30 A CLOSER LOOK AT OPEN DIALOGUE
36 WHEN PERFECT DOESN'T FEEL GOOD ENOUGH
42 THE ETHICS OF EDITING CLIENT NOTES IN AI
48 ADJUSTING TO FATHERHOOD

DECEMBER 2026/JANUARY 2027 I VOLUME 37 I ISSUE 10

THERAPY TODAY

bacp | counselling changes lives



Keeping score

SHINING A LIGHT ON THE LATEST TRAUMA RESEARCH

THERAPY TODAY
DECEMBER 2026/JANUARY 2027 | VOLUME 37 | ISSUE 10

NAOS

Advancing Psychosexual & Relationship Therapy Everywhere



2-Year Advanced Diploma in Psychosexual and Relationship Therapy 2027-2028

A globally informed, culturally inclusive training programme for professionals seeking to deepen their expertise in psychosexual and relationship therapy.

The NAOS Institute builds on over 35 years of international training excellence in psychosexual and relationship psychotherapy. Founded by leading figures in the field, the programme has contributed to shaping professional standards and training practitioners across more than 40 countries.

Now entering a new phase of development, NAOS continues this legacy with an international faculty and a renewed commitment to culturally informed, globally relevant practice.

Duration: 2 years (part-time)
Start Date: January 2027

Format:

- Monthly one Sunday and Monday
- Year 1: In-person (London)
- Year 2: In-person (London) + live online

This flexible structure supports both UK-based and international participants.

Minimum entry requirements:

- A foundation year in counselling or therapy, personal therapy and client work experience.

In exceptional circumstances these may be waived.

For full course details: https://www.naos-institute.com/training/naos-advanced-diploma-in-psychosexual-and-relationship-psychotherapy/ · Enquiries: info@naos-institute.com

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

6 Day Post Graduate Certificate in Psychosexual and Relationship Therapy 2027

6 days, online – 42 hours CPD

A high impact intensive 6-day training, blending self-directed distance learning with live and participatory skills training, designed for professionals seeking to expand their psychosexual and relationship counselling skills.

Enquiries: Bernd Leygraf: 07414 681 553 or email info@naos-institute.com

Course Dates:

- Block 1: Mon to Wed 8-10 Feb 2027, 9.30-16.30 hrs, via Zoom
- Block 2: Mon to Wed 8-10 March 2027, 9.30-16.30 hrs, via Zoom

For full course details: www.naos-institute.com/training/ www.psychosexualtraining.org.uk · Course application form: www.naos-institute.com/application-form

The course is accredited by COSRT, level 7



Contents

23 *'Amid a growing backlash against trauma misinformation, do we need to rethink one of the most influential clinical narratives of the past decade?'*

Ed Harkness ('Keeping score', pages 22-29)

IN THE KNOW
News • Research • Events

5 From the Editor
7 Noticeboard
News and events from BACP and beyond
8 From the CEO
13 From the President
15 Policy updates
17 Research digest
18 What's on
20 Bookshelf

22 The big issue
Does the body always keep the score?

30 In conversation
A discussion following the results of the ODDESSI trial



36

IN THE ROOM
Client issues • Case studies

34 Book extract
Is our system fit for purpose for clients in crisis?

36 Reflections
The pressure for Black therapists to be more than 'enough'

41 It changed my life
Finding support after medical-related pregnancy termination

IN PRACTICE
Ethics • Good practice

42 Dilemmas
Is it OK to use AI to edit my client notes?

48 Good practice
Supporting fathers who find it hard to open up

IN PROGRESS
Training • CPD • Careers

52 Awards
Celebrating the winners of BACP's Member Awards 2026

58 Professional development
Reflecting on the loss of Professor Jason Arday

42



OPPORTUNITIES
Courses • Practice services

60 Classified, mini ads, recruitment, CPD, training and service support

OVER TO YOU
Feedback • Opinion • Profiles

70 Viewpoint
Understanding our 'personas' online

74 What I've learned
Michael Toller



74

HAPPY CHRISTMAS FROM ALL OF US AT WEBHEALER!

SCAN THE CODE TO SET UP AN APPOINTMENT. SPEAK TO CIARA, GRACE, RACHEL, LAURA, TARA, YOMNA, DIRCE OR BRITNEY TODAY TO SEE HOW WE CAN HELP.

#BUILTBYHUMANS
#AISEARCHFRIENDLY



The number of new clients you'll need before your WebHealer website pays for itself*

GET YOUR WEBSITE BUILT - FAST **FIND NEW CLIENTS** **COMMUNICATE PROFESSIONALLY & SECURELY**
RANK ON SEARCH ENGINES **GET FOUND ON GOOGLE BUSINESS PROFILE** **ENJOY FULL SUPPORT FROM WEBHEALER**

What are you waiting for? WebHealer have been working with BACP members for over 20 years. Speak to us today and see how we can help you win clients and manage your practice more effectively.

- COST-EFFECTIVE SOLUTION
- EASY TO COMPLETE
- TAILORED TO YOUR PRACTICE
- FULLY SUPPORTED
- CONTINUITY OF CLIENT CARE

Have you arranged your clinical will?

From 3rd November BACP members must have a clinical will in place. It's an important part of planning for the unexpected, ensuring your clients are properly assisted if you can no longer practise. PolicyDiary makes it simple to create yours, with a cost-effective, fully supported solution designed around the needs of therapists. Get your clinical will sorted for **only £39/year** - without the stress or guesswork.

Find out more at policydiary.co.uk

PolicyDiary

CALL US ON 0345 557 0300 OR VISIT WWW.WEBHEALER.NET

webhealer

★★★★★ Check out our 390+ Google reviews!

* Based on 1 client attending 5 sessions each priced at £60. ** Offer price of £39 one-time setup (excl. VAT), then £20 monthly fee (incl. VAT) after 30 days. Offer valid for December 2026 & January 2027.

THERAPY TODAY

This year marked the fourth year of the Oxford Transform Trauma Conference attended by some of the world's leading voices in trauma. The popularity of the event is telling: as the language of trauma has reached mainstream discourse beyond specialist therapy rooms so too have concepts around trauma become popularised. The phrase 'body keeps the score' is uttered increasingly among influencers and celebrities. But earlier this year *Frontiers in Systems Neuroscience* published a paper challenging the concept entirely. Ed Harkness helps us find out more in this month's 'Big issue' (page 22).

It would seem that questioning the status quo is in the air for our profession generally. This year former MP Norman Lamb wrote a book interrogating crisis care, while *The Lancet* revealed illuminating findings on Open Dialogue, a relational model of mental health care from Finland trialled in the NHS, just as the country is seeing a major rollout of 24/7 neighbourhood mental health centres. To highlight these changes an extract from Norman's book is included in this issue on page 34, and an in-depth conversation between BACP President Professor Lynne Gabriel and Dr Russell Razzaque, who served as Clinical Lead during the Open Dialogue trial, is presented on page 30.

Amid this palpable sea change on the horizon for mental health care comes concerted discussion around ethics in our ever-changing online world: as AI and online culture continue to shape our practice, our 'Dilemmas' section addresses the use of AI for writing notes (page 42), Michael Toller explores online solutions to now mandatory clinical wills (page 74) and Cordelia Wyche asks us to really pause on what we're putting out there online (page 70).

'Amid this palpable sea change on the horizon for mental health care comes concerted discussion around ethics in our ever-changing online world'

With this idea of the profession evolving, the themes of parenthood and perinatal mental health are also strong within these pages. Our member spotlight features Dr Miriam Donaghy for her work as founder of MumsAid (page 13), Rosanna Brown reflects on medical-related pregnancy termination (page 41) and Thomas Quayle offers a perspective on new fathers and identity (page 48).

On the notion of passing things down, Banjo Aromolaran closes the issue with a poignant reflection on learnings about bias from the tragic death of Professor Jason Arday (page 58).

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.

For information about advertising in *Therapy Today*, please contact cara.termine@thinkpublishing.co.uk

Please email bacp@bacp.co.uk to: Opt out of receiving paper copies of *Therapy Today* Inform us of a change of address Report a missing issue

BACP Executive Team
Chief Executive Officer Dr Phil James
Chief Regulation and Standards Officer Dr Lisa Morrison
Chief Operating Officer Philippa Foster **Chief Experience Officer** Ben Kay

BACP Board of Trustees
Governors Bumi Akinmutande, Josephine Bey, David Chenery, Matt Cormack, Emma Farrell, Emily Garvie, Ewan Irvine, William LLorel-Antoine, Erin Stevens, Dr Paul Taylor

Editor Katerina Georgiou
Art Director Amanda Richardson
Managing Editor Marion Thompson
Consultant Editor Sally Brown
Contributors Ellie Broughton, Sally Brown, Jeanine Connor, George Salaminios
Project Manager Adele Payne

Client Engagement Director Melissa Michael
Production Director Justin Masters
Executive Director John Innes
Senior Commercial Partnerships Executive Cara Termine ☎ 020 3771 7214 cara.termine@thinkpublishing.co.uk

Sustainability *Therapy Today* is printed on FSC® certified paper supporting sustainable forestry and produced using suppliers who conform to ISO14001, an industrial, environmental standard that ensures commitment to low carbon emissions and environmentally sensitive waste management. Both the cover and inner pages can be widely recycled.

CARBON BALANCED PAPER
www.carbonbalancedpaper.com
CBP016930

FSC www.fsc.org MIX Paper | Supporting responsible forestry FSC® C017177

THINK

Therapy Today is published on behalf of the British Association for Counselling and Psychotherapy by Think, 65 Riding House Street, London W1W 7EH
thinkpublishing.co.uk

Printed by: Warners Midlands Plc
ISSN: 1748-7846

Subscriptions Annual UK subscription £76; overseas subscription £95 (for 10 issues). Single issues £8.50 (UK) or £13.50 (overseas). All BACP members receive a hard copy free of charge as part of their membership.
☎ 01455 883300
bacp@bacp.co.uk

BACP BACP House, 15 St John's Business Park, Lutterworth, Leicestershire LE17 4HB
☎ 01455 883300
bacp@bacp.co.uk
bacp.co.uk

Disclaimer Views expressed in the journal and signed by a writer are the views of the writer, not necessarily those of Think, BACP or the contributor's employer, unless specifically stated. Publication in this journal does not imply endorsement of the writer's views by Think or BACP. Similarly, publication of advertisements and advertising material does not constitute endorsement by Think or BACP. Reasonable care has been taken to avoid errors, but no liability will be accepted for any errors that may occur. If you visit a website from a link in the journal, the BACP privacy policy does not apply. We recommend that you examine privacy statements of any third-party websites to understand their privacy procedures.

Case studies All case studies in this journal, unless otherwise stated, are permissioned, disguised, adapted or composites, to protect confidentiality.

Copyright Apart from fair dealing for the purposes of research or private study, or criticism or review, as permitted under the UK Copyright, Designs and Patents Act 1998, no part of this publication may be reproduced, stored or transmitted in any form by any means without the prior permission in writing of the publisher, or in accordance with the terms of licences issued by the Copyright Clearance Centre (CCC), the Copyright Licensing Agency (CLA), and other organisations authorised by the publisher to administer reprographic reproduction rights. Individual and organisational members of BACP may make photocopies for teaching purposes free of charge, provided these copies are not for resale.

© British Association for Counselling and Psychotherapy

bacp | counselling changes lives

Company limited by guarantee 2175320
Registered in England & Wales. Registered Charity 298361
BACP and the BACP logo are registered trade marks of BACP

FRONT COVER: ALICE MOLLON

COUNSELLING TUTOR

Working Therapeutically with Autistic Clients



This course is **designed for therapists who want to better serve their clients on the autism spectrum** by developing a nuanced understanding of neurodivergence.
It offers **practical skills and knowledge** to enhance your practice.

SCAN ME

AUTISM - INFORMED PRACTITIONER

- The **training takes place online**.
- Access your course via the **self-directed learning portal at any time.**
- **One full-day live implementation workshop working with your peers** under expert guidance.
- Access to a **private learning group.**
- A **completion certificate** to evidence your learning and CPD.

Find out if this course is right for you.
This takes less than 2 Minutes!

1 **Scan the QR code:** Instantly access the course details

2 **Get your free course handbook:** Find all the essential information

3 **If the course meets your needs:** Enrol on a cohort that fits your schedule

Or Visit:

https://counsellingtutor.com/bacp-autism/

Trustpilot TrustScore 4.9

"...lots of tangible things I can immediately implement into my practice to be more inclusive."
Kim Rackstraw

"As a neurodivergent counsellor, I can confidently say this course is a game-changer."
Vicki Petrou

"...superb combination of theory, personal testimony and discussion"
Sarah Lloyd

Noticeboard

Our monthly digest of news, updates and events



NEWS REPORT



PEOPLEIMAGES/SHUTTERSTOCK

UK Government publishes Fonagy review

On 9 October the UK Government published an independent review into the prevalence of mental health conditions, autism and ADHD, led by British psychoanalyst and clinical psychologist Peter Fonagy.

The findings reveal a genuine rise in mental health problems for young people as well as uncertainty around housing, employment, finances, educational pressure, social media and loneliness contributing to a substantial increase in mental health problems and self-injury.

The review also reveals that people are facing long waits to get the support they need rather than the system catching issues early before mental health deteriorates further.

Health Secretary Yvette Cooper has welcomed the review, agreeing that mental health services need to focus more on 'early support'.

Key recommendations include moving from a system dependent on diagnosis to access support to a needs-based system where people can access help earlier.

The review emphasises a need to tackle the drivers of mental distress and ill health through prevention, early intervention and improving public mental health and wellbeing, protecting specialist services and improving data collection and evaluation for diagnoses.

Read BACP's response to the Fonagy review on page 15, or find out more at **bit.ly/4eXP7ei**

1 in 8

new mums are embarrassed to admit their true feelings surrounding perinatal mental health*

BACP NEWS

Supervision Expert Review Panel underway

To help support a review of our supervision standards we've created a Supervision Expert Review Panel formed from members who are experts in both supervision training and practice. We're committed to raising the standards of supervision and to recognise and create pathways for members who supervise.

Our new *Ethical Framework 2026* highlights the important role of supervision and the minimum standards that are needed to make sure it is both ethical and effective.

The launch of the framework makes it timely to review all aspects of supervision in terms of our monthly requirements for members at different developmental stages, supervision training and CPD and the development of new supervision accreditation schemes for supervisors and supervision training courses to help ensure that our supervision standards remain clear, relevant, proportionate and aligned with contemporary counselling and psychotherapy practice.

The panel members are meeting over a six-month period until March 2027 to review and feed back on papers. We'll update you as the review progresses.

Find out more about our Supervision Competence Framework at **bit.ly/4BsZ5y2**

*RESEARCHONLINE.LSE.AC.UK/ID/EPRINT/59885

Noticeboard



4–5%

of women develop PTSD after giving birth*

*THEO-CLARKE.ORG.UK/BIRTH-TRAUMA-REPORT



MIKE SEWELL

FROM THE CEO

Dr Phil James, Chief Executive Officer

The start of a new year always brings a moment to pause. A chance to reflect on where we've been, where we're heading and what matters most. For BACP 2027 feels particularly significant. This year marks our 50th anniversary.

For half a century counsellors and psychotherapists have come together through BACP to support one another, strengthen our profession and improve the lives of the people we serve. As well as looking back, anniversaries are an opportunity to take stock of where we are now and look ahead.

One of the privileges of my role is meeting members from across our community. At our recent Member Event I heard something that stayed with me. Again and again members spoke about BACP feeling different. More open. More willing to listen. More willing to engage in conversation, especially when the issues are difficult.

Perhaps most importantly, more willing to act on what it hears.

That doesn't mean we've got everything right. Far from it. The profession faces significant challenges. The world around us is changing, as are the needs of the people who turn to counselling and psychotherapy for support. Important questions remain about access, standards, recognition and the future shape of our profession.

But what encouraged me was not simply what was said. It was how those conversations felt. They felt like shared conversations. We are moving away from the idea of BACP as an organisation on one side and members on the other. Away from the idea that one voice speaks while everyone else listens.

Instead we are rediscovering something that has always been at the heart of our profession: meaningful progress happens through relationship, listening and dialogue. Through a willingness to stay connected, even when we see things differently.

That is what community means to me.

Being one community does not mean sameness. Nor does it mean the absence of disagreement. We will not always see every issue in the same way – and nor should we. The challenge is not to agree about everything but to learn how to belong together across difference. In that I think we discover what unites us: a commitment to the people we serve, pride in our profession and a desire to leave things better than we found them.

As we enter our 50th anniversary year that gives me real confidence. Not because the work is finished but because I see those qualities every day across our community: professionalism, care, curiosity, challenge, generosity and commitment.

The future of BACP is not something that will happen to us. It is something we are creating together.

BACP NEWS

Supervisors Event picks up Memcom award

Our 2025 Supervisors Event has won a 2026 Memcom Excellence Award in the Best Non-Celebratory Event (costing less than £100k) category following its nomination earlier this year. The sold-out event, held in Leeds in September 2025, was created specifically for clinical supervisors, bringing colleagues together for a programme of learning, reflection and connection.

The event was developed in response to a gap in opportunities dedicated specifically to clinical supervisors, creating a space where supervisors could come together to learn, reflect, connect and feel valued. BACP member Satinder Panesar, who was part of the working group that organised the event, described it as a 'truly phenomenal event', adding that it created something the profession really needed.

The programme brought together expert speakers and supervisors from across the profession, providing dedicated time and space to learn, share ideas and connect with others working in clinical supervision.

Rebecca Gibson, Member Resources Manager, said: 'This award is a fantastic recognition of the passion, creativity and hard work that goes into creating and delivering the event. A huge thank you and congratulations to everyone involved – the award belongs to the whole team. The evening was a lovely way to celebrate what we do and why we do it.'

Read more at **bacp.co.uk/news/news-from-bacp/2026/28-september-supervisors-event-wins-memcom-excellence-award**

DIARY DATES

bacp.co.uk/events

2 DECEMBER

ONLINE

Working with healthcare

Working with healthcare in challenging environments



RIDO/SHUTTERSTOCK

7 JANUARY 2027

ONLINE

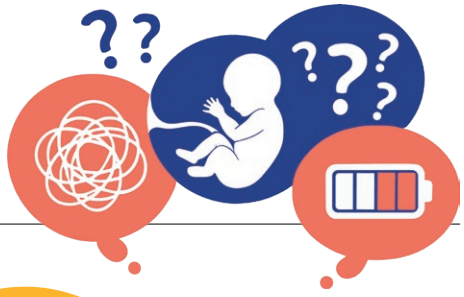
How to help clients with their anger – a therapist's toolkit

Professional development day



YUGANOV KONSTANTIN/SHUTTERSTOCK

1 in 3 women find some aspects of their birth experience traumatic*



*THEO-CLARKE.ORG.UK/BIRTH-TRAUMA-REPORT

Workplace counselling in the real world: navigating complexity, boundaries and sustainable working lives

Join us on **Wednesday 13 January 2027** for an opportunity to critically reflect on the changing nature of workplace counselling, ethical decision-making in complex situations, and evidence-informed approaches to supporting clients in meaningful and sustainable working lives.

As clients present with increasingly complex mental health needs, workplace counsellors are often required to balance therapeutic care, ethical boundaries, contractual limitations and risk management within time-limited models of support. This event will explore the evolving challenges facing counsellors working within employee assistance programmes, occupational health settings, private practice and other workplace-funded services, and how to work safely and ethically within the limits of the support they are able to provide, including time-limited counselling models.

Delegates will explore the realities of working with complexity and risk and how professional judgment and ethical decision-making can support good practice.

Alongside these discussions the event will explore the relationship between counselling, work and wellbeing. Presentations will consider how counsellors can support clients to navigate workplace difficulties and develop agency and realistic expectations as well as recognise how different lived experiences may affect an individual's relationship with work, workplace opportunities and wellbeing outcomes.

Delegates will leave with a greater understanding of how diversity, identity and workplace context can shape therapeutic work, helping them to provide more inclusive and effective support for a broad range of clients.

Book your place at **bacp.co.uk/events/www130127-working-with-workplace-2027**

Spreading the word

Promoting our members and our profession through the media

In *Stylist* **Sarah Wheatley** and **Jenny Warwick** explored why new parents argue, while **Graham Johnston** and **Sandhya Bhattacharya** shared advice on knowing when a relationship has reached rock bottom. • **Arabella Russell** explored how growing confidence can influence women in their 30s in *Cosmopolitan*. • In *Metro* **Danielle Frake** discussed why social interactions can leave us feeling drained, while **Cate Campbell** and **Baljit Kamal** explored whether to warn a new partner about an ex. • **Amanda Macdonald** spoke to the Press Association about seasonal affective disorder. • **Paula Hall** featured in *Men's Health* on how to spot signs of problematic porn use. • In *Psychologies* **Megan Baldry** discussed becoming a parent and intrusive thoughts. • **Lisa Bruton** and **Indira Chima** explored healthy relationship patterns in the *iPaper*. • **Rahi Popat** spoke to BBC News about stress and teeth grinding. • **Donna Gibson** discussed pet bereavement on ITV Anglia. • In *HuffPost UK* **Armele Philpotts** shared advice on welcoming a child's partner, while **Susie Pinchin** explained why children may release pent-up emotions after school. • **Kamalyn Kaur** spoke to *The Guardian* about the pressures some people feel about hosting friends at home.



SANDHYA BHATTACHARYA



RAHI POPAT



AMANDA MACDONALD

12 JANUARY 2027
ONLINE

Working with context, normativity/diversity, and EDI embedded in the self, practice and the curriculum

Professional development day



RAWPIXEL.COM/SHUTTERSTOCK

13 JANUARY 2027
ONLINE

Working with workplace

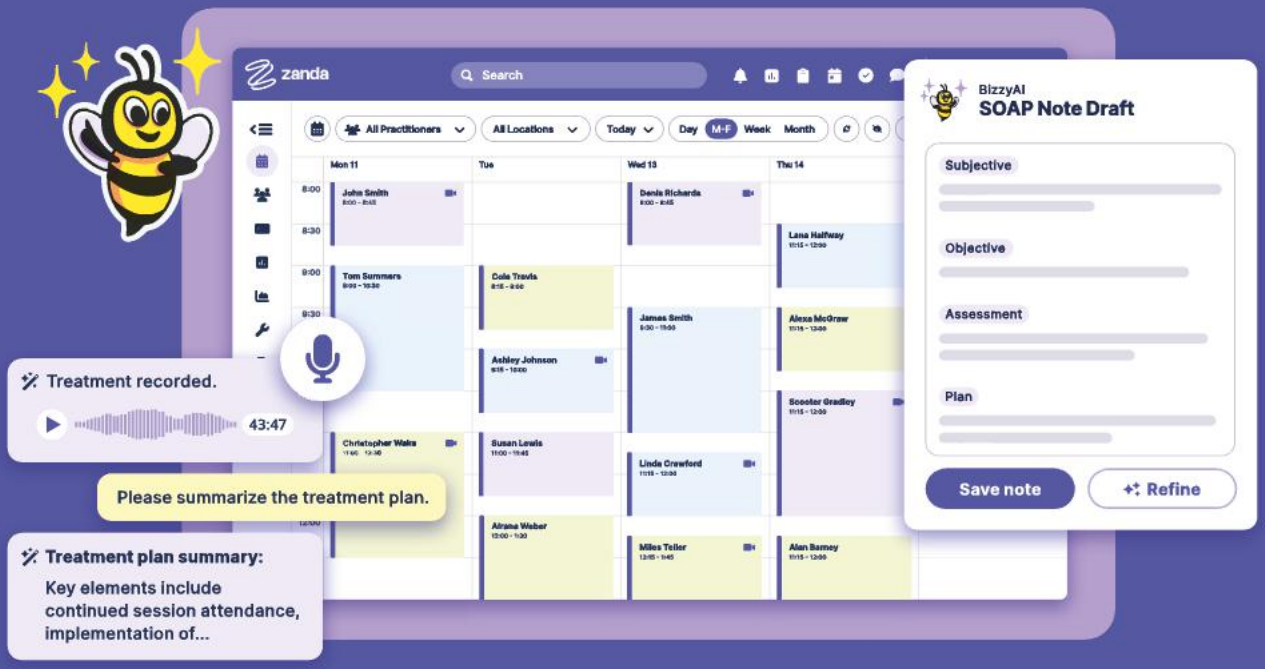
Workplace counselling in the real world



ANTONIO GUILLEM/SHUTTERSTOCK

Your admin? Already done.

Zanda is practice management software with AI inside.
More time for clients. More time for you.



BACP members get 50% off (incl. AI Scribe) for 6 months + 500 SMS credits*

Get started at **zandahealth.com/BACP**

★★★★½

4.7 from 1,000+ practitioners

Zanda has reduced my workload by 15-20%. That time back is massive."

— **Mark L.** Private Practice Owner



zanda

*New customers only



53% of women who experienced birth trauma are less likely to have children in the future*

*THEO-CLARKE.ORG.UK/BIRTH-TRAUMA-REPORT

YOUR QUESTIONS ANSWERED

50 years of changing lives together



Adam Pollard, Head of Marketing and Engagement

As BACP prepares to celebrate its 50th anniversary in 2027, we're looking back on five decades of changing lives through counselling and psychotherapy – and we'd love you to be part of the story.

How can I get involved? Share your story, photo or video about the moments, achievements and experiences that have shaped your journey as a member.

What kinds of stories are you looking for? We're keen to hear what you're most proud of, your hopes for the future of the profession, and the impact BACP and its members have made on individuals, communities and society.

Is there a deadline for sharing my story? The campaign is running from now and throughout 2027, so stories may be submitted at any point during that period.

How can I share my story? Visit **50yearsofbacp.co.uk** to submit your story via our form, or email **50years@bacp.co.uk** with any questions.



BACP EVENTS

Students Conference 2027

Taking place on **Saturday 20 February 2027** this hybrid conference is designed to support students transitioning from training to professional practice.

This popular event takes place every two years and plays a key role in supporting students on their pathway to practice, through shared learning, lived experience and practical insight.

The programme will explore current challenges facing the profession and provide you with the tools and perspectives to help you to build confidence.

Josephine Bey will be joining us as a keynote speaker with a session on 'Ticking all the boxes: race, neurodivergence and finding your place in a profession that wasn't built for you'. This session will aim to challenge you to think critically about representation, access and belonging, and inspire you to become a practitioner who doesn't just enter the profession but changes it. We are also pleased to welcome David Weaver who will deliver 'The counsellor and psychotherapist you are becoming: confidence, authenticity and growth in an uncertain world'. Drawing on his experience as a former BACP President and Trustee, alongside his work in leadership, communities and social justice, David will explore the journey from student to practitioner, reflecting on how confidence, authenticity and professional identity develop over time.

Book your place to join us either in Birmingham or online at **bacp.co.uk/events/sc2027-students-conference-2027**

15 JANUARY 2027
LONDON

Erotic transference

Professional development day



PEOPLEIMAGES/SHUTTERSTOCK

21 JANUARY 2027
ONLINE

Working ethically with risk in counselling

Professional development day



JACOB LUND/SHUTTERSTOCK

MARSH

Get your free, no obligation quote at
www.marshcommercial.co.uk/probodies
or call 0333 920 8114

Breathe easy with Oxygen™

Tailored business insurance for talking therapists and wellbeing professionals

- Award-winning customer service[1]
- 20% discount for BACP members[2]
- Same transparent pricing for new and existing customers
- No admin fees for policy changes or documents
- No excess on core business insurance[3]



This is a marketing communication.

Oxygen is a trading name of Marsh Ltd. Marsh Ltd is authorised and regulated by the Financial Conduct Authority for General Insurance Distribution and Credit Broking (Firm Reference No. 307511). Copyright © 2026 Marsh Ltd. Registered in England and Wales Number: 1507274, Registered office: 1 Tower Place West, Tower Place, London EC3R 5BU. All rights reserved.

1 https://www.feefo.com/en-GB/reviews/oxygen.

2 The discount applies to the insurer premium and is a minimum of 20%, however does not apply to the insurance broker admin fee.

3 No excess applies to the core therapists and wellbeing insurance (public liability, professional indemnity, employers liability, and directors and officers liability); however, for any additional insurance taken out, certain excess may apply. Please contact us for details.

MEMBER SPOTLIGHT

Perinatal mental health care

Dr Miriam Donaghy, who won two awards in BACP's Member Awards in October 2026, offers insight into her charity and life's work.



Dr Miriam Donaghy, Founder and CEO of MumsAid

What brought you to this line of work?
I realised that the transition to motherhood is something all women should be able to get support with if they need to when I had my first child in 1998, and so when I returned to Greenwich Mind after maternity leave I set up a weekly postnatal support group. It was there that I learned about the extent of unmet need for maternal mental health support, how inequality shaped new mums' experience, and also determined who could access help. Developing accessible services that aimed to remove the barriers became my driving passion – and led to me founding MumsAid in 2012.

What are you most proud of? I'm proud of the difference we've made to so many women and their families, particularly through YoungMumsAid, our service for mothers under 22. This reflects my long-standing focus on reaching mothers least likely to get support with their mental health. Many of the young women we see have lived through significant trauma and adversity, which can include abuse or difficult experiences in care. It's wonderful to witness how, with support, they can transform their own lives and give their babies a better start than they had themselves.

How has the landscape changed, and where is more attention needed?
In the late 1990s the term 'perinatal mental health' was rarely heard; at best there was some awareness of postnatal depression. Now there are specialist NHS teams and much more policy attention. The MBRRACE-UK reports have shown that mental health is a leading cause of maternal death, and the parliamentary Birth Trauma Inquiry has finally brought birth trauma into the open. But NHS thresholds remain extremely high, and the underfunded voluntary sector picks up much of the need. Young mothers and neurodivergent mothers are still falling through the gaps.

What is the next step for you? At MumsAid we're developing counselling for neurodivergent mothers and a systems change programme building on YoungMumsAid. I'm also writing a book on the STARK model – the non-pathologising approach that underpins all our work with mothers.

Is there any wisdom you'd like to pass down to readers? If you want to build something you believe in you don't need to wait until everything feels ready, but do be prepared for a rollercoaster of ups and downs. With clients, remember that new mothers are not a homogeneous group; to be effective, support needs to be tailored to each woman's needs. And if you're a new mum, asking for support isn't failure. It's one of the strongest things you can do for yourself and your baby.

Read more about Miriam and the Member Awards on page 52.



FROM THE PRESIDENT

Professor Lynne Gabriel OBE

Two years ago, in December 2024, I asked in this column: 'Are we fit for purpose now, and for moving into the future?' At that point BACP's Board, staff and membership were navigating significant and sustained turbulence. It was clear that the organisation could not continue as it was. Change was not only necessary but urgent.

What followed was a powerful period of transformation. The concept of liminality captures something of that lived experience: a threshold space, unsettling yet generative, where old structures loosen and new possibilities begin to take shape. Through concerted effort, courage and a resolute focus on positive change, the seeds planted during those difficult months began to take root. Some flourished quickly; others required patience. But across 2024 to 2025 I witnessed, and was actively part of, deliberate, thoughtful shifts that strengthened collaboration and rebuilt trust across our membership body.

My own anxiety during 2023 to 2024 was real. The potential for destructive processes felt ever present. Yet what emerged across 2024 to 2025 was a collective movement away from siloed thinking towards relational, dialogical engagement. Staff, Board, members, volunteers, partners – all leaning in, all contributing to a more connected and productive Association, all proud and honoured to be connected.

This spirit was palpable at the BACP Member Event on 10 October 2026. A vibrant day of keynotes, presentations and roundtable dialogues it showcased the best of our community. My heartfelt thanks to our Executive Team – Dr Phil James, Dr Lisa Morrison, Ben Kay and Philippa Foster – to our Heads of Department and to the many staff, members and volunteers whose energy and commitment shaped this successful event.

We are now entering a more fertile professional landscape. A landscape where relational and dialogical ways of working are not aspirational but lived. And as we move through Samhain and the winter solstice we are reminded of the symbolic power of endings, losses and renewal. These seasonal markers invite us to reflect on resilience, community and the return of light — a metaphor for hope, growth and the capacity to begin again.

BACP is moving forward. Collectively. Deliberately. And with renewed purpose.

Ethical Framework for the Counselling Professions 2026

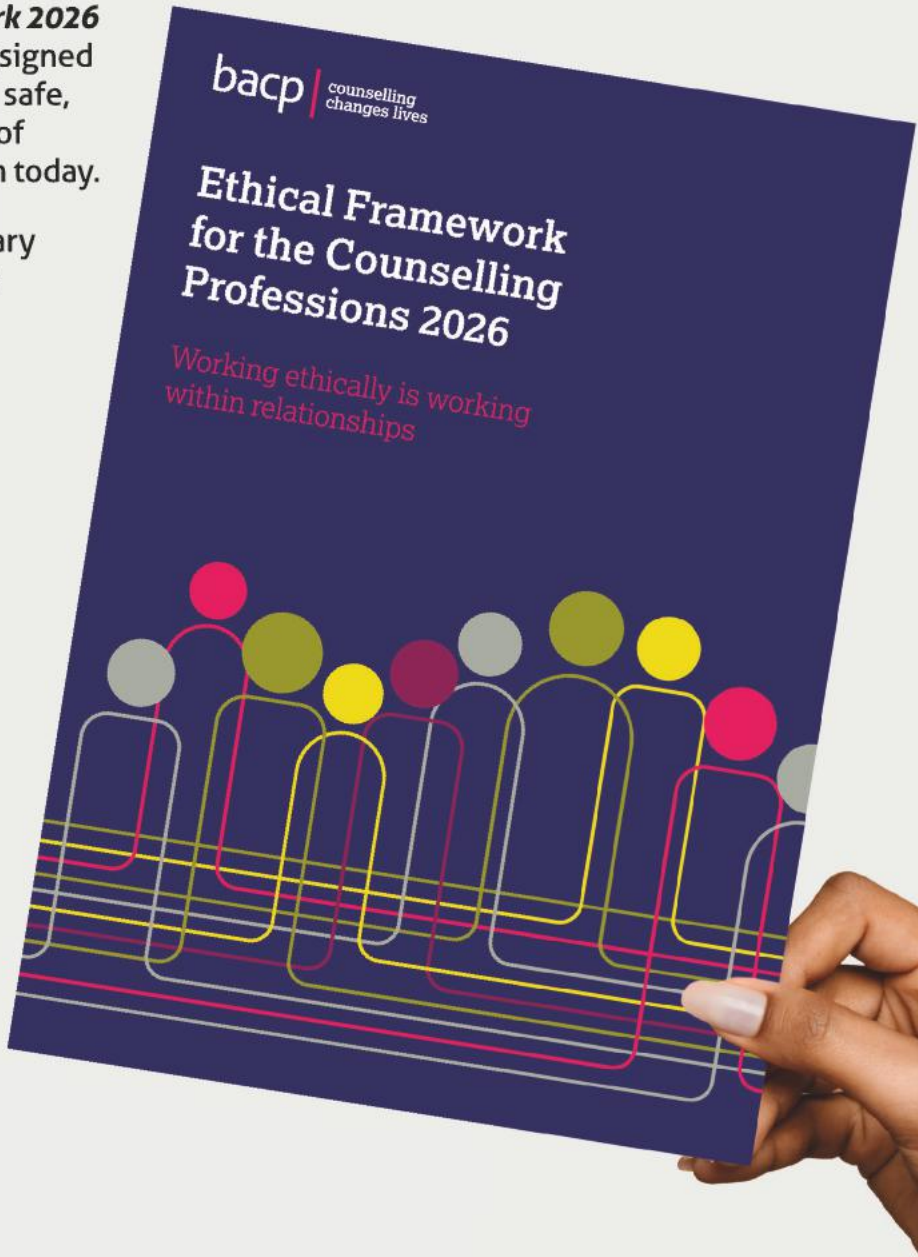
SCAN ME

Mandatory for all BACP members from Tuesday 3 November 2026

You helped shape the ***Ethical Framework 2026*** through your feedback and insights. Designed to support ethical decision-making and safe, effective practice, it reflects the needs of clients, practitioners and the profession today.

Access the framework and supplementary resources designed to help you apply it confidently in your work.

Visit our website here:
www.bacp.co.uk/ethical-framework
or scan the QR code above.



bacp | counselling changes lives

WORKING FOR YOU

Updates from BACP's Policy team

Support must not depend on diagnosis

BACP believes that waiting for a diagnosis shouldn't mean waiting for mental health support. We support Professor Peter Fonagy's call, in his independent review published in October, for a more flexible, needs-led approach, where people can get help based on what they're experiencing rather than having to wait for a diagnosis. This would be a fundamental and essential change in the Government's approach to mental health support.

The Government has responded to the review with a commitment to earlier support, earlier access to help, and prevention and early intervention.

The review highlights growing mental health needs, particularly among children and young people, and the pressure this is placing on existing services. It calls for earlier intervention and better co-ordination between services, helping people access appropriate support before their difficulties escalate.

Dr Lisa Morrison, BACP Chief Regulation and Standards Officer, said: 'For counselling and psychotherapy this may be one of the most significant policy reviews of the decade. It's put people's needs, rather than diagnosis, at the heart of the conversation. A diagnosis can be valuable but it must not be the primary gateway to getting timely access to mental health support.

'People shouldn't have to wait months or even years for an assessment before they can get help. Early access to psychological support can make a real difference, helping people get support while they're struggling rather than waiting until their difficulties become more severe.

'It's essential that we create the pathways and opportunities needed to expand the mental health workforce so people can get the support they need sooner. We have a skilled workforce with additional capacity to help – if only the opportunities within the NHS existed.'

Professor Fonagy's review recognises that diagnosis remains important, particularly where it helps people understand their experiences or access specific support. But it also highlights the importance of looking at someone's quality of life rather than relying on diagnosis alone. This is particularly important when people are facing long waits for assessment. In our member survey earlier this year 97% of therapists said long waits for diagnosis is a barrier for their clients, while 75% cited the cost of private assessment.

Counselling and psychotherapy can give people access to psychological support while they wait for assessment or where a diagnosis isn't the starting point.

We've previously highlighted that trained counsellors and psychotherapists could provide around 100,000 hours of extra therapeutic time a week to the NHS. Much of therapy already being provided takes place outside the NHS and isn't captured in official service data. This means the contribution of the existing workforce may not be fully reflected in planning for mental health services.

Lisa continued: 'This is an opportunity to make better use of the counselling and psychotherapy workforce and give people more choice about the support they receive. There are skilled professionals ready to do more, and we need to make sure their expertise is utilised.

'The forthcoming Mental Health Strategy is the Government's opportunity to act on the findings of this groundbreaking report, address the mental health crisis and deliver services that truly meet people's needs. It is important that BACP is part of key conversations with the Minister, Alison McGovern MP, to enable more counsellors and psychotherapists to support the nation's mental health.'

Read more at **bit.ly/4A0fAQO**

Third sector report and campaign

Third sector counselling services are supporting thousands of people every day, preventing mental health problems from escalating and reducing pressure on NHS services. Yet the organisations delivering this essential support are facing unprecedented financial pressures.

The report from our recent third sector counselling services survey shows a sector under increasing strain. Community-based counselling services are receiving growing numbers of referrals from the NHS while struggling with short-term, insecure funding that threatens their future.

You can support our campaign by contacting your elected parliamentary representatives, to help ensure that decision-makers across the UK better understand the vital role played by third sector counselling services and the urgent need for long-term investment.

Using our online campaign tool you can quickly find your elected representatives and send them a message together with a copy of our report, calling for action. The campaign tool will also use data from BACP's workforce mapping survey to show the capacity of qualified BACP members working in the third sector, which could be used to help address growing need if investment was forthcoming.

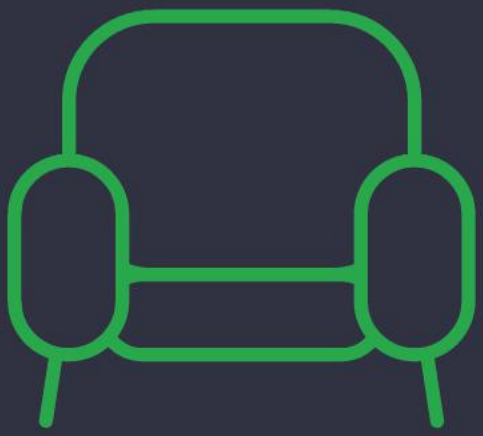
Read more and download the report at **bit.ly/4jK7qXJ**

PROFESSIONAL CONDUCT

- **BACP's Public Protection Committee holds delegated responsibility for the public protection processes of the Register. You can find out more about the Committee and its work at bacp.co.uk/about-us/protecting-the-public/ bacp-register/governance-of-the-bacp-register**
- **BACP's Professional Conduct Notices can be found at bacp.co.uk/professional-conduct-notices**

for counsellors

by counsellors, for counsellors.



- Clinical wills
- Websites
- Payments
- Appointments
- Placements
- Secure notes
- Contracts
- Supervision
- Wellbeing
- CPD
- Policies
- Safeguarding

We've sat in your chair.

So we built the practice platform we wished we'd had. Everything a counsellor juggles, from session notes to clinical wills, in one calm place.

Free until you qualify

Students track placement hours, supervision and contracts at no cost.

£0 to start in practice*

Pricing that grows with you. Professional plan £28.50 a month.

Serious about data care

UK hosted, encrypted, and with compliance that's built in, not bolted on.

Start free today.

forcounsellors.com

*Starter plan: 1.5% ForCounsellors fee on card payments, plus Stripe's processing fee (1.5% + 20p per UK card transaction). Professional has no ForCounsellors fee.

RESEARCH DIGEST

To mark National Grief Awareness Week on 2-8 December, this issue presents research on working with grief.

1 How to make grief therapy work

THE STUDY: The authors explored how emotion-focused therapy's empty-chair task can support those with complicated grief. The study included video recordings of 12 therapy cases, seven of which were rated as successful and five as unsuccessful on the basis of post-treatment grief score improvement. These were used to analyse client processes and therapist interventions related to therapeutic change in grief counselling.
THE FINDINGS: Successful cases involved clients experiencing core emotional pain, identifying unmet needs and accessing adaptive emotions, which supported them to reconfigure their relationship with the deceased and reorient themselves in life. Unsuccessful cases showed difficulties in engaging with the imagined deceased, accessing compassion and tolerating painful emotions.
THE TAKEAWAY: The empty-chair task may offer an experiential approach to complicated grief but requires modifications depending on the experiences of loss and relationship with the deceased. Therapist attention to clients' difficulties with compassion, self-criticism and connection may be important for progress.
READ MORE: Gamoneda J, Jódar R, Timulak L. Emotion-focused therapy's empty-chair task for complicated grief: how to make it work. **onlinelibrary.wiley.com/doi/10.1002/capr.70084**

2 Working with pet loss grief

THE STUDY: Pet loss grief is insufficiently understood and underestimated. This study examined how people navigate this form of bereavement through exploring the experience of pet loss grief in seven online support groups.
THE FINDINGS: Participants expressed deep emotional reactions and experienced profound shifts in daily routines, identity and meaning-making following the death of their pets. This highlights the importance of recognising and validating pet bereavement as a significant yet often overlooked experience.
THE TAKEAWAY: There is a need to integrate specific interventions within mental health services and veterinary clinics for this type of grief. This study highlights the importance of validation and mutual support, demonstrating that the group dynamics could facilitate the processing of grief where it feels acknowledged.
READ MORE: Alves AFR, Matioli CAP, Scorsolini-Comin F. Experiencing grief over the death of a pet: a phenomenological study in an online support group. **onlinelibrary.wiley.com/doi/10.1002/capr.70060**

3 Bereavement counselling in the initial phases of loss

THE STUDY: The authors undertook semi-structured interviews with six therapists who provide bereavement counselling, to explore their experiences of offering support to clients during the early stages of loss.
THE FINDINGS: Key themes included normalising the client's grief experience, respecting client autonomy in navigating their grief process, providing psychoeducation about grief, assessing risk, engaging in active listening and providing a safe space that can support the client's emotional release.
THE TAKEAWAY: A therapeutic approach that prioritises client autonomy and individuality, acknowledges cultural considerations and relies on empathic and non-judgmental listening may facilitate coping during the early stages of loss and prevent escalation into prolonged grief at a later stage.
READ MORE: Kiełkiewicz K, Mackey AM. Exploring grief: an in-depth analysis of bereavement counseling in the initial phases of loss. **researchgate.net/publication/398927311_Exploring_Grief_An_In-Depth_Analysis_of_Bereavement_Counseling_in_The_Initial_Phases_of_Loss**

MY RESEARCH



Eleanor Warman
Senior Lecturer

Eleanor Warman is a senior lecturer on the MA in Clinical Counselling at the University of Chester. She is a WELS Faculty PhD Studentship recipient at The Open University. She holds a small private counselling and supervision practice and is one of the authors in our author bank for writing good practice resources.

My PhD research looks at the ways in which the textiles of the deceased, usually clothes, may facilitate ongoing connection following death. My research has a specific focus on refashioning, where textiles are deconstructed and remade into an object such as a quilt, cushion, toy or new garment. I became interested in textiles and bereavement during my decade working as a hospice counsellor. Clients regularly described dealing with the clothes left behind following a death; these experiences were challenging, meaningful and rarely shared beyond the counselling room for fear of judgment. During this time I was making baby quilts out of family clothing. I felt the weight of responsibility as I cut through familiar, well-worn items, and wondered how the experience of cutting irreplaceable garments would be for bereaved clients. I began looking for more information and was surprised to find little has been written on refashioning in grief; thus it became a clear choice of topic for my PhD.

My qualitative research will explore the lived experiences of people who have engaged in refashioning following a death. My literature review revealed this process can be meaningful, cathartic and full of opportunity for continuing bonds, whether undertaking the entire process personally (cutting, designing, sewing) or outsourcing the making to a professional sewist. Clothing can come to embody the deceased, retaining their scent, shape or traces of a life lived through the wear and tear. For some this is confronting. Intact and refashioned textiles can convey the deceased's identity and values, extend their social presence, invite meaning-making and burst through cultural silence around grief.

It is my hope this project will illuminate how textiles may facilitate ongoing connection and aid coping in grief, and will inform therapeutic exploration around meaningful ways to memorialise the deceased.

What's on

Mental wellbeing in the arts and media

ART



ANA MENDIETA, *IMÁGEN DE YÁGUL* 1973 © THE ESTATE OF ANA MENDIETA COLLECTION, LLC. LICENSED BY ARTIST RIGHTS SOCIETY (ARS), NEW YORK/DACS, 2026/COURTESY MARIAN GOODMAN GALLERY AND ALISON JACQUES, LONDON

Ana Mendieta

A woman lies in a woman-shaped hole in the ground, foamy white flowers bursting up through her body: images like these surprise the viewer throughout this retrospective into the work of multidisciplinary artist Ana Mendieta and her passion for plants, animals and earth. Shakespearean characters mingle with Santeria goddesses and scenes from Cuba, her home country. Mendieta's show also contains some shocks: violence was a persistent theme in her career, emerging in works like *Rape Scene*. Having died young, she is still mourned by many – but this exhibition puts her death to one side. Instead curators have celebrated her life and brought the work towards a new generation of fans. Until 17 January at Tate Modern.



QUALEASHA WOOD, *A FLAW IN MY CODE*, 2025. COURTESY THE ARTIST AND PIPPY HOULDSWORTH GALLERY, LONDON

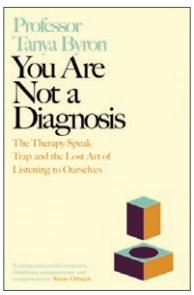
EXHIBITION

Compulsory Continuous Connectedness

This new group show takes inspiration from the alliterative term in its title. It describes the experience of being unable to log off, and the feelings of overwhelm and isolation that follow. A major installation in the second half of the exhibition is based on emerging research into the 'default mode network', the name for neural connections that activate during wakeful rest, daydreaming and wool-gathering. Artists Caroline Sinders and Romy Gad el Rab warn that compulsory continuous connectedness directly threatens the life of our minds, down to our very biology. As global policy makers and legislators begin to react to the risks of being overconnected, artists make a persuasive argument in favour of protecting our capacity to reflect. Compulsory Continuous Connectedness: rest in a networked world is on until 9 January at Focal Point Gallery, Southend-on-Sea.

Rediscovering our humanity

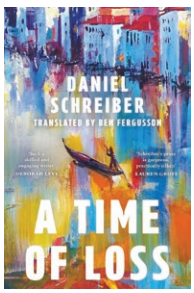
BOOKS



Professor Tanya Byron's latest book *You Are Not a Diagnosis* makes a persuasive argument for breaking free from therapy speak in favour of using our own language to describe what's going on inside us during our rich emotional lives. Drawing on years of practice, she's a refreshing voice on trends that aren't going anywhere. (Out now, Penguin)



Tim Winton's memoir *Songs from the Firefront* grapples with trauma, loss and the challenges of raising a family as a working-class writer. But its greatest strength is a thread that grapples with the climate crisis. His writing finds much organic beauty in the face of cataclysmic change. (Out now, Picador)



Daniel Schreiber's *Alone* was a landmark reflection on living life without a partner. His concise new book *A Time of Loss* reflects on losing his father, the burnout he endured afterwards and the connection between his personal grief and collective social losses. An unmissable meditation for the dark months. (Out now, Sceptre)

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



FILM

Elsinore

Elsinore tells the story of actor Ian Charleson (played by Andrew Scott) who used the last months of his life to play Hamlet at the National Theatre. Seriously ill with AIDS, Charleson's dedication to his work became legend among British actors, with Sir Ian McKellen handing his Actor of the Year award to him following the final performance. His legacy persists today in the provision of a day centre offering counselling after HIV diagnosis. Charleson's decisions speak not only to the power of creativity to help us through the darkest periods of life but also to the courage it takes to become more visible and vulnerable in the face of social stigma. Out on general release.



PHOTOS BY ANTHONY DICKENSON/ANTHONY DICKENSON. © 2026. FOCUS FEATURES

PODCASTS







Changes afoot

In podcast series *Understand*, Nathan Filer leads a new season, *All Kinds of Minds*, about neurodivergence: how we describe, understand and assess it, what diagnosis means, and how our world is changing to fit it. On BBC Sounds.
bbc.co.uk/programmes/m001dwr7

Black Box is back for a season called *The Chatbots*. This *Guardian* investigation asks how AI psychosis is affecting those who rely on virtual companions. With over a billion of us using AI, the race is on for global prevention strategies. On *The Guardian* online.
theguardian.com/podcasts

Weekly podcast *The Happiness Lab* looks at the evidence that counters common misconceptions about mental health. As 2027 approaches and we think about resolutions, listen back to Dr Santos' personal piece about how she managed to set up a sabbatical year.
drlauriesantos.com

DOCUMENTARY

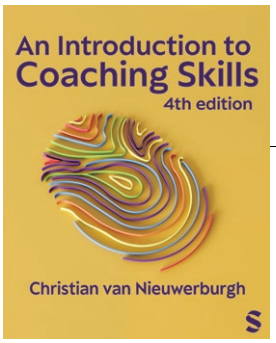


Climate in Therapy

Seven climate scientists gather in an ugly New Jersey hotel, but this is no conference. Group analyst Richard Beck facilitates a two-day process that reveals that the experts are just as worried as the rest of us. This documentary follows an experience that is by turns moving, frustrating and funny. Scientists grapple with Beck's interventions to draw their feelings or try 'empty chair' exercises and as the cameras roll we see the fear of vulnerability play out in real time. But the participants' generous decision to allow their personal experience to be recorded – however uncomfortable – highlights how urgent the subject matter has become, for us and for them. Whether you're a group practitioner or not, this fascinating film is well worth a watch. Screenings on request via
climateintherapy.com

Bookshelf

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



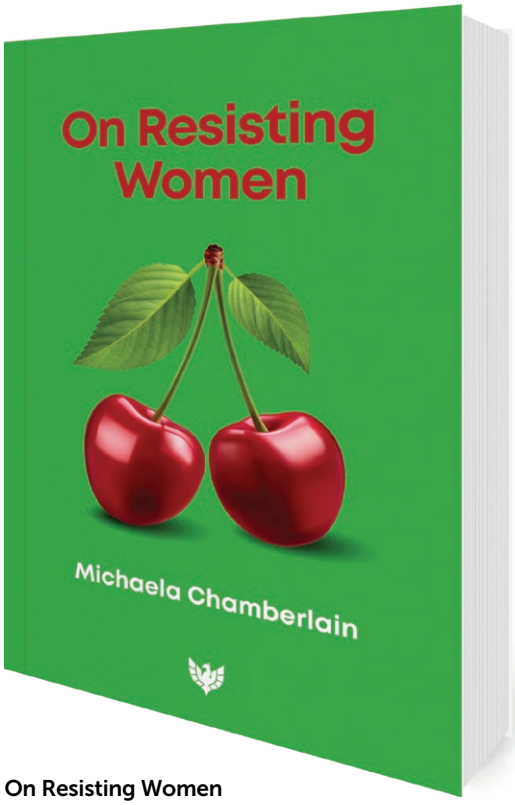
An Introduction to Coaching Skills (4th edition)
Christian van Nieuwerburgh (Sage)

This book is aimed at trainee and novice coaches, who often have no background in counselling, and much of the content reflects that. However, it is also a great foundation for therapists who are considering moving into coaching. It helps us appreciate the commonalities between counselling and coaching and recognise that we already possess many of the skills and attributes required to become a coach. The less familiar content, on coaching process, the emphasis on goals and links with the positive psychology movement, helps us to appreciate the differences between therapy and coaching, and provides a useful starting point for developing a coaching mindset.

An unusual and valuable aspect of the book is the links to video clips of the author's real coaching conversations. These are a highly informative resource and a helpful insight into coaching practice. The author uses straightforward language and a clear structure, and I particularly liked the clear signposting to external references, which provide a map for exploring more widely in the coaching profession.

I would have liked to have had access to this book during my coaching training, and I highly recommend it for the coaching-curious, trainees and trainers. For seasoned coaches, it's a valuable aide-mémoire and resource map.

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



On Resisting Women
Michaela Chamberlain (Karnac)

This book, and its predecessor *Misogyny in Psychoanalysis* (2022), reflect the author's observations of institutionalised misogyny in our field. Beginning with Freud, as many of us did during training, Chamberlain points out that theories of psychosexual development focus on 'the privilege of the penis', ignoring menstruation, pregnancy and birth. Women are described as losing a penis and gaining not a vagina or clitoris but a baby. Reflecting on her previous book she says that her 'invitation' into a conversation about misogyny was too polite. In this book she's insisting on it.

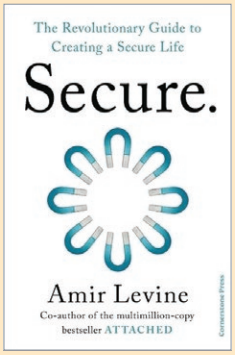
Chamberlain claims that psychoanalysis has a 'paternal preoccupation' that attributes all the world's ills to bad mothering. She criticises the persistent teaching of and reverence for the likes of Bowlby and Winnicott, asserting they are not only out of date – what was 'good enough' then is not 'good enough' now – but also culturally biased, cisgendered, heteronormative and misogynistic. Klein's theories too are criticised for their focus on good breast/bad breast as the giver or withholder of bliss, with a complete absence of the mother's subjective experience.

Chamberlain likens misogyny to a 'fascist state of mind' and 'omittive genocide' whereby the life, work and culture of women is intentionally excluded. A compelling read and a reminder that, in psychoanalysis and more widely, we could and should do better.

Jeanine Connor MBACP, psychodynamic psychotherapist and supervisor

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

'Reflecting on her previous book Chamberlain says her "invitation" into a conversation about misogyny was too polite. In this book she's insisting on it' **Jeanine Connor**



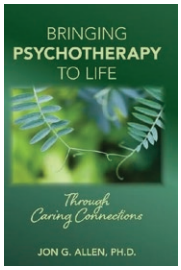
Secure: the revolutionary guide to creating a secure life
Amir Levine (Penguin)

This follow-up to the international bestseller *Attached* – the book credited with bringing attachment styles into the mainstream – sets out to challenge the idea that our attachment style is fixed for life. Levine's central argument is based on the (not new) theory that healthy relationships help us become more consistently secure.

It's a pet peeve of mine that books feel compelled to squeeze their ideas into neat acronyms, and this one is no exception. Levine argues that security develops through relationships that are 'CARRP': consistent, available, responsive, reliable and predictable.

That aside, there is much to like. Levine offers accessible, non-patronising explanations of both attachment theory and neuroscience, perhaps unsurprisingly given that he is a professor of clinical psychiatry at Columbia University. His medical rather than therapeutic background may also help explain one ethically troubling case study. A 'naturally talented' therapist, 'Deborah', is praised for helping a young client develop secure attachment by encouraging him to call whenever he had difficult feelings and offering to go jogging with him. The apparent absence of discussion about boundaries or dependency is concerning. For that reason, while this is an engaging and informative read, I would hesitate to recommend it to clients.

Sally Brown MBACP, therapist, supervisor and coach



Bringing Psychotherapy to Life Through Caring Connections
Jon G Allen (American Psychiatric Association)

As a passionate proponent of 'plain old therapy', clinical psychologist and researcher Jon Allen is troubled by the proliferation of branded therapies – especially prescriptive methods that proclaim their 'evidence base' and overemphasise cognition and the brain. In this culmination of a 50-year career specialising in trauma and attachment, Allen argues we should prioritise the personal and interpersonal development of therapists themselves. His aim is the restoration of care – which has been marginalised, devalued and unhelpfully gendered – to the centre of our work.

This isn't passed off as an easy project. Our individual capacity for caring depends on the social and political context, yet contemporary culture overvalues autonomy. While our best regulatory 'tool' is a trustworthy caring relationship, not all clients can access this. Some of our most difficult and vital work may involve cultivating a responsiveness to care in clients with histories of abuse and neglect.

I was captivated by the snippets of everyday exchanges with Allen's own clients – profound in their simplicity – and wished for more of these to balance the extensive quotations. This book successfully connects the dots between philosophy, religion and science, clinical concepts and common sense. Yet in taking us on such a thorough browse of his bookshelves, Allen ironically underestimates the importance of the reader's direct connection with himself.

Isobel Todd MBACP (Accred), psychodynamic psychotherapist and supervisor



Mystery, Hope and Reason: faith in the therapy room
Kate Graham (Karnac)

I welcome this book, which is a thoughtful addition to a profession that might do well to engage more with considerations around faith. An area easily skipped over, Graham makes compelling arguments for why we need to be curious about therapy and faith; how they come together, and how we might converse with our clients about such matters.

My favourite chapter is titled 'An elusive relationship: is hope friend or foe?' Here the author posits that the challenge for us as therapists 'isn't about whether we hold hope but how we hold hope'. This pushes us to ask uncomfortable but necessary questions around not just our clients' faith, but also our own personal beliefs, such as how hope fits with our world views and how we cope with despair and hopelessness.

There are useful practical suggestions on how we might go about broaching the subject of faith with clients in a normalised, relational way. Plus, the text is enhanced by reflective questions posed at the end of each chapter, encouraging the reader to think more deeply by applying the material directly to themselves and their practice.

The prose did not always draw me in as much as I might have liked it to, but nevertheless this is a book on a crucial topic that can't help but make you think.

Caz Binstead, MBACP, integrative therapist, supervisor and author



Keeping score

Ed Harkness unpacks the latest backlash against our common understanding of trauma

For more than a decade *The Body Keeps the Score* has helped shape how therapists – and the wider public – think and talk about trauma. Bessel van der Kolk's bestselling book popularised the idea that traumatic experience can affect the body as much as the mind, influencing everything from emotional regulation to physical health long after the original danger has passed.

But does the body really 'keep the score'? A recent paper in *Frontiers in Systems Neuroscience* has challenged one of the most influential metaphors in contemporary trauma discourse. In 'The Body Does Not Keep the Score', researchers argue that the language used to explain trauma has increasingly been interpreted too literally, helping to fuel misconceptions about what trauma is, where it resides and what is required to heal it.[1]

Their argument is not that trauma has no bodily effects, nor that van der Kolk's work should be dismissed. Rather, they propose a different way of understanding what happens after an overwhelming experience: trauma is not 'stored' in muscles, tissues or organs waiting to be released but is maintained through patterns of prediction and adaptation within an interconnected brain-body system. As they put it: 'The body does not keep the score; the brain keeps predicting it.'[1]

How trauma is understood – and misunderstood – has significance far beyond the therapy room. The language of trauma science has moved rapidly from specialist clinical settings into social media, self-help and everyday conversation. Along the way, complex and sometimes contested ideas have often been reduced to simple certainties: that the body stores trauma, that talking is insufficient to resolve it and that an ever-expanding range of ordinary difficulties can be understood as evidence of unresolved trauma. These ideas have a direct impact on our work, shaping clients' ideas of what has happened to them and what they expect treatment to involve.

So where does the evidence currently stand? Amid a growing backlash against trauma misinformation, do we need to rethink one of the most influential clinical narratives of the past decade?

The metaphor

The idea that trauma is stored in bodily tissues has been taken too literally, says Steven Kotler, Executive Director of the Flow Research Collective, a non-profit research and training organisation studying the brain, and one of the four authors of the paper.[1]

The idea is still prevalent, however, as evident at this year's Transform Trauma Oxford conference where somatic experiencing practitioner Betsy Polatin told a packed audience that, 'There are layers of meaning that are woven into our muscles. There are memories that are etched into our bones and there are stories that are imprinted on our fascial system.'

Kotler and colleagues argue that, rather than being stored, etched or imprinted, trauma likely arises from a combination of faulty predictions, lack of neural flexibility and the feedback loop this creates within the brain-body system. They suggest that, ideally, as we experience the world, our 'neural networks continually integrate and segregate in response to context' through a process they describe as the 'healthy brain's metastable dynamics'. Trauma, they propose, represents 'a reduction in the brain's dynamic repertoire: connectivity patterns shift toward defensive configurations, and the system's capacity for flexible reconfiguration is diminished'. Their suggestion is that healing from trauma 'is not about "releasing" stored emotion but reestablishing dynamic equilibrium'.

Locus of control

Nonetheless, Kotler says, 'I want to separate what the book says and what happened to the book inside the worlds of therapists, coaches and psychologists. Those are very different things. I have certain challenges with the book itself, but I have a lot of other challenges with where it has gone in popularity. I think the reaction to it has been damaging because it has produced so much victim mindset and external locus of control.'

What is clear is that Kotler comes at trauma from a different direction: while van der Kolk's perspective was born out of treating clients with PTSD as a psychiatrist, Kotler's interest comes from his background in action sports journalism and his research into flow and peak performance.

'The example we use is that you are driving a motorcycle down a freeway and you get cut off by a car,' he says. 'You swerve around the car. Same swerve but different internal experiences of that swerve. One swerve produces trauma and could lead to PTSD. The other swerve produces flow, post-adaptive growth and all kinds of downstream benefits.' The question for Kotler is: 'What happens in that two seconds that determines whether you go towards trauma or flow?'

What Kotler is ultimately calling for is a shift in perspective rather than a different course of action. Indeed, many of the effective trauma treatments described in *The Body Keeps the Score* could be considered successful due to their capacity to restore metastability.

'The general thinking is that if you look under the hood at a lot of

ALICE MOLLON



'Healing from trauma is not about "releasing" stored emotion but reestablishing dynamic equilibrium'

Steven Kotler, research fellow at Florida Atlantic University

disparate mental health conditions, neurobiologically what they seem to have in common is a loss of network flexibility,' he says. 'It seems incredibly likely that flow restores metastability which is literally network flexibility.'

He suggests that post-traumatic growth can speed healing from trauma. 'We are learning stuff that might really help us do that. What we are saying is that this is the mechanism, and this explains why all these things are working, and it gives us a therapeutic target.'

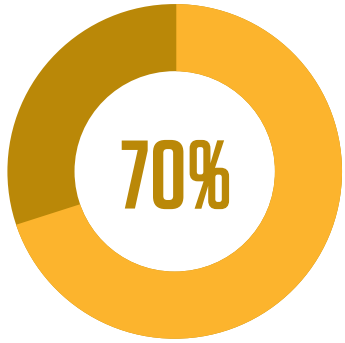
Part of Kotler's optimism is founded on interpreting some of the data used in *The Body Keeps the Score* differently. 'The central finding from the research by George Bonanno, who ran the study on the impact of 9/11, is that mostly everybody's trauma resolves naturally through the course of normal development. Yet a different story is being told in the book. If the body necessarily keeps the score, then cognitive behavioural therapy and exposure therapy would never work. Evidence shows that they can.'

This perspective aligns with the World Health Organization (WHO). According to WHO, around 70% of people globally will experience a potentially traumatic event during their lifetime, but only 5.6% will go on to develop PTSD.[2]

Restoration

Helping to restore client agency has long been a focus of trauma work. If *The Body Keeps the Score* has disseminated narratives about lifelong trauma, it might have inadvertently discouraged clients from considering their own agency for change.

But this was never the intention, says Janina Fisher, who is widely acknowledged as an international expert on the treatment of trauma and a long-time colleague of van der Kolk: 'Back in the 1990s we found that if we educated clients about trauma they did better, rather than simply talking about what had happened to them. Then we got EMDR and more clients did better.



of people globally will experience a potentially traumatic event during their lifetime, but only 5.6% will go on to develop PTSD[2]

Then we had *The Body Keeps the Score* and the somatic way of thinking and more clients did better. But there was still a group of clients who couldn't tolerate any of the above.'

Fisher now trains therapists in trauma-informed stabilisation treatment: a structured, compassionate approach for healing complex trauma that she has developed to meet the needs of this client group.

'What I found was that not all clients could go into their bodies. Many trauma survivors have a phobia of the body and are unable to be mindful of it. Working with the body requires that the client be mindful, able to collaborate with the therapist and able to follow directions. I've moved toward trauma-informed stabilisation treatment because it combines a somatic way of thinking with a trauma-informed parts model.'

What does she think about Kotler and colleagues' criticisms of van der Kolk's central metaphor? 'That's a misunderstanding and a simplification of the message,' she says.

'I don't think that Bessel really wanted to suggest that trauma is stored and you just release it. In the early brain scan research that he conducted, when volunteers remembered the traumatic event, the prefrontal cortex shut down. This meant limited access to verbal memory and expression. What became more active was the limbic system, especially the amygdala. So all these ways of working are designed to stimulate the prefrontal cortex.

'There is other brain scan research showing that increased activation in the medial prefrontal cortex is associated with reduced activity in the amygdala. Fear memories are held in the amygdala, so most of what traumatised people are dealing with is stimulation of those implicit



ALICE MOLLON

feeling memories. We want to help people develop a different relationship to their feeling memories, which I think is at the heart of *The Body Keeps the Score*.'

Embodied process

In many ways Kotler and Fisher follow the same logic: the brain is centrally important to both of their conceptions of trauma, and they agree that different people require different interventions. They both express concern that therapists are prone to misconceptions of trauma based on their cultural context, including from their training. This concern is shared by psychotherapist Graham Music – author, trainer and former Associate Clinical Director of the Tavistock Clinic's child and family department.

'There is a danger in any sort of therapy of focusing solely on content rather than how things are being said,' he says. 'How is the client sitting? What is their breath doing? Where is there muscular tension? When we get near something difficult, is an anxiety pathway triggered like a stomach ache or headache or feeling sick?'

Music uses an example from psychodynamic training, where you are expected to type up verbatim transcripts of sessions. 'That's words on a page,' he says. 'It is hard to put into words the complex, intricate dynamics between two people in a room. For years I have been trying to develop ways of working and supervising that also include the capacity to be in touch with bodies. That might mean getting the supervisee to inhabit the body posture of the client. Something can happen when a therapist feels what it might be like to inhabit the client's body. It can change things for the client without them even knowing that the therapist has done anything.'



'For years I have been trying to develop ways of working and supervising that also include the capacity to be in touch with bodies' **Graham Music, psychotherapist**

Meanwhile working with trauma can challenge much of what we have learned in therapy training. Without adequate guidance it can be difficult to know how to adapt our approach. Music considers this a limitation of *The Body Keeps the Score*.

'The backlash was waiting to happen. People loved the book; it had a profound influence. But many people don't know what to do with it. Unless you have done body psychotherapy training or some other form of somatic training, people can be scared of working with the body. So how do you hold the body in mind and the mind in the body in a psychotherapeutic session?'

In his 2022 book *Respark: igniting hope and joy after trauma and depression* (Mind-Nurturing Books), Music used a central metaphor much like van der Kolk. Reflecting on what it is about metaphor that lends itself to explorations of trauma, he describes 'the way metaphor arises from a different place. In psychoanalysis we are working with unconscious processes of free association in the client. Also, the reverie: what might pop into your mind as a therapist that may or may not be significant. But it's not just in your mind; it's also in your body. The first clue about something might be that my leg is jangling or that my breathing has got a bit shallower or that my muscles are tense. Now that's not metaphor; it's quite literal, but it comes from a different place. It's not a logical place; it's certainly not a mind place.'

Lived experience

Relating in less logical and more embodied ways may seem daunting to therapist and client alike. Engaging in this process requires mutual trust within the therapeutic relationship. Dr Susanna Alyce has carried out research with survivors of child sexual abuse and told me why trust is so important.

'There is a belief in mental health services that survivors of child sexual abuse have had their ability to trust destroyed or warped out of shape. Dentists, GPs, surgeons, therapists can often feel that they are inherently trustworthy. Survivors don't. So the logic goes that survivors trust the wrong people, or don't know how to trust at all. But all the survivors I work with say: "Well they're not trustworthy. When I try and tell them what's happened to me they do a series of things that retraumatise me. They don't want to hear; they haven't got the time; they haven't got the capacity. They look away; they don't give me respect, so I have stopped telling them."'

Trust, Alyce says, manifests both physiologically and psychologically. When working with trauma we may have to consider how to promote trust not just through what we say but also how we are.

'In my research survivors were asked: "How do you know that you trust somebody? Where do you feel it in your body?" They expressed a felt sense of the person they were with.



'There is a belief in mental health services that survivors of child sexual abuse have had their ability to trust destroyed or warped out of shape' **Dr Susanna Alyce, psychotherapist**

WriteUpp™

Allowing you to focus on what's most important.

Transform your practice with our easy to use and affordable **practice management software** for **counsellors**, and **psychotherapists.**

Scan the QR Code for a free 30 day trial, plus 50% off for 6 months



writeupp.com



'Often what you see is that the problem is located within the child or adult when it's the system that is retraumatising them' **Dr Asha Patel, clinical psychologist**

It was just who they were; it was just the feeling, or the opposite. "It was the shiny suit he wore, the way he rushed in; he didn't look me in the eyes." So there is a body language component to what is and isn't trustworthy. That wasn't broken in survivors, but the parameters were very tight.'

Like Music, Alyce warns against the dangers of therapeutic approaches being inflexible, and links back to Kotler and colleagues' criticisms of *The Body Keeps the Score*.

'I don't think the phrase "the body keeps the score" was ever meant to be accurate to the neurobiology of how the human organism stores or processes trauma. I think it highlighted that trauma is physiological as much as it is mental. For me that's the crucial thing about trauma. If you are approaching it simply from a neuroscience perspective you might miss the opportunity for the survivor to heal because that is an embodied process. If you only look at it through the point of view of what's happening in the mind you're missing a huge amount that you need to help somebody process trauma.'

Systemic response

Alyce's research highlights how not only therapists but services themselves can inadvertently perpetuate rather than accommodate trauma. Clients who have faced adverse life experiences may find engaging with services retraumatising. Dr Asha Patel founded Innovating Minds, an award-winning social enterprise, to help tackle these kinds of systemic issues.

'Not every child needs therapy. Frontline practitioners can provide that support. Our model is around upskilling frontline practitioners who work with children and families – so health workers, people in family hubs, schools, who are not necessarily clinically trained – and giving them access to evidence-based interventions. Children can then access help and support from people they already know and trust, in spaces where they already feel safe. This model means that there is no wrong front door and you don't have to meet a threshold via assessment. It also means people aren't digging around in children's histories or getting them to relive their trauma.'

Patel's work is based on her vision for a trauma-informed society, promoting access to help when needed and with the appropriate support systems in place.

'Often what you see is that the problem is located within the child or adult when it's the system that is retraumatising them. If we change the system and make it supportive for everybody, regardless of whether they have trauma or not, it benefits everybody, including the staff.'

Innovating Minds' therapeutic resources are accessible and easy to understand. 'The important part is how to simplify what the trauma-informed practices are saying so that it lands and influences practice,' Patel says. 'Currently a lot of training raises awareness but hasn't translated that into practice. I think that is the next biggest hurdle. We have become more trauma aware, but how do we become more trauma informed within our practice so that families and children start to feel the difference?'

Structural change

Ton Mazzone, the filmmaker behind recent documentary *Traumality*, shares this vision for change at a structural level. In his documentary he details his own lived experience of trauma. 'When I first sought help for my mental health the questions they asked were about the last two weeks of my life. I was given a diagnosis and a pill and there was no check-in. I struggled for so long and had to go out looking for the answers. I feel like the doctors should have known that past experiences shape how we react to the world. I should have been taught this at school. Just some psychoeducation would have been a massive help in itself. And they could do that.'

He hopes that his film will play a part in making structural change happen. 'I wanted to create the resource I wish I had stumbled across – a resource that healthcare professionals and schools could learn from. Already I'm having conversations with schools and not-for-profit organisations that want to use it in their training.'

What now?

With all this in mind, how can therapists determine the best ways to progress their clinical work with trauma? At the end of *The Body Keeps the Score*, van der Kolk tells us: 'The choice is ours to act on what we know.'[3] Unfortunately, in the information age, what we know is not a fixed point.



'Trauma science evolves. Let's just use all of that, as long as we are using science to help things evolve and not to shut people down' **Ton Mazzone, filmmaker**



Curious about how **compassion science** can support your therapy?

An introduction to the Theory & Practice of **Compassion Focused Therapy**

Discover ways to help clients cultivate compassion focused brain states to address difficulties including shame, self-criticism, depression and anxiety.

Develop your clinical practice with this fast growing, evidence-based psychotherapy.

3 DAYS ONLINE TRAINING

Multiple training dates available

21 hours CPD | £429

For more information and booking, visit:
compassionatemind.co.uk/training
or scan the QR code

THE Compassionate Mind FOUNDATION

Celebrating 20 Years

Science develops at speed and is open to interpretation. Or as Kotler puts it: 'Somebody has an idea. It raises questions. We answer those questions and we move forward.'

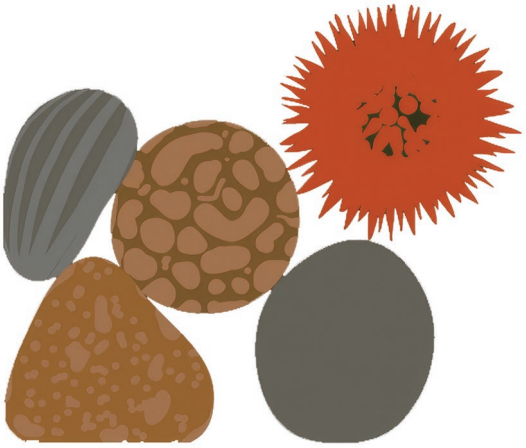
Perhaps therapists need to model some of the flexibility we seek to cultivate in our clients. Patel says: 'It's important to ask yourself as a therapist: "Does this align with my approach, my values and how I would like to practise?" If it doesn't you are trying to fit a square peg into a round hole, and that is a disservice to the people we are here to serve.' Part of this process involves seeking guidance from colleagues.

For Music it's about 'making sure we have a sufficient understanding to do that work. If we don't we need to seek out people who can help us. It doesn't have to be further training; it could equally be a good supervisor. For me it will always be reading, watching, talking to people and getting as much help as I can from my colleagues.'

Professional development

For those of us who are committed to working with trauma it may be difficult to know whether to pursue general or specialised training. Fisher says that we shouldn't feel the need to limit ourselves: 'If you are a therapist who feels moved to help traumatised clients then, in a perfect world, you would have an opportunity to have specialised training in one or more trauma-informed approaches.'

ALICE MOLLON





'This field will not survive if we keep people on pedestals and treat people like gurus. This field needs all of us' **Wendy D'Andrea, clinical psychologist**

With such an enormous amount of knowledge, experience and insight about trauma at our disposal, therapists may feel unsure of where to focus their energy. When our core texts are challenged we may feel that the foundations of our understanding are being undermined. But Mazzone's outlook is hopeful: 'Trauma science evolves. Let's just use all of that, as long as we are using science to help things evolve and not to shut people down.'

This kind of consensus can sometimes feel difficult to achieve. One of the concerns for a panel addressing Kotler and colleagues' paper at the Transform Trauma Oxford conference was the paper's provocative title. In a session entitled 'The Future of Trauma Therapy', speaking alongside van der Kolk, Fisher, Prentis Hemphill and Wendy D'Andrea, Dr Scott Lyons, author of *Addicted to Drama* and a body-based trauma specialist, described it as 'clickbait'. Van der Kolk said: 'I'm sorry that they wasted time that they could have spent on something more useful.' Here, at least, the paper's title seems to have undermined Kotler's desire to engage in meaningful scientific discourse.

Trauma seems to be, more than ever, part of the zeitgeist, but perhaps we are still learning how to talk about it societally. Progressing our collective understanding of trauma will require us to engage with challenges to the orthodoxy of our core texts. Hopefully this can happen in ways that feel like moving forward rather than attacks. The good news is that this is a process we can all be involved in through therapy, research and broader systemic changes.

Wendy D'Andrea's final thoughts felt especially pertinent: 'This field will not survive if we keep people on pedestals and treat people like gurus. This field needs all of us.' ●

Transform Trauma Mexico will take place in person and online in February 2027. ***mexico.mastersevents.com***

Registration is open for Transform Trauma Oxford 2027. A 10% discount is available to BACP members. Scan the QR code or use the link below and add the code BACP10 at checkout. ***mastersevents.com/oxford-2027***

REFERENCES

1. Kotler S, Mannino M, Fox G, Friston K. The body does not keep the score: trauma, predictive coding, and the restoration of metastability. Frontiers in Systems Neuroscience 2026; 20: 1-5.
2. Kessler RC, Aguilar-Gaxiola S, Alonso J, Benjet C, Bromet EJ, Cardoso G, et al. Trauma and PTSD in the WHO world mental health surveys. European Journal of Psychotraumatology 2017; 8(sup5): 1353383.
3. van der Kolk B. The body keeps the score. London: Penguin; 2014.

ABOUT THE AUTHOR

Ed Harkness MBACP is a person-centred integrative counsellor working in the third sector and private practice. He is a non-fiction writer and winner of the Pete Sanders Student Writing Award 2023.



In Open Dialogue



Lynne Gabriel and Russell Razzaque discuss how Open Dialogue could be set to revolutionise the landscape for mental health care

Open Dialogue, a person-centred, systemic mental health model established in Finland, was trialled in recent years across five NHS mental health trusts, the results of which were published in *The Lancet* earlier this summer. Professor Lynne Gabriel OBE speaks to Dr Russell Razzaque, who launched the UK trial, about ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) and why this is a step in the right direction for therapists looking to work relationally within the NHS.

Lynne: Can you explain what Open Dialogue is and how it came about?

Russell: Open Dialogue (OD) started in northern Finland in the 1980s: the country had some of the highest hospitalisations and suicide rates in the world. They shut down lots of their services and restarted them as a series of experiments, one of which was OD. I first found out about OD in the early 2010s at the National Conference of Psychosis. People were asking why we are not doing that in this country. So I went and investigated.

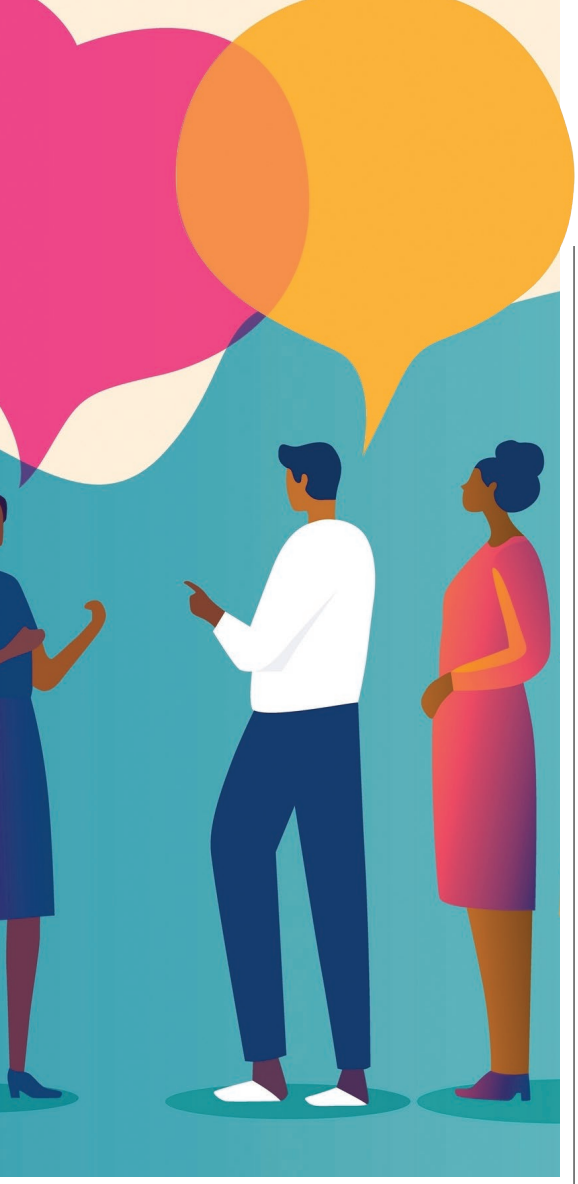
We know that therapeutic relationships have a big effect on long-term outcomes, but statutory services in the UK are not currently focused on the wider family context when it comes to crisis care: family members only tend to get involved as an afterthought, and people are typically passed from one service to another.

In a nutshell, OD trains staff to think more systemically. It invites family and friends into meetings, and the service user chooses who is invited. If they choose nobody that's fine too. The clinicians don't set themselves up as the experts who decide the meaning for the patient and formulate a plan: it's a case of equalising the pathway and offering a space where people feel safe enough to say their piece and develop meaning through their own story. It's less top down, more collaborative. You then retain that throughout the care pathway: the same people who have those early conversations and created that trust stay with you the whole time you're in care. This continuity is something services have been asking for for decades now. OD does just that.

The issue until now has been that OD hadn't had any kind of randomised trial, which is why policy makers weren't implementing it. That's where I came in. I liaised with a series of academics around the country, led by Professor Steve Pilling at UCL, the lead academic for NICE, in order to implement a proper evaluation.

We implemented it in pilot services across five different NHS trusts and evaluated them in a custom randomised trial. That involved comparing OD to treatment as usual in a randomised distinction so that we would know if any

'We know that therapeutic relationships have a big effect on long-term outcomes, but statutory services in the UK are not currently focused on the wider family context when it comes to crisis care'



GEJSI/SHUTTERSTOCK

differences occurred because of the intervention and new model rather than anything else that might have happened in that moment of time.

This is where we are now with it.

Lynne: What were the standout results of the trial? Anything that you had concerns about?

Russell: There were things we looked for that we didn't find and other things we didn't expect that surprised us. Initially our primary interest was time to relapse: how long does relapse take once you've had your first crisis episode? We recruited people in crisis, at the edge of hospital admission, and followed them through that crisis with OD over a couple of years to see the effect. What we found was that the time to relapse was about the same – a tiny bit longer in OD, but that wasn't a statistically significant difference – but the odds of being admitted to hospital were three times less if you'd had OD compared to treatment as usual. We also found that there is a 50% reduction in re-referral back into crisis or secondary healthcare services. This tells us that while people were still relapsing it wasn't as intense or as impactful as it would have been, and therefore they were avoiding going back into hospital.

The tragedy we see so often in mental health services is that people are on a revolving door coming in and out of the system year after year. That, for many people, will have stopped. Yes they might come back, but it won't be as severe. That's very meaningful to people who are using our service, and makes a big difference to their lives.

We also found that health-related quality of life improved when a patient had OD. They scored their patient experience higher in OD compared to treatment as usual.

This all stacks up: if they are taken out of that revolving door their quality of life is better, their sense of their own recovery is better and the services that treated them were better. Then fewer people come to hospital and less money is spent on hospital beds, which also benefits the system. We are going to launch another health economic paper later this year, but clearly reduced hospitalisation is going to have a positive effect on finances.

All these things combined make OD a reasonable thing now to scale up.

Lynne: I know this is the culmination of a lot of years of hard work. It sounds like absolute determination, commitment and energy to get you where you are now. Where next?

Russell: We always knew that if we succeeded in demonstrating something useful in the trial then the next stage would be about how we implement it across a large scale, across whole trusts. We won't be able to speed up to national implementation straight away but we have potential funding from the third sector, which might enable us to demonstrate what it's like on a larger scale across parts of the country, and continue the evaluation. We need to build the evidence base all the time, so we'll be spending considerable resource on that evaluation importantly.

It would be good to implement it in areas looking to collaborate, particularly because we've demonstrated such an impact on inpatient admissions, certainly in areas that are struggling with out-of-area placements where they're sending people far away. That will take a number of years and we will see how it goes. If that reinforces what our findings are then we move to the next stage of wider-scale implementation.

Lynne: I love hearing you talk about this trial. I see potential for synergy with the evolution in England and the Government's drive for DHSE and NHSE, and the Government Health Minister's drive to grow Neighbourhood Mental Health Centres. It's my hope that over time OD approaches and the OD networked approach become interconnected with those centres. I know from my own profession in counselling, psychotherapy and mental health coaching that in the charitable sector many of the people going to those charities for help are people with serious mental illness and distress. We have to ensure that it becomes available in main cities and places across the nation. For me it's not just a dream scenario for the NHS but also for the voluntary sector. What's your view of where you think it sits

'We have to entrust that OD becomes available in main cities and places across the nation. For me it's not just a dream scenario for the NHS but also for the voluntary sector'

with the talking and psychological therapies and in the voluntary sector?

Russell: OD is a collaborative model of care. It brings everybody involved to the table from different parts of the country. People can join the OD teams who are not traditional multidisciplinary staff but those with therapy backgrounds who join the network and train to become OD practitioners and work in those teams. That's something we think could easily happen as we roll it out. People from a therapeutic background are well placed to join the OD training and teams. In fact we are creating roles that folks who are of the disposition are able to join so this improves the mix of service. Along with the 24/7 centres it's a very exciting development, and there's more emphasis on care in people's localities so that people can get support, such as beds, in their local areas, which stops them from ending up going to hospital beds. As a clinician I see that all the time: if someone could have had that space before going to hospital it would have avoided a pretty horrendous hospital admission. Using OD with a clinical model within that construct makes a lot of sense.

Another aspect is lived experience. When we started the trial peer workers were fairly unknown to the NHS, but we insisted that all the teams had peer workers in them. Now peer workers are more common and it's required by NHS England to have lived experience workers in every service. Having peer work as an integral part of the system is very much a part of what OD advocates.

Lynne: As you know, person-centred therapy was developed by Carl Rogers back in the 1950s and 1960s, and there are people who fiercely protect the term 'person-centred'. I want to ask how your person-centred approach chimes with Rogers' approach?

Russell: When it comes to system change in the NHS and the mental health system more broadly, culture change is the hardest thing to bring about. We are good at structural change but the culture remains the same. OD is about fundamentally changing the culture of mental health services towards a more Rogerian, person-centred direction; there is absolute alignment there. I don't say it enough, I should, I'm glad you asked me about it. Because just the personal presence, the warmth, the unconditional positive regard – these are the fundamental ingredients of OD. It's about creating a space where people feel fundamentally heard. That takes some change in training and culture. An interaction with a service user becomes not 'how can I extract information from them to deduce a formulation?' but 'how can I give them that sense of being heard, warmth and presence?' That becomes our objective. Crucially it's person-centred at a systemic level. If you expand Rogerian culture into a more system-wide culture this is what it looks like. But it requires effort, which is why the training is pretty intensive. Most people who have been on the training share that they are getting people telling them that nobody has ever listened to them like this before. That's how we know it is landing. All sorts of things can change as a result: people will be less inclined to avoid care or feel alienated by it, or less likely to be lost to follow up. That's how you end up reducing usage of different services because they are happy with what they have in this.

Lynne: I'm curious on the use of OD in an early intervention space so we aren't waiting until people reach that crisis point. I'm thinking of Alan Milburn and Peter Fonagy's work and mental health report around the health of the nations across the different areas of our lifespan. How might OD be part of that earlier intervention?

Russell: OD works best when it works early. Ultimately it is what you do when you come through the door. In our trial we only looked at people in crisis, but in Finland OD is something you have at the beginning of your time in care. We looked at how burden of care on carers reduces significantly as a result.

Lynne: For me there is something important about that systemic way of thinking across disciplines so that people are open to and willing to work across them. I'm thinking about counsellors, psychologists, occupational therapists, etc who might see this as a threat coming from psychiatry or psychology, but I don't see it as that: what you brought to me originally was about opportunities. I'm curious about your take on how OD sits with a multidisciplinary approach and across those disciplines that might previously have been vying for acknowledgment?

Russell: OD is a bit like a carpet on which you can put any furniture: it's the organising principle of the culture on which the service is delivered. It doesn't exclude anything. It's essentially what we call a 'need-adapted' approach: whatever the person needs is how we adapt it to them. We train people to be human first. Keep your specialism in your back pocket, like social work, those things will be needed, but in the beginning we need the human first.

Naturally that element of it is more psychotherapeutic so people from that background can feel at home in a system based on OD. People with lived experience also have a fundamental role in maintaining that culture and connection so that it doesn't lead to people feeling threatened. Because we are under financial restrictions people can

'OD is about fundamentally changing the culture of mental health services towards a more Rogerian, person-centred direction; there is absolute alignment there'

feel nervous about something new leading to their job becoming insecure, which shouldn't be the case. Those who have been on the edge of the system like counsellors and therapists can be invited in more usefully and logically to a system that sits with that, including systemic therapists, in adult services, especially where they've been pushed out on the edge. They can feel more welcome in a service based more on systemic understandings of people's distress. If anyone feels threatened then we haven't done our job right.

Lynne: Indeed, you recently became the UK's very first relational psychiatrist. Because of my past as a mental health nurse I'm aware that psychiatry was always top of the tree. There may be legal aspects to being present as a psychiatrist or social worker or clinical psychologist, but in the context of working in that systemic, interconnected, networked way everyone has a place in this non-hierarchical structure. It is levelling the different people into that relational space. That to me seems pretty powerful.

Russell: There are times when hierarchy is needed but it's about removing unnecessary hierarchy. It can't be the case that one professional has the monopoly on wisdom and everyone has to fall in line but that we've all got creative wisdom and capacity, and our backgrounds, life stories, demographic, etc, to provide unique perspectives. It's the first step to a relational service. That's why in OD training, cultivating stronger relationships between team members is a big part of it so that a psychiatrist doesn't have to feel responsible to have all the answers but we do it as a team. We do that through deep-level work with each other. As much as the work is on developing relational health systems it is about staff working on themselves and as a team. That culture then spreads into how we work. It's not something you can just teach a couple of protocols for – you have to work on the whole system.

Another thing is that in existing crisis services you might see someone new every day. In OD the people who see you at the beginning wrap around you and stay with you the whole time. And we have an OD discharge process. Currently you might have to go to your GP to get referred for an assessment and then a team will allocate you to whoever is available. In OD the hope is that we stay with you for the rest of your life. We encourage people not to wait until they become in crisis again – they can still give us a call if there is a minor challenge and the same people and networks will endeavour to see you again. This creates a safety net. Of course the chances of that reduce if the staff leave, but we have found that retention of staff is higher in OD compared to treatment as usual, making that continuity more possible. This was the case in Finland: the same people who set it up decades ago are still there working. That continuity sets the experience apart.

> *'For me there is something important about that systemic way of thinking across disciplines so that people are open to and willing to work across them'*

Lynne: Could you clarify for readers what you mean by 'networks', Russell?

Russell: Networks could be friends, colleagues, another therapist, agencies, healers, priest – anyone you think can support you, we will try and facilitate it to get them in the room. We do something called social network mapping to see who is in their network. Even if there is nobody there is still a relational field, so in that case we would ask 'What would your mother or colleague say if they were here?', so we are keeping that relationship alive whoever is in the room.

As part of this, another cornerstone of OD is the concept of 'nothing about us without us'. There are two or more professionals in the room and they have a conversation about what they're hearing in front of the service user and family members, who get the chance to reflect back. There is a lot of training on how to do that to make sure it is validating and driven by empathy. When I first started doing that I found that sometimes the network would stand up to leave and I would explain we'd want them to stay to hear what we were saying. It was no coincidence that their scoring was higher compared to treatment as usual because they weren't being kept in the dark.

Lynne: Anything left to share?

Russell: Ultimately there are lots of people who will read this who will have family or friends or themselves in the system. Now is the time to keep the momentum going by talking about it because the riskiest time for change is just once the research is delivered because it can take 17 years on average to implement something that has been found. We don't want this to fade away.

Early next year BACP and Russell's team will announce which parts of the country they are implementing Open Dialogue and offering training and how to access it.

ABOUT THE AUTHORS



Professor Lynne Gabriel OBE MBACP (Accred) is the President of BACP, Professor of Counselling and Mental Health at York St John University, a practising psychotherapist, a clinical supervisor, a global accredited coach and a former psychiatric nurse.



Dr Russell Razzaque is Professor of Relational Psychiatry at SOAS and consultant psychiatrist at North East London NHS Foundation Trust, with 20 years of experience in adult mental health. He has consulted for the UK Home Office, Ministry of Justice and University of Cambridge.

Being more human

In an edited extract from *Be More Human*, former member of parliament Norman Lamb explores what's going so wrong in our crisis services

The horrifying murders committed by Valdo Calocane in Nottingham in the summer of 2023 demonstrate what can go fatally wrong. Calocane had been suffering paranoid delusions when he killed Barnaby Webber, Ian Coates and Grace O'Malley-Kumar. In that case there were many clear and obvious failures of care, particularly the decision to discharge Calocane back to his GP after he had failed to engage with the mental health team, and in the knowledge that he had repeatedly not taken his medication and had already viciously attacked people.

While recognising these mistakes in Calocane's case we can't escape from the fact that predicting risk is notoriously difficult – and that keeps many people working in mental health services awake at night. It is one of a small number of tragic cases over the years – one other example being the 1992 murder of Jonathan Zito by Christopher Clunis, who had been diagnosed with schizophrenia six years earlier. As Jeremy Walker, a former NHS professional, put it, commenting on the Calocane case, community mental health services 'contend with challenges like those presented by Calocane every day'.[1] The current state of mental health services increases the risk of further tragic losses of life. And cases like these, and the media coverage that follows them, can have both a conscious and unconscious impact on those having to make decisions about detention – making it more likely that people are detained.

This is an understandable response, but we fail everyone if we respond to tragedies in a way which focuses disproportionately on detaining people – particularly given the doubts about the effectiveness of inpatient care. Doing so undermines basic humanity but may also have unintended consequences. Money spent on locking people up is then not available to support people in the community, with the result that more people may end up in crisis – potentially posing a risk to themselves or others. Reforms to the Mental Health Act aimed at ensuring that people are only detained when it is absolutely necessary with more frequent reviews are welcome. But it remains to be seen how much impact they will have on a deeply flawed system.

Continuity of care

Caseloads are heavy in mental health community services. The impact of this on an individual is infrequent contact. People also often get referred from one team to another if, for example, a decision is made that their needs have changed or that they require a different level of support. They can also move in and out of inpatient care.

With each change the individual will meet a new set of professionals, making it impossible to build relationships or provide continuity of care. Professor Tim Kendall [former National Clinical Director for Mental Health at NHS England] describes graphically how things have gone wrong:

'We can now have 13 different community mental health teams in every area – a primary care mental health team, a community mental health team, a crisis team, a home treatment team, an assertive outreach team, an early intervention team, an older adults community mental health team, an older adults crisis team, a community enhanced rehabilitation team, a community forensic team, a homeless mental health team and so on. As one colleague put it: "a team for everyone and a place for no one." Going into community mental health services is like going into a pinball machine.'

It follows that the risk of this person falling into crisis without anyone noticing is very real, and without an ongoing relationship or knowledge of the individual the risk of them being detained under the Mental Health Act is increased.

Investment in community mental health services has improved, but still nearly half of the clinical resources in mental health trusts is spent on inpatient care, leaving insufficient resources for effective community support.

There are around 20,000 NHS-provided adult and older adult mental health beds in England but over 700,000 people supported by community mental health teams. The average cost of one acute adult mental health bed in 2023/24 was £229,218 – equivalent to the cost of supporting 50 people in the community.[2] Have we got that balance right? Could we address risk and enhance lives better if we shifted resources from institutional care into improving community support? Experience elsewhere suggests this is achievable.

'Could we address risk and enhance lives better if we shifted resources from institutional care into improving community support?'

ALICE MOLLON/IKON IMAGES

Risk of suicide

I have focused so far on that relatively small number of people who may, in moments of crisis, pose a risk to other people. There are also so many people who may end up taking their own lives at times of immense distress. Kendall thinks we get the approach all wrong – again with perceptions of risk dominating our approach. When we met he talked about suicide prevention:

'Risk totally dominates the way the system works in a really adverse way. We know that out of all the people who kill themselves by suicide about 28% are already within mental health services. Of those within mental health services who take their own lives, 82% of the 1,300 every year who kill themselves were judged to be at low or no risk at their most recent risk assessment. The way we deal with risk has led to the ridiculous situation where we are possibly making suicide more likely.

'I am not saying that we shouldn't be interested in risk, but we should not put risk as the prime focus of what we do. We should be thinking: how do we help people become safer? Our approach to safety should be to enhance people's lives so that they are safer. Not that they are risk-free, but that they are safer than they were before they met us. And for people with mental ill health, safety isn't just about suicide. It's also about safety from sexual or physical violence from partners or others, it's about safety from becoming or staying homeless, it's safety from having no income or from hunger and more.'

To me this sounds like a great starting point for a more humane and a more effective approach.

The suicide rate among inpatients has come down markedly over recent years, but Kendall makes the point that most inpatients who take their own lives do so after they are discharged. This was the case with my own sister, Catherine.

In all, 2,389 people died within three months of discharge from inpatient care between 2011 and 2021 in the UK. In total there were 18,339 suicide deaths of people who had been in contact with mental health services within 12 months of death over the 10-year period from 2011 to 2021.[3]

Take a moment to digest these numbers and to consider such horrifying loss of life.

We know a lot about action we can take to reduce the risk of suicide yet the numbers remain stubbornly high. Could we do more to save lives?

Here is something to think about: across the world societies have made dramatic progress in recent years to reduce the loss of life through conditions such as stroke, cancer, AIDS and heart disease.[4]

Yet globally the loss of life through suicide remains high despite a substantial amount of accumulated knowledge about how we can save lives.

Is it that we don't care enough? ●





© Norman Lamb

• Extracted and edited with permission from *Be More Human: why mental health care is broken and what we can do to fix it* (Jessica Kingsley Publishers).

uk.jkp.com

REFERENCES

1. Walker J. I've met many Valdo Calocanes. This is how a mental health crisis can lead to tragedy. The Guardian. 20 August 2024. theguardian.com/commentisfree/article/2024/aug/20/valdo-calocanes-mental-health-crisis-tragedy-nhs-nottingham **2.** Data provided by Stephen Watkins, former CEO of NHS Benchmarking (personal communication). **3.** National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health. Annual Report 2024: UK patient and general population data 2011-2021; 2024. sites.manchester.ac.uk/ncish/reports/annual-report-2024 **4.** International Initiative for Mental Health Leadership. Zero suicide: an international declaration for better healthcare; 2016. preventsuicidect.org/wp-content/uploads/2021/05/zerosuicidedeclaration_2015.pdf

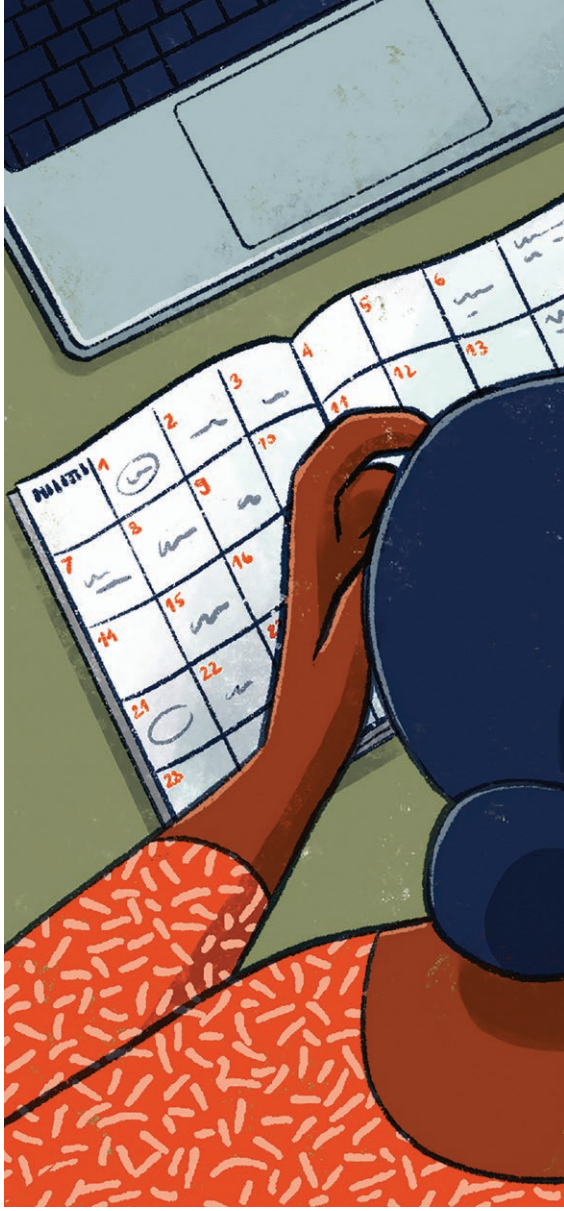
ABOUT THE AUTHOR



Sir Norman Lamb was the Liberal Democrat MP for North Norfolk from 2001 to 2019 and was appointed Minister of State for Care and Support at the Department of Health in September 2012 until the end of the Coalition Government in May 2015. In 2019 Norman received a knighthood for his services to mental health, and from 2020 to 2025 he was Chair of the South London and Maudsley Foundation Trust, a specialist mental health trust.

The right to be enough

William Njoki asks whether therapy can offer enough room for excellence to become a choice rather than the price we believe we must pay for our worth



DANAE DIAZ/IKON IMAGES

A young Black client arrives in the therapy room thriving. They are successful at work, ambitious, doing well online, and from the outside their life seems to be going well. Yet in the room they are exhausted, burnt out, barely surviving. As we work together I begin to notice how difficult it is for them to stop. There is always something more to achieve, another expectation to meet, one more reason they cannot quite rest yet. Their ambition is real, and I don't want to diminish it, but I begin to wonder with them about the cost of carrying it. When does achievement become less about what we want and more about what we need to be to feel that we are enough?

As we explored this together I became interested in the language of 'must'. I must keep going. I must make something of myself. I must not let people down. I must be able to cope. Beneath the achievements seemed to be a weight that was harder to name. At one point I remember thinking about how much of their energy was being used just carrying everything they felt they had to carry, leaving so little room to stand up for what they actually wanted. This wasn't a lack of ambition; if anything there was an abundance of it. But there seemed to be a difference between moving towards something they wanted and pushing because stopping felt unsafe. I recognised something uncomfortably familiar in that.

Danger in comfort

During my own degree I wanted to do well, but somewhere along the way doing well stopped being enough. I became increasingly preoccupied with the idea that my work had to be exceptional. What looked from the outside like commitment and ambition became much harder to sustain from the inside. Eventually I reached a point where I could barely function at all. Looking back what strikes me is how difficult it was to recognise what was happening while I was inside it. I thought I was pursuing something I wanted; I hadn't noticed how much of it had turned into something I felt I must do. The perfectionism wasn't merely ambition. Maybe it was a mask I had mistaken for skin.

It made me think differently about ambition, both in myself and in my work with Black clients. Excellence can mean something different when you belong to a group that has historically been told, explicitly and implicitly, that you are less capable, less intelligent or less deserving. To excel can be an act of resistance, a source of pride, a way of refusing those assumptions. I'm not trying to pathologise that. But I am interested in what happens when the possibility of being ordinary begins to feel dangerous; when 'we must be twice as good' is no longer just advice about surviving an unequal world but turns into an internal demand. What happens when excellence shifts from something we can choose into something we feel we have to be, and



achievement turns into not just an expression of who we are but a way of protecting our sense of worth?

Burden of excellence

Trying to make sense of some of this led me to Janelle Raymundo's work on what she calls the 'burden of excellence'. Writing about perfectionism among Black college students, Raymundo places striving for excellence within a wider racial context, where Black people may already be negotiating assumptions about their ability and worth.[1] I found other research making connections between racial discrimination, socially prescribed perfectionism and psychological distress. None of this means that Black ambition can be reduced to racism, or that perfectionism has a single racial origin. I would be uncomfortable making either claim. What the research did was help me think differently about something I was already noticing: that striving might be genuinely ours while also being shaped by what we have learned it takes to be valued.

That complexity feels important. Recent work with high-achieving Black women has explored both adaptive and maladaptive dimensions of perfectionism.[2,3] Striving can motivate us, create opportunities and come from a genuine pride in doing something well. But it can also grow exhausting when rest feels undeserved, mistakes begin to mean too much or success only brings relief until the next thing needs to be achieved. Maybe the distinction I'm trying to make is less about ambition versus perfectionism and more about 'I want to' versus 'I must'. That difference feels increasingly important to me.

'Striving can motivate us, create opportunities and come from a genuine pride in doing something well. But it can also grow exhausting'

Frantz Fanon helps me think about why that 'must' can become so difficult to separate from the self. In *Black Skin, White Masks*, he writes about what it is like to experience yourself in a world where you are already being seen through racial meanings and expectations.[4] Dwight Turner's writing on racism and psychotherapy brings this closer to the therapy room, particularly the ways we can internalise adaptations to racialised environments.[5] I find that idea of adaptation useful because it stops me seeing striving simply as a problem to be fixed. What if it has helped someone survive or find their place in the world? Being excellent, composed, productive or endlessly capable may have helped someone find recognition, safety or belonging. Maybe the problem is not the mask itself but reaching a point where taking it off no longer feels possible, or where, as I had begun to recognise in myself, it starts to feel like skin.

Ngũgĩ wa Thiong'o takes me towards another part of this question: imagination. In *Decolonising the Mind* he explores how colonial power works not only through material conditions but through language, culture and how people come to understand themselves and their world.[6] It makes me think about the lives we are able to imagine for ourselves. If, as Black people, we learn something about who we need to be in order to be respected, capable or safe, perhaps that shapes not only what we feel we must achieve but what we allow ourselves to want. There may be little room for desires that are uncertain, unproductive or simply our own when the pressure to be exceptional is always there. This feels important in therapy. Beneath 'Who do I need to become?' there may be another question: 'What do I actually want?'

Impossible beginnings

I think of another client – a musician who longed to create but found themselves increasingly unable to do so. The desire was there, sometimes intensely, but beginning felt almost impossible. An idea could be abandoned before it had been played, a possibility dismissed before it had been given enough space to become anything at all. As we explored this it seemed there was very little room for the imperfect stages that creativity requires. Making something new means risking making something that doesn't work. It means being a beginner, experimenting and sometimes failing. And I began to think about the particular weight failure might carry when, as a Black person, how you perform can shape how you are seen. I have to be careful here. I don't know how much of that belonged to the client and how much I was bringing from my own experience. But if failure has come to mean something about your worth, rather than just being part of learning, even imagination can begin to feel dangerous. Sometimes the weight of everything we feel we must carry leaves very little room to play, experiment or discover what might emerge.

Carl Rogers' concept of conditions of worth gives me another way of understanding this. Rogers described how we can learn that some parts of our experience are more acceptable than others, gradually organising our sense of self around the conditions through which we receive approval and regard.[7] I keep thinking about what happens when some of those conditions are also racialised. Achievement itself might become one of them: I am worthy when I succeed; I am safe when I cope; I belong when I do not disappoint. For a Black client some of this may also be shaped by how they have experienced being seen and valued in the world. The person-centred task is not to decide that their ambitions are false but to create enough safety for them to grow curious about what sits underneath them. What happens when I rest? What does failure mean to me? Which expectations feel like mine and which have I learned to carry?

That question of what feels like mine leads me to trust. Therapy asks clients to pay attention to their own experience, but that may not be so simple when external measures of success



DANAE DIAZ/IKON IMAGES

'Sometimes the weight of everything we feel we must carry leaves very little room to play, experiment or discover what might emerge'

have mattered for a long time. For Black clients those measures may also be tied up with wider messages about what it means to be successful, respectable or enough. It is difficult to ask 'What do I want?' when you have become very good at answering 'What is expected of me?' Perhaps part of the work is becoming curious about whose standards we have learned to live by, and which parts of ourselves we have learned not to trust. For me this is where creativity starts to feel important: a space where we don't have to know in advance what something is supposed to become.

Making something

Natalie Rogers' work on the creative process helps me think about what that space might look like. Her person-centred expressive arts approach is less concerned with the quality of what we produce and more with what can happen when we express, experiment and create.[8] That feels important when every attempt has become another test of whether we are good enough. For the musician who cannot begin, perhaps the invitation is not to make something good but simply to make something: to play without knowing where the music is going, to leave something unfinished, even to make something that doesn't work. There is a freedom in creating without already knowing what the outcome has to be. Its value may lie not in making us exceptional but in giving us moments in which we no longer have to be exceptional at all.

What might this mean in the therapy room? I'm not sure it requires a particular intervention. For me it begins with noticing what happens when achievement enters the relationship between us. I can be impressed by a successful client, but in doing so could I also reinforce the very conditions of worth they are struggling beneath? With Black clients I may be drawn towards familiar stories of resilience, strength and overcoming, without always noticing what sits underneath them. Celebrating resilience is one thing; being curious about its cost is another. When a client tells me what they have achieved I want to understand what that achievement means to them rather than assume that more is always better. And when they fail, stop, change their mind or admit that they cannot cope, does anything change between us? For someone used to earning recognition, or even acceptance, through performance, perhaps a relationship in which disappointment does not diminish their worth can offer something different.

Nothing to prove

I don't write this from a place of having resolved these questions in myself. I still recognise the pull towards achievement and the reassurance that can come from doing something well. Nor does recognising something of my own experience in a client's story mean that I know what their striving means for them. If anything it asks me to be more careful. Am I hearing the client, or finding myself in them? Awareness has not removed my own conditions of worth, but it has made them easier to notice and perhaps a little easier to question. It has also changed the questions I bring to my work. Alongside 'What are you trying to achieve?' I am increasingly interested in asking, 'What would happen if you didn't?' And alongside 'Who do you want to become?' perhaps there is room for something simpler: 'Who are you when there is nothing to prove?'

Perhaps then the aim is not to free Black clients from excellence. Excellence can be joyful, creative, resistant and deeply our own. I would not want therapy to turn into another place in which someone else decides what a Black person should aspire to. What interests me is whether therapy can offer enough room for excellence to become a choice rather than a condition of worth; to notice the difference between 'I want to' and 'I must', between achievement as an expression of the self and achievement as the price we believe we must pay for our worth. ●

REFERENCES

1. Raymundo J. The burden of excellence: a critical race theory analysis of perfectionism in Black students. The Vermont Connection. 2021; 42(1): 110-120. **2.** Lambert SF, Robinson WL, Ialongo NS. The role of socially prescribed perfectionism in the link between perceived racial discrimination and African American adolescents' depressive symptoms. Journal of Abnormal Child Psychology 2014; 42(4): 577-587. **3.** Leath S, Latimer A, Inniss-Thompson MN, Seward MD, Ball P. The pressure to be perfect: stereotype management, (mal?) adaptive perfectionism and well-being among Black college women attending predominantly white institutions. Psychology of Women Quarterly 2025; 49(2): 182-204. **4.** Fanon F. Black skin, white masks. London: Pluto Press; 2008. **5.** Turner D. Lost in the echo: understanding racial echoism within psychotherapy. The Journal of Critical Psychology, Counselling and Psychotherapy 2018; 18(4): 204-216. **6.** wa Thiong'o N. Decolonising the mind: the politics of language in African literature. London: Pearson Education Ltd; 1986. **7.** Rogers CR. A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In: Koch S, (ed). Psychology: a study of a science. Volume 3, Formulations of the person and the social context. New York: McGraw Hill; 1959 (pp184-256). **8.** Rogers N. The creative connection: expressive arts as healing. Palo Alto, CA: Science and Behavior Books; 1993.

ABOUT THE AUTHOR



William Njoki has 20 years' experience working with young people in referral units and SEN education. Recently trained as a person-centred pluralistic counsellor, his developing practice explores culture, decolonisation, empowerment and creative therapeutic approaches.

MARSH

Get your free, no obligation quote at
www.marshcommercial.co.uk/probodies
or call 0333 920 8114

Breathe easy with Oxygen™

Tailored business insurance for talking therapists and wellbeing professionals

- Award-winning customer service[1]
- 20% discount for BACP members[2]
- Same transparent pricing for new and existing customers
- No admin fees for policy changes or documents
- No excess on core business insurance[3]



This is a marketing communication.

Oxygen is a trading name of Marsh Ltd. Marsh Ltd is authorised and regulated by the Financial Conduct Authority for General Insurance Distribution and Credit Broking (Firm Reference No. 307511). Copyright © 2026 Marsh Ltd. Registered in England and Wales Number: 1507274, Registered office: 1 Tower Place West, Tower Place, London EC3R 5BU. All rights reserved.

1 https://www.feefo.com/en-GB/reviews/oxygen.

2 The discount applies to the insurer premium and is a minimum of 20%, however does not apply to the insurance broker admin fee.

3 No excess applies to the core therapists and wellbeing insurance (public liability, professional indemnity, employers liability, and directors and officers liability); however, for any additional insurance taken out, certain excess may apply. Please contact us for details.



‘Therapy helped me believe that I deserve to live this life’

At 22 weeks pregnant my husband and I found out that our son’s airways had not grown. He would die within seconds of birth.

My pregnancy was already dangerous for me. We could continue, despite those risks and knowing that my son’s short life would be one of pain and suffering; or we could have a termination.

If we chose the latter my son’s heart would be injected inside the womb in a procedure known as feticide, so that he would die inside me rather than suffocate to death at full term. I would then give birth to him, dead, before going back to ‘normal life’.

We chose a termination. We felt it was the most loving choice we could make.

It was so far from a choice. But making it felt like an element of control. We would not allow our son to suffer. His death would be planned. We were educated on it. Doctors knew the science of what they needed to do. The procedure would be precise. There would be no uncertainty. My son would die on mine and my husband’s terms. Somehow we viewed this as the ‘easier option’. But living with the trauma of losing him in this way, I am not so sure.

Termination for medical reasons (TFMR) is the complete submission of your body to science. Every bodily system is affected – and this is hugely complicated by guilt and love. I felt like I’d been broken into parts. Now I understand that TFMR changed me on a cellular level, but back then all I understood was the logic. I could not comprehend how death had been created within me. I couldn’t process what I felt happen to my son – the stillness where minutes earlier there had been life. And I hated it. Hated that I’d had the information to make this choice. Hated the science, and how much power and control it had given me. And how terminating this baby was viewed as such an ‘obvious’, logical decision when I was in utter chaos.

The weeks, months and years that followed were impossible as I tried to balance my son’s death alongside the reality of normal life. I suffered with flashbacks, nosebleeds, aches and pains. I saw horror everywhere. Certain sounds, images and feelings would take me right back to the needle coming towards me, or to visions of my son’s dead body. My brain felt as if it was made of pieces clashing against each other. Nightmares collided with memories, grief collided with logic, stress collided with expectation. I desperately tried to maintain the persona of the young woman I’d been before, yet I would go to sleep every night with the constant feeling that I was falling.

It took a long time to accept that I needed help. But living with a brain and a body that is so out of control takes a toll on you. I wanted to get better but I didn’t know how. The only thing I knew was that I didn’t understand what was happening to me – that I needed to talk about it and learn. So I looked for therapists who specialised in post-abortion mental health and signed up for grief therapy with an accredited integrative psychotherapeutic counsellor.

She saved me.

Before her I was embarrassed by the way my body was behaving. I felt ashamed, weak. I questioned if I had the right to be struggling because, after all, I’d made the choice to lose my son. His death was planned – a ‘termination’. And I knew that some didn’t even see my son’s death as a big deal. But with her it was different. She reminded me that my value wasn’t reliant on other people’s opinions of how I was coping. She reassured me that I had a right to grieve and that what I had experienced was trauma. I felt validated. Understood. And she also helped me to understand. I learned the science of PTSD, about polyvagal theory and the ways the body responds to trauma. I wasn’t a freak. My body wasn’t broken. It just hadn’t had time to catch up. With this knowledge came self-compassion. From self-compassion came the ability to move forward. I began to recognise my triggers and what I needed to put in place to manage them. I began to advocate for myself and my recovery. I began to give into the grief because I understood that my body needed time and space to process what it had gone through.

So often I hear people dispute the importance of therapy. But to those people I say this: therapy isn’t just sitting around talking about feelings, although that’s part of it. It can also offer you the science of how and why your body and mind are behaving in certain ways. For me that’s when the stigma was removed and when healing could begin. Looking back therapy didn’t just change my life – it saved it. And it gave me the confidence to believe that however different I am I still deserve to live this life, even if my son never got the chance to live his.

BEREGIS5/SHUTTERSTOCK



ABOUT THE AUTHOR

Rosanna Brown is a former English teacher. Her self-help book, *The Silence of TFMR* (Watkins), written for families facing termination of pregnancy for medical reasons, is out now. **@thesilenceof_tfmr**



IS IT OK TO USE AI TO EDIT MY CLIENT NOTES?

Q **I've always struggled to keep on top of client notes because I'm dyslexic and find written work particularly time-consuming. Recently I've started verbally inputting my reflections on sessions into ChatGPT, which then turns them into concise therapy notes using a template I've created. It has transformed my record-keeping. The notes are clearer and more consistent, and the process often helps me reflect on the work. I don't use client names or obvious identifying details such as workplaces or locations, and I delete the original recording and the AI-generated material afterwards. For the first time I feel properly on top of my notes. But am I overlooking confidentiality, data protection or other ethical issues? Is it acceptable if I remove identifying information, or should client material never be entered into a tool such as ChatGPT?**

A

There is a great deal to sympathise with here. Appropriate record-keeping is a professional responsibility (*Ethical Framework* 2026, Section C: Core responsibilities, point 3.2), but it can feel like a burdensome task for many of us, including those who, like you, have dyslexia. With the assistance of artificial intelligence (AI), you finally feel 'on top' of your notes and feel that the process may also help you reflect on the work.

Before we consider your AI use in more detail, let's pause and think about your pre-AI note-making practice. I wonder if you discussed your struggles with keeping on top of client notes in supervision? Taking some time to reflect on your written process with your supervisor may help you understand why it feels like a struggle – were you trying to write too much and including unnecessary details? Would devising a template to follow have helped? There may be simple changes that can help you keep on top of your notes without using AI and also avoid compromising your ethical commitments to maintain client confidentiality and comply with data protection regulations.

You may be aware that specific responsibilities relating to AI use are part of the new *Ethical Framework for the Counselling Professions* (*EF*). These include ensuring that before using an AI tool or digital platform we have assessed its risks and can demonstrate that we are competent to use it. This means that we understand how data are handled and stored and the associated confidentiality risks, and have mitigated those risks as far as possible. We are also required to be honest and transparent with clients about our use of an AI tool and the risks and benefits involved, and to have obtained informed consent before entering any of their personal data (Section C: Core responsibilities, point 2.1e). To help you understand what all this means in practice it might help to watch the Ethics essentials video featuring BACP's Tina Williams and ethical AI consultant Richard Miller in conversation (see 'Support and resources' on page 44).

Risks and benefits

The use of AI – however ubiquitous it may seem – is still new territory for most of us, and as Richard Miller points out, 'Well-intentioned counsellors who are trying to do good are the ones who are probably most at risk of making some simple errors, not out of malice but just out of not being familiar with the technology.' When it comes to AI, 'we all need to be adults in the room', he says, because 'the wider regulatory framework doesn't give us straightforward answers'. Just because the *EF* does not ban or discourage the use of digital tools it doesn't mean we have the green light to use them in our work. We have a responsibility as practitioners to fully assess the risks and benefits of any tool we choose to use, including its impact on our practice and our clients. This means reading and understanding the terms and conditions and, if necessary, taking some specific CPD to increase our knowledge.

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.

ELIOT WYATT/IKON IMAGES



Even if you delete the text from the AI app on your device, and opt out of data sharing in settings, which is usually phrased along the lines of 'do not use my data to train the model', whatever you input will be stored on 'the cloud' (essentially massive industrial warehouses filled with high-capacity hard drives, and maintained by a third-party provider). If you read the small print you may find that your data may be accessed by company employees for quality assurance or model training purposes and potentially stored indefinitely or traded and shared with third-party providers.

For these reasons the measures you have taken to protect client data – not including identifiable details and deleting recordings and answers – reduce the risk of a confidentiality breach but don't eliminate it. This is what your clients need to know before they consent.

Knowing that other practitioners are using large language models (LLMs – machines trained on vast amounts of text to learn sentence patterning and predicting) such as ChatGPT to process their notes does not mean this is now 'the norm', or safe – remember, most consumer-facing LLMs are not designed for handling protected data.

'The measures you have taken to protect client data reduce the risk of a confidentiality breach but don't eliminate it'

Conducting a proper risk assessment means you won't get caught out following the crowd. For you this means considering a key question: do you have sufficient knowledge to assess the risks involved and to be able to fully and clearly explain the risks (and benefits) to your clients so they can give informed consent? Bear in mind that the new *EF* refers to a requirement to be transparent with clients about our use of AI – it's a 'must' rather than something we aim for (Section C: Core responsibilities, point 2.1e, iii).

Making a decision

Working through the *EF*'s decision-making questions in supervision may provide a structure for your thinking:

1. What are the ethical issues?

The central issues are confidentiality and privacy; the protection of clients' personal data; informed consent; transparency; the security and data-handling practices of the AI platform; and maintaining responsibility for the clinical record.

There is also the issue of how your use of AI may alter or shape your own professional skills and decisions – does it make your work easier and better, or just easier? How would you demonstrate being able to test the difference? Does the benefit that the technology offers apply to you and the client, and have you considered any other ways to achieve those benefits which offer better protection to client confidentiality?

There is also another ethical consideration in your favour: accessibility. Using AI is enabling you to meet your professional obligation to keep appropriate records in a way that works with your dyslexia. Abandoning a useful accessibility aid may not necessarily be the most ethical solution if the associated risks can instead be appropriately managed.

Many of the Ethical principles (Section A of the *EF*) apply here, including confidentiality, honesty, transparency, doing no harm, acting in clients' best interests, respect, trust and integrity.

2. How will the person impacted be involved in the decision?

Have you met your obligation to be 'honest and transparent' with your clients about your use of AI, and the benefits and risks involved (Core responsibilities, 2.1e)? To work collaboratively with clients (Core

SUPPORT AND RESOURCES

Ethical Framework for the Counselling Professions 2026 (mandatory from 3 November 2026): **bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/preparing-for-the-2026-ethical-framework**

Using AI Tools, a new Ethics essentials checklist, is now available from: **bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/ethics-essentials**

The following Ethics essentials videos, created as part of the support resources for the new *Ethical Framework*, are also available:

- *Ethics and the use of Artificial Intelligence (AI)*
- *How to use the* Ethical Framework
- *Forming a rationale for ethical decision-making*
- *Understanding our legal and professional responsibilities*

responsibilities, point 1.4a) you must provide your clients with enough information about your note-taking process to allow them to give informed consent before you start using the system. This might involve a verbal discussion as well as inclusion in your written contract, explaining the process in easy-to-understand terms – for example, that an AI system is used to help turn dictated reflections into written clinical notes, what information is shared with it, what precautions are taken and what happens to the resulting material. More details can be added to your data protection policy document.

You must make it clear that the clients do not have to consent to this, and have an alternative note-taking process for those who do opt out. How will you ensure you remember which note-taking process applies to which client?

3. What internal factors should be considered?

Your dyslexia is clearly relevant, as is the amount of time traditional written record-keeping takes you. Other internal factors include the nature of the material you dictate, how much clinical detail you include, your understanding of the AI tool, your ability to evaluate what it produces and your reasons for using it.

On the last point, it may be worth considering how much interpretation you are asking the AI to perform. You may like how an AI-generated interpretation of your transcript makes your work look more 'professional' but is it an accurate representation of what happened in the session and how you work (given that AIs are trained to make us feel good)? You feel it helps you reflect on your work, but remember that AI outputs are nearly always agreeable, so you are likely to experience finding it helpful, regardless of whether it actually is or not. Another question is whether this process has replaced existing ways of reflecting on sessions – if so, how does this sit with your responsibility to not defer or outsource your decision-making to AI tools ('Core responsibilities, 2.1e, v)?

4. What external factors should be considered?

This includes understanding the particular AI tool you are using and what happens to information inputted, including how it is processed, retained and protected. Another external factor is compliance with the UK GDPR and the Data Protection Act 2018, and whether your use of AI contravenes your obligations to safely collect, use, store and protect client data.

5. What decision is being made, and is it consistent with the *EF*?

There are several decisions that may come out of this process. You may decide to:

- investigate and document the data-handling arrangements of the particular tool you use
- invest in some CPD to improve your knowledge of using AI and how data are processed and stored (for example, the BACP online workshop, 'Artificial intelligence and the human connection', next scheduled for 10 March 2027 – for more details see bacp.co.uk/events-and-resources/bacp-events)
- change how you use the tool – for example, by further minimising the information you input and the level of interpretation you ask the AI to do. Alternatively, install a local LLM model on your computer to keep the information off the cloud entirely (see the reader response from Richard Miller on page 46 for more information on this)
- schedule time in upcoming sessions with clients to discuss your use of this tool and update your contract
- consider using a specific model designed for clinicians that stores data in the UK and meets UK ICO standards for data protection (while remaining aware that standards and company policies can change).

6. How will the process be reviewed, and with whom?

The first step is documenting your rationale: why you are using the tool, the benefits it provides, the risks you have identified, how you have reduced those risks, what clients have been told and how informed consent has been sought.

Then consider how often you will review whether the process still fulfils your confidentiality and data-handling requirements (given that AI terms and conditions of use can change, and providers may change ownership) and who you will do this with. If this is your supervisor consider whether they have sufficient knowledge to help you, and bear in mind that their views on AI use may differ from yours (perhaps more so on this subject than other areas of practice).

Final thoughts

If the tool is enabling you to create better and more consistent records, and reducing a disability-related barrier to doing so then you can argue there is a good reason for you to use it. But those benefits do not override clients' rights to confidentiality and control over their personal information. The solution need not necessarily be to stop using AI, as long as you ensure that the way you use it is safe and transparent enough so that the benefits are not being achieved at your clients' expense.



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.

'You may like how an AI-generated interpretation of your transcript makes your work look more "professional" but is it an accurate representation of the session?'

READER RESPONSES

There are alternative solutions

I think we need to exercise great caution when using terms such as 'delete' and 'erase' when considering computer systems in general and cloud-based AI systems in particular. These terms are relative and do not carry the certainty we tend to imagine. Once client notes disappear into the maw of AI, those data are there forever. You can delete things from your own hardware but there is no assurance or certainty that data are also deleted from cloud-based systems.

I recently used ChatGPT to design a presentation with text and PowerPoint. Having supplied the parameters and context I was equally delighted and appalled by what I received; it was shockingly good and I felt I had done a deal with the devil. I was curious to know what the *quid pro quo* was. I asked it why I have access to such powerful computing power at no cost. The answer I received was, 'The AI system learns from the data you supply.' If that does not chill your bones then it should. That same AI system will be learning from your client notes, and that learning could be applied in ways we have no control over or knowledge of.

The nature of AI would suggest that your client data are subsumed into a system over which you have no control. Confidentiality may not technically be breached, but to share even redacted notes in this manner is at the very least ethically questionable.

Dyslexia undoubtedly raises significant difficulties when writing client notes but there are alternative solutions. Windows and Apple both offer native speech-to-text applications that do not use AI or cloud-based systems, ensuring that data are kept locally, which supports control.

There are many reports and predictions about AI from the wondrous to the apocalyptic. The truth is, nobody knows what AI is or will be capable of in the future, and I would suggest for this reason alone that therapeutic client notes should never be part of its data set.

GEORGE MITCHELL MBACP (ACCRED) is a retired counsellor and supervisor.

What do we actually need?

Much of the conversation about AI in counselling assumes we need the most powerful tools available. I'd like to suggest a more modest question: what do we actually need?

Many AI tools marketed to counsellors are likely to run on the same frontier models as ChatGPT, accessed behind the scenes. These models are fast and impressive. But your clients' words may then pass through more than one company, on servers you will never see.

I call the alternative 'minimum necessary utility' – choosing the least powerful tool that does the job well enough for the stakes involved. For some tasks that tool can now be run entirely on your own computer.

Free applications such as Ollama (ollama.com) and LM Studio (lmstudio.ai) let you download a language model and run it on a reasonably modern laptop, with no subscription and no data sent to the cloud. Whisper, a speech-to-text model, can also run locally to transcribe recordings. Local models are slower and less capable than frontier ones. But if keeping a client's story on your own machine means waiting 20 minutes for a transcript rather than five, that may be a sensible trade.

Local is not automatically safe. You remain responsible for encrypting your device, securing backups and getting informed consent before recording anything. Small models can summarise inaccurately, and transcription tools sometimes invent words nobody said, so every output still needs checking before it becomes part of a clinical record. Running locally decides where the data go. It doesn't decide whether the output is right.

Nor does this suit everyone. For many counsellors a well-run therapy-specific platform with clear data agreements may be the better choice, and probably much better than pasting notes into a free chatbot. The point is to choose deliberately rather than be guided by what the market is selling you.

If you're curious start small. Install Whisper, record yourself reading a page aloud, and see what you make of the transcript. When it comes to AI the most useful question may not be what's best but what's enough.

RICHARD MILLER MBACP is a counsellor, supervisor, trainer and AI ethics consultant. He is the author of *AI and Counselling: a practical and ethical guide*, to be published by PCCS in spring 2027.

Sometimes we need support

My answer to this dilemma is a 'both/and' rather than a 'yes or no' because I think that is the most honest place our profession currently stands.

Because I am also a neurodivergent therapist I recognise the potential for genuine transformation in the use of AI tools. I use AI frequently for reading, summarising and processing written content. As such, I share the dilemma writer's experience in seeking a means to process their thoughts and materials differently, and sometimes the need for support on that. Accessibility in practice does make a difference.

I certainly appreciate that using an AI tool provides the practitioner with the ability to feel on top of their notes for possibly the first time. However, I will acknowledge that the therapeutic relationship is based on confidentiality. The boundaries regarding data protection within AI tools are becoming increasingly ambiguous. I have chosen not to use AI for client notes or reflection as I have been unable to discern where client information resides once entered into AI systems, who can access it and how it will be used or stored.

If I were contemplating doing so I would take a few precautions. First, I would conduct an exhaustive investigation into the data protection policies of any tool I was considering using, examining all related documentation. Second, I would address this concern through my supervision sessions. Third, I would refer to our commitments relating to this in BACP's *Ethical Framework*. Fourth, and most importantly, I would be transparent to my clients about their information being processed via AI technology.

In essence, I suggest that you exercise caution when using AI technologies and, prior to incorporating AI into your practice, consult with others.

TATI SILVA MBACP (ACCRED), MUKCP, MBPA is a psychotherapist and DPysch researcher.

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 aged 20-30, 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

Do we always need therapy in training?

I'm required to complete 50 personal therapy sessions as part of my counselling training. I've previously had quite a lot of therapy and have also done a lot of personal development work, so I came into training feeling that I had already explored many of my childhood experiences, relationships and recurring patterns. I like my current therapist but after 20 sessions I increasingly feel there is nothing in particular I need to 'process'. Therapy is expensive and is another commitment to fit around college work, placement hours and supervision, and I'm beginning to resent having to attend simply to fulfil a course requirement. I understand why personal therapy can be valuable for trainees but is it ethical for a training provider to insist on a fixed number of sessions regardless of an individual student's needs? And if I do have to continue, how can I use the remaining sessions meaningfully rather than allowing them to become conversational or feeling that I am simply clocking up hours?

Issue: April 2027 **Deadline:** 25 January 2027

Can I ask my client to stop using ChatGPT to analyse our therapy?

A client recently told me that after every therapy session they put what we've talked about – including my interpretations and reflections – into ChatGPT and ask it to analyse how the therapy is going. They also ask questions such as, 'What is my therapist missing or getting wrong?' They told me this quite light-heartedly, almost as a joke, adding that so far ChatGPT thinks I'm doing everything right. I've noticed that I now feel more self-conscious in sessions, knowing that my interventions may later be scrutinised by AI. I'm also unsure how much information about our work the client is sharing and what happens to it once it has been entered into an AI platform. Is this simply the client's choice about how they reflect on their therapy, or is it reasonable for me to raise concerns? Do I have any right to ask them to stop?

Issue: May 2027 **Deadline:** 25 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.

When the uniform comes off

Tom Quayle shares how his adjustment to fatherhood after years serving in the military offers insight into how to best support new fathers around identity



After the excitement, the rush to the hospital and the whirlwind of the whole experience had died down, those first few mornings of paternity leave felt so perplexing.

For the first time in years I woke without an alarm, no plan for the day ahead, no sense of urgency, nowhere to be; just stillness and calm all around me. My partner asleep, our newborn baby boy beside her, his tiny chest rising and falling almost in rhythm with hers. This house that had been a home for years now felt unfamiliar, everything just a little too quiet, almost suspiciously so.

I walked into the kitchen and flicked on the coffee machine. As it hummed to life I found myself instinctively straightening things, adjusting appliances, organising coffee pods. Years in the army had conditioned me to movement: the need to be ever ready, the quiet hum of vigilance. But fatherhood was different and demanded something new. I began to realise that it wasn't about staying alert; it was about staying present.

Adjusting

A peculiar shift often happens when a man takes off his uniform – whether that's his army uniform, a three-piece suit or his workman's boots – and trades them for a baby carrier. For me, in one life I had command, clarity and a sense of order. In the other I found myself feeling utterly lost, pacing the living room in the middle of the night with a crying baby, whispering things I hoped would soothe him but mostly soothed me. I remember in these moments feeling both proud and disoriented – this new role was as intimate as it was destabilising.

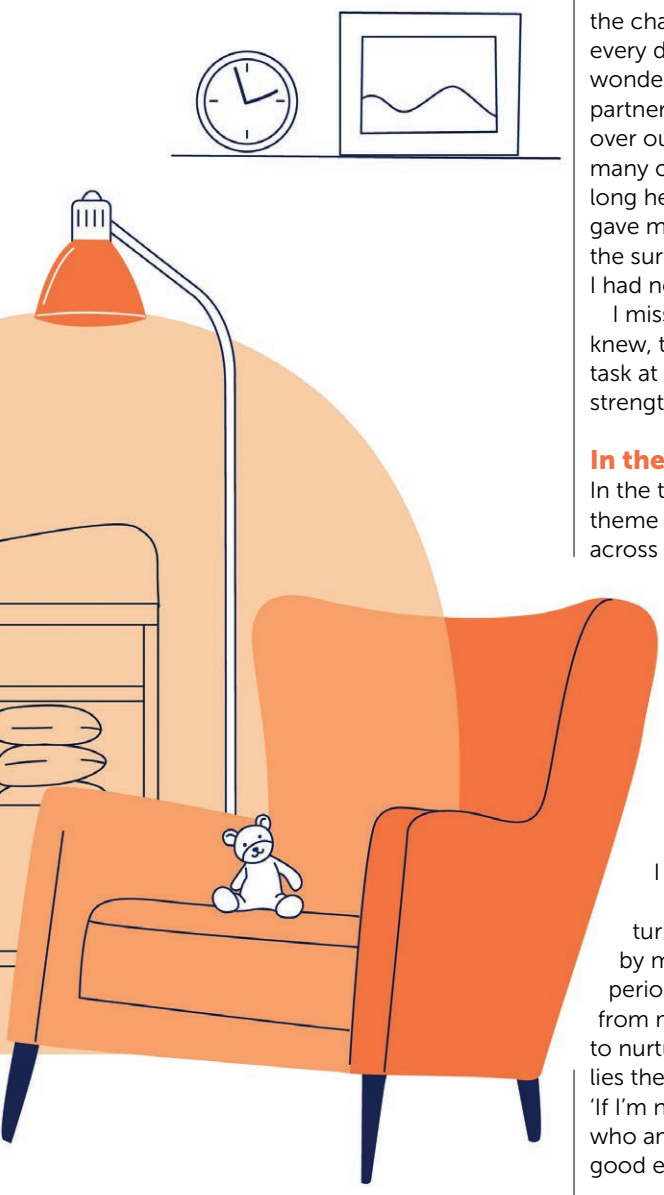
I had trained for years to manage crisis, to stay calm in chaos, but no one trains you for the small crises of fatherhood – the slow erosion of sleep, the invisible weight of responsibility, the fear of getting it all wrong. This was a new kind of battle: not with an enemy, nor on a battlefield far away, but with myself, in those dark moments alone.

Control to connection

In the military identity is tightly bound to function. Purpose is defined by utility – that is your ability to act, endure and follow through. As I stepped into fatherhood I found this sense of identity being challenged, almost dismantled.

When my son was born I found myself face to face with a version of masculinity

VASILKOVS/SHUTTERSTOCK



that felt entirely new to me. There was no battle plan, no training that had been drilled time and time again until it had become second nature, no 'objective achieved or mission complete' after a feed or nappy change. Just the repetitive, humbling rhythm of caring for a little human life. My sense of worth that had once been anchored in performance and discipline now had to find a new footing in gentleness and patience.

At first I found this shift more difficult than I would admit. I almost resisted the change. I caught myself questioning every decision and moment, and wondering, 'Am I doing enough?' My partner would sleep while I watched over our son, trying to calculate how many ounces he'd been fed or how long he'd slept for, as if these data points gave me a sense of control. Beneath the surface though, a feeling grew, one I had not expected: grief.

I missed the clarity of the life I once knew, the simplicity of facing the task at hand and being needed for strength alone.

In therapy

In the therapy room I see this same theme mirrored in the men who sit across from me – the mourning of identities lost. One client, a former firefighter, said, 'When the pager stopped I felt like I stopped too.' Another client, an ex-athlete shared, 'I thought I'd feel joy but now I feel lost.'* Hearing these words landed heavily on me: they sounded familiar. I recognised them, almost as if I had said them myself.

These words speak to a hidden turbulence, a turmoil often faced by men experiencing a transition period in life, from solider to civilian, from man to father, from protector to nurturer. Beneath each shift in roles lies the same silent, unasked questions: 'If I'm no longer what I trained to be, who am I now? And what if I'm not good enough?'

Masculine expectation

Men are not taught to grieve change; we are taught to adapt, 'crack on', normalise discomfort. In the army we used to joke that pain was simply weakness leaving the body. Looking back I see just how much a simple phrase like that can mask. What it really does is glorify endurance while quietly exiling vulnerability. Masculinity, as it is often scripted by society and culture, is somewhat of a performance of stoicism, endurance and even of fortitude.

Often because of this expectation or societal view men are more likely to suppress emotional distress after becoming fathers, particularly those from highly structured or masculine-coded professions.[1,2] Anxiety and low mood in new fathers are significantly underdiagnosed, often emerging as irritability, withdrawal or overinvestment in work rather than overt sadness or worry.[3]

For me paternity leave challenged this societal view and gave me space to feel the things that I'd always tried to numb: exhaustion, sensitivity, even a sense of gentleness. But it also stirred feelings that I hadn't expected: guilt for stepping back from work, for being tired, even for wanting some time alone.

Being seen

One night at around 3am I stood at the foot of my son's cot watching him sleep. His face still a little red from crying, his tiny fists finally unclenched – the twilight feed had been a struggle this night. My partner had gone back to sleep, the house seemed silent again, but as I stood there watching him breathe my mind was anything but silent. I found myself crying too, quietly, carefully, as if I was afraid to disturb the hard-fought silence.

It wasn't sadness exactly, or just a sense of relief. It was the realisation of the weight of a simple moment. In that moment I felt stripped of every role I'd ever played. There was no solider, no counsellor, no man performing acts of strength. Just a father, raw and unguarded.

'I missed the clarity of the life I once knew, the simplicity of facing the task at hand and being needed for strength alone'

'Fatherhood often forces a confrontation of the parts of yourself that have long been ignored: tenderness, dependence, even vulnerability'

That experience influenced how I work in the therapy room. I often see men sit across from me, their jaws tight and their voices measured as they describe fatherhood in terms of logistics: feeding schedules, workloads, mortgage stress – the lists go on. Beneath all of that there is usually something deeper. A fear of failing, of not being enough, or fear of change. In those moments I hear these men question who they are, and I feel the pressure that they face to have the answers.

A client once shared that his wife became a mother overnight but he was still figuring out who he was, which scared him. Sitting with that together, we explored the questions it proposed: what it meant to be a father when it felt like the world's definition of 'father' didn't fit. What happens when the protector needs protecting? What does it mean if the answers can't be found?

I see echoes of my own therapy story in these moments. I hear myself in their words. The transition to fatherhood is, for many men, the first time they encounter the limits of what they can control. It often forces a confrontation of the parts of yourself that have long been ignored: tenderness, dependence, even vulnerability.

As therapists, when we offer space for men to speak these truths, we are not dismantling their masculinity but helping to expand on it, helping them learn how to be seen. Men and fathers are rarely taught emotional fluency; no lessons are given for emotional eloquence yet the expectation is ever present. When we hold these spaces for men to feel safe we help men learn these unfamiliar skills.

Battlefield to nursery

Leaving the army was in many ways a rehearsal for becoming a father. Both changes involved a loss of identity, the redefinition of purpose and the need to find meaning beyond performance. In uniform my purpose was external: I was driven to serve, protect and achieve; out of uniform my purpose became more relational: to connect, nurture and find belonging.

The army had instilled in me a belief that composure equals strength, but I soon found out that babies have a way of undoing that composure. There is no negotiation to be had with a crying infant, only surrender, and in that surrender, I found that something profoundly human happens: acceptance, and an understanding that no matter how hard you might try some things are out of your control.

During my transition from army service to civilian life I experienced what Williamson et al describe as 'identity foreclosure'.[6] For me this was a collapse of my sense of self-definition and a focus on who I 'should be'. Many veterans I have worked with find themselves asking the same questions, describing a feeling of being 'untethered', unsure of how to translate their discipline and endurance into the emotional language of family life.

This transition, although often difficult at times, has taught me that courage isn't just the capacity to face danger head on, or the ability to endure hardships or to quietly handle challenges. It is the willingness to stay with the discomfort, to hold a crying child at 4am, not knowing what's wrong, and to resist the urge to try and fix, control or retreat, and just simply be there in the moment. Learning that sometimes 'being' is not passive; it's an act of profound presence.

The myth of 'doing'

In my practice I routinely meet men caught in what I call the 'doing trap'. They equate care with action. If they can't fix a situation, change it or influence it in some way they often feel useless. A male client in his 30s said: 'She's got it all figured out with the baby so I just keep myself busy. Keeping busy feels better than sitting around. There's always odd jobs to do around the house.'* Underneath what he was trying to say as a joke lay a sense of shame for not knowing how to nurture, for feeling surplus and for feeling useless.

In many Western cultures masculine worth is often tethered to productivity and control.[4,5] The paradox is that fatherhood often demands the opposite: stillness, receptivity and patience. In the therapy room I try to name this paradox through the lens of compassion. A reflection I sometimes offer to clients is, 'you don't need to fix it, you need to feel it'. Clients will occasionally reflect that it sounds



VASILKOVS/SHUTTERSTOCK

counterintuitive, even weak. Through this we explore how allowing ourselves to feel is an act of courage not weakness – an act that many men have never been given permission or even space to practise.

During my paternity leave I had to unlearn this reflex myself. There were moments when my partner would ask for help and I'd respond by offering a plan rather than presence. It took time, and humility, to realise that sometimes the most meaningful support is quiet and unheroic.

When I reflect on my military years I see how the skills that once kept me alive – vigilance, detachment, endurance – can, in civilian fatherhood, become barriers to intimacy. Therapy, both giving and receiving it, became the bridge between those worlds.

There's an irony in how society still treats paternal wellbeing: fathers are expected to be pillars of stability yet are rarely offered emotional scaffolding themselves. Research suggests that the prevalence rates of paternal perinatal stress, anxiety and depression might be as high as 69%,[7] although this figure could be higher, given men's reluctance to disclose distress.

In therapy I see the aftershock of this silence. Men talk about 'snapping' at their partners, feeling detached from their babies or numbing things with alcohol, screens or overworking. What they rarely name is grief – for their old lives, the version of themselves that seemed simpler or more certain. This form of grief may be defined as what Doka proposed as disenfranchised grief – a loss that society doesn't recognise or legitimise – often because it doesn't fit in line with traditional grief.[8]

Therapeutic integration

Becoming a father didn't just change me personally; it reshaped my therapeutic lens.

I've become more attuned to the subtle languages of overwhelm, noticing the half sentences, the long pauses and the faint tremors in men's voices when they talk about 'being fine'. It's also deepened my appreciation of relational repair: babies, after all, teach repair better than any textbook. You rupture connection dozens of times a day – by misreading a cue or missing a cry – and then you repair it by returning, holding and trying again. Therapy, I have found, is no different. Fatherhood has made me less afraid of ruptures in the room and more comfortable with the mess. In supervision I've noticed myself speaking more about presence than technique. It's not that theory matters less; it's that attunement matters more. The experience of holding a newborn, entirely dependent, wordless, trusting, mirrors the therapeutic stance of unconditional positive regard.[9]

When clients speak about feeling unseen or unseen as men I draw from my own experience of the quiet visibility fatherhood demands – the kind that comes not from being watched but from being felt.

New strength

In the months following paternity leave I returned gradually to my practice. My sessions felt different, a little slower and a little softer. I no longer rushed silence; I trusted it. I noticed more: a client's shifting posture or the tightening of a jaw when they mentioned 'coping'. I realised I was learning from the very men I sought to support. Their courage wasn't in conquering emotion but in surrendering to it.

When a client once told me that you can't command a baby to sleep we both laughed, but beneath it was truth. You can't command life into stillness; you can only learn to sit beside it. The military taught me resilience; fatherhood taught me tenderness. Both matter and belong. Somewhere between those two worlds – between order and chaos, discipline and surrender – I've found the most human version of myself.

Reflection

When I look at my son now, happy, laughing, entirely unconcerned with who I used to be, I feel gratitude for the disorientation that fatherhood brought. It stripped away illusions of control and forced me into intimacy with the present. It also connected me more deeply to the men I work with – men navigating unseen wars of identity, purpose and belonging.

As therapists, especially those working with men, our task is not to pathologise that stoicism but to understand it, see it as armour forged from survival not defiance, and gently invite what lies beneath. Because sometimes the hardest thing a man can do is not to fight but to stay present to hold his child, to hold his partner and to hold himself.

**Details have been changed to protect confidentiality.*

REFERENCES

1. Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. American Psychologist 2003; 58(1): 5-14. **2.** Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon HM. The role of masculinity in men's help-seeking for depression: a systematic review. Clinical Psychology Review 2016; 49: 106-118. **3.** Baldwin S, Malone M, Sandall J, Bick D. Mental health and wellbeing during the transition to fatherhood: a systematic review of first time fathers' experiences. JBI Database of Systematic Reviews and Implementation Reports 2018; 16(11): 2118-2191. **4.** Kiselica MS, Englar-Carlson M. Affirming the strengths in men: a positive masculinity approach to assisting male clients. Journal of Counseling and Development 2013; 91(4): 399-409. **5.** Mahalik JR, Good GE, Englar-Carlson M. Masculinity scripts, presenting concerns, and help seeking: implications for practice and training. Professional Psychology: Research and Practice 2003; 34(2): 123-131. **6.** Williamson V, Murphy D, Greenberg N. Military veterans and transition: the impact of identity loss and meaning reconstruction. Journal of Mental Health 2019; 28(2): 132-138. **7.** Philpott LF. Paternal perinatal mental health: progress, challenges and future direction. Trends in Urology and Men's Health 2023; 14(5): 14-18. **8.** Doka KJ. Disenfranchised grief. Bereavement Care 1999; 18(3): 37-39. **9.** Rogers CR. A way of being. Boston: Houghton Mifflin; 1995.

ABOUT THE AUTHOR



Thomas Quayle MBACP, GMBPsS is a person-centred counsellor who specialises in helping men and teenage boys. His military background and personal experiences with counselling inspire his passion for supporting others. **tqcounselling.co.uk**

AND THE WINNERS ARE...

BACP presents the winners and highly commended candidates for the first-ever Member Awards celebrating the success and achievements of members



Wendy Showell Nicholas MBACP (Accred)

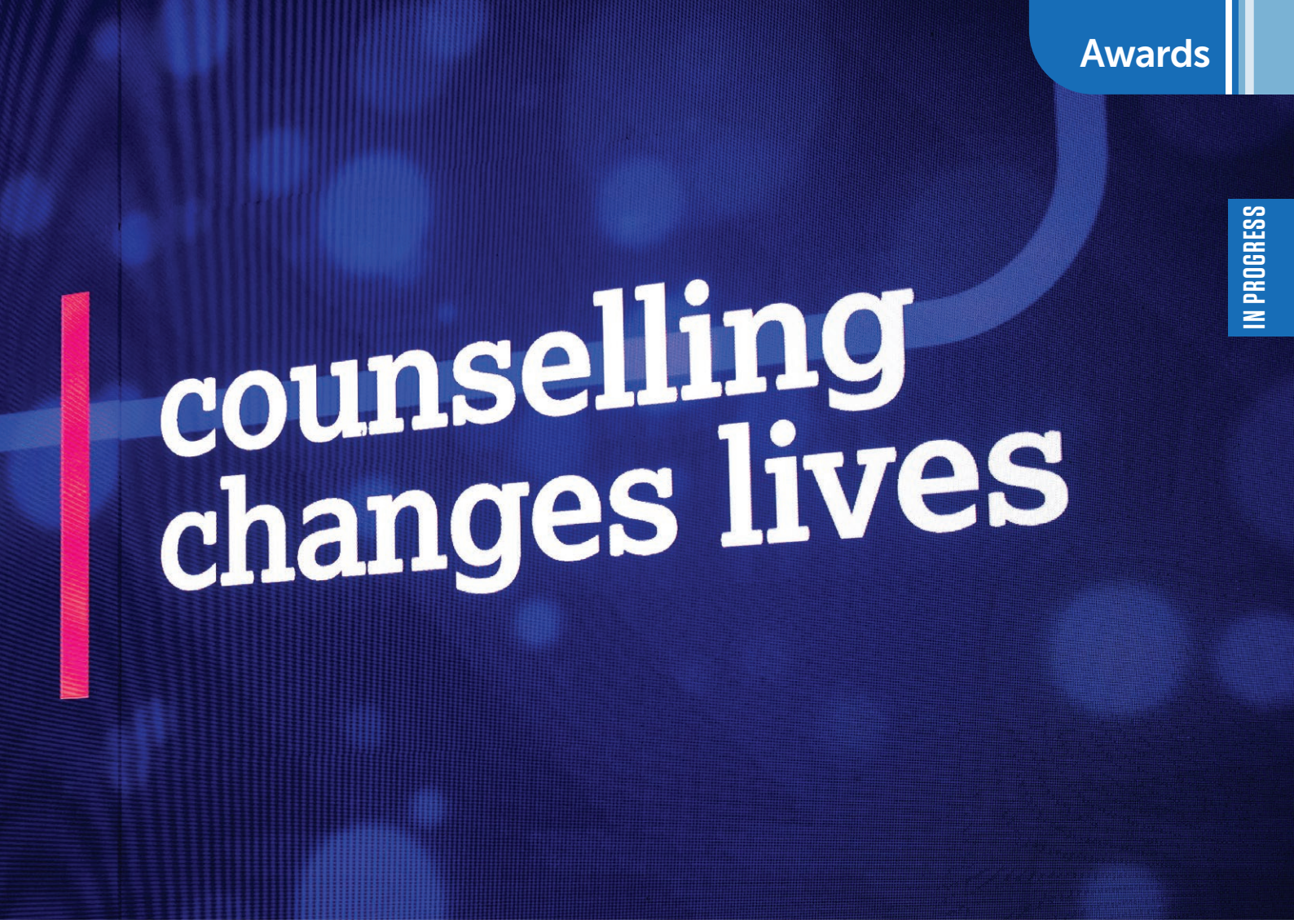
President's Award

This award celebrates unique, unsung, outstanding and demonstrable impact in communities where the work of an individual, team or partnership advances counselling and psychotherapy access, quality and equity to change lives and remove barriers.

WINNER

Wendy Showell Nicholas is a published author, psychotherapist in private practice and an organisational consultant with more than 20 years of experience in supporting individuals and institutions. She has a specialist interest in trauma and vicarious trauma, and also works with organisations to improve systems by building emotional intelligence and compassionate leadership. Wendy has delivered consultancy, training and advisory services to some of the UK's most prominent legal, healthcare and public sector bodies, schools and hospices.
showellnicholas.co.uk

Wendy says: ***'I still can't quite believe it. To be recognised in a room full of such remarkable practitioners was completely overwhelming. In a world where fear and division are so often amplified in headlines, I think awards like these are a quiet form of radical resistance. They turn our attention to the extraordinary work that ordinary people do every day. It is a privilege to be counted among them.'***



Lifetime Achievement to Counselling and Psychotherapy Award

This award recognises and celebrates exceptional and sustained contributions in a career in counselling and psychotherapy.

WINNER

Christopher Butler is a consultant in student mental health and wellbeing, researcher in ethnomusicology at Royal Holloway, University of London, a senior steward elder at Union Church Margate and works in construction and arts-based projects at Margate's Rosslyn Court. Trained by Relate, Christopher subsequently led a university counselling service, wrote a counselling textbook, contributed to national publications and consulted for many organisations. He now creates psychologically safer, inclusive spaces in artistic and faith communities.

Christopher says: *'I feel deeply touched – by colleagues who nominated and supported me, by BACP for selecting me and by everyone who helped make the event such a joyful occasion. It means a great deal to me to be recognised by such an important profession.'*



Christopher Butler MBACP (Accred)

EVENT PHOTOS: MIKE SEWELL 2026



Dr Miriam Donaghy MBACP

Distinguished Contributions to Counselling and Psychotherapy Award

This award is for work that has made an outstanding and lasting contribution to a particular area for the benefit of people or organisations – rather than a culmination of a career in the profession.

WINNER

Dr Miriam Donaghy is the founder and CEO of MumsAid. She set up one of the first postnatal depression therapy groups in the UK and created a groundbreaking framework for therapeutic approaches to postnatal depression. **mums-aid.org**

Miriam says: *'To be recognised by BACP for work I've believed in for almost three decades is incredibly validating. For the charity, the Excellence in Service Delivery Award (see page 57) is also very special: it recognises our whole team and the difference we make to the mothers and families who turn to us for support. At a time of such uncertainty for charities my hope is that it also helps funders and commissioners see our value.'*
Read more about Miriam on page 13.

Distinguished Contributions to Diversity, Equity, Inclusion and Belonging in Counselling and Psychotherapy Award

This award recognises individuals, teams or services who have demonstrably advanced DEI and belonging in counselling and psychotherapy through practice innovation, leadership, research, supervision or training, and achieved meaningful impact for people and communities.

WINNER

Silva Neves is a COSRT accredited, BACP and UKCP registered psychosexual and relationship psychotherapist, a trauma psychotherapist and a clinical supervisor. He is the author and editor of several textbooks on human sexuality. **silvaneves.co.uk**

Silva says: *'Winning this award is very meaningful to me because it is a recognition from the profession that LGBTQ+ people and other sexually marginalised people matter. Our profession cares about us.'*



Silva Neves MBACP



Rebecca Wilde MBACP

Innovation Award

This award is aimed at recognising a particularly innovative approach to practice, teaching, research or supervision. The award can be made to a team or project as well as to an individual practitioner, researcher, trainer or supervisor.

WINNER

Rebecca Wilde is a pluralistic psychotherapist trainee and Director of The Gypsy, Roma and Traveller+ Therapists Network. Research and advocacy underpin the network's anti-oppressive focus on culturally responsive practice and widening community access to mental health support. **grttherapists.com**

Rebecca says: *'I'm honoured to receive this award for launching The Gypsy, Roma and Traveller+ Therapists Network. This recognition affirms the importance of visibility and representation in our profession, and has strengthened my commitment to advocating for Gypsy, Roma and Traveller communities' experiences being heard and uplifted.'*

Supervisor Award

This award recognises, promotes and rewards good practice by members of BACP. It seeks to salute achievement in the preceding 12 months and to help support the development and continuous improvement of the professional skills and competences of counsellors and psychotherapists.

WINNER

Satinder Panesar is an integrative psychotherapist, clinical supervisor, consultant and author of *When Therapy Goes Wrong*. Some of her work focuses on reflective practice, ethical accountability and the mentoring and professional development of clinical supervisors. **satinderpanesar.com**

Satinder says: *'I'm incredibly honoured and genuinely moved to receive this award. After more than 25 years in the profession this recognition means so much to me. I genuinely love being a clinical supervisor and feel privileged to be invited into the complexity, uncertainty, growth and joy that therapists bring to our conversations. Some of our greatest professional learning comes from moments when we feel challenged. This belief inspired my book and continues to shape my passion for developing clinical supervisors. I'm grateful to BACP for celebrating my work, and I hope this award also shines a light on the often unseen but invaluable contribution of clinical supervisors everywhere.'*



Satinder Panesar MBACP (Accred)

HIGHLY COMMENDED

Michele Crooks MBACP

Michele Crooks is an integrative, relational therapist with more than 20 years' experience, a trainer and supervisor, author of the children's book *The Worry Puppy*, and the CEO of Watch and Wonder, a child/parent attachment programme. Her book for adults *The Anxiety Myth* is out soon.

Michele says: *'This recognition was particularly meaningful because it came from my peers. Their affirming, unsolicited feedback deeply moved and encourages me. This award belongs to them too because I am constantly shaped by my interactions and learning with others.'*



Trainer Award

This award recognises, promotes and rewards good practice by members of BACP. It seeks to salute achievement in the preceding 12 months and to help support the development and continuous improvement of the professional skills and competences of counsellors and psychotherapists.

WINNER

Jo Oxley founded Optima Attachment Training, offering diplomas in attachment psychotherapy and adoption alongside CPD, podcasts and retreats. Her passion is helping counsellors and psychotherapists develop confidence, curiosity and deeper relational understanding in their practice. **optimaattachment.co.uk/therapy/online-attachment-therapy-uk**

Jo says: *'Winning BACP Trainer of the Year means a great deal to me. I'm passionate about attachment and helping counsellors and psychotherapists bring that understanding into their relationships with clients. It's a privilege to be part of that process.'*



Jo Oxley MBACP (Accred)

HIGHLY COMMENDED

Christopher Bello Gresch MBACP (Accred)

Christopher Bello Gresch is a psychotherapist, clinical supervisor, trainer and doctoral researcher. Across academic teaching, private practice and supervision he champions compassionate, relational learning that helps people grow in confidence, insight, connection and shared purpose. **ifoundhelp.uk/about.html**



Christopher says: *'To receive Highly Commended Trainer Award has touched me more deeply than I can say. I feel humbled, grateful and full of emotion. I receive this honour with a full heart and share it with every person who has been part of my journey.'*

Excellence in Course Delivery Award

This award recognises particularly innovative and creative design or delivery and assessment of programmes for the benefit of the student experience while maintaining or furthering the highest quality of teaching and learning.

WINNER

Warwick's four-year part-time contemporary degree programme is founded on relational principles that put the quality of the therapeutic relationship at its heart. It offers a holistic way of working to meet the therapeutic needs of a range of clients, considering mental health needs and cultural influences. University of Warwick was recently awarded Gold in all categories of the Government's latest Teaching Excellence Framework (TEF) rankings.
warwick.ac.uk/study/cll/courses/undergraduate/ba-counselling-psychotherapeutic-relationship

Cathryn MacLeod MBACP (Accred), Associate Professor and Team Leader, says: *'This award means a great deal to us. We as a team and our colleagues have put such effort and love into creating and developing this course which embodies our inclusive and relational values. This is a super recognition of all of our students, alumni and staff who make it what it is.'*



Warwick University, BA (hons) Counselling and Psychotherapeutic Relationship Team

HIGHLY COMMENDED

Foundation Degree in Integrative Counselling, Ulster University (delivered at Northern Regional College)



Michelle Laverty MBACP (Accred) is a clinical supervisor and lecturer with extensive experience across voluntary, community and private practice settings. Her specialist interests include integrative counselling and child therapy.

Minford McBride MBACP (Accred) is an integrative LGBTQ+-affirming therapist, qualified clinical supervisor and lecturer. His counselling practice focuses on issues associated with self-esteem, interpersonal relationships and bereavement/loss.
bit.ly/4iwXmyW

Michelle says: *'I'm delighted to share this recognition with Minford. We feel incredibly honoured to receive this award. Our students are at the heart of everything we do, and it is a privilege to support them as they develop into compassionate counsellors. We are proud to contribute to a profession that makes such a difference to people's lives.'*

Excellence in Service Delivery: Private and Public Sector Award

This award recognises a service (or service team) that demonstrates outstanding ethical, evidence-based, inclusive and client-centred counselling or psychotherapy delivery, resulting in meaningful positive impact for clients and communities.

WINNER

The Atrium Clinic and Therapy Centre team at Oxleas Health Trust and for work in London prisons

The Atrium Clinic is a dedicated team providing compassionate, specialist therapeutic support to men in custody. Through skilled relational work, collaboration and commitment it helps individuals overcome adversity, improve wellbeing, reduce risk and build meaningful change.
atriumclinic.co.uk



Alex Wyld-Sinclair, Clinical Lead for Atrium Forensic Counselling and Psychotherapy service, says: *'I am immensely proud of what the team has achieved, bringing dedication, professionalism and compassion to a client group whose needs are often complex and overlooked. With many thanks to my assistant manager Lorna Francis.'*

HIGHLY COMMENDED

The Eaves Counselling and Psychology Ltd



Bridget Walford, owner, says: *'To be recognised by our professional body for the hard work and perseverance dedicated to The Eaves over the past 22 years makes me feel humbled and proud. From one practice room to 30, from one Eaves Affiliate to 180, The Eaves remains a family-owned company providing high-quality care to our communities through private referrals, our EAP and affordable service and supporting the next generation of practitioners through our placement offering.'*

JAMESWILLSPHOTOGRAPHY

Excellence in Service Delivery: Voluntary and Community Award

This award recognises BACP organisational members who provide outstanding therapeutic services operating within the voluntary, community and not for profit sector. It celebrates the essential role voluntary and community organisations play in delivering accessible, ethical and high-quality counselling and psychotherapy to communities – often in contexts of limited funding, rising demand and significant social need.

WINNER

Established in 2012, MumsAid is an award-winning charity providing pregnant women and new mums who wouldn't ordinarily be able to access support with specialist counselling for emotional and mental health difficulties. The charity trains frontline professionals in perinatal mood disorders and challenges stigma surrounding postnatal depression. MumsAid's work is featured on Public Health England's website as an example of best practice in perinatal mental health.
mums-aid.org



MumsAid team


The Southmead Project

HIGHLY COMMENDED

The Southmead Project is a charity providing free specialist trauma counselling and therapeutic support for survivors of abuse and those impacted by addiction across Bristol and the surrounding areas.
southmeadproject.org.uk

Emma Bull, Acting Chief Executive Officer, says: *'We were delighted to receive the Highly Commended Award for this category and have the Southmead Project's work recognised in this way. I feel so proud to be part of such a thoughtful and committed team, and grateful to everyone who has trusted the Southmead Project when they needed support.'*

Bright Future Award

This award recognises early career practitioners who show exceptional promise, innovation, ethical practice and clear potential to make a significant long-term contribution to counselling and psychotherapy.

WINNER

Georgina Sturmer is a BACP senior accredited integrative counsellor, clinical supervisor and lecturer specialising in attachment-based therapy. Alongside her private practice she delivers training and workshops and regularly contributes psychological insights to the press.
georginasturmer.co.uk

Georgina says: *'I'm absolutely thrilled to have won the Bright Future Award. Like many therapists I came to this profession later in life, having tried my hand at all sorts of different things. I've loved discovering just how many directions my career can take me, learning so much and meeting some fascinating people along the way. I feel as though I've finally found my professional home, and I'm really proud of how far I've come.'*


Georgina Sturmer MBACP (Snr Accred)



Losing Jason

Banjo Aromolaran reflects on the fatal public shaming of an admired colleague

My last communication with the late Professor Jason Arday was on 8 August 2026. Less than a week later he was found dead.

That week I felt like I was witnessing the systematic takedown of a person whose achievements stood as a lighthouse of hope for my professional aspirations in an ecosystem I'd existed in for much of my professional life.

All I could do was stand by helplessly while this person I admire was publicly humiliated, their credentials questioned and their life's work picked over to find flaws and inconsistencies. If the messaging coming out of certain sections of the media was anything to go by, this was all because he dared to occupy space not historically meant for his 'sort' to survive.

Representation

As a Black academic with more than 20 years' experience in academia, I had only ever met two Black male professors: Professor Jason Arday, former Cambridge University Professor, and Winston Morgan, Professor of Toxicology, Equity and Inclusive Practice at University of East London (UEL).

Encountering them in the course of navigating the higher education ecosystem was, for me, tantamount to a sighting of the mythical unicorn. Their collective achievements and presence in the highest echelons of academia made my aspirations feel realistic. I thought if they could make it in such rarified, esteemed spaces then my hopes of achieving something hopefully comparable were possible.

So it was with chilling disquiet that I watched what felt like the 'digital lynching'[1] in the media of an admired colleague and acquaintance.

What hope?

That week I remember reaching out to Jason to assure him that there were more in support of him than the few that were against him. Despite my sense of helplessness I had hoped that surrounded by collective support he would weather the relentless media onslaught and intense personal scrutiny because what was being written about him had no bearing on the person I knew.

In retrospect what hope did he have? I still wonder whether I, or anyone I know, could endure round the clock so-called 'public interest' coverage in the mainstream media over a 22-day period.

The original basis of the accusations against Jason were predicated on the resurgence of a legacy of eugenics repackaged as 'race realist' philosophy.[2,3] This pseudoscientific theory feels like old wine being poured into new bottles, with wider social, emotional and psychological ramifications that cannot be overemphasised or denied, especially when it can lead to the destruction of another human being.[4,5]

It didn't seem to matter that the 'fabulist' accusations were later contested. It seemed to only matter that accusations were being levelled against a Global Majority academic who was thriving in spaces traditionally deemed to be the sanctum of a privileged few. I can't imagine that many would survive unscathed from such a professional and personal death knell once rung.

In the days leading up to Jason's death, all I experienced was someone being commodified, relentlessly hounded with a disturbing level of glee that ended in their tragic loss of life.

I can't help but ponder on Britain's status quo as a 'tolerant society'. Not in the least because tolerance suggests the presence of a powerful, established patriarchy putting up with, rather than embracing and celebrating, the achievements of a lesser powerful, diverse group of people who exist in spaces they were not fundamentally

ANGELINA BAMBINA/SHUTTERSTOCK

expected to thrive in. But because this very British notion, when first conceptualised, was predicated on the supremacy of the British Empire, persistent imperial attitudes of racial superiority seem to have provided a context for race realism to gain a foothold because 'tolerance condones judgmental interference by the judging, dominant, and powerful'.[6]

Therapy relevance

My reasons for exploring this aren't simply about academia and society. It would be remiss of me not to reflect on the wider social, emotional and psychological impact of what happened to Jason. Because in my view this all has implications for the therapy room. It is highly relevant to our profession.

While I can't help but conclude that racism played a significant part in Jason's story I am loathe to reduce my reflections down to racism alone. In this instance it was racism, but next it could be ageism, ableism, sexism, classism, whichever ism doesn't fit the dominant narrative looking to maintain its status quo by limiting access to sections of its diverse community.[7]

In an August *Guardian* opinion piece Minister for Women and Equalities Bridget Phillipson warned that 'racism and sexism have become normalised in Britain... fuelled by online interactions and statements by politicians that would not have been acceptable a few years ago'.[8] As therapists it is something that we need to pay attention to. It would need to be our collective responsibility to acknowledge this normalisation because all it takes for evil to flourish is to turn a blind eye. The Black Policy Institute expanded on the *Guardian* piece, concluding that we should move 'beyond accusation and denial towards an honest examination of how racism operates' using civic dialogue, institutional leadership and practical policy solutions as organising principles.[9]

From my perspective, a useful starting point is to remain mindful of the conscious and unconscious biases we all carry when engaging with those perceived as 'other', particularly in spaces historically shaped by established power structures. I personally feel that this includes honestly assessing the assumed belief of tolerance in the UK: looking at the evidence of what our clients tell us in our therapy rooms, is that description fit for purpose? Perhaps this will provide the impetus for a conscious movement beyond being a 'tolerant society' to a society that embraces and celebrates the beauty of its diversity.

I'm grateful to the special people who held a supportive and non-judgmental space for my anger, moral outrage and grief to be heard, and whose presence and unconditional positive regard was much needed as I formulated the emotional chaos around what happened to Jason.

The Office for Institutional Equity at my university also convened a safe space where the individual grief of UEL colleagues and students could be processed. For an event planned with only a few days' notice over the summer recess it was very well attended, in person and remotely, indicating how necessary these opportunities are on an institutional level.

But the need for institutions to hold a space where individual grief can be collectively processed is very real and urgent.

The collective sense of grief of the 30,000-plus attendees at the vigil held in Jason's honour at Trafalgar Square on 17 August 2026 was palpable, settling like a heavy blanket on a hot summer's night.

As mental health professionals we ultimately collectively hold the mental wellbeing of the nation in our counselling rooms. It therefore seems to me that it falls to us, in understanding and accepting the fact that structural racism is a determinant of mental ill health, to be able to provide a space for clients in which anger, fear, sadness and grief of those affected by events like the circumstances around Jason's death can be expressed and held.[10] Our preparedness to work with this isn't only in relation to clients from the Global Majority but also with clients who we presume would be less affected because they are from the Global West.

I am still processing my individual grief at the untimely death of Jason, as I am sure many are. My hope, as we move forward, is that the memory of Jason becomes more tied to what he represented for a lot of us. ●

'Accusations were being levelled against a Global Majority academic who was thriving in spaces traditionally deemed to be the sanctum of a privileged few'

REFERENCES

1. Tarhan N. Digital Lynching is not criticism, but an act of destruction. 6 February 2026. uskudar.edu.tr/en/new/nevzat-tarhan-digital-lynching-is-not-criticism-but-an-act-of-destruction/76518 **2.** National Genome Human Research Institute. Eugenics: its origin and development (1883-present). 30 November 2021. genome.gov/about-genomics/educational-resources/timelines/eugenics **3.** The British Academy. The 21st century resurgence of eugenics. 13 June 2025. youtube.com/watch?v=u4UZE_W6k3Q **4.** Berenstain N. Biological race realism and the legacy of racial pseudoscience. Australasian Journal of Philosophy 2025; 1-24. **5.** Mental Health Foundation. Racism and mental health. 20 March 2023. mentalhealth.org.uk/explore-mental-health/blogs/racism-and-mental-health **6.** Roberts D. The delusion of racial tolerance in the UK. University of Loughborough. 21 December 2022. blog.lboro.ac.uk/edi/the-delusion-of-racial-tolerance-in-the-uk **7.** Adisa TA, Abdulraheem I, Isakia SB. Patriarchal hegemony: investigating the impact of patriarchy on women's work-life balance. Gender in Management 2019; 34(1): 19-33. **8.** Stacey K. Racism and sexism have become normalised in Britain, says equalities minister. The Guardian; 20 August 2026. **9.** The Black Policy Institute. When racism becomes normal, what should public institutions do? [Online post.] 5 September 2026. **10.** Marmot M, Naqvi H, Ofori C, Fenton K. Structural racism and the social determinants of health. BMJ 2024; 387: q2139.

ABOUT THE AUTHOR



Banjo Aromolaran MBACP BERA is a senior lecturer and co-chair of the LGBTQ+ Network at the University of East London, where he teaches on the Postgraduate Diploma and MA in Integrative Counselling and Psychotherapy.









For job opportunities, visit bacp.co.uk/jobs

CHANGE YOUR LIFE

BECOME A COUNSELLOR

CPD WORKSHOPS

Continuing Professional Development (CPD) is vital for maintaining high standards in counselling. It ensures practitioners stay up to date with new research, emerging approaches, and ethical best practice. CPD also supports reflective practice, helping counsellors to grow both professionally and personally.

UPCOMING DATES

- 5th Dec 2026 - Chrysalis Workshop in Working with Addictions
- 23rd Jan 2027 - Chrysalis Workshop in Mental Health Awareness
- 6th Feb 2027 - Chrysalis Workshop in Introduction to PTSD & Trauma
- 21st March 2027 - Chrysalis Working in Preparing to Work with Couples

LEVEL 5 CERTIFICATES

Designed for qualified and registered counsellors or psychotherapists, these short courses offer an accessible introduction to working in specialist areas of practice.

While not full qualifications, they provide valuable CPD by equipping practitioners with up-to-date knowledge and practical skills relevant to specific client groups.

UPCOMING DATES

- Working with Sexual and Gender Diverse Clients
- 14th Jan 2027 - Certificate in Solution Focused Brief Therapy
- 10th Feb 2027 - Certificate in Online & By Telephone
- 16th April 2027 - Certificate in Working with Neurodiverse Clients
- 13th May 2027 - Certificate in Working with Children & Young People

ADVANCED COURSES

Expand your horizons and deepen your counselling expertise with every course. Each qualification enhances your skills, empowering you to make a greater impact. Continue your studies with confidence, curiosity, and a passion for growth.

UPCOMING DATES

- 6th March 2027 - Level 5 Diploma in Counselling Children and Young People
- June 2027 - Level 6 Diploma in Psychotherapeutic Counselling (Research in Counselling)
- Sept 2027 - Level 5 Diploma in Advanced Counselling Practice

Chrysalis Membership

Meet your CPD requirements, cost-effectively.

CPD Membership from £60 per year

Ongoing CPD, workshops and exclusive course discounts.

Full Membership from £180 per year

All CPD benefits, enhanced discounts, access to Chrysalis Talking Therapies and Chrysalis Workplace.

IN-PERSON CPD FOR THERAPISTS

Yellow Frog
Psychotherapy Training

CAROLYN SPRING & SALLY ATKINSON

CHOOSE FROM ONE OF OUR TWO CURRENT COURSES

Working with Attachment *or* Shame in the Therapy Room

'It's the relationship which heals'

Small group, in-person, experiential training days with discussion, reflection and case consultation, with access to Carolyn's online training to supplement the learning experience – up to 18 hours' CPD.

See the website for next available dates and course details

£150 inc VAT

The Pad @ Rutland Therapy Centre, Oakham LE15 6AY · 9.30am–4.00pm



Carolyn Spring
Trauma trainer, consultant, and author of 'Unshame'



Sally Atkinson
UKCP psychotherapist, clinical supervisor, and Level 7 Masters tutor

BOOK YOUR PLACE OR FIND OUT MORE AT
www.yellowfrogtraining.com

National Centre for Eating Disorders

NUTRITIONAL THERAPY EDUCATION COMMISSION
CERTIFIED

BPS Approved training for therapists working with Eating Disorders & Obesity with mentorship & support via zoom

Master Practitioner Eating Disorders & Obesity
15 days
Each course is stand-alone; with experiential content to transform your own relationship with food.

Working with Autism & Eating Disorders/Disordered Eating (including ARFID) - 3 days

Recorded Online Learning Platform
A 3 day online course to gain essential skills for understanding & supporting autistic people experiencing Eating Disorders or Disordered Eating Patterns, including ARFID

the british psychological society
CPD QUALITY MARK 2026

Excellence in Practitioner Skills for Eating Disorders 9 days

This world-renowned Diploma Course which teaches integrative skills from a wide range of up-to-the-minute therapies for the treatment of binge eating, bulimia and anorexia. You will also get to transform your own relationship with food.
Spring 2027: Zoom 11-13, 18-20 March & 1-3 April

Essential Obesity: Psychological Approaches 4 Days

Help people who want weight change, without dieting, compassionately & effectively with state-of-the-art skills from counselling, clinical & health psychology.
Summer 2027: Zoom 10-11 +17-18 June

Nutritional Interventions for Eating Disorders 2 days

A superlative, unique course to teach nutrition-related aspects of eating disorders & obesity for psychotherapists.
Autumn 2027: Zoom 18 + 25 November

Receive a big discount if all 3 course are booked together, please call for details

View a prospectus for each course & book online at www.eating-disorders.org.uk/training Call 01372 439184

For job opportunities, visit bacp.co.uk/jobs

DELANCEY THERAPY ROOMS
Camden

Professional therapy rooms within the Association of Jungian Analysts available to book for single sessions on an ad-hoc basis or for regular blocks.

• Comfortably furnished • Excellent soundproofing • Ultra-Fast Wi-Fi
• Air purification • Private garden • Group room available

From £11 per hour (conditions apply)

We welcome qualified therapists and counsellors from all modalities.



Enquiries: office@jungiananalysts.org.uk
www.delanceytherapyrooms.org/

the minster centre
psychotherapy • counselling • training

Enhance your career with training from the Minster Centre

Our integrative, experiential approach will give you a wider understanding and strengthen your professional practice

Post-qualification Courses:

MA/PGDip - Advanced Clinical Practice in Counselling & Psychotherapy (Jan 2027)

In-person Diploma/MA/PGDip in Supervision (Jan 2027)

Continuous Professional Development:

Certificate in Body Psychotherapy: Developing Embodied Resonance (Nov 2026)

See www.minstercentre.ac.uk for full details
Contact us on 020 7644 6240 or admissions@minstercentre.ac.uk

For job opportunities, visit bacp.co.uk/jobs

Centre for Stress Management

promoting the cognitive behavioural approach for over 35 years

The Centre has been providing training based on the cognitive behavioural approach to stress management and therapy since 1987. Our training programmes are BPS Learning Centre Approved for the purposes of CPD. The Centre's Director is Prof Stephen Palmer PhD.

Courses delivered using Zoom virtual training platform

Certificated Courses	
Stress Management*	19-20 Nov; 26-27 Jan; 6-7 Apr
Problem Focused Counselling, Coaching & Training	17-18 Nov; 18-19 May
Assertion and Communication Skills Training	16-17 Mar; 21-22 Sept
Psychological Resilience – a coaching perspective †	18-19 Mar
Developmental and Transitions Coaching †	19-20 Jan
Positive Psychology Coaching †	20-21 May
Acceptance and Commitment Coaching Training (Intro)	10-11 Dec; 21-22 Jan; 1-2 Jun
Acceptance & Commitment Coaching (Intermediate)	2-3 Mar

* this course fulfils the training component for Professional Level Membership of the International Stress Management Association (ISMA)
† these three courses form the Certificate in Positive Psychology Coaching

Our Trainers are Chartered Psychologists and Accredited CBT and REBT therapists

Other Courses	
Foundation Certificate in CBT and REBT (4 days)	Modular
Foundation Certificate in Cognitive Behavioural Therapies (4 days)	Modular
Diploma in Stress Management (15 days)	Modular
Certificate in Coaching (5 days)	3-9 Dec; 11-17 Feb; 15-21 Apr

This course is part of the Association for Coaching's CPD Hours scheme and also fulfils the training for our Institute of Leadership approved Coaching Development Programme

156 Westcombe Hill, London SE3 7DH Tel: +44 (0) 208 853 4171 Email: office@iafpd.one www.managingstress.com
Part of the International Academy for Professional Development Ltd. www.iafpd.com

the british psychological society CPD QUALITY MARK 2026

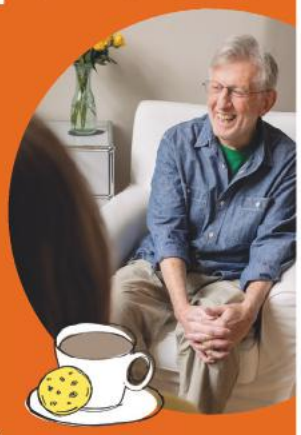
ISCP

Is your supervision...

Inspiring?
Encouraging?
Motivating?
Working?

NO?

We should meet!



Let's chat on a free, informal, no commitment Zoom call.

Specialist Supervision by Allan Kelly
BACP Accredited Supervisor
allankelly.com

THE Allan Kelly PRACTICE Est.2002

We offer excellence in short courses and professional development workshops for therapists, practitioners and mental health professionals

NORTHSIDE TRAINING

Dreaming in the Consulting Room: Contemporary Approaches to Dreams in Psychotherapy
Series of 90 min online workshops from Brad McLean bringing together some of the most compelling theoretical frameworks for working with dreams in therapy. Wednesday mornings starting February 2027. *£25 per workshop*

Key Perspectives for Psychotherapy
Dr Elvin Aydin Keles brings together perspectives from a range of modalities and frameworks to deepen our understanding of development, relationship, complexity and therapeutic change. Each online series includes 3 live two-hour workshops, with the option to add reflective practice groups to consolidate learning. £160 per series.
How We Become Who We Are. Jan – Mar 2027,
Making Sense of What is Happening. Apr – Jun 2027
When Therapy Gets Stuck Sept – Nov 2027

Introduction to Transactional Analysis (TA101)
Sat/Sun 17 & 18 Apr 2027, 17 & 18 July, Leeds £220
Develop your therapeutic skills to include TA on the official 2-day intro course. And the starting point for further training

To see our full training programme
visit www.northsidetraining.co.uk, email us on info@northsidetraining.co.uk
or call 0113 2583399

NORTHSIDE TRAINING

For quality, up to date and outward looking training in Leeds & online
On-site training takes place in North West Leeds. Prices listed are VAT not applicable.

National Centre for Autism and Mental Health

www.ncamh.co.uk
Course enquiries call: 07545 190915
E-mail: hello@ncamh.co.uk



ON-LINE BPS APPROVED AUTISM AND MENTAL HEALTH TRAINING COURSES

the british psychological society CPD QUALITY MARK 2026

Are you looking to increase your knowledge and skills when supporting autistic people with co-occurring mental health support needs?

TRAINING COURSES FOR 2026-7
NEXT START DATE 22ND FEBRUARY 2027

- **BPS Approved Certificate in Autism and Mental Health (14 Days online)**
- **BPS Approved Diploma in Autism and Mental Health (26 days online/with bi-weekly one hour live zoom sessions)**

STAND ALONE ONLINE MODULES/SHORT COURSES FOR 2026-7 (START ANYTIME)

- Understanding Autism and Mental Health
- Autism and Eating Disorders/Disordered Eating (including ARFID)
- Autism, Sensory Awareness & Regulation
- Cores skills, assessment & adjustments to practice.
- Autism, Alexithymia, Masking/Camouflaging
- Autism and Anxiety
- Autism and Demand Avoidance.
- Autism and OCD
- Autism and BPD
- Autism and Suicide
- Autism and ADHD

Complete training online at your own pace/time.
Individual modular route also available for completing both the Cert/Dip. Start anytime.
View the full course at: www.ncamh.co.uk

National Centre for Autism & Mental Health

For job opportunities, visit bacp.co.uk/jobs

Training in Child and Adolescent Psychotherapy and Counselling

terapia TRAINING est.2003

MA in Child and Adolescent Psychotherapy and Counselling
Can lead to UKCP registration, CPC and BACP Individual Accreditation
Duration: four years part-time

MA in Child and Adolescent Psychotherapy and Counselling (Conversion Course)
Can lead to UKCP registration, CPC and BACP Individual Accreditation
Duration: two years part-time

Foundation Course
Certificate in Adult Psychotherapy and Counselling, required for candidates who are applying for MA course and have not undergone any basic training
Duration: one year part-time

Diploma in Child, Adolescent and Adult Psychotherapy and Counselling Supervision
Duration: one year part-time, eight weekends



For more information about training with Terapia
Call: **020 8201 6101**
Email: **training@terapia.co.uk**

In partnership with Middlesex University London · UKCP · Child Psychotherapy Council Associate Member

SCAN HERE

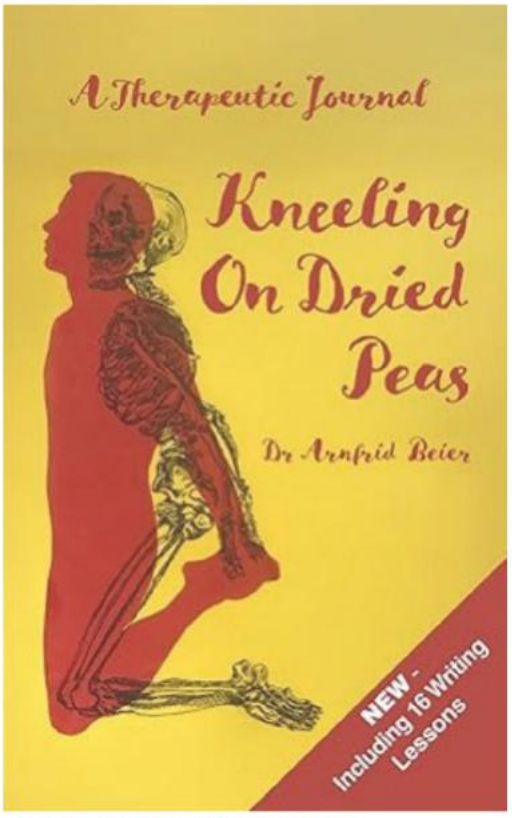
www.terapia.co.uk

KNEELING ON DRIED PEAS
Dr Arnfrid Beier

An Author's Reflections on the Therapeutic Value of Writing.

We all have a story in us. This is my personal story from counsellor to author and how it has been healing for me.

All our clients have stories to tell. Why not use "Kneeling on Dried Peas" in your work to help your clients and groups?



AVAILABLE AS PAPERBACK OR KINDLE EDITION ON AMAZON NOW

For job opportunities, visit bacp.co.uk/jobs

2027 TRANSFORM TRAUMA MEXICO



How much more is there to understand about trauma?

New possibilities for your practice

From the latest insights in neuroscience to ancient traditions of healing, discover the ideas and approaches challenging established thinking about trauma.

Join 40+ experts including **Bessel van der Kolk, Dan Siegel, Dick Schwartz, Janina Fisher and Ruby Wax.**

19–20 February 2027 | Live online
CPD opportunities | 90-day access to conference recordings

Exclusive BACP member offer
Save 15% on virtual tickets with code BACP15 at checkout
mexico.mastersevents.com

MATRIX college

Diploma in Clinical Supervision

through a relational integrative lens

In person teaching with two highly experienced tutors

Mapped to the BACP **supervision competence framework**

7 weekends **Feb - Oct 2027**

scan to get the **early bird discount**

matrix.ac.uk

LC&CTA
TRAINING • DEVELOPMENT • CPD

Practical, specialist CPD for today's counsellors



Two Specialist Online CPD Programmes

Build your confidence and develop practical skills to work more effectively with neurodivergent clients.

COURSE 1

Autism, ADHD and the Adult Counselling Relationship

8 SESSIONS • 24 CPD HOURS
FEB – JUL 2027 | ONLINE VIA ZOOM

Explore how Autism and ADHD may influence the therapeutic relationship in adult clients, and learn practical ways to adapt your approach.

Who is it for?
Qualified counsellors and psychotherapists, with suitable counselling trainees considered.

Alternate Thursdays (evenings)
6–9pm | Feb–Jul 2027

£745 per person

COURSE 2

Autism, ADHD and Therapeutic Work with Children and Young People

8 SESSIONS • 24 CPD HOURS
FEB – JUL 2027 | ONLINE VIA ZOOM

Explore developmental considerations and practical, creative and relational approaches to support neurodivergent children and young people.

Who is it for?
Qualified child and adolescent counsellors, CYP practitioners and appropriately experienced counsellors working in child-facing services.

Alternate Thursdays (evenings)
6–9pm | Feb–Jul 2027

£950 per person

Live online via Zoom
Interactive, practical and reflective sessions
Certificate of attendance (24 CPD hours per course)
Accessible from across the UK

Invest in your practice.
SUPPORT YOUR CLIENTS. GROW YOUR SKILLS.

Book your place today →
admin@lcandcta.co.uk
www.lccta.co.uk | CPD

Diploma in Clinical Supervision

Online Training

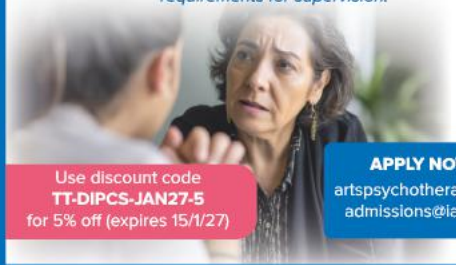
THE INSTITUTE FOR ARTS IN THERAPY & EDUCATION

January – June 2027 | *12 online training days one weekend per month | 10am-5pm*

Enhance your professional practice by training as a qualified supervisor, developing the skills to support practitioners working with the client group/s of your qualification.

This integrative training draws on psychodynamic thinking, attachment theory, neuroscience of mental health and ill-health, trauma-responsive practice recognising the unique power of art media and mental imagery as conscious and unconscious forms of communication. Central to the programme is a collegial, rather than hierarchical, supervisory relationship, creating safety, trust, openness and deep reflection.

The training is aligned with BACP Counselling and Psychotherapy Supervision Training Curriculum and UKCP requirements for supervision.



Use discount code **TT-DIPCS-JAN27-5** for 5% off (expires 15/1/27)

APPLY NOW
artspsychotherapy.org
admissions@iate.uk

For job opportunities, visit bacp.co.uk/jobs

HUTCHINS PSYCHOLOGY



Dr Jonathan Hutchins
Consultant Clinical Psychologist
EMDR Europe Accredited Trainer

SCIENTIFIC | CLINICAL | ACCESSIBLE

EMDR EUROPE-ACCREDITED TRAINING

EMDR BASIC TRAINING

JANUARY 2027 COHORT — ONLINE | WEEKEND DELIVERY

Build your confidence and clinical skill in EMDR through an integrated, EMDR Europe-accredited programme led by Dr Jonathan Hutchins.

Interactive training online, with group supervision between course parts.

YOUR 2027 TRAINING DATES

PART 1	Friday 29 - Sunday 31 January 2027	3 days
PART 2	Saturday 10 - Sunday 11 April 2027	2 days
PART 3	Saturday 19 - Sunday 20 June 2027	2 days

All training days run 9.00am - 5.30pm via Zoom.
Group supervision follows Parts 1 and 2.

COMPLETE PROGRAMME £1,440

ELIGIBILITY
Counsellors and psychotherapists must hold full accreditation with an eligible professional body. All applicants must meet EMDR UK / EMDR Europe criteria.

Explore dates and apply
emdrconsultancy.com/schedule-with-jonathan-hutchins
Contact: info@hutchinspsychology.co.uk

BALENS

Caring for our Clients since 1950

Insurance for
Counsellors and Psychotherapists



£6m* Professional Liability cover

£6m* Public Liability cover included as standard

* Higher limits of indemnity are available upon request, please contact us for details

Exclusive premiums for BACP members of: £57.35 (for a full member)
£23.70 (for a student) Both prices include Insurance Premium Tax and fees
*Prices are subject to change

01684 580 771 info@balens.co.uk balens.co.uk or speak to us via our Webchat

Balens are authorised and regulated by the Financial Conduct Authority. Firm Reference Number 305787. Balens is a trading name of Balens Ltd. Registered in England and Wales under No. 04931050. Registered office: Rossington's Business Park, West Carr Road, Retford, Nottinghamshire, United Kingdom, DN22 7SW. Balens Ltd is part of the PIB Group. BD261050. FP26277.

Scan for more

For job opportunities, visit bacp.co.uk/jobs

SOMATIC TRAUMA THERAPY TRAINING 2027-2028 (Course 18)

CAMBRIDGE body Psychotherapy CENTRE

Our next 12 day course online with **Babette Rothschild** author of The Body Remembers and The Body Remembers, Volume 2 **starts in May 2027**. It consists of 3 blocks of 4 days, and replicates the previously offered in-person training as closely as possible, including plenty of interaction. Numbers are limited to 24.

Participants should have a qualification in psychotherapy, counselling, or clinical psychology, be seeing clients, and able to implement the course content.

It costs **£1980.00**

Details:
Email: gillwestland@cbpc.org.uk
www.cbpc.org.uk

CBPC is a full organisational member of UKCP

DACTARI
DOMESTIC ABUSE COUNSELLING SPECIALISTS

Specialist Domestic Abuse Counselling Training

Held Online on the
16th, 19th, 23rd and 26th February 2027

4-day specialist course, providing 28 hours of CPD, covering everything a qualified or trainee counsellor would need to start domestic abuse counselling work.

Led by Dr Jeannette Roddy.

"Fantastic course, really informative and excellent balance between theory and practical skills. Engaging and thought-provoking teaching in a supportive environment. Invaluable experience, suitable for a wide range of experience levels. Highly recommend!"

£150 Early bird discount available until 19th January 2027

Creative Counselling for Domestic Abuse Saturday 27th March 2027

1-day online experiential workshop for counsellors offering practical and safe creative interventions to assist client recovery from domestic abuse led by Karen Nolan.

For more information on both courses see www.dactari.co.uk/domesticabusefoundationtraining

---

Dialogues Counselling, Psychotherapy & Wellbeing Services

- **Clinical Will Service- we provide everything you need!**
- **CPD training online & In person- 2 hr, half day or full day**
- **Personal Development- Sessions and Courses**
- **Therapy 4 Therapists- special rates for our colleagues- online & in person**
- **Self-Care Away Days- Morning, Afternoon & evening mini retreats, pick up from beautiful Hebden Bridge!**

Dialogueslife.com

Email: talktodialogues@gmail.com

Unit 11/ The Doyle Room, The Town Hall, Hebden Bridge. West Yorkshire. HX7 7BY.

BACP Commercial Organisational Member: 00277013

2027 TRANSFORM TRAUMA OXFORD

13 - 16 September 2027
University of Oxford and online



The biggest names in trauma. The latest thinking for your practice.

Four days exploring trauma, human connection and belonging, with fresh perspectives and practical insights for your therapeutic practice.

Join leading international clinicians, researchers and practitioners at **Transform Trauma Oxford 2027** to discover the latest research, therapeutic approaches and ideas on healing.

10% off for BACP members
Use code BACP10 at checkout
mastersevents.com/oxford-2027

For job opportunities, visit bacp.co.uk/jobs

Accredited Counselling and Psychotherapy Courses in Sussex and Online



UPCOMING CPD COURSES (ONLINE):

MENTAL HEALTH FAMILIARISATION WORKSHOP

DIAGNOSING AND TREATING MENTAL 'ILL-HEALTH'
- **8 January 2027**, 9.30am-4.15pm

MODELS OF ASSESSMENT: HOW THE MENTAL HEALTH CARE SYSTEM UNDERSTANDS CLIENTS WITH 'MENTAL ILLNESS'
- **5 February 2027**, 9.30am-4.15pm

These online workshops are part of a series helping trainee and qualified counsellors and psychotherapists deepen their understanding of mental health care systems while meeting UKCP Mental Health Familiarisation Placement requirements.

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

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.

CERTIFICATE IN DELIVERING GROUP THERAPY
- **12th March – 12th June 2027**

Designed for qualified counsellors, psychotherapists, and advanced trainees who wish to expand their practice and make a meaningful impact through working with groups.

FIND OUT MORE AND BOOK:
www.thelinkcentre.co.uk

CORE TRAINING PROGRAMMES:

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

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.

ADVANCED DIPLOMA IN INTEGRATIVE PSYCHOTHERAPY
- **October 2027 – July 2028**

Flexible routes whether you're already qualified or just starting out. Accredited Prior Learning (APL) may apply.

FREE ONLINE TALKS

HOW TO BECOME A SUPERVISOR
- **25 January 2027**, 6.30-8pm

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

OPEN EVENING
- **20th January 2027**, 6.30-8pm

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

the Link Centre

@TheLinkCentreUK www.facebook.com/TheLinkCentre www.linkedin.com/company/thelinkcentreuk @TheLinkCentre

VISIT **WWW.THELINKCENTRE.CO.UK**
OR CALL **01273 646 712** OR EMAIL **ENQUIRIES@THELINKCENTRE.CO.UK**

FREE ONLINE CPD COURSE

Treating Trauma with Internal Family Systems Therapy

Step-by-Step Procedures for Healing Trauma, Anxiety, Depression and More

With world-renowned IFS experts

FRANK ANDERSON, MD
ALEXIA ROTHMAN, PHD
NANCY SOWELL, LICSW



You've heard about the astonishing results thousands of therapists globally are achieving with their clients using the **Internal Family Systems (IFS) Therapy** model...

...now you can discover the transformative power of this revolutionary modality for yourself with our **FREE** online CPD course!

MODULE 1 - An Introduction to the Internal Family Systems Therapy Model | With Alexia Rothman, PhD

Alexia uses her decades of clinical experience as an IFS certified therapist to introduce you to the basics of the IFS model. You'll learn the foundational principles and methods that underlie all IFS techniques you may go on to use in your practice.

MODULE 2 - Leading by Example: The Presence of the IFS Therapist | With Nancy Sowell, LICSW

Senior IFS lead trainer Nancy Sowell explains the importance of being Self-led for the IFS therapist. She shows you proven techniques that will enable you to stay attuned, engaged, and present when working with clients so that you can facilitate the deep work that leads to lasting change.

MODULE 3 - Powerful Interventions for Working With Parts | With Nancy Sowell, LICSW

Direct access is one of the most powerful tools available to the IFS therapist. Nancy teaches you the ideology and practical applications behind the technique so that you can facilitate deep, internal parts work with your clients.

MODULE 4 - IFS Therapy in Action: Real Client Demonstration | With Frank Anderson, MD

Now you have a foundational understanding of IFS therapy and its techniques, watch certified IFS clinical consultant and therapist Dr Frank Anderson in action as he uses parts work to help a client struggling with procrastination. The session deepens as more of the client's younger parts come forward and reveal how they felt criticized and unsupported during childhood.

EARN UP TO 4 FREE CPD HOURS

Register for free at: www.pesi.co.uk/IFS

T: 01235 847393 | E: info@pesi.co.uk

PESI® UK
A Non-Profit Organisc

Understanding our digital persona

Cordelia Wyche invites us to wonder about the way we sell ourselves online



Online the common abbreviated acronym 'IRL' means 'in real life' – a way of referring to the reality that exists out there in the offline world. A popular comment used in digital spaces, 'go touch grass', is used to poke fun at those whose reactions online are considered to be the result of being 'chronically online' and thus detached from IRL.

Originally, where social media could be used for connection, community and a space to cultivate new ways of being, the idea of social media now is perhaps no longer based in reality. In an article named 'Social Media is Now Parasocial Media' Danah Boyd argues that today's platforms 'are no longer centred around sociable activities... [i]nstead, most platforms offer us a broadcast medium'.[1] The asymmetry in interactions and lack of reciprocity leaves little that is social.

Within this context content creators can endlessly curate their online self, recording as many takes as it requires to achieve an end result that represents them best. In this way social media offers a remarkable opportunity to witness how we relate to different parts of ourselves.

With the external observer in mind, what do we notice about what of us perhaps gets amplified and what gets toned down? In *The Psychodynamics of Social Networking* Aaron Balick describes how Winnicott's concept of the 'false self', and Jung's 'persona' can be used to explore how we present ourselves online, as both concepts describe a means of managing the space between the internal self and the external other.

While the 'false self' can have negative connotations of being fake, Balick explains how the false self can also be understood as taking on 'the social role so that the true self can carry on being'. Similarly, Jung's persona utilises a mask, which although distorting is also 'suited to the individual' and is more like a partial self than a complete misrepresentation.[2]

For therapists setting up social media profiles we too necessarily make use of false self/persona. I often see social media accounts from trainees inviting people to join them on their journey to becoming a therapist, or accounts from experienced therapists 'answering the questions you're too afraid to ask your therapist' or decrying the use of social media by other therapists.

In each of these choices is a persona in action offering something that simultaneously holds some truth for the individual (self) while also clearly being conscious of and adapted for the external other.

To be clear, it is not hard to find therapy content online that could be described at best as ethically dubious, at worst harmful, but that's not the focus of this piece. Instead I want to explore the relationship between therapist and their online self.

'As a therapist...'

As a marketing tool, social media works best when it is engaging, when the consumer chooses to stay and even actively welcomes the content on offer. For therapists, in the Venn diagram of what they are looking to sell and what the imagined audience might want, three strategies seem to emerge:

Selling answers or reassurance: this content offers psychoeducation, tools and often something reassuring in the form of motivational quotes or validation of feelings and experiences. Depending on the focus, the sell could be some combination of the therapist's expertise and their ability to be holding.

Selling a peek behind the curtain: this content typically taps into the frustrations, fears and hopes of clients that can often be difficult to bring into the room. It sees the therapist explain cancellation policies, why sessions end on time and what your therapist's silence means. Notably this content is rarely about the therapist's personal practice or reasoning but rather offered as general guidance. This distance might help to promote their own trustworthiness and authority.

Selling intimacy: this category ultimately in some way aims to build rapport and invites the audience to imagine the content creator as their own therapist. It typically offers something personal that invites the viewer in, like joining the therapist for their morning coffee, and provides a point-of-view impression of them reacting to different clinical scenarios or a disclosure about their own mental health or past experience that has led them to becoming a therapist. In a field where one of the clearest messages is the importance of the relationship, the sell may ease relational anxiety by offering something of a 'preview' as well as warmth and hopefulness.

Any of us who advertise our practice, whether via a directory listing, website or social media account, may use some version of these techniques. However, how we relate to these platforms matters.

Under stress our sense of self may feel more vulnerable or threatened in the face of a client's frustration, criticism or helplessness, or from the pressure of the sector.

Social media can be immediately available to offer soothing. In response to feeling not good enough our honed persona can create a piece of content foregrounding the professional (external) part of the identity as a therapist, and in doing so ease the pain of the deeply personal (internal) part of this identity that is so essential to a sense of self. In other words, under the guise of social media marketing other vital needs may be covertly played out. Using the 'outward' facing themes above, here are some alternative interpretations for what else might be going on behind the mask.

Therapist need

In the case of selling answers or reassurance, whether under pressure to

'As a marketing tool, social media works best when it is engaging, when the consumer chooses to stay and even actively welcomes the content on offer'

MARIE MONTOCCHIO/IKON IMAGES

'When our sense of self feels foggy it may be incredibly reassuring to record ourselves offering answers and guidance, to watch this version of us, coherent and clear'

compete and stay up to date or due to something coming up in the room, tolerating uncertainty may give in to shameful feelings like incompetence. In such instances it can be useful to look to our reflection to make us feel solid and certain.

Paula Elkisch in 'The Psychological Significance of the Mirror' describes how when someone loses their sense of self or experiences a threat to it, mirrors seem to provide reassurance and protection against the loss.[3] Perhaps the same can be said of social media: when our sense of self feels foggy it may be incredibly reassuring to record ourselves offering answers and guidance, to watch this version of us, coherent and clear. In this, a grateful comment section is surely also a boost.

In the case of offering a peek behind the curtain, many of us come into this profession because in some way we care. Many boundaries we have are based on creating a sustainable and facilitative environment so that we can offer this 'care' consistently and safely. Sometimes those boundaries can be experienced as clinical, unfair and distinctly uncaring. To be interpreted in this way may leave us feeling deeply misunderstood or wounded. For example, Ferenczi describes the children who very early on need to become psychotherapists, who have had to parent their carers and in turn parent themselves: 'They thus extend to others the knowledge painfully acquired in coping with their own sufferings, and they become kind and helpful.'[4] Where the therapist cannot make use of this tension in the session or the need to be 'kind and helpful' cannot be internally contained, it can potentially be acted out and satisfied online.

As for selling intimacy, the relationship with the client has already begun before the client even makes their first contact. Whether this is in how the client relates to the idea of speaking to a therapist (for example, in the context of the Kleinian part-object) or in having chosen to get in touch with us specifically, an idea of who or how we might be has already started to take shape.

Selling previews of the potential relationship might encourage strong, positive transference. Heinz Kohut, in his idea of 'mirroring', described the role of the primary carer in reflecting back to the child a sense of self-worth and value. Mirroring helps to build confidence in your sense of potential: the child looks to be 'the gleam in the mother's eye'.[5] However, where the therapist's content consistently projects hope and positivity, perhaps the therapist is looking to be the gleam in the client's eye and to see their own goodness and potential reflected back at them.

Neither good nor bad

This conversation is not about whether it is right or wrong to be on social media as a therapist. As Mary Jo Peebles reflects, 'The goal of psychotherapy, all turf-battles aside, is to rattle our patient's certitude about his conclusions.'[6] Binaries (and the turf-battles they foster) can offer comforting certitude, but it comes at the cost of exploration and discussion, and in an environment where social media might be used as a marketing tool and as a tool to meet other needs, like regulating the therapist's sense of self, a discussion is necessary.

This is where the concepts of the false self or the persona, sympathetic mediators as they are, can offer more nuanced frameworks through which to understand the ways in which we might be using social media to bridge the divide between our internal and our external worlds. Once we recognise this we can then pay attention to the kinds of feelings and experiences that might see us reaching for the relief offered by our social media persona. To help us navigate the relationship between the therapist we are and the therapist we wish to be perceived as the following might help:

- What element of my practice am I hoping to advertise?
- What part of the content achieves that, and how?
- What prompted me to create this particular piece of content?
- Do I feel comfortable putting in the caption that this is an advert, and if not why not?

To borrow Kranzberg's First Law of Technology, 'Technology is neither good nor bad; nor is it neutral.'[7] The same is true of social media. Fortunately for us as therapists we are likely accustomed to the most interesting question not being 'Is this right or wrong?' but rather, 'What might this mean?'

REFERENCES

1. Boyd D. Social media is now parasocial media. Social Media + Society 2026; 12(2). **2.** Balick A. The psychodynamics of social networking: connected-up instantaneous culture and the self. London: Routledge; 2014. **3.** Elkisch P. The psychological significance of the mirror. Journal of the American Psychoanalytic Association 1957; 5(2): 235-244. **4.** Ferenczi S. Child-analysis in the analysis of adults. The International Journal of Psychoanalysis 1931; 12: 468-482. **5.** Kohut H. The restoration of the self. International Universities Press; 1977. **6.** Peebles MJ. When psychotherapy feels stuck. London: Routledge; 2021. **7.** Kranzberg M. Technology and history: 'Kranzberg's Laws'. Technology and Culture, 1986; 27(3): 544-560.

ABOUT THE AUTHOR



Cordelia Wyche MBACP works in private practice in Glasgow and contributed the chapter 'Shame in the Practice, Shame in the Practitioner' to the upcoming book *Clinical Perspectives on Working with Men and Shame* (Routledge). **cordeliawyche.com**

the grove

The State of Practice survey 2026

What does practice really feel like right now?



Share your experience in our five-minute anonymous survey, and help build an honest picture of the profession today.

Be heard

Tell us about the pressures, rewards and realities of your practice

Shape what comes next

Your answers become a free visual report for the whole community, and inform the learning we create

Win a course place

Two respondents will win a free place on any of The Grove's 2027 course intakes

Win

1 of 2

free course places

Take part today

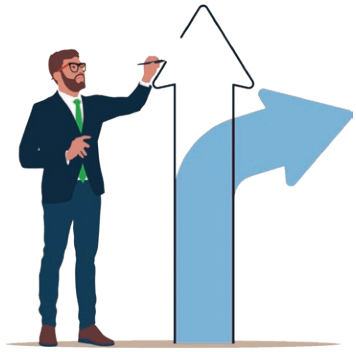
thegrovepractice.com/state-of-practice

Five minutes · Completely anonymous · Open to practitioners everywhere

Winners announced January 2027. Prize draw entry is separate from the survey, so your answers stay anonymous. One free place per winner on a 2027 course intake; course fees only. Terms apply.

PRACTICE, EMPOWERED.

Michael Toller



GANNVECTOR/SHUTTERSTOCK

My decision to begin working as a counsellor was motivated by a mix of the personal and professional. A history of depression in my wider family and several periods of crisis around important transitions in my own life had made me curious about talking therapies, from their origins in the psychoanalytic tradition to the more humanistic, person-centred approaches. Added to this, I began to pay attention to a growing desire for more meaningful work as I entered my 40s.

I made a commitment to myself to make the most of what I then termed 'the second half of my working life' and started taking steps towards giving up my old job in event management.

I became a father for the first time during my training years and knew that I needed to explore other sources of income while I built my counselling career. The answer came in the form of a coaching training and building a business as a career coach, which provided a financial safety net.

Like many colleagues my training gave me a good foundation for clinical work but had not prepared me for the practicalities of setting up as a private practitioner. Confronting the task of meeting all the ethical and legal standards required of a counsellor, especially, felt a challenge.

I was in denial about the idea of getting ill or dying unexpectedly myself. Creating a clinical will fit for purpose was more complicated than I had imagined. A colleague agreed to act as my clinical trustee, but I struggled to come up with a solution to a more practical problem: where to keep an up-to-date list of my clients' contact details without compromising confidentiality.

The answer was to begin building a standalone clinical will platform, which I began in 2021. A digital system seemed the best way forward, but I wanted to make sure access was properly protected. A former coaching client who worked in tech helped me explore what it would take to build a digital tool to bring all the relevant information together securely in one place. I've enjoyed working with a business partner again. Working as part of a team has given me the chance to share ideas and solve problems together.

My journey from event management to coaching and counselling, and now developing digital tools for therapists, has not followed a path I ever expected to take. I thought I would be swapping one professional identity for another. Instead I have discovered that these different but complementary parts of my career have added up to something that is more layered and less linear than anticipated.

There is a paradox inherent in turning to tech to solve some of the problems it has created. Ultimately, and rightly, we are responsible for staying compliant and ethical, so my guiding principle is always to consider whether technology is helping to meet a real need. Does using a new system mean we spend more or less time doing the real work of counselling? Does it support ethical practice or just add to the list of practical tasks we need to carry out? And, importantly, does it reflect the lived experience of practitioners like me, doing their best to run a business that allows them to do the work they care deeply about?

Making the most of my working life has been about staying curious and using all of my experience to respond to what I discovered along the way, rather than what I imagined I would find.

After almost 10 years in private practice I still value the clinical work I do above everything else. But the meaningful work I was looking for 10 years ago goes far beyond the thinking I do with and about clients – I find it as much in my work with my business partner and in the conversations I have with fellow practitioners as I do in the consulting room. If there is a lesson I have taken it is that staying open to what else is possible has given me more meaning than I ever imagined I would find from work. By understanding the problems faced by real practitioners there is an opportunity to build new solutions for us all. ●

'If there is a lesson I have taken it is that staying open to what else is possible has given me more meaning than I ever imagined I would find from work'



ABOUT THE AUTHOR

Michael Toller BPC works in private practice as a psychodynamic counsellor and professional coach. He is also one of the team behind ClinicalWill.app, used by more than 1,200 counselling and therapy professionals to create and maintain their clinical wills.





the british psychological society
CPD QUALITY MARK 2026

CBT:
INTRODUCTORY COURSE

3-day Intensive
BPS Approved Certificate

LIVE ON ZOOM

FULL RECORDING AFTER THE COURSE FOR YOU TO KEEP

1 – 3 March 2027
8 – 10 June 2027
5 – 7 October 2027

"This course has changed my life; I am what I am now because of this course."

"The course was brilliant - I thoroughly enjoyed it and learnt a lot."

"Thank you so much for the last three days! Learned a lot!"

BPS Approved Certificate in
CLINICAL SUPERVISION

LIVE ON ZOOM

FULL RECORDING AFTER THE COURSE FOR YOU TO KEEP

9 – 10 March 2027
15 – 16 June 2027
2 – 3 November 2027

Meets the training standards required for Chartered Psychologists to confer eligibility to the British Psychological Society's Register of Applied Psychology Practice Supervisors (RAPPS).

SDS

"CPPD goes beyond teaching you the theories and practice of counselling. A rewarding and life changing experience."

Introduction to Counselling - part time (year-long)

Certificate in Humanistic Integrative Counselling
Spring 2027

BACP Accredited Training Programme in Humanistic Integrative Counselling - part time (two years)

Diploma - Year 1
Spring 2027

Advanced Diploma - Year 2
Spring 2027

Short Courses - Professional Development

Neurodiversity & Working with Neurodivergent Adults - therapeutic starting points
May 2027



CPPD is one of the UK's leading humanistic integrative counselling schools, offering tuition responsive to the needs of each individual student.

We value each student's existing life experiences and skills within our friendly and creative environment.

CPPD
COUNSELLING SCHOOL

Please visit www.cppdlondon.com/our-courses for more information and application forms

Unit 1-2 Palace Gates, The Campsbourne, Hornsey, London N8 7PN www.cppdlondon.com • mail@cppd.co.uk • 020 8341 4843

CELEBRATING 25 YEARS OF TRAINING
25 YEARS