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Private Practice

FOR COUNSELLORS AND PSYCHOTHERAPISTS
IN PRIVATE PRACTICE

Mind or body: what's in charge?

The conference special issue

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Welcome

In *The inflamed mind: a radical new approach to depression*, Professor Edward Bullmore, a psychiatrist who specialises in the workings of the human immune system, makes a scientific case for inflammation being a possible cause of depression.

Sarah Van Gogh reviews Professor Bullmore's book on page 37, and discusses his research in her regular 'My Practice' column on page 17. Professor Bullmore writes about the process by which our bodies fight infections by producing cells and chemical messengers to target and destroy alien intruders. But, he also explains that our immune systems can become overly sensitive and prone to act as if we are fighting an infection when we are not, and that this can result in inflammation spreading to the brain, affecting the emotional regulation network, and thereby causing depression.

Professor Bullmore argues that adverse childhood experiences, as well as extended periods of prolonged stress, can cause such a propensity, and this therefore has important implications for our work as counsellors and psychotherapists, as we begin to understand more about the ways in which our bodies can behave as if we are under biological threat, causing an inflammatory auto immune response, when we may not be under bacterial threat at all, and that this can then adversely affect our brains.

This leads neatly into the theme of this conference special issue on the mind-body connection, which includes features by both keynote speakers, Professor Alessandra Lemma (page 8), who writes that we cannot avoid telling the story our body narrates, and Diane Danzebrink (page 22), who argues the importance for all therapists of understanding the emotional, psychological and physiological impact of the menopause. This is particularly crucial given that, in a 2018 survey by the BBC, 48 per cent of women aged 50 to 55 reported their mental health was affected by their menopause symptoms.[1]

'Therapists who understand menopause and the possible effects of hormone fluctuation,' Diane writes, 'have an ideal opportunity to close the current knowledge gap among both the public and healthcare professionals to empower their clients to seek out factual, evidence-based information to enable them to make informed choices about how they manage their symptoms. This can be life changing for some women.'

We also include features written by conference workshop presenters on topics ranging from body dysmorphia (page 30) and eating disorders (page 26) to the science of sleep (page 10) and the potential psychological, emotional and physiological impacts of elected cosmetic surgery procedures (page 32). Each of the contributors responds to the question posed by the conference title, 'Mind or Body: what's in charge?', and resoundingly concludes that psyche and soma are inextricably interlinked, and that the separate and distinct ways in which they are still sometimes unhelpfully treated within the Western medical model, are onerous at best, and damaging to health and wellbeing at worse.

In his feature, 'Psyche and soma' (page 18), Peter Afford, whose book, *Therapy in the age of neuroscience: a guide for counsellors and*

therapists, was recently published by Routledge, explains how neuroscience has 'penetrated the mystery' of the mind-body connection and 'offers a picture of the whole person'. Also taking up Professor Bullmore's research, mentioned earlier, Peter provides a user-friendly introduction to the science that explains how our brains and bodies affect each other via neural and biochemical pathways, and how mental activity generates emotional body states, and body states change the neural landscape in the brain, affecting how we feel, what we perceive and what we think about.

He goes on to explore the causations of psychosomatic illness, correcting the common misconception that psychosomatic illness is imaginary, but explaining how it 'reflects something real happening in the brain, as well as the body'. Like Professor Bullmore, Peter writes about how childhood abuse and neglect and other traumatic life events can trigger psychosomatic illness, because of the effect of the stress response, activated by the release of cortisol into the bloodstream, on the immune system. When stress is severe and sustained, an excess of cortisol suppresses the immune system, increasing the risk of immune-related illnesses.

Given that we all somatise, and that stress and distress will inevitably be reflected in the way brain, mind and body function as an ensemble, Peter concludes by saying, 'There's probably a psychological element in any illness, and it's the aspect of illness that therapy is able to address.'

Reference

1. ComRes. BBC menopause survey. [Online.] www.comresglobal.com/polls/bbc-menopause-survey/ (accessed 1 November 2019).

John Daniel, Editor
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Catch up with the latest BACP news and resources

Meeting with Children's Commissioner for England

BACP's Children, Young People and Families Lead, Jo Holmes, had a positive meeting with the Children's Commissioner for England, Anne Longfield, in support of her office's manifesto calling for a CAMHS school-based counsellor in every school. The commissioner is keen to secure NHS core funding from the £20bn rolling out over the next five years, to part-fund counselling services in all schools, ideally commissioned out to the voluntary sector to provide age-appropriate counselling provision, which fits within BACP's CYP core competency framework.

The meeting provided both organisations' policy teams with a focus to explore potential workforce development opportunities for BACP members in a climate where NHS mental health provision is currently understaffed and under-resourced. Jo stressed to the Commissioner's team that school counsellors should be qualified and working in paid roles. She said: 'This was a fantastic meeting discussing school counselling with a team who are passionate about improving mental health support for young people.
The Children's Commissioner is an influential voice on children's rights and their wellbeing, and I look forward to working with her and her team more in the future.'

Jo Holmes, left, with the Children's Commissioner, Anne Longfield

Counselling for people with age-related sight loss

BACP's Older People Lead, Jeremy Bacon, has met with CEO of the Macular Society, Sarah Oakley, and Suzanne Roberts, the Macular Society's telephone counselling service manager, to discuss shared areas of interest, how our older people strategy relates to their work, and access to future case studies. As a result, we've produced a briefing exploring counselling for people living with age-related sight loss. In the UK, 80 per cent of sight loss happens to people aged 60 and older. The Macular Society's telephone counselling service provides therapy and signposting to people with age-related macular degeneration.

Review of IAPT positive practice guide

BACP is part of a working group, hosted by Age UK and commissioned by NHS England, reviewing the *IAPT Older people positive practice guide*. Originally published in 2009, the guide provides information for practitioners, GPs and commissioners on shaping services to reduce barriers to older people accessing therapies.
In the consultation, we've emphasised the importance of choice of therapy and the findings from analysis of National Audit of Psychological Therapies (NAPT) data, showing similar outcomes for counselling and CBT. Publication of the revised guide is planned for early in the New Year.

Delay to NICE Depression in Adults guideline

The National Institute for Health and Care Excellence's (NICE) plan to launch its third consultation on the updated draft of the *Depression in Adults* Clinical Guideline at the start of October has unexpectedly been delayed. The consultation was due to take place over six weeks, with the final guideline planned for publication in February 2020. The timescale for both consultation and publication has since been moved to a TBC status. The guideline is crucial because the treatment recommendation it makes underpins the interventions offered by many statutory services. At BACP, we've long campaigned for a change in the recommendations to ensure that they're less restrictive and enable the public to access a full range of evidence-based psychological therapies. More information about our campaigning work can be found at **bacp.co.uk/news/campaigns/nice-depression-guidance/**

Coming soon: resources for consortia building and public sector contracting

Consortia building and public sector contracting was the theme of a workshop at the BACP Private Practice conference in September. It followed an article on the same theme by Kris Ambler, BACP's Workforce Lead, published in the September 2019 issue of *Private Practice*.[1] We have had a good response from members to these developments and we're finalising a resource pack and online materials on consortia building and public sector contracting.

Reference

1. Ambler K. Welcome to the jungle. Private Practice 2019; September: 22–25.

BACP Resources

New BACP guide on safe lone working

In a recent survey of BACP members, 79 per cent said they work alone, while 15 per cent said they'd experienced violence or aggression while working with clients and or colleagues. This is significantly higher than the national average of 1.3 per cent.[1] BACP's Ethics Hub has released *A quick guide to lone working*, a new three-part guide on safe lone working, designed to support you as you consider your own safety and the implications of lone working. It addresses questions to ask yourself in relation to where you work, who you work with, steps to mitigate risk, safety planning, how to act on concerns and ethical considerations. Available at: **bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-guide/**

Reference

1. BACP and Suzy Lamplugh Trust. [Online.] bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-survey/ (accessed 18 November 2019.)

Good Practice in Action guidance on workload

Good Practice in Action (GPiA) 109, Clinical Reflections for Practice: Workload in the context of the counselling professions, published on 31 May 2019 and updated on 27 August 2019, aims to stimulate ethical thinking in respect of a practitioner's workload. If our workload is excessive, we may not be able to meet our commitments under the *Ethical Framework*, such as putting clients first, keeping our skills and knowledge up to date or ensuring our own wellbeing. But underload can also be a problem: if our work fails to use our skills, knowledge, experience and abilities, it can lead to boredom, disengagement and mistakes. Available at: **bacp.co.uk/gpia**

BACP's GPiA resources provide supplementary information to help you implement the *Ethical Framework* within your practice. To view all GPiA resources, see **bacp.co.uk/gpia**

Catch up with the latest news from BACP Private Practice

Data protection and Brexit: business as usual

Will data protection change in the event of Brexit? The short answer is: not much – probably. The long answer depends on conditions like a deal being agreed, the type of deal, any arrangements for a transition period, etc.

As a member of BACP, it is unlikely data protection will change for you in any significant way, whatever the outcome of Brexit. In the (perhaps extreme) scenario that the UK leaves the EU without a deal, the Government has published guidance, available at **gov.uk/government/publications/data-protection-law-eu-exit**. The guidance suggests that there will be little change for most people.

There are some scenarios in which Brexit may impact you; specifically, if you are processing the personal data of individuals outside the UK. Multinational organisations are also likely to be impacted. Find out more in the ICO guidance: **ico.org.uk/for-organisations/data-protection-and-brexit/**. There are no guarantees, and it's well worth bearing this in mind; but, for the time being, it does appear to be business as usual.

Dan Gibson, *Data Protection Lead, BACP*

BACP Private Practice network meetings

BACP Private Practice network meetings are held in a number of locations nationally and offer the chance to meet, network and share learning with other BACP Private Practice members in your area.

BACP staff are interested, and willing, to present at network meetings, so facilitators could consider asking staff to present at their meetings.

Kris Ambler, BACP Workplace Lead, will be visiting the South London network meeting on 31 January 2020 to discuss consortia building. Whether you are a regular attendee or are interested in finding out where the closest network meeting is to you, visit **bacp.co.uk/events/network.php** for further information.

Members are invited to attend forthcoming network meetings in:

Glasgow on 10 Jan, 9 Mar
Teddington on 17 Jan
Leeds on 18 Jan, 29 Feb, 11 Apr, 16 May, 27 Jun
Grays, Essex on 25 Jan
South London on 31 Jan
Cambridge on 7 Feb, 22 May, 18 Sept, 20 Nov

For further information, visit: **bacp.co.uk/events/network.php**

BACP Private Practice annual conference 2019

Just under 300 delegates attended this year's BACP Private Practice conference at Etc Venues in London on Saturday 28 September, and a further 900 people logged on to the webcast.

Ani de la Prida, who has been selected to join the BACP Private Practice Executive committee since attending the conference as a delegate, said: 'The keynote speakers [Alessandra Lemma and Diane Danzebrink] were excellent, and the workshops were very relevant. I enjoyed networking with other members. It was my first time at the conference, and I found it friendly, informative and well organised, and genuinely helpful to me in developing my practice.'

We will shortly be announcing the date and theme of the 2020 conference, tailored specifically for therapists and supervisors in private practice. To register your interest in attending, email **jade.ingham-mulliner@bacp.co.uk**.

Alessandra Lemma, BACP Private Practice conference 2019

Letters

Let's stay safe

It was heartening to read the toolkit idea for the personal safety of therapists ('From the Chair', September 2019). We all, regardless of experience, need to pay regular attention to our personal safety. I try not to be too cynical, but my original career was as a police officer, serving 15 years in London. We seem to be paying more attention, quite rightly, to our self-care, in terms of client numbers, work/life balance etc, but I do not get the impression we pay enough attention to personal safety. I hear colleagues' conversations that range from naivety to complacency to over-anxiety.

Working alone and in isolation is familiar to many in private practice. Whether based at home or an office location, we need to review and remind ourselves of possible dangers, and never overlook the importance of letting another trusted person know where we are and when we'll be home. All of us, even with time and experience, can become complacent. I have called upon my past skill sets many times when assessing new clients. A recent article by Sally Brown on assessment, published in the September issue of *Therapy Today,* is excellent in this respect, and caused me to review my own assessment criteria and methods.

We seem to be paying more attention, quite rightly, to our self-care, in terms of client numbers, work/life balance etc, but I do not get the impression we pay enough attention to personal safety

Walking home after dark on winter evenings, I was putting cash payments down my boots; not recommended for safe practice. I now take payment via card, alter my hours according to season, and vary my route home when this is not possible. I carry a personal alarm and am relatively certain I can still 'handle' myself if required to do so in a difficult situation, but I encourage myself and colleagues to think ahead to avoid being in such a situation in the first place.

My therapy room is a home from home; I prefer to rent office space rather than have clients at my home, as I like the separateness and easier boundaries it affords. I sit nearest the door, use a plastic water carafe and plastic tumblers for water, and stow pens and pencils away. Some might say this is 'over the top', but my life experience informs me that we can never truly 'know' another person. Better than most, as therapists, we realise that some vulnerable people may have difficulties with anger management and emotional regulation.

In over a decade, I have only had two moments of concern in the therapy room. In both cases, I remained calm and talked clients out of the room. Confidentiality had to be broken. In those two brief moments, I was reminded, however experienced we may consider ourselves to be, that anomalies occur.

A lone working survey of members by BACP and Suzy Lamplugh Trust (**bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-survey/**) provides interesting and essential information on safety. I love my job, but there is a constant need to review safety strategies. It is uppermost in my mind and I would encourage all colleagues to see it as more of a priority and not become complacent. Let's stay safe. See news item on page 5 about the new BACP A quick guide to lone working.

Julia Berrington *MBACP*

See page 5 to read about a new BACP guide on safe lone working.

We want to know what you think
Please write to tell us your opinions about any of the issues discussed in this edition, or if you have any thoughts about working in private practice that you'd like to share with readers. Email your letter to **privatepractice.editorial@bacp.co.uk**

New Executive member

We are delighted to announce that Ani de la Prida has accepted a position on the Executive. Ani introduces herself in her own words below:

I'm really excited to be joining the BACP Private Practice Executive and am looking forward to connecting with members and developing new ways to help and support the division. I've worked in private practice for about 15 years and understand some of the challenges, as well as the enjoyment, of working independently.

I am a lecturer, supervisor and therapist and have practised in a variety of settings, including addiction programmes, the probation service, schools and charities. Currently, I also work with the police, the fire service and a local mental health team. I really enjoy working with a diversity of clients in private practice, and I hope that my varied experience will help me understand the issues and experiences of other division members.

I'm passionate about therapy and practise in a mainly person-centred way with children and young people, as well as adults. I have an interest in the transpersonal, specialise in working with creative arts, and have a research interest in digital media and practice. I think it's important to raise standards in the profession and have been involved in various projects for BACP, such as Counselling MindEd and SCoPEd. I have also developed several university courses.

Alongside my private practice, I am Chair and founder of the Association for Person-centred Creative Arts and I run a small counselling CPD/workshop/training organisation. I am also a passionate foodie and co-founder of a health food company and am interested in the connection between what we eat and mental health. I have written a couple of therapy articles for publication and contributed a chapter to the *Handbook of counselling children and young people*, published by Sage. I would really like to develop my writing and research, and am currently working on writing a book.

I think there is a danger of feeling isolated in private practice. Social media has its downside, but it can be a great way to communicate.

If you'd like to connect with me, or you have any questions, find me on Twitter or email me at **anidelaprida@sky.com.**

From the Chair

Communication is key

Lesley Ludlow
lesley.ludlow@counselling-in-croydon.co.uk

Welcome to the conference special issue

I'm writing this in the week following the BACP Private Practice conference in September and am just beginning to feel I'm re-entering 'normal life'. When I think about the subject matter of the conference, 'Mind or Body: what's in charge?', and the week leading up to it, I'm not sure which part of me was in charge. The conference usually creates a heady mix of anxiety, adrenaline and excitement for all involved in its organisation, which kept all of us going for a week; and then, the week after, I, for one, looked and felt like a damp rag.

The BACP Private Practice Executive Committee decided on the theme in November 2018 and, from that moment, immersed ourselves in finding conference presenters. Our collective Google searches made interesting reading: menopause, tattoos, body modification, challenging physical conditions, psychosomatic illness, sleep (and the lack thereof), body dysmorphia, eating disorders, neuroscience. You get the picture. And then there was the endless watching of YouTube videos; so, putting the programme together took a lot of work. And the final weeks leading up to it created the worry that delegates wouldn't find the subject matter as interesting as we did.

The feedback we have received so far, however, is that they did. On the day, just under 300 delegates attended the live event, and a further 900 people were logged on to view the webcast. Our two keynote speakers, Alessandra Lemma and Diane Danzebrink, presented on two very different subjects (body modification and the menopause respectively) and were equally enthusiastic and passionate about their topics. And, as in the past, there was a lovely buzz on the day, with delegates sharing their thoughts with the committee, BACP staff and each other.

I asked BACP Governor Una Cavanagh, who co-hosted the webcast with James Rye, forher feedback on the day. She told me: 'I was really excited to be invited to co-host the conference again this year. It was a huge privilege to interview some of the amazing speakers and ask questions sent in from fellow members at home. The day had such a positive vibe and I really hope everyone watching at home was able to get a sense of that. Here's to the next conference in 2020.'

BACP staff members were available on the day to interact with delegates. I particularly liked the stand from the Ethics team: 'The only way is ethics'. Adam Pollard from Membership Services was on hand to answer questions throughout the day. Kris Ambler, Workplace Lead, talked to delegates during the lunch break about 'consortia building'. I want to say a massive thank you to all the people involved in the day. The BACP Events and webcast team, plus their support staff, put a huge amount of effort into organising events like this and it's not always apparent to see how hard they work during the year.

I mentioned in my opening speech at the conference that we are keen, as a division, to find ways to communicate with BACP members in private practice, and we are working closely with the web team to achieve that goal. I realise that not everyone chooses to access, or likes to use, social media, so while it has its uses to publicise events, we need to be more inventive in the ways we can reach counsellors in private practice, and to make our communication more accessible on the BACP website.

Delegates attending the conference were evenly split between BACP Private Practice division members, BACP members and reduced fee members. The breakdown on reduced fee members is difficult to analyse, so we are not sure what percentage of that group are students, low income or retired members. The net result is that we have a mixed audience and the message for the committee to understand is that we need to provide support to all sectors of counsellors in private practice. That is our plan going forward.

I have mentioned network groups consistently through this column and also in my opening speech at the conference. Given that we all generally work in isolation, a network group of fellow practitioners is a valuable resource and support. I'm pleased to report that a few counsellors have come forward to consider volunteering to facilitate new groups.

Given that 60 per cent of BACP members work in private practice, there's a lot of work to be done... to assist us all in our businesses

We will keep you posted through the website and journal when these are up and running.

Given that 60 per cent of BACP members work in private practice, there's a lot of work to be done, and the committee is going to be busy this year collating and updating relevant information to assist us all in our businesses. The overall message is that communication is key for counsellors working in private practice, to help us all feel more connected and involved.

Lesley Ludlow is a counsellor and supervisor in private practice, working with individuals and couples in Croydon, South London.

Written on the body

The story we can't avoid telling is the one that our body inevitably narrates, writes **Alessandra Lemma**

Our relationship to our body is the most concrete marker we have of how we feel about ourselves and others. I have come to understand that the more compulsive and extreme forms of body modification reflect a difficulty in integrating this most basic fact of life: we cannot give birth to ourselves.

Nowhere is this 'truth' felt more acutely than in our bodies, which are testament to our interrelatedness. The shared corporeality of mother and baby is the physical prototype of psychic dependency, and the emergence out of this shared physical space is never absolute because the body is inscribed with the imprint of the (m)other. When the fact of our dependency on others cannot be integrated into our sense of who we are, the subjective experience of the body is compromised. Given that the body develops within our early relationships with other people, its modification invariably expresses something about the quality of internalised relationships.

How we experience being-in-a-body is not solely dependent on whether our body has been intruded into, but also on whether we feel our body to be desirable. The early physical exchanges between mother and baby are vitally important for attachment, but also central to shaping our experience of ourselves as desirable. The importance of the gazing relationship, and of the skin-to-skin contact between mother and baby, cannot be emphasised enough. Touch and vision underpin the earliest physical and psychical experiences, and, at their best, can confer the gift of love. But when these are absent, or in short supply, or laced with hatred, possessiveness or envy, then the body self may feel neglected, shamed or intruded upon.

The extent to which the decision to modify one's body can be understood as self-affirming rather than self-destructive divides writers on this subject

Mind-body dualism

In the consulting room, what we can sometimes observe is what I have come to think of as the 'Cartesian psychic retreat': the way in which the patient defensively maintains a mind-body dualism in which the mind is 'the self' and the body is 'other' – as 'other' it can be dispensed with, improved, modified or triumphed over. Ostensibly overly invested in the body's appearance, the unconscious aim is to bypass the implications of reality rooted in the body, in order to protect the self from awareness of the unconscious meaning of an embodied self.

The extent to which body modification practices have entered the mainstream suggests a degree of caution in assuming pathology too readily. Moreover, to pathologise these practices as something 'we' don't do, may be construed as a defensive manouevre to bypass a more personal connection with the meaning of the body in our own minds. After all, we all modify our bodies, through clothes, make up or hair dye, and some of you reading this will have piercings or tattoos, and have undergone cosmetic procedures, orthodontics and possibly even cosmetic surgery.

We are all dependent upon the gaze of the other, and hence these practices most likely provide solutions to *universal* anxieties. Indeed, we *all* struggle to manage two basic facts: we are beings-in-a-body and the subject of the other's gaze. Being cognisant of our own specularity, leads to the discovery that our foundations lie outside of oneself or, as Sartre[1] put it, that we 'exist for the other'.[1] This implies a state of dependency, experienced first and foremost in the body. This presents ongoing challenges, requiring us to integrate the meaning of our corporeality into our sense of who we are. I am particularly concerned with how the challenges presented are managed internally, primarily through the external manipulation of the surface of the body.

The extent to which the decision to modify one's body can be understood as self-affirming rather than self-destructive divides writers on this subject.[2-4] There is a difference between body modifications that are attempts to decorate the body or 'figurate' it,[5] and those that may be said to be in the name of beauty or social affiliation, but that instead are underpinned by a despairing and/or violent state of mind towards the self and the other. The difference lies in how *compelling* and *necessary* the pursuit of body modification becomes for the individual, and hence how compelling the underlying phantasy has become, such that without the enactment of the phantasy, the individual's sense of self fragments.

Defence against fusion

The patients I have seen, and the individuals I interviewed for my book who have used tattoos and piercings, suggest that skin markings allow some individuals not only to reclaim the body, but also function as a signal to the world that all is not well. The tattoo, for example, can be a visible mark of personal distress – made visible presumably because there exists in the mind an other who needs to look and see the damage.

Skin markings appear primarily to provide a means for demarcating the boundary of the body as separate and belonging to the self. The theme of taking control over the body has been very prominent. In my experience, people who modify the skin surface are less likely to do so with the explicit or implicit aim of becoming more desirable to the other. My hypothesis is that, in this group, relative to the cosmetic surgery group, the psychic function of body markings appears to be primarily a defence against fusion with the other, whereas cosmetic surgery more readily lends itself to creating the phantasy of an idealised version of the self, fused with an idealised object.

Nowadays, self-identity has become a global product and the body has become a project. The narcissistic cultivation of bodily appearance is a response to these social realities, but also an expression of a need to construct and control what the body unconsciously represents. Throughout life, the body remains an exposed site. No matter how much we conceal it, even change it, the body always bears the trace of the other. This fundamental psychic truth has to be integrated into our image of ourselves. At its best, however, the body is the site for the most loving exchanges and sense of community.[6] If we are to experience it thus, mind and body need to be managed as inseparable.

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This is an edited version of the paper given at the BACP Private Practice conference on 28 September 2019 and represents a synthesisof ideas expressed in *Under the skin* by Alessandra Lemma, published by Routledge (2010).

About the author

Professor Alessandra Lemma is a Fellow of the British Psychoanalytical Society, Consultant Clinical Psychologist at the Anna Freud Centre, and Visiting Professor at the Psychoanalysis Unit, University College London, the Istituto Winnicott, Sapienza University of Rome and 'Centro Winnicot', Rome. For many years, she worked at the Tavistock Clinic where she was, at different points, Head of Psychology and Professor of Psychological Therapies. She is the editor of the New Library of Psychoanalysis book series (Routledge) and was one of the regional editors for the *International Journal of Psychoanalysis* until 2018. Alessandra has published extensively on psychoanalysis, the body and trauma.

Your thoughts please

If you have any responses to the issues raised in this article, please write a letter or respond with an article of your own. Email: **privatepractice.editorial@bacp.co.uk**

The science of sleep

Because the associated difficulties of sleep deprivation are far reaching and often misdiagnosed, supporting clients to help improve their sleep can be of vital therapeutic benefit, write **Ruth Webb** and **Emma Pipe**

Sleep. Love it or loath it? That depends on you. Do you love your bed, can't wait to get there to drift off for a relaxing night's sleep, and wake feeling refreshed? Or do you dread walking into your bedroom, knowing sleep will be a battle? Are you a night owl who is most productive in the evening, doesn't go to sleep until the early hours, and struggles to get up in the morning? Or a lark, up at the crack of dawn, raring to go?

What is sleep and why do we need it? Despite continued research, we still don't fully understand it. What is known is that sleep is a biological function, necessary for life. We can last far longer without food and water than without sleep; hence, the use of sleep deprivation as a form of torture, because it impairs our functionality. When sleeping, we are in a state of reduced consciousness during which our muscles are paralysed.

However, a great deal goes on when we are asleep. Hormones and enzymes are released to aid bodily functions and support our immune system, and white blood cells increase to promote healing. Sleep is a restorative and rejuvenating process in which muscles grow and tissues are repaired. Growth hormones are also released during sleep; hence the reason why sleep is particularly important for children. Two other significant hormones are also linked to sleep: leptin, an appetite suppressant released while we sleep, and grehlin, an appetite stimulant released while awake. The longer we are awake, the more grehlin increases our desire for sugary food; hence the link to increased risk of obesity with sleep deprivation.

If left to its own devices, our sleep should function perfectly, thanks to two processes that work simultaneously. We all have our own circadian rhythm, a cycle of approximately 24 hours, although everyone's is slightly different. This is located in the hypothalamus of the brain and is responsible for the release of melatonin, the sleep-inducing hormone, and cortisol to alert you. It regulates body temperature and promotes bodily responses at different times of the day. The second process of homeostatic sleep is the drive to sleep; the longer you have been awake, the greater the urge to sleep. Sleep need is the lowest in the morning and greatest in the evening, apart from at about 2pm, which we may all have noticed, where a natural peak in our sleep drive is triggered by a drop in body temperature, inducing sleepiness.

Our sleep should follow a pattern of a period of deep sleep initially, when we are not responsive to stimuli, hence our house could be broken into and we would not be aware. The second part of the night is characterised by periods of shallower sleep and rapid eye movement (REM) sleep. During REM sleep, information and emotions from the day are processed and put into long- or short-term memory or discarded. We also have two natural night wakings, which should be brief awakenings when we quickly settle again, and may not even remember we have been awake.

Over the years, we have evolved a model, originally adapted from a hypnogram/model by VW Lin et al,[1] which plots the various stages of sleep throughout the night and observes their particular characteristics. In stage one sleep, we are drowsy but easily woken, and it typically takes 10–15 minutes to fall asleep again. In stage two sleep, body temperature decreases, heart rate slows, and although we are still in fairly light sleep, we are not so easily woken. In stage three sleep, muscle paralysis occurs, and we are hard to wake. This is a biologically important sleep stage, in which tissue repair and hormone production occur. Rapid eye movement sleep (REM), also known as 'dream sleep', occurs in increasing time blocks throughout the night. It is a light sleep but where the brain is busy. In REM, heart rate and blood pressure increase; muscles go into

The frontal lobe of our brain is affected by lack of sleep, and our ability to make decisions is compromised

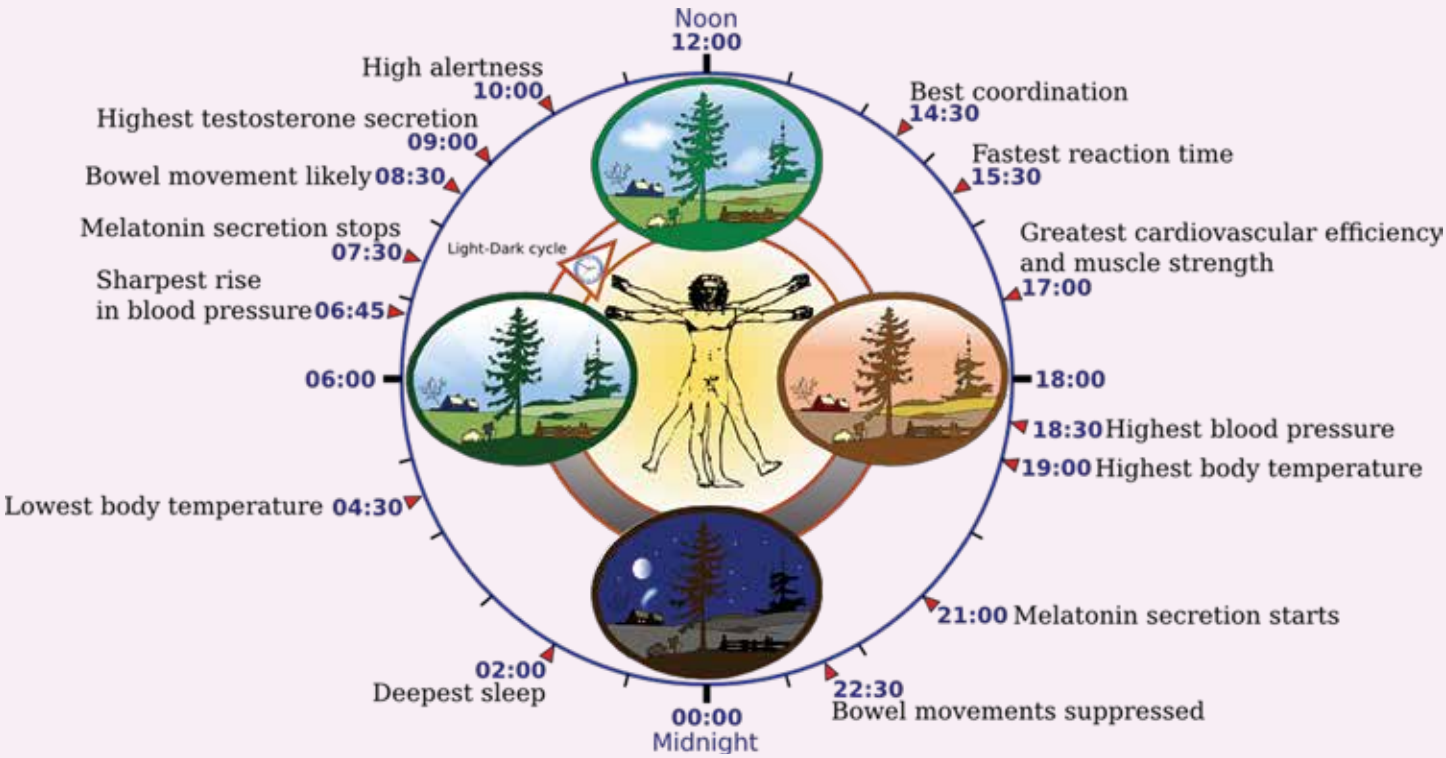

Image: The human biological clock[2]

paralysis; breathing is fast and shallow; emotions are processed, relieving stress; learning and memory consolidation take place; and nightmares occur. Sleep disorders in stage three include bed-wetting, night-terrors, sleepwalking and sleep apnoea.[1] Babies spend 50 per cent of sleep in the REM stage; three-year-olds, 33 per cent; and 10–14-year-olds, 25 per cent – the same as adults.

Every stage of sleep is important, but by having less sleep than we need, we can significantly reduce our REM sleep and our memory consolidation and processing of daily information. Studying into the early hours is counterproductive, as we lessen our capacity to retain information and process what we have learnt. Research has shown that an hour of extra sleep at night can result in a 50 per cent increase in grades.[3]

Everyone has their own unique sleep requirement and we cannot change the amount of sleep we need. We can alter the timings of when we sleep, but if not enough sleep is achieved, we incur a sleep debt, and this is where the problems can begin. The associated difficulties of sleep deprivation are far reaching and often misdiagnosed. Symptoms linked to ADHD, such as poor concentration and hyperactivity, can be present with sleep deprivation, and we can appear overstimulated and not drowsy, as you might expect. 'Brain fog' is a term often used by clients whose ability to think rationally and clearly is compromised. The frontal lobe of our brain is affected by lack of sleep, and our ability to make decisions is compromised. Disasters, such as the Selby train crash and Chernobyl nuclear disaster, have been attributed to human error due to sleep deprivation.

Causal factors

So, where does it all go wrong? Our body should be working fine – asleep at 11pm, awake at seven – but our lives have changed. Back in the times when it was usual to work by day and sleep at night, body rhythms worked perfectly, but due to the impact of modern life, we can have a tendency to mess about with that. Shift work has a huge impact on desynchronising our body clock, forcing it to sleep in the day and be awake when the signals are priming our bodies to sleep. Our lives are busy with so much to cram in that we often ignore our bodily cues. When melatonin is released, telling us to sleep, we often can't because we still have things to do. We might try and push through those cues with stimulants, such as sugary, carbohydrate-laden foods, caffeine or alcohol, but this only exacerbates the problems in being able to settle to sleep.

Technology is a major culprit, playing havoc with our sleep cues. Blue light from computers, phones and TVs stimulate our brains, so don't expect to go straight to sleep after an evening of emails and social media. This is a particular issue for teenagers, for whom technology is a vital part of life. Gaming and keeping in touch can be a hard habit to break, often leading teenagers to miss out on sleep and struggle to get up for school. Plus, the impact of sleep deprivation alongside raging hormones is not a great combination.

Late nights at weekends also serve to push our circadian rhythm out of sync, leading to the familiar Monday morning feeling. Our lives can be characterised by stress and anxiety. We really can't sleep well when we have so many things on our minds, so when we have a natural night waking, the to-do list springs into our mind, and getting back to sleep with so many thoughts is a challenge. This can lead to a vicious cycle of negative thoughts around sleep and a dread of going to bed. Similarly, with depression, inactivity and too much sleep exacerbate thoughts of not wanting to do anything, and sleep can be a way of blocking out our issues.

Physical factors may also contribute, with illness and pain causing sleep disturbance due to increased levels of cortisol. Menopause brings decreasing levels of progesterone, a sleep-inducing hormone that can also cause increased anxiety. Along with night sweats, poor concentration and memory, sleep can suffer for many women during menopause. Snoring and gasping for breath during sleep is another concern and should be investigated should it be caused by sleep apnoea. Parasomnias, such as nightmares and night

terrors, sleep walking and sleep talking, can cause disturbance for the sleeper and other family members. Clients with children who are poor sleepers often suffer from sleep deprivation.

Psychoeducation

So, what can we do? Much of our work starts with psychoeducation about sleep. Through understanding the science of sleep and how we may exacerbate problems, we can begin to look at behaviours and thoughts around sleep. We can help clients identify how to make changes to work with their bodies, instead of fighting against natural rhythms. Of course, it is also about motivation to change, finding a reason for doing the difficult bits, such as going to bed earlier or cutting out the caffeine. The results can be outstanding, and it's only when changes are made that clients realise how much poor sleep was affecting their whole being.

When working with teenagers, it can be particularly challenging to help them find a motivation to change; why would they want to give up chatting to their friends or gaming into the night? It's finding the win for them, such as academic achievement, or it could be a link to health or decreasing the risk of obesity. Many teenagers are getting as little as three or four hours' sleep. Their body clocks naturally shift later at puberty, so they won't be tired at their usual time, but often it gets pushed back later and later with their behaviour. Bringing bedtime back in half-hour increments, along with a regular wake time and a strong routine, give good results. In one case, a child we worked with had a diagnosis of ADHD removed, as it was sleep deprivation causing the symptoms.

Sleep routine also links to night owls who are not ready for sleep until the early hours. You may naturally be a night owl or become one through pushing bedtime back later. A recent study by Birmingham and Surrey Universities showed that

We can help clients identify how to make changes to work with their bodies, instead of fighting against natural rhythms

night owls can bring their readiness for sleep back by three hours in a few weeks by following a structured routine.[4] These 'rules' apply to anyone wanting to reset their sleep patterns, and should be followed for up to six weeks, seven days a week, to establish a pattern. Bringing forward our waking time to the time we want to be up in the morning helps; by doing this, our drive to sleep will naturally come earlier in the evening. Have a fixed bedtime routine of winding down and dimming the lights in the evening, as light is one of the greatest factors to remaining awake. A snack that includes sleep-inducing foods containing tryptophan, which converts to melatonin, can also help, as hunger will keep us awake if we wake in the night.

Having a bath is relaxing and raises your body temperature for it then to lower, which induces sleepiness. Getting out in the daylight is important for the production of vitamin D, which helps with seasonal affective disorder and is important for naturally resetting our circadian rhythm. Regular mealtimes also help us to work with our body's natural timings; it's all about routines.

Supporting clients to improve sleep

In the therapy room, supporting clients to help improve their sleep can be important. To what extent might depression and anxiety be exacerbated by sleep deprivation? We often ask a quick question at assessment about sleep, but how many other symptoms are caused or exacerbated by poor sleep? Once the importance of sleep is better understood, and by making improvements here first, many other symptoms, such as poor concentration, inability to make decisions and emotional dysregulation, can decrease. This leaves room in therapy for other issues to be addressed.

Different methods to improve sleep can be used, depending on what works for the client. Using a structured approach, such as CBT, can be very effective. Sleep diaries and thought challenging can be used to provide factual evidence to tackle unhelpful thoughts relating to sleep, and behavioural interventions can also help clients make changes. Sleep-restriction

therapy can work for insomniacs, if they can buy into the idea of not going to bed until they are tired, and only being in bed for the amount of time they are asleep. This may initially be for a few hours to improve sleep efficiency, but can increase over time by following a strict programme of routine and rules. Stimulus-control therapy forms one of the rules, complementing sleep restriction. This makes the bedroom very minimalist, with only a bed and very plain, neutral décor. Plus, the bedroom is for sleep and intimate relations only. Colin Espie's book,[5] *Overcoming insomnia and sleep problems*, provides excellent further guidance on these techniques.

Acceptance and commitment therapy can also be effective, using techniques such as relaxation, imagery and mindfulness. It aims to help clients accept being awake and the thoughts that might pass through their minds, refocusing on the environment they are in: the weight of the duvet, the sensation of their breath and what they can hear. Reading or listening to meditations and using breathing techniques are all valued sleep actions.

It does of course depend on the client as to which approach may be appropriate, or whether a combination of strategies might be required. Something that seems to work for the majority is a technique called the 'cognitive shuffle', which is effective at addressing worrying thoughts that seem 10 times worse at night. The cognitive shuffle – or serial diverse imagining (SDI) – is a technique designed by Dr Luc P Beaudoin[6] to help people get to sleep by diverting thoughts, helping to keep the mind off issues that hamper sleep, and stop the brain from trying to make sense of thoughts. It involves thinking of random items that are easy to visualise, non-threatening and conducive to sleep, using the right side of our brains to access visual images rather than the left brain, which focuses on language and thinking. Using a seed word (such as 'bedtime'), we imagine random objects in detail, representing each letter making up the word, which means sleep regulators are 'tricked' into thinking it's time to fall asleep.

Blue light from computers, phones and TVs stimulate our brains, so don't expect to go straight to sleep after an evening of emails and social media

So, coming back to the original question about what's in charge of our sleep, mind or body, the answer is not that simple. Our body has its own natural rhythms, which work well if left alone. The exceptions to that are sleep disorders and physical conditions that we have no influence over. However, medical interventions can help to a point with these. We do have some control over our minds and behaviours, which are by far the greatest contributing factors to poor sleep. By exploring clients' sleep patterns and getting into the nitty gritty of what is contributing to the problems, solutions can be found to make the best of their situation.

We may not be able to help a client change shift patterns, but we may be able to help them understand and value their sleep to improve their wellbeing. We can't always make worries go away, but we can find ways to assist clients to postpone and manage them at night, so they are able to get the restorative sleep they need. This will help them tackle them more effectively in the day. Changing behavioural patterns and unhelpful thought cycles offers another option, alongside specific interventions aimed at tackling insomnia.

What we would say is to give it a go and try a different approach of tackling sleep first. Mind or body? Both need good quality sleep.

Sleep-inducing foods

Food Type	Foods
Dairy	Milk, yogurt, soya milk, cheddar cheese, tofu, cottage cheese
Meat	Chicken, turkey
Fruits	Cherries, kiwi, banana, apples, blueberries, strawberries, avocados, peaches, pineapple
Fish	Tuna, cod, mackerel, salmon
Nuts and seeds	Walnuts, pistachios, almonds, peanuts, cashews, sesame, pumpkin, flax and sunflower seeds
Bread and grains	Whole wheat bread, wheat, oats, corn, brown and red rice
Beans	Kidney beans, lima beans, chickpeas, soya beans

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Your thoughts please

If you have any responses to the issues raised in this article, please write a letter or respond with an article of your own. Email: **privatepractice.editorial@bacp.co.uk**

SOCIAL MEDIA IN AN ANXIOUS AGE

The FOMO is Real: How Social Media Increases Depression and Loneliness

IS INSTAGRAM STARTING TO TAKE MENTAL HEALTH SERIOUSLY?

Want to feel happier? Take a break from Facebook

SNAPCHAT DEPRESSION

SIX WAYS SOCIAL MEDIA NEGATIVITY AFFECTS YOUR MENTAL HEALTH

Is Facebook Destroying Society and Your Mental Health?

Fat, fit or frumpy

When you work with a self in the room, you are working with their online self too, writes **Catherine Knibbs**

Is social media to blame or responsible for poor body image, low self-esteem and related presenting issues? In my view, it's not. To fully understand why I take this view, I firstly have to challenge the current narrative about social media, and the plethora of pseudoscience that is likely making up much of your social media feed, news/magazine reading and TV viewing. Over the last few years, a skewed narrative has emerged, blaming and shaming many of the population's ills and issues as being 'caused by', or the result of, an 'excess of' [insert chosen tech platform here].

This is simply not true, nor does it demonstrate meaningful critical thinking around the issue. It's sensationalism taken to the next level. This biased approach has been challenged by researchers at the Oxford Internet Institute (OII),[1-3] where its analysis on the misrepresentation of research in the media shows that there is no direct cause related to technology for mental health issues, or the demonising terminology of the 'selfie generation'.[4] To date, no robust research can show causation, which is highly important for our profession, if we are to work in a neutral and non-judgmental capacity with our clients. Many of our clients who use social media, computer and online games, pornography and so on, would be mortified to think that we held a view that their issues have their roots in the 'power' of only social media influences.

My background is in engineering, computing and working with children and young people and, as such, I have grown up with the internet through my own use, and that of my children and clients. I have developed and taught a theory about why we engage in online behaviours, and run training on the use of technology in therapy. This is because I'm definitely influenced by people and ideas, often through technology and the many platforms on which I have met with other minds around these topics, including my podcast, *Cyber Synapse*, where I interview people from many sectors, such as the OII, among others.

Text to images

To see how we can be influenced by social media, I introduced attendees at my conference presentation to the culture and evolution of online connections, ranging from text-based forums, to the images we now see in such high volumes. This is important when you consider the impact each of these mediums has, and how we function as human beings. I showed a slide that had an image, and then a slide with text, to compare the level of information that each one conveys. It is likely we would struggle to survive if we relied solely on text; images are much more powerful in our understanding of the world. Add moving images to this, and you begin to see how social media has capitalised on our humanness, in order to create something that we can attend to at the rate we do. In fact, some of you reading this will already have veered off from the text on the page into your own thoughts, or indeed have checked your social media perhaps.

Child development and the self in 'selfie'

The self is a developing process from infancy to the beginning of adolescence, and, through these stages, a child learns who they are, based on feedback from others, in the form of non-verbal communications, language, social norms and shame, to name a few. These moments during growth, shape and change, mould and redirect a child's sense of self before the age of 12, which, coincidentally, is the age at which children and young people are able to sign up for many social media accounts. However, we know that children and young people go online from early years, and information about them is often posted online while they are still in utero.

We know from many approaches in psychology, psychotherapy and counselling that children and young people are influenced by their parents, families, peers and social context; and

...there is no direct cause related to technology for mental health issues, or the demonising terminology of the 'selfie generation'

that, through these interactions, they develop an identity, which is solidified throughout adolescence and matures in the late 20s.
At my workshop at the BACP Private Practice conference, I introduced the current landscape of social media narratives, ranging from those relating to being fat (shaming or celebrating), fit (obsessive to sexual), and frumpy (ageist to growing old). We considered the debate between radical feminists and men's rights activists; self-harm ('How to' versus 'How could you?'); sex and sexuality; and the beautification/destruction of the body through modifications. I asked: Where is the OK online? How can we develop a self, an identify, if there is nowhere that allows us to do this free of the expectations and permanence of online reality?

Some of the influences of social media

I also highlighted the helpfulness, impact and pressure of some websites and platforms that children, adults, young people and older clients may face. I talked about the major players in social media, such as Instagram and YouTube, and some of the issues that can arise from their use (far too many to write about here). I talked about trends that both children and adults have engaged in and fallen foul of, and the implications of this for us as therapists. For example, the person who tried to alter her eyebrows using a beauty technique that 'went wrong', which she then posted about online. Her post went viral, resulting in her being cyberbullied and trolled. Had this been a client, there would have been many issues for us to work with, such as: why they engaged in this behaviour; what happened when it went wrong; the resulting shame, blame, humiliation and ridicule; and the fallout from the viral image that would now forever be on the internet; which relates to my theory around cybertrauma.

The influence on me

At my workshop, I also talked about my journey into functional health from a social media post that caught my eye a number of years ago, resulting in my having my DNA sequenced, using an approach called nutrigenetics. And how I was influenced to completely change my approach to health, based on a few Google searches a number of years ago, and ended up on a training course at Imperial College London on the back of that post. I explained that I use technology, apps, and follow many functional health individuals online, routinely looking into the 'biohacks' they suggest, in order to achieve optimal health. I balance this with the influence of being too health conscious or driven, and read the research for myself; because you can't believe everything you read online.

I also showed my Pinterest page on tattoos, as I have many of these myself, and, in keeping with the theme of the conference, discussed my motivation for getting these, using varying theoretical approaches, and counterbalancing the perspective offered by Alessandra Lemma in her keynote (see page 8), discussing how some of my clients (and I myself) have tattoos to mark significant life events, such as overcoming illness, leaving a violent marriage, beating cancer and memorialising deceased loved ones, among others. We are always more complicated than one perspective allows, and, as an integral and integrative critical thinker, I talked about how we can be given filtered information offline as well as online, through biases, limiting beliefs and opinions.

On the back of gaining new knowledge for myself, I influence others via social media through my own podcast aimed at professionals, parents and anyone who wants to learn about anything related to my interests in the overlapping world of online activity, client presentations, biohacking and health, and privacy laws and cybersecurity. I have been influenced by others on and offline, and I influence, whether I am in my consulting room with a client, or online through my posts, podcast or vlogs/blogs. I wonder how you perceive your influence, both active and passive, received or given?

Technology moves forward: what about private practice?

As therapists in private practice, how can we ensure we keep up to date on the issues relating to technology that affect our clients? This is not an easy question to answer, but using the basic tenets from your training, your personal history where possible, in line with your model of practice, and learning about the online world, can stand you in good stead when working with clients who present with issues regarding their online self. When you work with a self in the room, you are also working with their online self too. Where possible, learn about different online platforms, how they work, what they offer, and how your clients use them. Learn about the risks associated. And, most importantly, consider the implications of using these platforms – for yourself and your clients. Real world pressures and influences can be magnified online and some 'selves' are more robust than others.

About the author

Catherine Knibbs is a UKCP registered child and adult trauma psychotherapist and a clinical researcher specialising in human behaviours in a digital world. She is a speaker, trainer, vlogger and podcaster, has created her own theory of online behaviour, is currently completing a PhD in cybertrauma, and is the director of ACTO's Research and Development section. She is also a functional psychotherapist, using nutrigenomics to support her work with clients, and a #Biohacker who uses food, supplements, light, sleep and tracking technology to help her attain optimal performance and flow for her busy life. Catherine will be running courses in 2020 on technology in therapy, cybertrauma and functional health.
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Invisible connections

New research shows that isolation affects the biophysical core and wellbeing of trees as well as humans

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If you grew up in the 1960s or 70s, you probably remember those weekly Music and Movement lessons, when teachers would take everyone to the school hall and play a reel-to-reel recording of a well-to-do lady who invited you to listen to the music and then pretend you were a tree, growing from a tiny seed to a young sapling, and then growing taller and stronger. 'Feel your toes like roots deep in the earth. Stretch up your arms and let your fingers spread out, like the twigs at the very end of the branches.' Joyce Grenfell's famous parody of this kind of lesson highlighted the twee ridiculousness that can result: 'Sydney, what tree are you being? Oh, all right, you can be a fat daisy, but be it gently.'[1]

But the intimate and age-old affinity that exists between trees and people does not have to be sentimentalised. The mechanics of exactly how trees and humans, two such distinct life-forms, have so much in common, are fascinatingly revealed by various different areas of contemporary scientific research. One of the things that such research is revealing is exactly how loneliness can be such a central cause of a failure to thrive, and in what ways other living beings, as well as humans, could be seen as experiencing this debilitating state.

In *The hidden life of trees*[2] and *The inflamed mind*,[3] the respective authors, Peter Wohlleben (a forest expert) and Professor Edward Bullmore (a psychiatrist who specialises in the workings of the human immune system), both uncover the fantastically intricate dance that goes on between the different parts that make up any one tree and any one human body, and also the intricate web that weaves between any individual tree or person and their surroundings.

Trees, we now know, indisputably communicate with each other. They do this via chemical and electronic impulses that travel through a fungal network around their root tips, which spreads underground, and which has been drolly dubbed 'the wood wide web' by Dr Suzanne Simard.[4] They can also send messages to each other to warn of a danger, such as an animal eating their leaves, by emitting a gas which nearby trees of the same species can detect, and which prompts them to pump toxins intotheir leaves to make them bitter and unappealing, in case the grazing animals attacking their companion, end up coming over to their patch.

> ...feeling acutely stressed can lead some individuals to being in a chronic state of internal inflammation

Among his descriptions of all the ways that trees interact, Wohlleben includes the process by which trees that are cut off from their mates, and that have no access to their usual networks of connection and communication, can end up struggling. These include trees that get uprooted and planted away from their original area, or ones grown in artificial environmments and put into urban settings. Many such trees can end up too stressed to flourish, and often die prematurely.

Isolation also leads to all sorts of health problems for humans; and here too, modern science is explaining to us more of the 'why' and 'how' of this phenomenon. In his book about the ways in which the biophysical condition of inflammation can be a hidden cause of many chronic health problems, Bullmore looks at the process by which our bodies fight infections by producing macrophages (cells that effectively eat bacteria), which in turn produce a kind of chemical messenger, called cytokines, to alert other macrophages in the area to hoover up the alien intruders. He argues that although the inflammation macrophages and cytokines cause is usually a hopeful sign (it is often the side effect of our body effectively fighting an infection), if it goes on for a prolonged time, such inflammation can spread to the brain and damage the amygdala, the cingulate and other crucial parts of the emotional regulation network, and can, he suggests, thereby cause a state of depression.

And it is not only fighting an infection that can cause such unhelpful inflammation; our immune systems can be made overly sensitive and prone to act as if we are fighting an infection when we are not. If, for example, we have had a high number of adverse childhood experiences, or if we have inherited a propensity for a hypersensitive immune response, it seems, we can get triggered by emotional and psychological stress, so that our bodies behave as if we are under some biological threat that requires a mass production of macrophages and cytokines, when there is no bacterial threat at all. In short, feeling acutely stressed can lead some individuals to being in a chronic state of internal inflammation (leading to all sorts of disorders, especially of the skin and the digestion system, as well as depression). And we all know that one of the biggest sources of stress for humans is feeling lonely, excluded, isolated and unsupported.

It seems reasonable to conclude that at least a part of the common ground that humans and trees share is that both life forms need to be connected to, and attached with, others, and able to communicate and exchange with their fellow beings. These communications may not always need words, and they may sometimes be subtle and slow, but they are no less life giving, to both trees and to people, for all that.

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Psyche and soma

Some illnesses have a psychosomatic element, but how exactly does the mind have this effect on the body? By **Peter Afford**

We know from personal experience that mind and body affect each other. Thinking about something can trigger feelings in our body, and pain and illness dampen our mental state. How does this actually happen inside us? How mind and body affect each other may seem mysterious, and philosophical debates about the 'mind-body question' abound. But neuroscience has penetrated the mystery and offers a picture of the whole person – psyche and soma. Psychosomatic issues that have provided fertile ground for conjecture and speculation can now be explored more concretely.

The mind-body connection

Brain and body change each other via neural pathways (nerves) and biochemical pathways (hormones and peptides etc in the bloodstream).

Psychosomatic issues that have provided fertile ground for conjecture and speculation can now be explored more concretely

The brain evaluates external sensory signals and triggers the movement of limbs and emotional changes in the body. It decides, for example, where in the body gets more blood when we're stressed. In the other direction, it needs blood and oxygen from the body, and sensory signals from within so it knows what's happening there. Mental activity generates emotional body states, and body states change the neural landscape in the brain, affecting how we feel, what we perceive and what we think about.[1] For example, a body made anxious by an anxious brain then biases the brain into further anxious thoughts.

A rule of thumb: the brain initiates what happens in the body (such as emotional states), and the body influences what happens in the brain (emotional states affecting the brain in a feedback loop) – though there are exceptions. To unravel mind-body mysteries, we must explore the details of what passes in either direction.

The neural pathways between brain and body mean that the brain reaches far into the body, since it belongs to the central nervous system, which includes the spinal cord. From there, it's only one more link via the peripheral nervous system to every nook and cranny of the body. The autonomic nervous system is the part of central and peripheral systems that we cannot consciously control – for example, nerves governing heart rate and blood pressure. It sub-divides into sympathetic and parasympathetic branches for, respectively, arousal and energy, on the one hand, and restand sleep, on the other.

There are more sensory nerves from body to brain than motor nerves from brain to body. This is because the brain's signals to change something in the body are relatively straightforward, whereas the body's signals about its inner state are detailed and complex.

The biochemical pathways between body and brain also flow in both directions. A prime example of brain to body is the HPA axis (hypothalamus-pituitary-adrenal), a sequence of hormones that starts in the hypothalamus in the brain and ends with the release of adrenaline and cortisol from the adrenal glands. This is the biochemical half of the stress response, the other half being the sympathetic nervous system that makes the heart beat faster and raises blood pressure. From body to brain, biochemicals such as cortisol enter the bloodstream and get into the brain, tweaking the neural landscape.

The brain 'maps' the body: the five senses, the movement of muscles and limbs, the configuration of the body in space, and the state of the viscera and internal milieu (the organs and fluids sloshing around inside the body).[1] Mapping is dynamic, especially in the right hemisphere, as our internal somatic state is forever in flux. Body mapping means we have a 'neurosymbolic' body in our brain, which sometimes leads to strange phenomena, such as body dysmorphia, whereby our perception of our body differs from how it appears to others.[2]

Differences between the left and right hemispheres shed light on the mind-body connection, since the right is more interconnected with the body than the left. The right hemisphere changes inner things

like heart rate and breathing, in the background, in response to what's happening around us. It triggers sympathetic arousal in the body, and therefore the stress response. It has a more complete map of the whole body, including viscera and internal milieu, than the left has, and is therefore dominant for interoception, the sense of our body from within.[3] It's where our felt sense of a situation arises.

The left hemisphere sees mind and body as separate, while the right sees them as an ensemble. The left says, 'I have a body.' The right says, 'I am my body.'[4] We can posit a foreground mind in the left and a background bodymind in the right, and a right brain-body ensemble. We project the wonders of the right's holistic functioning into the apparently unsolved mysteries of the body, including 'the wisdom of the body' – such wisdom arises in the right hemisphere, informed by the body. And since bodymind is background, the psychosomatic aspect of illness easily eludes us.

Psychosomatic conditions

The potential for psychosomatic illness was recognised by Jung: '...a wrong functioning of the psyche can do much to injure the body, just as conversely a bodily illness can affect the psyche; for psyche and body are not separate entities, but one and the same life'.[5] His notion of psyche points to the right hemisphere, our inner world where body, feeling, and less conscious aspects of mind intertwine.

Somatisation is the tendency to have physical symptoms in response to stress or emotion, a normal feature of life in which the body expresses mental or emotional distress. Psychosomatic symptoms are physical symptoms that occur for psychological reasons.[6] The patient complains of symptoms that cause real distress and disability, but the doctor cannot find any signs of illness. The patient is experiencing something rooted in emotional distress rather than infection or injury (or modern medicine is missing something!). To qualify as psychosomatic, this distress should be suppressed or dissociated rather than expressed.[7] But we cannot know any of this for sure, so clear distinctions between illnesses with psychological and physiological causes may be impossible.[2] Maybe all illness has a psychological element, while no illness is purely psychological in origin.

Somatisation is the tendency to have physical symptoms in response to stress or emotion, a normal feature of life in which the body expresses mental or emotional distress

The two most common psychosomatic symptoms are fatigue and pain, which cannot be objectively measured.[6] Others are non-cardiac chest pain, pelvic or abdominal pain, painful peeing, shortness of breath, itching and rashes, blurring of vision and hearing loss. Psychosomatic symptoms can affect any part of the body and involve palpitations, paralysis, convulsions, or almost any sort of disability. Every bodily function can malfunction, and any biochemical can be over-produced or under-produced. Other illnesses thought to be linked to emotional suppression and poor affect regulation include asthma, heart disease, ulcerative colitis, back pain, tension headaches and intestinal problems.[8,9]

Unsurprisingly, childhood abuse and neglect are all associated with psychosomatic disorders.[6] Psychosomatic illness is often triggered by a traumatic event, such as bereavement (especially if tragic or guilt-ridden), serious physical or sexual assault, or by feeling trapped in, for example, debt or marital disharmony. Early childhood trauma, including attachment trauma, can leave the right brain-body ensemble and the autonomic nervous system in a state of chronic readiness to deal with threats, including interpersonal ones – which links with polyvagal theory, especially for gut problems.[10]

The two main players in psychosomatic conditions are the stress response and the immune system, so let's explore these.

Stress and illness

We get sick from activating the stress response (via the sympathetic nervous system and HPA axis) too often, for too long, and for purely psychological reasons.[11] Ongoing stress doesn't make us ill *per se*, but it does increase the risk of disease, '...making it more likely for the roof to cave in at some point'.[12] This happens via an over-activated cardiovascular system and chronically high blood pressure (the sympathetic nervous system), and chronically high cortisol (the HPA axis) suppressing the immune system, leaving us more prone to infection and less able to fight back once infected (as happens when we're stressed and catch a cold).

The stress response accounts for some but not all psychosomatic symptoms.[6] Under chronic stress, the sympathetic nervous system can be activated for long periods at a low level, causing high blood pressure or heart palpitations. Bodies react in sympathy to the mind's distress. Cortisol plays an important role: normally, rising levels influence the hypothalamus and pituitary gland to reduce any further release, a feedback loop that prevents an overactive bodily response to stress. The failure, under chronic stress, of this feedback loop to dampen cortisol release is implicated in psychosomatic illness.

Another scenario is the under-secretion of cortisol that can lead to chronic fatigue syndrome, fibromyalgia, and rheumatoid arthritis.[12] Low cortisol is associated with unresolved trauma and implies poor recovery from stress (for which cortisol is needed).

Too little sleep

Stress and anxiety can mean disturbed sleep, and sleep deprivation is itself a stressor, creating a vicious circle.[12] Insufficient sleep can contribute to all sorts of health problems: cardiovascular disease, stroke, congestive heart failure, and type 2 diabetes, Routinely sleeping less than six hours a night 'demolishes your immune system', increasing the risk of cancer.[13] And too little sleep links with hormones that make you want to eat more (weight gain).

The immune system

Combine psychology, neuroscience and immunology and you get psychoneuroimmunology, the science of mind-body interaction via the immune system that comprises cells, including white blood cells, found all over the body and brain. There are macrophages which 'eat' bacteria, lymphocytes which produce antibodies that help macrophages fight infection, and cytokines, proteins secreted by macrophages that circulate in the bloodstream, enlisting the help of other macrophages.

The psyche affects the immune system via the stress response: '...the brain has a vast potential for sticking its nose into the immune system's business'.[12] Normally, cortisol activates it and then suppresses it to avoid over-shooting into auto-immunity, but severe and sustained stress can lead to the HPA axis releasing too much cortisol for too long, thereby suppressing the immune system below baseline, increasing the risk of immune-related illnesses. The opposite can happen too: chronic emotional stress, from bereavement or social isolation, for example, can lead to an over-active immune system. Excess cytokines and macrophages can inflame the arteries, triggering heart attacks and strokes.[14]

In the reverse direction, soma can affect the psyche via the immune system. Cytokines fight infection in the body by triggering fever, but they can also cross the blood-brain barrier to 'inflame' the mind, causing depressive symptoms, including excessive or chronic fatigue.[14]

Psychosomatic illness is often triggered by a traumatic event, such as bereavement... serious physical or sexual assault, or by feeling trapped in, for example, debt or marital disharmony

Furthermore, changes to immune cells following trauma can make the immune system over-sensitive to social stress and threats, so it kicks off unnecessarily with disproportionate inflammatory responses, triggering depressive symptoms.

Autoimmune disorders

The immune system can cause illness as well as protect against it – autoimmune disorders, such as allergies, rheumatoid arthritis, ulcerative colitis and MS.[15] Lymphocytes can mistake the body's own proteins for alien proteins and mount an immune response. Macrophages churn out cytokines that cause inflammation, and this can go on for years. Psychoneuroimmunology means that trauma may play a role, but this doesn't necessarily mean that it causes autoimmune disorders.

Inflammation

The immune system generates inflammation in the body as more blood goes to the injured area. It becomes red and swells up painfully, lymph fluid leaking through blood vessel walls to attack alien invaders.[14] Inflammation must be kept in balance by cytokines and neuropeptides: enough to fight infection, not so much that it becomes damaging. Chronic stress can mean chronic inflammation in joints, connective tissue and organs, and chronic high blood pressure causes inflammation in blood vessels. Both are fertile grounds for serious illness, such as heart disease and cancer to develop. The gut is naturally in a permanent state of controlled inflammation to deal with the alien invaders we eat, and chronic stress means the balance can tip over into inflammatory bowel disease. In the other direction, inflammation in the body can lead to biochemicals crossing the blood-brain barrier to affect how we feel and what we think about – and to trigger depression.[14]

Psychosomatic conditions in therapy

The science demonstrates how stress and trauma can contribute to psychosomatic illness via the right brain-body ensemble, affecting the stress response and the immune system. Whether they cause illness is less clear. Furthermore, clinical experience shows that emotional expression and psychological transformation don't necessarily lead to physiological healing.

A psychosomatic disorder is really a hypothesis. When we suspect a person's psychology might underlie their illness, we may be tempted to interpret an illness as psychologically meaningful.[7] The left hemisphere can be categorical and dogmatic, while the right is needed for a shared understanding of the psychological aspect of an illness to unfold between therapist and client. Reflecting on the possible meaning of symptoms can be done jointly, rather than the therapist being the expert, or looking them up in a book. They can reflect on what purpose the illness serves and where the gain lies.[6]

To avoid shaming and angry reactions, it's often better to talk to people about their stress levels than interpret illness psychologically: 'You're not mad, you're suffering from stress, anxiety and trauma in ways you haven't yet realised.' Therapist and client can work to identify stress and reduce it, and they can work to resolve old traumas.

Conclusion

Chronic stress and unresolved trauma can contribute to psychosomatic conditions via excessive sympathetic arousal, too much or too little cortisol release, sleep disruption, immune suppression, or an overactive immune system, generating inflammation and autoimmune conditions. The troubled mind feeds into poorly regulated physiology.

Maybe 30 per cent of GP consultations are for psychosomatic symptoms.[6] Psychosomatic illness is not imaginary but reflects something real happening in the brain, as well as the body. It's easy to be unaware how stressed we are – it may be a constant background state. We all somatise, and from the right hemisphere's perspective, our stress and distress will inevitably be reflected in the way brain, mind and body function as an ensemble. There's probably a psychological element in any illness, and it's the aspect of illness that therapy is able to address.

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Your thoughts please

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What are we up against?

In these troubled times, our work is more powerful than we realise

Jim Holloway
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Sometimes I imagine supervision sessions as subversive cells of invisible activity, as if we're creating remedial pockets of resistance to the madness and destruction going on around us. If you've ever thought of your supervision as an oasis of sorts, or a kind of safe haven, you'll probably know what I mean. Such a restorative space isn't necessarily 'subversive' in the revolutionary sense, but I often get a feeling there's something we're seeking to overthrow or turn upside down.

To push against anything requires firm footing. When supervision provides a holding field with solid ground to stand on, it strengthens our connection to our foundational values. The benign, fair, inclusive and equitable world evoked by BACP's *Ethical Framework* is hopefully what we're pushing for – and all the while an uncaring, unjust and oppressive world 'out there' inevitably pushes back. And still we continue to push on through, as best we can.

In supervision, the individual stories we recount from people's lives constitute something far greater than 'case histories' in the clinical sense. With each person, at each session, through each therapeutic encounter, we're dealing with the human struggle to overcome suffering. We want to make sense of how our clients suffer and to help them help themselves find a way to suffer less. This is what we're good at. And because we habitually reflect on what we do, we keep getting better at it. Our supervisory skills in collaborative sense-making and appreciative enquiry can make the process of supervision itself feel like an antidote to suffering, even if only partially and temporarily. The truth is, we know we all suffer, and because we're all in this together, we press on.

It's this pressing on that heartens me every day in the role of supervisor. Practitioners in supervision often say how deeply some of their clients inspire them. I hope that supervisors never overlook how often they are in turn moved and inspired by their supervisees. Clients, service users, patients, clinicians, supervisors, pastoral carers – whatever our role, we're all people who learn from each other. It would be grandiose to place supervision right at the heart of this collective learning, but it does perform a vital role in keeping our professional body alive.

In supervision, the individual stories we recount from people's lives constitute something far greater than 'case histories' in the clinical sense

All heart metaphors are bloody ones. I'm reminded of a recent conversation with a colleague about what it means to be truly whole-hearted when supervising. She talked vividly about trusting herself to get her blood up in supervision when she needed to, pointing out that real passion is rarely polite. For myself, I know I sometimes take advantage of the robust confidentiality of the space to spout things about my working life I might never let loose anywhere else. How about you? If an issue within or around your professional practice makes your blood boil, be sure to let your supervisor know about it. The same goes for what you might perceive in yourself as 'bloody-mindedness': if you find it applicable, that curious term probably says less about your stubborn ways than it does about your steady resolve and fortitude in adversity.

The sheer effort we frequently put into supervision isn't always obvious, even to ourselves. While we engage in our somewhat specialised dialogue, focused on finding meaningful language and imagery to create more understanding, our bodies are also busy making sense of the wide-ranging and often richly metaphorical conversation. Embodied experience in supervision can be more intense than we appreciate. Sensations of physical tiredness, for example, may arise after a session which at the time did not feel at all tiresome or draining. Conversely, I often feel mentally and physically 'charged up' following supervision, despite having been sitting down in largely reflective mode for an hour or more.

As our psychosomatic states ebb and flow, they may be only partly traceable and explicable, yet we owe it to ourselves to notice the changes as they occur and ask ourselves what they could mean. What might be identified as vicarious trauma or second-hand shock is very likely to affect any of us in some way at some time. Supervision reminds us we're not superhuman. We persevere with our fine sensitivity because we've also learnt what to do to restore ourselves. You know your supervisor really cares about you and your work when they gently and persistently check to see if you're practising effective self-care. Almost no other profession applies this crucial ethic as part of regular and continuous support.

We would be extraordinary creatures if we never felt pulled out of shape or unpleasantly disturbed by our client work. Talking about these experiences in supervision fulfils our ordinary human need for recognition and understanding. This process is commonly called resilience, but I think there is something else going on, which is not usually acknowledged.

When I referred to 'subversive cells' and 'pockets of resistance' earlier, the associations with underground liberation movements were intentional. I'm not suggesting that by engaging in supervision we become militant protagonists in some kind of covert insurrection, but I am saying we are involved in a movement against the established order of things. I'd like us to say this to ourselves more assertively and more often. The processes of supervising and being supervised are not carried out with the purpose of keeping everything just the way it is.

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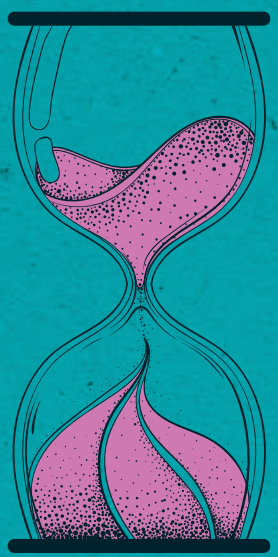
Menopause Matters



59%

of women between the ages of 45 and 55 experiencing menopause symptoms, say that they have a negative impact on them at work

38%

of partners said that they felt helpless to support their partner going through menopause

Diane Danzebrink on why menopause matters in the therapy room

I was delighted to deliver the closing keynote speech on the subject of menopause at the BACP Private Practice conference in September. Menopause is a subject very close to my heart and I am passionate about sharing what I have learnt, both personally and professionally, to ensure that women do not continue to struggle due to a lack of both education for health professionals and the public, and factual, evidence-based information.

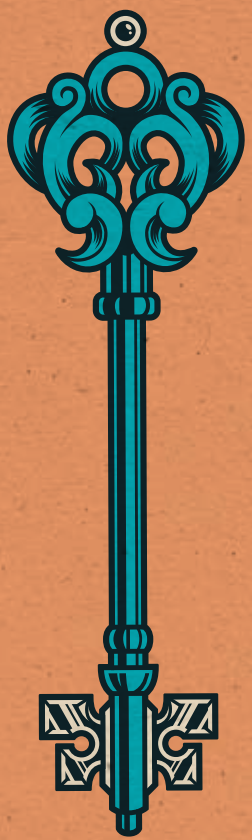
My own experience of menopause began in 2012, considerably earlier than I had expected, when, due to concerns over my general health, I visited my doctor. As a result of our consultation, she ordered blood tests, which showed I was anaemic. I was prescribed an iron supplement and asked to return in a few weeks time if I had not improved. I was sitting in front of my doctor again less than two weeks later, as I felt considerably worse. More blood tests were ordered and a few days later my phone rang. As soon as I realised it was my doctor, I knew something was wrong. She explained that my CA125 was considerably raised. CA125 is a protein found in the blood, and while it can be raised for several reasons, it is currently the only indicator available for a possible diagnosis of ovarian cancer. As my mother had been diagnosed with ovarian cancer some years before, I completely understood my doctor's concern.

Over the following weeks, I had a series of scans, hospital appointments and more tests, resulting in the decision to undergo a total hysterectomy, including both of my ovaries. While I was aware that this would put me straight into surgical menopause, I had no idea what that really meant, in terms of the possible symptoms and long-term health considerations; and, sadly, nobody explained it to me.

Having been given a possible ovarian cancer diagnosis, I was focused on the surgery happening as soon as possible. The day after my surgery, the gynaecologist told me she had discovered not just complex cysts on both of my ovaries, but that I also had stage four endometriosis, a painful condition where tissue similar to the tissue that lines the womb grows outside of the womb and causes lesions in the pelvic area, and adenomyosis, another painful condition where the lining of the womb grows into the muscle that surrounds it, and a huge fibroid. While it was shocking to hear that I had been living with all these conditions, it also explained why I had experienced so much pelvic and back pain for so many years, wreaking such a disruptive effect on my everyday life. The good news was that she felt she had performed the surgery just in time and that I should rest for a few weeks before visiting my doctor. I left the hospital less than 48 hours after my surgery, with no information about how the results of it could affect me in the future.

In an attempt to support my recovery and future health, I visited a nutritionist to explain what had happened to me. I left the appointment with seven different supplements and an assurance that the herbs, vitamins and minerals she had prescribed would help with any menopause symptoms and my general health. The next few months were very much focused on my recovery and getting back to normal and all seemed to be going well until I began waking in a state of panic in the early hours of the morning. I began to struggle with anxiety, which rapidly escalated to the point where I became nervous of leaving the house, driving, seeing friends, answering the telephone and even opening post. My world became very bleak, very quickly, and getting through the day felt like wading through chest-deep treacle. Despite repeated pleas from my husband and mother, who had to come to stay to care for me while my husband was at work, I refused to go back to the doctor, as I was terrified that they would offer me animal-derived hormone replacement therapy, the only option as far as I knew, or a lifetime of antidepressant medication.

Early in 2013, the decision to see the doctor was taken out of my hands when my husband became so concerned about my mental health that he made the appointment and took me himself. As I sat in front of her and sobbed, she

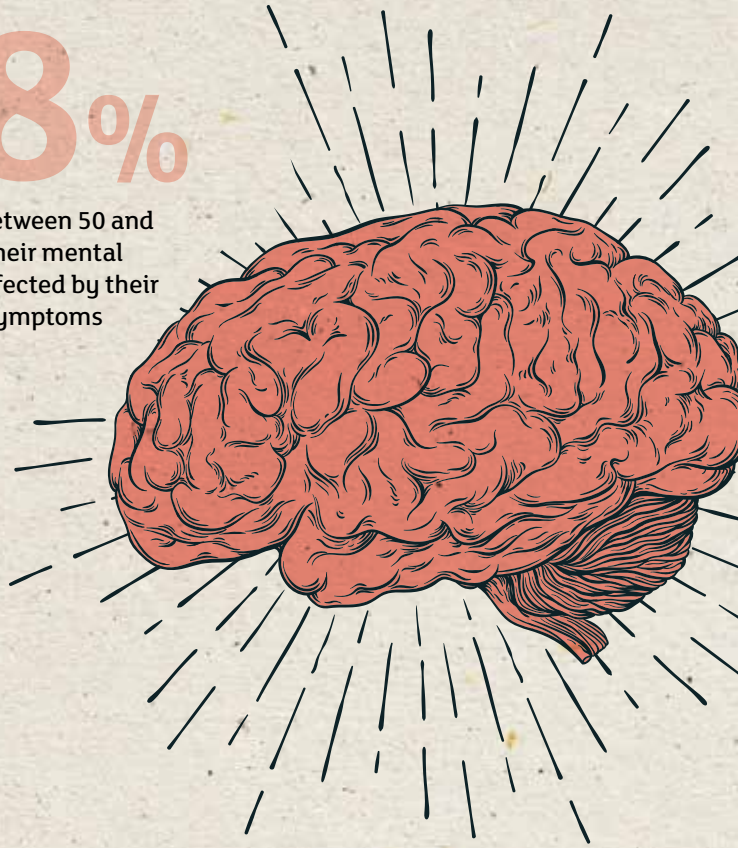


25%

of the women surveyed said it made them want to stay at home

48%

of... women between 50 and 55 said that their mental health was affected by their menopause symptoms



1 in 4

experience debilitating symptoms

My world became very bleak, very quickly, and getting through the day felt like wading through chest-deep treacle

explained that my surgery had resulted in a dramatic loss of hormones, which was responsible for my symptoms. I explained that I couldn't possibly take medication that was animal derived and then she said the magic words, 'You don't have to. You have a choice. We now have plant-derived hormone replacement therapy.' In that moment, I felt, for the first time, that there might be hope for the future. I started treatment the same day and began to feel an improvement in just 48 hours. But soon after, I felt really angry; I had needlessly suffered due to a lack of vital information, but had been so fortunate to have amazing family support. What about those women who were not so fortunate?

Once I felt well enough, I started to research and found an online world that I had no idea existed, full of women saying things like, 'Please help, I think I'm going mad'; 'I feel so alone'; 'I don't know who I am anymore' etc. These women were invariably in their mid to late 40s, but only some of them were experiencing hot flushes, night sweats and changes to their periods; there was a plethora of other symptoms that they couldn't understand. The common theme among these women was that many of them had been prescribed antidepressant medication for anxiety or depression, which generally had not improved their symptoms.

Menopause and mental health

Menopause matters because every woman will experience it at some point in her life. One in four will experience very few symptoms, but three in four will experience symptoms, with one in four describing them as debilitating.[1] In a survey for the BBC in 2018,[2] 48 per cent of the women between 50 and 55 said that their mental health was affected by their menopause symptoms, and 25 per cent of the women surveyed said it made them want to stay at home, which corresponds with the one in four who experience debilitating symptoms. More recently, the Chartered Institute of Personnel and Development has released the results of a survey which tells us that 59 per cent of women between the ages of 45 and 55 experiencing menopause symptoms, say that they have a negative impact on them at work, and 30 per cent have taken sick leave because of their symptoms.[3] In a 2017 survey for the British Menopause Society, 51 per cent of respondents said that their menopause symptoms had affected their sex lives, and 38 per cent of partners said that they felt helpless to support their partner going through menopause; 28 per cent said this caused arguments.[4]

Contrary to popular belief, menopause does not happen to women in their 50s. Perimenopause, which is the period from when symptoms begin, to the time when a woman has experienced 12 months without a period, typically begins in the early 40s and is rarely marked by the onset of hot flushes. The symptoms are much more likely to be anxiety, low mood, reduced concentration, broken sleep, fatigue, poor memory, irritability etc. The brain is full of oestrogen receptors and as the hormone levels begin to fluctuate, so can mood, self-confidence, self-esteem and cognitive function. It's also important to point out that for those women in a premature, surgical or medical menopause, these hormone declines can be dramatic, as in my own example, and need medical intervention with hormone replacement at the earliest possible opportunity to protect both wellbeing and long-term health.

Oestrogen has a key role to play in every part of a woman's body, and symptoms can be very different for every woman. The ones that are least likely to be spoken about are the urinary and vaginal symptoms, which can be embarrassing, debilitating and very painful if left untreated. In my own practice, I have counselled women who were at the end of their tether being given continual rounds of three days of antibiotics for repeated urinary tract infections, when, in fact, the cause was a reduced level of oestrogen.

The entire pelvic area is completely reliant upon oestrogen and without it up to 80 per cent of menopausal women are thought to suffer from vaginal symptoms, which can have a devastating impact on women and their relationships.[5] There is a simple non-invasive localised treatment for these symptoms, but sadly very few women visit their doctors, partly due to embarrassment or because they feel it is just part of getting older. Those who self-treat for conditions like thrush are also potentially putting themselves at risk, as there is a skin condition called lichen sclerosus, which needs to be managed with medication, as in some cases, without correct treatment, it can increase the risk of getting vulvar cancer

The costs of menopause can be devastating for women's health and wellbeing, their work lives, family lives and personal relationships

The costs of menopause

The costs of menopause can be devastating for women's health and wellbeing, their work lives, family lives and personal relationships. Sadly, many of the women I have worked with have booked multiple GP appointments for their symptoms, and many GPs are simply not equipped to help, as they have not been given adequate menopause education. Unfortunately, some of these women find themselves being referred on to secondary care for cardiology appointments for palpitations; rheumatology for aching joints and, most worrying of all, psychiatry for what invariably turn out to be symptoms related to fluctuating hormone levels.

Approximately one in four women considers giving up work due to their symptoms.[5] Those who take the decision to leave the workplace because of symptoms, often report feeling unsupported and unable to discuss their situation with managers.[6] Some feel they were performance managed out of the workplace; others were made redundant. With hindsight, all believe that their menopause symptoms were key.

The most heartbreaking experiences I hear are of those women who have experienced a breakdown of their relationship as a direct result of their menopause symptoms. At workshops, when I have talked about the subject of intimacy during menopause, and how both physical and emotional symptoms can lead to a breakdown in communication when neither partner really understands what is happening, when I have described some of the common symptoms, I have had women tell me they wish they had known this earlier, as they think the information might have saved their marriage.

The menopause transition can be a challenging one for some women and couples, but therapists are ideally placed to offer support, guidance and, where appropriate, signposting when we are able to recognise these hormonal shifts in our clients. Clearly, every woman in her 40s and 50s seeking therapy will not be experiencing menopause symptoms – lives are complex and lived at increasing speed, with constant, often overwhelming, demands.

But perhaps, having read this far, you are now considering clients who you are currently working with, or those who you have worked with in the past. Perhaps you have had a personal light bulb moment, as I know many of those at the conference did who were kind enough to come and share their thoughts with me or to contact me afterwards.

Menopause can be a transformational time of life with the right help and support, and my own menopause experience prompted me to seek support, which set me on the path I am currently following. There is no doubt that the treatment from my doctor saved my life, but the therapy that I engaged in as part of my menopause experience was an important part of my journey, which helped me to reassess what is really important to me and how I wanted to use my experience to help others. Both were key in helping me to regain health, both physical and mental, but I would not have been able to engage in the therapeutic process without having first accessed the right medical treatment.

Therapists who understand menopause and the possible effects of hormone fluctuation have an ideal opportunity to close the current knowledge gap among both the public and healthcare professionals to empower their clients to seek out factual, evidence-based information to enable them to make informed choices about how they manage their symptoms. This can be life changing for some women. There is nothing more rewarding than somebody who begins their consultation by telling you that they think they are going mad, but closes it by saying that they no longer feel alone. If you support women in your work, menopause matters.

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51%

of respondents said that their menopause symptoms had affected their sex lives

Imperfect Therapist

Mothers and daughters, sons and lovers

Lizzie Thompson
lizzie.s.thompson@gmail.com

A life-changing phone call distracts Lizzie as she tries to focus on the latest antics of her favourite four o'clock client

It's cold and dark and I have one more client to go. Normally, I'd be beginning to think about the evening, looking forward to some relaxing time, but today, and for several days now, I've been anticipating the phone call that's going to propel me into a new chapter of my life.

I open the door for my four o'clock. He strolls in, hands in pockets, a bit of a swagger. I enjoy this client. Is it bad I don't feel that about all my clients? There's something about his youthful antics, enthusiasm and angst that brings energy into the room and evokes maternal benevolence in me. He's describing his conflicting feelings around his crush on one of his lecturers. On the one hand, he's relishing the agony of unrequited love. On the other, his sexual fantasy life is super active, and he's keen to share. He enshrines this in a sort of faux I-know-we-have-a-deep-spiritual-connection context. But still, TMI. I'm probably just getting old, but I'm also amused by the way he's keen to shock me, as if I've never had any fantasies of my own, or, indeed, a sex life that involved keeping the lights on. Anyway, I'm engaged and, for the moment, only a little in touch with the nerves and fear that lurk in the background, as I think of my child about to have a child.

Forty minutes into the session, the phone rings. I rarely hear this from my consulting room, but, like a mother of a newborn (I'm clearly over-identifying), my antennae are razor sharp. My instinct tells me this is The Call. I glance at the clock. Fifteen minutes to go. I try and convince myself it's probably only some call centre wanting to tell me they know I have had an accident at work. I focus back on my client, but my attention is interrupted every couple of minutes by my racing heart. I feel really nervous. My faithful inner critics, Boris and Mrs Danvers, appear at the edge of my awareness. 'Focus on the task in hand,' advises the former, 'you will be able to head out when your client has gone'. Mrs Danvers, more brutal, of course, reminds me that women in Africa squat in the fields and drop their babies without, seemingly, stopping whatever task they're doing for more than a couple of minutes. Her implication? That my daughter and I are making a massive deal of what is, in the end, a completely natural process that zillions of women do all the time. I imagine the only troublesome aspect of childbirth for her, would be the tiresome messiness of it all. I become distracted trying to remember whether the character of Mrs Danvers from Daphne du Maurier's novel *Rebecca* (on whom my inner critic, morphed with my mother, of course, is based) had any children, or whether the title 'Mrs' was a safe way of covering her spinsterhood.

I'm planning my departure, while my client harkens back to the familiar theme of how to seduce his apparent soulmate. I, as many times before, try and explore what is going on for him in this relationship. 'What will it give you, to seduce your lecturer?' I ask. He looks at me as though I'm completely stupid. 'Well, I get to have sex with her, obviously,' he responds. 'And then?' I follow up. 'Then all my mates will be jealous as hell, as we become an item. We're meant to be together.' Dear God.

He has shown me a photograph of this lecturer, the mugshot from the university website. She is at least a decade older than him and has a sexy sassiness about her. I imagine pencil skirts and f*** off shoes. My client, when I think about it, is not a natural match with his grunge style and grubby trainers; but then, who knows what attracts one person to another? I remember having a weird fascination and sort of attraction for my English teacher. He had a reptilian profile and used to lick his lips as he asked his female students to read aloud from John Donne's love poetry. There was something both horribly mesmerising and utterly distasteful about the whole thing.

The session draws to an end. I show him to the door, trying not to rush him out, with both Boris and Mrs Danvers muttering in my ears about my lack of focus. I check my answerphone. I was right. My adrenalin kicks in. I'm organised and out of the house in five minutes. Well, my bag was packed, to be fair. I half-walk, half-run to the station and leap into a train as the doors are closing. My face is red. I'm hot and flustered and collapse into a seat. I shut my eyes in relief at being on my way. I reach for my phone to call my daughter and

> I'm probably just getting old, but I'm amused by the way he's keen to shock me, as if I've never had any fantasies of my own

something makes me look up. And there he is, my four o'clock. He's standing, turned away from me, engrossed in his phone. Should I gamble that he will not look up or should I move seats? I'm convinced that my breathing is loud enough for the whole carriage to hear. I try to remember our first session. Had I named the boundaries around bumping into each other outside sessions? 'I'll acknowledge you only if you acknowledge me, and, at most, this will be with a nod of the head or a smile.' I must have done, mustn't I? I'm not convinced and sneak into the next carriage like a thief in the night. Was I noticed?

Lizzie Thompson is a pseudonym. Although this is a work of fiction, the author welcomes feedback at the address above.

What triggers the eating disorder gun?

Understanding the underlying causes of eating disorders will have practical benefits for tackling a disease that's often frighteningly resistant to treatment, writes **Allie Outram**

Eating disorders are serious, complex, costly and challenging mental illnesses. Although often perceived as discrete, subtle and silent conditions, the message they send out is loud, crystal clear and speaks volumes. Individuals may suffer in silence with hidden feelings, neglected thoughts and dismissed emotions, but their message is one of the most powerful examples of non-verbal communications known. All eating disorder symptoms are significant and can only be understood as an expression of underlying issues and difficulties. They contain a message that goes beyond the limits of the behaviour itself. Eating is never a mere physical function: it contains and carries much more than is evident on the surface. As therapists, if we ignore the meaning of the eating pattern, we miss the essential symbolism of the problem.

Eating disorders are frequently seen as difficult to treat. Clients sometimes appear to be reluctant to change, and severe anorexia nervosa is a frightening and confusing disorder for anyone who comes into contact with it. Where the therapist works in a multidisciplinary team, roles can be negotiated and shared, along with the sharing of anxiety, and a team approach enables practitioners to cover the many different aspects of treatment. However, an independent therapist in private practice can feel confused and isolated, particularly so if, as the weeks pass, they witness a client relentlessly losing weight. It is not uncommon to find a cooperative client attending sessions but becoming dangerously thin, leaving the therapist feeling impotent and frustrated.

Some facts about eating disorders

Eating disorders are more common in females than males.[1] Males represent 25 per cent of individuals with anorexia nervosa, and they are at a higher risk of dying, in part because they are often diagnosed later, since many people assume males don't have eating disorders.[2] Subclinical eating disordered behaviours (including binge eating, purging, laxative abuse and fasting for weight loss) are nearly as common among males as females.

Compared with other populations, gay men are disproportionately found to have body image disturbances and eating disorder behaviour. Gay men are thought to represent five per cent of the total male population, but among men who have eating disorders, 42 per cent identify as gay.[3] Eating disorders have the highest mortality rate of any mental illness, claiming precious, promising lives ever year.[4] One in five of the most seriously affected will die prematurely. Of all psychological conditions, they also have the worst prognosis. The sooner someone gets the treatment they need, the more likely they will be to make a full recovery. Treatment is patchy at best, inadequate at worst, and that unacceptable variability nationally is putting hundreds of lives at risk every day.

Eating disorders are characterised by two key features: disturbed eating habits and disturbed weight control behaviours. Disturbed eating habits can include restricted food intake, strict dietary rules, preoccupation with food, binge eating and altered mealtime behaviours. Disturbed weight control behaviours may involve excessive exercise, vomiting or the misuse of laxatives or diuretics. These eating habits and behaviours are termed 'disturbed' when they become harmful through extreme use. Most eating disorders change in form over time; 'diagnostic migration' is the norm, rather than the exception. Two-thirds of clients originally diagnosed with a specific eating disorder had a different diagnosis 30 months later.[5] All eating disorders share:

- clinical features – extreme weight control, purging, preoccupation
- core psychopathology – self-worth judged largely or exclusively in terms of shape and weight
- maintaining features – severe perfectionism, low self-esteem, intense mood states, interpersonal difficulties.

Feeling out of your depth

One of the persistent challenges in diagnosing and treating eating disorders, and indeed in analysing trends in prevalence and reporting, is that it is common for eating disorders to occur alongside other mental health issues. Therefore, eating disorders are often one of a number of conditions that simultaneously impact upon individuals. This is a contributing factor to the difficulty in recognising and ultimately treating eating disorders. Linked conditions include depression, OCD, substance abuse, personality disorders, body dysmorphic disorder and bipolar disorder.

As a therapist, you will frequently come across ambivalence in clients with eating disorders; the internal battle between the healthy self and the eating-disordered self. There is part of the client that is eager to get healthy, and another part that is terrified of giving up their disordered eating, as it has become their lifeline. Anorexia nervosa is

described as egosyntonic because individuals experience their symptoms as congruent and in harmony with their own values. Anorexic individuals have a tendency toward perfectionism and place a high value on thinness and self-control. Most individuals will respond negatively to suggestions that they are ill, and will become deeply distraught by efforts to interrupt their ongoing drive towards weight loss. It is therefore very difficult to treat.

People with eating disorders, particularly anorexia, seem to have a characteristic cognitive style or share certain personality features. Sufferers tend to be over-analytical, seeing only the detail, rather than being able to synthesise the moment into the tapestry of life. Additionally, they have a tendency to be single-minded, enabling them to focus on one thing without distraction. This strategy helps them avoid thinking or dealing with painful issues about themselves, stressful events, or their connections within the world and other people; a very powerful maintaining factor. The downside of this is increasing inflexibility, rigidity and entrapment in their compulsive behaviours and rituals.

What causes eating disorders?

The question of cause has two parts:

1. Why do eating disorders begin? (Development phase before onset of the problem.)
2. Why do they persist? (Maintenance phase after its onset.)

This crucial distinction not only helps us understand the role of all possible causes, but it also has significant practical implications. If the goal is prevention, the task is to identify those processes that exert their influence before onset – during the development phase – and to try to stop them from operating (predisposing and precipitating factors/triggers). In contrast, if successful treatment is the goal, the task is to identify the processes that are keeping the problem going (perpetuating factors). Clients will probably come to us at this point. Eating disorders do not have a single identifiable cause. There are psychological, biological and social risk factors that may increase the likelihood of an eating disorder developing, as well as behaviours and traits that can be changed (such as dieting, poor self-esteem, perfectionism).

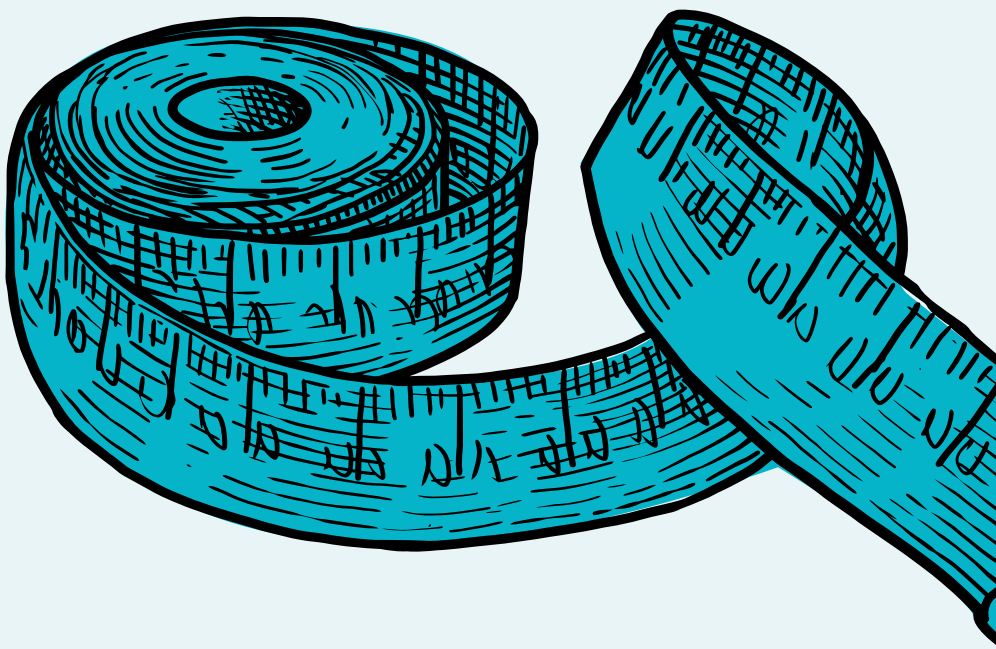
The theme of the BACP Private Practice conference in September was the links between the mind and body. The origins of anorexia are in both the mind and the body, according to an international study.[6] Up to now, anorexia has been seen as a serious psychiatric disease, but recent research has said that it should now be considered a 'metabo-psychiatric disorder', as it is a disease of mind and body.[6] Doctors at King's College London showed that changes hardwired into some people's DNA alters the way they process fats and sugars and makes it easier to starve their bodies. When most people lose weight, there are signals in the body that stimulate the appetite, but those with anorexia haven't got such strong drivers.

Mutations were also found in the instructions that control the body's metabolism, particularly those involving blood sugar levels and body fat. This groundbreaking research significantly increases our understanding of the genetic origins of this serious illness. There has been a difficulty in knowing what sort of disorder anorexia is. Now, we know it's a complex mixture of physiological and psychological interactions, alongside life events and other factors. This work is really important because it gives the message to sufferers and their families, and professionals delivering or developing treatments, that anorexia may not be conceptualised as a solely psychiatric condition. Rather, metabolic factors may contribute too. Knowing more about what drives anorexia will have real practical benefits in tackling a disease that's often frighteningly resistant to treatment and prone to relapses.

Eating disorders have the highest mortality rate of any mental illness, claiming precious, promising lives ever year

Just because a disease has a genetic component doesn't mean that the environment in which the sufferer is steeped is irrelevant, and in this case, researchers estimate genetics explain only about half of the cases of anorexia. It's a piece of the jigsaw, not the whole of it. But the greater our understanding of the complicated interaction between genes and environment, the more likely we are to find that conditions once blamed on human weakness – the idea that sickness must be someone's fault, or that they could get well if only they chose to snap out of it – have much more complicated pathologies. We're learning that genetic predisposition interacts with the culture to bring about anorexia and other eating disorders. You're born with the gun, and society – your cultural and environmental circumstances – pulls the trigger.

To summarise, all psychiatric conditions, including eating disorders, are caused by an interaction between a person's mind and body;



specifically, their biology, psychological makeup and social context. Gene activity itself can be determined by our environment through epigenetics. Biological processes are increasingly apparent in all mental illnesses through technical advances, such as functional brain scans and genomic studies. Advances in prevention and treatment will come through greater understanding of how both mind and body interact to cause a mental illness.

Athletics

I feel qualified to talk about eating disorders because I don't just know about them via training, research and qualifications. I know them personally, through lived experience. By the age of 13, I had many of the predisposing factors that would place any individual at risk, and I starved my way down to an emaciated 28kg with a BMI of 11. There was no early intervention for me and eventually, when I was diagnosed, my organs were failing, and I was given just a week to live. I was hospitalised immediately.

...if we ignore the meaning of the eating pattern, we miss the essential symbolism of the problem

My experience of treatment was barbaric, punitive and far from the collaborative approach I use with my clients today. I became very good at talking the talk, being the 'perfect patient', but walking the walk was a different matter. I externally conformed to the rules and regulations of the hospitals, but mere behaviour modification could not bring true change to my life. I cooperated so I could be discharged from treatment, but I remained the same on the inside. I was reluctant to invest in an emotional relationship with therapists due to fears of abandonment, and consequently my therapy became superficial and merely intellectual. I responded to the rationality and logic of cognitive therapy but was not able to access and resolve the emotional distress associated with my underlying beliefs about the world.

Treatment mainly concentrated on the physical side and restoration of my weight to a normal, healthy range. There was a strong emphasis on food, calories and meeting specified weight targets. However, food is not the issue, just a symptom of the underlying cause. My journey to recovery has taken time, but there has been a re-awakening of hope after despair, a breaking through denial and achieving understanding and acceptance.

At age 16, I ran in the World Junior Cross-Country Championships in Beijing and was miraculously placed fourth. I was Captain of the Great Britain team, which comprised six athletes. Shockingly, four of us had an eating disorder. However, this is not entirely surprising. Low body weight and/or low fat-to-muscle ratio (leanness) is of crucial importance for performance in endurance sports, such as running, swimming, cross-country skiing, and cycling. Weight category sports (wrestling, boxing, judo, martial arts and jockeys) and aesthetic sports (rhythmic gymnastics, ballet, figure skating and high board diving) also attract at-risk individuals.

Eating disorders and their associated levels of impairment, morbidity and cost are a significant public health concern.[7] Although they affect people of all demographics, research indicates that some populations are at increased risk.[8] Female athletes represent one such population.[9] As previously mentioned, I ran for Great Britain in 3,000m and cross-country events throughout my teenage years. 'Good athlete' traits, and characteristics of anorexia are very similar, so I could hide and legitimise my eating disordered behaviour for a long time. What appears as dedication to a sport in some women athletes, may actually be compulsive activity masking anorexic behaviour, and misperceived as attributes in the athletic world and therefore encouraged and reinforced.

Pressure to conform to a specific athletic body type can trigger eating disorder risk factors, which can evolve into clinical eating disorder symptoms. Importantly, research suggests that athletes are vulnerable to inadequate calorie intake, given their athletic lifestyles, making this a key target for intervention.[10] Insufficient calorie intake also increases the risk of developing the 'female athlete triad', which consists of low energy availability, menstrual disorders and decreased bone density.[11] The triad is associated with additional health concerns (eg cardiovascular disease, musculoskeletal, and bone stress injury), even in athletes who do not have a clinical eating disorder.[12]

In your work with clients with eating disorders, it may be useful to explore the contribution of exercise dependence. Dysfunctional exercise can be associated with detrimental health effects and complications in treatment outcomes. Exercise dependence comprises seven symptoms:

1. Tolerance – increased exercise needed for the same effects.
2. Withdrawal – exercise used to avoid negative emotions.
3. Continuance – continued exercise despite psychological or physical problems.
4. Lack of control – inability to exercise less.
5. Reduction in other activities – activities given up for exercise.
6. Time – excessive time spent exercising.
7. Intention effects – exercise for longer than intended.

Understanding which components of exercise dependence uniquely relate to eating disorder symptoms may help inform the creation of precise interventions targeting the function of dysfunctional exercise in eating disorders.[13]

Treatment aims

Choosing the most effective intervention for someone with an eating disorder should take account of a number of variables, including physical and psychological risk, motivation, social support, co-morbidity and age. Often, and particularly in anorexia, treatment planning will require coordinated, multidisciplinary, physical and psychological service interventions. Psychological interventions are, however, considered to be crucial in addressing the core attitudes that underlie these disorders and in influencing the longer-term outcomes.

I try to offer an empowering, whole-person approach to treating body image and eating concerns. I provide practical guidance that is deeply respectful of my clients' dignity while also motivating them to abandon destructive behaviours and embody positive change. I help clients understand their bodies' physiology, pay mindful attention to their eating behaviours, replace weight loss-motivated exercise with health-oriented movement, and compassionately transform their critical voices into supportive allies. I teach positive strategies, designed to address their beliefs about beauty and health that underlie their body hatred, and help them to create a community around them that supports their recovery.

Therapist-related factors affecting therapy

The therapist's individual characteristics, eg training level, optimism/pessimism, gender and even size, may influence the therapeutic relationship. Therapists who are very thin may be challenged about their own eating habits and weight. Therapists who are overweight may find these clients hard to engage with, as some have negative attitudes toward people who are overweight. Fat medical professionals are likely to be seen by both medical professionals and clients as less credible and trustworthy, and therefore clients are less likely to follow their professional recommendations.[14] There is an argument that the body shape/weight of a therapist does matter to clients because there is a prohibition on the therapist sharing personal information, so the body assumes

You're born with the gun, and society – your cultural and environmental circumstances – pulls the trigger

additional importance for clients, offering a place to read information about the therapist and a rich site for transference.

The counselling relationship is intimately affected by factors such as power, authority, difference, diversity, age, sex, disability and a range of other social issues. The two participants are attuned to many dimensionsin which they can perceive each other as either similar or different. Both of these perceptions can be helpful or destructive to the therapeutic relationship in quite complex ways. There is no doubt that clients with eating disorders evaluate therapists' body size and speculate on their relationship with food. Research has shown that 'healthy-looking' therapists were perceived to be the most helpful.[15] These results hold implications for clinical practice, and it might be useful to reflect on the impact of your body on the therapeutic alliance. Maybe, address the elephant in the room and have a discussion about it. However, at the end of the day, there is little that you can do to either stop clients from making assumptions about your food behaviours and ability to treat, based on your body size, or change your body size to better meet clients' needs. Obviously, diverse bodies are healthy, regardless of which bodies clients perceive to be healthy and thus most able to help them.

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About the author

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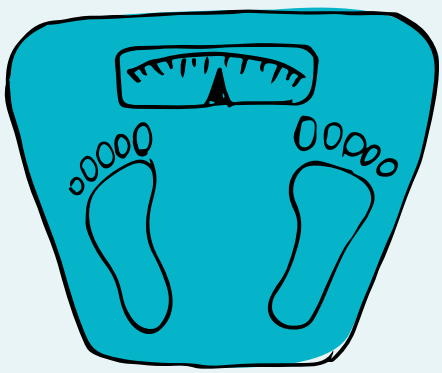


The mind in the mirror

Nicole Schnackenberg and **Alex Mummery** on working with clients experiencing body dysmorphic disorder

Body image-related mental health difficulties are a growing concern in the UK and worldwide. On the extreme end of the body image struggles continuum is body dysmorphic disorder (BDD), which most typically has its onset in the adolescent years;[1-3] beginning in 70 per cent of cases before the age of 18.[4] BDD is haracterised by a distressing preoccupation with perceived defects or flaws in one's appearance, which are either not visible to the outside eye or are attributable to normal human variation.[4] It is estimated to affect between two to three per cent of the population, affects males and females almost equally, and has one of the highest suicide rates associated with any mental health diagnosis.[3,5]

BDD is classified under the umbrella of obsessive compulsive and related disorders in the *Diagnostic and Statistical Manual of Mental Disorders – 5th Edition* (DSM-5),[6] putting it in the same category as obsessive-compulsive disorder (OCD). The main preoccupation with appearance in BDD is obsessional, leading both to repetitive and avoidance behaviours. Examples of such behaviours include repeatedly checking the perceived defect in the mirror, obsessively avoiding certain types of lighting for fear the perceived defect will be accentuated, and repetitiously seeking cosmetic surgery/dentistry/dermatology to 'fix' the supposed flaw.

A concerning proportion of people with BDD become housebound and struggle to remain in education or employment.[7,8] In fact, a detrimental impact on activities of daily living is a hallmark of the condition and a prerequisite for a diagnosis of BDD. Another common feature of a diagnosis of BDD is poor insight, or delusionality.[9] To varying degrees, people diagnosed with BDD do not realise that the severity or presence of the 'defect' is perceived to be the case only by themselves; they believe they are genuinely physically abhorrent to others.[10]

Muscle dysmorphia

Within the diagnostic criteria, there is a specifier for muscle dysmorphia (MD), a sub-type of BDD.[11] MD was originally referred to as 'reverse anorexia', due to the fact it involves an anxiety-inducing obsession with a perceived and unwanted slightness of physical frame, as opposed to a preoccupation with being too large or overweight.[12] Although anorexia nervosa is currently perceived as a separate diagnosis, MD also involves a desire to reduce body fat by restricting the diet; while also attempting to increase muscle mass through the use of protein powders, dietary supplements and, more dangerously, anabolic steroids.[13] This can have a detrimental impact on health, including resultant blood sugar and electrolyte imbalances and nutritional deficiencies.[14] This obsession with gaining muscle mass can lead individuals to push themselves beyond their physical limits, leading to gym-related injuries that often do not prevent continued exercise.[14] MD can also lead to social isolation and impact negatively on employment and education. It has a higher suicide rate than BDD discreetly, perhaps because it predominantly affects males, who are known to present with a heightened risk of suicide in the general population.[15] Finally, the issue of insight is also potentially heightened in MD, due to societal notions that low-fat diets and regular exercise are healthy and desirable.

What causes BDD?

The jury is still very much out in terms of the causal factors of BDD. A complex array of interrelated factors have been suggested by the research literature, including difficult early life experiences, such as developmental trauma and bullying, evolutionary aspects, visual processing differences, poor interoceptive awareness and possible genetic and neurochemical influences. Underlying, predisposing factors appear to include low self-esteem, poor self-concept and pervasive feelings of shame.

Shame was also highlighted as a key area of influence in BDD in recent doctoral research by Schnackenberg.[16] The Shame-Identity Model of BDD, emergent from this research, suggests that shameful relational experiences can lead to a sense of the self as a 'bad self'. This felt sense of badness is then projected onto a perceived defect with the hope that once the 'defect' is fixed, the shame will dissipate and there will be an experience of the self as a 'good self'. However, since the underlying sense of shame remains beyond the fixing of any perceived flaw, the person's hope for becoming a 'good self' is transferred and projected onto another body part and the cycle perpetuates. In this model, the safety behaviours, such as the use of camouflage to cover up aspects of the appearance, and the use of products and procedures to alter and 'fix' the appearance, are conceptualised as transitional objects;[17] actions utilised in an attempt to take the person from the felt sense of a 'bad self' to a 'good self' and as an attempt to self-soothe.

Common correlates of BDD

BDD is conceptualised as an anxiety disorder; a common correlate is depression. Feelings of depression and anxiety can precede the distressing preoccupation with the perceived defect and also become further heightened by

BDD-related intrusive thoughts and associated behaviours. BDD is a self-amplifying cycle whereby appearance-focused distress fuels safety behaviours, like covering up (camouflaging) the perceived defect with clothing, cosmetics and other means, which in turn further inflames feelings of anxiety, depression and despair.

Sometimes, people experiencing BDD are diagnosed with other mental health difficulties before or alongside their BDD diagnosis. Some of the most common are eating disorders, social anxiety disorder, skin picking (excoriation) disorder and hair pulling (trichotillomania) disorder.

What might you notice if your client is struggling with BDD?

Most often, and particularly in the early and acute stages, people with BDD perceive their difficulty as being physical as opposed to psychological/emotional in nature. Therefore, they are more likely to seek out physical treatments like cosmetic surgery than psychological treatments like psychotherapy. Clients struggling with BDD may come to therapy for adjunctive reasons, such as feelings of anxiety, depression, difficulties with social engagement and feelings of paranoia – eg that everyone believes they are physically defective or flawed. When therapists ask curious questions about these experiences, such as inquiring into why the client finds it so difficult to leave the house, underlying correlates of BDD may be uncovered.

If the client shares a view that they are experiencing a time-consuming and distressing preoccupation with an appearance defect that satisfies the above outlined criteria, one can consider whether BDD may be part of their experience. It may then be beneficial to ask further open questions about their self-perception and consider using a BDD screening tool, such as the Appearance Anxiety Inventory[18] or the Cosmetic Procedure Screening Questionnaire (COPS),[19] both of which are available in the Questionnaires section of the BDD Foundation website.

Suggested treatment for BDD

The NICE Guideline-suggested treatment for BDD comprises BDD-specific CBT with exposure response prevention, high dose selective serotonin reuptake inhibitors (SSRIs) or a combination of both. The research into treatment for BDD is, however, very much in its infancy. Thus far, there have not been robust scientific trials comparing CBT with other treatment options, or indeed comparing CBT, medication alone and CBT/medication combined.

Perhaps on account of the high suicide rate and low levels of insight, BDD has obtained a reputation in many therapeutic circles of being particularly difficult to treat. While referring on to specialists is naturally an option if personal knowledge and training is felt to be lacking, it is certainly possible to work therapeutically with people with BDD. Encouragingly, many people with BDD learn to manage and even completely overcome their difficulties and go on to live rich and fulfilling lives.

Given that in BDD the person's hope is completely pinned onto fixing their appearance, we would argue that BDD is better understood as an 'act of hope', as opposed to a destructive act; as an attempt at order rather than a 'disorder'. The focus when supporting people with BDD should be on refraining from taking the person's hope away, while gently offering them additional, alternative views of reality. The Theory A/Theory B model can be useful to this end:

Theory A
I am struggling with a physical difficulty.
I am ugly/I have a defect in my appearance.
If I fix the defect, I will be OK/happy/lovable.

Theory B
I am struggling with an emotional/psychological difficulty.
I do not see myself the way others see me.
I require psychological/emotional help.

It can be beneficial to ask clients to suspend Theory A (without demanding they should give it up completely if they do not feel able or ready to do so) and work with a professional in therapy 'as if' their experience was emotional and psychological, as opposed to physical, in nature. Encouraging clients to postpone any physical consultations or treatments, eg with cosmetic surgeons, dentists and dermatologists, is an important part of this process. Therapy for BDD involves psychoeducation (including how anxiety operates in the body); graded exposure to feared actions and experiences; reduction in safety behaviours like mirror checking; and addressing underlying feelings of shame and low self-worth.

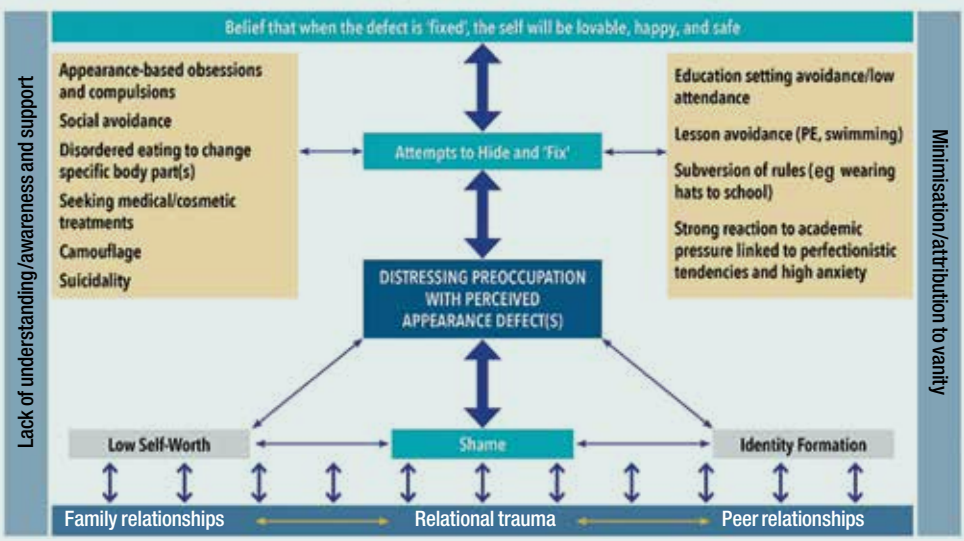
Finding a self beyond BDD

To move beyond BDD is, in part, to have recognised:

- that one has an identity outside of and beyond one's appearance
- that BDD is something one is experiencing at the moment; it is not who one is
- that one is good and lovable, regardless of how one looks.

If a person has been entrenched in BDD-related preoccupations and behaviours for any period of time, it can be challenging to re-find a self beyond these experiences. Part of the role of the therapist is, therefore, to help the client to re-find their true self and reconnect to their identity outside of their appearance-focused distress. This will involve returning to put-aside desires, passions and hobbies; re-engaging in social and educational/career-related experiences; and reconnecting with what makes the person feel most invigorated and alive. Working with people experiencing BDD can be extremely rewarding. The BDD Foundation website (see overleaf) is an excellent source of further information.

Shame-Identity Model of BDD in Young People



Find out more

Recommended reading

Body dysmorphic disorder: a treatment manual
David Veale, (Wiley, 2010)

Cognitive behavioural therapy for body dysmorphic disorder: a treatment manual
Sabine Wilhelm, Katharine A Philips and Gail Steketee (Guilford Press, 2013)

The broken mirror: understanding and treating body dysmorphic disorder
Katharine A Phillips
(Oxford University Press, 2005)

Understanding body dysmorphic disorder: an essential guide
Katharine A Phillips
(Oxford University Press, 2009)

The Adonis complex: how to identify, treat and prevent body obsession in men and boys
Harrison G Pope and Katharine A Phillips
(Free Press, 2002)

Reflections on body dysmorphic disorder: stories of courage, determination and hope
Nicole Schnackenberg and Sergio Petro
(The BDD Foundation, 2016)

Overcoming body image problems including body dysmorphic disorder
David Veale, Rob Willson and Alex Clarke
(Robinson Press, 2009)

Useful websites

The BDD Foundation
bddfoundation.org

OCD Action
ocdaction.org.uk

Mind UK
mind.org.uk

Anxiety UK
anxietyuk.org.uk

Depression Alliance
depressionalliance.org

SkinPick (online community for skin picking)
skinpick.com

Screening tools
https://bddfoundation.org/helping-you/questionnaires/

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Alex Mummery is a trainee educational psychologist at the UCL Institute of Education. Prior to this, he studied Fine Art at the Cambridge School of Art, and worked as a special needs assistant in primary and secondary schools in London before deciding to pursue psychology with a conversion master's course at Bristol University. He is currently undertaking a research project into how BDD can be better identified by educational psychologists, with the aim of increasing awareness of this hidden and destructive disorder and helping others on their path to recovery.

Your thoughts please

If you have any responses to the issues raised in this article, please write a letter or respond with an article of your own. Email: **privatepractice.editorial@bacp.co.uk**

Talking positively

The stigma associated with HIV can be an additional stressor for couples where one partner is living with the condition

Alex Sanderson-Shortt
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I wrote in my last column about how couples might manage illness, especially when it's a long-term, chronic, life-altering condition. In these circumstances, most couples are going to struggle. What we usually see though is a degree of support from people around the couple. But sometimes that support isn't available. The couple are left dealing with not only the illness but with guilt and shame. This has been highlighted recently with the appalling treatment of Gareth Thomas, whose HIV status was made public by a national publication. It's a sad fact that HIV is a condition that still carries stigma. There have been huge steps forwards in treatment, and much wider understanding of what it is and how it affects people. Thomas was forced to publicise his status so that he could control the news. What was taken from him though was the chance to talk to his parents before it became public knowledge.

HIV/Aids still affects more gay/bi men than lesbians or heterosexuals, and the new treatments and focus on testing mean that people are living longer with the disease. As a result, I'm working more with couples where one partner is positive and the other isn't (where they are serodiscordant). People who are positive and on the latest treatment regimens will likely be living healthy, active, full lives. Modern treatments work to reduce the amount of the virus present, known as the viral load. This load can be reduced to an undetectable level, and when this is reached and maintained, evidence shows that the virus cannot be passed on. Undetectable equals untransmissible, which organisations such as the Terrence Higgins Trust publicise through the international U=U campaign.

Sadly, public perception is some way from catching up with these breakthroughs and there is still stigma attached to HIV and the people who live with it. This stigma operates to silence and isolate people, which can have severe implications for a couple. Although people with an undetectable load are as healthy as the general population, this comes as a result of taking regular medication and looking after their general health. There may still be a need for support, physically and emotionally, which is not as easy to access when stigma is attached.

Even with the changes in treatment and undetectable viral loads, serodiscordant couples may struggle with managing their sex lives and communication around the virus. I have found this particularly in couples over the age of about 40, who experienced the trauma of HIV/Aids as it decimated the gay community in the 1980s and 90s. Few of us who were around at the time will ever forget the Don't Die of Ignorance campaign. Back then, the perceived prognosis was death, and many gay/bi men witnessed their friends dying, amidst a moral panic, general sense of disgust and increased homophobia from the population at large, represented by the implementation of Section 28.

I'm working more and more with couples where one partner is HIV positive and the other isn't

When couples present with relationship issues and one is HIV+, it's important to understand how each experience this and what their cultural, familial and historical understanding of HIV is. For many older gay/bi men, it is inextricably tied up with trauma and loss. If they are with an HIV+ partner, it may be hard for them to engage with the new treatments and be able to accept that their partner will live a long and healthy life. The partner with HIV may experience this also, and it isn't uncommon for them to experience a type of 'survivor's guilt'. These can be powerful intrusions into the relationship that affect how each asks for, and provides, care and support on a physical and emotional level.

Even where the viral load is undetectable, and both partners understand this, there may be issues associated with sex, which can be a tricky subject for many couples, for all kinds of reasons. If we add to the mix the potential for passing on a life-altering illness, especially one that carries such stigma, sexual performance may be impacted. Working relationally on this means exploring with clients their knowledge of the virus and treatments to reinforce the U=U message. It's important this is felt and understood at a deep level, so that the fear of transmission can be addressed. In addition, deeply held (and often not consciously known) feelings and memories about HIV/Aids need to be brought to the surface,so that we can acknowledge the stigma that has existed, as a way of moving on from it. Like working with internalised homophobia, each partner should be able to name the negative associations, as a way of being able to challenge them explicitly and then internalise new cognitions.

It follows from this that clients also need to think about and challenge if and how they are going to communicate with each other and others about having the virus. What would they need from each other, and how can they provide this, based on our usual relational model of understanding attachment and internal working models, as well as the wider societal position of the clients? No one should feel obligated to reveal their status, but nor should they feel shamed into not doing so.

HIV and the associated stigma can be an additional stressor for couples, one that might be addressed as part of ongoing relational work. It shouldn't be the focus of the work unless that is what the couple are bringing. Working in this area needs the therapist to be knowledgeable themselves about the condition and its treatments, as well as about their own countertransferences and reactions to it. For more information, the National Aids Map (NAM) is a great place to start (**aidsmap.com/about-hiv**).

Alex Sanderson-Shortt MA, NCS (Prof Accred) is an integrative therapist in private practice. As well as relationships, he specialises in counselling LGBTQ+ clients. Alex teaches for Relate and runs CPD courses for counsellors.

Outside in, inside out

Norman Wright asks what is being communicated when patients elect to undergo a cosmetic procedure or aesthetic treatment

As a psychotherapist in the 21st century, I feel a need to practise in ways that are relevant to the contemporary context, particularly given that so much of the philosophy that underscores counselling and psychotherapy has its roots in the 17th and 18th centuries. My interest lies in what occurs intrapsychically, emotionally, relationally and psychologically, and, since 2014, I have had the opportunity to consider the links between self-esteem, self-concept and the physical aspects of projected self-esteem, and how these interrelate.

So, in the context of my conference workshop on cosmetic procedures, aesthetic treatments and body modification, when considering the question, 'Mind or Body: what's in charge?', I explored a range of social, political, cultural, historical, philosophical, medical and psychological perspectives that influence patients' decisions to undergo such procedures. Presenting at the conference gave me an opportunity to review aspects of the work I have deployed in the cosmetic, aesthetic and beauty industries, and I was delighted to co-present with Deborah Vine, the CEO of a prominent cosmetic and aesthetic clinic in London, who has instituted a range of measures within the clinic to increase support and awareness of the patient journey, including introducing a pre- and post-procedure support initiative (PaPPS) for patients, and training for staff.

Alongside providing direct support through PaPPS, I have also learned much about the context, historically and within contemporary paradigms, of the condition of the cosmetic surgery patient, and in which their decisions to undergo procedures are made. As a clinician, another key learning for me is in relation to what is being communicated, both consciously and unconsciously, when a cosmetic procedure or aesthetic treatment is undertaken.

Looking good on the outside

Since the dawn of time, it seems human beings have sought to self-improve, at the very least externally, and we have only just begun to understand the link between looking good on the outside and feeling good on the inside. As a psychotherapist with a background in childcare social work, youth justice, adult mental health, fostering and adoption, I have primarily been concerned with the psychosocial aspects of people's lives. In my work, I draw upon and integrate the experiential knowledge I have acquired, alongside the systemic and psychodynamic approaches of behaviour modification, to gain a fuller appreciation of the intersubjective world of the person.

In developing a brief, issue-specific and targeted approach to support people considering having, or undergoing, cosmetic surgery, invasive cosmetic procedures and aesthetic treatments, I have come to see myself, my peers, and increasingly the counselling and psychotherapy profession, as 'social therapists', providing socially aware therapy that proactively integrates and recognises the notion that societal constructs can be a representation of, and symbolic of, individual identity.

...cosmetic plastic surgery strains the boundaries of what we understand to be our natural body, and ties the body ever more closely to the active achievement of one's self-identity

Since time immemorial, human beings have been engaged in body modifying practices for a whole range of reasons. Historically, the motivation has centred around attracting or engaging in particular relationships, or to signify achievement within, or affiliation to, people or groups, as rites of passage. In contemporary terms, this translates as a projection of self-concept, an attempt to improve self-esteem, a consequence of physical deformity or injury, and, in some instances, is based upon socioeconomic needs, trends and expectations.

Body politics

Karl Marx understood the body as a fundamental element of social structure,[1] as the person becomes an embodied actor and, as such, must interface directly with society through labour. Foucault conceived of the body as a site for examining power dynamics and action,[2] while feminist theories have posited the body as a location of oppression. I recognise and appreciate, therefore, the ways in which the body has become politicised.

Nietzsche talks about the importance of rites of passage, noting their absence in the contemporary context within which he was writing.[3] Similarly, Emile Durkheim, the 18th century philosopher, recognised industrialisation and capitalism as contributing factors in the increase of depression, resulting in a decreased sense of self, sense of belonging, and sense of knowing where one fits into society.[4]

It is necessary to understand how, and in what ways, individuals navigate the cultural norms and ideals pertaining to physical appearance in relation to their sense of personal identity. Adams,[5] referencing Shilling,[6] conceptualises the relationship between the individual and his/her body, particularly in affluent, capitalist, post-industrial, Western society, in terms of what he calls the 'body project', in which the body is 'seen as an entity in the process of becoming; a project which should be worked at and accomplished as part of an individual's self-identity'.[5]

I concur with Shilling's suggestion that cosmetic plastic surgery strains the boundaries of what we understand to be our natural body, and ties the body ever more closely to the active achievement of one's self-identity. Individuals engaging in body projects exercise some level of control over their bodies and the contexts/environments they inhabit.[6]

It is necessary to understand how, and in what ways, individuals navigate the cultural norms and ideals pertaining to physical appearance in relation to their sense of personal identity

This needs to be recognised in the individual electing to undergo surgery for aesthetic change. The ways in which the 'body politic' influences the decision to have cosmetic procedures or aesthetic treatments also needs to be explored by the clinician and all professionals supporting patient care.

In this sense, I consider it is the mind that is in charge when individuals consider having a cosmetic plastic or aesthetic procedure or treatment, as well as the individual's existential, spiritual and cultural sense of self, and external factors that influence their emotional, relational and psychological perception of their body .

Research indicates that increased media coverage of cosmetic surgery procedures influences people to consider undergoing cosmetic surgery, as well as contributing to decreased self-esteem and life satisfaction.[4] Concerns about the risks that consumers are willing to take to pass off as 'normal', or conform to cultural projections of beauty, have also been reduced for those who are dissatisfied with their appearance. This is partly due to improvements in technologies associated with surgery, and the fact that non-invasive treatments are becoming less expensive and therefore more accessible.

Despite these advances in technology, cost and accessibility, the consumer does not have enough of an opportunity to explore fully the ways in which their decision has been informed; how and in what ways they have prepared to enact their decision; and how their decision might affect their emotional, relational and psychological condition post-operatively. It is the clinics and their surgical teams that hold a duty and responsibility for cosmetic and aesthetic patients, therefore, to enable those patients to make meaning and define what beauty is for them, internally and externally.

This needs to be addressed by the patient, recognised within the surgical/clinical team, and facilitated pre- and post-operatively by all the people who are part of the individual's support network, to enable the patient to understand their condition, and the ways in which 'beauty politics' have influenced their decision to have a cosmetic procedure or aesthetic treatment.

How human beings define self within a fast-changing 24-hour society, driven by advances in technology and communication, including self-help applications on mobile devices, is undergoing a revolution. Consequently, supporting individuals seeking cosmetic surgery or aesthetic treatment to know more about their motivations for change, is a complex task for the therapist. This is further complicated if the therapist has not considered their own personal philosophy and ethic in relation to people who feel the need to modify their bodies, regardless of the rationale.

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Norman Wright MSc, Dip SW, Dip Clin Sup, is an integrative psychotherapist with more than 20 years' experience in private practice, and Clinical Director of The Wright Initiative (TWI), in which he has developed a pre- and post-procedure support (PaPPS) evaluative process for patients to raise awareness of the emotional, relational and psychological readiness and preparedness for elective cosmetic surgery or aesthetic procedures. TWI also offers PaPPS training to cosmetic and aesthetic clinics, their surgeons, clinicians and personnel. Norman represents the UK Council for Psychotherapy on the British Standards Institution committee that sets standards across the UK and Europe within the aesthetics industry. He is an expert witness, exploring and reporting on psychological injuries sustained from aesthetic and cosmetic litigation cases.

Book Reviews

The heartland: finding and losing schizophrenia

Nathan Filer (Faber & Faber, £14.99)

The collected schizophrenias: essays

Esmé Weijun Wang (Penguin, £9.99)

Why would a counsellor or psychotherapist in private practice, who is unlikely to be called upon to work with someone with a schizophrenia diagnosis, need to read a book on schizophrenia? Still less, two books on schizophrenia.

There can be many reasons. First, as Nathan Filer indicates in the title of his book, *The heartland*, the debates and discussions about schizophrenia (or 'so-called schizophrenia', as he calls it), its phenomenology, its relationship with 'normal' experience, its causes, the validity of the diagnosis and how to 'treat' (or support, work with, or help) those affected by it, are at the heart of the debates between the therapeutic and the medical worldviews about how we understand and help people experiencing distress or difficulties in living.

Then, equally important, we may open our minds to a broader perspective on human experience, and be less prone to panic and more capable of offering holding when faced with a client whose experiences are outside our purview. And, finally, because these books are works of literature which, while informing and educating us, will also move and delight us.

Filer was a mental health nurse whose name hit the headlines when, in 2013, his novel, *The shock of the fall,* won the Costa Book of the Year Award. In it, Filer imagines the story of a young man's journey through (so-called) schizophrenia. In the years since, many people wanting to tell him their stories have contacted him. This book grew out of these conversations, and reports on Filer's changing and increasingly nuanced understanding of the questions around 'so-called schizophrenia'.

The heartland: finding and losing schizophrenia is built upon a backbone of five of these stories, which together make up about half of the book. These personal stories, sensitively and compassionately recounted, are interspersed with chapters exploring more theoretical issues, such as stigma, diagnosis, causes and treatments. Here, he draws on the professional literature, as well as interviews and correspondence with leading radical thinkers, such as psychologist Dr Lucy Johnstone and psychiatrist Dr Joanna Moncrieff. These chapters convincingly present a range of alternative perspectives to the mainstream medical model.

Esmé Weijun Wang is a Chinese American writer who has received diagnoses of bipolar disorder and schizoaffective disorder (a variant of schizophrenia), as well as an alternative diagnosis of chronic Lyme disease. The essays in *The collected schizophrenias* chart something of her personal journey, including her treatment by Yale University (who forced her to leave because they didn't want to have to deal with her illness), her decision not to have children (because of the risk of passing on her vulnerability), speculations on schizophrenia being an auto-immune disease attacking the brain, and her explorations of the 'sacred arts' to better understand the psychic or religious ('liminal') experiences associated with psychosis.

Both books are beautifully written. Filer's is doubtless the more useful for therapists engaging with the debates around so-called 'mental illness', and the personal stories he recounts are told with a novelist's gift, but I found Weijun Wang's invitation to intimately witness her painful journey to some far-off places quite irresistible.

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The way of psychosynthesis: a complete guide to the origins, concepts and the fundamental experiences, with a biography of Roberto Assagioli

Petra Guggisberg Nocelli (Synthesis Insights, £20.15)

This comprehensive textbook will be an invaluable companion to any student of psychosynthesis, transpersonal psychology, or indeed any therapy training. The author has been brave in commencing with a full biography of its founder, Roberto Assagioli, rather than by diving directly into the subject. She then boldly devotes the next session to a highly informed potted history of the 'four forces' that have shaped our contemporary psychotherapy world, which helps to situate and contextualise psychosynthesis.

What makes this translated book particularly useful to English-speaking practitioners and students of psychosynthesis is that it introduces so much that has been written in Italian by Italian theorists, some of whom were clearly closer to Assagioli, such as Alberto Alberti. The extensive Italian bibliography, running into many pages, far outweighs the list of English language publications. Psychosynthesis in Italy has developed differently from most other parts of the world in that there are numerous centres of study there that are not geared towards formal psychotherapy qualification. This gives Guggisberg Nocelli's book a 'classical' psychosynthesis feel, which is both its strength, in conveying the unique perspective on the transpersonal, and perhaps its weakness, in that the psychodynamics of the lower unconscious are covered rather glibly. After all, the author states, 'It is now unanimously acknowledged that Assagioli, at the age of only sixteen, was the first in Italy to deal with psychoanalysis and to have translated Freud, recognizing the revolutionary extension of his discoveries.'

The forward nature of Assagioli's thinking is discussed well, particularly his early formulation of 'biopsychosynthesis', which criticised 'the materialistic orientation of medicine, which deals with curing the body while neglecting the human being in his/her totality'. Assagioli also made moves to embrace quantum physics by positing a 'fifth force', which he called 'psychoenergetics', and which embraced theories of different spiritual traditions.

The extensive and well-argued treatment of 'personal psychosynthesis' as distinct from 'transpersonal psychosynthesis' is where the book comes into its own, and the author states that 'confusing the two approaches can lead to serious mistakes, both from a diagnostic point

of view and also from a therapeutic, educational and self-training perspective'. Assagioli's classical 'egg diagram' is explored in detail as the author takes the reader systematically through the main models and exercises employed by practitioners, and emphasises 'the will', which is a defining difference between Assagioli and his friend Jung. Guggisberg Nocelli does not shy away from the old chestnut of essentialism, providing an extensive discussion on the difference between 'self as an object' and 'self as a process'.

Certain areas of the book may be unfamiliar (though useful) to English-speaking psychosynthesis readers, such as the classification of subpersonalities into depressed, obsessive, hysterical and schizoid. Also, personality typologies – which the author recognises as intrinsically problematic – situates the 'organising type' principally in terms of ritual, dance and acting, rather than in its wider manifestations. These issues aside, the book should prove to be a solid resource for those wanting to grasp the sophistication and subtlety of psychosynthesis as a modality.

Keith Silvester MBACP (Snr Accred), psychosynthesis psychotherapist, supervisor, trainer, coach and Alexander teacher working in London

Nietzsche and psychotherapy

Manu Bazzano (Routledge, £26.99)

It's hard to know where to begin with Friedrich Nietzsche. Professor at 24, admirer of Heraclitus, Goethe and Schopenhauer, stateless after renouncing his Prussian citizenship and, philosophically, firmly in the camp of experimentation and individuation (self-direction), he is effectively the author of a large flare, beneath which stand highlighted his many original, yet often contentious, ideas.

Bazzano does an excellent job of introducing us to a great swathe of Nietzschean thought, unashamedly pitting his subject as a luminary doing battle against a parochial world. Indeed, from the very first page, we are told that Nietzsche's thoughts are 'destined to remain *untimely*, even more so at a time when psychology and psychotherapy are being increasingly dominated by neopositivism and managerialism'. This is significant and ties in with Daniel Chapelle's view that 'most of those concerned with "mental health", "behavioural science", and "wellness" – those handmaidens of social-political hygiene – have no clue'.

Strong stuff. And certainly, a recurring theme throughout the book, and not unwarranted. For Nietzsche's ideas, however muscular and bold, resonate deeply and are not afraid to question *everything*. Philosophy is, after all – need we be reminded – another word for authorship or finding one's own voice. And Nietzsche, through his unwavering challenge to that around him, provides the tools and provokes something vital inside the therapist that might otherwise have been left cowering or feeling marginalised and insubstantial.

God is dead. Fear has transformative potential. Individualism is but the narcissistic search for authenticity. The self is plural. Incongruence is inherent to human existence, with the self emerging from only a *portion* of the experiencing organism. All these bear the distinct Nietzschean hallmark, yet it is the beautiful line from Bazzano which focuses on Greek culture's 'Socratic slide into rationalism' which really gives potent leverage to this book; Socrates, that well-known, respected sage, brought to life by Plato yet thoroughly lambasted and admonished in this text.

The very soul of the philosophical endeavour is at stake, Bazzano is asserting, and, by association, therapeutic space. Giving primacy to *becoming* is our task, thus purging the neat, Western obsession with *being*. What does this mean exactly? Well, I would echo Bazzano's words and suggest that it amounts to accepting 'the importance of struggle and conflict in human affairs' (*polemos*) rather than constantly being weighed down by the abstract extremes of being and nothingness.

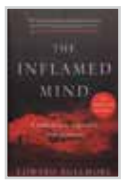
Absolutes do not help us. Transcendental narratives merely have us waiting around for some fictitious divine glory. The self is not *found* but rather *achieved* – this seems to be the central premise upon which Nietzsche's words toil. We are to honour and trust the senses and free ourselves from the shackles and fixation that the self can be made singular and whole.

Nietzsche is *for* the artist, creativity, axiology (the nature of value) and nihilism (life by itself is meaningless without elevation), and Bazzano impressively tasks himself with the 21st century responsibility of pulling us away from the bloodless 'cult of "left-brain" reasoning' into a formidable yet worthwhile land.

Jeff Weston, writer/existential psychotherapist, author of WAGENKNECHT
helpineedsomebody.org

The inflamed mind: a radical new approach to depression

Edward Bullmore (Short Books, £14.99)



This heartfelt, amusing and sometimes scathing book challenges much of the usual thinking and practice in the field of medical treatments for depression, and deserves to be taken on board by everyone working in the field of mental health. The book has three main themes, and Bullmore weaves them together in a skilful blend of personal storytelling, clear explanations of human anatomy, and a capacity to be both withering and witty at the expense of the greed, laziness and arrogance that have beset the treatment of depression.

Firstly, he uncovers the scientifically dubious manner in which antidepressants, in particular SSRIs, were developed, tested, marketed and prescribed. I was stunned to read his unequivocal revelation that there is 'not one piece of clinical evidence' that an abnormal level of serotonin in the brain is the cause of depression. He argues clearly that we can be reasonably sure serotonin is important for brain functions such as the regulation of sleeping and eating, but that this is not the same thing as knowing that a serotonin deficiency is the cause of depression. So, SSRIs may be reasonably effective at ensuring there is a greater uptake of serotonin, but hitting a target accurately is of little use if the target itself may be a pointless one. It is salutary to read the facts laid out so unmistakably and authoritatively on this matter.

Secondly, he provides an overview of the way health (especially mental health) has been treated since medieval times. He takes the reader on a whistle-stop tour of many key figures, including Paracelsus, Descartes, Darwin, Ramon y Cajal, Freud and Kraepelin, all of whom have had a vital part to play in the way that Western European cultures have formed a 'theory of mind'. And, thirdly, he outlines a convincing argument that we could look to inflammation as the cause of some sorts of depression, and proposes new ways forward with treatments for depression, and even schizophrenia and bipolar disorder. These include fine-tuned drug treatments that specifically target inflammation, and vagal nerve stimulation devices that artificially promote the vagal nerve's capacity to soothe and regulate our body's functioning. Both of these would essentially reduce the amount of inflammatory proteins called cytokines, which can pass from our bloodstream into our brain and cause damage.

This short book packs a punch. Bullmore is angry on behalf of those suffering mental health difficulties who are not served well by modern psychiatry. He reminds us that 'depression is still expected to be the single biggest cause of disability in the world by 2030', yet funding and research for treatment of conditions that have been decided are 'mental' rather than 'physical' (which is, he points out, a hopeless and unhelpful dichotomy), lags far behind other fields of medicine. He thinks we should be doing better, as a society, at looking at what can cause emotional and bodily anguish, and bringing together medical and non-medical approaches to address this. He reserves an especially hard stare of disapproval for psychiatry, which, he emphasises, is falling well short of other branches of medicine, as well as of many psychotherapeutic approaches, in terms of its sophistication, effectiveness and willingness to show more humility and respect to those who come for help

with depressive symptoms. He has written a passionate, accessible call for this issue to be given proper and urgent attention by us all.
Sarah Van Gogh MBACP (Accred), counsellor in private practice, trainer at Re-Vision, author of Helping male survivors of sexual violation to recover *(Jessica Kingsley Publishers) and co-editor of* Transformation in troubled times *(Kaminn Media Ltd)*

Psychoanalytic thinking on the unhoused mind

Gabrielle Brown (ed) (Routledge, £29.99)

Homelessness in the UK has increased by 124 per cent since 2010. Homeless men die at an average age of 47 and women at 43 (compared with an average age at death of 77 for the population as a whole). These are shocking statistics. But while they aren't the only ones to confront readers of this impressive new book, what distinguishes it is the way that its authors look beyond numbers and facts to the complex psychological processes underlying them.

For most of us, 'home' is virtually synonymous with feelings of comfort and security. 'There's no place like home', as the saying goes. But if the home you grew up in was a place of severe deprivation, abuse or neglect, as an adult it will be hard for you to feel at home, no matter what kind of accommodation you are in. Living on the streets, or in a series of temporary situations, might seem like a way out. Only, you will then be exposed even more directly to the fears of your mind – on top of those that go with not having a permanent roof over your head.

So, to the title of this collection of papers and the challenges presented to society by people whose need for housing often masks a much wider yet less determinate set of needs, derived from having had little place in the minds of their early caregivers. Its contributors are all psychotherapists experienced in working either with the homeless themselves (holding sessions on park benches if necessary) or with the various institutions, agencies and services whose responsibility it is to house them. Chapter titles like 'Beyond the Pale: psychotherapy with people with smell' and 'Elective Homelessness and the Shadow of the Institution: lessons from the lives of the survivors of the Irish industrial school system' will give some idea of the tremendous breadth of what is at the same time a slender, very readable volume, made visually attractive through the inclusion of several specially commissioned illustrations.

What conclusions does it come to? One that struck me was how unrealistic it is to expect people who might be considered borderline, in the true sense of the word, to inhabit a flat of their own. Often, what seems to work better are homes or hostels that come with various forms of support: halfway houses, if you like. This may go against the grain of a society obsessed by property and the dream of living behind one's own front door. But the point is made that there might be more to such dreams than we think, because in fact 'there are parts of all our minds that remain insecure, un-housed and intensely fearful'.
Johnathan Sunley MBACP, psychodynamic psychotherapist, London

Mind-brain-gene: toward psychotherapy integration

John B Arden (WW Norton & Co, £25)

This is a book with a bracing message: therapists need to take seriously a contemporary understanding of the mind, the brain and genetics; they should have an overview of current research; and, if you are a therapist in the 21st century and you are not making an effort to keep abreast of the science, you are way back in the 20th century and you are not serving your clients.

Arden also thinks it is time to leave behind the 'archaic' schools of therapy, along with what he regards as our childlike desire to belong to them. The hard work of understanding and then integrating contemporary scientific ideas is a much more pressing and important task; a task he also challenges 'antiquated and anti-intellectual' training institutions to face.

The scope of Arden's work is ambitious in the extreme. He is trying to revolutionise psychotherapy for the 21st century. In doing so, he casts a wide net across immunology (study of the immune system), epigenetics (study of changes caused by modification of gene expression) and neurobiology (study of the nervous system, including the brain). Nothing less will do, he says, given how the physiological effects of distress show up, for example, in blood pressure, pulse rate, gastric function, histology and the immune function. The point he makes is that there is now no separating the mind and the body. Anyone interested in one, ought to properly be interested in the other.

The problem with the book is how frequently Arden assumes too much knowledge on the part of the reader. Because much of the language is technical, it is easy to get lost very quickly. The breadth of the book, which is its strength, starts to feel like a weakness, as Arden fails to define terms or take the time to explain complex biological processes. While he succeeds in demonstrating that psychotherapy is a deeply biological intervention, he too often loses the reader along the way. This is an avoidable pity, given how well subject matter experts can translate what they know into language accessible to non-experts: just think of the best-selling work by Yuval Noah Harari on the evolution of homo sapiens, some of the most popular scientific TED Talks, or the way a skilled doctor explains risk to a patient.

The book's central premise nevertheless stands: human beings are complex, and therapists must honour that complexity; they must expect their work to be intellectually demanding; and, they must stay open to new ideas. Arden asks us to do that because our clients are in need and, because psychotherapy is such a powerful treatment, it deserves to be taken more seriously.
Matt Wotton MBACP

Could you write a review?

We have the following titles for review in a future issue. If you would like to review one, email **privatepractice.editorial@bacp.co.uk** stating your preference and including your address and brief details of your areas of professional interest. Review guidelines will be sent out to reviewers by email on request. After publication of the review, the title is yours to keep.

Overcoming everyday racism: building resilience and wellbeing in the face of discrimination and microaggressions
Susan Cousins (JKP)

The unconscious in social and political life
David Morgan (Phoenix Publishing House)

Practical ethics in counselling and psychotherapy: a relational approach
Linda Finlay (SAGE)

The brink of being: talking about miscarriage
Julia Bueno (Virago)

Transference and countertransference from an attachment perspective: a guide to clinical practice
Una McCluskey and Michael O'Toole (Routledge)

Mental health in crisis
Joel Vos, Ron Roberts and James Davies (SAGE)

An introduction to counselling and psychotherapy
John McLeod (Open University Press)

Therapy in the age of neuroscience: a guide for counsellors and therapists
Peter Afford (Routledge)

Person-centred counselling for trans and gender diverse people: a practical guide
Sam Hope (JKP)

Celebrity mad: why otherwise intelligent people worship fame
Brett Kahr (Routledge)

Members of BACP Private Practice can place a free entry on the Bulletin Board under one of four headings: supervision, placements, research and not-for-profit networking groups. Email your wording (approximately 40 words) to **privatepractice.editorial@bacp.co.uk**. The deadline for the next issue is **30 December**.

BACP PRIVATE PRACTICE MISSION STATEMENT

BACP Private Practice is the division of the British Association for Counselling and Psychotherapy (BACP) that supports members who are primarily in, or about to embark upon, counselling or psychotherapy in private practice, including those who work in voluntary agencies.

The division has the following goals:

- to minimise the distortion of professional benchmarks arising from working in isolation
- to provide a supportive, encouraging and integrative network with opportunities to exchange ideas, work ethics, methods and styles
- to alleviate the loneliness of the private practitioner by disseminating relevant information, providing tips and techniques, and revitalisation
- to develop a comprehensive, appropriate, and professional training programme primarily for those working independently
- to engage in and encourage constructive dialogue about the profession of counselling and psychotherapy, including explanation and discussion of BACP developments
- to offer therapists an opportunity to interact with the wider world of counselling and psychotherapy
- to protect clients by promoting BACP's standards and ethics.

The division provides a supportive network and training, with an emphasis on maintaining clear boundaries and having sufficient support and supervision. BACP Private Practice provides an interactive sense of professional belonging for all members of our multicultural therapeutic community. Equal opportunities are an integral part of this division's philosophy.

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Visit the divisional website at **www.bacp.co.uk/bacp-divisions/bacp-private-practice/**

SUPERVISION

Essex/Hertfordshire Border
Supervision for individuals and groups. Twenty-five years' experience counselling in statutory, voluntary and private sectors, working with children, adults and couples. Seventeen years' supervision experience.
Contact: Caroline Powell-Allen MA, MBACP (Snr Accred)
Tel: 01371 873270

South West London
Long-established peer supervision group seeks a fourth member. Three-hour meeting, once a month, usually held in New Malden, currently on a Thursday afternoon. Open to a new member of any modality with significant clinical experience.
Contact: Claire Djali or Mary Russell
Email: clairedjali@hotmail.com or m.russell11@btinternet.com
Tel: 07745 476771 or 07788 642646

Durham/Crook
Senior accredited counsellor and psychotherapist with 18 years' counselling experience offers a collaborative and supportive environment to explore work with clients. Experienced in supervising groups, trainees and individuals for 11 years, face to face and online.
Contact: Debbie Sharp
Tel: 07836 652734
dscounselling.co.uk

BACP divisional journals

BACP publishes specialist journals within six other sectors of counselling and psychotherapy practice.

Healthcare Counselling and Psychotherapy Journal

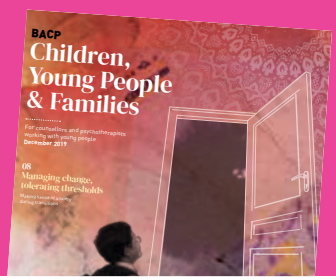
This quarterly journal from BACP Healthcare is relevant to counsellors and psychotherapists working within healthcare settings.

Coaching Today

The BACP Coaching journal is suitable for coaches from a range of backgrounds including counselling and pyschotherapy, management or human resources.

BACP Children, Young People & Families

The journal of BACP Children, Young People & Families is a useful resource for therapists and other professionals interested in the mental health of young people.



University & College Counselling

This is the journal of BACP Universities & Colleges, and is ideal for all therapists working within higher and further education settings.

Thresholds

This is the quarterly journal of BACP Spirituality, and is relevant to counsellors and psychotherapists involved or interested in spiritualty, belief and pastoral care.

BACP Workplace

This journal is provided by BACP Workplace and is read widely by those concerned with the emotional and psychological health of people in organisations.

These journals are available as part of membership of BACP's divisions or by subscription.

To enquire about joining a BACP division, call 01455 883300. For a free of charge consultation on advertising within these journals, contact Jordan Ngandu on 0203 771 7220, or email **jordan.ngandu@thinkpublishing.co.uk**

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