IRISH ASSOCIATION OF HUMANISTIC & INTEGRATIVE PSYCHOTHERAPY

“A Gathering of Psychotherapists.... 21 years on: Value and Values of Psychotherapy”
I was honoured to open the IAHIP Conference on the 18th October 2013. As part of the Conference Committee I had been involved in the hard work over the previous 10 months.

On the morning of the conference the presenters, facilitators, committee, Exploration through Dialogue Panel and administration staff all met for breakfast which was filled with an air of anticipation and excitement.

Upon reading through all of the presentations for the Booklet, I was struck by the depth and breadth of the material and also by the generosity of the authors. New and diverse research was presented which you will see in the Booklet.

IAHIP is delighted to be able to support and publish new and exciting research. We would also encourage regular future such gatherings in response to the requests from many of the conference attendees on the day. IAHIP would like to build on the momentum of the day and keep the interest in research going.

**Anne Colgan**

*Vice Chair IAHIP*
Foreword

Having enjoyed a very pleasant, productive and enriching association with IAHIP over the past number of years, I was recently invited to help in the publishing of a booklet, a compilation of papers as presented at the October, 2013 conference held in the Royal Marine Hotel, entitled ‘A Gathering of Psychotherapists…21 years on: Value and Values of Psychotherapy’.

Not having attended the conference I wasn’t immediately aware of the topic or the task at hand and I admit to being a little overwhelmed initially by the sheer volume of work in the collection. However, having spent many hours reading each paper, word by word, I came to appreciate the essence and nature of the writings as presented by the contributing authors: through their questioning, challenging, searching and probing, and ultimately, sharing, and I began to gain a better insight into the psychotherapist and their innate passion and desire to convey to us the importance of their findings in the complex and ever evolving, modern society that we live in today. All of this rich tapestry intertwined and played out against the backdrop of the IAHIP and the role that it too plays in communicating that knowledge not just for the betterment of those who need and require it but also among its members; it was a joy to experience.

I am not a member of IAHIP, I am not even a psychotherapist, but I do have a deep interest in the physical and mental well being of people. To say that I was moderately daunted by my initial collaborations with the Association is an understatement. But it did not take long to recognise that I was dealing with a most professional and accomplished team of people, a team whose passion and efficiency in delivering the issues, achievements, works and teachings of IAHIP in such a responsible manner, is astonishing. I would like to express my sincere gratitude to Ursula Somerville, Maire McAndrew, Dermod Moore, Kay Noonan and Jane Clancy, who have all been incredibly helpful and supportive.

The purpose of this conference was to highlight the progress that you, as psychotherapists, have made in the past 21 years. It allows you to refocus your mission and to take stock in the process of striving for betterment and understanding and to explore ways where your genuine beliefs and value systems can positively impact on the lives of others and I would like to take this opportunity to congratulate you on your work thus far and to wish you all continued success far into the future.

Ann Kilcoyne
Editor
IAHIP celebrated its 21st birthday in 2013 and to mark this occasion we held a Research Conference on the 18th October in the Royal Marine Hotel, Dun Laoghaire. The title of the conference was: “A Gathering of Psychotherapists....21 years on: Value and Values of Psychotherapy”.

This was both a Conference and a Celebration of a 21st coming of age of the Psychotherapy profession in Ireland and we gathered together (in the year of Gatherings) in an atmosphere of festivity and hope for the future.

The Conference was opened by Fergus Finlay, Chief Executive of Barnardos Children’s Charity. Fergus spoke about the mental health problems facing children in Ireland today. He also referred to the sense of hopelessness in Irish society in general. Fergus applauded the role of psychotherapy and believed that this was very valuable in helping people to cope, especially the children who use Barnardos’ services.

The opening speech was followed by a discussion on the Value and Values of Psychotherapy. This was led by the Exploring Through Dialogue Panel which was made up of an eclectic mix of people who were in some way involved in psychotherapy: Dr. Bill Shannon who had experienced being a client, Ed Boyne, a psychotherapy trainer, Isobel Mahon an actor and psychotherapist, Rhenda Sheedy an RTE producer and psychologist, and Gillian Demurtis who works in a GP practice and is a pre-accredited psychotherapist. All had 3 minutes to describe in differing ways their experience of psychotherapy and its value to society. Although the value and values of psychotherapy were by and large acknowledged to be useful and hopeful, this did not become just a collusive and self-congratulatory discussion. Some tough questions arose particularly around the safety of the therapeutic space and how this might be impacted if legislation around child protection were to be enacted in its proposed form. A bleak picture of our current society was acknowledged which gave us thought as to how we can continue to support people and one another as colleagues in difficult times.

Some of the papers and workshops reflected the realities and challenges facing not just Ireland but the global community in the 21st Century. Joan Sugrue’s research into Mothers affected by Suicide was swiftly picked up by the media prior to the Conference and created much interest. And there were other challenges: working with traumas as a consequence of war, understanding the difficulties of people who stammer, supporting those with Motor Neuron Disease, the difficulties faced by Interpreters who work with traumatized Asylum Seekers and whose presence in the room changes the therapeutic space from dyad to triad and all that goes with that; therapists were challenged on the issue of ‘race’ – we were asked the question ‘What is it like to be White?’

Other workshops reflected the diversity and creativity of the creative process through music, voice, spirituality and group dynamics. There was plenty of exploration and participation which was carried through the workshops and papers into lunch and right through the afternoon. Despite the dreadful weather outside there was a full turn out and plenty of warmth and sunshine within the hotel.

Kay Noonan
Conference Co-Ordinator
CONTENTS:

Giving A Voice To People Who Stammer: A Story Of ‘Insider’ Research Using Art of the Experience of Stammering and a Treatment Programme Called Free To Stutter...Free To Speak
James McCormack ................................................................. 5

The Influence of Gender Roles in Psychotherapy: Experiential & Ethical Dimensions
Brian Gillen .................................................................................. 11

Getting to Know Your Voice - An Experiential Workshop
Sarah Kay ..................................................................................... 17

Heterotopias of Healing? A Mixed Method Examination of the Impact of the Therapy Room on the Therapeutic Process
Louise Duggan ............................................................................ 19

Dependence, Independence and the Self: Maintaining a Separate Sense of Self Whilst in an Intimate Relationship
Deirdre Evans .............................................................................. 24

The Therapeutic Journey
Anne O’Connor ............................................................................ 30

Spirituality of the Psychotherapist
Colm O’Doherty ........................................................................... 36

What Impact Does Core Training Have on the Developing Psychotherapists’ Subsequent Professional Ethos?
Anne Burke................................................................................... 37

Reflections on Supervision Training: Significant Events Experienced by Supervisors in Training
Patricia Nannery .......................................................................... 41

Psychotherapy 2.0 the Approaching ‘Perfect Storm’
Karen Sugrue ............................................................................... 48

Artist in the Community (Musician) the Healing Power of Music
Anne Colgan ................................................................................ 54

Postnatal Depression, a Feminine Subject
Heather H. Gillin .......................................................................... 57

The Experiences of Mothers Bereaved by Suicide:
An Exploratory Study
Joan Sugrue .................................................................................... 63

A Phenomenological Exploration of Adult Adoptees Experience of Personal Achievement
John Phillips ................................................................................ 69

From Individual Psychotherapist to Group Conductor
Helen Jones .................................................................................. 75

Encountering Co-dependency and the Search for Self:
Ten Adults’ Experiences of an Intensive Treatment Centre
Charlotte Colchester ..................................................................... 77

When Words Are Not Enough: A Neurobiological Approach to the Value of Psychotherapy for Adults and Children with Intellectual Disabilities
Eimir McGrath .............................................................................. 85

A Psychodynamic Perspective on Staff Related Issues Observed in an Organisation Undergoing Change
Richard Sheehan .......................................................................... 91

An Exploration of the Witness in Core Process
Psychotherapy: its Significance and Function.
Patricia Chalmers ........................................................................ 98

Psychotherapy Integration in the 21st Century:
the Gains, the Losses and the Challenges
Gerry Myers ................................................................................ 104

Interpreters Working in Psychotherapy with Asylum Seekers: Vicarious Trauma and Vicarious Posttraumatic Growth
Alda Gomez .................................................................................. 109

Exploring the Experiences of White Irish Psychotherapists Working in Cross-racial Therapy Dyads
Miriam Lewis ............................................................................... 115

A Qualitative Study of Psychological and Psychotherapeutic Approaches for Motor Neurone Disease (MND) Patients
Mary Rabbitte .............................................................................. 121

4 A Gathering of Psychotherapists... 21 years on: Value and Values of Psychotherapy 2013
Giving a Voice to People who Stammer: A Story of ‘Insider’ Research Using Art of the Experience of Stammering and a Treatment Programme called Free To Stutter…Free To speak

by James McCormack

Introduction
This paper discusses a piece of research on the unique lived experience of three People who Stutter (PWS) and their experience of the Free To Stutter….Free To Speak (FTS….FTS) programme, a week long intensive programme for People Who Stutter (PWS) incorporating conventional speech therapy with a major component of narrative therapy. A critical Participatory Action Research methodology (Kemmis, 2010) was used with participants being recruited as ‘co-researchers’. The primary researcher, who is also a PWS, acted as an insider researcher making this a service-user-led piece of research. The research supervisor, or principal researcher Dr. Martina Carroll PhD, acted as the outsider researcher. Thus the research team consisted of two researchers and three co-researchers working in collaboration. Data was collected in a group interview followed by a group discussion that were videotaped and transcribed. Art was used by the co-researchers to aid in the free expression of personal experience. Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009) was used to analyse the data.

Co-researchers describe a problematic ‘stammerer’ identity, that exerts a controlling andominating effect on physical production of speech. However, the emotional struggle is greater – the feelings of shame, helplessness and fear of ‘social penalty’ (Quesal, 2010) that leads to avoidance of talking. Repetition of this predicament results in diminished expectations for their lives socially, educationally and occupationally. However, using their art pieces as a backdrop they describe a metamorphosis after attending the FTS….FTS programme in which co-researchers re-author an alternative identity that acknowledges the presence of stammering, but resists its dominance and control over their life choices.

Stuttering and stammering are used interchangeably in this paper.

A brief definition of stammering and will now be given together with some discussion on ‘what it is like to stammer’. A summary of the research method, Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) and its adaptation to incorporate art in this particular study is provided. The Free to Stutter….Free to Speak programme will be introduced along with an overview of Narrative Therapy (NT) and how it is used in the programme. A summary of the procedure used in the art workshop exercise follows.

What is stammering?
A definition of stammering from the Diagnostics Statics Manual IV (DSM IV) (www.psychtreatment.com) includes: ‘sound and syllable repetitions, sound prolongations, audible or silent blocking, words produced with an excess of physical tension, word substitutions to avoid problematic words’. What is missing from this definition is the experience of stuttering or ‘what it is like’ to stutter.

As a person (James) who knows first-hand what it’s like to stammer the research led me to many reflections on my own story. I don’t have many memories of stammering as a young child except sometime when older children or adults would imitate me. “JJJJames.” My response was to try to stop stammering. But I could not because stammering by its very nature is uncontrollable. After I began secondary school the mimicking and ridicule greatly increased and with it my anxiety about speaking situations. My stammer went from easy repetitions such as JJJJJJames to very difficult and tense blocks. Sometimes I felt unable to get my words out and would become quite breathless and exhausted.
I attended various speech therapy programmes up to aged 20 which helped me manage stammering to some degree. Thirty years later in 2009 I attend the FTS….FTS programme in which narrative therapy was used in conjunction with conventional speech therapy. I experienced how effective this combination was to help me change some of the unhelpful beliefs I held about myself. I also found that the art workshops on the programme were powerful for me to gain access to a huge ball of hurt about stammering that had been locked inside me for years. This was a life changing experience for me. The following year I began to facilitate on the FTS….FTS programme. It’s little wonder that my Masters research involved working with PWS including the FTS….FTS programme and art!

The ‘Insider’ researcher ‘empathy dilemma’

In my capacity as primary researcher I was already known to co-researchers from being a co-participant on the FTS programme or through my subsequent role as co-facilitator. A particular concern to me, my supervisor and the research ethics committee was regarding my role as an ‘insider’ and consequently my ability (or rather inability) to maintain objectivity during the research process. For this reason IPA was deemed a particularly good match for this study. A core feature of IPA is its striving to continuously make explicit or ‘fore-ground’ the researchers own experience and bias around the subject of research. IPA embraces the ‘humanness’ of the researcher and by necessity, his or her making sense of how a research participant is making sense of a phenomenon. This is inherently a researcher interpretation, i.e., an interpretation of the participants’ interpretations of their lived experiences, a second order account derived from IPA’s double hermeneutic method. However, the ‘checks and balances’ that are built into IPA methodology and the other measures taken by the researchers are an attempt to manage this personal interpretation thereby allowing the unique experience of the researcher participant to take centre stage.

IPA advocate that researchers who facilitate participants in deliberatelly controlled self-reflection will obtain rich data. What I did in preparation of my research interview was to ask three PWS who had been on the FTS programme to take time to consciously reflect on their experience of stammering and to represent this using art. They brought these art pieces to the research interview. This had the effect of co-researchers beginning immediately at the level of interpretation and meaning making which normally might come later in an interview. We laid the art out on a table and asked each co-researcher in turn to interpret their art, sometimes helped with prompt questions to elicit further elaboration. A subsequent group interview on the same day focused mainly on the FTS programme. As the analysis progressed it became apparent that using the art as a reflective canvas was in keeping with IPA’s focus on phenomenology, interpretation and personal meaning making and additionally served as an important ‘check and balance’ in that it helped to preserve each individual’s idiosyncratic story that is at risk of becoming diluted with the stories of others in group interviews (Smith, Flowers & Larkin, 2009).

Stigma began to emerge as a recurring theme. Stammering was not okay and was not acceptable in co-researchers’ lived worlds and therefore something to be stopped or avoided. Link and Phelan (2001) identify five recurring aspects of stigma: labelling, negative stereotyping, a separation of ‘us’ from ‘them’, discrimination and displacement of power. Stigma seemed to be at the root of the problem for these particular co-researchers in that our modern society appeared very intolerant of difference, which in this case is stammering.

Link & Phelan’s ‘Conceptualizing Stigma’ (2001) suggests a powerful argument why qualitative research into areas such as stuttering is a relatively recent development. Social science researchers who do not themselves belong to stigmatized groups tend to privilege perspectives that are uninformed by lived experience. Link & Phelan (2001) quote Schneider’s (1988) study of people with disabilities
that asserts that

*Most able-bodied experts ‘give priority to their scientific theories and research techniques rather than to the words and perceptions of the people they study’. The result is misunderstandings of the experience of the people who are stigmatized and the perpetuation of unsubstantiated assumptions.*

(Schneider, 1988: 365)

They highlight a tendency for stigmatized groups to be overlooked regarding funding for research and treatment. These factors can be generalised to stuttering. Quesal, (2010) a Speech & Language therapist, researcher and PWS himself highlights the difficulties that have arisen because of the acute difficulty a clinician who does not stutter will have with accurately empathising with the actual experience of the sometimes uncontrollable nature of stuttering.

This discussion is not suggesting that it is necessary to be an insider to do good research or work with PWS. However, it does seem to be singularly important for researchers and those working with PWS to have the ability to be deeply emphatic of the subject of their research (Quesal, 2010).

During the group interview co-researchers had a lot to say about the ‘chemistry in the room’ or what has been commonly described by others as ‘therapeutic relationship’ (Clarkson, 2003). It appears that the FTS programme provided a context in which the experience of stammering was de-constructed and then re-constructed in a way that changed the units of meaning the three co-researchers give to stammering. The narrative therapy concept of externalisation employed in the FTS programme of which the art sessions are an integral part, seemed to be a key component. Mary is now going to talk about her experience of working with the difficult problem of stammering including the problem of relapse from the perspective of a Speech and Language therapist and psychotherapist. She will also discuss some ideas from narrative therapy and its relation to art.

**Narrative Therapy & FTS...FTS**

Narrative therapy is a counselling approach developed in the 1980s by Michael White and David Epston. The authors presented their development of NT in the book *Narrative Means to Therapeutic Ends* (White & Epston, 1990) and since then, the ideas of NT have been developed, with further work being done at the Dulwich Centre in Adelaide, Australia, and other centres around the world. NT has been applied to stuttering therapy by various researchers and authors, including, for example: DiLollo, Neimeyer & Manning (2002), Leahy, O’Dwyer & Ryan (2012).

Free To Stutter….Free To Speak (FTS…FTS) is a six-day intensive residential therapy programme for PWS which has been provided within the HSE South since 2009. NT plays a central part in the programme, along with stuttering modification therapy and mindfulness as other major components. NT fits well with the aims of the programme to encourage openness and acceptance and to assist PWS to become confident, competent communicators as opposed to fluent speakers

NT reflects post-modernist thought, stressing that life is multi-storied. While clients e.g., people who stutter come to therapy with largely problem-based stories, a central premise of NT is that it is possible for people to re-author these stories so that they become less problem-based and more focused on strengths and resources. In developing the theoretical components of NT, White was influenced by the work of two French philosophers, Derrida and Foucault. Consequently, ideas about power and the deconstruction of normalising discourses regarding stuttering are embedded in the programme. Some of the processes involved in NT are known as externalisation, re-authoring, remembering and
definitional ceremonies. All are applied during the course of the FTS….FTS programme. While NT has a specific time each day during the programme, it is important to point out that the positions which the therapists take on problems are influenced by narrative ideas and that this permeates throughout the day and in all contact with clients.

NT views problems as separate from the people who have them and externalisation refers to conversations with clients where they are facilitated to see their problem in this way.

One of the most difficult and challenging aspects of stammering that we have noticed in our work is that stammering is rarely talked about both by the child or person who stammers and those in the person’s environment. It is there in the room as the proverbial pink elephant, with both parties for the most part doing their best to act as if it is not. Many people who stammer carry huge shame about stammering and consequently go to great lengths to hide it. As White states, they see themselves as the problem (White, 2007). And as James demonstrated earlier, their efforts to resolve the problem based on these understandings are precisely what exacerbate it.

Using art
Our experience is that many PWS are not only adept at avoiding speaking situations but also avoiding talking about their problems. PWS attending FTS….FTS are given the opportunity to represent their experience of stuttering using art. These art pieces then provide a context for narrative conversations. The art takes the focus off talking and allows people to access aspects of their stuttering that they have kept hidden for many years (Stewart & Brosh, 1997). It also facilitates the process of externalisation which can be difficult for PWS because they see stammering as something they have developed entirely on their own and independently of any external influences. One of the most difficult things for people who do not stammer to understand is the unpredictable and uncontrollable nature of stammering when it occurs. This leads parents and others to sometimes offer well-meaning but largely unhelpful advice such as "slow down", "relax" etc which all focus on the person who stammers being the problem. Beginning to view stuttering as separate from themselves can be difficult and art can play a key part in both visualizing it outside themselves and developing a rich description of their unique experience of stammering and the meanings they give to it.

People on the programme have found art to be a powerful experience which begins the important task of externalising the problem of stammering as something separate from themselves. Their experience of stammering begins to take a more tangible form and therefore becomes more open to accurate description.

Externalisation
Once the person begins to see the problem as separate to themselves, then they are no longer the problem. As White puts it: “the problem becomes the problem, not the person…The problem (which in this case is stammering) ceases to represent the “truth” about peoples identities, and options for successful problem resolution suddenly become visible and accessible” (White, 2007: 9).

This involves externalising the problem and allows for the development of agency. Some typical questions we might then ask in an externalisation conversation with a person who stutters are;

- Can you tell me a bit about P (the problem)?
- When did P first appear in your life?
- Is there a picture or image that describes the problem?
- Does the problem get in the way of ordinary everyday tasks?
- How does the problem get you to think about yourself?
Given some distance from the problem, the person can consider their position on the problem. There
are four components to externalisation conversations: Developing a rich description of the problem:
naming it, exploring the effects of the problem across the various domains of living, taking a position
on the problem and then justifying this position. Taking a position involves asking questions such as:

- Are you happy with the problem’s place in your life now or would you like it to expand or
  shrink or change in some way?
- Is this okay or not okay with you?
- What relationship would you like with the problem now?

Justifying this position links to the person’s hopes, dreams, values and ambitions. This involves linking
agency with meaning-making across time ranging from childhood to adult-hood and into the future.

**Re-authoring**

NT also takes the view that other more preferred stories co-exist alongside these problem stories but
which are ‘out of focus.’ Re-authoring is the process by which these preferred stories are identified
and developed. PWS are assisted to search for these other stories which run contrary to their dominant
stuttering story. We also use art to facilitate this process. Re-authoring conversations focus on the
development of alternative stories, the times and domains of life in which the problem is inactive or
only partially in control. For example, teenagers might report that stammering has no effect on them
whatsoever on the football pitch! The way into a re-authoring story is through the identification of
exceptions like these to the dominant problem-saturated narratives of peoples’ lives. Re-authoring
focuses on strengths and resources, as well as knowledge and skills already being employed by the
person to undermine the effects of the problem.

**Relapse**

"Relapse" is a core part of the experience of stuttering therapy particularly for programmes that focus
on fluency. This prompted us to include psychotherapy as a main component of our programme. This
provides a scaffold for clients to support changes and modifications they make in both how they speak
and how they view themselves and others in speaking situations. Because NT focuses on the
development of an alternative story, relapse becomes viewed in a different way and is part of a multi-
storied life and just one story line within it. This counteracts the view of relapse as failure. Instead,
through the meaning making which is central to narrative therapy, relapse can be externalised and
explored not as personal failure but as a problem separate to the person. This facilitates so-called
‘relapse’ to be powerfully exploited and contribute to the person knowing what their next steps
entail.

**Art exercise**

Participants of the workshop will be facilitated in an art exercise. The exercise will draw on ideas for
therapeutic art by Ferrucci (2004) and situated within the context of NT. They will be provided with
crayons and a sheet of paper divided into 4 quadrants representing the 4 components of externalising
conversations already described. However, as this is a training exercise and not a therapy session,
participants are not being asked to use art to represent a problem, nor will they be asked to discuss
their art piece once completed. However, they will be asked to use art to represent a recent action or
decision they have made that they were pleased about, or that went well. Approximately 3 minutes
will be given to complete a drawing on each quadrant. Participants will be reminded that this exercise
is absolutely NOT about producing a nice piece of artwork, and that in fact it might look like a
complete mess – or it might look rather splendid! The important thing is that it represents something
of their experience using colours, shapes, figures or whatever they choose. Some of the co-researchers
artwork from the research will be on display as examples and to assure participants of the workshop that ‘anything goes’.

Participants will first be invited to participate in a brief relaxation exercise after which they will go straight into the art exercise beginning with a focus on quadrant number 1. People will be asked to keep their eyes closed at this point (if they feel comfortable to do so or otherwise to cast their gaze down). A few short prompt questions will be asked by facilitators. Participants will be asked to consider these questions, and as they do, to allow images, pictures or ideas to arise in their minds that they can represent using colours or shapes in any way they like, whether abstract or concrete. They will be asked to work quickly, not thinking too much about it, and to work in silence out of respect for others. This procedure will be repeated for each of the 4 quadrants. Finally they will be asked to add some words to their drawings if they so choose. A brief discussion will follow on workshop participants’ experience of doing the art exercise.

References:
The Influence of Gender Roles in Psychotherapy: Experiential & Ethical Dimensions
by Brian Gillen

The times are changing. Change may be occurring too quickly for some, but change is not occurring quickly enough for many women and men, limited by their gender roles to less than full lives.

(Jacklin, 1989)

Introduction
The workshop explored how masculine and feminine gender roles and identification, for both client and therapist, can influence the therapeutic process. Therapists who are aware of their predisposed attitudes and beliefs regarding their own sex, the gender roles they occupy, and that of their client/s, will tend to better identify, assimilate and deal with related transference issues in the therapeutic relationship. In ethical terms, it is vital for the autonomy of the client and fairness in the therapeutic relationship that differences in gender roles do not overpower or distort congruence, empathy and mutual respect in a psychodynamic and integrative process.

What are gender roles?
Gender roles (often referred to as societal gender roles) are behaviours, expectations, and roles defined by society as masculine or feminine, which are embodied in the behaviour of the individual (Basow, 1986). In this context, it is important to separate out gender/sex roles as a socialized, learned and cultural phenomenon, as distinct from a biological one, which defines people as male or female depending on their organs and genes.

Gender role socialization is the process by which people in a culture or society are taught about, and adopt, gender roles. The degree to which a person identifies with or displays this societally defined masculine or feminine behaviour we call Gender role identity (Ibid, 1986). Gender role conflict describes the detrimental consequences of gender roles either for the person holding them or for those associated with this person (O’Neil, 1986). For example, this conflict may occur when the individual’s personal needs are at odds with what is considered the gender role norm in society, e.g. ‘boys don’t cry’, is an often quoted societal norm that can create restrictive emotionality in males, however the felt emotional need or response of ‘crying’ may often be crucially important for men.

In the therapy room, we cannot deal with the client in a vacuum; they come to us with their gender role identity and influences, and indeed we join them there with ours. Knowing what kinds of gender role issues might potentially influence or restrict us in therapy work is important if we wish to maintain congruence with clients and develop in the therapeutic relationship.

During the IAHIP Conference Workshop (October 2013) the following questions were asked and explored:
1. What does your gender identity i.e. being male/female, mean to you?
2. How does being male/female affect you as a therapist?

Evidence of gender roles in therapy

The ability to conduct psychotherapy effectively...is becoming increasingly relevant and is recognised to be important in addressing inequalities, which may also be patterned by differences in age, gender, class and sexual orientation

(Bhui & Morgan, 2007)
Male Clients

When dealing with male clients we need to be cognizant of how males in general are socialized in society and culture. As Gilbert (1987) observes, men are socialized to be emotionally inhibited, assertive, powerful, independent, and to equate sexuality with intimacy, manliness, and self-esteem. Furthermore, it is helpful to note how such qualities may influence participation in therapy: Given their socialization, men often do not seek therapy (it invokes fear for them) and, when they do, according to research, they are often fearful of disclosing, or quite unaware of their feelings (Carlson, 1987). Other evidence suggests that men express less affect in therapy than do women, are more prone to fidgeting and averted eye contact, and that their communication style can be different to female clients. For example, male client interactions have been seen to contain a higher percentage of ‘client one-up’ communication patterns and high rates of ‘rapid fire’ questions and answers (Heatherington & Allen, 1984). One common conclusion is that this may reduce threats to self-esteem given the potential power imbalance in the counselling situation.

Where a conflict exists in male gender identity, the impact in therapy can be more evident. As mentioned previously, Gender Role Conflict (GRC) is defined as a psychological state in which socialized gender roles have negative consequences for the individual or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self (O’Neil, 1982). There are four main aspects to MGRC, namely:

1. Success, Power and Competition issues (SPC);
2. Restrictive Emotionality (RE);
3. Restrictive Affectionate Behavior Between Men (RABBM); and

Of concern to us here, is the way in which these issues and dispositions influence the process of therapy. Male therapists may find it difficult to show concern and caring to male clients in cases where the client’s restrictive emotionality both discourages empathy, and cannot accept compassion. Where both client and therapist experience a significant degree of RE or RABBM, the disconnect may be more prominent. For example, a male client may feel terrified of his warm and perhaps dependent feelings towards the therapist (Ipsaro, 1986). Male clients may also feel shame and embarrassment in revealing feelings because of their gender role conflict.

My own master’s research thesis (2012) on the influence of Male Gender Role Conflict (MGRC) in therapy reinforces some of the previous evidence in the field. Based on a series of qualitative interviews with Irish male therapists, the experience of strong emotions with clients in therapy in certain circumstances could negatively impact therapists and cause or exacerbate emotional restrictiveness; masculine ideology and identity could be threatened by a fear of the feminine and this was reflected in client preference and experience; control and power issues, not unlike SPC above, were seen to be prevalent in therapy between male clients and male therapists; MGRC was related to the experience of failure in therapy, and this sense of failure could spill over from the professional into the personal; overall, the potential incongruence between masculine norms (in society and culture) and psychotherapy practise were highlighted.

Female Clients

Somewhat conversely to their male counterparts, women are socialized to be more “emotional, nurturant, and to direct their achievement through affiliation with others” (Gilbert, 1987). Much has been written about ‘the feminine mystique’, and how women tend to be much more open and affectively oriented than men with regards to feelings and how they express themselves. Society and
culture makes more allowance for this and actively encourages, and indeed expects such behaviour associated with female gender roles.

It’s probably no surprise then that women are much more likely to seek therapy, given its emphasis on uncovering feelings and an openness to trusting the other in the process. Collier (1982) concurs with this, finding that “help-seeking and inter-dependence are more familiar to the socialisation of women than men”. Within therapy itself, in one significant study, female client interactions were seen to contain a higher percentage of communication patterns that were “control neutral”, i.e. less motivation to be in control or be powerful (Heatherington & Allen, 1984), and this is in marked contrast to what has been observed with male clients in therapy.

Since the 1980’s, the preference of female clients for a male therapist has changed in favour of female therapists. This may be in part due to the fact that many more women became engaged in the therapy profession from this time, but there are other reasons too. Due to similar socialisation, emotional intensity and empathy experienced between a female client and a female therapist may be heightened (Jones & Zoppel, 1982). This may be particularly so depending on the intensity of experiences shared in therapy, including more emotional pain, anger at the therapist, discussion of difficult childhood experiences and interpersonal relationships (Ibid, 1982). In the past twenty years however, therapy between a female therapist and a male or female client represents the most typical care-giving patterns in our culture, and a reversal of more typical power dynamics. Male clients tend to prefer a female therapist because of their association with care giving (Heppner & Gonzales, 1987), however it may also be uncomfortable for men to enter therapy and abdicate a degree of power to a woman. Power issues may be evidenced by client behaviours such as disagreement with therapist interpretations, or an inability to go deeper in the therapeutic process for fear of losing control of the situation.

Ethical Considerations
Some key ethical maxims underpin why understanding gender roles will not only support and enhance the therapeutic process, but form a necessary foundation for good therapy. For the purposes of this paper we will refer to three such ethical considerations, namely Autonomy, Justice and Non-Malificence. According to Beauchamp & Childress (2009), Autonomy promotes the maximum degree of choice for the client whereby the therapist must facilitate the client’s best understanding of the implications of their choices and in doing so, not harm others. Decisions and choices made by the client need to be understood within the context of their gender role. These choices do not occur in isolation from their social conditioning, and may often be motivated by it. Choices and decisions are neither straightforward nor black and white, but contain a plethora of societal and cultural beliefs and influences.

Justice, as outlined by Beauchamp & Childress (2009) promotes the client’s right to be treated with fairness. Fairness and equanimity involve the therapist having an appreciation of the client’s point of view, as well as their own. For example, where the sex of both client and therapist is different, the therapist must be able to identify how their own gender role might clash with that of their client. Finally, Non-Malificence is an ethical standard that promotes the right of clients to be protected from harm (Beauchamp & Childress, 2009). As outlined above, power and control issues can become manifest in the therapy room, particularly where strong gender role conflict is present. If either therapist or client for example, has a strong need for control or dominance but is not connected with this issue, he or she may engage in power play behaviour both consciously and unconsciously. For the therapist especially, this type of feeling, and related behaviours, may disempower the client or encourage re-enactment of past traumas or difficult experiences.
Both IACP and IAHIP codes of Ethics contain within them implicit and explicit mention of gender roles and the importance of understanding societal and cultural influences on the client. The IACP Code of Practice describes how having regard to this wider context constitutes a professional service (2.0); it also espouses ‘having sensible regard for clients’ beliefs and values’ (1.1.1); and how therapy can become diminished without a clear appreciation of ‘factors such as gender, sexual orientation, disability, religion, race, ethnicity, age, national origin, party politics, social standing or class’ (1.1.2). Finally, the code speaks of ‘conveying sensible respect for prevailing community mores, social customs and cultural expectations (1.1.3).

Likewise the IAHIP Code of Practice espouses that, ‘therapy not exist in social isolation’ (3.3). For this reason psychotherapist’s responsibilities to the client, to themselves, to colleagues and to members of the wider community are implicit throughout its code of ethics. It continues, ‘IAHIP may represent the social and political concerns of its members and the manner in which social issues may impact upon clients and wider culture’.

So how do we as therapists, put all of this into practice? How can we ensure a sensible yet sensitive awareness of the influence of gender roles in the therapy room, and try to maintain good ethical standards with our clients? Gender Aware Therapy may hold the answer to this question.

**Gender Aware Therapy (GAT)**

GAT is a synthesis of gender studies and feminist therapy into the principles of counselling. GAT encourages therapists to facilitate the development of women and men through exploration of their unique gender-related experiences (Good *et al.*, 1990). It consists of some key ethical principles, not dissimilar from many of those noted earlier. They include:

1. A non-sexist approach to therapy work;
2. Consideration of the socio-cultural context of case issues (‘personal is political’);
3. Actively seeking to change gender injustices experienced by both sexes;
4. Emphasizing the development of collaborative egalitarian therapeutic relationships;
5. Respecting clients’ freedom to choose.

GAT principles can be integrated into all therapies, and at similarly typical stages of therapy, placing particular focus on the influence of social forms, customs and structures on the individual’s development. For example, during the initial assessment phase of therapy, where the therapist is trying to understand the client’s presenting issues, the therapist might seek to understand what aspects of gender socialisation might play a part in the client’s concerns and problems. Or later, during the therapeutic process, the therapist may introduce the client to emerging views of gender and socialisation, and how their own development may have been affected. This can be done by way of discussion, support, clarification, confrontation, interpretation, information offering, guided fantasy, experimentation, modelling, self-disclosure, or exploring family history.

**Case Studies**

During the IAHIP Conference Workshop, I made use of two case studies with the group for the purposes of exploring typical scenarios where GAT might apply or be used. A brief summary of the themes and outcomes from the workshop is included with both case studies below:

**A.** You are seeing an adult client (30 yrs) who has a six-month-old child. He/she is seeking assistance with his/her conflict in combining a professional job with their family/parenting role. The job entails that he/she doesn’t arrive home some evenings until eight or nine, and sometimes project work requires going in on a Saturday. He/she says that being away from the child can sometimes make them feel...
guilty and that he/she is missing out on precious moments. His/her partner is available to take care of
the child at these times, however that involves them putting their own career plans on hold.

1. How would you approach this issue with a female client?
2. How would you approach this issue with a male client?
3. Are there any differences in each approach?
4. Do you feel your gender role has influenced your approach in any way?

Summary of possible GAT responses:
Female Client: Neglecting to actively explore both the benefits and liabilities of sacrificing her career
to assume childcare responsibilities might mean abandoning the client to the pervasive societal
pressures urging her to leave her career.

Male Client: Therapist should not assume that a man in a dual career relationship would not want
to consider being the primary caretaker of the child

You are seeing an adult client (40 yrs) who was sexually abused by their uncle on a number of
occasions, one summer, at the age of 11. He/she has only started to talk about it now for the first time,
but says he/she has often had nightmares associated with it, and feels it has caused problems in adult
relationships, particularly with their current partner. They often experience anxiety, bouts of depression,
and anger, and he/she thinks these feelings are related to the abuse.

1. How would you approach this issue with a female client?
2. How would you approach this issue with a male client?
3. Are there any differences in each approach?
4. Do you feel your gender role has influenced your approach in any way?

Summary of possible GAT responses:
Male Client: Issues for a male client will include: Being in control; shame at having been overpowered.

Female Client: Issues for a female client will include: shame lest she be seen as seductress or
blameworthy.

Work with client to facilitate understanding of how he/she may have internalised stereotypic views of
maleness/femaleness and help them to realise that as a child they couldn’t be responsible for causing
or preventing the act.

Conclusion
Both theory & research indicate that gender roles exert an influence on how clients and therapists
communicate and relate together in therapy, both positively and negatively. Just as it is important to
understand the complex psyche, personal attitudes and acquired behaviours of the client, it is necessary
that we also understand the socio-cultural context from whence they come to therapy, none more so
than gender norms and roles. Therapists require a good working knowledge and awareness of gender
differences and roles for effective, non-sexist therapeutic practice. They also need to engage in self-
examination and supervision in order to avoid ‘doing gender’ following traditional gender
ideas/interpretations in therapy (Gilbert & Scher, 1999).

A greater awareness of each clients’ gender role will help us move from purely binary descriptions
and categorization of human experience i.e. masculine/feminine, maternal/paternal, homosexual/
heterosexual, to a more balanced and integrated approach. The integration of gender informed
counselling theories such as Gender Aware Therapy (GAT) is one way of doing this, and ensuring that our work as therapists has a solid ethical footing. It will ultimately lead us away from male bias in mainstream theories and practice, to an enhanced relation between the sexes and within the psychotherapeutic relationship (Maguire, 2004).

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References:
Getting to Know Your Voice - An Experiential Workshop
by Sarah Kay

This workshop arose organically many years ago and remains a work in progress as it develops along with continuing awareness, changes gone through and learning gained in a shared experience with the participants. An experiential workshop like this can only be researched anecdotally and subjectively through the direct experience of the people involved.

Increasingly, although slowly, the institutions of higher learning are becoming more open to a right-brained educational approach: an approach based on feminine (as in the Jungian – anima) principles such as diversity, inclusivity, process, paradox and presence in the here and now, which would include creative approaches and which respects direct experience as an alternative to the more conventional left-brained, linear, evidence-based methodologies employed by academics.

Little did I know when I was studying drama and the voice arts how close a relationship there is between drama and therapy so the slide through drama teacher to therapist seemed a natural process. I was unconsciously drawn to Gestalt therapy because some of the techniques incorporated by Fritz Perls were drawn from Dr. Jacob L. Moreno’s use of psychodrama, particularly what is known as ‘spontaneity-creativity,’ where people are encouraged to improvise in the here and now. This is a great way to work as improvisation bypasses the censor.

One of the big challenges in psychotherapy is becoming acquainted with our censors, many firmly embedded in our musculature and nervous systems as a consequence of early childhood experiences including trauma. The next challenge is to find creative and compassionate ways of unlocking these often conflicting energies held in the body and the psyche that keep the authentic self trapped or buried.

The release of sound is both challenging and sensitive. It is not by accident that we get the word ‘personality’ derived from the Latin ‘per sona’ meaning ‘from sound’. Our personality or sense of self grows in confidence and in the ability to express ourselves as we develop our sound, for each one of us has a unique voiceprint as well as a fingerprint. To experience sound fully is profound – it grounds us in our being, it develops confidence and a sense of feeling comfortable in our own skin, it allows us to speak up and speak out, and to make music; from resonating chants through operatic heights to the depths of soul music. To resonate with sound is to connect with emotions and for these emotions to naturally flow they must be released without censor and the voice in free flow will reflect those emotions. You can tell a person’s mood not just by watching their body language but by also listening to the tone of their voice: a flat monotone may signify depression, a fast pace and shrill pitch anxiety, a ‘thin’ voice trapped sexual energy, a voice struggling through gritted teeth and tight jaw, anger, and so on.

Sound is also connected to spiritual practice, be it through chanting, singing and preaching. Out of the deep I call refers to the power of the ‘silent’ voice when sound can be deeply accessed within and felt at a vibrational level. People have also experienced the hearing of voices and this is an area that needs further exploration. We already accept that we have many ‘voices’ in our heads and some of them have different and/or conflicting personas. Paradoxically many of these ‘voices’ remain frozen in our musculature and yet get played out like stuck records in our heads. The musculature needs to be gradually defrosted and the person encouraged to speak.

The tragedy is how many of us have kept our authentic voice under wraps. Not only have the negative introjections become ingrained in our bodies but our creative potential has also been subsumed. Some of these negative experiences include being humiliated as a child either at home or in school when
speaking out. Constant criticism of one’s speech and opinions may paralyze the speaker and in extreme cases cause the person to stammer or become mute. Many people were told to ‘be good is to be silent’. Fear of failure, of making mistakes, of being judged may become chronic responses when asked to speak causing the speaker horrendous anxiety with many physical symptoms similar to those of a panic attack. It is not surprising that fear of speaking in public is ranked very high in the phobia stakes.

Around the age of two, a child will be starting to shape sound so it is a critical time for this inbuilt natural instrument of communication and music to be encouraged to develop fully. We often joke that the first word a child says quite definitively is “No” and usually with force. This is a positive development. The child is defining itself as a person in its own right. It will then be encouraged to say “Yes” definitively thus creating a boundary between ‘want’ and ‘not-want.’ If this development is disrupted, as it so often is by authority figures, the authentic self will be squashed and in its place a ‘persona’ or ‘false self’ will emerge: ‘personas’ were the masks worn by actors in Roman comedies and tragedies to represent a stereotype – the clown, the scoundrel, the heroine, what we would now call ‘role players’ in family systems. Our ‘personas’ are often people pleasers, rebels, or victims.

Learning to use our voice is like learning to play any musical instrument – it requires practice, discipline, nurture and encouragement. To speak up is to be vulnerable. Every time we hear our sound, we experience the breaking of the sound barrier, which focuses attention on the speaker so we need to get accustomed to hearing our voice to avoid developing pre-stage anxiety or public speaking nerves. It’s not hard to imagine the damage done by teasing or bullying or to understand how a child picked on in front of the class and told that they are singing out of tune feels. Traumas and negative comments may set up chronic defensive and stubborn patterns in the body consisting of energy blockages and suppressed emotions. Habits and patterns are hard to change but they can change in the right environment. In my experience in a safe and nurturing environment, people have found their potential to speak up, recite poetry and sing.

This workshop starts by identifying the blocks held in the body that inhibit the voice and then gradually works through them using mime, movement, poetry, choral speech and song. Of course, this is just an introduction to a process of what is possible. Process requires patience, hard work and practice along with encouragement. Getting to know your voice is getting to know your true self and that can be empowering, liberating, enjoyable and satisfying.

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Bibliography:

by Louise Duggan

we do not live in a homogeneous and empty space, but on the contrary in a space thoroughly imbued with quantities and perhaps thoroughly fantasmatic as well. The space of our primary perception, the space of our dreams and that of our passions that seem intrinsic: there is a light, ethereal, transparent space, or again a dark, rough, encumbered space; a space from above, of summits, or on the contrary a space from below of mud; or again a space that can be flowing like sparkling water; or space that is fixed, congealed, like stone or crystal. Yet these analyses, while fundamental for reflection in our time, primarily concern internal space…

...I should like to speak now of external space. The space in which we live, which draws us out of ourselves, in which the erosion of our lives, our time and our history occurs, the space that claws and gnaws at us, is also, in itself, a heterogeneous space. In other words, we do not live in a kind of void, inside of which we could place individuals and things. We do not live inside a void that could be colored with diverse shades of light, we live inside a set of relations that delineates sites which are irreducible to one another and absolutely not superimposable on one another.

Michel Foucault (1986), Of other spaces. Diacritics, 16: 22-27

Introduction

Although research has documented the influence of the physical environment on well-being, particularly for healthcare settings, there are currently no official best practice guidelines on the design of the psychotherapeutic space. This research employed a mixed method approach to explore the impact of the environment on the therapeutic process. For the purpose of this article the focus will be the qualitative results of the research. Four interviews were conducted in order to investigate the therapist’s experience of the space. The interviews were a means of reporting, using a phenomenological method of enquiry, on the interviewer’s experience of each setting in order to gain a richer understanding of the therapeutic dynamic from a client perspective. This extract will focus on the phenomenological experience of two of the therapeutic spaces in order to illustrate how clients could potentially experience the space. The participating therapists, for the purposes of this article, are identified as Ken and Stephen.

The Emerging Self of the Therapist

In listening to the therapists describe their spaces I was granted glimpses of their personalities. Their spaces revealed their interests and aspects of themselves that they chose to share. I learnt that each had an interest in something outside of psychotherapy that they were very much engaged with, whether it was nature, animals, literature or theatre. These interests were illustrated by the objects selected and placed in their therapeutic spaces. I felt energised by witnessing the therapist’s interest in the world around them and felt this demonstrated their continued growth towards self-actualisation. It also communicated to me that these therapists were not ‘jaded’ or ‘burnt out’ as they were still exploring. I wondered if this was also felt by their clients and if it (unconsciously) added vitality to the therapeutic work. Perhaps it is inevitable that our working environment can be an expression of our growth, changing as we change. With long term clients especially, perhaps it’s exciting to see therapists still developing as people and exploring the world around them. Skovholt (2012) asserts that a strong sense of self can lend stability and energy to the therapist’s evolving professional identity. Ronnestad & Skovholt (2013) believe the integration of the personal self into a coherent professional self is a fundamental developmental task of the therapist's practice. McConnaughy (1987) asserts that the
therapist’s enthusiasm for personal growth is conveyed to the client therefore influencing the client’s movement toward positive change. Eskin (2013) discusses the importance of personal identity and how it can strengthen the therapist’s efficacy and contribution to the therapeutic relationship. He asserts that self aware psychotherapists are more conscious of their strengths, weaknesses and boundaries. He advocates psycho education and believes that psychotherapists can use themselves as role models. Eskin points out that many clients are coming to psychotherapy as they feel exhausted by life. He argues that a therapist without passion for their own life cannot be effective in helping the client tap into theirs. He recommends therapists always remain open to self discovery, Eskin (2013), “effective therapists have the tendency to discover themselves… psychotherapists should be ready to discover themselves over and over again”. (Eskin, 2013: 114)

Buddha’s and Butterflies: Therapeutic Space 1
Ken’s office looked to me like an Aladdin’s cave, containing an eclectic mix of treasures. Sandalwood incense burnt on a sideboard that was home to dozens of Buddha figurines and beeswax candles. An ornamental butterfly hung from a lampshade, a large glass hawk sat on a table beside the therapist. There were many books and paintings and professional certificates on the wall. I was very aware that I was entering into another’s space. As Ken talked me through the set up of his therapeutic space, I wondered if he had a preference to keep things suspended in time. There were candles he didn’t want to burn because they were so beautiful, the collection of objects, gifts and books that he didn’t want to part with as he saw them as ‘old friends’ and the mats he placed on the carpet underneath his and the client’s feet to ensure the carpet wouldn't get worn. I wondered if this preference for collection and keeping things untouched ever unconsciously played out in the therapeutic encounter. I found myself wondering what would happen if the candles were lit until they disappeared and if the mats were lifted and taken away - what would this reveal? I wondered what it would be like if all the figurines vanished - what would be left? I was struck by the number of objects in the room that had been given to the therapist as gifts from clients and supervisees. I imagined myself giving a gift to the therapist if I were his client. I wondered would I feel an unconscious expectation to give one and whether I would be competitive in selecting a gift. Perhaps I would want to choose a gift that I feel stood out more, one that is 'better' than the others. I wondered where my hypothetical gift might be placed in the room and if it would be placed according to its value. I wondered about the other clients and perhaps felt some envy/curiosity about the client who had given the butterfly. I imagined that client had undergone a metamorphosis and had reached great heights becoming free from needing therapy. I then questioned where I was in my own process, trying to calculate how I measured up in comparison. Because of the gifts in the office, I was acutely aware that I was not the only person that visited that space, I felt aware of my ordinariness. Some of the questions I left with included; how could I express myself in this already expressive room, is there room for me to express myself, where do I fit in this space? Would experiencing the therapist express himself encourage me to do the same or would it overpower and silence me?

Co-Creating Space
Once boundaries have been established, it appears that clients become more active in exploring their environment using the therapist as a secure base. It seems that different elements come into the foreground while others recede into the background. Like Ken's supervisee who noticed the large glass hawk for the first time after a year of supervision. The supervisee asked Ken what the ‘angel’ figurine was beside him. Ken took the opportunity to work with his supervisee's observation and bring it into the therapeutic work. Mac Kewn (2004) asserts that people are constantly changing their perspective of the field as they organise and understand it differently according to their needs, interests and prevailing conditions. According to Houston (2003), Gestalt therapy seeks to develop livelier contact between subject and environment, whether that environment is human or other. Mann (2010) believes
that the process of figure formation is of interest as it is an indicator of how an individual makes sense of their world. Mann asserts that a healthy figure formation is a fluid process that updates in response to changing situations. There is creativity in working with immediacy as Ken described. Being in the here and now with the client and being attentive to their observations can take the therapeutic work out of the narrative into a space of self-exploration for the client. Reality becomes somewhat suspended and the client is able to 'play'. Winnicott (1971) saw play as the creative aspect of all human activity and therefore also the essential element in analysis.

It was interesting to learn that there were objects either brought or made by clients that had gone on to become permanent fixtures in Ken and Stephen’s therapeutic spaces. Ken had been given a gift of a butterfly figurine from one of his clients which he attached to the lampshade on his ceiling. A symbol of metamorphosis, it could be said that the client was projecting their hope for change onto the object. The fact that the client gave this as a gift towards the end of their therapy suggests they felt they had made the transformation. It also implies that they wanted to leave something of themselves in the space, perhaps to ensure they would not be forgotten by the therapist. Was the gift a result of an unconscious communication between client and therapist about letting go? Does it help both in some way to know that the work together has been eternalised, a reassurance they would not be forgotten? Do clients become fragments of the therapists’ self, interwoven into the tapestry of our psyche? It is interesting to consider what clients leave with you, how they add to you as a person and to your practice. Stephen discussed how he had once made a therapeutic intervention by asking a client if he could keep and display a painting they had created. The painting which had been created by the client and been left discarded and lying around in the clinic. The client had an opportunity to experience having a value placed on something they had created. Perhaps this offered the client a sense of validation - that they had something unique to offer - and a sense of having being seen by the therapist and by others who would spend time in that space.

**Methadone and Munch: Therapeutic Space 2**

Stephen’s office was in a public sector hospital setting; his clients are primarily people with substance addiction issues and are frequently on methadone. The room is very small and cramped. It is a dual purpose space an office and a therapeutic space. There are two chairs, a desk, a sink, a wardrobe and shelving for books and files. It is noisy with vibrations from the traffic outside. There are cracks in the wall and a broken light fixture. There are small postcard type images on the otherwise bare walls. There is very little physical space between client and therapist. There wasn’t anything ‘nice’ or ‘calm’ about this space. It felt cramped and grim with rattling windows and cracks in the walls. Privacy and confidentiality seemed compromised when the interview was interrupted by a staff member asking the therapist to switch the tap on. (As the therapist had previously explained, the taps need to be run for five minutes every day to treat the legionnaires disease in the water). This experience seemed to add a sense of chaos and intensity to the space. Even though there was minimal artwork in the room it made an impression. There was a small print of Munch’s 'Scream' directly in my eye line. The image was sobering and I wondered if his clients, who were primarily coming with addiction problems, also experienced it as such. The strangled silent scream and wide frantic eyes of the Scream made me think of the terror of being trapped inside yourself while no one else can see what’s happening for you. It was evocative, I wanted to look at it (the image) but I also wanted to block it out, perhaps this in itself conveys to clients that their silent screams can be heard here. Sitting in the space with this particular art piece, while grim, gave me the impression that this therapist could sit with a client in their most darkest and primal places. I felt as though the client could feel permission to go to these places thus validating and legitimising their reality. Scott (2002) asserts that working with different art forms can help clients to experience authenticity, catharsis, projection, sublimation as well as helping to balance their locus of control. She believes that clients can experience cathartic relief from finding a symbol
that represents their inner world. Symbols allow us to give voice to aspects of ourselves that have no language or other way of being expressed. Scott believes that an art piece can be used as a projection, a mirror of the self thus helping clients gain insight. Scott asserts that working with art can assist in sublimation, providing a safe way to express pain and channel negative energies into a creative process instead of against the self or others.

Creators or Creations of our environment?
The therapist explained that his clients are ‘used to’ this type of environment. What does this environment consciously and unconsciously say to clients about how they are valued? What value is being placed on these clients and what messages are they interjecting about their self-worth? Stephen explains that the room was not originally intended or designed as a therapeutic space. He describes how spaces are handed down when they are no longer needed by other departments. He explains that there are no opportunities to have anything new, if something breaks, it is not replaced, they must 'make do'. Knowing that there was legionnaire's disease in the water, a potentially fatal pneumonia that thrives in stagnant water, makes me think of the room itself being sick and diseased. Is this a space that can facilitate healing? Gladwell (2013) believes that the environment has the potential to influence behaviour, that our inner states and expectations are often reflected externally through how we create our environment. He uses the ‘Broken windows theory’ developed by Wilson and Kelling to illustrate this. He argues that a broken window sends a message that the building and surrounding area is uncared for, that it can be abused and that there is no one in charge. He believes this message actually invites crime, and so it continues in a vicious cycle and self fulfilling prophecy. If, as Gladwell suggests, caring for our environment is an indicator of self respect what would it mean to be a client in a therapeutic space that conveys the message that the place is uncared for, can be abused and has no one in charge? Gladwell suggests that our inner states are often reflected externally - we bring to life our inner life and expectations through creating our environment, he sees caring for the environment as an indicator of self respect. Gladwell discusses the Stanford experiment led by Philip Zimbardo in the early 1970s. This experiment is a potent example of how the environment can affect and even change the behaviours of those who inhabit it. The guards, many of whom would have identified themselves as pacifists, displayed drastic changes in behaviour including signs of sadistic tendencies. One of the prisoners experienced a complete stripping of his identity, Gladwell (2013), “I began to feel I was losing my identity...until finally I wasn’t a person. I was [no] 416”. (Gladwell, 2013: 154).

Studies show that in medical settings, poor design has been linked to negative health effects, including increased anxiety, sleeplessness and higher rates of delirium (Hilton, 1985; Keep, James & Inman 1980; Rubin, Owens & Golden, 1988). Douglas and Douglas (2005) discuss the feedback that patients gave in terms of what they would like from a hospital setting. Some of these included; a welcoming atmosphere; good physical design in terms of usability, accessibility and controllability. Healing environments are claimed to have beneficial effects on a variety of health indicators (Ulrich, 1995). Research has shown that a simple measure of introducing plants to a medical environment can accelerate healing, thus providing a highly cost effective way of improving the space (Dijkstra, Pieterse, Pruy, 2006). If, as Stephen said, his clients are used to this type of environment, what would it be like for them to attend therapy in a different setting? Could this present with its own difficulties by causing them to feel alienated from their own environment? Perhaps moving a client to a completely different environment could cause them to feel displaced. What if the calmness of the therapeutic interior serves to highlight the chaos a client experiences in the outside world? Could this create too big a gap to for them to navigate? It could be important to be mindful that we are a product of our environment and also part of it, from our family systems to our communities. Perhaps we need to be mindful of being too dogmatic in our ideas of what constitutes a therapeutic space.
Conclusions
This study took a closer look at what at first glance appear irrelevant and very ordinary; a bookcase, a rug, the distance between the therapist and client's chairs, but on closer inspection, all have the potential to hold meaning for a client. This study found that the environment can impact on the therapeutic process in different ways. The environment can provoke, trigger and stimulate. Objects can be used to help express emotion by means of projection and identification. Growth can be facilitated by paying attention to the client’s observations about the space. Rather than dismissing a comment about the space as arbitrary, the therapist can encourage the client to voice their observations and to come out of the narrative. A client's growing awareness of the room could be indicative of their expanding awareness and perceptions in other areas of their lives. Self expression of the therapist in the space has the potential to impact the therapeutic relationship in both restricting and liberating ways. A therapist’s expression has the potential to overpower or drown out the essence of the client. Equally, there is the potential for self actualisation and creativity to be modelled through the creative expression of the therapist in the space. Therapist's self expression could pique client's curiosity about others and themselves thus enhancing the inter-dependent nature of the therapeutic relationship. The setting can be used to help establish boundaries and negotiate space to work towards a shared, more equal space. Finally, the study presents further questions. How much are we products of our environments? Are we irreversibly shaped by them and do we have the potential to create new environments, spaces that facilitate healing?

Louise Duggan completed the MA studies in Psychotherapy in Dublin Business School in 2013 and is currently working towards accreditation in My Mind in Ranelagh. Louise has also been working in the Arts for the past 10 years and is interested in the potential partnerships between Psychotherapy and the Arts.

References:
Dependence, Independence and the Self: Maintaining a Separate Sense of Self 
Whilst in an Intimate Relationship 
by Deirdre Evans

“And a rock feels no pain; And an island never cries” Paul Simon, ‘I am a Rock’

Katharine Hepburn once said: “I have not lived as a woman. I have lived as a man. I’ve just done what I damn well wanted to... and ain't afraid of being alone” (1981).

Introduction
I believe there are many of us who are afraid of being alone. Who, unlike Hepburn, eschew the insecurity, the unknown of independence, for the more secure, more familiar territory that is the dependant relationship. The case example of Hannah* illustrates how this fear of being alone can affect us. Hannah has just begun to have a more harmonious relationship with her partner following 10 years of discord; she is now reluctant to speak about any dissatisfaction she has in the relationship for fear that this may “open a can of worms”. She would prefer to maintain this harmony than to acknowledge what may be bitter emotional disappointments; to resolve these issues internally, than to face her fear of being alone.

Hannah suffers from panic attacks. A mother of two, an 18 year old and a one year old, she has essentially already raised a son and is now raising her second. Although she was never that fond of being on her own, her anxiety became particularly acute since her younger son began choking during the night and, alone, in a state of panic, she was unable to do anything. Although, with the help of her neighbours, her son made a full recovery, things have been markedly less easy for Hannah. She became anxious and began suffering more regularly from panic attacks. Her anxiety about being alone was particularly problematic given that Hannah’s husband is a fisherman, away from home for weeks at a time.

When Hannah and I first began working together, we spoke about her ability to cope with her everyday problems. I used an affirmation that I often use with clients that “you do have the ability to cope [with your problems]”. It was at this point that Hannah became extremely emotional and began exhibiting some of those panic symptoms she had described to me in previous sessions: Through shortness of breath she mustered the words “What if I don’t though?”: Hannah’s traumatic experience of being unable to respond in an emergency had meant she had lost faith in her ability to cope. This meant that when her husband was home she relied on him to deal with any situations that may have caused her anxiety. While he was away, she suffered from intense anxiety, and avoided those situations that might cause a panic attack. Hannah was literally dependent on her husband to manage her anxiety.

This aversion to being alone is not something that is unique to Hannah. Psychotherapist Colette Dowling hates being alone. Her Cinderella Complex (1981) examines the fear that many women experience when faced with the prospect of being alone: “More than air and energy and life itself, what I want is to be safe, warm, taken care of. This, I'm startled to find, is nothing new. It has been there, a part of me, for a long time” (Dowling, 1981: 1). And me: This fear has also been a part of me. It is what got me stuck, in a dysfunctional, dependent relationship. And this study is my can of worms.

So, I was once dependent. Unable to move backwards or forwards. Aware that where I was, was not where I wanted to be and yet unable to fathom anywhere else. As a child I was taught much about independence. My egalitarian up-bringing meant that I was constantly exposed to discussions about independence, equality and freedom. And yet that very independence and freedom was also something
I feared. The mere thought of being alone evoked epic anxiety. A foreboding lump in my throat, neck and chest. This sense of foreboding, I now realise, made me procrastinate. I convinced myself “I can get through this, I can make this work”, rather than go it alone; I overlooked those things in my relationship that didn’t feel right, suppressing with hypnotic resolve, the anger and disappointment I had felt at unfulfilled expectations. Afraid of being alone.

But what was I so afraid of? Much like Solaris’ Khari, in past relationships I often saw myself in relation to another, my self-concept seen through their eyes. My locus of evaluation placed firmly in their hands. I looked to another to gauge how I was in the world. Alone, I have to see myself through my own eyes; I have to decide who I am. This responsibility at once terrified and exhilarated me.

**Dependence and the Self**

“Become who you are? That means not only to perfect yourself but also not to fall prey to another’s designs for you.”

Nietzsche’s ‘granite sentence’ in Yalom’s *When Nietzsche Wept* forces us to contemplate the perils of considering another’s wishes when becoming who we are (1993: 297). So, can we truly become who we are whilst in an intimate relationship? Or does that relationship influence what we strive for in life, and thereby derail our becoming?

It would seem that our relationships play a big part in the development of our selves. Calkins proposed that the self, essentially, does not exist in isolation of the relationship (Calkins, 1930). Postmodernist theorists agreed that the self is influenced by the relationships in which it finds itself; that rather than being a robust and inflexible given throughout situations, the self is a fluid entity, continuously metamorphosing and in motion within an ever changing social milieu (Bohen, 2002). As such, the self is constructed amongst a social exchange (Bohen, 2002).

Indeed, our very motivation can depend upon the wishes of a significant other. What Markus and Kitayama term ‘relational reasons’ for pursuing goals can heavily influence whether these goals are translated into action (2003). For example, Kate is a client who has recently split up with her partner. Since the split, he has begun making attempts to win her back, prompting Kate to have second thoughts about the split. “I feel bad for him” she said in a recent session. “I keep thinking how it must be for him, back in his mam’s.” “So that’s how you feel for him?” I said. “How do you feel for yourself?” “I don’t know. I haven’t really been thinking about myself.” Kate is aware of how her [now ex] partner feels, yet she is unaware of how she feels. Those who, like Kate, emphasise interdependence thusly are more likely to circumvent the intensity of their emotions, in order to maintain harmony in a relationship (Markus & Kitayama, 1991). But at what cost? Kate’s focus on the relational, on preserving harmony, means that she is prepared to forgo personal understanding and happiness in order to understand him, to make him feel better. Her sense of self has been lost, and replaced by her sense of his self. She is motivated by his needs.

In her *Unfinished Revolution*, Gerson (2010) conducted both qualitative and quantitative interviews that examined our struggle between autonomy and dependence. One of Gerson’s interviewees, Anita, explained how she too prioritised the needs of another above her own. Having had a number of difficult early relationships, she came to the realisation that she had “given up too much of herself” in those relationships: “I would like to be in a relationship, but I haven’t had such great experiences. I would tend to say “whatever” even though it’s not really what I want, and look back on it later and see I ignored my needs until it became a real problem” (Gerson, 2010: 133).
The theory of relational self-construal proposes that some individuals tend to hold an internal cognitive representation of their important relationships, alongside their core characteristics and values (Gore & Cross, 2006). Such individuals define themselves according to their close relationships (Gore & Cross, 2006) and are more likely to take the needs of others into consideration prior to making decisions (Cross et al., 2000). For instance, Heyward’s sense of self was governed by her relationships (1993). Having had a history of abandonment in previous relationships, she came to expect it. Each of her actions was governed by the desire to prolong that which she saw as inevitable. She did this through divining the needs of the other, whilst ignoring the needs of the self (Heyward, 1993).

By the same token, in the fictional novel Before I go to Sleep protagonist Christine Lucas understands herself through another (Watson, 2011). Lucas suffers from anterograde amnesia. Each morning she wakes beside her husband, to her a stranger. She looks at the pictures that he has erected pertaining to her life. Each morning he narrates her life to her. In a very literal sense, Lucas’ sense of self does not exist without this relationship. If one’s self definition is defined according to one’s close relationships, it is little wonder that losing these relationships can evoke such anxiety. If I am my relationship, how can I exist apart from it?

Thus, while the postmodern self is constructed amongst the conversational exchange, there are many selves that are constructed in monologue; a monologue written by the other. And so, intimate relationships can indeed derail our becoming; often, to the extent that we lose ourselves, that we give up our selves whilst in that relationship.

However, losing our self does not mean we cannot find our self again. Giving up our self does not mean we cannot reclaim our self. Having had her career path diverted by an early relationship, one of Gerson’s (2010) qualitative interviewees did just that: “I lost myself during the marriage, so I actually got a lot out of [the breakup]. Now I know what I don’t want from a relationship. I know what I want from myself. It made me become the person I am, not the person he wanted me to be” (Gerson, 2010: 133).

Likewise, in order for us to understand what we need and want from others, we must first know what we need and want from our selves (Rosenberger, 2011). We must know our feelings, our thoughts, our beliefs; we must understand our goals, our internal resources, our desires, we must know the things that we need in order to feel content, so that when we are in a relationship we can discern what is ours from what is theirs (Rosenberger, 2011). Without this understanding, we do not seek another for love. We instead seek another out of a desperate desire to connect, out of our fear of being alone. These desires, these fears, can thus force us to relinquish our sense of self within that relationship (Rosenberger, 2011).

As well as understanding, maintaining boundaries within a relationship can allow us to decipher which input we need to assimilate, and which input we need to reject, so that we do not erode our sense of self (Ogden, 2006). By developing boundaries that surround our core self, we ensure that this does not occur. Boundaries can take the form of physical barriers; a door, a wall (Rosenberger, 2011). But boundaries can also encompass elements like space, time, emotional availability, self revelation, physical affection and emotions (Rosenberger, 2011). It is through the use of boundaries that we decipher where our self ends and where the other begins (Rosenberger, 2011). So that we do not confuse the person we are with the “person he (wants) me to be” (Gerson, 2010: 133). And so the strengthening of these boundaries can potentiate the maintenance of self whilst in a close relationship. In Ogden’s words, with boundaries we “can maintain both differentiation and connection” (2006: 1).
Minuchin (1974) proposes a boundary continuum, ranging from the flexible to the more fixed boundaries. Those boundaries that are at the more rigid, the more inflexible end of the spectrum allow for interpersonal distance. In her Master Hunter (2013) Laura Marling sings of her rigid boundaries: “I cured my skin, now nothing gets in. Nothing, not as hard as it tries.”

Marling has created impermeable boundaries, so that no one can penetrate her sense of self. Her boundaries reject, they do not assimilate (Ogden, 2006). Although posing less of a risk to our identity, these rigid boundaries can make it more difficult for us to connect within a relationship. At the opposite end of the spectrum are the more flexible, more porous boundaries. These have little or no limits, allowing individuals to interact with little intransigence. Therefore those individuals whose boundaries are at the flexible end of the spectrum are more likely to become enmeshed within a dyad: The more porous a person’s boundaries, the greater the risk to their sense of self. It is these polarities that should be avoided. To reiterate, the endeavour is to “maintain both differentiation and connection” (Ogden, 2006: 1).

However, there are no one size fits all boundaries. Each member of a relationship might have his or her own view of boundaries, might be placed at a different point on the boundary spectrum. Therefore boundaries need to be tailored anew in each relationship, need to grow and to move within that relationship (Rosenberger, 2011).

Somewhat paradoxically, Keating (1992) argues that it is the quality of empathy that enables us to maintain a sense of individuation while in a relationship. With inquisitiveness about the inner world of another, we become acquainted with our own innermost realities (Keating, 1992). This allows us at once to be merged with and separate from the other. However, Keating warns, a sense of empathy, devoid of a sense of our rights, may lead to the neglect of our needs.

And so relationships, at their best, can encourage and support self-discovery. Connecting with those who reflect our values can serve to enhance those values, so that with those individuals, our sense of self becomes all the more keen (Rosenberger, 2011). At their worst, relationships can (if we let them) undermine our values, our emotions, our behaviours. At their worst, relationships that do not support our sense of self, can make us question our very foundation, our very core, to a point where we question our very being. It is our responsibility within such relationships to develop appropriate boundaries, to remain cognisant of our needs, so that we do not lose sight of our sense of self.

Conclusion
And now to return to the case example of Hannah, to her fear of being alone. Hannah, with whom the very thought of coping alone evoked the symptoms of panic. A boating accident meant that Hannah had to fly to Exeter in order to support the husband upon whom she had always been dependent. Traditionally, travelling was a trigger for Hannah’s panic attacks, and so the session prior to her flight was fraught with anxiety. However, before the session ended, there was a shift. When I gave assurances that I believed she could do it, her response surprised me: “I believe I can do it Deirdre. I have to.”

And so through necessity, Hannah uncovered her hidden resources, and ultimately, her ability to cope alone; and so her fear of being alone was overcome.

So, am I suggesting that we end our intimate relationships as soon as this deadly dependence begins to infiltrate and erode our sense of self? Or perhaps to forgo relationships altogether, so that we can avoid the sabotage of self that is dependence? Not quite. No man is an island. Ideally, one should strike a balance between relatedness and autonomy (Bornstein & Bowen, 1995). There is a lot to be
said for compromise, for being able to endure the difficult times. Perseverance and compromise are often prerequisites for concord in relationships (Gerson, 2010). However, Lerner (1999) warns that we “de-self” ourselves when we do not speak up about those issues that are important to us, at the price of feeling embittered or unhappy (Lerner, 1999: 199). It is through remaining cognisant of those issues, through respectfully taking a stand in relation to those issues, that maintaining our sense of self becomes possible. Boundaries. Cognisance. Empathy. With them, we do not fall prey to another’s designs for us. With them we become who we are (Yalom, 1993).

Weiss argues that independence is gained through the capacity for mature dependency (Weiss, 2002). While Gerson’s research (2010) finds that the quality of self-reliance, can help us to avoid becoming stuck in a relationship that does not support our autonomy. Although I would like to develop Weiss’s mature dependency, it is more important to me to possess this self-reliance. I am unprepared to endure, to feel stuck in, another relationship with which I am dissatisfied, because I am afraid of being alone. Now that I am responsible for me; now that my locus of evaluation is in my hands. I am no longer terrified. Just exhilarated.

*Identifying information has been altered in the case of all of the clinical material used within this text

References:
The Therapeutic Journey

by Anne O’Connor

In Ireland, there is now an awareness of the prevalence of childhood sexual abuse which did not exist to the same extent in previous generations. Part of the dark, secret and shameful side of human society, culture and behaviour, childhood sexual abuse, or CSA as it is called in the clinical research literature, was not talked about openly in this country until relatively recently, in the last thirty years. In many ways it was the scandal of clerical child sexual abuse which brought this subject into the public domain and subject to intense scrutiny. However, this is really the tip of the iceberg, as CSA is a universal phenomenon which is prevalent throughout society in general, and the majority of such abuse happens within the child’s own home or neighbourhood, and with people known to the child. That this kind of abuse has occurred for generations in Ireland is now widely acknowledged (Lalor, 1998; Nolan et al., 2002; Fitzpatrick et al., 2010; Carr, 2009; Carr et al., 2010; Flanagan-Howard et al., 2009).

‘Sexual Abuse and Violence in Ireland: A national study of Irish experiences, beliefs and attitudes concerning sexual violence’, called the SAVI Report, (McGee et al., 2002) was a study undertaken by the Health Services Research Centre at the Royal College of Surgeons in Ireland, and sponsored by the Dublin Rape Crisis Centre, to examine the prevalence of various forms of sexual violence among Irish women and men across the lifespan from childhood through adulthood. In the random sample of 3,000 adults in Ireland in SAVI, it was found that 30% of women and 24% of men had experienced CSA before the age of 17 years.

This is the background that must be taken into consideration in any examination of the impact that CSA may have for individuals who have experienced this particular trauma. In this research study the central focus is not so much the traumatic CSA experience itself in the woman’s life, but rather what has helped her to overcome and heal those wounds, to survive that experience. I am deliberately seeking to allow the voices of women, who in previous generations were silenced, to be heard as they share their life experience, stories, and insights in this study. Note that while boys and girls are both subjected to CSA, the focus in this study is on the specific experience of girls and women.

This conference paper is based on an M.Sc in Integrative Psychotherapy research thesis which has just been submitted, and therefore has as its primary focus the research process, as distinct from a full discussion of the outcomes, recommendations etc., arising.

Introduction to the research project

This research project aims to explore the lived experience of the therapeutic relationship for Irish women qualified as psychotherapists who have experienced childhood sexual abuse (CSA) in terms of their emerging sense of self, identity and sexuality. The central focus is the lived experience of the psychotherapeutic relationship, and this is the first time that this experience is being explored using a qualitative research approach in the Irish context, with regard to this particular population.

The main objectives of this research are:

• To explore differences and similarities in the lived experience of the psychotherapeutic relationship of the individual participants.
• To explore the relationship between CSA and the developing sense of self, in terms of personal identity and sexuality.
• To contribute to academic research in psychotherapy.

In this way, I am seeking to bring into the light certain aspects of the therapeutic relationship during the process of psychotherapy, and to seek to understand the meaning of the relationship from the client
perspective. By sensitively interviewing three self-aware women, I am interested to understand how their therapeutic journey is enabled or not enabled through this relationship. Secondly, much research on the therapeutic relationship suggests that at core, it is the trust and intimacy that grows between client and psychotherapist which is of the greatest significance, as distinct from whichever modality or type of psychotherapy is actually being practised, and I am interested to explore this in the Irish context.

My approach in this study reflects my own integrative humanistic model in psychotherapeutic practice: it is a way of being and a way of working. Each psychotherapy relationship is unique as each therapist and client bring their unique selves to the encounter. Psychotherapy by definition is a singular, not a general, practice. A core characteristic of research in psychotherapy reflects the one-to-one therapist-client therapy relationship. This reality also frames my research study and grounds it in psychotherapy research, training, clinical practice, and supervision.

Therefore, the research question which is the driving force behind this study is: how do women, who have a history of childhood sexual abuse and who are now qualified psychotherapists, understand and make sense of their experience of the therapy relationship, in terms of their individual journeys and their developing sense of self, identity and sexuality?

Methodological overview
This study uses qualitative research methods to explore the lived experience of the research participants so that a rich and deep corpus of material is available for analysis.

A qualitative phenomenological approach (Creswell, 2007; Moran, 2000; McLeod, 2011) has been adopted as this was considered the most appropriate to explore the lived experience, and life world, of a woman who has experienced CSA and who has pursued a therapeutic journey in order to reach recovery and re-integration on a personal level, in terms of her sense of self, identity, and sexuality.

As Finlay (2009) states: “Phenomenological researchers generally agree that our central concern is to return to embodied, experiential meanings. We aim for fresh, complex, rich description of a phenomenon as it is concretely lived” (Finlay, 2009: 6)

Interpretative Phenomenological Analysis (IPA) is the preferred methodology in this study because deeply subjective, descriptive and rich accounts of lived experiences are sought. IPA is concerned with the detailed examination of human lived experience (Smith, Flowers and Larkin, 2009: 16).

It is appropriate to use IPA in this study as it has been developed as a method within health sciences and in psychological research (Smith, Flowers and Larkin, 2009; Smith, 2004, 2007; Smith and Osborn, 2003; Brocki and Wearden, 2006; Larkin, Watts and Clifton, 2006; Smith and Eatough, 2007; cf. Biggerstaff and Thompson, 2008). IPA dialogues with the empirical and scientific approaches, and is compatible with the evidence-based research approaches (cf. Finlay, 2011) within the wider field of research in the psychological professions. Discussing the value of IPA for nursing research, Pringle et al. (2011a: 24) state IPA studies are firmly rooted in the “evidence” of the words of participants. It “gives voice” to participants (Larkin, Watts and Clifton, 2006) and allows for gems of personal insight or metaphor (Smith, 2011) to come to light. Psychotherapy research is more concerned with individual case studies rather than generalities of research, and that is why IPA offers a systematic and structured methodology, whilst offering an adaptable and accessible approach (Pringle et al., 2011: 24), for conducting research on a case-by-case basis for this profession. Central to IPA is the focus on how people interpret their experience, and the researcher gave special attention to this during the interview and data analysis stages of the process. Thus, the “double hermeneutic” of IPA (Smith, Flowers, and
Larkin, 2009: 3) allows for the researcher’s interpretations of the interpretations made by the participants of their experiences to become part of this process.

**A Reflexive Approach**

Reflexivity is an essential component of the practice of psychotherapy (Hedges, 2010). Etherington (2004: 19) reminds us that in addition to being aware of our personal responses to the world around us, we need to be aware of the personal, social and cultural contexts in which we live and work and to understand how these impact on the ways we interpret the world. Reflexivity is also a skill that psychotherapists develop, and when this is extended into reflexive research:

> It encourages us to display in our writing/conversations the interactions between our selves and our participants, from our first point of contact until we end those relationships, so that our work can be understood, not only in terms of what we have discovered, but how we have discovered it. For myself and other like-minded individuals, these are ethical, moral, and methodological issues involved.

Etherington (2007: 601)

Etherington’s view here concurs with my own, and at all stages of the research process I have been open and honest about my own engagement with this research subject, as I have experienced CSA, and am a practising psychotherapist, who has been exploring my own sense of self, identity, and sexuality through the psychotherapeutic relationship for over twenty years. This has clearly informed the choice of subject and the approach taken, so, I have been especially vigilant to use a transparent, reflexive process throughout this research project.

**Research Design and Approach**

The participants in this study are three women who are qualified psychotherapists and who volunteered to be part of this study by responding to a call for participants. Sensitivity was uppermost, and every effort made to emphasise participant safety and confidentiality, including the use of a dedicated mobile phone number. While absolute confidentiality cannot be guaranteed, anonymity was assured through the use of pseudonyms and all names of people and places were changed. I have given the three participants the names “Máire”, “Aoife” and “Orla”.

Inclusion criteria specified that each of the participants must be qualified psychotherapists who have worked on and integrated their own life experiences in depth through at least three years of personal psychotherapy and the CSA experience must have occurred at least twenty years beforehand. These inclusion criteria were stipulated in order to reduce any concerns regarding participant safety, as qualified psychotherapists understand, and have been trained, in self-care. The obligations of the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 were explained to each participant, as the researcher was honour-bound to notify the Gardaí and relevant authorities if the identity of any perpetrator was to be disclosed during the interviews. The participants were free to withdraw from the process at any stage without penalty.

Ethical considerations were to the fore in the design of the research process. Ethical approval for the research was sought and provided by the Research Ethics Committee of Dublin City University. In addition, I was guided by the Codes of Ethics of these Irish professional psychotherapy bodies, as well as by their European equivalents:

Irish Association of Integrative Humanistic Psychotherapy (IAHIP) (section 6.4, see http://iahip.org/code-of-ethics),
Semi-structured interviews were recorded in safe locations chosen by the participants, with a distress protocol in place to ensure the safety and comfort of the participant at all times. I ensured that at least one qualified psychotherapist in the area of trauma and CSA was available should any of the participants wish to meet with them following the audio-recording. A list of resources was given to each participant. The researcher also advocated taking the experience of the discussion to their own therapy, and time was given for re-grounding and a cup of tea or coffee after the interviews. The researcher ensured that principles of professionalism, ethics, duty of care, respect, boundaries, time-management and sensitivity were uppermost at all times, and this is in keeping with the Rogerian core conditions also. All data was stored securely, and the data was transcribed and analysed using IPA.

Data Analysis
The IPA analysis process is analogous to the work of psychotherapy in that it requires all of me to be involved, engaged with the participant, not just hearing a story, but listening to the specific words they use, how they say those words and how I hear them, as well as the special images, metaphors and symbols that have such meaning for them. How the participants make meaning of their lives, their lived experience is core to the analysis, and because it also involves my interpreting that meaning-making and interpretation at a remove, involves me also as part of that circle of exploration.

Following the guidelines to an IPA data analysis process explained by Smith, Flowers and Larkin (2009), I examined the material collected in the participant interviews from four distinct but overlapping perspectives: the descriptive and linguistic analysis of what was actually said to describe the experience, and the conceptual questions, and later interpretations, arising from that description. I put each of these four perspectives into separate columns, alongside the body of the transcript. I was also careful to note my own reactions, feelings, thoughts etc., at all times.

I immersed myself in the data, reading, re-reading, listening to the interviews etc, and then began identifying emerging themes, noting any similarities and/or differences between the different accounts from each participant. I identified over one hundred emerging themes in the data collected, and grouped them under ten headings in the first instance. Later, through examining inter-relationships between themes, it was possible to identify super-ordinate themes and major sub-themes. Three super-ordinate and inter-connected themes in the material collected emerged, each comprising major sub-themes: Theme A, the Lived Experience of Trauma/CSA; Theme B, Relationship with Self; and Theme C, the Lived Experience of the Therapeutic Relationship for each participant.

Space does not permit a detailed discussion regarding these themes and how they are represented in the testimonies of the three participants for this research project. As might be anticipated, the experience of trauma such as CSA leaves deep wounds which have to be thoroughly worked through by the adult so that they may reach healing and full recovery (Herman, 1992). For each of the three participants of this study, years of such personal therapy had been undertaken. Despite this, the experiences of the women, of being re-traumatised in the therapy room, and their vulnerability often been misunderstood by counsellors and therapists who were not able to hold them or to understand how working with people with a history of complex trauma requires the highest imaginable standards in empathic attunement (after Evans and Gilbert, 2005) where the Rogerian core conditions are
observed fully and client safety is foremost, attest the courage, resilience and perseverance required when a person decides to confront these kind of traumatic experiences in psychotherapy.

Suffice to note that a result, which was surprising for this researcher, was the extent to which negative experiences of the psychotherapeutic relationship came to the fore. Recognising the issue that always exists with regard to qualitative research approaches, that it is almost impossible to “generalise from the particular to the universal”, nevertheless the range of positive and negative experiences of the psychotherapeutic relationship was a most striking outcome emerging from this data.

**Discussion**

I had already conducted a literature review prior to conducting the interviews with the three participants. A review of the research and literatures relevant to the research topic was undertaken by searching many electronic databases, journals and available research literature. The search through wide-ranging literatures such as trauma, CSA, identity, sexuality and the psychotherapeutic relationship, revealed a vast corpus of available material; but comparatively little pertaining to the specific focus of this research study, with this particular population, in the Irish context. However there is a significant growth in research in this general area, much of which is valuable from a comparative perspective and which points the way towards new opportunities for further investigation. Space does not permit a comprehensive review of all the literature available regarding this subject.

In an IPA study, the themes which emerge from the data analysis process constitute pointers to a specific body of research literature. Therefore, in my discussion of each of the super-ordinate themes and the ten major sub-themes, the relevant literature was re-examined in the light of the findings from the research process.

Focusing on the interpretations and meanings of the experience of the psychotherapeutic relationship I was making connections with the specific research literature with the aim of being able to offer specific recommendations, ask questions and note implications for further research, as well as for the training, clinical practice and supervision of psychotherapists in Ireland. Issues concerning policy, regulation and service provision were also significant.

**Conclusion**

In reflecting on the research process, this research project has been a therapeutic journey for me, as I met each of the participants, had the privilege of entering their lifeworlds and experiences, and re-encountered my own experiences of both the psychotherapy relationship and the trauma of CSA. I am able to reflect on those experiences from the perspective of who I am now, and to understand better why I have chosen the path of becoming a psychotherapist. I have gained many insights and feel I have grown in both a personal and professional capacity through this process. I have found the IPA approach as a very holistic process (Finlay, 2011: 140), and appropriate for the research study.

In conclusion, this study fulfilled its general aim and its objectives, and breaks new ground in Irish psychotherapy research in the areas of the therapy relationship, as well as the area of complex trauma, and CSA in particular. Further research possibilities have been outlined. The centrality of the psychotherapy relationship has been confirmed, and the crucial need for only the highest standards in ethical psychotherapeutic practice has been underlined.

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References:
How do we keep our nerve in all that we are exposed to through our client’s pain, and indeed through our own? Our training and experience with other clients, among other things, give us access to psychological insights providing us with some understanding of the client’s world. But have you ever felt that the psychological horizon, enlightening as it is, can be under strain when it comes to the question of meaning? Possibly a need for some further horizon?

I am interested in exploring with colleagues the theme I wrote about in the February edition of Inside Out, i.e. ‘Psychotherapy and Spirituality’. Is there room for a faith perspective - whatever that might mean - in our work? How comfortably do the ideas, constructs and practices of our profession sit with belief in transcendence or mystery? How might such belief be spoken of among psychotherapists, since it is so personal and intimate, and possibly never worded even to ourselves?

I would like us to think about how our belief or faith, or indeed non-belief, might impact on us as we work, possibly as avoidance, possibly as resource. We live and work with the immanence of so much mental and physical anguish and suffering. We are asked often to bear with our clients what for years has been unbearable to them. Terror, despair, futility we know of as part of the experience of both the client and also of the psychotherapist. As Bollas has written: "...there are 2 patients within the session..."

Can we make any sense out of what we meet and come to know in the therapy room? I may understand the hopelessness of my client, say, in terms of early and constant deprivation, but is it possible to imagine there being any meaning to it? What might belief or faith offer the psychotherapist in this regard, even as through a glass darkly? How might such access to meaning impact on the psychotherapist, on the client and on the psychotherapy process?

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References:
What Impact Does Core Training Have on the Developing Psychotherapists’ Subsequent Professional Ethos?

by Anne Burke

Introduction

In April, 2008, I embarked on a Master’s Degree with the University of Sheffield and I was awarded my Master of Science Degree in November and graduated in January, 2012. In order to complete my Master’s Degree I had to complete four Modules and then go on to complete a piece of research, a topic of my own personal choice. The whole course took three years with the thesis taking a little under a year to complete. The research piece that I chose to do was to discover the impact of core training on the psychotherapist’s developing ethos. This idea flourished based on some of my own experiences in training and working as a psychotherapist throughout the last ten years, as well as being aware of other colleagues and listening to their experiences in their professional and personal journey. The other thing that highlighted the importance of this question for me was the impending question of Statutory Regulation and the focus on more academic training and what this might or could mean for the profession of psychotherapy.

I conducted 12 interviews and the participants were therapists who had varied experience. Some had just graduated, others were working towards accreditation and some had been working as psychotherapists, trainers and supervisors for many years. I tried to get people who had trained at as many different colleges as possible to give a good overall perspective on the experience of training.

The research project was broken down into three main chapters. Chapter one was a literature review of the papers that were relevant to this particular subject and to explore what kind of research to date has gone into designing training courses for psychotherapy. Another question that was to be explored was how this training has impacted and continues to impact on students as they train and develop as professional psychotherapists. Chapter two explored the methods used in the research and how these proved relevant in helping to support, discover and use, to the best of its potential, the vast information that each and every therapist provided so readily in this research project. Chapter three proved very interesting in that I used two different theories of development: one was Erik Erikson’s Eight Psychosocial Stages of Development (Passer and Smith, 201:471) and the other was Kohlberg’s theory on Moral Reasoning (Gleitman, 1995:554). These theories were used in the context of believing that development may not be confined to these stages; life is a continuous learning process and we may learn to address certain areas of each of these stages as we branch out into new ways of learning. I think this is relevant to the psychotherapy field in particular because it is not just a matter of learning the theory, it is also a journey of self-discovery, an opportunity to learn all about our thoughts, feelings, behaviours and belief systems and how they have been developed and influenced with the opportunity to challenge these ways of behaving and thinking if we wish to do so; what might be described as developing a new sense of self.

This idea occurred to me, having being strongly influenced by two papers that I read: the first, True and False Self in the Development of The Psychotherapist (Eckler-Hart, 1987) and the second, Development Themes and Self-Efficacy for Career Counsellors (Marshall, 2000) Anton Eckler-Hart’s paper draws on Winnicott’s (1965) theory of the True and False Self and in brief talks about the journey of the student psychotherapist and their struggle to achieve a position of security within the context of their professional and personal identity:

Becoming a psychotherapist involves becoming more capable of dealing with the demands of the work; becoming more secure and able to use the self in relation to a patient in a spontaneous
way. This is a difficult task in that it is those creative, spontaneous aspects of a person which are the ones which it is most dangerous to expose.

(Eckler-Hart, 1987:63)

Anne Marshall’s paper explores the question of confidence and competence in her paper. Asking the question “How do Trainees come to believe in their ability to be a counsellor?” Marshall draws a comparison to Lerner’s 1986 concept of development, the three elements being “(1) development always implies change of some sort, (2) the change is organised systematically, and (3) the change involved succession over time” (Marshall, 2000:2). These elements Marshall discusses are a common denominator in all aspects of change, regardless of theoretical or philosophical input.

What was the core piece of the Masters?
The core piece of this research project was to discover the impact of core training on the psychotherapist’s developing ethos. In the first part of the research I felt it was important to see what the whole aspect of training covers and what kind of research has gone into developing training courses for psychotherapists. It was interesting to see that to date there seems to be very little research, either documented or carried out, on the process of training and no research to date as to what the impact of this is on students or on therapeutic outcomes. In the context of Statutory Regulation with a more focused view on the academic side, it was interesting to read many papers that highlighted the importance of more experiential and relational aspects to the training. These papers were: Psychotherapy Training: Suggestions for Core Ingredients and Future Research (Boswell and Castonguay, 2007:378-383); Big Ideas for Psychotherapy Training (Fauth et al, 2007); and Implications of Psychotherapy Research for Psychotherapy Training (Piper, 2004).

Core issues Highlighted
There were many core issues highlighted in the research. A number of these were as follows: The meaning of ethics and the importance of having an ethical framework, the writings of Tim Bond (2010) Standard’s and Ethics for Counselling in Action and John Callender’s (1998) paper Ethics and aims in psychotherapy: a contribution from Kant had some very interesting perspectives on this piece. Callender’s paper discusses the concept of free will, rationality and ethics and how they could be adapted to an ethical framework in psychotherapy.

Throughout the interviews certain themes were extremely prevalent, among these were: personal therapy and the process within training and how important it was for the therapist to have this experience, the synopsis being that it gave students a greater understanding of their blind spots and their own process. Group Therapy was also noted as a very important part of the process in that it gave the opportunity for group experience and a chance to broaden the perspective of the therapy within the group experience. It was noted throughout the research that there needed to be a much greater emphasis on the whole area of ethics and ethos in training; interviewees felt that a lot of what they had learned about ethics and ethos came after their training. This conclusion on experience and ethics may be understandable from an experiential point of view; however many of the participants felt that there should be a module dedicated to ethics during training and what is expected in the profession of psychotherapy.

Supervision was another theme that was given great emphasis and again noting the important influence that trainers and supervisors have in influencing their trainees, one participant described supervisors as the “gatekeepers” to the profession. Participants noted that often the student goes from trying to mimic their supervisors in the hopes that they “get it right” to being guided to develop their own style of working and a sense of what was referred to as their own “personal authority”.

38 A Gathering of Psychotherapists.... 21 years on: Value and Values of Psychotherapy 2013
Statutory regulation was discussed within the context of ethics and ethos and the drive towards more academic training, and where participants thought that Statutory Regulation was a good idea, there was a fear that the relational aspect of therapy could be focused on less, and that this could have a detrimental effect on the whole aspect of what psychotherapy and counselling emphasises; the therapeutic alliance and the therapeutic relationship, which is something that is often recognised as being one of the most important aspects of therapeutic change.

Theoretical influences

The theoretical influences that I was drawn to while analysing the data that had been researched were Erik Erikson’s Psychosocial Stages of Development (Sugarman, 2001) and Lawrence Kohlberg’s theory on Moral Reasoning (Sugarman, 2001). I also explored the existential perspective on what Emmy van Deurzen (2009) so aptly describes as the characteristics that we need as a psychotherapist.

Erik Erikson’s theory gave me the basis and understanding of psychosocial development from birth to late adulthood and I explored the potential connection of development to the developmental stages of the psychotherapist within the context of training. Based on my own experience of training and having worked with many students over the years, I see the potential to regress back into the various different stages of development that we may have not fully moved through in our younger years.

The theory on Moral Reasoning was one of great interest. As psychotherapists, we are bound to a code of ethics but these codes are guidelines and many dilemmas can arise within the therapeutic process and relationship that may at times not seem so black and white. What we depend on to guide and help us with the right decision at times like this may reflect on how developed our own sense of moral reasoning is, in other words our own “personal authority”.

The characteristics that Emmy van Deurzen (2009) discusses in her book Psychotherapy and the Quest for Happiness reflect many things that the various therapists discussed in the interviews for this research. Van Deurzen talks about the demands that therapy will make on the therapist and in order to accept and contain these demands, the therapist needs to be strong in character in order to accept the challenges and explore them; this can only be achieved by maturity and self-reflection. Characteristics that have been discussed throughout this book indicate that therapists need to be understanding, patient and flexible; they need a good knowledge of the “emotional palette”. There is a need to be able to manage and tolerate anxiety, despondency and have a good knowledge of life and what it means in order to hold steady when faced with the contradictions and paradoxes of life. It is also noted that therapists need to be ethical because of the powerful position that they hold with a vulnerable client and the potential for the abuse of this power if they do not have a good sense and understanding of professional ethos. Van Deurzen believes that therapy is a lifelong vocation with a willingness to continue to train and learn because that is the reality of life; to be continually developing and growing and bringing with those changes new challenges all the time (2009: 169-170).

This is a very brief synopsis of what the research thesis covered and if anyone is interested in getting a copy of it please email me at anneb@johnstowntherapy.com

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References:
Reflections on Supervision Training: Significant Events Experienced by Supervisors in Training

by Patricia Nannery

Introduction

Within the helping professions, the importance of supervision in the training and ongoing professional development of practitioners is widely recognised. As supervision is emerging as a profession in its own right (Carroll, 1996) the need for formal training in supervision is also acknowledged (Bernard and Goodyear, 1998; Falender et al., 2004). In the present climate of evidence-based practice, it would seem vital that supervisor training be empirically validated. Clinical Supervision training has received little attention in the literature. Criteria sought by professional bodies demand that counselling psychologists and psychotherapists are adequately trained to act as supervisors. Other professionals in the field of clinical supervision, mental health, caring professions and educators are also calling for formal training in supervision.

This retrospective qualitative study sought to address a gap in the literature by seeking to ascertain the experiences and events that enhance professional development. It also sought to increase the body of available research that helps identify the components of formal supervision training.

Enquiry into significant events draws from psychotherapy research (Timulak, 2007). Significant events are described as key learning moments that create within the individual a sense that something positive or eventful has occurred. These experiences, events or encounters give meaning to the experience and contribute to enhancing and increasing professional development.

Numerous questions and calls for further research into supervision training abound in the literature and in the words of Worthington:

Unwilling as we might be to accept it, most supervisors might simply not improve with experience. One reason for this might be that supervisors have little training in how to supervise effectively and thus might perpetuate the mistakes of their own supervisors.

(Worthington, 1987: 189-208)

Kaiser & Kuechler stated: “supervisors’ duties are different and performing them requires additional skills and propensities” (Kaiser & Kuechler, 2008: 76-96).

Kaslow proposes that “competencies consist of relevant knowledge, skills, and attitudes that affect practice and they are developed and enhanced by professional training” (Kaslow, 2004: 774-781).

Milne defines clinical supervision as “the formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues” (Milne, 2007: 437-447). This is a comprehensive definition of clinical supervision and the inherent focus of educating and training supervisees. The definition of providing formal supervision by approved supervisors is pertinent to this study.

In an effort to establish clear training guidelines, Falender (2004) proposed six competency areas in supervision:

1. knowledge
2. skills
3. values
Standards for counselling supervisors have been specified by the governing bodies of several helping professions. A primary responsibility of educators is to provide comprehensive education comprising components of didactic coursework, practice and clinical supervision. It is now understood and recognised that training facilitates the integration of (a) theory, (b) empirical research, (c) skills development and (d) professional values. Ireland and Britain are distinct from the United States in that the supervision requirement for clinicians is a life-long commitment (British Association of Counselling & Psychotherapy Code of Ethics and Practice for Counsellors, 1990). Practitioners both in training and credentialed are expected to be in supervision throughout the duration of their practice. As a result, training programs in Britain and Ireland need to be more diverse to address these widely divergent developmental needs.

Many supervisors have had little or no formal training for the role they find themselves performing and there is agreement in the literature that supervisors’ duties are different and therefore require other skills and competencies. In recognizing the necessity to promote best practice within professions and to provide for the education and growth of supervisees, supervisors need formal training. With training, supervisors increase their ability to apply specific areas of knowledge and skills to their supervisory practice. Falender et al., state that “formal graduate education is suited uniquely for the transmission and acquisition of knowledge. One of its important components is professional training, which is the primary vehicle by which trainees develop applied competencies” (Falender et al., 2002).

Without training, it is probable that the provision of supervision is quite incompetently practiced by many supervisors. In many instances, individuals have to supervise as part of their role in the workplace and consequently seek training. Their primary motive in many cases is career advancement rather than pursuit of excellence in clinical supervision. Whatever the motive, it is quite clear that adequate training is central. It is important to learn from on-the-job experience, but is it an adequate learning modality on its own?

Kaslow & Keuchler (2004) assert that “competencies consist of relevant knowledge, skills and attitudes that affect practice and they are developed and enhanced by professional training”. Didactic instruction and theory alone is not adequate to teach a trainee supervisor the skills of effective supervision. The job of being a supervisor is multifaceted and complex. The training of supervisors needs to be equally comprehensive to prepare the supervisor for the role.

**Context**

- This paper reports on a study conducted with graduates of a one year Postgraduate Diploma in Clinical Supervision in an Irish University.
- Participants were experienced helping professionals from various theoretical backgrounds who engage in supervision over the lifespan of their careers.

**The training course objectives were:**

- To gain sound theoretical principles and skills training.
- To gain knowledge of a range of theoretical perspectives.
- To gain a mastery of knowledge, principles and methods of the discipline of clinical supervision.
The research aimed:
- To explore participants’ experiences of supervision training.
- To increase the understanding of what are the components of effective training.
- To inform further development of supervision training.
- To inform further development of supervision research.

Methodology
The significant events approach employed in this study has been adapted from psychotherapy research (Timulak, 2007). This approach was applied to the study wherein ‘significant events in training’ were defined as key learning moments that created, within the supervisors in training, a sense that something positive or eventful had occurred and that this experience enhanced their professional development as supervisors.

Ethical approval was sought and obtained and a qualitative phenomenological approach was deemed most relevant to exploring participants’ experiences.

Participants were contacted by the college, using purposeful sampling, and eight participants, 4 male and 4 female, took part. Participants were graduate students of the one-year part time Postgraduate Diploma in Clinical Supervision (Psychology). They comprised: psychotherapists, counsellors, psychologists, mental health workers and health care practitioners.

Data analysis drew on an Interpretative Phenomenological Analysis (Smith, 1996) approach. The following methods were used:
1. A demographic information form
2. In-depth semi structured interviews
   - Interviews lasted 45 to 60 minutes
   - Interviews were audio-taped
   - Data was transcribed, coded and analysed

After a period of engagement with the data, the emerging themes were copied from each transcript and clustered. A table of themes was produced that encapsulated the experiences of the participants and that captured the essence of meaning of the lived experiences of the trainee supervisors.

The criteria for reliability and validity to establish credibility and trustworthiness for this study were:
- “Bracketing” of biases and expectations
- Auditing and peer reviewing
- Additional reviewing, by the research supervisors
- Catalytic validity

Analysis
The data collected revolved around learning events and experiences that contributed to acquiring a competency in knowledge, theory and skill along the way to learning ‘how to’ be an effective clinical supervisor. The data findings clustered around three Master Themes:
1. Learning theory and practice of supervision
2. Professional knowledge and experience (putting new learning into practice)
3. Integration of knowledge and professional identity
Key Findings 1
Learning Theory and Practice of Supervision:
  The Learning Environment
  Learning Processes and Learning Styles

Gaining professional knowledge of theories, models of supervision, principles, facts and concepts, rated highly and was explicitly expressed by all eight participants. The data is replete with references to the activity of learning and underpins all master themes. Making one’s own learning style explicit not only enhanced the experience of learning for the trainee supervisor but enabled engaging with the various learning styles of supervisees more fruitful. The studying and understanding of learning processes and styles had a dual purpose of facilitating one’s own learning to be a supervisor and the witnessing of the learning and development happening for the supervisee.

Key Findings 2
Putting New Learning into Practice:
  Building the Working Alliance
  Acquiring Competencies in Supervision
  Sharing the Experiences and Feedback

The second theme of putting new learning into practice resulted from the clustering of data of accounts of supervision session experiences. This learning could be described as the experiential knowing, the knowing of ‘how to’ carry out the tasks and functions of being a supervisor. Participants talked about their role development as they performed the tasks of supervising, experiences gained in the relationships, particularly in the task of giving and receiving feedback, and the impact of all of these factors on the working alliance.

Participants regarded the acquiring of competencies as a key component of competent practice and cited technical skills, clinical reasoning, communication, knowledge and reflection skills as essential competencies necessary for capable functioning in the role. The data stressed the necessity of ‘the relationship’ as being a very important factor in the development of the supervisor.

Participants all valued the facility during the training of discussing workplace learning with college peers and tutors and the feedback facility that contributed to collateral learning by normalizing of experiences and addressing insecurities. This anchored the learning experiences for the trainees.

Key Findings 3
Integration of Learning and Practice:
  Self-Reflecting and Self Monitoring Lifelong Learning
  Forming a Professional Identity as Supervisor

The third master theme of ‘integration of learning and practice’ arose from the data as participants described significant changes in their own perspectives. The consequences of the significant events seem to contribute to increased self-awareness and the development of the self as supervisor.

The narrative of the data and the language of the participants in their descriptions in this master theme become more ‘affective’ than the descriptions of previous themes. The third theme could be viewed as a deeper internal layer of integration of the two previous themes.
The data is heavily laden with references to self-directed learning and lifelong learning. The data reveals a personal active engagement with the process of training and learning.

Ubiquitous in the findings is the importance of self-reflection. Some refer to self-monitoring, self-awareness, self-observations and/or a reflective internal space. Whatever the particular wording to describe the process of self-reflection and/or the development of self as supervisor, the usefulness of gaining skills that associate with the reflective practitioner is borne out in the data, both developmentally for the trainee supervisor and in the benefit to the work taking place between supervisor and supervisee.

Central in the data of the training course experience is the process of identity formation and a shift from the role of practitioner to that of supervisor. This manifests as a transitional experience from the identity of supervisee to the new identity of clinical supervisor. Some participants refer to multiple levels of identity processes that materialised as they acquired new skills, competencies and knowledge. Other data reveals an internal identification of blind spots, of transference and counter-transference that contributed to becoming more identified with role of supervisor. Data showed participants grappling over the initial months of training with the identity formation journey as they describing experiences of ‘being out of my depth’ and of ‘not knowing’. The data reveals these experiences as growth spurts in identity formation and developmental stages at both professional and personal levels. Data also reveals not just the process of integration during the training but a hope and expectation that integration, development and growth will continue throughout the career of the supervisor.

**Implications for Supervision Training**

This study supports the necessity for continued professionalisation of clinical supervision as a discipline in its own right. From this and other studies, the evidence suggests that separate knowledge, skills and competencies are required for the role as supervisor. The combining of training in competencies with experiential practice, together with a reflective practice model, would seem to be an integrated training plan worthy of further exploration.

Many of the writers on supervision training such as Bernard & Goodyear (2009), Stoltenberg et al., (1988), Rodenhauser (1977) believe we ought to devote more effort to research and to studying the subject of training supervisors so as to ensure the highest quality of supervision. Future research might investigate what is the content and quality of effective supervision and how do we train supervisors to provide quality supervision. Further study is necessary into what additional training supervisors need throughout their working life.

The strengths of this study is that the participants were all experienced clinicians and therefore represent a unique demographic compared to other studies wherein participants would have had minimal professional experience. Highlighted is the need for further research into the area of the maturation process of supervisors, the issues and processes that they encounter and what additional training needs are required over their working life.

**Discussion**

The aim of this study was to explore the significant events experienced by supervisors in training to identify ‘key learning moments’ that help graduates in their professional training programme. A further aim was to explore how these key episodes corresponded with the training programme and the components of formal training in clinical supervision.
The graduates provided data that demonstrated a series of changes in perspectives on their emerging role, practice and identity as clinical supervisor.

Three main influences emerged in the findings:

1. **Acquiring theory and knowledge of supervision**

   From a supervisory perspective, one task is to create learning partnerships so that learning takes place in a collaborative relationship. The developmental process for trainees centred around the attaining of the concepts of didactic instruction in theories of supervision and the implementation or blending of acquired theory with experiential practice. Falender *et al.* (2004) refer to professional training as the “primary vehicle by which trainees develop applied competencies” and they include the perspective that “professional development is a lifelong, cumulative process”. All participants commented on the basic need to gain a rich conceptual professional knowledge base and a skillset of competencies in the practice of supervision.

2. **Professional knowledge and experience - putting new learning into practice**

   Data showed that while learning is uniquely personal, the learning attained in a social context of shared experiences amongst trainees was instrumental in the gaining of competencies. The group interactions and the andragogical and reflective practice underpinnings of the training programme met the needs of trainees in supporting their developmental processes. As per the Supervisor Complexity model of Watkins (1900, 1993) the first development stage of ‘role shock’ was transversed by participants by having the arena of practical experiences discussed and studied in a forum of discussion groups and peer supervision.

3. **The integration of professional and experiential knowledge and the forming of a professional identity as supervisor**

   The results of this study reveal a process of assembling previous learnings and experiences with new learning and new experiences that together expand the store of personal and professional wisdom. This expansion includes collaborative and continuous learning which consequently contributes to greater awareness. The findings reveal a movement towards introspection, a deeper more internal channel of development of integration and self-reflection. In a study by Pelling she states that “if the factors that relate to, and may facilitate, supervisory identity development can be investigated they may indicate how better to address supervisory competence and training needs” (Pelling, 2008: 235-248).

   Kaiser & Kuechler (2008) asked the question “what constitutes competent supervision?” Future researcher studies may undertake to identify what constitutes competent supervision and consider how training programmes can incorporate a competency framework into the curriculum.

   Ubiquitous in the findings are descriptions of a deepening of ability to self reflect, what some participants called ‘the internal supervisor’. Participants revealed that reflexivity led to new understandings in all aspects of providing effective supervision and a sense of a more professionally competent and mature engagement with the work of supervision. Data showed this more competent nature manifested in such areas as trainees being able to hold and define good boundaries; an increase in competencies; ability to work with transferences; increased knowledge of theories, and a growing confidence in providing feedback to supervisees.
Conclusion
The results of this investigation suggest that graduates underwent a series of changes in perspectives on their emerging role as supervisor with contributions from a gathering of practice and experiences, well grounded in theories that led to the formation of identity as a clinical supervisor. This series of changes help the newly trained supervisor to feel equipped to provide effective and competent supervision.

The central role of clinical supervision is that of monitoring client welfare. Aiming to identify the critical components of clinical supervision training and of providing competent clinical supervision serves to highlight the impact of such on the competence of the supervisee, therefore improving client outcome.

The results in this study suggest that combining training in competencies with experiential practice, together with a reflective practice model, would seem to be an integrated training plan worthy of further exploration.

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References:
Psychotherapy 2.0 the Approaching ‘Perfect Storm’
by Karen Sugrue

This paper proposes that there is a ‘perfect storm’ approaching the modern world around the question of information provenance and pedigree (where information comes from and whether we can trust it) and that this perfect storm will have a very significant impact on the profession of psychotherapy in Ireland today.

There are a number of elements to this coming storm. Firstly, citizens of the modern world tend to place a very high social worth, an almost blind trust, on cyberspace. Giddens (2013:799) refers to it as the ‘guarantor of authenticity’. If we read it online, we assume it must be true.

A second element is our current relationship with social media which a number of social theorists have argued affects the ability of social actors to identify what is ‘real’, changes the nature of relationships and transforms the entire basis of how we communicate as a society. Certainly if we look at figures for social media usage it is clear that enormous numbers of us are spending increasing amounts of time interacting virtually.

- Facebook – 1.11 billion users
- Twitter – 500 million users
- Tumblr – 216.3 million users
- Flickr – 87 million users – 8 billion photos
- Second Life – 50,000 – 60,000 users online at any given moment

People meet, date, fall in love, have sex and split up online. Friendships are found and lost online. People are bullied and harassed online. Births and deaths (and everything in between) are recorded and ‘posted’ online or live tweeted. Contemporary life is lived in a digitally mediated way as never before and the question of what is ‘real’ has never been more important or difficult to answer.

As with all social trends, this one leads to both threats and opportunities across all sectors and no more so than in psychotherapy.

The two most immediate threats to the profession at the moment are firstly, websites that use unvetted, unsupervised, unsupported volunteers to interact online with distressed and potentially suicidal individuals - youth2youth.org.uk is one example.

Secondly, there is currently evidence mounting and prosecutions pending against individuals who set themselves up as online psychotherapists in order to groom, meet and abuse young and vulnerable individuals.

In both these cases people avail of services online without knowing who or what is behind them, simply trusting the medium.

However, threats lead to opportunities and IAHIP has an opportunity now to embrace the digital medium and to become an industry leader and regulator in the emerging area of the online provision of quality services by qualified, accredited psychotherapists.
Psychotherapy: An Analog Profession in a Digital Age?
It is my belief that as we head further into the 21st century, our discipline has no option but to engage with the digital medium because, quite simply, it’s the only game in town.

If we are to embrace opportunities however, a number of issues must be discussed. In our postmodern globalised world of social media where ‘contact’ has taken on many new faces, can digitally mediated psychotherapy or supervision still hold the nourishment and enrichment of the face to face environment? Can Buber’s I and Thou be achieved on Skype? Can we be physically distant from somatic as well as physical and auditory cues and still attain ‘relational depth’? Does the ‘in-between’ exist on line?

As long ago as 1981, Baudrillard, commenting on the potential power of media, argued that we have entered what he called ‘hyper reality’ where the line between reality and fiction has not only been blurred but eradicated and ‘simulated copy has superseded original article’ (Baudrillard, J. 1981/1994:156). The line between what is real and what is fiction is no longer certain.

According to Baudrillard, (1981) “it is no longer a question of imitation, or duplication, or even parody. It is a question of substituting the signs of the real, for the real” (Ibid:156). He is not merely suggesting that postmodern culture is artificial, because the concept of artificiality still requires some sense of reality against which to recognize the artifice. This, he identified, as the simulacrum. In this context there is no longer a stable and fixed notion of what is ‘real’.

If we also bring in the Marxist idea of commodity fetishism (Marx, K. 1867), that our society gives value to commodities or processes that are unrelated to their intrinsic use or labour (sweat) value, and argue that in keeping with 3rd millennium digital capitalism the online world has been fetishized, we enter into what I have called, a Baudrilliardian simulacrum loop. This is where we no longer know what’s real but because everything ‘on-line’ has been fetishised (given a false value) its very lack of reality gives it high value.

Habermas envisioned a Public Sphere as having the potential to be: “a discursive space in which individuals and groups congregate to discuss matters of mutual interest and, where possible, to reach a common judgment”. Habermas, J. (1962/1989)

When we look at social media products such as Tumblr, Facebook, Twitter, Pinterest etc. there is undoubtedly great potential in the medium for this ideal to be realised. However, Rheingold (1994) argues that ‘discourse’ has degenerated into publicity, and publicity uses the increasing power of electronic media to alter perceptions and shape beliefs (Creeber & Royston, 2008). What dies in this process is the rational discourse at the base of civil society. Instead of the public sphere being used for meaningful political discourse as Habermas envisioned, the process of commodification has transformed it merely into a place which encourages us to buy (Ibid). Because of the blurring of the line between what is ‘real’ and ‘not real’ in the simulacrum loop, we now place a very high value on cyberspace which has an elevated status based on nothing. In other words, there is now an element of blind faith to our online interactions.

Our irrational belief in all that is ‘cyber’ and the erosion of what constitutes ‘real’ means that we are uncritically using online services and drawing on information from the internet without knowing its provenance or pedigree.
I believe that social media and our cultural preoccupation with it and hyper usage of it is a newly emerging form of Durkheim’s social cohesion in the form of organic solidarity (Durkheim, E. 1893/1997). There is a school of thought that suggests that human beings are biologically hardwired to yearn for and strive towards relationships (Bowlby, 1982; Ainsworth, 1985; Karan, 1998) in whatever form, healthy or unhealthy, is available to them. One could argue that the 1.1 billion current Facebook users in the world are evidence of our urge to connect even in the face of modern societies tendencies toward the breakdown of the old networks of community and extended family.

But technology and social change have not lessened the existential fears which have always plagued humans. Fromm (1997) believed that when we evolved from our pre-human existence as animals that we also became aware of our mortality and our disunited human existence became a source of shame and guilt. He argued that the solution to this existential dichotomy is found in the development of one's uniquely human powers of love and reason and that we can use them to find relief from uncertainty.

Existential isolation has been identified by some as underpinning a great deal of dissatisfaction and unhappiness in the world and some existential thinkers are very firm in their positions that the only concrete anchoring points in a world of uncertainty and isolation is acceptance, honouring of self and the nurturing of deep and nourishing relationships (Yalom, I. 1980).

I see Facebook, Twitter, Tumblr, Instagram, Snapchat and all forms of social media as filling the space left by the breakdown of traditional social ties. Old kinship ties and community values have broken down; new forms of economic activity (online banking, shopping, business) have changed all the old structures of casual interactions and possibilities for relationship building. The world is re-situating itself and its vital interactions online.

I believe that we are using forms of technology and social media to stave off existential anxiety, an anxiety only made worse by the blurring of the line between real and not real that is being brought about by new media. This phenomenon can be seen very clearly in the case of self-identity. On-line forums allow individuals to create a *self* that may have little or no bearing to their real life selves, blurring the previously fixed lines of gender, sexuality and ethnicity as well as body type, size and shape and exploring behaviours and lifestyles that might not be possible IRL (in real life). This strongly reflects Baudrillard’s belief (1994) that, *“the notion of an authentic self in post modernity is becoming more fluid and contestable”* (Baudrillard, 1981/1994:105).

In a world, where nothing is as it seems, where reality is confused with image, where messages are lost if they are not amusing or less than 140 characters (Twitter), where meta narratives are cynically scoffed at, where our bodies are commodities to be fetishised, sold or changed at a whim and nothing, especially one’s own self, is solid: in this world psychotherapy takes on ever more important meaning and the search for a stable self in the maelstrom of meaning and images has become, quite literally, a life or death quest.

In this world however, technology is becoming the vehicle for both sides of this quest and the most vulnerable cohort of digital users is young people; the most numerous, and fully socialised into this new digital world – the group the literature calls ‘net-gen’(Creeber & Royston, 2008).

In 2013, it was announced that in Ireland, “10% of children or adolescents can have a mental health problem at any one time” (Craven, C. 2013) and that in relation to existing services, “demand is rising while cutbacks are being implemented”. Craven went further to say that with regard to service
implementation proposed by the 2006 ‘A Vision for Change’ document, that “progress on turning rhetoric into reality has been slow and inconsistent”.

In light of this shortfall between demand and service provision, online options are increasingly being used by Irish people experiencing mental health difficulties. As with every sector of the economy, supply has emerged to meet demand. In light of this trend, IAHIP now has an unprecedented opportunity to lead the sector by creating safe online psychotherapeutic spaces in which we guarantee the provenance and pedigree of the expertise that we would offer online.

I have drawn on Durkheim and Fromm to argue that in a society that does not promote individual authenticity, people will turn to other mechanisms to bridge the gap of relationship and ease the tremor of existential terror and that this process could be seen as occurring ‘online’. It is possible to argue further that perhaps social media is Marx’s new opiate of the masses. When used to stave off existential fears, is new media also dulling our senses and political awarenessnes in the same way that Marx saw religion doing 150 years ago?

Perhaps today Marx would have said of Facebook, that it “Is the sigh of the oppressed creature, the heart of a heartless world, and the soul of soulless conditions. It is the opium of the people”. (Marx, K. 1976)

Post-modernity is the consumption/leisure experience wherein “any point of reference beyond the commodity and any sense of experience as separate to technology is slowly disappearing”. (Chandler, 2004. In. Creeber & Royston, 2008)

Relationships have become a commodity; high status being allocated to young people with a large number of Facebook friends (500+ ‘friends’). As the contemporary adage goes, ‘if it’s not on Facebook, it didn’t happen’.

The director of the RSCI (Royal College of Surgeons, Cyber Psychology Research Centre. Launched October, 2013) Dr Ciaran McMahon has pointed out that we are the generation in charge while this massive technological and social change is happening which is why we have a responsibility not to ignore it.

We are standing at a point in history where technology, with all its potential for both good and evil, has advanced to the point where it can enable and facilitate real and meaningful and contactful relationships and where society has reached a point where a gap has formed between our need for relationship and our ability to access it. In a society that allows less and less time for f2f (face to face) interaction, I believe that technology can provide a new mechanism for community and relationship and contact and real existential reassurance that we are not alone. Further, I believe that psychotherapy, as a profession which situates itself as the arbiter of relationship and the promoter of the healing power of connection, must find itself a safe incarnation in the digital universe or risk becoming obsolete as 19th century coffee house existentialism once did.

**Supervision On-Line?**

Relationship, or as Clarkson (2008:3) refers to it “the interconnectedness between two people” is undoubtedly at the core of all meaningful lived experiences. Increasingly studies are showing that it is the relationship between the client and the psychotherapist that is the dominant factor influencing the outcome of psychotherapy (Steering Committee, 2001; Norcross, 2002; Watkins, K. 2010; Cooper, 2008). If 1.1 billion Facebook users attests to anything, it is that people can and do have relationships ‘online’.
I have conducted a piece of research into the possibilities offered by on-line psychotherapeutic supervision. The study was small in scale and involved self-selecting users of online technology and Skype supervision and so there are obvious limitations to the findings. While keeping those limitations in mind, I still argue that contactful, meaningful and effective supervision can take place online – with some people, at some times and as long as it takes place as part of a mutually agreed upon and co-created therapeutic space. I believe that while the old orthodoxy required the ‘therapeutic space’ to be constructed face to face, new technology and new modes of exchange require us now to re-imagine all the foundation stones of our orthodoxies. If doctors can prescribe medications online based upon a questionnaire (see LloydsOnlineDoctor.ie) then psychotherapists must discuss the construction of a new therapeutic space appropriate for the third millennium.

I believe that a supervisee for whom the digital medium is appropriate and supportive, who works with a practitioner for whom the same is true can together negotiate and collaborate on co-creating an online therapeutic space that works for them and that the very collaboration that this new space requires can strengthen the bonds of therapeutic alliance that the literature says is of huge importance in efficacy, safety and the development of the working alliance (Bordin, 1983:35-41; North, G. J. 2013).

The interviewees all support this position also. They very clearly have said that for some clients and supervisees, at some times, it works brilliantly, and at other times and with other clients it would be entirely inappropriate.

However, it must also be recognised that as much as technology has created new opportunities, it has also created new problems. For example, Richards (2009 in Wolf, 2011) argues that the accessibility of information afforded by the internet threatens the confidentiality and privacy of psychotherapy notes in electronic medical records. And this concern was raised prior to the disclosures in 2013 about the ability of state bodies to access information online for any purpose and at any time. Another challenge is presented by online social networking with regard to issues such as informed consent, boundaries, self-disclosure, and multiple relationships, (Barnett & Russo, 2009 in Wolf, 2011). Bessière et al (2010), note that the simulated realities of video games, online gambling and the fantasies of pornography are leading to a compulsive immersion in virtual realities. Increasingly, couples present for treatment because of emotional affairs started on social networks. Children are vulnerable to cyber bullying and sexual predators. There is even evidence that use of the Internet to obtain health information is associated with increased depression (Wolf, 2011). As Ward (2010) pointed out, there are also a large number of very pressing ethical concerns that urgently need to be addressed to support online practice in Ireland.

Of immediate importance is the issue of the provenance and pedigree of information available on the internet. We can now get medications prescribed by online ‘doctors’ whose qualifications we don’t know and who reside in jurisdictions we are not aware of. Psychotherapists of unknown and unknowable qualifications and experience provide online counselling and therapy in increasing numbers.

In the discussions that must come next, it would be vital to remember the warning of Reingold (1994), that “we owe it to ourselves and future generations to both look closely at what the enthusiasts fail to tell us, and to listen attentively to what the sceptics fear” (Creeber & Royston, 2008).

**Brand Awareness and Marketing**

I believe that the big opportunity now lies in the need to maintain and protect the ‘brand’ of Psychotherapy in Ireland. With registration in sight and technology changing the social landscape in which we operate, it is vital that we adapt.
With new online services being offered every day, professional bodies like IAHIP need to start discussing how they can maintain their brand of excellence in an era which confers status and respectability onto a practitioner simply by virtue of them offering their services online. Once the cases pending against online predators come into public awareness it is possible that psychotherapy in Ireland will take a knock in the public consciousness. Our opportunity now lies in the possibility of leading a national discussion about safe online service provision on the one hand while concurrently marketing ourselves as source of excellent and accredited on-line psychotherapeutic services on the other. A starting position could perhaps be to allow accredited psychotherapists to advertise their online services on the IAHIP website.

As with every vibrant and dynamic field, the ‘leading edges’, the innovators of Irish psychotherapy are ploughing ahead with digital and media resources and offering supervisory and clinical services online in response to high demand. With an eye to the approaching perfect storm of provenance and pedigree, we need to proactively get ahead of events and control where they go, rather than follow where we are led.

Karen Sugrue has been a Sociology lecturer in Limerick Institute of Technology since 2002. She received a Grad. Dip. in Integrative & Humanistic Psychotherapy from UL in 2011. She is currently completing her dissertation for the MA in Psychotherapy and the conference paper she presented is drawn from that research.

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Artist in the Community (Musician) the Healing Power of Music
by Anne Colgan

I first came across the term Artist in the Community in 2004 when I was working as an Artist in Residence with clients who had profound physical and intellectual disabilities. It was my introduction to sharing my music with others in a person-centred way. It wasn’t called that at the time but that is how I worked instinctively with the clients because of my work as a humanistic and integrative Psychotherapist. I have always been a performer (singer) and during my psychotherapy training, I began to look at how the importance of being heard and making a sound is to the essence of our being.

I believe that we all have an ability to make a sound, a sound that is ours. Every sound that we make is valid. Many people have been silenced and told, “Don’t sing”, “You’re like a crow”, “Just mime.” Clients will say, “I don’t have a voice.” In my experience, their voice has been silenced so they stop using it. It also has to do with breath and confidence.

Breath, and our use of it, is essential when making sound. We need to support the sound with our breath. What matters here is that we breathe from our diaphragm. Shallow breath will not provide sufficient support when making sustained sound and singing. Some people breathe in this way, but many people don’t. You can teach yourself. I find this way works best in the beginning:

Lie on your back. Put your hands just above your navel. Pull your navel in towards your backbone using your hands for focus and blow out all of the air in your lungs. Then, let go and let your body breathe in for you. Don’t be surprised if you feel dizzy when you do this at first. Be gentle with yourself. The next step is to make a sound, any sound, on the out breath, uuu, or aaa… This sound is what makes vibrations in your body. These vibrations in turn give you a massage from the inside out.

*If you do this every day for a few minutes it will lead you on to making more and more sounds and to chanting and to singing. You will enhance the voice that you have and you will find your own voice, the sound that is unique to you. Every sound is valid. There is no wrong sound.

Alfred Tomatis MD is a French physician who has been working with the understanding of the human ear. He discovered how toning is therapeutic:

*He was called in to a Benedictine Monastery after the Second Vatican Council. The Abbot had decided that the monks were spending too much time chanting. The monks became lethargic and they were unable to continue their rigorous schedule of work and prayer. Once Tomatis re-established their daily chanting, they were soon able to return to their twenty hour workdays. (Goldman 1996).*

In our day-to-day, life we are often controlled by the music that is around us in supermarkets, boutiques and restaurants. In the fast food restaurants, the colours and the music create an energy that encourages us to eat up quickly and bring about high turnover. The clever high-end boutiques will have relaxing music, which will have the customer linger and spend more money.

Listening to music is powerful and we can use it to our own advantage. “The voice is where the body and mind meet. Our vocal chords, located between our head and the rest of our body, are the channel through which we link these two aspects of our self.” We need to listen not just with our ears, but with all of our body. When listening to music we can become distracted by how it is constructed or by the words. Try letting the sound in to all of your body, allowing your emotions to come up. Music brings us in to the right side of our brain. As well as its healing properties, music accesses our creativity.
Criticism kills creativity. When we make a sound, it is important that we allow ourselves to know that it is good enough, to trust that we can like and love our own sound. Sometimes, in our school going years, your sound didn’t matter, didn’t count if it didn’t fit in. In my workshops, we experiment with any sound that comes to us. The result is profound. There are no restrictions, no barriers and it brings about sadness, anger and joy. This in turn can turn to playfulness and a freedom to experiment and produce more and more sound.

I believe that if you can speak you can sing. You may not be an Opera Singer, but you will be able to sing. Sometimes clients/students are just singing the wrong songs in the wrong pitch. Everybody’s voice has its best parts. Some voices are high and some are low. When you discover where your true voice is you will find that that is where you have the most potential and the most volume. You can try this out yourself. If it is hard work and you are forcing then chances are you are in the wrong place. That is one of the first things I do when someone comes to me and wants to see if they can sing, if they have a voice. The more you sing, the better your voice will be. It seems simple and it is. It is very important to build up gradually and coax your vocal chords to make more and more sounds.

In my work with clients with Physical and Intellectual Disability, I invite them to play with music with me. Every sound counts. I discovered that when I mimicked their sound (most of them couldn’t speak, just make a sound) we made a connection. From there, we danced and sang in their way. Most of the dancing was with wheelchairs. The music gave us courage to experience more and more sound and movement. For two years, we went out in to the community and had integrative Christmas Carols. It was scary because of the physical restrictions but it gave all of us great feelings of fun and joy. This was the beginning for me of Community Music – sharing with everybody.

I was fortunate to be able to work in a Person-Centred Alzheimer’s unit with music. I found that the music formed a connection when words were unavailable or impossible. The challenge when working in a person centred way is that it is really important to be clear this is not just “singing a few songs”. I feel very passionate about clients’ needs being met in a very gentle and empowering way. I found that creating the safe therapeutic container helped me greatly. I would use the same music (chant) to begin and end the session. This was music that I had composed myself so they would not have heard it before and therefore would not have any associations with it, either good or bad. Following that, I would explore the different kinds of music from when they were much younger and build up a repertoire for each client. Songs like, “It’s a Long Way to Tipperary”, were a common bond. During one of the sessions, I began to sing, “When I Grow too Old Too Dream”. One of the clients began to sing it, all the words, all the verses. Before this she would smile, but not engage. When she was singing she was catapulted right in to the present with me. I could see it in her smile, her energy and in her eyes. We had made a deep connection.

The clients were free to come and go, if it became too much for them, they could leave. The medical staff told me that in these sessions the clients were still for longer than at any other time. The music really helped with their anxieties and agitations. Some clients were only able to tap a foot. Any connection at all was exhilarating and powerful. The sessions were two hours long with a 20-minute break for cups of tea in the middle.

Some clients could not get out of bed, so I would go to their bedside. I was always conscious of the fact that they could not move and would watch to ensure that I was not impinging. Often I would just sing a lullaby. I loved this work.

Music heals our body and our soul. It can soothe us and give us great joy. Treat yourself.
Caveat

- These exercises can bring about deep emotions and if you are doing this with somebody else, it is important that you can hold whatever happens.

Anne Colgan is a Psychotherapist who works with music and the creative arts. She has composed two CDs and has had three poems published. She works with clients with physical and intellectual disabilities, cancer and Alzheimer’s. She facilitates Creative Workshops. She also has a private Psychotherapy Practice and is a Supervisor.

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Postnatal Depression, a Feminine Subject
by Heather H. Gillin

Introduction
What is this phenomenon of postnatal depression (PND)? This paper will make an exploration surrounding postnatal depression. The reason I have chosen this pervasive subject is the significant implications for female mental health and the essential trans-generational repercussions that may arise. My purpose is to explore this phenomenon of PND through different discourses. An investigation will be put forth, as to what treatments are available by exploring medical diagnostics versus psychoanalytic diagnostics. For the purpose of my investigations within psycho-diagnostics, I will be focusing on Freudian and Lacanian psychoanalytic theory.

A psychoanalytic examination will be made to understand how the subjectivity of the woman comes into being and how that will inform her identity of not only being a woman but, also a mother. My intention is to illustrate how identification can be viewed as a principle concept in the states of depression.

Medical Diagnostics versus Psychoanalytic Diagnostics
The examination of medical diagnostics will demonstrate that the aim of treatment is to observe, categorize, diagnose and prescribe medication with intent to eliminate symptoms for the patient to return to a prior normal state. Treatment for PND by this discourse will indicate the limitations posed by the medical model when viewing the patient as an object.

A medical diagnosis of postnatal depression is given by the General Practitioner (G.P) after a collection of symptoms presented by the individual, is gathered and objectively evaluated. These individual symptoms are interpreted as signs, signs that point to an underlying disturbance that can be both isolated and generalized (Verhaeghe, 2004). The Edinburgh Postnatal Depression Scale (EPDS) is a diagnostic tool of quantitative measurement, used to track the response to treatment. The outcome of EPDS shows if the woman is getting back to a healthier, normal state, a referral can be made within the provided health care system to another health professional, including a psychologist or psychiatrist.

Psychiatric diagnosis relies on an objective, codified nosological, internationally recognized and categorized system known as the Diagnostic and Statistical Manual of Mental Disorders (DSM). The current reedited version is the DSM-IV-TR does not recognize postnatal depression as a separate diagnosis. Patients must meet the criteria for a major depressive episode and the criteria for the postnatal-onset specifier. The definition is therefore a major depressive episode with an onset within four weeks of delivery.

The patient has to present with only five or more symptoms in order to receive the diagnosis of major depression (See note 1). In the case when the patient is a new mother, the feelings of sadness, a diminished interest or pleasure in activities, weight issues, sleep disturbances, fatigue and a diminished ability to think or concentrate, would be very common. DSM-IV-TR Criteria 7 raises the questions about the presence of what is described as ‘feelings of worthlessness or excessive or inappropriate guilt’. But, what is a person’s economical subjective value of worth equivalent or to whom? Or, what is an inappropriate or appropriate amount of such an emotion as guilt? To measure an emotion seems to be a quite difficult task. Is there an ideal, healthy or normal amount of guilt one should or shouldn’t feel?

The overwhelming experience of having a new baby may cause the woman to doubt her capabilities and qualities. Suicidal ideation of course, alarms for a risk assessment. The aim of treatment again is
to observe, categorize, diagnose and prescribe medication to eliminate the symptoms. Anti-depressants are prescribed to increase the patient’s mood.

I think at this point, there are a few more questions which should be asked in order to enable a more in depth investigation. Should the elimination of the symptom be the only goal of the treatment? Or, is it possible to ‘get better or to get back to a healthier normal state’ (EPDS website) through the medical approach with its pharmacological treatment only? Are the answers offered by the medical model sufficient to answer for instance, why some women suffer from postnatal depression and others do not, or why the symptoms return in some cases? I will try to answer these questions by the exploration of psychoanalytic diagnostics.

In the psychoanalytic approach, the woman suffering from PND is viewed as a subject and there is a great importance placed on listening to her particular unique history. Clinical psycho-diagnostics cannot be restricted to the individual, the impact of the Other is fundamental. The Other is represented by parents, education, society and culture, which influences the woman’s identity.

The subject’s symptoms carry meanings and have a function that transcends the individual, which can yield more gain than losses. These symptoms unvaryingly come down to a patients’ economic attempt at a solution for an underlying, structurally determined problem. The symptom is a manifestation of an unconscious conflict. It carries a certain kind of a message for the subject and during the psychoanalytic treatment it manifests itself as what Jacques Lacan would call the ‘truth taking shape.’ The structural problem is not limited to the individual but understood from within the terms of a relation with significant others Verhaeghe, P. (2004). The event of giving birth to a baby and becoming a mother changes the balance sheet of the subject, to the point, that her loss finally becomes too significant. The PND symptoms portray either a gain or loss towards the Other. There is a necessity for the restoration of the previous economic balance rather than the removal of the symptom itself. The aim of psychoanalytic treatment is to allow the change within the underlying structurally determined relation with the Other, through going back to where the symptoms originally materialized.

Identity of Woman, Mother and Other
I would like to explore subject formation, more precisely, to see how the subjectivity of the woman comes into being and how that informs her identity of not only being a woman but also a mother. I will be putting forth a brief examination of Freudian and Lacanian theory of the Female Oedipus Complex as a way of understanding how the woman negotiates herself as a sexed being and informs her fantasies of being a mother.

In his thesis of Feminine Sexuality, Freud did not try to describe what a woman is, but how she comes into being. Her identity is constructed by the Other. The Other is represented by parents, education, society and culture and it influences the woman’s identity.

Subject formation engages three moments for the subject: incorporation, identification, and alienation. The very first identification takes place during the mirror stage and provides the casing, or bodily representations that will hold all later identifications. It is an image of an object that is brought inside or internalized through the pleasure-unpleasure balance. These representations are based on and provided by the primary care giver i.e. the mOther. The intimate identity of the subject or subjective identity is nothing more than an integrated collection of identifications. The subject identifies with word, signifiers and images of the mOther. The mOther is responsible for the success of this relationship. She establishes the processes of the drives, as well as, the first layer of identity. External and internal worlds are developed at the same time. Subjective identity is created originally through
the Other’s mirroring. The mOther mirrors what the child internally experiences. Lacan (1939) calls this process the ‘Mirror Stage’.

It is impossible for the mOther to fully satisfy the demand and need of the child, the mOther is seen as inadequate and she will be the one to blame for what goes wrong internally. Lacan stresses the importance of the mirroring process in the identity formation i.e. ‘alienation’. The image is represented by the mOther, which the child takes in and forms the foundation of the ego but it is alienating because the image appears to be whole. The child’s internal experience is mirrored and symbolized, put into words by the mOther. This is a dualistic relation between I and mOther. The Oedipus complex turns the dyad into a triangular relationship, by way of castration and the ‘Paternal Metaphor’, which separates the woman from the child, opens the space and possibility of difference.

The castration complex is the instance, the creation of the human as a subject and the installation of the law, ‘The Name of the Father’ or ‘Paternal Metaphor’ (Lacan, 1957). It is the father, or his representative, who instals the law by cutting off the mother’s dualistic desire for the child. If the law is denied or foreclosed, then the dual relation of the mOther and child continues to exist with no sexual difference and the structure of psychosis ensues. If however, the presence of the law is accepted, repression occurs, sexual difference is acquired and with that, the fortunes or misfortunes of neurosis follow.

According to Freud, the Oedipus complex has a different outcome for the boy and girl. In the case of the little girl, she must give up her mOther as her primary love object and does this by her discovery of the penis, that of which she lacks. What arises for the girl is ‘penis envy’ (Freud, 1925). The girl acknowledges the fact of her castration and with it, her own inferiority and the superiority of the male. The way she gives up her mother is by a feeling of resentment because her mother failed to give her a penis. This depreciated mother is now viewed as castrated/lacking. Freud states that the penis envy originates in discovery of the anatomical distinction of the sexes and it is a fundamental element in female sexuality. The wish (Wunsch) with which the girl turns to her father is no doubt originally the wish for the penis, which her mother has refused her, and which she now expects from her father. The feminine situation is only established, however, if the wish for a penis is replaced by one for a baby, if, that is, a baby takes the place of a penis in accordance with an ancient symbolic equivalence (Freud, 1933: 128). Freud considers that the female attains her final normal attitude where she takes her father as her love object and finds her way to the female Oedipus complex (Freud, 1933: 376). The girl re-identifies with her mother to create her feminine identity. The girl is assured that someday she will be ‘whole’ either through the love of a man or by having a child. This will sustain her being and inform her fantasies of becoming ‘whole.’

In the theories of Freud and Lacan, the distinction between the sexes brought by the castration complex and the different positions that must subsequently be taken up, confirms that the subject is split and the object is lost (Lacan, 1967: 25). In the 1924 article The Dissolution of the Oedipus Complex, Freud describes that the Oedipal wishes need to ‘be more than’ repressed, to the point of destruction. It is in every neurotic symptom that hides a particular formation of the Oedipus complex. Freud connected women’s depression with her position toward castration. The position towards castration is one of a lack.

A woman’s pregnancy, for some, may be represented as a fiction or maternal fantasy that a child, her object cause of desire, will sustain her and create the oneness or wholeness she longs for and which may not have been achieved through a sexual relation. The realization of such lack may now be attempted to be satisfied and fulfilled in expecting a child. Expecting represents two as one, the only
time two can co-exist, differentiation in co-emergence as one (Ettinger, 2009). This expecting, co-existing, has a long gestation period which can either be felt as a unity of creation or as an invasion of the body, felt as something ‘weird’ (Hollway, 2011). “That earliest enwrapment of one female body with another can sooner or later be denied or rejected felt as choking possessiveness, as rejection, trap, or taboo; but it is, at the beginning, the whole world” (Rich, 1976: 218). The woman is on the threshold of being a mother. This differentiation in co-emergence, co-existing unity will become separated and she will be faced with life and death on a parallel. The woman is faced with her own mortality along with that of the child’s. She has been responsible in co-existence, for the survival, of this infant and the imagined object cause of her desire is now in the ‘Real’.

Giving birth can leave many traces with the woman and infant which have several consequences later on. She has transitioned, her identity from the woman to mOther, bringing along all her own particular associations and identifications as to what a mOther is. Birth can be an experience filled with overwhelming jouissance, excitation and pain. The jouissance of the body is very difficult or impossible to signify. As Adrienne Rich describes;

Emerging from the fear, exhaustion, and alienation of my first childbirth, I could not admit even to myself that I wanted my mother, let alone tell her how much I wanted her, I wanted her to mother me again.

(ibid: 222-223).

Rich is making an important observation here, by showing us the link between the woman and her own mother. The woman’s own identification with the newborn, as a representation of herself is the desire for her to be mothered once again. Now confronted with this infant in the ‘Real’, the woman experiences many emotions. The loss of the unity she felt in pregnancy and the overwhelming responsibility to nurture this helpless human life.

Anxiety is felt and questions arise as to if what she is doing is right, or how is she supposed to know what to do. Postnatal distress accompanies a variety of different intense feelings ranging from guilt, anxiety, persecutory experience and states of depression. Psycho-social, economic and cultural factors also contribute to the women’s feelings and expectations. Feelings of ambivalence occur, these conflicting feelings of love and hate stem back to her particular pre-Oedipal relation to her own mOther, her first love object. Adrienne Rich also describes her own early maternal experience:

The excitement of long buried feelings about one’s own mother, a confused sense of power and powerlessness, of being taken over on the one hand and reaching new potentialities on the other, and a heightened sensibility which can only be bewildering, exhilarating and exhausting.


Joan Raphael-Leff (2010) terms this reactivation of experience and confusing identifications with both mother and baby as ‘contagious arousal.’ These primitive emotions are a retriggering sensual non-declarative memories and procedural emotions.

Conclusion
The state of depression is symptomatic for the subject and carries a particular meaning back to the mOther, where the woman’s identity began. We could say that the state of depression is a calling to the mOther. It is the inner image of the subject that has become disassembled, which entails a losing of anchoring points in the subject’s life. Depression is a sign of a moment of passage, a transition, that can either be taken or missed, occurring within the larger framework of what is sometimes called
the symbolic realization of the subject, although, some subjects are more susceptible to the states of depression due to their particular history. The Psychoanalytic treatment allows the woman to investigate her identifications within the process of transference. Although I am aware that there are no definitive answers in regards to questions concerning the phenomenon of PND, my intention was to investigate the different discourses of treatments available and to illustrate that identification can and should be considered as a principle concept in treating the states of post natal depression.

Notes:
The standardised approach for the criteria in a major depressive episode in the DSM-IV is:

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either

A) (1) depressed mood or

(2) loss of interest or pleasure

Note: Do not include symptoms that are clearly due to a general medical condition, or mood, incongruent delusions or hallucinations

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

4) insomnia or hypersomnia nearly every day

5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6) fatigue or loss of energy nearly every day

7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B) The symptoms do not meet criteria for a Mixed Episode
C) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., hypothyroidism).

E) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

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The Experiences of Mothers Bereaved by Suicide: An Exploratory Study  
by Joan Sugrue

Little is known about the impact of suicide on the ‘survivors’ or the suicide-bereaved and the concept of a mother’s grief following the suicide of her child remains poorly understood. The mother-child bond is often one of the strongest (Farnsworth & Allen, 1996) and the death of a child creates profound changes in a mother’s life (Thrift & Coyle, 2005). Little research has examined the impact on mothers of losing a child and researchers have given little attention to mothers’ own accounts of their experiences, despite the general consensus within the literature, that the death of a child is the most traumatic loss that can be encountered (Stroebe & Schut, 2001).

The aim of this study was to explore the bereavement experience of mothers following their child’s death by suicide.

Participants
All were biological mothers and all had at least one other child. Five of the suicide victims died by hanging or strangulation; one died from an overdose and one died from an overdose plus suffocation.

Materials
A semi-structured interview schedule was developed to guide the interviews and to explore: reflections on motherhood and relationship; immediate aftermath of suicide; and the impact and meaning of the suicide.

The study was approved by the Royal College of Surgeons in Ireland Research Ethics Committee.

Procedure
The researcher read and re-read transcripts, and recorded initial thoughts and emergent themes. Themes across all transcripts were then summarised using colour codes. This ‘connecting the themes’ allowed the themes to be clustered together and for each cluster, a superordinate theme was produced. Repetitions of the emergent themes were assumed to be indicative of shared understandings. A master set of superordinate themes was used as the basis for writing up the findings into a narrative, illustrated with selected quotes. Extracts that best captured the ‘essence’ of participants’ experiences were selected for inclusion.

Results
Four separate but interrelated themes were identified:

Silencing of my grief
Initially, the mothers reported that they felt compelled in some way to keep their emotion and pain hidden and to ‘put on a brave face’. Six reported that they were afraid to release their pain and grief publicly and believed that they had to protect others from it: “I had to keep myself in check and did not want to lay my grief on them [other adult children]. I thought I was looking at a film on TV and put myself outside of this or I would have screamed”.

Although the funeral and burial rituals provided an opportunity for open grieving for other mourners, this was not the case for most present mothers. For example, a 50-year-old woman who had lost her son spoke about how she noticed the pain of others both at the hospital and during the funeral, but was unable to acknowledge or show her own pain:
I remember the doctor asking me if I was Barry’s mother and telling me she was sorry but Barry was dead and she [the doctor] was crying. I had never seen a doctor crying before. Also, I was conscious of soldiers in uniform at the graveside and tears rolling down their faces. I knew soldiers in uniform were not meant to show emotions...everyone thought I was coping as I hid it well, but I just went to rock bottom and ended up drinking and taking an overdose of tablets.

It was important for one mother to feel that she had validated her son’s life and she wanted him to be remembered as a hero. She was determined that he would have a tumultuous send-off and that she was going to be as brave as he had been: “There is no way there was screaming and crying...there was honour and music soared up to the sky...inside, I felt I could not bear to take another breath.”

Another said,

...you can’t make a fuss. You have to do things and behave in a certain way. I thought to myself, ‘I don’t think I can survive this. It’s the end of my life too’. I asked myself ‘why am I not going off the rails?’ But inside it was like my whole insides were pulled out. Inside I was screaming.

In contrast, another mother became highly emotional at the cemetery: “I just screamed and screamed and went totally berserk when they went to lift the coffin. I threw myself on top of the coffin and was kissing it and telling him how proud of him I was”.

Shattered Assumptions – ‘It’s the end of the world as I know it’
Each of the participating mothers felt compelled to confront a situation in which the tragic loss of their child through suicide had turned their whole world upside down and shattered many of the assumptions that they previously held about themselves, their life and their world. Two mothers said:

I expected to die before my child, leaving everything organised for them...this is a big empty void that shoves everything in [sic] perspective and makes you realise what life is all about.

...And I just knew the world would never be the same again. It was the end of the world as I knew it...

A 67-year-old mother, who had grown up within a religious family, experienced a profound loss of her faith and belief in many aspects of her life when her son died: “I don’t believe in almost anything I was taught. I see life in a totally different way now. It [the world] changed utterly when he died and became a completely different place. When he died, it was just the end.”

Another mother spoke in a more positive way about how the death of her child led her to completely re-evaluate her life and how she became less upset about things. One of the mothers used a powerful metaphor:

...it was like if you look through one of those kaleidoscopes and you see a pattern and you think it is beautiful and you do not want to move it, and then it moves and it all changes and that’s what happened in my life.

Constructing a narrative
Arguably, attempting to make sense of the death of a child is a major challenge for any bereaved parents (Neimeyer, 2000), yet many of the mothers in this study were able to construct a narrative that explained the death to others and to themselves. “He did this to make things easier for everyone. He has shown huge courage.” “In the end he was totally worn out by it all. It just sort of broke him.”
Mothers identified family issues such as poverty, alcoholism, violence, and past bereavement as influential factors in their child’s life and consequently their death. The mother of the youngest child in the sample cited bullying as a contributory factor in his death and how her son had stopped her from openly addressing this issue because he believed it would only compound his difficulties.

A sub-theme of ‘love and forgiveness’ was prevalent throughout each of the interviews and the mothers appeared to have a great sense of understanding of the pain their child must have felt in order to choose to die in this way. Ironically, for some participants, it was the legacy of pain following their child’s death that had facilitated that understanding. “After he died I wanted to die myself. I finally understood the pain he must have been in.” “There were times after his death I just wanted to die and suddenly realised this is what he must have been feeling.”

The following excerpt illustrates well the level of love and forgiveness many of the mothers showed for their deceased child:

“I said ‘thank you’ for not going outside and for not having to drag through a river looking for your body, or wait for it to be washed up at sea. He was one of the most unique people I ever met. I was privileged to be his mother.”

Blaming is endemic in families after a suicide (Ness & Pffeffer, 1990) and usually involves the projecting of anger and guilt outside the immediate family members onto someone or something else. However, failure and self-blame also permeated most of the mothers’ accounts:

“I should have seen it coming. We should not have gone on holidays and left him.

“I never saw nothing [sic] I just thought he was distancing himself because he was growing older.

“I do feel I failed him. I was not there when he died.

“I don’t know why the hell I didn’t cop on? I should have picked up that something was wrong.

Several participants felt that the death impacted their role as parents to their surviving children. For instance, one mother described how she was alerted to her surviving son’s pain whilst another was jolted back to the reality that she had other children who needed her support:

“It was not until one of his tears fell on my cheek that I woke up to the fact that my other son was crying every night of the week.

“One of them said ‘Ma what about us, you are putting all your love into him and he is dead. We are here too’.

The narrative of ‘failure as a mother’ is striking in its direct contrast to that of love and forgiveness’ described earlier; the mothers had no difficulty in finding forgiveness for their children and yet appeared to struggle to forgive themselves.

The depth of a mother’s grief, ‘This leaves a scar on the soul forever’

Predictably, it would be expected that stories of unhappiness and pain would emerge within a study of this kind, but the level and depth of suffering and sorrow described by the participants was striking. The following excerpt from one interview expands upon this theme:

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A Gathering of Psychotherapists... 21 years on: Value and Values of Psychotherapy 2013  65
Total devastation. I will never come to terms with this because he was my baby. What I feel is total sadness for my child that it came to a child putting something around his neck and taking his own life. His feet was [sic] only inches from the ground and his whole body was just scrunched up.

The intensity of the mother-child bond and the natural inclination for mothers to want to hold and touch their child is well established in the literature (Rando, 1986). In the current study, one of the participants described the constant longing to hold her lost child and smell his skin; for her, this was one of the most difficult feelings to manage. Similarly, another mother commented that, had her son not been cremated, she would have battled with an urge to go and “dig him up” from his grave and bring him home again. Notably, all of the mothers indicated that they had experienced mental health problems following the suicide. One mother described her pain as follows: “I sat looking at a wall for weeks and had to go on medication. It’s a hole in my stomach that doesn’t go away and it’s like someone putting their hand in your body and pulling your heart out.”

Another mother who discovered the body of her dead son described her reaction when she found him: “I just lay beside him and tried to hold his hand but rigor mortis had set in. I did not want to tell anyone – as I did not want them to take him away from me.”

This seemed to be her special time to say goodbye to her son in private before his body was removed. These intense feelings of love were peppered throughout all of the transcripts and led to great agony and anguish. The strength of this mother-child bond and the intense bereavement is continued in these powerful excerpts:

And to know your son is locked in a freezer and you want to cover him up and warm him and get him to sing our songs from when he was a baby.

I was very scared as I did not know what I would see. I did not want to go and see my only son in a coffin. I thought I would die.

The very worst thing was seeing him in a coffin. I collapsed and I vomited before I went into the inquest. The fact that he was going into a furnace was so hard and knowing his beautiful eyes would be burnt to a cinder.

A further constant source of anxiety for many mothers related to how their child felt and what they may have been thinking at the time of their death. The following comment illustrates the depth of their anguish:

I would get this feeling of ‘Oh God’ imagine how he felt. He must have been so lonely. I can’t bear how unhappy and lonely he must have been.

He must have thought that nobody wanted him.

Importantly, many of the mothers alluded to having had strong suicidal feelings and one admitted to a suicide attempt following her son’s death. The urge to want to still take care of their child, even in death, was prevalent in many of the transcripts:

I wanted to go and find my child and know he was ok. I drove to his grave and took tablets and waited for him to come and pick me up. My partner found me and took me to hospital. I woke up two days later and finally understood the pain he must have been in.
I just wanted to die myself. The grief I have is like a tsunami at times and the draw to go to him was more than the draw to stay at times. I have not done it but have been lucky.

I know it’s a terrible thing to say but I won’t mind dying and I don’t think I can survive this. It really is the end of my life too.

I needed to mind him and the only way I could do this was to go to him. It was like I could not let go of the umbilical cord.

Present mothers totally rejected the commonly held belief that time heals grief. Emotive language was particularly evident as the women searched for appropriate words to describe how it felt to be told repeatedly that ‘time will heal’, ‘grief is a cycle’ and ‘you will feel better in time’:

This will never heal – never go away. I will take this grief to my own grave.

Time does not heal the scars that are left after a suicide. The scars of suicide are with you forever.

In suicide, this nonsense about time heals is a load of ****. This is a scar on the soul forever and with a mother it goes beyond the grave.

All the mothers who had experienced the death of other family members agreed that the bereavement from suicide was very different in terms of the intensity of the pain and the complex mix of emotions that it brings.

Discussion
The findings reported here add to the limited literature regarding the impact of, and difficulty in resolving, maternal bereavement following suicide. The results provide a rich, meaningful, and often disturbing account of the personal experiences and profound stress of maternal bereavement following suicide, whilst also giving ‘a voice’ to this vulnerable and often neglected group.

A further significant finding from this study was that despite the construction by mothers of positive narratives regarding their lost child, the most common narrative they constructed around themselves was one of ‘failure as a mother’. This may perhaps be best understood in the context of McGoldrick et al’s (1991) argument that a child’s psychological flaws become the exclusive responsibility of the mother and can lead to mothers carrying blame.

The commonly acknowledged ‘depth of a mother’s grief’ evident in this study was identified as the final theme in this study. Many mothers reported physical and mental health problems and similarly, Maples (2005) found that parents may experience a wide range of health difficulties immediately after the death and in the longer term. An additional key finding in the present study was the mothers’ abuse of medication and/or alcohol to help them cope; alcohol use is not incorporated in many studies as an outcome variable and it is interesting to note that this was spontaneously raised by the mothers here.

Most of the study participants also developed significant suicidal thoughts/ideation and indeed, one mother had attempted suicide. The mothers in the current study put forward reason to account for their suicide ideation/behaviour. Although they all had other children, they felt an extraordinarily strong desire to go and seek out their dead child. They wanted to know that their child was alright, even in death and they felt the only way they could do this, was to die themselves. This finding is previously unreported in the literature and it is possible that this phenomenon is unique to mothers and closely related to the mother–child bond.
Conclusion
This study highlighted a number of factors not previously reported in the literature, including participants’ reasons for wanting to die in order to be with their child and the impact of guilt and blame on their belief of themselves as a ‘failure as a mother’. These findings highlight a need to focus on this vulnerable sub-group in future research as well as other subgroups such as fathers, siblings and the wider family circle. It would also be interesting to establish the extent to which bereaved mothers are accessing health and social care services such as GPs, mental health and alcohol treatment services. Another potentially fruitful line of research might involve assessing the cross-generational impact of suicide (in view of the potentially large numbers of family members affected).

Overall, this study suggests that the needs of those bereaved by suicide should be a concern for health care providers. The total cost of the unmet needs of this group, in terms of suffering, health problems and economic losses, are unknown and incalculable (Muller and Thompson, 2003). This exploratory study shows that suicide-bereaved mothers deal with immense grief and a complexity of issues, which not only impact on their overall health and wellbeing, but more importantly, change their lives and the lives of their families forever.

Joan Sugrue is a counsellor and family therapist who has worked in the addiction field for over 20 years. She has a Masters Degree in Bereavement Studies awarded by the Royal College of Surgeons in conjunction with the Irish Hospice Foundation. Joan completed a study of Mothers Bereaved by Suicide.

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A Phenomenological Exploration of Adult Adoptees Experience of Personal Achievement
by John Phillips

Introduction
The choice of research area is one of personal significance, as I was adopted through Ireland’s closed system of adoption. It was through the exploration of the self through the process of personal therapy as a counselling and psychotherapy student over the last four years that the personal recognition of my adopted status came very much to the forefront of my thinking, a rather significant influential factor of my lifespan development which I had conveniently put to one side, as something which had little bearing on my behaviour.

My adoptive parents were, from the outset of my infant existence, very vocal in explaining to me that I was adopted and offering future support should I wish to search for my biological parents at some point. This openness to adoption within the family unit appears to be consistent with the experience of the participant adoptees who kindly took part in the research, however, there was one exception to this experience, as one of the five participants was reared in the North of Ireland whereby his knowledge of his adoption was only realised during middle adulthood, this participant further regaled during the course of his interview that two of his cousins only discovered their adopted status in early adulthood.

Although the contrast in the research participants experience of how their adoption was communicated to them is analogous to polar opposites, as one imagines was the policy of the respective adoption agencies on informing adoptive parents on how to broach the issue of adoption or not, whatever the case may be. One item is clear from the aforementioned former agency policy and doesn’t even apply to the latter policy on informing the adoptive parents, is that there was a complete oversight into the affects of breaking the genetic attachment on the adoptee.

This ethos was a main stay of the 1952 Adoption Act which was made law in Ireland complete with the approval of the Roman Catholic Archbishop John Charles McQuaid, didn’t envisage that the adoptee would seek to make contact with his/her biological parents at any point in the future. The ethos of the 1952 Adoption Act was in direct contrast to earlier views on adoption espoused by adoption researcher and member of the Boston Psychoanalytic Society – Florence Clothier when in 1943 she stated that -

> Besides the usual demands made upon the ego, the abandoned child must also compensate for the wound left by the loss of the biological mother: He is denied the primal relationship, the continuity of nurturing and security experienced in utero, as he makes his entrance into the new and alien world outside the womb

(Clothier, F. as cited by Verrier, 2011: 28)

This quote would suggest that adoption and the break in early attachment leaves a void in the adoptees sense of self which has to be filled.

One of the hypotheses in the research is that this void is filled with the adoptee’s need and drive to achieve. The decision to research achievement in adoptees was strongly influenced by future research recommendations in Lauren O’Brien’s (2011) dissertation on Adoption and Attachment which identified achievement as one of the themes. This was coupled with my own experience as an adoptee and the internal pressure I had placed on myself to reach the highest levels on whatever structured
endeavour I became involved in, typically structured, as this was a concrete means of self-evaluation. On the surface, this would appear to be quite a positive personality trait, however it can become exhaustive and can have negative implications in maintaining personal relationships. Through self-exploration and through reading adoption literature, I believe this motivation to achieve is strongly linked to the need to be accepted, a primal need which wasn’t fulfilled for the adoptee. Therefore, the motivation to achieve which when in turn links with perfectionism as an unconscious defence against rejection form the (m) other. Simply put, “If I do everything perfectly, this will in turn give the (m) other no reason to find fault in anything I do which effectively means finding fault in me, which of course must have been the case when I was born, otherwise my birth mother wouldn’t have rejected me”. Clearly, from numerous accounts of outlining the reasons babies are relinquished for adoption, it is rarely if ever as a rejection by the birth mother, but rather typically through socio-economic reasons and the influence the Catholic Church had on post independence Ireland through to the mid 1990’s. It was through the formation of this hypothesis that culminated in the list of research questions as means of exploring adoptees experience of personal achievement.

The Research Outcome
It was decided to use a qualitative approach to the research due to its rich means of gathering data and of course given the emotional aspect of the research topic, it was felt that through using semi-structured interviews would allow a greater scope of each participants very individual experiences and thoughts would bring to the research whilst being supported throughout the interview process. The participant sample was somewhat random as it was formed through word-of-mouth and was limited to five participants comprising of two males and three females over the age of 21 and adopted in Ireland. Apart from seeking a participant gender balance and being of 21 years or older and reared in Ireland, there was no other limiting criteria in the sample outside of the ethical considerations. The participants were each interviewed for one hour and the following outline of ten questions was adhered to as summarised by the following topics:

The participant’s demographic details i.e. age at adoption and what age were they told/find out about their adoption; Education/Career attainment; Both their biological parents (if known) and adoptive parents educational/career attainment; Number of siblings (if any) and their adoption status; Sense of self and perception of how one might be described by others in comparison to one’s self description; The experience of growing up as an adoptee; Relationship with adoptive parents; The interest or motivation to search for ones birth parents and if a meeting has taken place, what was the outcome?; Satisfaction level with educational/career achievement to date and what these achievements have been.

The outcome of the five interviews and through the analysis of the subsequent verbatim transcripts, five main themes were identified – Independence, Career Focus, Medical History, Betrayal & Fantasy. All five participants were very clear in how they perceived themselves as being very independent; this was coupled with a subordinate theme of control. This is consistent with the literature on the infant adoptees experience on breaks in early attachment from the bond which is ultimately broken between infant and biological mother, a bond which becomes established during pre-natal development.

Followed by this, the adoptee infant, in the majority of cases spent a period of approximately between two weeks and three months in a state run institution until suitable adoptive parents are found. Again, any attachments with nurses/care workers which are formed are broken when the infant is ‘handed over’ to the adoptive parents (incidentally, such attachments were discouraged due to the inevitable break in same and to prevent favouritism to one infant over the care of many others). Lastly, when the infant is placed in the adoptive home, there lies uncertainty from the perspective of the adoptive parents unconscious or conscious whether they can fully emotionally commit to the infant whom for a period
of up to one year may be removed from their care and returned to his/her biological mother, thus there may be a further delay in attachment formation.

It is believed that the severing of early attachment during the adoptees early developmental stages leaves an indelible mark in their unconsciousness which manifests itself in the need for independence and control, two elements that were absent from their early infancy as profound life decisions were made for them by others, thus the innate desire to regain control and independence. Interestingly, all of the five participants had achieved considerable career success, all were very modest in their achievements and attributed their motivations to being no different from any of their non-adoptee peers, however one participant’s narrative displayed a very unambiguous desire to achieve, this was demonstrated through a strong sense of self assessment and criticism. Furthermore, all five participants were adamant that their adopted status has made no impact on their lives. Consistent with the majority of previous research into measures of educational achievement in adoptees which reported below average scores in academic performance measures up to the age of ten years, whereupon the adoptees academic scores later fell more into line with their non-adoptee peers and often excelled in early adulthood.

In addition, medical research into the stress on the developing foetus found that mothers, whom experienced high levels of stress throughout the term of their pregnancy, firstly, resulted in a reduction in blood flow to the uterus and foetus. Secondly, the transplacental transport of maternal hormones to the developing foetus activates stress, and thirdly, the stress-induced release of placental cerebrospinal fluid to the intrauterine environment, resulted in more movement in the womb, particularly observed in the developing male foetus. From birth to ten years of age, poor psychomotor performance and more difficult behaviour was also recorded by the researchers. It is plausible to suggest that mothers whom experienced an unplanned pregnancy and have to give their baby up for adoption are likely to be highly stressed during the term of their pregnancy, thus this research may add to the explanation of early developmental issues in adoptees.

All five participants noted how their memories of early formal education wasn’t pleasant, in part as a result of difficulties experienced in comprehending class lessons resulting in a general disinterest in school. However, in late adolescence/early adulthood, significant change was reported by the participant group as they excelled in their chosen area of study and or profession. The concern over access to one’s medical history was reported across the participant group, as fundamental to Ireland’s closed system of adoption, such information is withheld from the adoptee. This provided the catalyst for initiating a search for the adoptees biological parents whereupon for two participants, their search was successful and they were provided with access to this information through their meetings with their biological mothers. Interestingly, both of these participants reported that they had no emotional attachment with their biological mothers and met only very rare occasions although they really empathised with their biological mothers and what it must have been like for them to give their baby up for adoption and the lack of social support they would have received at the time. This contrasted with how two of the participants whom had yet to initiate a search for their biological mothers believed that they would form a very close attachment should they meet, this fantasy was again contrasted with one participants concerns that there might be a potential that should he initiate a search and be successful in this, he was concerned that his biological mother might “see him as a meal ticket”. The participant regaled how a friend who was also adopted, found herself in such circumstances, and thus was his fear that he would experience a similar outcome. Common to all five participants’ feelings in seeking to or having made contact with their biological mothers was a strong sense of betrayal, the betraying of the adoptive parents whom selflessly took them in. Again, there were contrasting participant reports on how they envisaged/experienced how their adoptive parents might/have react/ed
when the subject of searching for their biological parents was broached. These reports ranged from the adoptive parents being very supportive and also inquisitive through to being somewhat upset by the subject. An area of concern but not a surprise for the researcher was the severe lack of information made freely available to adoptees when or if they decide to initiate a search for their biological parents as all three participants who hadn’t met their biological parents believed that the only conduit for making contact was through the adoption agencies. This is no longer the case, since, now deceased former minister for children, Brian Lenihan, had to reverse legislation in 2001 made by his former predecessor to the position, Mary Hanafin, who had made it illegal for adoptees to initiate an independent search for their biological mothers which could incur a punishment of up to one year’s imprisonment. Initiating an independent search places the adoptee at the wheel in giving more control over the process, which has the additional benefit of making the process much speedier.

Conclusion
The vast majority of the previous research into adoption and achievement was longitudinal and used a quantitative research method. This research primarily focussed on the developmental outcome of adoptees compared to their non-adoptee peers in measuring educational attainment. Although this literature was of great significance in giving an insight into the early academic lives of adoptees, it stopped short of offering an explanation with regard to why adoptees in early life underperformed and in many cases excelled in later life. Through linking medical research into prenatal stress with social science research with the aforementioned educational attainment in adoptees research, the author concluded that it is plausible that adoptees may suffer with varying degrees of ADHD in their preadolescent developmental phase. Although this only offers the potential of uncovering one layer of what influences the behaviour of the adoptee, the attachment developed during the prenatal phase which is so abruptly severed at birth which through an understanding of the affects of this trauma can add another degree of understanding the behaviours of independence and control which was common across the participant group of adoptees interviewed. It was felt by the researcher/interviewer that at times during stages of the interview process, the participants displayed a great deal of defensiveness, particularly around exploration of differences in being an adoptee as opposed to a non-adoptee. However, the outcome of the research did find behavioural patterns that were synonymous with previous research, in particular in the areas of educational attainment from infancy to adulthood. It is the aforementioned defensiveness that protects the adoptee from exploring a history that is very difficult to really begin to actually consider.

John Phillips graduated from Dublin Business School in November 2013 with a Masters Degree in Psychotherapy, having previously been awarded a BA Hons in Psychology followed by H-Dip in Counselling and Psychotherapy in said institution. John continues to practice in Aris Counselling and Psychotherapy using a psychodynamic approach.

References:
From Individual Psychotherapist to Group Conductor
by Helen Jones

My first training and professional identity is as an Integrative Psychotherapist in Individual work. In 2004, I embarked on a Psychoanalytic Training course in Group Analysis, which I completed in 2012 having been awarded an M.Sc in Group Psychoanalytic Psychotherapy (also referred to as Group Analysis). This workshop aimed to describe that journey which was challenging and enriching. My thesis also spoke to this experience of moving from Individual Psychotherapist to Group Conductor - and back again. At times the experience can be compared to a ‘regression’ in which I felt deskillled and incompetent. At other times it was like a ‘progression’ and a professional expansion. At this remove I can reflect on the experience and hopefully integrate all that I learned. Some of the challenges relate to the sense of loss of one’s competency. The group setting tends to evoke oedipal issues such as rivalry, competition and loss. The move into the Conductor’s role takes time to integrate …the therapeutic position is quite different e.g. it is less active and interactive and the “listening” involved is of a different nature. It also demanded an increased capacity to wait and to be patient as the group themes emerged.

The workshop introduced the Theory of Group Analysis, in particular the ideas of S.H. Foulkes, the influences on his thinking and the development of Group Psychoanalytic Psychotherapy.

Among the important influences on Foulkes’ thinking was the work of Norbert Elias, author of The Civilizing Process (1939). Elias privileged group and society over the individual and he and Foulkes carried out a rich correspondence over many years.

Another important influence was the work of Kurt Goldstein, a neurobiologist with whom Foulkes worked during the years 1926 to 1928. The individual is always considered in the context of his group and Foulkes used the metaphor of a nodal point in a network of neurons to describe the individual in his group. Interestingly, Goldstein also had an influence on the development of Gestalt psychology.

We are born into already existing groups and communities and these groups are part of our internal worlds. To quote from Foulkes:

"Each Individual, itself an artificial though plausible abstraction is basically and centrally determined inevitably by the world in which he lives by the community, the group, of which he forms a part."

(Foulkes, 1948).

Foulkes saw the value of Individual Analysis (he was trained as a psychoanalyst) as well as Group Analysis. He did not see these treatments as an either-or option. It is possible for the treatments to complement each other.

The workshop described some of the personal and professional challenges which confronted me as a practitioner in moving from the ‘dyadic’ therapeutic relationship to the ‘group’ therapeutic relationships. Some of the themes referred to relate to Narcissism; Omnipotence; Disillusionment and Autonomy. Finally the Workshop concluded with a group experience of reflection and discussion.

Helen Jones worked as a teacher for eleven years and trained as a Psychotherapist from 1990 to 1994. She works with adults, adolescents and groups. She is also an accredited Supervisor. She was a Director and Trainer with the Institute of Creative Counselling and Psychotherapy for 14 years. She has an M.Sc in Group Analysis.
References:
Encountering Co-dependency and the Search for Self: Ten Adults’ Experiences of an Intensive Treatment Centre

by Charlotte Colchester

Introduction
Co-dependency has attracted limited research outside of the United States. This phenomenological study explores the concept as it is expressed in Ireland, through the experience of ten Irish adults. These participants are of mixed gender and three different generations and have sought help through a unique residential programme of intensive psychotherapy. The participants had no prior knowledge of the concept of co-dependency and this was their first contact with psychotherapy. Their stories encompass a range of co-dependent relationships, predominantly with younger people. Their interview transcripts provide insight into their lives before, during and after, treatment.

This paper begins with a brief exploration of the literary discourse on co-dependency, followed by a description of the research process and treatment with the findings and conclusions that emerged from the data.

Rationale
Co-dependency was one of the most controversial psychological concepts of the late twentieth century. There are no studies concerning the approach to treatment considered in this research and no scrutiny of the actual therapeutic impact.

Through thematic analysis of the interviews, it was expected that this study would illuminate responses over time, offering an insight into the process of change. This could inform future treatment practice by widening the discourse to include a population who spoke from a different cultural context and whose voices had not been heard.

From the literature, it can be seen that the theories converge to a common point: Co-dependents appear to lack a mature, robust and clearly defined sense of self in relation to the other. This confluence brought a focus to the research questions:

Is this lack of selfhood at the heart of the relational difficulties of the people attending this treatment centre? Does examining their experiences before, during and after treatment illuminate the concept of co-dependency and the impact, if any, of this treatment?

The Literature

“I need the mediation of the other in order to be what I am”
(Sartre, 1966: 168)

From Sartre’s enigmatic statement, we sense a hint of the complex world of interdependency. A concept that throughout history has re-invented itself with the times and prevailing influences. The large volume of literature about co-dependency arose like a wave rolling across America in the 1980s and 90s. From the social and psychological disciplines and the plethora of populist writers, the debate intensified over its definitions, its existence and non-existence, the empirical and theoretical evidence and its clinical value. In the last decade quantitative research has diminished, however the space seemed to have opened up for more reflective, qualitative work, to unpick the hype and attempt to reach the core of a condition that stubbornly presents in psychotherapy.
Definitions
O’Brien and Gaborit (1992) defined it as a lack of individuation, resulting in over responsible care taking, whilst sacrificing personal needs. Codependents Anonymous suggest it is a disorder arising when people become dependent on relationships where they can derive their sense of self, of wholeness, by serving the needs of others to the exclusion of their own welfare. The self help champion Beattie (1987) describes caretaking, repression, obsession, controlling, denying, poor communication, weak boundaries and lack of trust.

Scaturo (2005), the family systems theorist, asserts that co-dependents learn caretaking and enabling behaviours as survival roles in their dysfunctional families of origin. Feminist theorists state that co-dependency has attempted to make a socio-political problem into a mental illness, (Goldner, 1993; Frank & Golden, 1992). Or as Haaken (1990) asserts, co-dependency amounts to another description of the socially imposed role of women.

An operational definition for this study is, a relationship between two or more people where the parties collude in maintaining a mutually abusive interdependency.

Research studies
Co-dependency has been identified and studied since the 1930’s by Alcoholics Anonymous, by Horney (1950) after which it merged into family therapy and addiction studies from the 1970’s. Considering more contemporary qualitative studies Douglas (2009) and Peled and Sachs (2008) investigated women’s internal dynamics illustrating the difference between, in the former case a cohort of self diagnosed co-dependents, and in the latter those unaware of the concept. From social psychology Aloni et al (2009) demonstrated that there are unseen processes designed to move dependency towards interdependence and following Bowlby’s (1969) attachment theory, Fricker and Moore (2002) explored the apparent homing instinct of adults when choosing partner relationships that mirror the qualities of infantile attachments.

Historic and contemporary treatment for co-dependency
Treatment since the late 1980’s has been directed in three ways: generally unilateral treatment towards spouses of alcoholics prioritising a reduction in the drinking of their partners (Thomas, Yoshioka and Ager, 1996). Secondly, directed towards families with co-dependent and addicted adults, aiming at alleviating the dysfunctionality of all family members (Scaturo, ibid). Thirdly, via the self help movement Co-dependency Anonymous, through candid sharing of experiences, emotional reactions and strategies for coping (Barber & Gilberston, 1997).

It is contended that the treatment offered in this Irish context evolved in a unique way, by trial and error, over many years. The clients were met at a seminal moment in their lives when, for the first time they turned towards psychotherapeutic help, a step well beyond their cultural norm.

The treatment centre
An adolescent addiction rehabilitation centre which established an intensive therapy centre (CN) for adults in a house separate from the main buildings. Groups of between four to eight adults, male and female, strangers to each other at the outset, share the house for five days. CN offers daily group and one-to-one psychotherapy, art, psychodrama, massage and therapeutic bodywork. The atmosphere described is one of a group almost “alone in the world, going on a journey with each other.” From five o’clock, having no further intervention from the centre, an inevitable intensity of relationships evolves, through the long evenings together and the deep sharing over cups of tea. Different generations hear each other speaking for the first time, either as they foresee themselves speaking, or
as they remember having spoken. Different genders open up from their isolation and discover, not unbreachable differences, but emotional confluence. Personal relationship patterns display themselves through the relentless inter-relating, arising from being cut off from the outside world. For people relying on co-dependent patterns of relationship, the environment provided by the centre is challenging and quickly reveals these dysfunctional dynamics.

**The research process**
Following consultations with the centre manager and consideration and fulfilment of the ethical issues and requirements, ten participants, connected to the centre through the family support programme, were chosen and each gave a one hour recorded interview.

**List of Participants**

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE RANGE</th>
<th>POSSIBLE CO-DEPENDENT DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annie</td>
<td>early thirty</td>
<td>mother</td>
</tr>
<tr>
<td>David</td>
<td>fifties</td>
<td>children</td>
</tr>
<tr>
<td>Ella</td>
<td>early thirty</td>
<td>mother</td>
</tr>
<tr>
<td>Harry</td>
<td>sixties</td>
<td>wife/son</td>
</tr>
<tr>
<td>Kathy</td>
<td>late forties</td>
<td>son</td>
</tr>
<tr>
<td>Paddy</td>
<td>fifties</td>
<td>son</td>
</tr>
<tr>
<td>Peggy</td>
<td>sixties</td>
<td>children</td>
</tr>
<tr>
<td>Rhonda</td>
<td>fifties</td>
<td>sons</td>
</tr>
<tr>
<td>Theresa</td>
<td>forties</td>
<td>son</td>
</tr>
<tr>
<td>Tony</td>
<td>thirties</td>
<td>nephew</td>
</tr>
</tbody>
</table>

*Organisation and interpretation of data*
Following Dennscombe (2003) meaning was induced from the interview transcripts. This process produced 164 codes which were generalised into 5 themes and three overall categories.

Table 2 Organisation of codes into themes forming categories *(see overleaf)*
The following quotations demonstrate some of the themes that became the three categories:

**Category 1: Experience of life, self and other before treatment**

**Theme: The significance of hitting rock bottom**

*Like I had two sons, they used to bully me.... I thought I’d be better going under a lorry, that frightened me.* (Rhonda)

*Trying to get my son to take things on and stop taking drugs... I wanted to control him. I couldn’t imagine just letting him go. The more things I threw at my son the more he threw them out of the cot...I felt helpless about just telling him to go his own way.* (Paddy)

*I shouldn’t get up at midnight because me ma is depressed. I could never stop it and I felt smothered by it and I felt if I don’t she might commit suicide... she uses me and I let her and it’s that piece I hate about myself. It’s like I owe her because she had me... anytime I cried or got upset she’d just leave me. I lie in bed and think it over and over. I’m tormented. I had to come in here.* (Annie)
Category 2: The experience of life, self and other in treatment
Theme: Recreating family

The women, one of them certainly I could see as a mother figure and I came close to her, the house was real homely and peaceful and very, very safe. (David)

It gave you a base. I was able to bring up so much in there and I never thought in a million years that I would be able to do it. It was everything, really everything. (Peggy)

I learnt something from each of them... Billy who was in the house, he was so like Jim, my husband. I'd just like to stay and talk to him and be with him, like that he helped me. (Annie)

Category 3: The experience of life, self and other after treatment
Theme: A beginning and an ending

I think I had to listen to the stories [of others in CN] and look at what had worked for other people, but enabling is the first thing that has to stop. Addicts are so good at telling lies, unbelievable, I could so easily get drawn in again. It's a long, long journey. (Kathy).

I was hiding, didn't know anybody and didn't know how to talk about it. That's the way I was brought up...that's why I completely changed. I always owe so much to here [CN], you know, because even though it was sad for my son's addiction, I got free of him and coming here I found my voice. (Rhonda)

All I am trying for now is peace of mind, freedom from thinking that you can do something for somebody else, you can't. I have another son who is very bad in addiction, he won't last so long, but if I get that call tomorrow, I will be able for that, it's fear of the unknown and I know it now. And, As a man now, I would never, never have any worries about speaking. I can speak from the heart, it's reality now. Our house was just total chaos, we were always fighting. I'm not trying to control her [his wife], or the children anymore, there's no secrecy between us, I let her live her own life now. (Harry)

Discussion
This discussion addresses the research questions beginning with the purported “lack of selfhood”.

If the formation of selfhood begins in infancy, a person’s sense of who and how they are is influenced by the reflection they see in the eyes of their parents. What they know about themselves can be based on what they saw in that reflected look. If selfhood initiates in this mirror image, that seminal distortion can be interpreted as the reality and a hazardous childhood environment leaves little room for readjustment. Douglas (ibid) reports damaged attachment (p173) leading to a sense of inauthentic self which appears throughout the literature and is expressed by two of the men in this study. Blackmore and Frith (2003) call it not hearing one’s own inner voice (p9). It also appears in Peled and Sacks (ibid) as the participants wishing to leave their alcoholic partners in order to discover their real selves.

The findings in regard to selfhood in this study can be generalised across all the participants’ problematic relational behaviour. They appeared to have a compulsive need to fill a void, an aloneness, an emptiness and an abandonment, which propelled them to draw the other into themselves, both physically and emotionally and to bind them therein. In this way they could be seen as controlling and holding them in a self sustaining bond, encapsulated by Rhonda’s sentiment about her son, “If I
walked away [from him], I would be leaving my way of knowing myself”. This state is described by Scaturo (ibid) as “emotional fusion” (p103). Four of the participants appeared to experience the relationship with their sons and one with his nephew, as somewhat like a partner. The three women had isolated their husbands, to protect their intimate, bubble-like, relationship with their sons.

This lowering of the boundaries of self, between adult with younger relatives, appears to fulfil their need for physical, psychological and emotional connection, possibly as a reparation of their past fractured, parental relationships, thus agreeing with Douglass’ theme (ibid) of “Enmeshed self” (p153). The need to control the co-dependent other, found in all the transcripts, is a standard diagnostic feature of co-dependency, noted by Beattie (ibid). The replacement of the primacy of the marital relationship by being co-dependent on a son, emerges as an unusual feature of this study, and is not restricted to the women.

It could be conjectured that the projection of the need to augment the sense of the completeness of self by living through a son, daughter or nephew, may have been initiated in the child’s infancy, as intimated by three of the participants. Theresa described “When my son was born he was on a life support machine, it was a frantic time. I was always with him more after that. I blamed myself for everything.” Could this sense of acting as an alter ego throughout childhood, fulfilling the most intimate need of the parent, their sense of sense, have stimulated the adolescents into drug abuse as an act of rupturing differentiation? Were these young people attempting uncoupling as part of their own desperate journey towards selfhood?

The feminist model of a co-dependency as being a dependency between an over responsible carer and an under responsible addict, as advanced by Bepko and Kreston (1985), is developed by Peled and Sacks (ibid), which showed that this dynamic leads to a sense of aloneness and loss of a social identity, or place in society. This mirrors the condition of emptiness, and low self-worth, expressed by some of the Irish participants in the current study. In both studies, emptiness appears to mean an emptiness of some sense of a true self.

The research question relating to the possible value of recording the participants’ experience of life and self before, during and after treatment gave an insight into the reality that co-dependency is a process, understood and experienced differently, at different life stages. Also that treatment will be received and used differently according to these stages. Equally it highlighted the fact that mixing people at different stages offered psycho education, stimulation and enhanced therapeutic effect.

What was the impact of the treatment? Joining a group, being accepted, understood and empathised with appears to have been one of the major influences, acting therapeutically on the participants. There seem to have been stages to this process: initially there is the shock of separation and isolation and a sense of dislocation of self. The disruption stimulates the beginning of committing to a new identity, which Philbin (2009) asserts that “persons realise self truths, self entrapments and self preferences” (p11), because of gains within the new structure and being helped, supported and inspired by the others. There is then a “keeping true to these [new] identities” (p213), followed by what Irvine (ibid) calls “narrative transition” (p98), requiring sharing, which means integrating into the new accounts of self. Safety, a recurring code, appears to have enabled the journeys back and forth into their infancy and childhoods, stimulated by their projections onto other group members and the counsellors. These memories, retrieved by psychotherapeutic body and art work and psychodrama, are then processed by one to one therapy and the group. The effectiveness of these process-orientated therapies was commented on in the findings and agrees with Sheet’s (ibid), phenomenological study of group therapy.
for people in relationship to an addicted other. Here she advises studying the whole healing process over time and found that body work, family sculpture, and psychodrama, were most effective.

All the participants spoke of opening, release of the tension of fear and aloneness, of sharing, bonding and intimacy. The fact that the participants did not construe CN as “treatment” enhanced the sense that they had crossed a frontier into the unknown and anything could happen. Collectively they got to play out different roles and watch each other’s performances and then spend long evenings processing for themselves what had happened. Labelling people co-dependent may be useful as psycho-education. However, it is suggested that in this treatment, by using psychotherapy to assist the participants in constructing a new self-story, the process was based on the unique subjective meaning that each person drew from their experience. Is this project perverted if everyone starts with an understanding of their “one size fits all” label? Effectively, when is psycho-education useful in this regard?

**Conclusion**

This study offers insights into where co-dependency begins and whether there is a connection between parent/child co-dependency and adolescent addiction. It takes co-dependency beyond its well worn sphere of spousal dynamics forming a counterpoint to the literature. It describes a range of different co-dependent dyads demonstrating the underlying dynamic similarities, despite the overt differences. In a similar way, this has been shown to be the case in work place co-dependency, well studied in the caring professions. However, studies continue to be done on either student populations, or on spouses married to addicts. This could explain how little the concept has developed in the last decade.

Outside of addiction treatment circles, co-dependency is relatively unknown in Ireland. It is likely that any services that touch on family dysfunction and family and marriage breakdown would benefit from a comprehensive understanding of this contributing factor in family systems and uncoupling relationships. Those teaching pre-marriage courses, marriage guidance counsellors and mediators, would do well to ensure that they understand this concept. Co-dependency can find its way into any relationship, adolescent friendships or workplace social dynamics and is often hidden in subtle forms of bullying, only surfacing as somatised illness. It follows that services such as school counselling and human resource management also need to be cognisant of the distress and dysfunction that co-dependency can cause.

Social change in Ireland is relentlessly diminishing institutional anchors. Substance, process and activity addictions are all increasing. Co-dependent behaviour follows family dysfunction and addiction. An understanding of how people develop self-narrative mobility and the capacity to re-root their sense of identity, is to some degree illuminated in this study. Co-dependent people start from a disadvantaged position by being already distant from the well-spring of possible new identities, which is an authentic core being.

*Note:* Charlotte Colchester did not present at the Conference.

**Charlotte Colchester** MSc MIAHIP, is a pioneer of Social Farming having maintained an open farm offering a therapeutic environment to troubled people since the 1980s. She is also a psychotherapist practising in North Kilkenny.

**References:**


Introduction
The value of psychotherapy for people with intellectual disabilities has received little attention in the current literature, yet even the most profoundly disabled person has the capacity for an active emotional life that can be supported and enhanced through experiencing a therapeutic relationship (Sinason, 2010; Simpson and Miller, 2004; Alvarez, 1992).

It is still a widely held belief that people with intellectual disabilities do not have the facility to engage fully in a psychotherapeutic relationship. Research has shown that there is a higher incidence of experiences of neglect and abuse in those with intellectual disabilities when compared to the general population (Stalker and McArthur, 2012), yet psychotherapeutic support is not often available for this client group when trauma is experienced. The Vision for Change document (2004:127) highlights the lack of support services available in Ireland for those with intellectual disabilities who also have mental health issues, and psychotherapy training programmes very often ignore this area of specialization, consequently limiting the availability of psychotherapists with the appropriate skills.

Historically, interventions tended to focus on how to change behaviours that were deemed either socially unacceptable or labelled as ‘challenging’, rather than exploring psychotherapeutically the underlying meaning of the communication contained within the behaviours.

This paper will offer a rationale based on neurobiological research in support of psychotherapy for people whose disabilities significantly impact on their ‘being in the world’. Through looking at the fundamental element of psychotherapy, the relationship, it will be shown how even with the most profound disability, a client can engage in such a relationship and experience healing, growth and change.

Firstly, a very general overview of disability and how it is understood will be discussed, followed by an exploration of the neurobiological elements of attachment and socialization upon which all human relational connection depends.

The meaning of disability
Living with a disability in contemporary western society inherently means living within a system that discriminates against, and excludes to varying degrees, all those whose bodies and minds do not fit within the accepted notion of normative functioning (Garland Thomson, 2009; Snyder and Mitchell, 2006; Linton, 2007; McGrath, 2012). This is the lived reality of disability. What should be experienced as a shared interdependence and an acceptance of vulnerability between all members of a community, often becomes a disempowering experience with disability being perceived as deficit and loss, rather than an alternative way of being.

Having witnessed such disempowerment time and again as a member of a multidisciplinary clinical team working with children and adults with disabilities, it became obvious that the communal response to those who are differently abled tends to be based on a combination of not only pity, but also at times an underlying fear and need for avoidance. This can be a reflexive reaction related to a primordial emotional response that identifies difference as threatening (Cozolino, 2006: 266).
When disability is considered as a social construction, it uncovers the existence of negating learned responses that are expressed as an uncomfortable sympathy coupled with a patronizing admiration for the disabled individual, imagining an ongoing struggle for survival as a result of the burden of being disabled. Sometimes an even greater degree of admiration is extended to the perceived ‘carers’ of those with disabilities, reflecting an understanding of disability that is based on deficit and rehabilitation, an inherently medical interpretation of embodied difference as ‘abnormal’ (Longmore, 2009:143). For any therapist working in this field, personal preconceived notions of disability need to be explored and challenged so that therapeutic relationships can be formed that are fully open to the humanity of the other. The non-disabled professionals involved in the care of disabled clients can easily be drawn into accepting a societally imposed regulatory role, containing their clients either within a regime of attempted normalization and acquiescence (Sinason, 2010: 23), or upholding an exclusionary ableist understanding of disability as ‘not really-human’ (Kumari Campbell, 2012: 215).

Psychotherapy offers one means of redressing this imbalance, providing an experience of relationship that focuses on the person, not the disability. This is what makes psychotherapy such an effective intervention, even for those with severe to profound intellectual disabilities.

The Building of Relationship

Intersubjective engagement is at the core of the relationship between therapist and client and the client’s nonverbal micro-communications are the building blocks of this relationship. Developing a healthy sense of self has its roots in the first experience of relating that occurs between an infant and the primary care giver, where moments of synchrony come about (Hughes, 2007). Recent neurobiological developments are uncovering the essentially social aspects of the human brain, demonstrating how we are ‘hardwired’ to seek interaction with others (Siegel, 2012; Schore, 2012). Developmental psychologist Colwyn Trevarthen’s research with newborn infants has shown that a baby as young as twenty minutes old will interact with an adult, ‘demonstrating coherence of its intentionality and its awareness of a world outside the body, and especially a world that offers live company’ (2003: 57). It is this level of interaction that needs to be awakened within the therapeutic setting, providing the basis for growth and change. For clients with severe to profound intellectual disabilities, these pre-verbal patterns of interaction need to be gradually developed in a one-to-one therapeutic situation so that an experience of successful relationship is created that can then be built upon.

Sensorimotor psychotherapist Pat Ogden describes this process:

*The therapist meticulously watches for incipient spontaneous actions and affects – the beginnings of a smile, meaningful eye contact, a more expansive and playful movement – that indicate positive affect, and capitalizes on those moments by participating in kind and/or calling attention to them and expressing curiosity, enabling the moment to linger...and help expand their regulatory boundaries.*

(Pat Ogden, 2009: 221)

This reflects Allan Schore’s research into affect regulation in infants, which is particularly relevant to therapeutic work in the field of intellectual disability. He has shown that change mechanism is not necessarily mediated by insight, but is the product of an experience of therapeutic synchrony. He states that ‘psychotherapy is not the “talking cure” but the affect communicating and regulating cure.’ (2009: 128). In the transference and counter transference between client and therapist, affects are communicated through right brain emotional relational processes, not through language.
Schore goes on to explain that in order to know about the client’s unconscious process, we need to become not only keen observers of our clients’ physiology and the associated bodily changes, such as body position, facial expression, shifts in eye gaze, changes in muscle tension and breathing, but also fully aware of our own physiological responses and what they are communicating, as well as the emotional content of our presence.

In the dance of communication, therapist and client can achieve synchrony through a pattern of engagement, arousal, withdrawal and re-engagement. This replicates the early pattern of rupture and repair (ibid.) where infants learn to differentiate and separate from their mothers, develop self-regulation, tolerate waiting and frustration, and acquire further interactional skills. In therapy, clients with severe to profound intellectual disabilities tend to be at this level of interaction and the therapeutic relationship gives the opportunity for the experience of synchrony with another. This is especially important where there has been relational trauma:

...the sensitive empathic therapist allows the patient [sic] to re-experience dysregulating affects in affectively tolerable doses in the context of a safe environment, so that overwhelming traumatic feelings can be regulated and integrated into the patient’s emotional life.

(Schore, 2009: 130)

Where symbolic thought is absent and communication is nonverbal, ‘relatedness becomes more important than cognition’ (Corbett, 2009: 62), and interpretation can be communicated in a way that is receivable, it can be ‘held’ in the therapist’s mind rather than verbalized. The therapist becomes a thinking presence on behalf of the client and gives meaning to interactions through her embodied self and her use of voice. The pitch, timbre and rhythm of her vocalizations can ‘provide an aural sense of holding and containment’ (ibid, 2009: 49).

Underlying all of this is the ongoing creation of a shared language, the fundamental work that starts with the therapist being attentive to every nuance of the client’s presence in the room and offering responses that acknowledge these communications, opening the door for more complex and meaningful interactions. This is often a slow process that demands patience from both the client and the therapist, as each searches for the other’s meaning and intent, as the following vignette demonstrates:

At the beginning of our therapeutic relationship, Danny used tapping in attempting to regulate himself whenever he began to experience emotional overwhelm. As a non verbal young man with a dual diagnosis of severe intellectual disability and Autistic Spectrum Disorder, he liked predictability and calm. Unexpected occurrences upset him and he had created a means of calming himself. He tapped with his fingertips on any available surface, doors, windows, walls, or tables; if holding an object in his hand, that became a tool for tapping. He would become completely absorbed in his actions, oblivious to his surroundings in his need to self soothe. Whenever it occurred, I began to match his tapping in the pauses, mirroring the intensity of his actions with my own, and using my words and voice to reflect the quality of his emotional state.

Each time I vocalized, I gradually modulated my voice and actions, supporting Danny with this external regulatory mechanism to help him regain a sense of calm, as you would with a very young infant. He responded well to my joining in and together we usually managed to reduce the intensity of his anxiety. Danny became curious. He began to tap when not anxious, watching for my response and smiling when I replicated the rhythmic pattern of his taps. Over time, a game developed between us as he varied his rhythms and extended the tapping to include different surfaces. I introduced
drumsticks and a drum, Danny included shakers and a tambourine. The volume began to vary, along with the length and complexity of the rhythms as we alternated leading and following. The game invariably ended with a crescendo of noise as we both gleefully tapped and bashed our rhythms simultaneously. What had begun as a regulatory behaviour had evolved into having several shared meanings and purposes for Danny. He further extended this use of sound and rhythm to actively express his emotional states, seeking an empathic, attuned response through his actions. In a sad moment for example, his taps were slow and lethargic. When I mirrored his sadness both verbally and in my tapping response, tears welled in his eyes and we shared the depth of his communicated feeling. Attuned mirroring of his actions had provided Danny with an entry point into an interpersonal communication from a position of isolation.

By mirroring Danny’s actions along with the emotional content of his embodied communication, an interpersonal connection was made at the most fundamental level. Psychiatrist and neuroscientist Daniel Siegel speaks of the mirror neuron system in the brain that allows us to connect in this way with others' minds. Siegel states:

*We use our first five senses to take in the signals from another person. Then the mirror neuron system perceives these 'intentional states', and by way of the insula alters the limbic and body states to match those we are seeing in the other person. This is attunement and it creates emotional resonance.*

(Siegel, 2007: 167)

Through the dynamic relationship between client and therapist, with non verbal interaction as the primary means of communication, complex social and emotional issues can be addressed in a clinically safe, contained and effective way (Cozolino, 2006). The client is met at his or her developmental level through the therapist’s sensitivity to all modes of communication, valuing both embodied and projective expression of inner subjectivity, and so making therapeutic change possible. For Danny, his limitations in verbal communication and cognitive ability did not prevent him from engaging in the therapeutic process. Psychotherapist Jason Upton states:

*...despite any challenges of poor memory, poor verbal and communication skills, or poor capacity for cognitive linking, clients can still express their life experiences, their perceptions and understanding, and their emotional and behavioural responses to life. These are the fundamental prerequisites for the therapeutic process to take place.*

(Upton, 2009: 33-34)

Building a relationship with an empathically attuned therapist allows this to happen. It also creates the possibility for the building of other relationships that can meet social and emotional needs outside the therapy space.

**Conclusion**

The inclusion of intersubjectivity into scientific investigation has heralded a new era, and discoveries have been made that have revolutionized the scientific understanding of brain growth and development. This is especially true of early infant development and the necessity of social interaction, which directly impacts on each person’s ability to become attuned to another (Trevarthen, 2003; Cozolino, 2006; Siegel, 2012; Schore, 2012). Schore speaks of the ‘paradigm shift from behavior, to cognition, to bodily based emotion’ (2012: 4) in which scientific research has transitioned from studies of language based cognitive processes and voluntary motor functions, to emotional processing and embodied systems independent of cognitive processes. It makes it possible to move from the realm of the
cognitive and analytical to the realm of experience based emotional growth, where relationship is paramount.

This is of huge significance when looking at the importance of psychotherapy as an effective intervention for people with intellectual disabilities. Words are not enough. However, through a therapeutic intersubjectivity that is embodied and relational, a full spectrum of needs from the development of interpersonal relationships to the treatment of complex trauma can be successfully met.

**Note**
In order to protect confidentiality and privacy, any reference to clinical work is created from a composite of several clients rather than one individual. Any artwork that is included in the presentation of this paper is used with full, informed consent of the clients. It is outside the scope of this paper to discuss the question of capacity for informed consent by clients with intellectual disabilities, which is under legal review at present within the Assisted Decision Making (Capacity) Bill, 2013. In clinical practice where informed verbal consent to attend psychotherapy is not possible, consent is based on assessing the client’s continuing, willing engagement in the therapy process through careful monitoring.

For more information on the proposed amendments, see: http://humanrights.ie/mental-health-law-and-disability-law/assisted-decision-making-capacity-bill-2013

**Eimir McGrath** MIAHIP, MIAPTP, MIAPPC, MIPD is a psychotherapist, play therapist, supervisor and trainer who specializes in attachment, trauma, and disability issues, as well as lecturing at post-graduate level in Psychotherapy, Play Therapy, Disability Studies, and Dance. The intersection of psychotherapy, dance and critical disability studies provide the basis for her recently completed PhD and her published works.

**References:**


A Psychodynamic Perspective on Staff Related Issues Observed in an Organisation Undergoing Change
by Richard Sheehan

Introduction
In the current economic climate, many organisations are facing threat and uncertain future. Change in all its forms (closures, restructuring, pay-cuts, increased demands for performance and so on) is leading to one thing – increased pressure on employees and threat to personal security. Change in all its manifestations raises anxiety and stress levels and can lead to an increase in workplace mental health issues. From a HR (human resources) point of view this is typically witnessed as an increase in illness, increased absenteeism, higher rates of staff turnover, low morale, poor time-keeping and so on. For the organisation examined in the case study, mental health issues are on the increase and have been growing over the past two years. The past two years is notably when the organisation as a whole experienced significant change, change which has had direct impact on employees.

The central thesis presented is that underlying psychodynamic processes can explain many of the behaviours and staff related issues observed within organisations which are experiencing significant change. The research presented is based on an actual organisation which underwent significant change, and looks to psychodynamics for an explanation of observed outcomes for the staff impacted by the change.

The research attempts to demonstrate that an understanding of organisational change and its effects on employees will be limited unless it includes an understanding of the unconscious processes within individuals and within organisations. It is only when both sociological and psychodynamic perspectives are deployed that a more complete understanding of the effect of organisational change on mental health is possible.

Theory
A theory of psychodynamics that was found to be relevant in the context of understanding staff related issues in an organisation undergoing change was primarily drawn from a review of:

1. Psychoanalytic and Object-Relations concepts
2. Bionian Group Theory
3. Psychodynamics within Organisations

1. Psychoanalytic and Object-Relations Concepts
Psychoanalysis is concerned with understanding the dynamic processes of fragmentation and integration; key concepts include denial of internal and external reality, splitting, projection and idealisation. It is useful to understand these processes as they occur within the individual. Based on this understanding it is then possible to extrapolate to a broader understanding of such processes in group behaviour and in organisational dynamics and hence to individuals in an organisation undergoing change.

At the core of the psychoanalytic approach to organisational behaviour is the mental energy present in each individual which ultimately fuels the driving force within organisations. It is this very energy that can either be directed at the task, or used by the individual (or group) as a defence against anxiety. In this latter mode, it is a drain of energy away from productive work and also may give rise to group dynamics which are detrimental to mental health. In his work ‘The Psychoanalysis of Organisations’, de Board’s tenet is that ‘group behaviour is individual behaviour writ large’ (1978:24). Thus when
we look at what psychoanalysis has to say, unlike psychological perspectives, it is looking at group and organisational behaviour as it is extrapolated from intra-personal behaviour, i.e. it looks to the source – the psyche of each individual.

Klein’s seminal work on object-relations is crucial to our understanding of the psychic mechanisms of splitting and projection and their origin in the early psychological processes of the infant (Klein, 1955). Underlying Klein’s work are her theories on the development of the paranoid-schizoid and depressive positions. In the paranoid-schizoid position the infant experiences intense anxiety as a result of maternal deprivation, an anxiety that stems from a fear of annihilation and persecution (Klein, 1946). Such intense feelings are identified with the only object in its world – its mum’s breast which now becomes the target for projected unpleasant feelings. However, because the breast is alternatively a source of intense nourishment and bliss, the same object being alternatively ‘good’ and ‘bad’ can only be psychically achieved by the process of splitting. Whereas the ‘good breast’ is held onto by a process of introjection, the ‘bad breast’ is projected outwards. Thus, in the earliest object relations, the bad part, that which is experienced as frustrating or persecutory, is rejected. These early infantile mental processes are, in Klein’s theory, the prototype for our later adult processes. The process of splitting was regarded by Klein as the earliest defence against anxiety. It is as a result of the persecutory fear (paranoia) and splitting (of the ego, between an integrated and a fragmented state) that Klein termed this phase in life the paranoid-schizoid position (Klein, 1955). The development of this position was regarded by Klein to be particularly relevant in providing an understanding of adult defences when dealing with anxiety.

Also of importance to the case study is the development of the depressive position (Klein, 1935). The depressive position is characterised by ambivalence and conflict for the baby. In this position, the baby’s maturation has allowed it to now become aware of its mum as a single integrated object. This recognition and restoration of the whole object promotes an integration of the ego and a diminution of splitting and projection. The extent to which a child manages to successfully work through the depressive position determines the degree to which the level of splitting and projection will be a feature of mental processes and their use as a defence against anxiety in adult life. As in babyhood, in adult life the depressive position will manifest itself via feelings of conflict and ambivalence.

Klein also provided an understanding of the process of projective identification; this is the process, within an interpersonal interaction, whereby one person deposits unwanted feelings into another person’s feeling system (Klein, 1946). According to Mitchell, ‘in this the ego projects its feelings into the object which it then identifies with, becoming like the object which it has already imaginatively filled with itself’ (1986: 20). This psychical process is thus a defence against painful feelings which the self cannot contain. Again, it will be shown that this process is never too far from dynamics within an organisational context, e.g. whenever an organisation is experiencing conflict or change.

Based on Klein’s theories of early infantile positions and mechanisms such as splitting and projection, we now have a useful model to explain the intra-psychic life of an adult when threat is perceived. De Board tells us (1978: 33):

Klein believed that normal adults, when experiencing situations of persecutory anxiety, revert to this earliest pattern of behaviour and use the process of projective and introjective identification as a defence against anxiety.

Thus, for example, in the case of an infant not working through the paranoid-schizoid position, in adult life he may exhibit paranoia, a tendency to split the self and, as a consequence of his own
projections onto another, justify himself that the target of his projections is in fact a persecutor (projective identification).

2. **Bionian Group Theory**

Bion took Klein’s theory, albeit based on individual psychical processes, but saw the same mental processes applying equally to group phenomena (de Board, 1978). Bion felt that group members protected themselves from anxieties within the group context ‘in what may be a massive regression, to mechanisms described by Melanie Klein as typical of the earliest phases of mental life’ (Bion, 1961: 141).

Bion developed an approach for analysing some of the more irrational features of *unconscious group life*. A central tenet of Bion’s work is that group behaviour is determined by unconscious processes whose function it is to keep anxiety at bay (Bléandonu, 1994: 70). This differentiates from the manifest *conscious* level work group which is a mental state which claims the group exists to carry out its task. On the other hand, the unconscious group exists to maintain itself and shut out anxiety. This latter group is termed the *basic assumption* group, that is, the group’s behaviours suggest certain basic assumptions of the group members.

The word *assumption* indicates that members behave as if all members held a common basic assumption. Of particular relevance to a study of organisational change are the basic assumption groups (i) Dependency and (ii) Fight/Flight.

In relation to the dependency assumption, Bion tells us “the first assumption is that the group is met in order to be sustained by a leader on whom it depends for nourishment, material and spiritual, and protection” (1961: 147). Under this assumption the leader is omnipotent and the members are powerless and in thraldom. According to Stokes, “any attempts to change the organization are resisted, since this induces a fear of being uncared for” (1994: 21, italics added). De Board discusses what happens when the leader fails to live up to the group’s expectations. In this case, the group reacts with hostility and can expel, demote or replace the leader. This also provides relevant context for considering the perceived failure of an organisation’s management (leader) in a workplace context. In Bion’s view, an oscillation can be established whereby leaders are ejected, replaced and reinstated in a highly emotional situation until the anxiety can be spread to outside groups to absorb the reaction.

The assumption group, fight/flight, is of particular relevance to the case study. Per Bion (1961), under this assumption “the group has met to fight something or to run away from it” (152). Furthermore, de Board (1978) tells us that Bion believed fight or flight seemed to be the only two techniques of self-preservation known by the group (41). Under this assumption, the group look to their leader to lead the group against a common enemy and crucially, where this does not exist, to create one. Bion’s view is that leadership in a fight/flight group is based on paranoia – there is an external ‘they’ who are threatening the group, ‘they’ are bad and need to be fought and destroyed. The unconscious anxiety stems from the reality that the enemy is within, not outside the group. As such, reality is not tested and a leader who does not succeed in shutting out this reality will be expelled.

3. **Psychodynamics within Organisations**

There is a large body of available literature looking at organisational behaviour and theory and design of organisations but generally rooted in a *sociological* or *organisational psychology* perspective and far less so rooted in a psychodynamic perspective. Despite the above bias, there are however some key works on the subject of unconscious psychodynamic processes within organisations, notably by de Board (1978), Hirschhorn (1988), Obholzer & Roberts (1994), Brewer (2003) and Sher (2013). In
order to extrapolate individual psychoanalytic theory to organisational dynamics, Sher tells us (2013: xiii):

The psychoanalytic contribution to work with organisations and society rests on theories of infant development and its influence on adult relationships, especially the Kleinian views that the infant instinctively seeks pleasure and comfort, avoids pain, and polarises its world accordingly.

A further discussion of psychoanalytic concepts in organisations is provided by Stokes (1994). Stokes interestingly says, “Institutions can easily become personifications of persecuting figures from our internal worlds” (1994: 127). Halton (1994) also uses the psychodynamic perspective to make some interesting observations on group dynamics in a workplace context. He maintains that a staff member’s behaviour, often usually ascribed to personal problems, can in fact be due to institutional dynamics via the psychoanalytic concept of projective identification. This concept was also observed in the case study now presented.

Case Study
Description of Organisation
The organisation on which the case study is based is a large multi-disciplinary company. Like most other companies in Ireland, it has come under pressure as a result of the economic downturn leading to sizeable organisational change involving measures such as pay-cuts, downsizing and redundancies. The case study focuses on a specific business unit within the main organisation which experienced significant change. As a result of a cessation of production in that location, it has undergone particularly severe changes, outlined below:

The wider organisation has departments which provide EAP (Employee Access Programme) and Occupational Health Services; staff can voluntarily avail of these services to support them across a broad range of health and wellbeing issues. In the case study, key personnel in both departments were interviewed to provide useful data regarding staff issues arising as a result of organisational change. Interviews were also carried out with a staff manager in a work area particularly affected by change.

Nature of Change
The main workplace changes brought about included:-
- 80% reduction in workforce numbers
- The structure of the management changed significantly locally
- Change to organisational structure and hence working regime
- Financial – significant cuts to pay.

Findings
Even though only a limited number of interviews were carried out, there were ample observations of staff behaviours which mirrored the early infantile processes proposed by Freud and Klein. Projection and paranoid-schizoid mechanisms, psychical structures that are laid down in infancy, were clearly in operation in an ‘adult’ organisation and observed as manifestations of anger, insecurity, displacement, uncertainty, helplessness and aggressive behaviour towards management. Both EAP and Local Manager gave ample evidence of polarisation and a victim mentality (them versus us). EAP and Local Manager stated that staff had reported that they felt things were being ‘forced on staff’ and that they had ‘no control’ and that there was ‘fear of the unknown and of uncertainty’.
It is suggested that the depressive position, characterised by ambivalence, was also in operation because the organisation was now playing the simultaneous role of ‘good’ and ‘bad’ breast, as described by Klein. The ‘good breast’ was mirrored in the organisation providing work and reward to its staff, a virtual form of nourishment. However, the organisation also withdrew some of this nourishment, as a result of introducing change, effectively becoming the ‘bad’ breast. The Local Manager made observations of the confused relationship that the staff had with the organisation, the difficulty of not knowing who to blame. As a result, their anger was targeted at unknown individuals or authorities who represented the perpetrator.

Projective identification processes, per Klein, were possibly in operation in the evidence of contagion of painful feelings between groups - the contagion could in fact be regarded as projection of difficult emotions from one group to another by the mechanism of projective identification; projective identification was also possibly in evidence in role suction where certain individuals may have taken on the aggressive or depressive feelings projected by their work colleagues. Based on interviews conducted we know that certain individuals were ‘launched’ at management and displayed aggressive behaviour – possibly individuals who were induced into taking on the aggression of the group. We also know from observations made that certain individuals fell into depression and were referred to EAP on that basis and sought early retirement. Again, we may wonder whether such individuals were induced into carrying the depression of other group members.

Evidence was also gleaned from interviews of the existence of basic assumption groups, per Bion’s model. The dependency assumption group was evident from the staff’s dependency on management and on their union representatives. The issues around dependency came to the fore when the staff (group members) felt a sense of let-down or abandonment by their leaders. The let-down brought on anxiety and led members to annul the relationship in a variety of ways (we can consider examples such as exiting the company, blaming, perhaps falling to depression, or not attending work). In fact, it is possible to postulate that the leaders failed the members not alone by not containing their anxiety, but by being the very source of anxiety by introducing change in the first place.

The fight assumption group was also in operation and witnessed as aggression against management, protestations against the organisation and the motivation to create an enemy to fight against. Based on EAP and Local Manager responses it is clear that employees created an enemy (essentially a phantasy of an enemy) in identifying ‘Head Office’ as the persecutor to fight against and onto whom they could project anger; when questioned as to the identity of the enemy, no identification was forthcoming. We can conclude that the imagined enemy nonetheless served the purpose of absorbing the group’s projected anger.

The more prevalent assumption group however was perhaps the flight assumption group. The characteristics of the flight group were observed in many ways – notably the increase in absenteeism. The location in question revealed a sizeable increase in sick leave when compared to peer locations – this can be regarded as a form of ‘flight’ whereby staff virtually ‘fled’ to their sick beds. To support this observation the absenteeism statistics for the case study location are compared with other locations within the overall organisation (Figure 1). This clearly shows a higher rate of absenteeism in the case study location. While all parts of the organisation experienced change to some degree, the case study location experienced the greatest rate of change. Assuming that people’s general health is the same in all locations, the marked increase in sick leave at the case study location would appear to provide convincing evidence of a ‘flight’ mechanism.
In addition there was evidence of exits from the organisation and the drop in morale and productivity, all of which are considered ‘flight’ responses. Interestingly the Local Manager reported that staff tended to resort to *humour* to try to mask the fear (in the form of repetitive tea-time humour). This was further evidence of flight whereby staff were unconsciously fleeing to the familiar (tea time banter) to avoid confronting the painful emotions brought up by change.

Thematic analysis also found that on-the-ground observations revealed another psychodynamic process in operation, and one that is not adequately addressed in the literature – the immobility response. This was shown to be akin to the ‘freeze response’ in trauma. This psycho-dynamic occurred as a result of staff not knowing who the aggressor was or from whence the threat came in addition to the absence of a leader who would help contain their anxiety – thus thwarting the fight/flight response. The interviewees also spoke of staff feeling stuck, not knowing who to blame and feeling they had nowhere to turn to. In the face of an unknown threat it was perhaps difficult to fight or take flight, and this may have contributed to a ‘stuck’ position.

The interviews also interestingly revealed that members of management, particularly front line and supervisory management level are also impacted as a result of change, despite being agents of the change process. Based on psychodynamic theory we can infer that management are affected in two ways, (i) they are impacted by change itself, by the same dynamics that apply to all individuals; (ii) also, management are taking on the additional burden of displaced anxieties from staff, i.e. management are recipients of negative emotions that are projected as a result of staff anxieties. Whereas the literature tends to focus solely on the impact of change on *staff*, there appears to be a glaring omission of the effect on the individuals who make up the management. Organisations going through change crucially need to consider the emotional burden that management carry and support them through the process.

![Figure 1. Absenteeism at Case Study Location versus Other Locations within the Organisation](chart.png)
Conclusion

The thematic analysis showed that many staff related issues in an organisation undergoing change, in terms of observed behaviours and emotional outcomes such as absenteeism, aggression, drops in performance and morale and so on, can be explained when viewed with a psychodynamic model. For example, the individual regarded as a problem worker who is fighting change (e.g. an ‘aggressor’) may in fact be an object of projective identification processes and is merely a conduit for the anxieties of the wider group. This model views organisational change as a threat to survival which stirs up primitive anxieties around annihilation and fragmentation. This is mirrored in Freudian and Kleinian theory in relation to the intra-psychic processes which occur for the baby when it is threatened with a sense of annihilation. The relevance of the psychodynamic model was illustrated by consideration of processes such as projection and splitting, paranoid-schizoid and depressive positions and projective identification.

It is recommended that organisations that are implementing change need to consider the powerful unconscious psychodynamic mechanisms which drive the behaviours and emotional responses of individuals and groups and which ultimately make change implementation either extremely difficult, or alternatively facilitate change if understood better. Organisations which have a more enlightened approach based on a psychodynamic perspective will be better positioned to understand personnel problems and identify better solutions. When equipped with an understanding of psychodynamic processes organisations would be better positioned to predict the impact of change and plan for eventualities (e.g. rises in absenteeism; drops in performance; cater for likely emotional outcomes etc.). Mirroring individual therapy, we might infer that organisations may also possibly heal through organisational self-awareness and containment of anxiety. Thus, if organisations can become aware of feelings and somehow contain the anxieties they stir up, it may be possible to bring about change in a healthier manner.

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References:

An Exploration of the Witness in Core Process Psychotherapy: its Significance and Function
by Patricia Chalmers

Introduction
It is generally accepted within western psychology that being seen is essential to the development of humanness. Frank Lake’s “umbilical gaze” and Winnicot’s “mirroring” are two infant-mother dynamics that stress the importance of recognition in early life. A great deal of human suffering arises because of the manner in which we are seen or not seen and, the manner in which we allow ourselves to be seen or not seen. On the eastern side of the globe, Buddhism teaches that the root of suffering is ignorance, meaning, in part, our lack of awareness of connection. We suffer when we see ourselves as separate individuals, when we experience ourselves as fragmented. We forget we are connected at the core of our being with the very matrix of creation, even with Source.

Core Process Psychotherapy (CPP) integrates Buddhist psychology with western understanding of human development. It is based on two premises, namely that awareness is curative and that there is a core of Inherent Health or Pristine Awareness in every human being. Suffering arises as this core of health becomes obscured in the process of primary and secondary conditioning. A sensitive enquiry into suffering and its affect provides a pathway to self-empowerment, healing and wellbeing. The dynamic of seeing and being seen, aspects of witnessing, is central to the therapeutic process in CPP.

The Collins dictionary defines a witness as a person who has seen or can give first-hand evidence of some event. The verb to witness is defined as to see, be present at or know first-hand. A witness is expected to see things in a non-biased way. However, the theory of relativity informs us that the very act of observing impacts the observed. Witnessing therefore cannot happen in a detached manner; it is accompanied by some form of affect. Once we have witnessed something or someone, we become necessarily implicated in what we have seen or heard. The quality of our witnessing also impacts on the object being witnessed. I can testify to this from my own experience. One day in my teens, I inadvertently caused my mother some distress. I felt deeply judged by those in authority and guilt proliferated into a diffuse and lingering anxiety. Years later my chemistry teacher witnessed my growing anxiety and existential despair. I experienced her compassionate gaze and sensitive enquiry into my distress and this was the start of a long healing journey. Some years later, the despair returned for different reasons. I remember the morning when I was formulating a way out, a colleague looked at me and said “You look so tired. Are you well?” That comment proved to be a lifesaver. Her caring witnessing of my distress was enough for me to abandon my plan and embrace life anew.

In CPP, not uniquely, but significantly, the therapeutic process engages in a joint enquiry into conflictual and distressing life events with a view to seeing anew, to listening more deeply, to entering into a new relationship with self, others and life experience. The therapeutic space is a container, for seeing the client, a safe space for the client to allow suffering to be witnessed. My own experience of being witnessed made me question how does witnessing impact on the therapeutic process? Does the witness have a therapeutic function? Is there a therapeutic witness?

Firstly, I will talk about the qualities of the witness. Then I will locate the witness in the Core Process Psychotherapeutic dynamic with reference to client practice. I will explore witness perspectives in western theories of human development and identify the embodied aspect of the witness.

The qualities of the witness
Witnessing is an aspect of human consciousness. My experience informs me that the qualities of the witness can be expressed along a spectrum of witness consciousness.
At the grosser end of the spectrum, the witness behaves in the manner of Freud’s superego, critical and judgemental, ever on the watch to maintain ego identity. Chogyam Trungpa (1973) speaks of layers of watchers, “the watcher of the watcher of the watcher.” The watcher is there to protect us from insecurity. It incessantly interprets and analyses our negativity, justifying our patterns of avoidance and grasping. It reinforces our illusion that we are in control. Chogyam notes that the watcher is not a villain; however, its activity is counterproductive. In its attempts to be protective, it becomes judgmental or paranoid and creates contraction, conflict and suffering.

Tarthang Tulku (1994) claims that the witness serves to give us an identity in space and time. It confirms our presence “here I am” and offers substance to our present experience. It aims to get a grasp on reality by attempting to reduce the unknown and incomprehensible into apparently orderly, qualifiable and quantifiable measures. Identification with the past freezes time and excludes the possibility of new knowledge, perpetuating the frustrating patterns of suffering.

At the other end of the spectrum, the witness assumes the characteristics of the bodhisattva dedicated to altruistic service through mindful awareness of the present moment (Chogyam, 1973). Consciousness is no longer fixed on objects in the past. Awareness shifts from subject to subject in the present bringing clear and precise comprehension to the whole reality (Chogyam, 1973). Tulku suggests that this involves a process of “turning (attention) inwards” into the subjective experience of the object in the present moment in time. This empathetic moment allows a concept, thought or feeling to reveal something new and unconditioned. It harnesses the power of change through new knowing that is inherently arising in the moment (Tulku, 1994). There is an uncoupling of objectivity and subjectivity, the past is released and the self enters a process of new becoming in the present moment. This is the dynamic of the therapeutic process enabling new self-constructs as conditioning is released. The witness active here, is reflective rather than critical. It displays openness and unconditional acceptance. It has the substance of what I would like to name as the therapeutic witness.

**Locating the witness in Core Process Psychotherapeutic dynamic**

Core Process Psychotherapy was founded by Maura Sills in 1986 and developed together with Franklyn Sills. Within the field in CPP there are two energetic fulcrums in operation. The vertical fulcrum is the Source-being-self axis described by Franklyn Sills (2009). Source is non-individuated and refers to “a field of interconnection and openness” that encompasses the matrix of Pristine Awareness or Brilliant Sanity. Being is the core of human sentience, the “true agent of awareness”. Self is a “constellation of psycho-emotional-physiological processes” that emerges out of life experience and gives us a misconstrued sense of identity. Source mediates to being the higher spiritual values of loving kindness, compassion, joy and equanimity that infuse the holding field. Coherence and continuity of being with Source is necessary for a cohesive self. The horizontal fulcrum is the relationship between therapist and client. With the therapist aligned to the Source-being-self axis, the process starts off as a being-to-self relationship and proceeds, in the course of therapy, to a being to being relationship.

The therapeutic process in CPP unfolds through a co-enquiry in to the suffering of the client. The therapeutic dynamic rests essentially on the holding field, the quality of presence, the client-therapist relationship and the degree of abiding awareness. CPP speaks of “witness consciousness” as the stance of the therapist and the emerging state of the client (Sills, F., 2009, Sills, M., 2000: 187-196, & Donington, L., 1994). The witness functions in the field as a presence of awareness in relationship. It is established by the intent of the therapist aligning with the Source-being-self axis and coming into an open presence in attunement and unconditional acceptance. Under the compassionate gaze of the witness, the client learns to trust the safety of the space and allows herself to be seen, to be witnessed in her wounding. As the witness energy infuses the field, it impacts on the client’s subtle energy body.
and through the process the client eventually comes into resonance with it and moves into a witnessing mind state, which is essentially a state of mindful awareness. She learns to differentiate different mind states, feeling tones and sense impressions. By breaking down experience into its different components, the client learns to be present to her experience rather than attempt to analyse or interpret it. The witnessing presence orients the therapist and client to the experience arising in the moment, slowing down reactivity, uncoupling present thought and affects from past experience. Being present to what arises in the moment requires a slowing down of the proliferation of thoughts and affect to allow the gap between experience and reactivity to emerge. This point of “mental inactivity” may be equated by the client as the emptiness of despair (Welwood, 2000). In reality, it is the void that precedes a new creation. The courage to stay with the slowing down process ultimately leads to the “stillpoint” between therapist and client. Here the enquiry lapses into a charged and catalytic silence, pregnant with the potential for transmutation, providing a locus for the reconstruction of selfhood and the reclamation of being (Stern, 2004).

The aim of CPP is to bring awareness to both the conditioning and the core of inherent health encouraging a shift from a contracted sense of self to an expansive state of being attuned to life experience. Indeed CPP is more concerned with witnessing experience rather than interpretation and meaning. Based on the premise that awareness is curative, mindful witnessing effects healing by being present and paying attention to the depth of being, underlying reactive conditioned influences, from whence a new and direct knowing emerges with its capacity for wholeness and wellbeing. Through mindful witnessing, the client comes to a direct knowing of present unconditioned experience. This enables her to disidentify from split off objects and to gather in the fragmented aspects of the personality into a new self-construct with the reclamation of being. Witnessing by definition is about direct knowing and I venture to say that it is this quality that renders the witness a significant healing presence in psychotherapy.

There is, of course, the possibility of losing the witness position. This happens in instances where the therapist may be triggered by the client’s process and is not able to put her agenda on hold in the moment. Doubts, insecurities, memories, stresses of life taking hold of the therapist’s mind state all detract from witness presence. Unskillful or premature interpretation or reactivity rather than responsiveness also cause the witness position to slip away. The impact on the client’s process depends on the quality of the therapeutic relationship. Where trust is strong, it could divert the process for a while providing more material for enquiry and offering the opportunity of repair. Where the therapeutic relationship is fragile and the client unstable, highly vulnerable and not adequately resourced, it could culminate into a rupture of the process with lingering unfinished business that can only be negotiated on an individual basis.

In my practice, I have observed the transformative effect of the witness. Clients who had no self-reference because of non-attunement, exposure to domestic violence, physical or emotional abuse came to therapy in a withdrawn or aggressive state, with an array of emotional feelings ranging from confusion, anxiety, depression, anger and guilt to fear and shame. I have witnessed such clients taking the risk to name and claim their need and desire for acceptance, recognition and love. I have been in resonance with the expansive spaciousness that occurs as they discover a point of self-reference, establish boundaries and learn to be receptive to loving kindness in their lives. I have seen dark faces shine, relationships come alive, and the making of empowered choices for new life directions.

Clients who moved into the witness position learnt to step back from overwhelming experience giving themselves the opportunity to be present to their thoughts and feelings, to discern what belongs to the past, what has been imposed by significant others. Some have come into a new relationship with
painful memories that have lost their charge. Others have learnt to witness their own embodied experience of different mind states with their capacity to shift from one to another. In this way, they have discovered their power to regulate and create their own life experience in their daily circumstances. All this comes about by direct knowing of what is previously unknown and which has emerged under the influence of the witnessing presence and the witnessing gaze resonating in the field and with the client’s own inner processes.

I have also experienced the impact of losing the witness position with both the opportunity for repair as well as the unfortunate rupture. Both instances arose from premature interpretation and reactivity. This reinforces for me how a witnessing presence, responsive and resonant, is paramount to the psychotherapeutic relationship.

**The witness in western theories of human development**

It is commonly accepted that relationships to primary and secondary caregivers are replayed between therapist and client. As the witness is actively present in the therapeutic relationship, it would be reasonable to deduce that it can be encountered in early human development. Western theories of development do not explicitly speak of the witness. However, the approaches of Winnicot, Stern and Frank Lake, among others, emphasise the importance of the infant being seen, recognised and accepted by mother for healthy emotional and mental development. Seeing, recognition and acceptance are characteristics of the witness that facilitate the therapeutic process.

The infant is born with a relatively mature visual apparatus and has the capacity to focus on and respond to mother’s facial expression within 6-8 weeks. The infant thrives by making human contact. Object relations theorists uphold the infant’s innate capacity for seeking out human relationships and regard this as essential for emotional and psychological development. In an ontological analysis of the normal mother-child relationship, Lake (1987) speaks of the “umbilical cord of sight” whereby the mother and infant meet in a “contemplative gaze”. ACCESS to the SIGHT of the Mother is access to Life, to knowledge of whom I am. The Infant’s Being is in the light of her countenance. To be shut out is slow death” (Winnicott, 1967: 149-159). Being seen, accepted and recognised is crucial for nurture and wellbeing in early development. Lake claims that what is learnt in early life can be transposed in later years into self-recognition facilitating an integrated and mature sense of self and wellbeing.

Winnicot (1967:149-159) referred to the mother’s face as the precursor of the mirror in the infant’s life. He notes how mother reflects back to the infant what she perceives in the child and in this way gives back to baby an experience of himself. If baby is happy or sad, the mother reflects the joy or sadness back and this makes baby feel alive. This resonance of the mother’s form is internalised by baby and begins to build up a sense of selfhood and “continuity of being”. Here we see witness activity at work both in the umbilical gaze and the act of mirroring as mother witnesses infant and infant witnesses itself back.

Winnicot and Lake regard the holding environment in the first nine months to be an undifferentiated fusion of identity with mother. In contrast, Stern (1998) has introduced the concept of an intersubjective matrix operative between infant and mother from the moment of birth. He perceives the infant as a process of emerging organisation that is innately aware of experience within a sense of me and other. The experience of being with the other in the intersubjective matrix becomes an act of active integration rather than nondifferentiation. Intersubjectivity implies the interaction of two minds sharing, a “mental landscape” (Stern, 2004). Various psychologists agree that infants have an innate capacity to attunement, to the sharing of experience, to knowing and feeling what the other knows.
and feels. This view has introduced a shift from an intrapsychic to an intersubjective dynamic in development (Stern, 2004). In this, we find implicit references to a locus for the function of witness consciousness in infancy effected by a connection between two minds, the seer and the seen. Further, the empathetic attunement also points to the infant’s capacity for witness activity.

Where the mother is dysfunctional, the witness aspect of interaction breaks down. Baby is objectified, mother’s face no longer resonates with his own inner state and what he internalises is at odds with his own reality. Compliance with these alien forms of felt experience create a dislocated internal structure and a fragmented sense of self (Stern, 1998, and Wright, 2009).

Subjectivity disintegrates into shame and possible impending annihilation. The extent of fragmentation depends on the severity of the dysfunction. A “good enough” holding will equip the infant with resilience in adversity (Winnicot, 1967: 149-159). Where objectification persists, however, the skilful engagement of the witness in a therapeutic setting in later life can restore the deficit imposed in childhood by witnessing back to the client what had not been seen in infancy. On the other hand, objectification of the infant with the displacement of the witness and the retraumatisation of the client can be reproduced in the therapeutic situation by the premature or misattuned interpretation.

The witness embodied
The witness is an aspect of mind that functions within an embodied process. Its qualities and effects are experienced as felt somatic and visceral sensation. Consider the warmth of recognition, the expansiveness of self-discovery that inform the client of his inner reality. It can be deduced therefore that its function is accompanied by cerebral activity. Neuroscience has mapped out cerebral activity in meditation. “Resonance circuits” (Stern, 2004) stimulated by attunement in early years have also been determined. Schore, (2001a 22: 7-60, and 2001b 22:201-260), has confirmed that brain development is dependent on the emotional experience of the primary relationship in the first three years of life. The discovery of “mirror neurons” provides further neural evidence of the impact of intersubjectivity (Stern, 2004). The prefrontal cortex is known to register self-awareness and reflective capacity (Gerhardt, 2004) and can therefore be considered to be the locus of therapeutic witness activity. The knowledge of neuroplasticity indicates that repair is possible. Where attunement has been deficient, simulating the primary relationship in a therapeutic context enables the differentiation and neural integration of underdeveloped parts of the brain (Shore, 2001b: 22:201-260, Gerhardt, 2004, and Siegal, 2007).

Within the therapeutic relationship, the power of intention in mindful witnessing has the capacity to trigger “mirror neurones” in the prefrontal lobes of the client. Empathic attunement enhances the interconnections between the prefrontal lobes and the emotional and memory centres in the limbic system of the brain. As reflective capacity opens up in the client, the resonance circuits developed in intersubjective attunement become active within self-awareness, no longer requiring an external trigger. The client can then engage self-witnessing and self-attunement and come into an experience of equanimity and wellbeing that transmutes patterns of reactivity. Neurologically, the therapeutic process is a right brain to right brain witnessing relationship acting as a substitute for the failure of integrated empathic attunement in early life.

Conclusion
The witness is central to the therapeutic process in CPP. Its activity harnessed within the psychotherapeutic field enhances the quality of presence and attunement and supports the therapeutic relationship. It provides a safe container for clients to be seen. Significantly, it facilitates the transition from reactivity to responsiveness and resonance, from analysis and self-judgement to self-acceptance,
from a constant search for meaning to attunement with life experience. The “witnessing gaze” facilitates the direct knowing of the unconditioned self, promoting new self-constructs and the reclamation of being and is integral to coming into wholeness and wellbeing.

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Psychotherapy Integration in the 21st Century: the Gains, the Losses and the Challenges

by Gerry Myers

Psychotherapy integration is deeply embedded in the practice of psychotherapy in Ireland. Ed Boyne’s book Psychotherapy in Ireland, through its successive editions in 1993, 1995 and 2003, charts the changing landscape of integration that has been taking place in Irish psychotherapy since the 1970’s. A definitive history of Irish psychotherapy remains to be written and such an enterprise would make an interesting challenge for a doctoral student looking for a research project, or for someone who holds the memory of the way psychotherapy came to life in Irish society since the 1970’s. When I first became interested in training as a professional counsellor in 1988, there were only a handful of training organisations in Ireland. Examples of training institutes that operated at that time were the Clanwilliam Institute, the Creative Counselling Centre and The Irish Gestalt Centre. In the 90’s, the Dublin Institute for Counselling and Therapy, the An Tracht Centre in Kinvara and the postgraduate courses in UCD, UCC and UL also came on the scene. Growth in the number and variety of training courses and services to clients has continued into the 21st century. But the impression I got in the late 80’s was that people were trained in a definite way of doing therapy, be it psychoanalytic, constructivist, psychosynthesis, gestalt, systemic family therapy, or otherwise.

As a potential customer of training bodies in 1988, I knew nothing about psychotherapy integration. Indeed none of the training programmes that I checked-out raised my consciousness about it at all. If they were interested in psychotherapy integration, they weren’t broadcasting it from the rooftops. In the end, I opted to travel to London to do my training in Regent’s College where, I mistakenly believed, I would get a good solid training rooted in straight-down-the-line existential psychotherapy. You see, in the London of 1990, apparently pure forms or schools of psychotherapy were actually engaging with other forms of psychotherapy as well. And this wasn’t limited to London. Ross Skelton, who participated in the early growth of Irish psychoanalytic psychotherapy, wrote a chapter in Ed Boyne’s 1995 edition of Psychotherapy in Ireland in which he states that:

Looking back over this essay, I am struck by the fact that it seems to be divided into schools: Freudian, Kleinian and Lacanian, whereas most practitioners in Dublin (and elsewhere) draw inspiration from more than one school. Thus we have here in Ireland a healthy mix of differing ideas which is the precondition of growth.

(Skelton, 1995: 29-30)

When I trained in London in a college that specialised in existential psychotherapy, I also took modules in communicative therapy, classical psychoanalytic psychotherapy, systemic psychotherapy and person-centred therapy. I discovered that eminent existential psychotherapists such as Emmy van Deurzen could share professional discourse, and sometimes the same class, with practitioners who were versed in classical psychoanalysis or systemic therapy. As Skelton indicated, that mixing of “schools” was in play in Ireland too, even in the early 90’s.

By the late 90’s, there emerged in Ireland a number of courses that had integrative psychotherapy in their title as well as having integration buried in their syllabus. It is possible to speculate that this move was influenced, at least in part, by the desire of academic institutions to have accurate titles for their programmes. Hubble et al tell us that:

The days when models and theories arrived and were pursued with all the alacrity that only the latest designer drugs could excite on the streets are over. New therapeutic approaches are still
emerging, but the fire for the novel, different, and exotic has for the most part been extinguished
(Hubble et al 2010: 24-25)

If we move our focus away from psychotherapy courses to psychotherapy practice, there is rich
evidence that effective practitioners practice in increasingly similar ways as they advance in
experience, irrespective of the model of psychotherapy in which they first trained (Norcross and
attest to the effectiveness of psychotherapy in relation to psychological distress. Taking Carr (2009)
as an example, he notes the approximately similar effectiveness of a variety of psychotherapy models.
Norcross and Goldfried (2005) draw on extensive meta-studies to show how it is common-factors,
rather than modality-specific factors, that have the most positive impact on the effectiveness of therapy.
International research indicates that it is what is common between us therapists that is more important
than what is specific to our modality, at least in terms of the effectiveness of therapy.

And so we have a scene in the Ireland of the 21st century where: a) experienced psychotherapists
probably practice in broadly similar ways, but with subtle differences too, b) our professional body
at its 21st birthday conference lays claim not just to humanistic but also to integrative psychotherapy,
c) practitioners increasingly identify themselves as integrative psychotherapists and d) courses
increasingly explicitly incorporate integration into the curriculum. Psychotherapy integration is clearly
alive and well in Ireland. What then are the gains, the losses and the challenges in psychotherapy
integration? Referring to the international landscape, Hubble et al (2010) use the analogy of Dickens’
A Tale of Two Cities (Dickens, 1992) to explore these gains and losses: it is “the best of times” and
“the worst of times”, they say (Hubble et al 2010: 24). What might we, here at our professional body’s
21st birthday “party”, say about the best and worst of psychotherapy integration in Ireland?

Sitting around this conference setting, are psychotherapists of many hues and shades, just like the
autumn scene outside the window of this room. We are all interested in talking to each other, supporting
each other, and learning from each other. We trained in many different places, but we share core
humanistic values that are expressed in a wide variety of constructs, epistemological biases, forms of
professional discourse and espoused modes of practice (Cooper and McLeod, 2011).

Let me now address what I see as the first gain from psychotherapy integration in Ireland. Recently
we heard that the statutory body responsible for academic awards in Ireland, Quality and Qualifications
Ireland (QQI), is consulting with us prior to setting definitive award standards for counselling and
psychotherapy (QQI 2013). Through IAHIP and the Irish Council for Psychotherapy (ICP), we are
expressing our voice to QQI, and they are paying attention to us. We now learn that statutory
registration is coming sooner rather than later and that our training and professional standards, which
we developed ourselves, are well regarded by the relevant state bodies. It looks like we have played
our cards well and that we are coming in from the margins to take our seats at the grown-up’s table,
which is appropriate on our 21st birthday! One of the fruits of the psychotherapy integration movement
is that we have come to recognise what is common between us. We are now better at speaking with a
one-ish voice, which has strengthened our impact and caused funders, service-providers, employers
and regulators to listen to us more than they have done in the past. That is one gain from psychotherapy
integration.

A second good effect of psychotherapy integration is that we have an increased capacity to understand
one another, our similarities and our differences (Duncan et al, 2010). The ICP is currently engaging
in a creative re-visioning process in which people from the major strands of psychotherapy are
attempting to think outside their “silos” so as to imagine new ways of configuring Irish psychotherapy
that are more effective than the current structures. What is impressive about this re-visioning process is the degree to which practitioners, officers of professional bodies, educators etc. are able to embrace a creative dialogue without all the Shibboleths, the technical language, that usually trip us up when we talk with therapists of other persuasions (Elton-Wilson and Syme, 2006). We are, effectively, developing a common-enough language to structure our profession and our professional discourse. Mick Cooper and John McLeod, in the UK, advocate for pluralistic psychotherapy in which the “other” is prized (Cooper and McLeod, 2011). Perhaps one of the fruits of psychotherapy integration is that we have moved out of the silo of our original training (be it pure-form or integrative) and we have opened up to, and prized, the “other” within psychotherapy. We have, to some extent, become pluralists.

I would like to say that a third benefit of psychotherapy integration is that we are carefully applying and evaluating the very best of what we know works for clients in psychotherapy (Carr, 2009). But if I was to be able to say that with any conviction, there would have to be a rich research landscape in Irish psychotherapy, and that is not the case. We simply don’t know enough about whether psychotherapy integration has delivered benefits to clients in the Irish therapy room and we have to extrapolate from international research.

So have we lost anything by embracing psychotherapy integration? For me a key potential loss is diversity. I come from Newbridge in County Kildare. It is horse-racing territory. In Newbridge, GAA means football. But I live in Nenagh County Tipperary, where horses are for hunting, not racing, and GAA means hurling, not football. We live in a very small country, but diversity is important to us and helps us to express identity. The QQI award standards for counselling and psychotherapy have the potential to impose homogeneity upon us, to strip out the colour of Irish psychotherapy, to give us trainings that increasingly look like each other. If that happens, we will have practitioners who march in identikit ways to the beat of a managed-healthcare or a standardised drum. By coming in from the cold and gathering around the warm hearth of state recognition and shared standards, we have created a scene where diversity may struggle.

A second potential loss touches into my own doctoral research. Whilst Norcross and Goldfried (2005) remind us of how practitioners become more alike as they become more experienced, that does not necessarily extend to how we talk and think about our practice (Elton Wilson and Symes, 2006). There is a comfort in having a tight, manageable way of structuring what we do and how we think about it. Fritz Perls (1969) gave us one such a structure in gestalt therapy. Norcross and Halgin talk of how psychotherapists who pursue psychotherapy integration can be overwhelmed by the “morass of choices and the hundreds of therapeutic methods” that are available (Norcross and Halgin 2005: 444). Those of us who were trained in pure-form therapy always have the comfort blanket of a very clear and specific way of formulating the work that we do, even though we draw from a variety of approaches in our actual practice. When I talk with postgraduate students, I often suggest that the principal benefit of having a specific approach in the therapy room might be that it scaffolds the therapist’s presence with the client. I frequently hear therapists and trainers advocate for the importance of a specific way of thinking about therapy, and they often express the sense of loss of structure when they have to formulate work in more integrative ways. That loss of a specific conceptual structure can be disconcerting for therapists, students and trainers alike.

A third domain of loss arises as psychotherapists coalesce into a more powerful body of people who expect to be taken seriously by employers, health services, and managed-care providers. As we become more mainstream ourselves, we find ourselves engaging with mainstream funders and service
providers who often have different objectives, epistemologies, theories, practices and values than us. Increasingly, we find ourselves tied to time-limited therapy, manualized practices and layers of review that seem to have little to do with what the needs of the client in front of us. In that setting, we could well lose that privileged place that we have heretofore held for the client. Our gain of status has put us into contact with forces that may severely curtail our freedom to work in whatever way seems best with our clients.

So let me now turn to challenges for the 21st century. I will begin with psychotherapy training, as it is closest to my heart. Research evidence shows that the effectiveness of psychotherapy rests principally in common-factors that run through various modalities, rather than in modality-specific factors (Asay and Lambert, 1999; Wampold, 2001; Cooper, 2008; Carr, 2009). The trend towards psychotherapy integration is an effort to capture what is best and most effective in the practice of psychotherapy (Norcross, 2005). The challenge for us in this small island is that we have too many training courses that are integrative in nature. The number of courses that are starting up, closing down or simply struggling is worrying. Courses need to be sustainable, so that they can be sufficiently resourced to offer a stable, challenging, learning environment that is well grounded in theory, reflexivity and practice. Furthermore, I believe we need to avoid having too many courses that offer the same thing. The key risk that arises when courses embrace psychotherapy integration is that they all start to look alike. In that scenario, courses compete with each other with similar curriculums and with inadequate resources. Let us hope that the current shake-out that is going on among courses, and that will intensify with the increasingly important role of QQI, will lead to a smaller number of well-resourced courses that express diversity and that cater for the needs of different groups of learners, not all of whom will find large third-level institutions conducive places to learn.

In this presentation, I have not been able to give hard data for Ireland. Most of what we know about effective therapy comes from elsewhere. A second challenge for the 21st century that I would like to identify is that we need to know more about what makes for effective therapy in Ireland. Irish psychotherapy has been bedeviled by the splitting of resources. As a small country, we can only sustain good, useful, socially-relevant research by pooling resources. Currently, we have several good general-interest journals and newsletters, but no high-quality, peer-reviewed journal on psychotherapy theory, practice and research. This gives rise to a lack of hard data with which we can advocate for resources for vulnerable clients and communities. If we are receiving the key of the door at our 21st birthday, we need to be adult enough to engage in high-level inquiry into the effectiveness of what it is that we offer to our clients. So far, we have been content to dabble at the softer edges of this, and it is time for us to assume our adult role.

A final challenge that I wish to identify concerns IAHIP itself. The arrival of award standards for counselling and psychotherapy under QQI, and the impending arrival of statutory regulation of counsellors and psychotherapists, means that some of the key functions of IAHIP will instead be carried out by statutory bodies. What will be the function of IAHIP then? A little history would be helpful here. IAHIP didn’t start out as a regulatory body. Initially it was an association of like-minded people who were passionate about humanistic values and who cared about vulnerable people. Over time, that care for the vulnerable translated into the pursuit of best practice, which ultimately lead to setting high voluntary standards for psychotherapists and for training, and the policing of same. What is to stop us returning to our original role as an association of like-minded people who share humanistic values, are passionate about humanistic and integrative psychotherapy, care for vulnerable people, and who offer support to colleagues? Wouldn’t it be nice to devote our energies in that direction, rather than towards regulatory functions, as we do at present? The integrative movement in psychotherapy has brought us a long way. The gains have been good for our clients, for us as practitioners and for the
profession. Our diversity is at risk, as is the comfort-blanket of pure-form approaches to psychotherapy. Also at risk is the freedom to work creatively with clients in the co-created, open space of our therapy rooms.

The challenge that lies ahead for us as we embrace integrative therapy in the 21st century, is to use our resources well in the service of clients and of our members, and to have confidence in the relevance of humanistic values and integrative practice.

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Interpreters Working in Psychotherapy with Asylum Seekers: Vicarious Trauma and Vicarious Posttraumatic Growth

by Alda Gomez

My first degree was in translation and interpreting. In my faculty corridors, rumours had it that it was safer to become a translator than an interpreter because most interpreters ended up in psychiatric hospitals due to stress. As I am a very cautious person, I decided to become a translator. Over time, having forgotten those rumours, I started my interpreting career. Not only that, in 2004 I enrolled into a community interpreting postgraduate course and started to work in therapy sessions with survivors of torture. Interpreting is very stressful in any situation. An interpreter needs to become temporarily familiar with alien jargon, solve memory lapses, translate impossible jokes and proverbs on the spot, and remember speeches that are not always clearly produced. If we add to the usual stresses having to deal with traumatic stories, the triggering of previous experiences, “interpreter-transferential” feelings, and not really knowing what is happening in a therapy room, we have all the ingredients for the making of a vicariously traumatised interpreter. This paper refers to a study aimed at giving a voice to interpreters who work in psychotherapy with traumatised people and seeing if any measures could be put in place to assist them in their work. It is also aimed at studying the extent to which working in psychotherapy has a positive impact on their lives, through vicarious posttraumatic growth. Without knowing it, the study became a reflection on my own journey as an interpreter, who ended up becoming a psychotherapist instead of ending up in a psychiatric hospital. The paper is based on my psychotherapy MA thesis: Vicarious traumatisation and vicarious posttraumatic growth: a study of how interpreters working in psychotherapy with refugees and asylum seekers are impacted by their work.

Context of the study

In what is now popularly called “multicultural Ireland”, psychotherapeutic settings need to adapt to the foreigners who have settled down in the country. An interpreter is necessary when a client does not speak fluent English and wishes to express themselves through their own language. Among foreign nationals, refugees and asylum seekers are one of the most vulnerable groups. In Ireland, there are no regulations regarding interpreting training, qualifications and working conditions. Interpreting needs of public service users are covered with foreign language speakers who are not necessarily qualified interpreters. With regards to vicarious traumatisation, interpreters who work with refugees and asylum seekers are especially vulnerable because of the traumatic experiences of this particular client group. But interpreters may also experience growth as a result of their work. The research in this area is scarce and most of the studies have been done by mental health professionals, unaware of the specific issues and needs of interpreters. As I am a professional interpreter as well as a qualified psychotherapist, I thought that my study could add a different dimension to the research. But because of the closeness of the material studied, I made every effort necessary not to be influenced by my own experience and I endeavoured to remain as objective as possible, paying close attention to the material presented by the interviewees.

Six interpreters were interviewed, three male and three female, all foreigners, between the ages of 34 and 45. The languages represented in the sample were Arabic, Farsi, German, French, Serbian, Croatian, Bosnian, and Lingala, with three interpreters working in more than one language into and from English. Three of the interpreters selected shared similar experiences to the ones recounted by the clients they work with. All of the interpreters have worked on a regular basis with refugees and asylum seekers who have experienced torture, with an average of three working hours per week, for at least two years. The material for this qualitative research was collected through recorded and transcribed semi-structured interviews and a questionnaire.
While analysing the data, it seemed clear that most interpreters interviewed felt some impact as a result of their work, but most of them emphasised the positive rather than the negative aspects of their occupation. During the data analysis four themes emerged: 1) The need to handle difficult emotions and their impact; 2) Importance of self-care, training and support; 3) Work as a source of inspiration, learning and satisfaction; 4) Difficulties related to the role of interpreter and interpreting issues.

1. The need to handle difficult emotions and their impact

All of the interpreters interviewed reflected on the impact of listening to traumatic stories. Some interpreters recalled feeling the emotional load during the sessions and others emphasised the impact after working hours. Some interpreters had similar experiences to those of their clients. Whereas one interpreter feels that sharing experiences eases the impact of the work, another one feels that it brings back memories, and makes the work more difficult:

‘INT2: what they say most of them did that happen maybe to myself, so for that reason, it is not new to me, but of course it reminds me of what happened, it’s difficult, but (clears his throat)’

The need to clear his throat suggests the difficulty that he experiences while interpreting material which reminds him of his own experience. Another interpreter felt that she was carrying the emotional impact of the words and passing it on to the therapist:

‘INT6: during the session, ‘cos if she feel like “I was raped” say you say “Yes, I was raped” you feel that you are the one who is different, so it’s like you’re carrying whatever pain she has and then give it to the therapist.’

Using the first person may be emotionally charging for her. A question arises about who holds strong affect in sessions with triads through interpreters: is it the therapists, the interpreters or both? The literature does not seem to be able to clearly answer this question. Splevins et al. (2010: 1010) warn against the danger to interpreters of becoming emotionally involved with clients, which can lead to a sense of overwhelming distress. This can relate to the lack of training for interpreters and the lack of role clarity.

The aim for both professions is to create a healing environment similar to that described by Fox (2001:1): the therapist trusts the interpreter with the language; the interpreter trusts the therapist with the direction of therapy; and the client trusts both. In this environment, roles and responsibilities are clear: interpreters are responsible for the language; therapists are responsible for the direction of therapy. This way of working is often called the “black box model”. Due to the lack of training among interpreters and therapists, interpreters may be asked to take on other roles. This is called the “relational model”. The black box model aims at making the interpreter invisible, minimising the awareness of their presence in the room and emphasising their role as a linguistic agent. On the other hand, the relational model often asks of the interpreter other tasks not directly associated to the language: co-therapist, cultural mediator, among others (Miller et al., 2005; Zymanyi, 2009). Miller et al. (2005: 37) reject the black box model as inappropriate, consistent with ‘clinical recommendations’ that favour the relational model. However, the black box model facilitates a direct communication between therapist and client and tends to be the preferred option among qualified interpreters.

As a professional interpreter, my preferred method of working in therapy sessions was the “black box model”, but in time, I intuitively adapted it to therapy needs, as I felt that my presence seemed as important as conveying words. On the other hand, I am still uneasy about a relational approach that can easily break the boundaries of professional roles between interpreting and psychotherapy. That is
why I suggest a model of neutral presence, in which interpreters know that their role is only to convey a message, while being sufficiently aware of their own presence (incl. body language) to not let it adversely impact on the progress of the therapeutic work. This model may protect interpreters from overwhelming emotions associated with over-involvement with clients.

2. **Importance of self-care, training and support**

Four out of six interpreters expressed their awareness of the negative impact that this type of work can have on their lives, together with the need to prevent being affected by it. Their coping strategies are varied, but they all seemed to agree that support, training and self-care are important. This is consistent with the existing literature in this field. Four interpreters recognized the value of the specific training they received in the NGO where they work. One interpreter mentioned the usefulness of learning about trauma. Two of the interpreters emphasised the need to be psychologically prepared before a session. Some interpreters reported being trained by therapists in practical ways of coping with stress and other self-care strategies. They find this training very useful not only for their work in the centre, but also for their everyday lives:

‘**INT5**: Well, basically, how to manage your own stress as well. I’ve been learning this and then some interesting exercises and stuff.’

Four interpreters defined the psychotherapists in the NGO where they work as supportive and helpful, being open to debrief after the sessions. Two of the interpreters mentioned a monthly support group organised in their workplace. While most have been trained to use breathing and tapping exercises, most of them prefer to use individual coping strategies, such as dancing, walking, writing or cooking. One of the interpreters emphasises the need to stay connected:

‘**INT1**: It’s very funny, I keep going. Socialising, socialising is very important, keeping yourself connecting with your friends, going out, like going to the cinema, you know, clubs, music…’

Most of the self-care strategies used by the interpreters interviewed are consistent with the literature in this field. Regarding training, Valero-Garcés (2006: 143) states that there is a generalised concern among community interpreters, interpreting researchers and trainers about the need for specific training on prevention and follow-up of emotionally-challenging material. Most of the studies done by mental health authors state the need for debriefing to support interpreters. One therapist in Zymanyí’s study (2009: 237) expresses the need to debrief periodically to protect the interpreter. Four interpreters in the study also found this tool useful and were open to approaching a psychotherapist if they felt the need to talk to someone after an emotionally charged session. I agree that debriefing is a useful tool for interpreters, but I feel that such support should not come from the same therapists that interpreters work with in triads. This is consistent with Patel (Tribe & Raval, 2003: 235), who posits that such support should come from an independent source outside the context of their work.

3. **Work as a source of inspiration, learning and satisfaction**

All the interpreters expressed some sort of positive impact as a result of their work in psychotherapy with refugees and asylum seekers. However, this is the most diverse theme, as this positive impact seems to have manifested differently for each one. Some interpreters find satisfaction at witnessing a client’s happiness. INT1 finds inspiration for his creativity:

‘**INT1**: I can add some of them without mentioning any names of anything in my stories, in my fiction, it is only fiction, ok, but I am trying to present this kind of human experience to the people.’
He expresses his wish to make those voices heard and create fiction which would spread the stories. He seems to view his trauma work as a potential trigger for social change. Tedeschi and Calhoun (2004: 9) explain that the narratives of trauma and growth carry potential of VPTG by spreading the lessons to others. The stories can then transcend individuals and challenge whole societies to initiate beneficial changes. This is consistent with INT1’s account of his experience.

INT6 expresses a very positive outlook about her experience in a very enthusiastic tone. For her, this type of work brings satisfaction because she learns to value different aspects of her live, minimizing her concerns when she compares them to those that she is witnessing:

’INT6: And sometimes you may think that you have a problem and when you go to the turn of the session, you listen to other people’s problems, you realise that what you have is not that big compared to the other person has.’

She becomes more appreciative of her own life. This is a sign of growth, consistent with the domain identified by Tedeschi and Calhoun (2004: 1) as an increased appreciation for life. She also emphasises having learnt how to establish relationships with diverse people.

Another interpreter says that she started to pay more attention to people. A new domain of growth is identified, in which interpreters learn new ways of relating to others, paying more attention to and being more comfortable with diversity. This domain seems to be consistent with the feelings of respect and non-judgement of others expressed by the participants in the study by Splevins et al. (2010: 1711). As a whole, most interpreters felt that their work is a source of satisfaction and learning, encouraging them to continue.

4. Difficulties related to the role of interpreter and interpreting issues
Some interpreters talked about their difficulty maintaining boundaries with clients. INT5 reports having additional stressors related to the profession, such as memory lapses, and challenges related to her role. The speakers may say too few words for the interpreter to grasp any meaning, or too many so that the interpreter loses part of the speech because their short-term memory limit is reached.

Most of the interpreters talk about the importance of a good relationship and trust between the different parties for the work to progress. Two interpreters emphasise trust from the psychotherapy staff around language issues. Here is what one of them says:

’INT3: I do remember one time I was interpreting for a woman from Iraq and she said (gesture) and she meant “no” but the doctor was there and she said “no, she said yes”; I said “no, this is no. This is not yes’.

Interpreters seem to feel that some psychotherapists find it hard to trust interpreters. Three interpreters placed emphasis on trust from clients. They believe that a client needs to feel comfortable with an interpreter and feel that they will be able to keep confidentiality. Issues of mistrust can arise in any of the three members of the triad. Therapists can mistrust interpreters about their lack of skills. Interpreters can mistrust therapists, especially if not familiar with different therapeutic techniques. Or they can be made to feel unwelcome by therapists who do not wish to have an observer in the room. This is consistent with Boyle’s findings (2010: 14). Clients can mistrust either of the other two. Clients may mistrust an interpreter because they come from the same region as the client (Bot & Wadensjo, 2004: 373), or create intimacy faster for that same reason (Miller et al., 2005: 32). Different problems with trust have been reported in the literature and by the participants in the study and this creates a lot
of stress for interpreters working in psychotherapy. Possibly most of the mistrust by therapists of
interpreters and vice versa comes from the fact that they do not know much about the other person’s
role and profession. I agree with Tribe and Sanders (Tribe & Raval, 2003: 54) about the usefulness of
training for therapists and interpreters on how to work together in mental health.

In general, there is a good working relationship among therapists and interpreters, which facilitates
growth in therapy. However, because of the delicate nature of psychotherapy with a third person in
the room, one of them may feel excluded. Bot and Wadensjo (2004: 374) refer to this when they state
that if interpreters and therapists show their alliance very overtly, their client may feel excluded. This
situation may add to feelings of powerlessness in clients at the thought of needing two carers. It is for
this reason that support provided by therapists from the same workplace may compromise the
therapeutic work, as it may create a strong bond between therapists and interpreters, which can be
perceived by clients as exclusion. It may also affect an interpreter’s neutrality, eventually resulting in
a breach of the code of ethics for community interpreters.

Recommendations
Taking into account the findings of the study and the research previously carried out in this area, a
few recommendations are made for good practice:

- Creating a standard training course for interpreters on issues related to mental
  health interpreting.
- Designing a standard training course for psychotherapists on how to work in
  psychotherapy through interpreters.
- Incorporating a module for both training courses, in which interpreters and
  psychotherapists discuss and understand each other’s roles in psychotherapy.
- Support (personal therapy, group supervision, peer support) for interpreters who
  work in psychotherapy with traumatised clients, preferably from a source outside
  the interpreters’ usual workplace.
- Putting in place any means necessary to support interpreters in their need to maintain
  good boundaries with their clients, such as separate waiting rooms.

Conclusion
The research is limited, as, even though it does provide an introduction to the topic, it does not provide
a general overview of the situation in Ireland. All of the interpreters were working in the same NGO
in Dublin where support systems seemed to be in place for them. Further data could be gathered in
areas such as training. Further research by a team of combined professionals may prove useful. It is
worth investigating the potential impact of the use of the 1st or the 3rd person while conveying the
message. It would also be of interest to research whether a more neutral presence of the interpreter in
the room protects them from being vicariously traumatised by deflecting the emotional impact onto
the therapist. The availability of support for interpreters working with trauma survivors also needs
further research, as does the quality of that support.

Most of the experiences expressed by the participants in the study are consistent with the literature in
the area. Although emotionally challenging, working in psychotherapy with refugees and asylum
seekers seems to have a positive impact on the participants’ lives.

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Exploring the Experiences of White Irish Psychotherapists Working in Cross-racial Therapy Dyads
by Miriam Lewis

Introduction
The population of Ireland is becoming increasingly multicultural and there is a growing likelihood of psychotherapists encountering clients who are members of minority groups.

Individuals and groups who are marginalised in society are at greater risk of emotional disturbance, and psychotherapy services have an ethical responsibility to recognise and respond to the needs of diverse client populations. Concepts such as race, ethnicity and culture can be difficult to differentiate and understand — and they certainly overlap — but for this paper, I have deliberately chosen to focus on the emotionally-charged subject of race.

My research considered the significance and the impact of cross-racial therapy dyads, and explored the experiences of white Irish therapists working with racially different clients. My observations and my experiences as a black client in therapy with a white practitioner stirred me to feel passionately about opening up a discussion around a topic that I feel is important and timely but is not given due credence here in Ireland. However, when friends and colleagues first started asking me about my research, I noticed that I felt embarrassed and apologetic when explaining that I wanted to talk about race. I realised that even I was nervous around this subject matter. Perhaps I feared rejection; I did not want to be dismissed as an angry black woman with a chip on my shoulder and an axe to grind. Then I was assigned an academic supervisor who refused to work with me unless I removed the topic of 'race' as the central focus of my thesis. I hadn't even started my research but it felt like I was about to touch on something that was potent and unsettling and there were people out there who wanted me to stop poking around and to leave it well alone.

Thankfully, I got a new supervisor who was supportive of my work and encouraged me to persevere, but at this point, I was really rattled. I started to question my position: How could racial difference bear any relevance to the therapeutic relationship? Are therapists not trained to see past skin colour to recognise a shared humanity; to love the uniqueness of each individual? Isn't the abhorrent topic of racism a million miles away from the world that therapists inhabit, especially our consulting rooms?

The reality is that we live in a racialised world whereby the racial group you are assigned to affects your position in society. The psychotherapeutic relationship cannot be isolated from that fact (regardless of our level of discomfort around it), even if we ourselves are free from racial prejudice. My research explored how therapists are resourcing themselves to work cross-racially, as they grapple with personal and political issues of identity, in a country apparently lacking appropriate training opportunities to support practitioners in this challenging field.

Context of the study
Scientific advances have dismissed the validity of biological racial categories, but race remains one of the most significant variables for classifying people in contemporary societies. Furthermore, notions of black inferiority have remained prevalent, even with the absence of empirical evidence. Although race is a biological myth it is a social reality and is a powerful determinant of individual and group experience. Racial labels (e.g. white, black, Asian, Latino) are arbitrary but are also immensely important because they can evoke strong emotional responses, influence how people are treated by others and affect access to power, resources and status in society. In this paper, the term ‘black’ will be used in its political sense (as it is widely used in academic literature) to describe the collective
experience of non-white groups, although it must be noted that not all non-white individuals would subscribe to this label.

In cross-racial therapy, any clinical approach to psychotherapy that focuses solely on a black client’s **inner** world, at the exclusion of social realities and political concerns will have severe limitations. Over-concentrating on individual pathology is likely to block empathy and prevent therapists from gaining a deep, holistic understanding of the client’s experience and could cause irrevocable damage to the relationship (Lago, 2006). In order to work effectively with racially different clients, a therapist must be aware of how society works in relation to race, power and discrimination and to acknowledge his or her own position within a system that continues to perpetuate inequality.

**Race**, as an identity marker, has a particular salience in psychotherapy because it is based on visible characteristics such as skin colour, which is likely to be immediately apparent to a therapist and client who know nothing else about one another. This makes race a probable site for projections and other unconscious phenomena, which can affect the real or transferential therapeutic relationship. Crucially, the therapy room is a microcosm of the world outside, so a therapist must be aware of the mechanisms of oppression, in order to avoid them being re-enacted unconsciously in the therapeutic relationship.

**Research Methodology**

The purpose of this study was to explore phenomena and deepen understanding; thus, an inductive, qualitative approach was taken. A purposive sampling strategy was employed and respondents had to meet specific inclusion criteria in order to participate; to ensure that they had sufficient and relevant professional experience.

Four participants were selected, then in-depth, semi-structured interviews were conducted with the two male and two female psychotherapists, all of whom were white and Irish. To safeguard anonymity, pseudonyms - Karl, Una, Sean and Cathy - were assigned and any other personal details that might allow for identification of the participants were removed or altered.

All the participants belonged to a similar age demographic, ranging between 45 and 65 years old. With the entire corpus of data comprising only four interviews, there are inherent drawbacks of this small sample; the focus on individual experiences will not allow for generalised claims and conclusions to be made about the broader research topic. The process of thematic analysis of the four transcribed interviews elicited three major themes which are discussed below.

**Theme A: Culturally sensitive therapy**

The subjects all stressed that cultural differences between them and their clients presented obstacles to effective therapy and that therapeutic approaches should be appropriately tailored, in order to effectively overcome cultural challenges.

Some participants perceived that the social inequity and subordination experienced by black people in society can also be evidenced in the inherent cultural bias of psychotherapy. For example, the goals of western psychotherapy - such as ‘actualisation of the self’ and ‘development of individual autonomy’ - may be culturally inappropriate and even discriminatory for an African client who espouses the values of a collectivist culture.

“The concept of ‘I am because I belong’ …is so much more powerful than our western notion, ‘I am because I think’. Sometimes [therapy] can lead to a kind of alienation - for somebody who is being asked to **individuate**... into a place of aloneness, rather than a place of community building”. (Cathy)
Notably, all the participants asserted that cultural competency training was important for therapists but commented that their own core psychotherapy training programmes had not adequately explored issues of diversity or equipped them with transcultural skills.

**Theme B: Therapist Self-Image**
Each participant was asked to talk about his or her own racial identity and how this has informed their work with racially different clients. Exploring their own racial identity did not appear to be a familiar or a comfortable experience for these white therapists. An interesting trend emerged in the data, that they had a strong sense of national identity (what it means to be Irish) and a much weaker sense of racial identity (what it means to be white). Irish identities may carry the scars of centuries of subjugation under the English, which might give the Irish a natural affinity with other peoples who have historically been colonised or oppressed.

It emerged that all the participants had lived and worked abroad in other continents with cultures radically different from Ireland. The respondents felt that their identities had been shaped by their experiences of being an ‘outsider’, and implied that this attracted them to want to work with clients from ethnic minorities and, moreover, helped them to empathise more deeply.

Karl used the metaphor, “Sherpa of the soul”, to describe himself as an experienced guide, qualified to accompany his black clients across this “psychic landscape” because he is familiar with its treacherous terrain. Sean, on the other hand, warned of the dangers of over-identifying with his black clients' experiences of being marginalised: “That can be a poison. Just because I’m seeing it here, doesn’t mean it’s the same there... Check it out – because you’ll be getting it wrong”. (Sean)

He suggests that toxic misattunements are likely to occur if the white therapist ‘presumes to know’ and uses his own frame reference (instead of the client’s) to understand the narrative.

**Theme C: Race and power in the therapeutic relationship**
The participants’ discomfort around discussing issues of race (compared with issues of culture) was especially noticeable when the issue of inequality between racial groups was made explicit in the interview questions.

> *When you say ‘inequality’, what do you mean exactly? Racial inequality?...In a therapeutic setting, the more important thing is the human interiority of the person. I really don’t notice race.”*  
> (Cathy)

Over the course of the interview, Cathy markedly altered her position on her understanding of racial dynamics in cross-racial therapy, increasingly reflecting on how the therapeutic process is not impervious to the effects of racism in society. She described the intense and conflicting feelings that accompany the process of her ‘owning her whiteness’:

> *I have experienced when it can be humiliating, embarrassing... I can feel anger. [Pause] I try to distance myself from [the feelings]...and other times then I think, how can I bring about change here?*  
> (Cathy)

She acknowledged that, as a white person, she can be perceived as a racial oppressor which can evoke feelings of guilt and shame. Engaging with the idea of white power and privilege in society elicits these unpleasant emotions that she might naturally prefer not to experience.
Una said that she thought it was essential to 'name it' when racial dynamics emerge in the transference but admitted how intensely difficult she finds this:

*It poses a challenge for me always. Because I always have the fear of how it could be interpreted, perceived and understood. The possibility of breaking the relationship... The possibility of feeling superior by even just bringing it in...*  

(Una)

In naming the social reality of white privilege and power she risks damage to the client’s perception of her and consequently to the relationship; but there is also the threat to Cathy’s own ego as she is faced with the fear of 'feeling superior'. This conjures the persecuting anxiety of being in touch with deep, disavowed beliefs about white supremacy that are the inheritance of a white person acculturated in our racialised world.

**Results**

The participants’ accounts were enthusiastic, vivid and rich with detail about counselling people from other cultures. Race and culture are terms that some people use interchangeably but race is, in fact, a specific facet of culture and arguably the most taboo. Whilst cross-cultural psychotherapy is a very valid and deserving area of research, it was not the intended area of enquiry for this study and it was not introduced to the participants by the researcher at any stage. Therefore, it is a striking finding that all four subjects seemed to come with an agenda to speak about general cultural factors which they used in apparent attempts to sidestep specific racial factors. An analogous scenario would be if participants signed up to take part in a study about sex addiction, but during the interviews spoke mostly about addiction issues in general and avoided answering the questions in relation to sex addiction.

The term ‘culture’ is sometimes used as a euphemism for race because it dissipates the intense political and emotional connotations provoked by the latter word. A desire to appear ‘politically correct’, fear of causing offence, fear of being associated with racism and anxiety about racial conflicts within the self are some of the reasons that people might want to avoid the highly charged topic of race. The sub-text of ‘race-avoidance’ in the data is an interesting finding because, if there is evidence of these white therapists avoiding racial issues during a research interview (which was also a cross-racial dyad because the researcher was black), there is a high likelihood that a similar process is occurring in their therapeutic work. A seminal study by Thompson & Jenal (1994) showed that ‘race-avoidance’ by a therapist in a cross-racial dyad limits the extent to which the client can utilise the therapeutic relationship. Race-avoidance is also a predictor of client drop-out from treatment, a phenomenon that Morgan (1998) called the ‘silence of race’.

Two of the participants initially presented strong beliefs that racial difference between them and a client could and should be minimised by focussing on the unique subjectivity of the individual. They espoused a ‘colour blind’ approach to therapy, claiming that a client’s race was not an important factor, no more than ‘is the person wearing glasses’ (Cathy). Colour-blindness can be viewed as a well-intentioned but ultimately racist approach to therapy because, in not seeing the client’s race, the therapist implies that there is something wrong or shameful about it. Furthermore, there is a denial of the significance of racial categories affecting access to opportunities, power, privilege and status, which is a social reality that most black people are acutely aware of.

When the reality of racism in society is acknowledged by white therapists, they may experience acutely uncomfortable feelings, such as anxiety, guilt and shame. For white Irish psychotherapists, defence
mechanisms against ‘owning whiteness’ may be further enabled by the identity factor of ‘Irishness’ which denotes membership of a colonised and oppressed ethnic group. Whilst this may enhance empathy towards black clients, it is not necessarily a realistic reflection of present-day power relations and can serve to deflect attention away from the discomfort of being associated with white oppression.

Having an under-developed sense of racial identity may not be an apparent concern for white people because of the phenomenon of ‘white invisibility’. (White invisibility involves the unawareness or non-acknowledgement of whiteness as a racial position; rather whiteness is treated as a neutral baseline from which others outside the norm can be measured from.). In the context of cross-racial psychotherapy, this is problematic because when a black client has a more developed sense of racial identity than his unwitting white therapist (which the data suggests is a probable scenario), the dissonance between them prevents the promotion of growth and healing for the client.

White therapists have an ethical, professional responsibility to continuously explore their own identities and to uncover whatever is being suppressed out of awareness so it can be worked with. This applies to racial identity issues just as it does to all other aspects of human functioning. Thus, unless white therapists come to recognise themselves as racial beings, and reflect on the significance of how they perceive others and how they are perceived in the context of this racialised society, their ability to work at depth with client issues will be necessarily impeded. This journey of self-discovery may begin during a therapist’s training but should never be seen as completed because defences are persistent and understanding can always be deepened.

The participants all intimated that the institutions of psychotherapy (including the professional accrediting bodies and the various training institutes) in Ireland are generally failing to adapt appropriately to address the needs of the increasingly culturally diverse population. All of them expressed the opinion that cultural competence should be an essential component of psychotherapy training but none of them felt that their own core training had adequately equipped them with skills in this area. They felt that the responsibility for self-resourcing had been taken up by themselves, by undertaking individual research or reflecting on their personal experiences of people from other cultures.

**Conclusions**

This research has important implications for the handling of racial dynamics in cross-racial psychotherapy dyads. Arguably therapists are, by definition, already more powerful than their clients, and this is heightened for white therapists using culturally biased (Euro-American) models to counsel black clients. A denial of the significance of race by a white therapist counselling a black client is also a denial of the inequity of power. This has a particularly toxic potential for the treatment, because disavowed feelings can manifest in the transference-countertransference relationship, making it a likely site for enactments that mirror the unequal power relations in society. If mishandled, the therapeutic relationship is likely to stagnate or rupture, thus the client loses the opportunity for insight, for integration and for having an emotionally corrective experience.

It can be concluded that appropriate training and supervision are indispensable factors; cursory ‘box-ticking’ exercises and add-on modules covering issues of diversity may be insufficient preparation for the personal challenges of cross-racial work. Meeting people from other races may be useful in kick-starting a journey of deeper racial identity awareness but such intercultural experiences alone are insufficient to equip therapists to handle the complex and distressing unconscious dynamics that undergird black-white interactions. A recommendation would be for intercultural awareness to become integrated as a compulsory aspect of psychotherapy training in Ireland; and for it to incorporate
experiential processing, to provide a safe space for the required level of self-reflection. In order for rigid unconscious defences to shift, self-awareness needs to be experienced at a deep, emotional rather than a superficial, cognitive level; therefore, the learning process must be sensitively managed due to the painful and confusing material that is likely to surface. The accounts of the participants in this study suggest that in Ireland, awareness of cultural and racial difference is low on the agenda of psychotherapy institutions, if it is there at all.

Ignorance, resistance or mere indifference to issues of diversity could be factors preventing the predominantly white psychotherapy establishments from advocating for inclusivity to ensure that therapy services are equitable and accessible for members of minority groups.

The full version of the thesis on which this paper was based is available for download at the following webpage: http://bit.ly/19KjsYv

Miriam Lewis has an MA in Psychotherapy and is working towards accreditation with IAHIP. As a mixed-race woman (of English and Ugandan heritage), raised in Essex and resident in Ireland since 2003, Miriam has developed a keen interest in how issues of identity, diversity and interculturalism intersect with the therapeutic process.

References:
A Qualitative Study of Psychological and Psychotherapeutic Approaches for Motor Neurone Disease (MND) Patients
by Mary Rabbitte

Introduction
This research examines counsellors’, psychologists’ and psychotherapists’ experiences of different psychological and psychotherapeutic approaches which they use when delivering therapeutic services to Motor Neurone Disease (MND) patients. This study incorporates the views of therapists working in Ireland and a few therapists from the UK and Italy.

MND is an incurable terminal neurological disease characterised by progressive physical disability and is known to cause psychological distress and adversely affect the wellbeing of patients (Kurt et al., 2007). In spite of this, MND patients have raised concerns about inadequate emotional support provided as part of their care (Foley, Timonen and Hardiman, 2012). To date there is very little information about the type and effectiveness of interventions being delivered to this population.

Aims and Objectives
The aim of the study is to examine therapists’ experiences of the different psychological and psychotherapeutic approaches they use when delivering services to MND patients.

The objectives of this study include:

- Review of counsellors, psychologists and psychotherapists experiences of different psychological and psychotherapeutic approaches for MND patients.

- Insight into psychological and psychotherapeutic approaches delivered by MND care centres outside Ireland in UK and Italy.

- To develop a map of therapeutic care, theories drawn on, interventions and perceptions of efficacy and outcomes, from a therapist’s perspective that could guide the provision of a draft framework for psychological and psychotherapeutic approaches for MND patients in Ireland.

- Recommendations on what therapists perceive as future practise developments and identify potential directions for future research.

Background to the Research
MND, also known as Amyotrophic Lateral Sclerosis (ALS), is an incurable, terminal, neurological disease characterised by progressive physical disability. MND has a mean survival of 3.5 years from diagnosis to death and an incidence of 1-2 cases per 100,000 populations per year (Leigh et al., 2003; Leigh and Ray-Chadhuri, 1994). The psychological distress caused by MND, to both patient and their carer, has been studied using self-report measures of depression, anxiety and Quality of Life (QoL), as evident in a recent review by Pagnini (2013).

Psychological symptoms for MND patients include symptoms common to the terminally ill of depression, anxiety, hopelessness and fear (Block, 2010). From a review of studies, (in relation to psychological health and MND) using DSM-IV criteria, Kurt et al. (2007) quotes average figures of 9-11%. Averill et al. (2007) reported an average figure of 5.5% for major depression across all stages of MND disease which is in line with a review of European averages for major depression of around 5% (Paykel, Brugha and Fryers, 2005). However individual studies of depression and MND have shown figures exceeding this, for example, up to 57% (Palmieri et al., 2010). For MND patients,
anxiety is seen to range from 0-30% (Kurt et al., 2007). A study by Plahuta et al. (2002) of hopelessness and MND, found that on average 22% of participants were moderately hopeless and 10% as severely hopeless, with hopelessness correlated to an externally oriented locus of control and a poor sense of meaning for purpose in life. A feeling of hopelessness in MND patients has in other studies been linked to greater suffering (Ganzini, Johnston and Hoffman, 1999) and considerations of suicide (Whitehead et al., 2011; Ganzini et al., 1998). A study by Borasio et al. (2001) highlights how MND patients also express a fear of “choking to death”, which presents from diagnosis to end-stage illness.

Other studies have also highlighted psychological symptoms more uniquely related to MND, including emotional lability and existential shock. Emotional lability that is pathological crying, laughing or smiling is seen to range from 20-49% in MND patients (Moore et al., 1997). Existential shock, as reported by the MND patients in the study by Brown (2003, p. 210), was seen as “losing confidence in their bodies, recognising their physical vulnerability and being scared of facing their imminent death”.

It is known that MND patients prioritise emotional well-being, family and social support over physical condition as the disease progresses and are often dissatisfied with the level of care provided in these areas (Foley, Timonen and Hardiman, 2012). From a literature review there appears to be very little research relating to how psychological and psychotherapeutic services could support MND patients in the reduction of depression and anxiety as well as increasing QoL. A recent call for research by Pagnini et al. (2012) confirmed the need for additional research to explore what does and could work from a therapeutic intervention perspective, which could be seen as the next step.

This study used face-to-face semi-structured interviews to collect data from therapists whose role includes the delivery of therapeutic services to MND patients in Ireland. In order to gain a greater understanding of MND services in other EU countries a few participants were recruited from MND care centres in the UK and Italy. As the majority of published literature on MND support services appears to come from the UK (Leigh et al., 2003) and Italy (Palmieri et al., 2010) and they serve a greater demographic, it is recommended to include participants from these countries.

Selection of the Research Methodology
The grounded theory method was used to analyse the data collected. Grounded theory is a qualitative method of data analysis first proposed by Glaser and Strauss (1967) and developed further by Rennie (2006) and Charmaz (2006). This method has been widely used and is well recognised in the field of psychology and psychotherapy research.

When using grounded theory, data collection and analysis proceed simultaneously, and as stated by Bryant and Charmaz (2010) the:

> Iterative process of moving back and forth between empirical data and emerging analysis makes the collected data progressively more focused and the analysis successively more theoretical.

(Bryant and Charmaz 2010: 1)

> Interpretative Phenomenological Analysis (IPA), a qualitative bottom up-approach was also considered, however as it recommends a small and homogeneous sample it was discounted for use in this study.

(Smith, Flowers and Larkin, 2009)
Population and Sample
The participants for this study were recruited from counsellors, psychologists and psychotherapists, whose role includes delivering therapeutic services to MND patients. Therapists were recruited from both the public service (hospital, hospice) and private practice in Ireland. In order to gain an insight into therapeutic service delivery outside Ireland, participants whose primary role is to deliver therapeutic services in MND care centres in the UK and Italy were included. The diverse and robust nature of the participant group was thought to lead to a more comprehensive review and insight of what is actually being delivered as regards therapeutic services to MND patients.

Rationale for the Research
From the literature review, there seems to be an abundance of research about the parameters affecting MND patients’ QoL and the type of psychological symptoms that may present during illness progression. However there seems to be an absence of research investigating the range and effectiveness of different therapeutic interventions that could impact emotional affect for MND patients, such as depression, anxiety, hopelessness, existential shock and QoL. The current research has highlighted that family, social and emotional support is a priority area for MND patients and their carers. Nevertheless other than looking at possible positive coping strategies, self-hypnosis, peer group support and providing information, there appears to be no published research into what type of individual therapy could support MND patients to improve well-being and reduce psychological distress. A very recent call for research by Pagnini et al. (2012), has confirmed the researcher’s hypothesis, that this area of exploring what does and could work from a therapeutic intervention perspective could be seen as important and research worthy.

High Level Summary of Main Approaches
The therapists’ experiences of the different approaches they use when working with MND patients included the following model themes:

Supporting them in how they are now
This theme was linked to therapists’ awareness of known anxiety levels of MND patients and wanting to support the patient in reducing their anxiety. In this study focussing on what the patient can do now, rather than facing fears of imminent death were seen to be supportive. As one therapist stated, “I do feel that it helped if he could stay where he was right now”. The interventions that supported this approach included the therapist being able “to turn up and be brave enough to sit there” and put a “fine focus” in building awareness of what the patient still has, validating and assigning a value to it. This could be seeing the value of the support the patient receives from family and friends.

Adjusting Rhythm and Pacing
This theme is related to the nature of MND, the physical and cognitive impacts on the patient, and the corresponding adjustment required in way of working by therapists. This was only mentioned by therapists in the public service, with greater experience of MND and who see patients in less well states than those in private practice. In this study familiarity with different communication aids, patients’ possible fatigue and being patient in waiting for dialogue to happen were cited as needing to be addressed by the therapist.

Affirming the Patient
This theme included interventions of providing respect and control, following the patient’s lead and empowering them to take practical steps to manage their situation. The international therapists defined this theme as being linked to the goal of supporting the patient to have a more active role in their life. This was seen to support the patient in coming out of their “paralysis”.

Exploring Feelings
This theme describes the different ways therapists support the patient in exploring emotions and their experiences of feeling cut off and not able to engage, engaging at a cognitive and emotional level, to finally an integrated approach of being very present. A gentle, persistent, patient approach with interventions around this way of working, to provide engagement while managing resistance was emphasised.

Difficulty of Working with Dying
The difficulty of working with dying and sense of hopelessness that it brings was experienced as being challenging for therapists to work with. Most interventions cited were in relation to this theme. The most useful interventions cited were supporting the patient to stay in the present, exploring fears of the process of dying or “just listening”. Patients’ suicidal ideation and wanting to have control around when they go, was experienced by only one Irish therapist. The international therapists cited interventions around listening to patients’ expressions of suicidal ideation and validating their expression but at the same time not endorsing or colluding.

To Keep them Functioning and Coping
Therapists considered that supporting patients to cope by providing information was a pragmatic approach. This theme was only cited by therapists working in the public service which had overall, more experience of MND and were familiar with palliative care models.

Seeing the Individual behind the Disease
This study shows that the ability to see the individual behind the disease, allows the therapist to see what is important for the MND patient. This may be a family issue and not related to MND disease. The interventions that supported this approach included not assuming, checking in with patient, and getting a feel for who the person is who happens to be affected by MND.

Psychological Evaluation
Psychological evaluation as a theme was cited by those working in the public service only. This approach was used to assess for any cognitive or communication impairment due to MND.

Mary Rabitte has a Masters in Integrative Counselling and Psychotherapy from DCU. She completed her clinical training in Our Lady’s Hospice Blackrock and is currently receiving a grant from the Irish Hospice Foundation to support the development of training in MND. Her clinical practice is in the Dublin Gestalt Centre.

References:


