years ago it seemed a no-brainer to focus the provision of my therapeutic services on this area. If I am honest it hurt my brain a lot to think about narrowing my offering. But the marketing course I put myself on at the start of going self-employed was adamant that this was the way to get seen above the parapet. The course has not been wrong. With each moment of learning I felt as though I was being hauled through a gorse bush backwards.

None of the junctions along my life have been planned. I have followed the signs from the universe. When I look back in hindsight I feel that there has been a design there all the time and I have been led to every major junction in just the right order, and at exactly the right time.

SAINOVAL/SHUTTERSTOCK

It seems that all the research I did to keep me well over 20-odd years has paid off not only personally but also for my work. When I did get the correct diagnosis and started to learn about MS, all the previous learning applied, and I found myself piecing things together quickly. Add to that my master's in transpersonal integrative child, adolescent and family therapy, and I found that the neuroscience module, which back then was ahead of its time in 2006, sat firmly in the seat of my understanding. Suddenly all the pieces fitted as though drawn together magnetically. Attachment learning had a similar coalescence.

My work has always been individually tailored. That is for me of utmost importance, particularly nowadays in a world and culture that love homogeneous, system-developing tasks. Conditions like MS insist that the individual is seen by ensuring that everyone's symptoms behave differently. For me this underlines the uniqueness of all living things on this planet – a uniqueness that is borne of each of us following our own path in our very own way.

I have learned that even this condition has been sent to me to teach me things. Things I clearly was not willing or able to learn before its arrival. So my body had to take over at the helm and steer me into waters that I could not, would not, have foreseen. Similarly, I did not envisage being an advocate for disability, being selected to speak on behalf of many disabled others to political ministers (via MS Society) about how unjust systems were in place; neither did I envisage becoming Chair of the Private Practice division, especially as someone who is visibly disabled. Learning to speak to the people behind the labels, within man-made hierarchies, was one of my most immediate learnings. So too was learning to lead a team, realising that I don't want to lead in a traditional way, learning to do things differently.



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'Conditions like MS insist that the individual is seen by ensuring that everyone's symptoms behave differently. For me this underlines the uniqueness of all living things on this planet'

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