



# **Beyond the Label: Working with Diagnosed Clients in Counselling**

**Dr Chris Andrew**

# Causes of Psychological Disorders

## NATURE

### INHERITED FACTORS

Genetic Factors

Family History

Family Traits

Twin Studies

Developmental  
Factors



## NURTURE

### ENVIRONMENT

In Womb Trauma

Childhood Trauma

Developmental Trauma

Abuse

Insecure Attachment

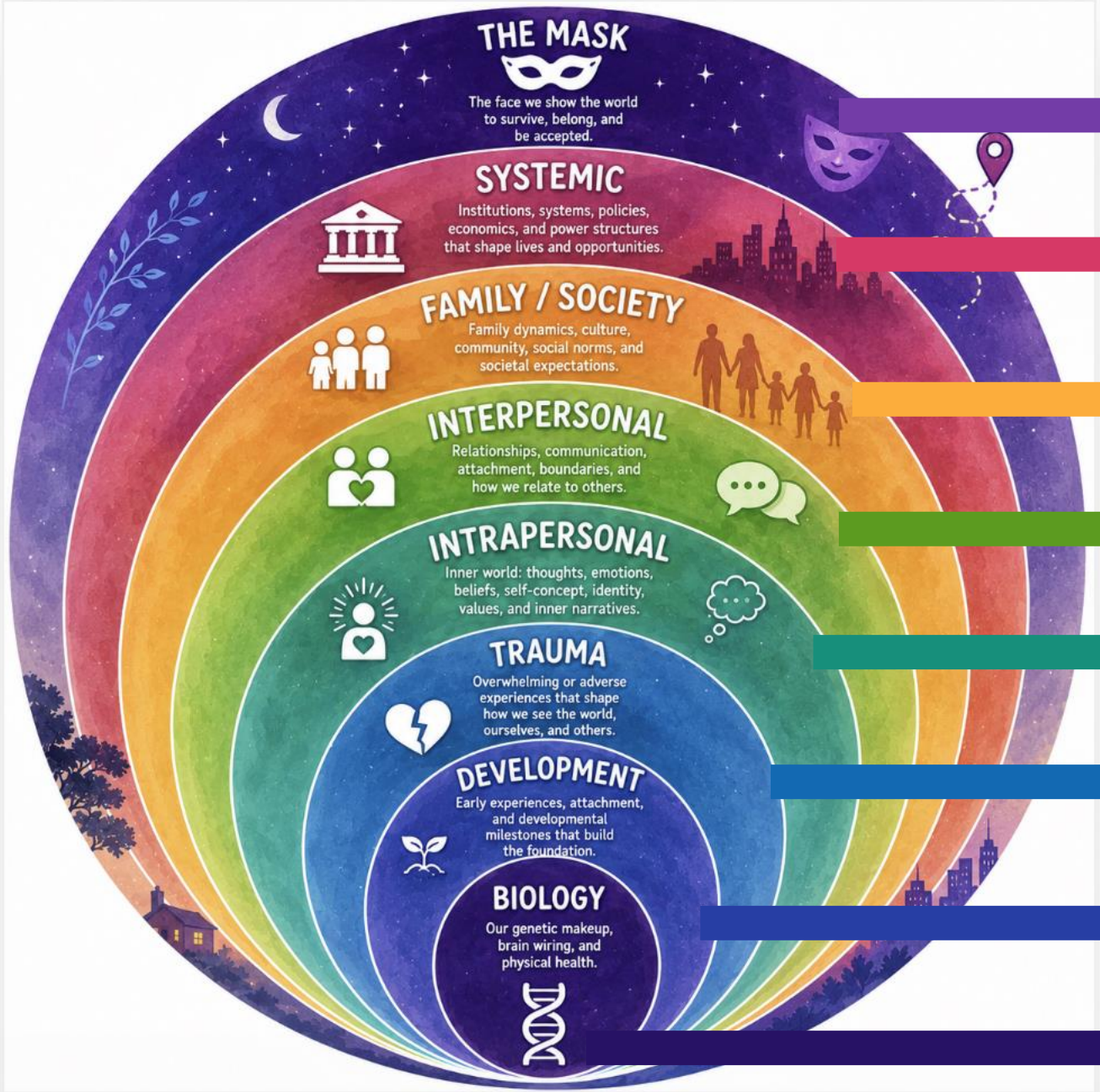
Bereavement

Abandonment

Illness

**BOTH / AND**  
**100% / 100%**

# The layers of who we are



The face we show the world to survive, belong and be accepted

Institutions, systems, policies, economics, power structures that shape lives and opportunities

Family dynamics, culture, community, social norms and societal expectations

Relationships, communication, attachment, boundaries and how we relate to others

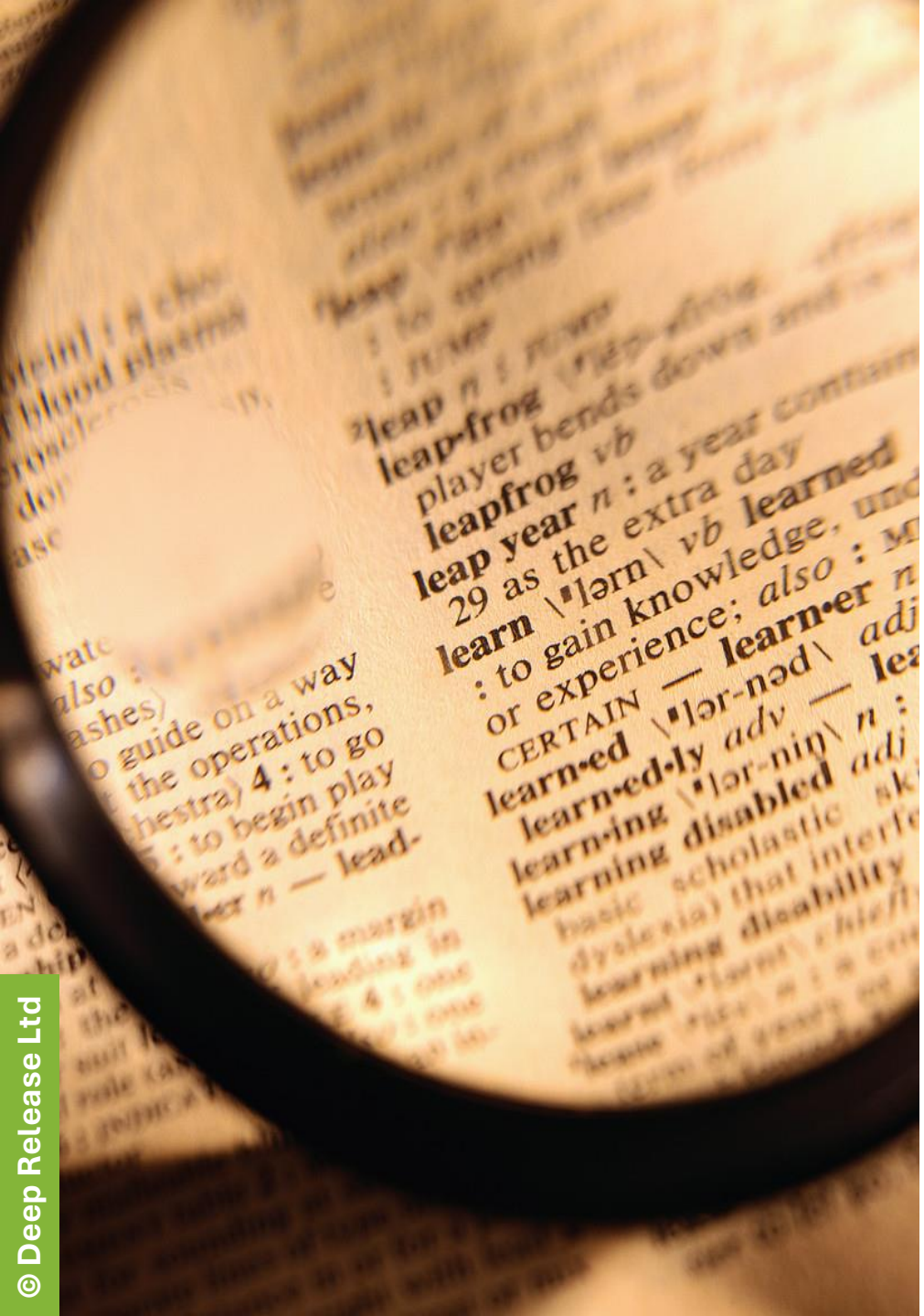
Inner world, thoughts, emotions, beliefs, self-concept, identity, values and inner narratives

Overwhelming or adverse experiences that shape how we see the world, ourselves and others

Early experiences, attachment and developmental milestones

Our genetic make up, brain wiring and physical health

# Basic Terminology



# Basic Terminology

## COGNITIVE FUNCTION

To do with concentration, memory, understanding, intelligence, grasp, judgement

## AFFECTIVE DISORDERS

Disorders of mood

## NEUROSES

Disorders of emotions, belief, behaviour and the will, associated with anxiety, fear, and/or depression but less than psychosis.

A magnifying glass is positioned over an open dictionary. The lens is focused on the word 'learn', showing its phonetic transcription and various forms like 'learned' and 'learning'. The background text is blurred.

# Basic Terminology

## PSYCHOSIS

- A greater disturbance of mental functioning – hallucinations, delusions
- Abnormal behaviours, eg gross excitement, over-activity or slowing down of movements to the point of being catatonic, often related to hallucinations or abnormal mood

## HALLUCINATIONS

- Abnormal sense experiences
- Seeing visions, hearing sounds/ voices, feelings or sensations not usually regarded as normal or healthy

# Basic Terminology

## DELUSIONS

- Mistaken beliefs in spite of evidence to the contrary
- Not understandable in social setting
- eg *I am being spied on, I am impoverished, my guts are rotting away, I am Napoleon...*

## DELIRIUM

- Confusion and disturbance of consciousness
- Usually associated with physical illness, alcohol or drugs

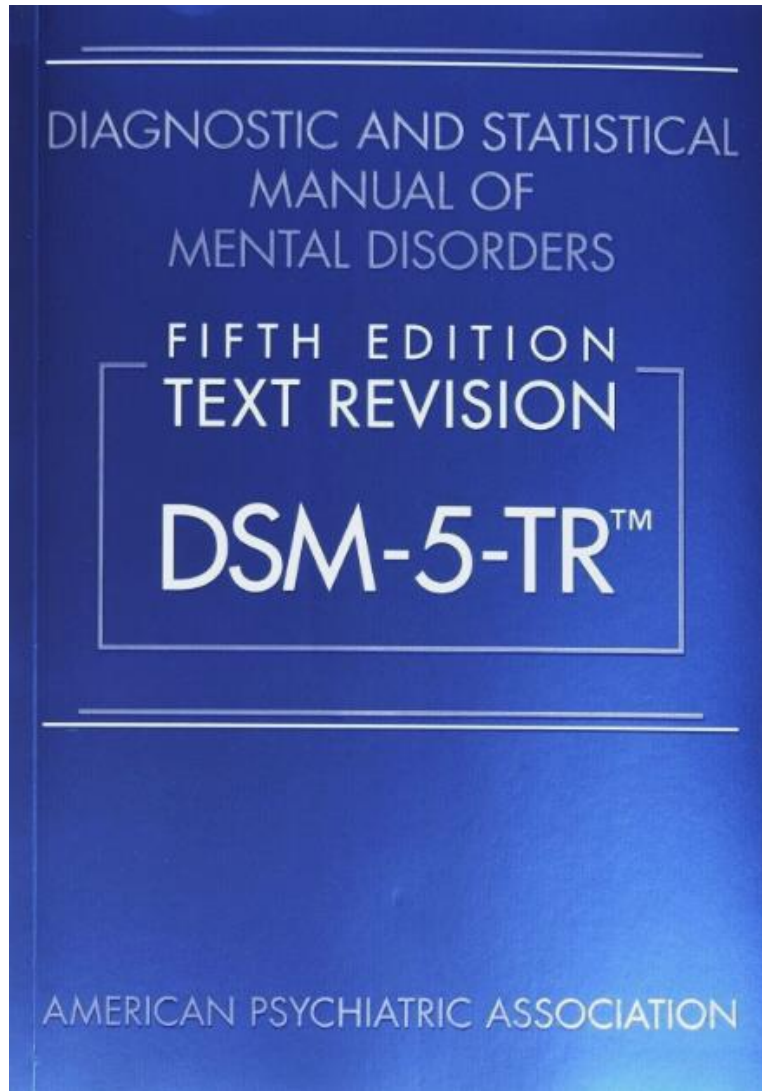
# Basic Terminology

## DEMENTIA

- Disturbance of higher brain function, memory, thinking, orientation, comprehension, calculation, learning, language and judgement.
- Consciousness is not clouded.
- Impaired cognitive function accompanied by deterioration in emotional control, social behaviour and motivation.
- Interference with personal activities of daily living, eg washing, dressing, eating, hygiene.

# Classification

# How are Mental Health Disorders Classified?



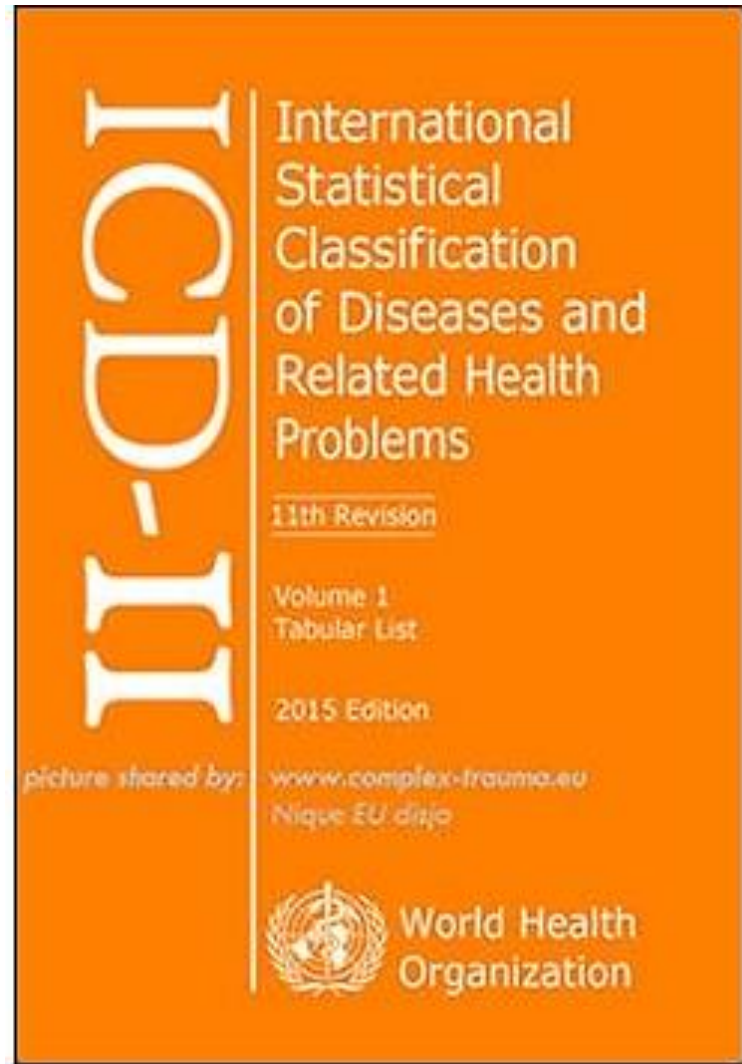
The latest edition of the American Psychiatric Association DSM-5-TR:

- updates research and descriptive text, and revises some diagnostic criteria
- has dispensed with the classical '5 Axes of Classification'
- includes greater attention to culture, racism and discrimination
- adds *Prolonged Grief Disorder* as a formal diagnosis
- updates suicide-related coding and risk-related guidance

**It is a substantial revision of DSM-5**

(A coding is like a library catalogue number)

# How are Mental Health Disorders Classified?



ICD-11, adopted by the World Health Organisation, came into effect globally in 2022. Some notable mental health changes include:

- *Complex PTSD* now recognised as distinct from PTSD
- Dispensing with the ‘clustering’ system for classifying PDs
- *Prolonged Grief Disorder* is included
- *Gaming Disorder* has been added
- The system was designed to be more culturally applicable and digitally usable

# Gaming Disorder

**Gaming Disorder is about gaming becoming so difficult to control that it causes significant problems in a person's relationships, education, work, health or wellbeing.**

- The WHO's position is that the diagnosis should apply only where there is significant loss of control and significant impairment in daily life:
- *using gaming to manage emotions*
- *preferring virtual achievement to real-world challenges*
- *difficulty tolerating boredom*
- *increasing social withdrawal*
- *becoming distressed when gaming is interrupted*
- *fewer offline interests and activities*



# The Significance of the Introduction of Complex Post Traumatic Stress Disorder

Many clients previously diagnosed with

- Personality Disorders
- Chronic Anxiety
- Depression
- Emotional Dysregulation

are now increasingly understood through a trauma lens.

This shift alone has significantly changed conversations in counselling rooms over the past few years.

**Complex PTSD is often a response to living for a long time in traumatic environments, particularly where safety, trust and relationships were repeatedly disrupted**

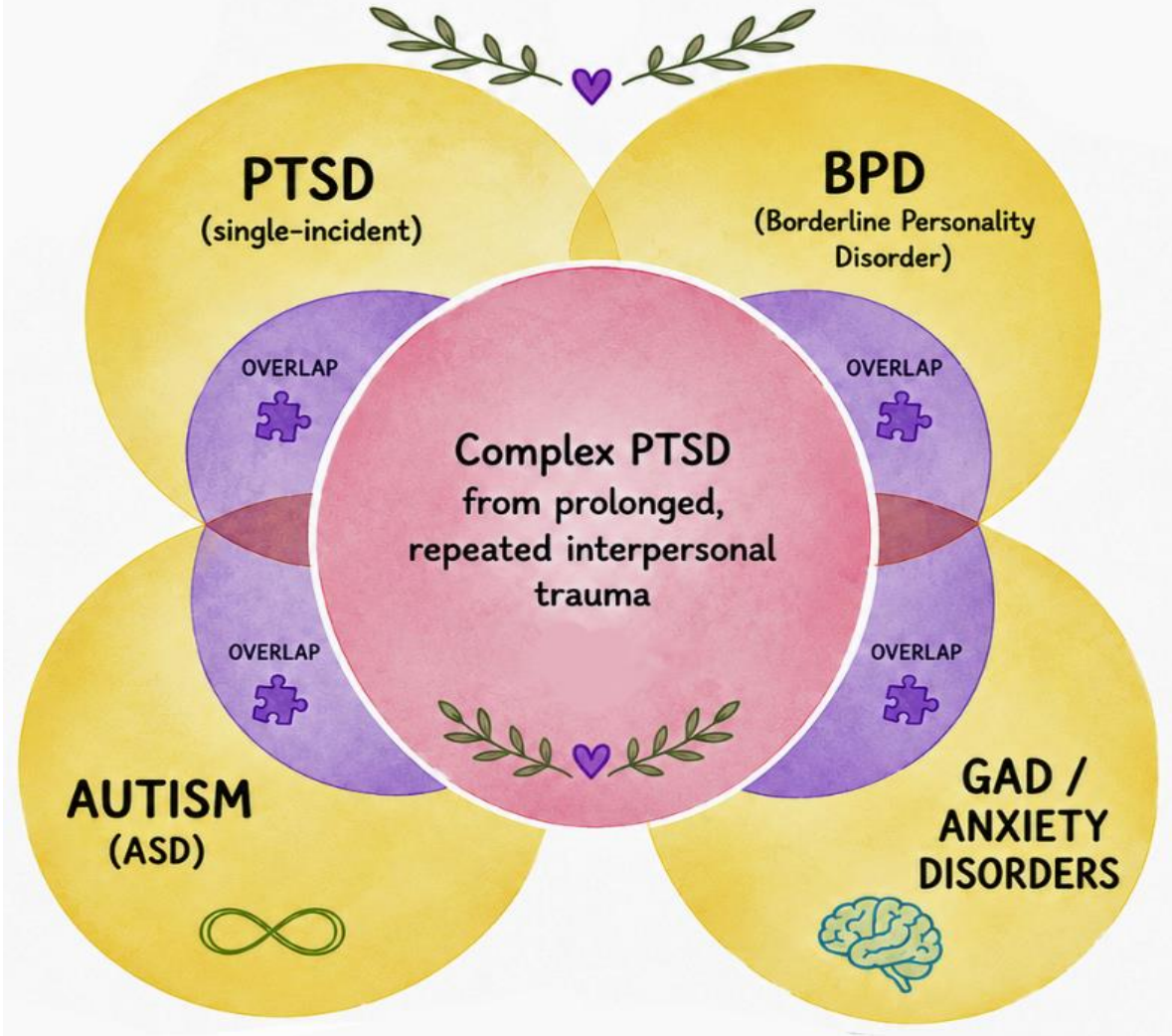
# Complex Post Traumatic Stress Disorder

The impact of repeated, prolonged or inescapable trauma, particularly when it occurs within relationships where the person feels powerless

- Childhood abuse or neglect
- Domestic abuse
- Coercive control
- Trafficking
- Torture
- War and conflict
- Prolonged bullying
- Repeated Attachment trauma

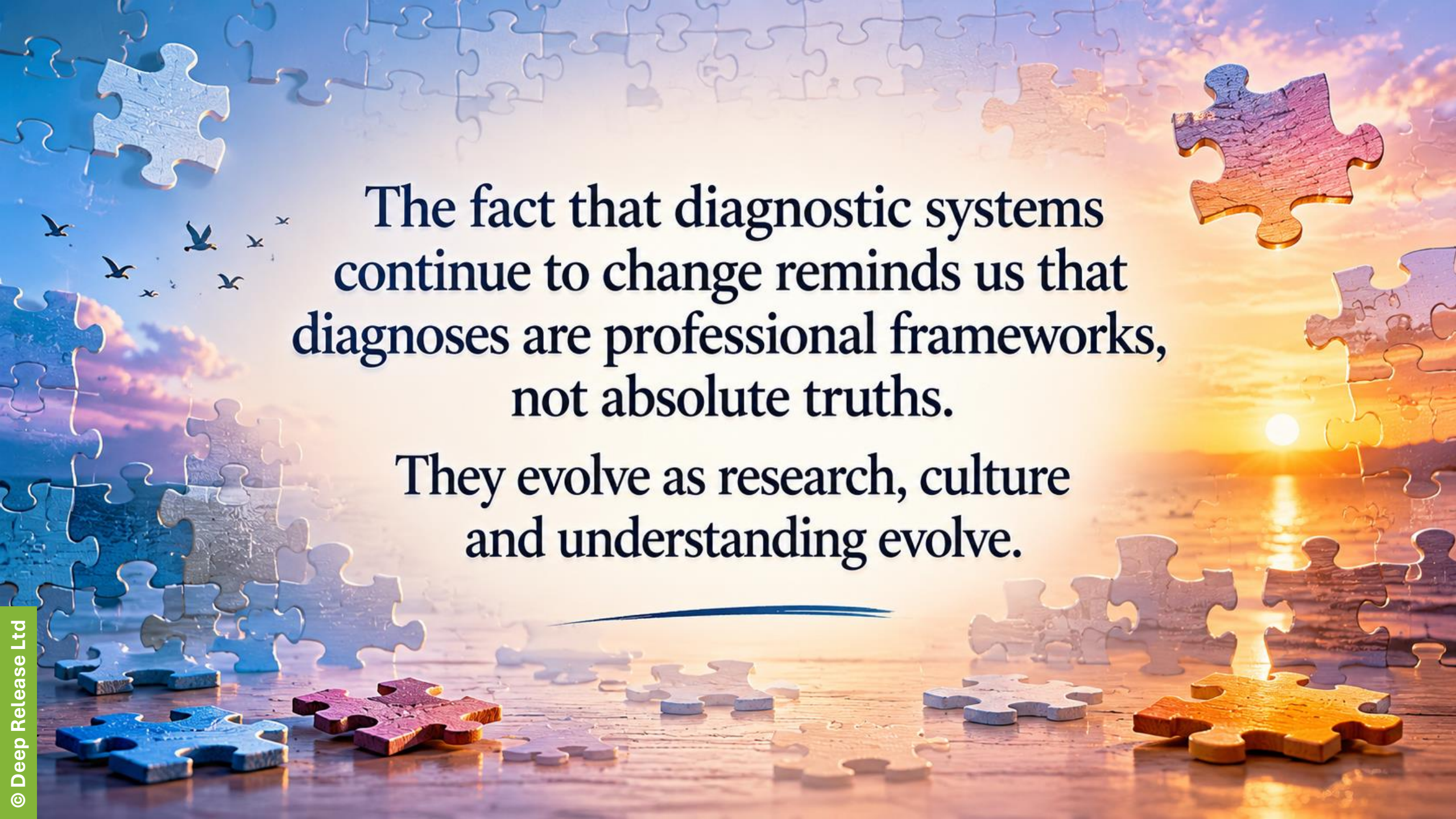


# COMPLEX PTSD



**CPTSD is about the impact of prolonged interpersonal trauma on the whole self – emotions, body, relationships, identity, meaning and the nervous system.**





**The fact that diagnostic systems  
continue to change reminds us that  
diagnoses are professional frameworks,  
not absolute truths.**

**They evolve as research, culture  
and understanding evolve.**



# **Labels: For and Against**

# What diagnosis does and does not mean

- A diagnosis is best understood as a ***clinical description of patterns***
- These patterns include the patient's thoughts, emotions, behaviours, bodily responses and relational experiences
- For some clients, finally 'having a name' for their experiences can feel validating and relieving, reducing shame and isolation.



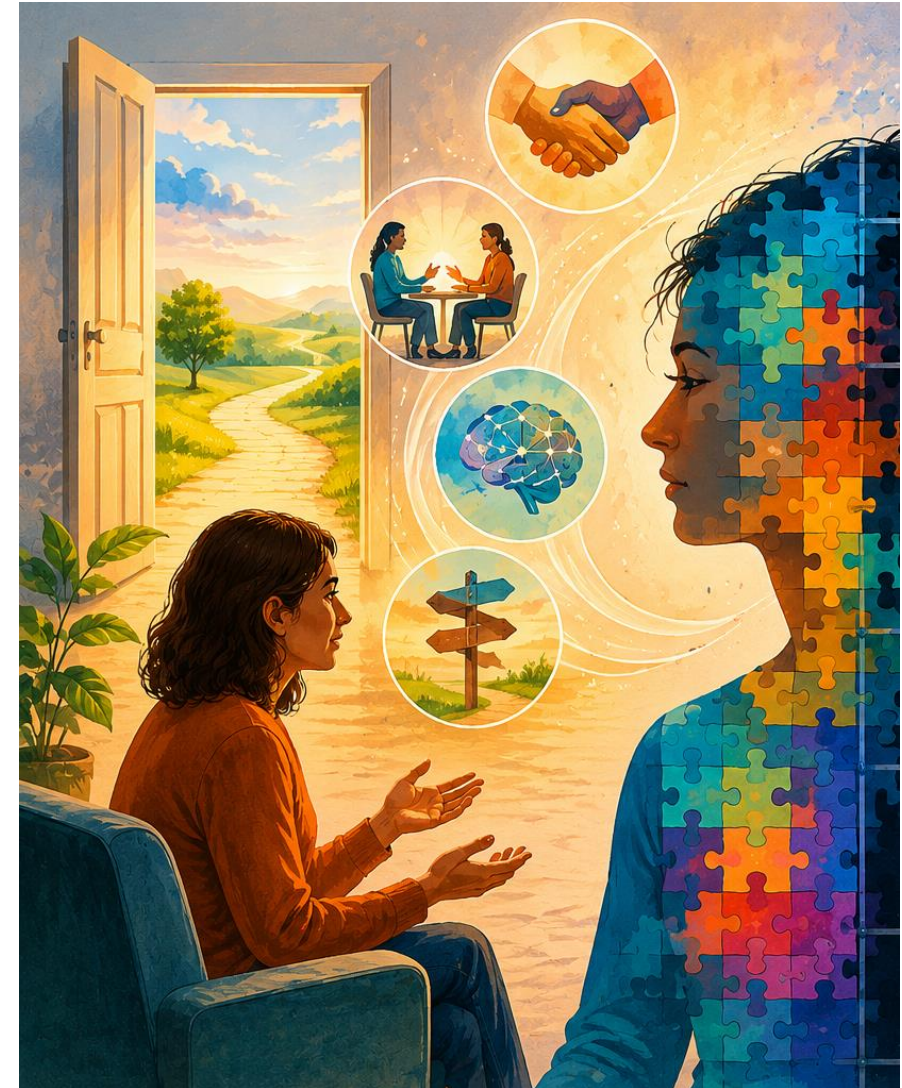
There's a reason  
this feels so  
overwhelming.

I'm not  
imagining it.

Other people  
experience this too.

# Diagnosis as an access route

- It can open access to care, validation and treatment pathways
- In many systems, diagnosis opens doors to:
  - referrals
  - medication
  - specialist services
  - workplace adjustments
  - insurance or benefit support
  - recognition within healthcare systems



# Diagnosis as a kind of shorthand

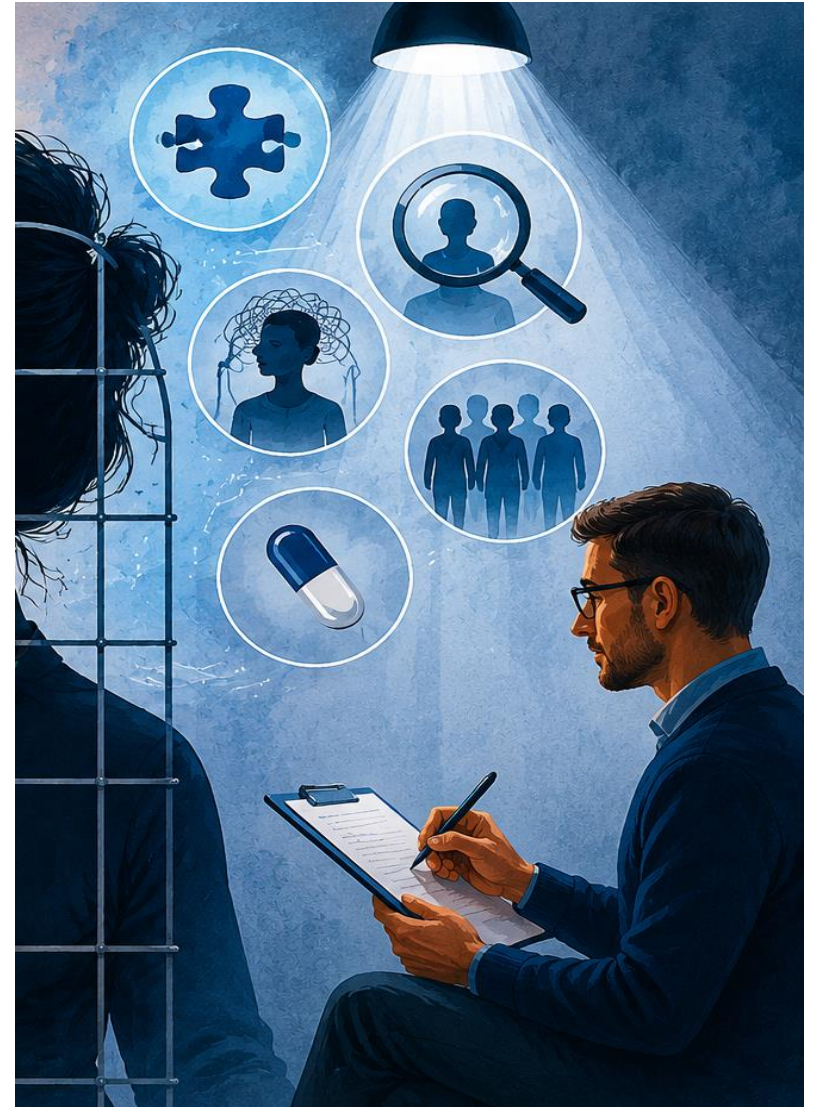


Without some form of shared language, people may struggle to access consistent support



# However...

- Mental health diagnoses can be very helpful, but they are never the whole story of a person, or their ‘identity’
- A diagnosis can also invite stigma, or make counsellors feel they must somehow ‘treat the disorder’, rather than meet the person
- Counsellors can help clients explore whether the diagnosis feels helpful, restrictive, frightening, stigmatising or over-identifying



# Not forgetting...

- Shorthand diagnoses can become reductionistic if we forget that two people with the same diagnosis may have profoundly different histories, cultural meanings, coping strategies and relational needs
- Two clients with the same diagnosis may present entirely differently in the counselling room



A diagnosis may describe common patterns but it doesn't tell us:

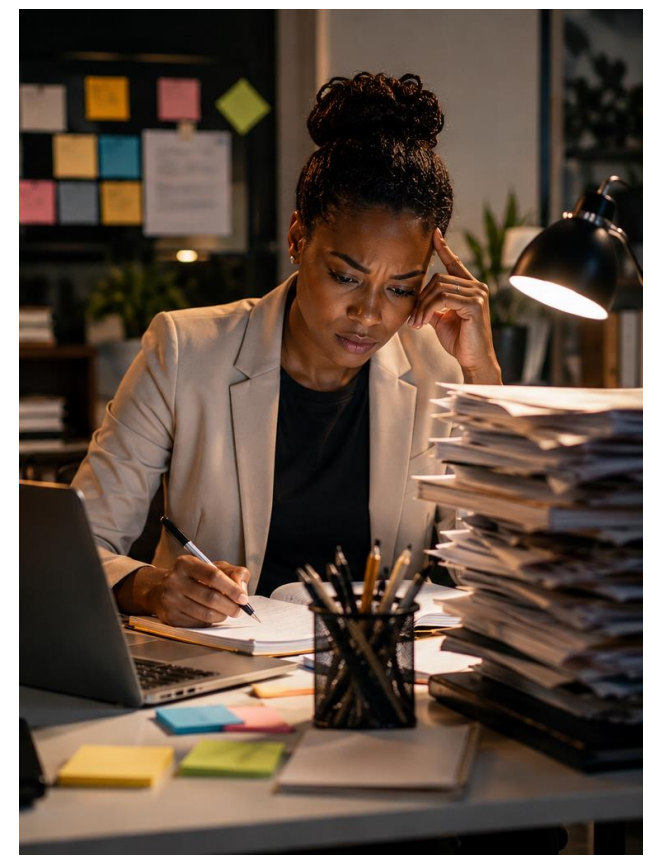
- what happened to the person
- what their background was
- how they learned to survive
- what meaning they make of their experiences
- what relationships feel like for them
- what strengths they hold
- how their distress uniquely presents





## And remembering...

One person with depression may appear tearful and withdrawn; another may present as high-functioning, perfectionistic, irritable or emotionally numb



A PTSD diagnosis might reflect combat trauma, childhood abuse, medical trauma, racial violence or coercive relationships

All require different levels of sensitivity and understanding

# Overlap between conditions

- Mental health diagnoses are not neat boxes
- Many conditions share symptoms, eg
  - sleep disturbance
  - concentration problems
  - emotional dysregulation
  - avoidance
  - irritability
  - dissociation
  - anxiety
- Trauma in particular can present in ways that resemble depression, ADHD, personality disorder, anxiety disorders or autism-spectrum disorders

**Counsellors should resist certainty and remain curious about the function and meaning of symptoms**

# Possible Ideas to share in Buddy Groups

- As much as feels safe, share personally and professionally what has come up for you with your group.
- Send any comments or questions to Hannah.

**15 minutes**



# TAKE A BREAK

5:00



# Anxiety Disorders

- ❖ **Generalised Anxiety Disorder**
- ❖ **Panic Disorder**
- ❖ **Obsessive Compulsive Disorder**
- ❖ **Phobic Disorders**

# Anxiety Disorders: Generalised Anxiety Disorder

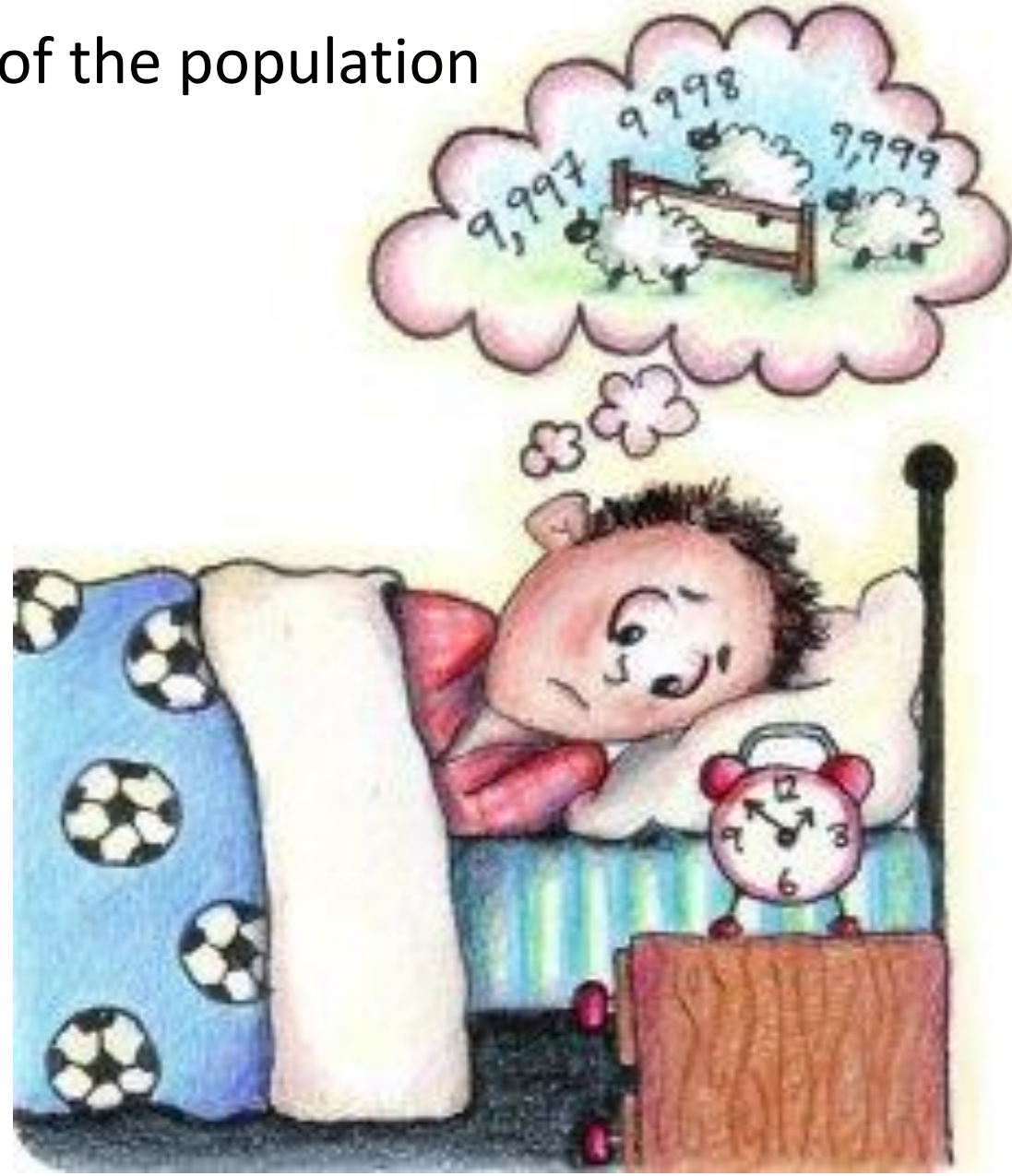
- Highly prevalent - estimated up to 15% of the population
- Higher incidence in females than males

## CLINICAL FEATURES

- Apprehensive - Hypervigilant
- Disturbed sleep
- Muscle tension - Autonomic arousal

## AETIOLOGY (Causes)

- Genetic predisposition
- Childhood stressors
- Current stressors



# Anxiety Disorders: Generalised Anxiety Disorder

## MANAGEMENT

- Reassurance
- CBT
- Mindfulness
- Medication
- Anxiolytics – short term
- Antidepressants
- Beta Blockers



# Anxiety Disorders: Panic Disorder

- An intense anxiety attack
- Feelings of apprehension/ impending doom

- Feelings of unreality
- Fear of dying
- Fear of going crazy
- Fear of doing something uncontrollable

## Associated symptoms

- *Rapid heartbeat*
- *Shortness of breath*
- *Chest discomfort*
- *Dizziness*
- *Numbness*
- *Hot flushes*
- *Cold hands*
- *Sweating*
- *Faintness*
- *Trembling*



Often begins in late adolescence  
More common in women than men

## Treatment

- CBT
- Medication
- Psychodynamic Counselling
- Other therapies

# Anxiety Disorders: Obsessive Compulsive Disorder



- Unreasonable thoughts, fears or worries
- Try to manage through ritualised activities to reduce the anxiety
- Frequently occurring distressing thoughts or images are called **obsessions**

# Anxiety Disorders: Obsessive Compulsive Disorder



- The rituals performed to try to prevent or dispel them are called **compulsions**
- The most common compulsions include repetitive hand washing/checking/ touching
- Aim to avoid contamination or contaminating / harm or harming
- May be characterised by excessive orderliness and perfectionism
- Difficult to treat

# Anxiety Disorders: Phobic Disorders

Can you name the top 10 most commonly recognised phobias?

A grid of 10 yellow ovals arranged in three rows. The top row contains ovals numbered 10, 9, and 8 from left to right. The middle row contains ovals numbered 7, 6, and 5 from left to right. The bottom row contains ovals numbered 4, 3, and 2 from left to right. Each oval is empty, intended for the user to write a phobia name.

# Share in Buddy Groups

*What do you think are the top 10 phobias?*

5 minutes



# Anxiety Disorders: Phobic Disorders

Clinicians are reporting substantial increases in

- health anxiety
- contamination fears
- social anxiety
- emetophobia
- school avoidance/anxiety in young people

since the pandemic



# Anxiety Disorders: Phobic Disorders

## Phobias are rarely ‘just irrational fears’ and often involve:

- nervous-system learning: associating certain situations with danger, even when the threat is no longer present
- avoidance – this brings short-term relief but makes the fear stronger over time
- shame – many feel embarrassed/weak/stupid so they hide their fears
- catastrophic meaning-making – *I’ll die, I’ll lose control, I’ll be humiliated*
- attempts to regain safety and control



**Our role is not to make anxiety disappear before someone faces the feared situation. Our role is to help them discover that they can cope with the anxiety while facing it.**

# Treatment for Phobias

- ❖ **Exposure Therapy:** *Avoidance keeps the phobia going. Supported exposure helps the brain learn that the feared situation is safer than it expects*
- ❖ **Virtual Reality Exposure Therapy:** *Increasingly common, and used for flying phobia, height phobia, public speaking fears and social anxiety*
- ❖ **Cognitive Behavioural Therapy:** *Exposure work plus cognitive work towards more realistic thinking*
- ❖ **Counselling:** *Exploring the meaning of the fear, shame, avoidance, confidence, underlying anxiety, trauma*
- ❖ **Medication:** *Not considered a primary treatment for specific phobias; on its own it doesn't usually resolve the phobia. SSRIs may be prescribed if significant anxiety is present, or beta-blockers for performance situations*

# Affective (Mood) Disorders

- ❖ **Depression**
- ❖ **Cyclothymia**
- ❖ **Bipolar Disorder**

# Depression

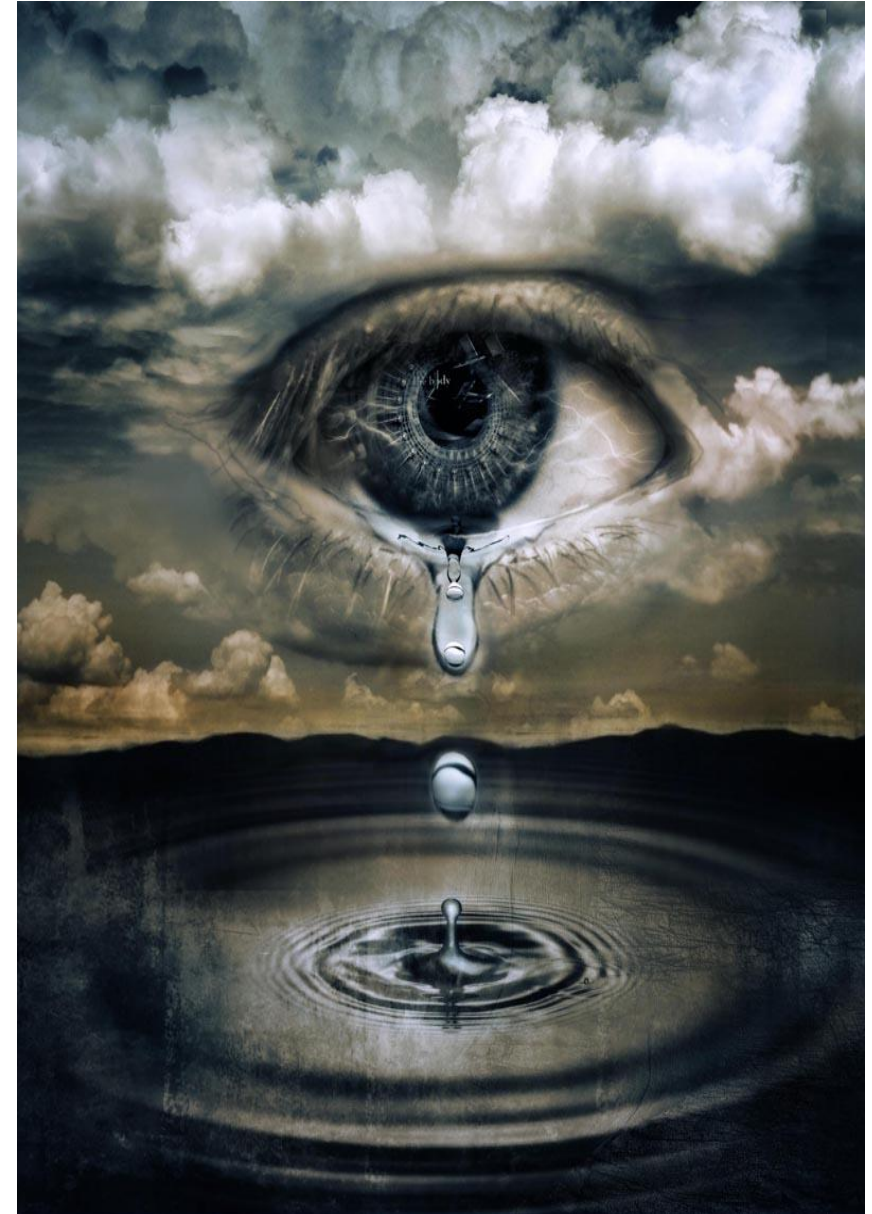
## SYMPTOMS

- Depressed mood, worse in the morning
- Early morning waking
- Loss of interest/concentration
- Tiredness, hopelessness
- Reduced self-esteem, sense of guilt, unworthiness
- Perplexity, agitation
- Loss of energy/libido/appetite
- Hypochondria
- Depersonalisation (outside oneself/watching a movie)
- Derealisation (world around you unreal/'foggy')
- Suicidal ideation

### **Psychotic Symptoms when severe**

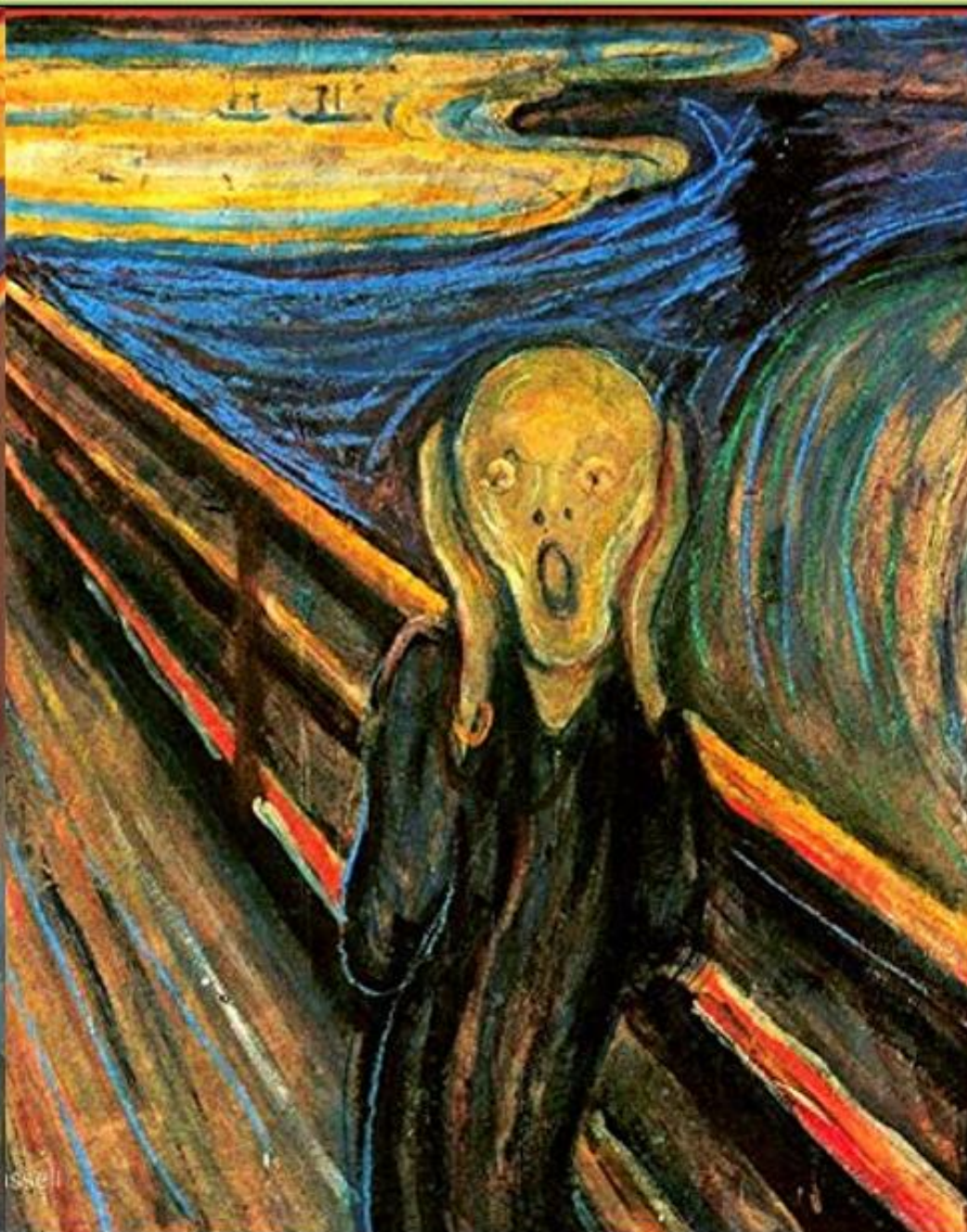
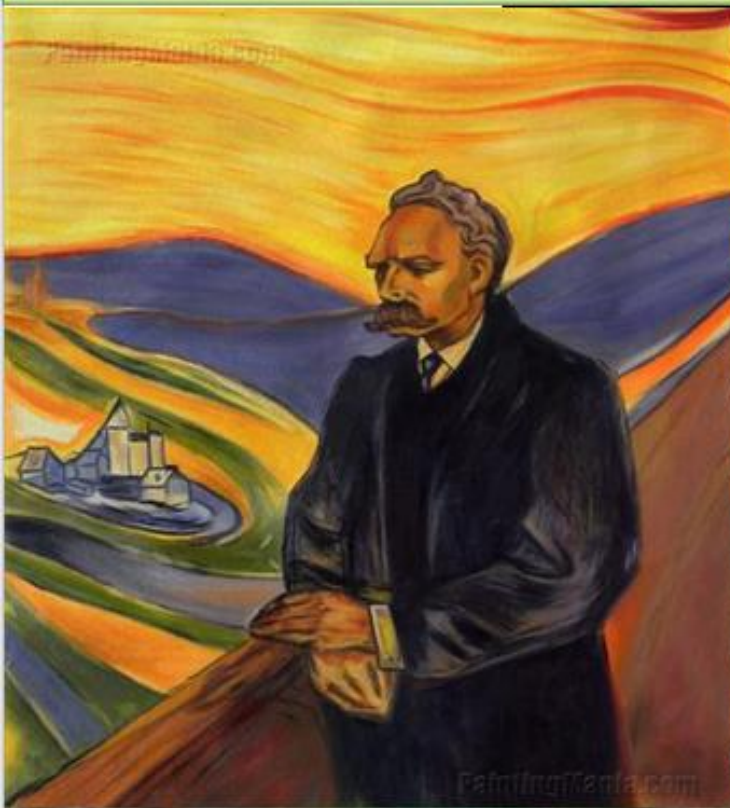
Delusion of sin/poverty, imminent disaster, physical illness, auditory hallucinations, accusing voices, stupor

### **Recurrent Depressive Disorder**



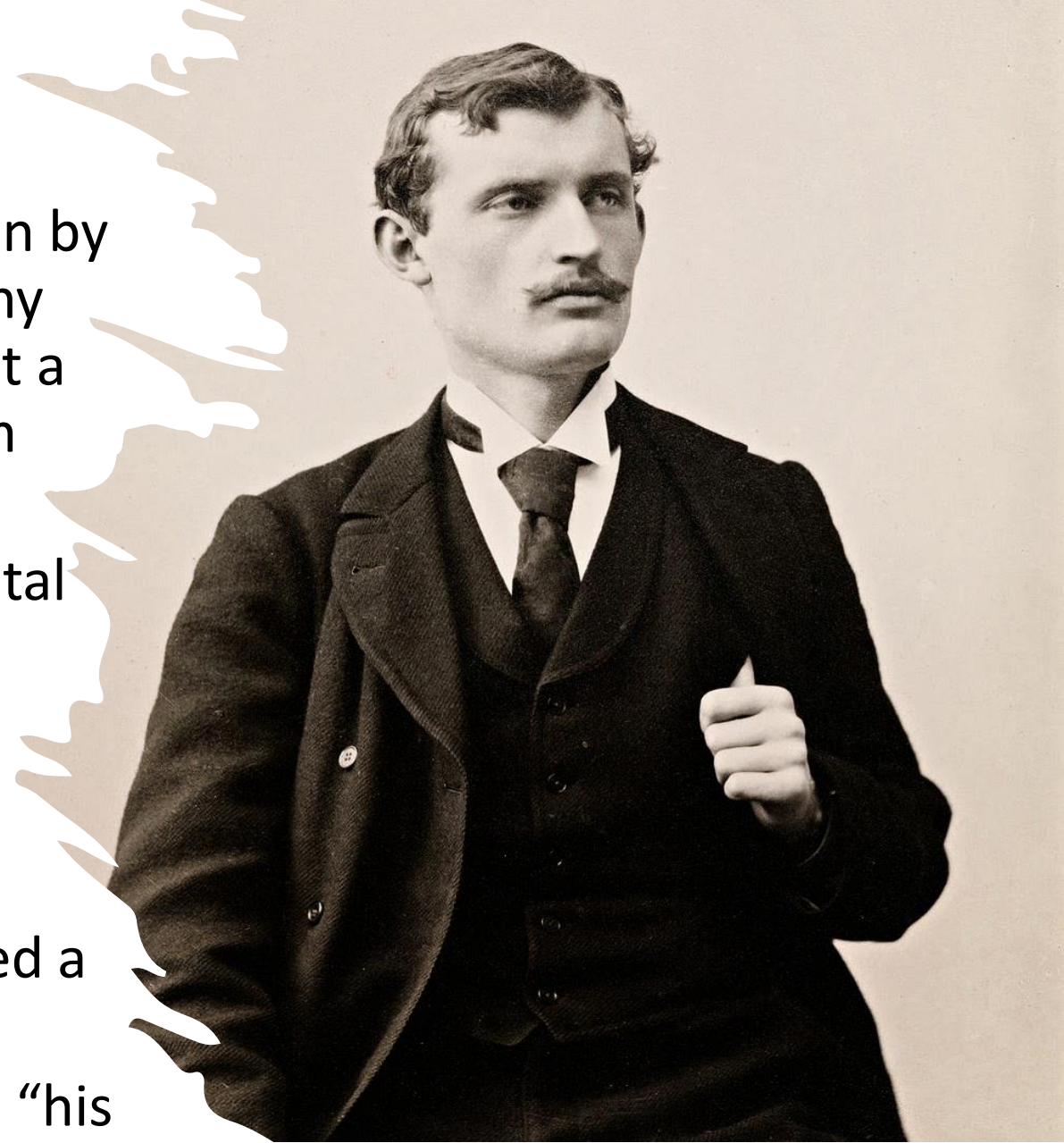


# EDVARD MUNCH



# EDVARD MUNCH (1863 – 1944)

- Age 2 – his mother died (left 5 children)
- Father instilled deep-rooted fear in children by repeatedly telling them if they sinned in any way they would be doomed to hell without a chance of pardon - mother “watching from heaven”
- One of his sisters was diagnosed with mental illness at a very early age
- Age 14 – his favourite sister died
- Munch often ill with depression/anxiety/bipolar disorder/alcohol addiction
- Only 1 sibling, Andreas, married but he died a few months later
- Munch never married – his paintings were “his children” – never wanted to be parted from them.

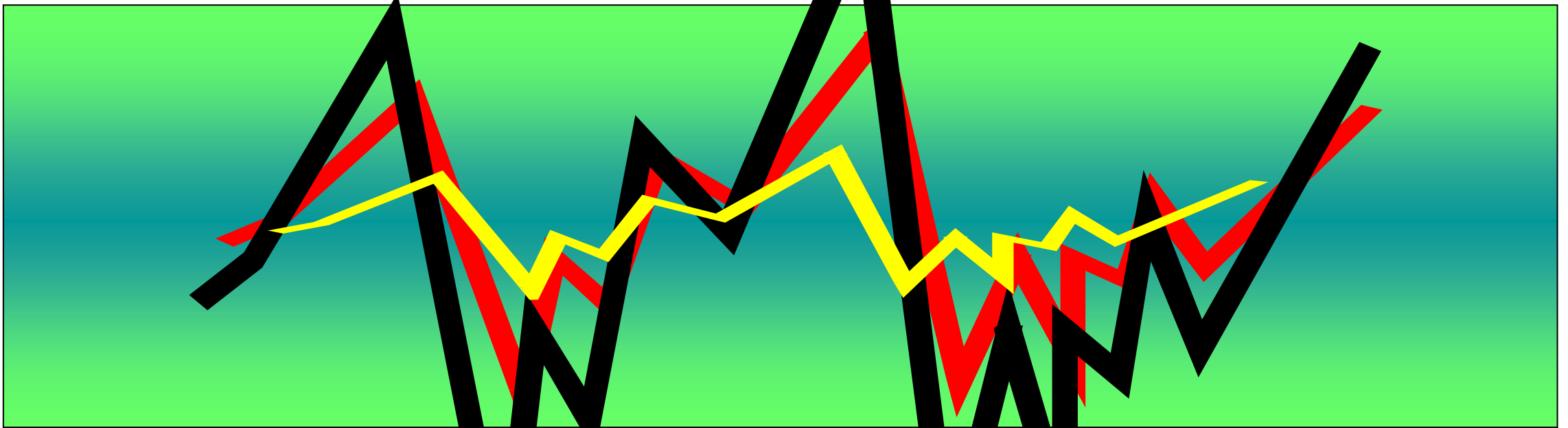


<https://www.smithsonianmag.com/arts-culture/edvard-munch-beyond-the-scream-111810150/>

# The Window of Tolerance: The Spectrum of Mood Disorders

**Mania**

**Hypomania**



Normal mood changes

Cyclothymia

Bipolar

**Neurotic Depression**

**Psychotic Depression**

Daniel Siegel

# Cyclical Disorders : Cyclothymia



- **Mood swings**
- **Begins early in life**
- **May have no obvious triggers**
- **May be passed off as 'normal' for that personality**

# Cyclical Disorders : Bipolar Disorder

## HYPOMANIA

### *Symptoms may include:*

- Persistent elevation of mood for several days
- Increased energy and activity: less sleep
- Feelings of well-being
- Increased mental and physical activity
- Increased sociability, talkativeness, over-familiarity
- Increased sexual energy
- Irritability, conceit and boorishness
- New ventures
- Interferes with work and social activity



# Cyclical Disorders : Bipolar Disorder

## **MANIA - May include:**

- Elation, pressure of speech
- Grandiose schemes
- Inflated self-esteem
- Over-optimistic
- Distractibility
- Sexual lability
- Reckless spending
- Aggressive and disruptive





# Denise

## A diagnosis of Bipolar Disorder



# Possible Ideas to share in Buddy Groups

- As much as feels safe, share personally and professionally what has come up for you with your group.
- How did you respond to Denise's story?
- Send any comments or questions to Hannah.

**15 minutes**



# TAKE A BREAK

5:00



# The Schizophrenias

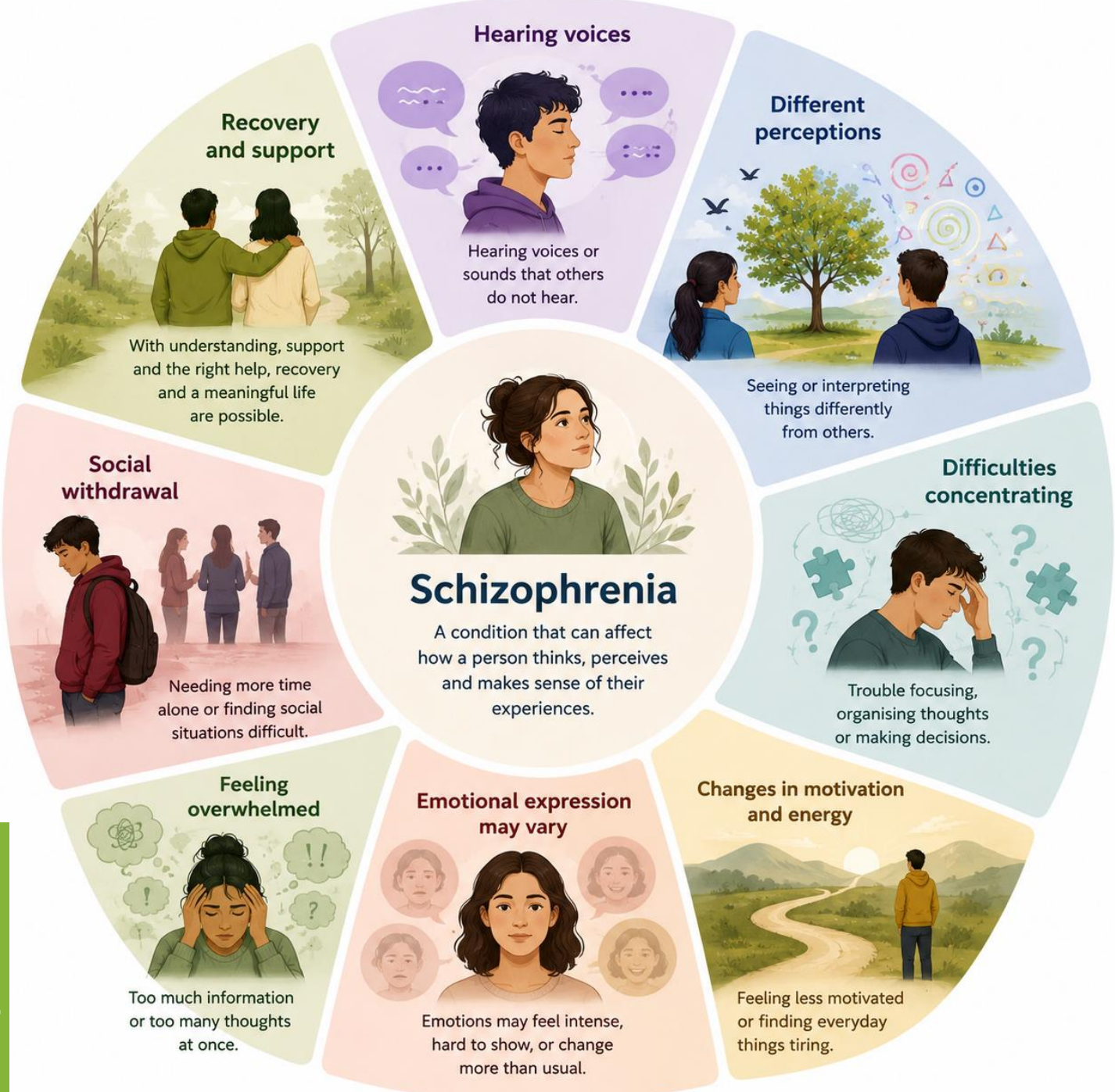
# The Schizophrenias

It is not about having a 'split personality' like Jekyll and Hyde!!

- A group of mental illnesses with specific psychological symptoms leading, in some cases, to a disorganisation of personality
- Schizophrenia affects how someone perceives, interprets and understands what is happening around them
- People with schizophrenia may see, hear or believe things that feel very real to them, even when others do not share those experiences.



# Schizophrenia Symptoms



- Confusing thoughts
- Different perceptions
- Low motivation
- Relationship difficulties
- Concentration problems
- Anxiety
- Recovery and Support

# Schizo-affective Disorder

The person experiences symptoms of **Psychosis**  
and  
significant **Mood symptoms, such as depression or mania**

**Psychotic Symptoms might include:**

- ✓ hearing voices
- ✓ delusions (unusual beliefs)
- ✓ confusion about reality
- ✓ disorganised thinking
- ✓ suspiciousness/paranoia

**Mood Symptoms might include:**

- ✓ elevated mood
- ✓ reduced need for sleep
- ✓ racing thoughts
- ✓ impulsive behaviour
- ✓ inflated confidence

...or sometimes both at different times

# Schizo-affective Disorder

## What might the client present with?

- Depression
- Anxiety
- Hearing voices
- Unusual beliefs
- Social withdrawal
- Confusion
- Low confidence
- Difficulties in relationships
- Fear and uncertainty about their experiences

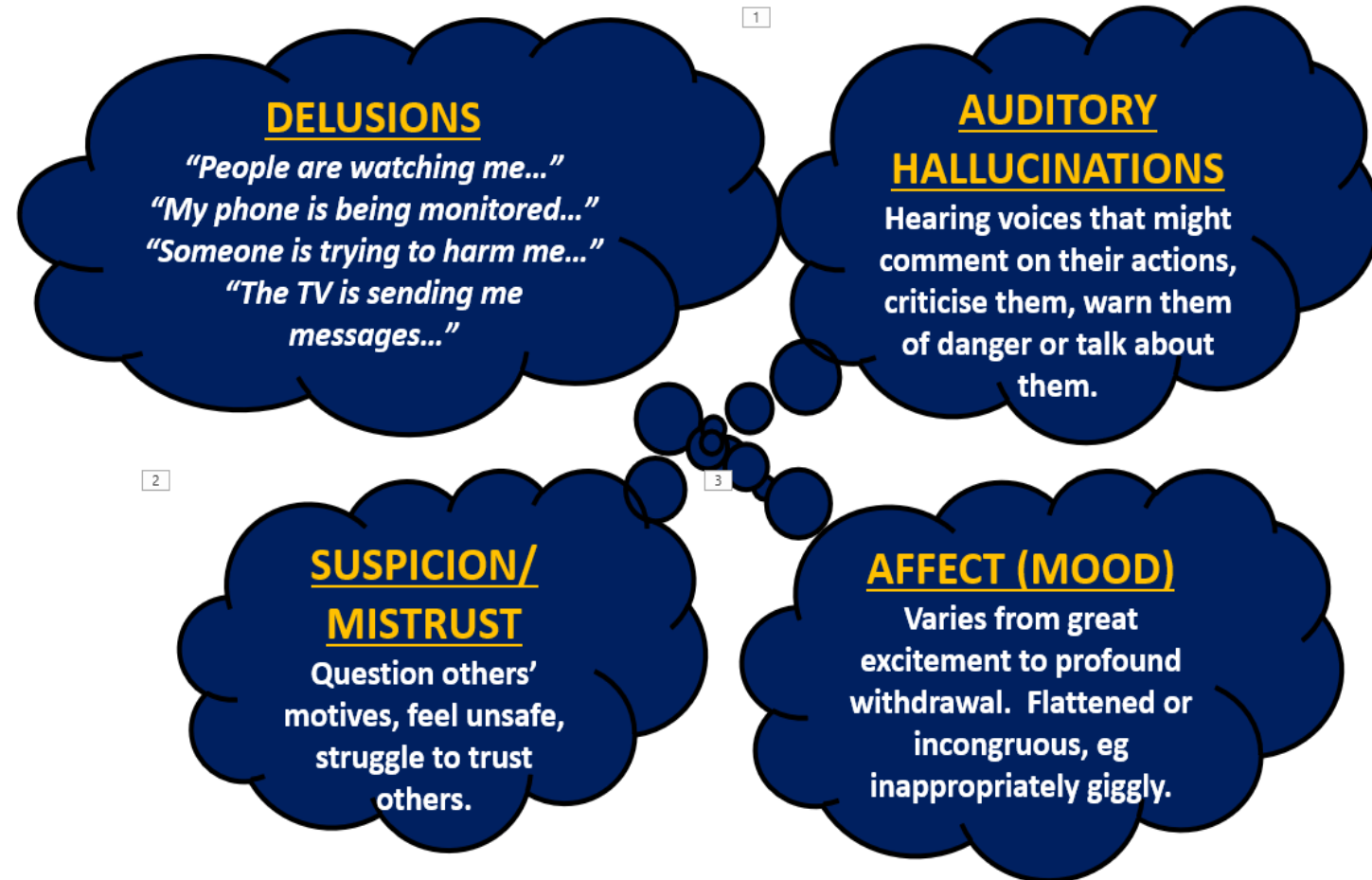


# “Paranoid Schizophrenia”

This term is **no longer used** as a separate diagnosis in either DSM-5-TR or ICD-11

Historically, schizophrenia was divided into subtypes:

- Paranoid
- Disorganised (hebephrenic)
- Catatonic
- Undifferentiated
- Residual



Clinicians found that people often moved between the different categories over time and these subtypes didn’t predict treatment or outcomes. They were therefore removed.

# What might a counsellor notice?

A client may:

- seem guarded
- test whether you can be trusted
- ask unusual questions
- become concerned about confidentiality
- struggle to believe reassurance
- appear frightened rather than aggressive

Many people experiencing paranoia are:

- frightened
- confused
- overwhelmed
- trying to stay safe

**Instead of**  
***“That’s not happening”***

**Try:**  
***“That sounds frightening”***

# Points to consider

Have you had a chance to talk to your GP about these experiences?

Have these experiences been assessed before?

Is anyone else supporting you with this at the moment?

Are you taking any medication?

It sounds important that you have access to the right support alongside our work.

Take to Supervision

- Psychotic symptoms may require medical assessment
- Symptoms can sometimes worsen rapidly
- Medication may be playing a significant role
- There may be a care plan in place
- Working as part of a team is often very helpful

# Personality Disorders

The traditional system asks:  
*Which box does this person fit into?*



Instead of asking, “*What’s the diagnosis?*”  
We ask: “*Which human themes are most prominent for this person?*”

# Personality Disorders: A Changing Understanding

**We used to think PDs were:**

- Fixed, personality flaws
- Difficult or disordered character traits
- Lifelong and unchangeable
- *“The problem is the person”*

**Clinicians now assess severity as:**

**Mild Personality Disorder**

**Moderate Personality Disorder**

**Severe Personality Disorder**

**We increasingly understand them as:**

- Enduring patterns of experiencing self, emotions, relationships and the world
- Often influenced by early attachment experiences, trauma, adversity and temperament
- Ways of coping that once made sense but may now cause distress or difficulties
- Patterns that can change through relationships, therapy, reflection and support

# A Changing Understanding of PDs

ICD-11 calls a Personality Disorder:

*“A persistent disturbance in the way a person experiences themselves and others, resulting in significant problems in personal, social, occupational or other important areas of functioning.”*

The trend is to dispense with many of the previous labels and think in terms of traits and dimensions.  
It all becomes fluid....

# Personality Disorders

DSM-5-TR still holds to traditional categories

## CLUSTER A – *odd or eccentric*

Paranoid

Schizoid

Schizotypal

## CLUSTER B - *dramatic or emotional*

Antisocial

Borderline

Histrionic

Narcissistic

## CLUSTER C - *anxious or fearful*

Avoidant

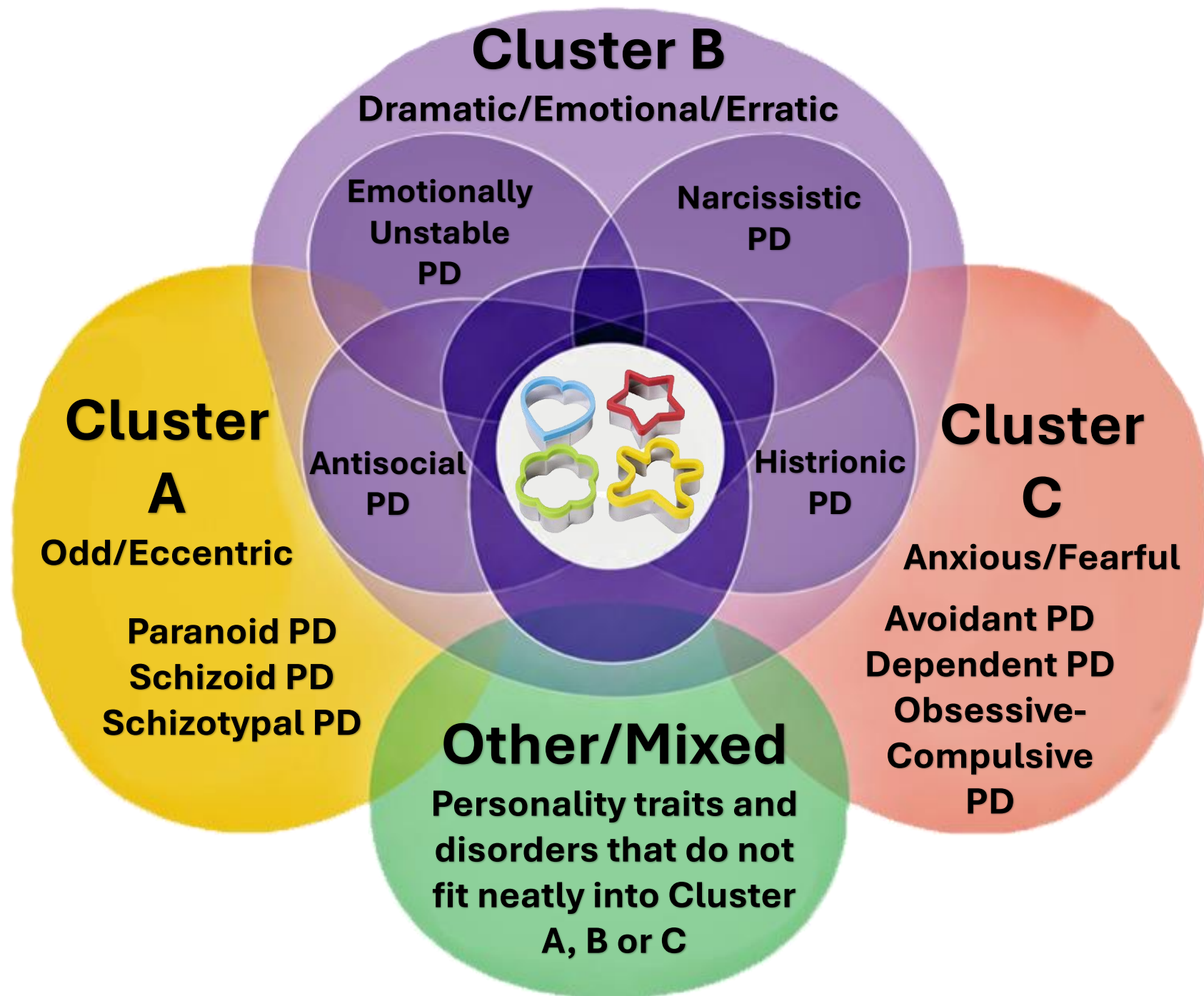
Dependent

Obsessive-Compulsive



Which box shall we  
put you in?





# THE PERSONALITY CLUSTERS

A colourful bunch!

## CLUSTER A ODD / ECCENTRIC



Trust no one.

**PARANOID**



People are overrated.

**SCHIZOID**

## CLUSTER B DRAMATIC / EMOTIONAL / ERRATIC



I feel everything so deeply.

**BORDERLINE**



I'm better than you.

**NARCISSISTIC**



Look at meee!

**HISTRIONIC**



Rules? What rules?

**ANTISOCIAL**

## CLUSTER C ANXIOUS / FEARFUL



What if they don't like me?

**AVOIDANT**



I can't make decisions on my own.

**DEPENDENT**



If it's not perfect, it's not worth doing.

**OBSESSIVE-COMPULSIVE**

# Personality Disorders

HOWEVER.... DSM-5-TR now also contains an “*Alternative Model for Personality Disorders*” (AMPD)

## Impairment in:

- Identity
- Self-direction
- Empathy
- Intimacy

## Pathological traits such as:

- Negative affectivity
- Detachment
- Antagonism
- Disinhibition
- Psychoticism

**Many researchers now believe:**

- Personality disorders are not completely separate diseases
- They are extreme or maladaptive variants of normal personality traits
- People often meet criteria for several personality disorders simultaneously
- Severity of dysfunction may be more important than the specific label

# Emotionally Unstable Personality Disorder



## INTENSE EMOTIONS

Big feelings, fast and overwhelming



## ANGER

Explosive, sudden or out of proportion



## IMPULSIVITY

Acting without thinking, risky behaviours



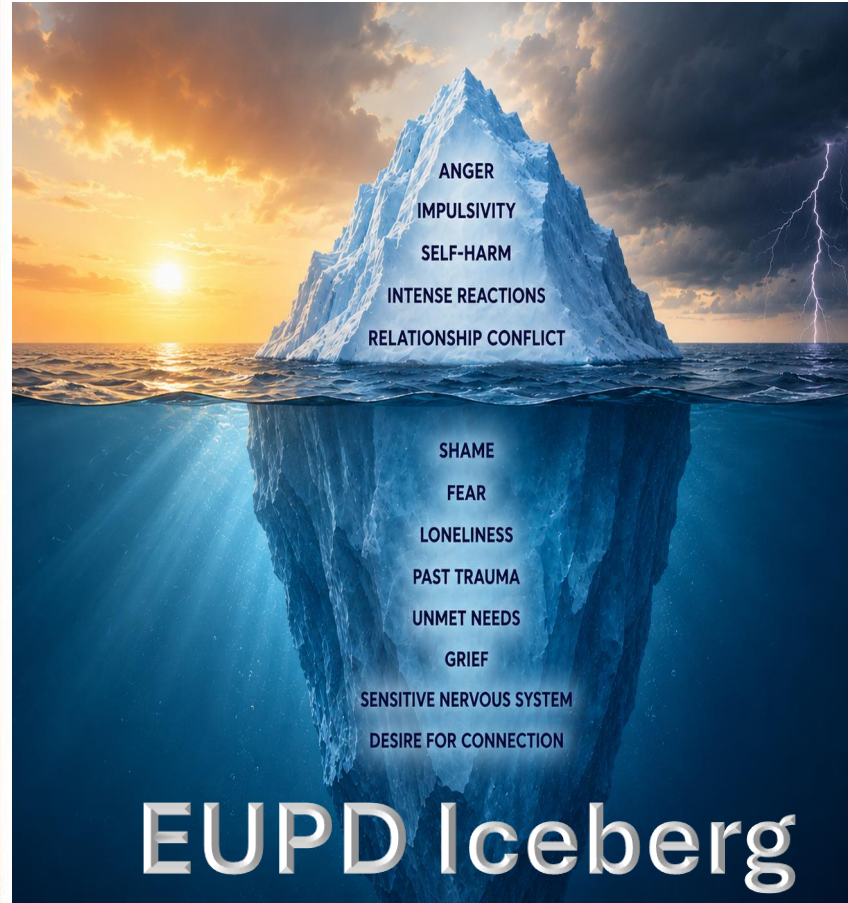
## CONFLICT IN RELATIONSHIPS

Push-pull dynamics, fear of abandonment



## SELF-HARM

Coping strategies that cause harm



## WHAT LIES BENEATH

The pain, fear and needs we don't always see



### DEEP FEAR

Fear of abandonment, rejection and being alone



### SHAME

Feeling unworthy, not enough, or defective



### LONELINESS

Feeling unseen, misunderstood and fundamentally alone



### PAST TRAUMA

Old wounds that still hurt and shape the present



### GRIEF AND LOSS

Unresolved sadness, losses and unmet needs



### STRONG NEED FOR CONNECTION

A deep longing to be loved, accepted and safe

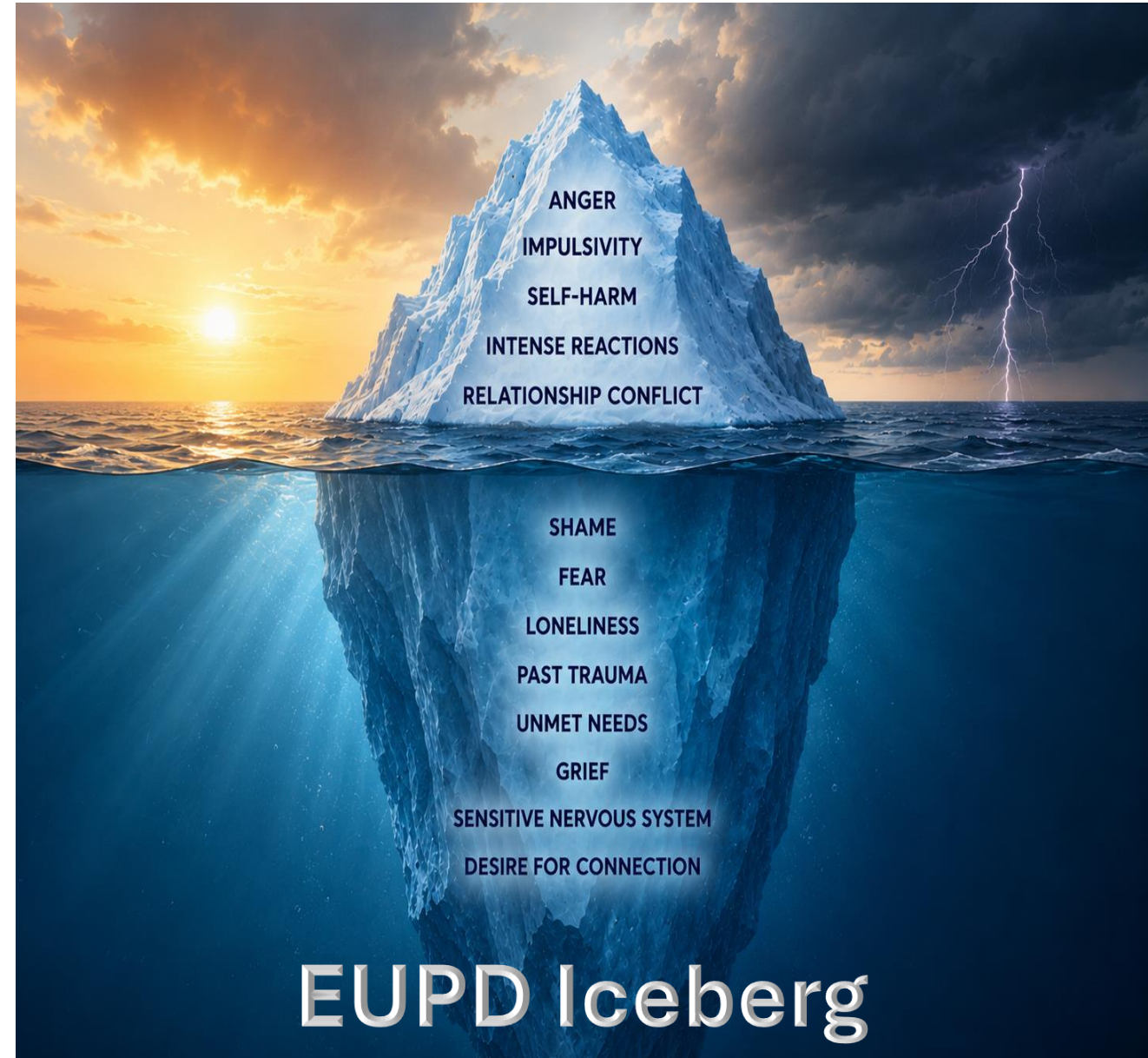


### SENSITIVE NERVOUS SYSTEM

Highly sensitive to stress, criticism and fear

# Personality Disorders and Suicide

- There is increased evidence of suicidality across almost all personality disorders.
- It is particularly associated with **Emotionally Unstable** (Borderline) **Personality Disorder** which has been studied more extensively than other PDs – so the research is uneven.
- Most individuals with EUPD experience suicidal thoughts at some point in their lives:
  - Approximately 50-75% make at least 1 suicide attempt
  - Around 5-10% die by suicide



# Autism Spectrum Disorder



# AUTISM SPECTRUM DISORDER (ASD)

WHAT HAS CHANGED, WHAT REMAINS, AND WHAT IS DISTINCT



## What has been subsumed into ASD

The diagnoses (labels) below are no longer used separately.



### AUTISTIC DISORDER

Previously used for individuals with clear autistic features across all domains.



### ASPERGER SYNDROME

Previously used for individuals with strong language and intelligence but social difficulties and restricted interests.



### PDD-NOS (PERVASIVE DEVELOPMENTAL DISORDER – NOT OTHERWISE SPECIFIED)

Previously used when someone showed some autistic traits but didn't meet full criteria.



### CHILDHOOD DISINTEGRATIVE DISORDER

Previously used for children who developed normally, then lost skills across multiple areas. Now included in ASD.

## What remains separate

The following are not considered part of ASD, although any of these may coexist with autism.



ADHD



INTELLECTUAL DISABILITY



DEVELOPMENTAL LANGUAGE DISORDER



SOCIAL (PRAGMATIC) COMMUNICATION DISORDER



SCHIZOID PERSONALITY DISORDER



SCHIZOTYPAL PERSONALITY DISORDER



SCHIZOPHRENIA



OCD (OBSESSIVE–COMPULSIVE DISORDER)

# Interview with Louise





**Let's talk  
about  
Meds**



Prof Joanna Moncrieff, psychiatrist, Professor of Critical and Social Psychiatry at University College London and the leading figure in the Critical Psychiatry Network





**Denise**  
**4 years later**



# In conclusion...

- ❖ Always: meet the person, not the label
- ❖ **See diagnosis as shorthand, not identity**
- ❖ **See personality difficulties as adaptations rather than flaws**
- ❖ **Consider phobias as learned attempts at safety**
- ❖ **Understand schizophrenia as lived experience rather than stereotyping**
- ❖ **Think CPTSD and trauma-informed assessment**
- ❖ Always: meet the person, not the label

# Key References

- **American Psychiatric Association (2022). *DSM-5-TR***
- **World Health Organization (2022). *ICD-11***
- **Herman, J. (2022). *Trauma and Recovery***
- Bateman & Fonagy (2019). *Mentalizing in Mental Health Practice*
- Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). *Suicidal behavior in borderline personality disorder: Prevalence, risk factors, prediction, and prevention*. *Journal of Personality Disorders*, 18(3), 226–239
- British Psychological Society (2017). *Understanding Psychosis and Schizophrenia*
- Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). *Maximizing exposure therapy: An inhibitory learning approach*. *Behaviour Research and Therapy*, 58, 10–23.
- Johnstone & Boyle (2018). *The Power Threat Meaning Framework*
- King, D. L., & Delfabbro, P. H. (2018). *Internet Gaming Disorder: Theory, Assessment, Treatment, and Prevention*. Academic Press.
- National Institute for Health and Care Excellence (NICE) Clinical Guidelines (current editions) Social Anxiety Disorder: Recognition, Assessment and Treatment (CG159) Anxiety Disorders Guidelines
- Soloff, P.H., & Chiappetta, L. (2019). *Prospective predictors of suicidal behavior in borderline personality disorder at 6-year follow-up*. *American Journal of Psychiatry*, 176(10), 832–840
- van der Kolk, B. (2015). *The Body Keeps the Score*



# Resources

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[PACT-RESOURCES.CO.UK](https://pact-resources.co.uk)

ORIGINAL & CREATIVE  
COUNSELLING RESOURCES



Understanding  
Burnout: Supporting  
Clients to Reconnect to  
Self  
with Katy Bodman

Friday 26<sup>th</sup> June  
9.30am-1.00pm  
via Zoom

[deeprelease.org.uk](http://deeprelease.org.uk)

*Counsellors Together*



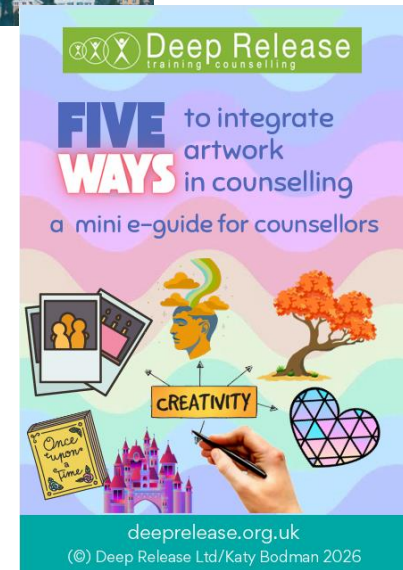
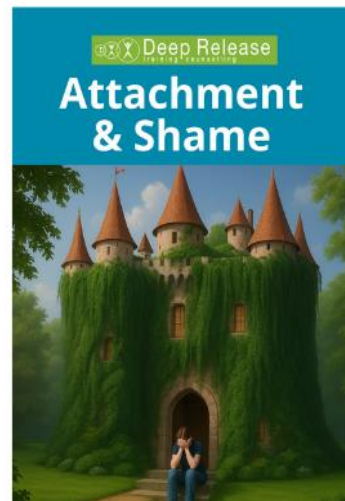
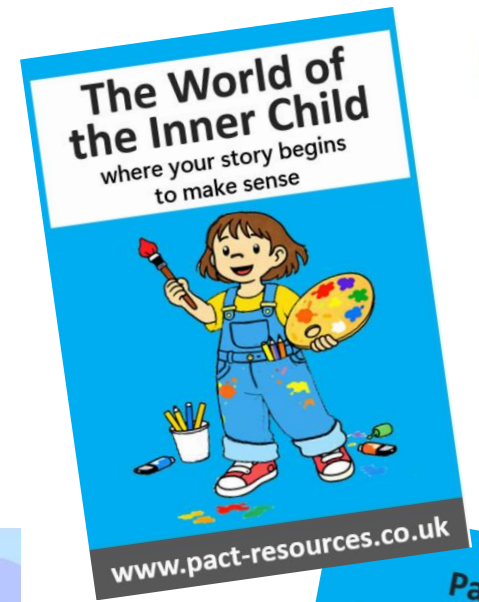
**WEEKEND**



**The Deep Release Counsellors  
Together Weekend**

**Friday 18<sup>th</sup>-Sunday 20<sup>th</sup> Sept  
Moor Hall, Cookham**

# What's new!

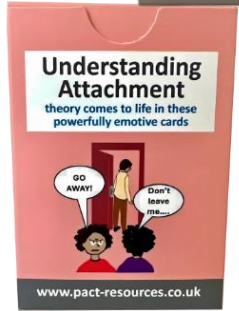


pact-resources.co.uk

# Cards



From  
£28.50

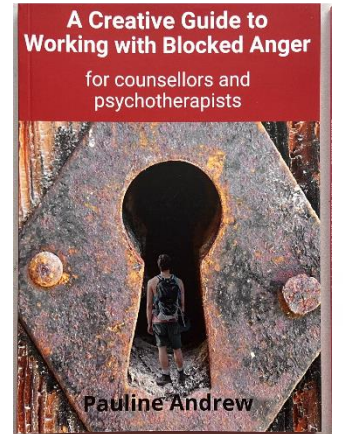
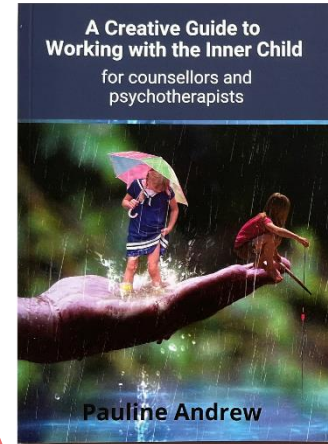
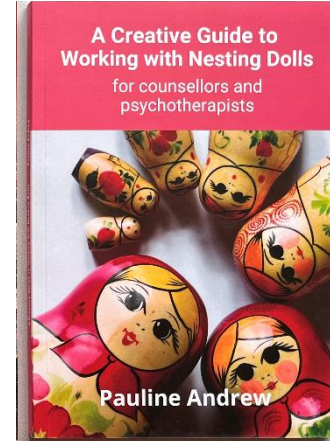


Extra Set A characters available!



# Books

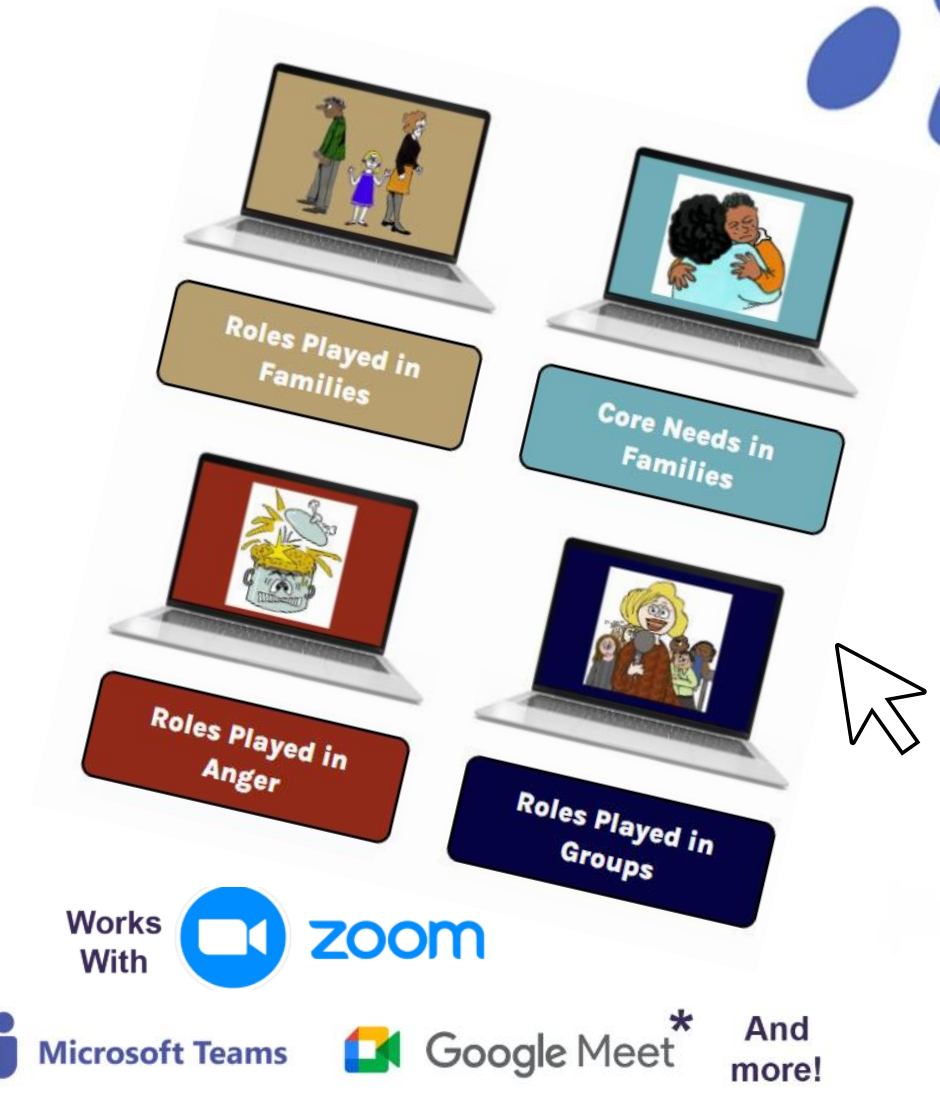
Also available on Kindle



£11.50  
each  
Or 3 for £32  
(save £2.50)

# Have you explored our Online WebApps?!

- Use Pauline's cards online!
- Working with Sand Trays
- Working with Nesting Dolls
- Free Erikson's Life Stages
- Free Wheel of Life
- Free Working with Stones



pact-resources-online.co.uk

# Expressing Difficult Emotions

when feelings are hard to put into words

a visual therapy tool



Who they are for?


- ✓ Adults
- ✓ Teenagers
- ✓ Clinical supervision

What counsellors say:

“Highly recommend, such a powerful resource.” – Caroline

“Freed up my supervisee’s reaction to their client in moments.”  
– Jacqueline

**HARD**  
**FEELINGS**

Explore the cards   
[hardfeelingscards.co.uk](http://hardfeelingscards.co.uk)



**Deep Release Ltd - Counselling & Training**



# Pauline Andrew Creative Counselling

Working with fairy tales in counselling



Choosing your Nesting Dolls



Working with aspects of self using nesting dolls



6 ways of working with plain nesting dolls in counselling



How to introduce creative interventions in counselling



How to paint and work with stones in counselling



How to work with animal figures in counselling



# Brain Body & Beyond

## Left and Right Brain



## The Top Down Brain



## Catch Up



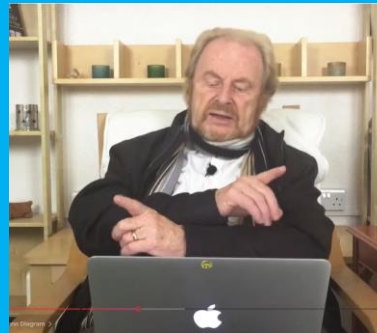
## The Left and Right Axes

Sciences  
Objective  
Prose  
Particular  
Analyse  
By the book  
Hardware  
Law  
Quantitative  
Zoom in

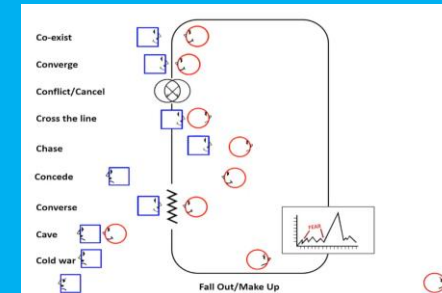


Arts  
Subjective  
Poetry  
General  
Synthesise  
Extemporise  
Software  
Liberty  
Qualitative  
Zoom out

## The Warzone



## Fixing Broken Relationships Part 1



## Fixing Broken Relationships Part 2



**Please send  
us your  
feedback!**



Thank you so much for joining us and supporting our work! If you have found the day helpful, please would like leave some feedback in the Deep Release Facebook group, or send us an email at [info@deeprelease.org.uk](mailto:info@deeprelease.org.uk). It would mean so much to us! 😊

**[info@deeprelease.org.uk](mailto:info@deeprelease.org.uk)**

[deeprelease.org.uk](http://deeprelease.org.uk)

[pact-resources.co.uk](http://pact-resources.co.uk)

*Thank you*