IRISH ASSOCIATION OF HUMANISTIC & INTEGRATIVE PSYCHOTHERAPY

“Keeping Psychotherapy Relevant to These Changing Times”
The members of IAHIP continue to challenge the boundaries of psychotherapy and this years conference, held in the Clarion Hotel in Cork, on 4th March, 2016 was no different. Entitled “Keeping Psychotherapy Relevant to These Changing Times” attendees sought to change awareness of existing challenges by analysing current practices and examining how these can continue to stay relevant within the constraints of changing, and sometimes uncertain, times.

Over the years I have been afforded the opportunity of working with IAHIP on a number of projects, from the uploading of their very informative publication, Inside Out, to the editing of this conference. For this I am most grateful. Reading the various articles and papers has not only enabled me to reflect upon my own life as a mere mortal – but equally it reassures that a dedicated circle of professionals relentlessly demand perfection in the pursuit of understanding and improving the lives of those who live and struggle daily, often in difficult circumstances. To know that this is at the very core of their beliefs and central in their plight for best practice is infinitely reassuring.

As previously stated, I am not a psychotherapist and therefore not qualified in any way to adequately critique the work that I read in my role as editor but as a bystander and looking in from the sidelines it is clearly evident that the standards sought by all members within the IAHIP network is extremely impressive.

At this years conference the work undertaken has produced 27 papers, posters and workshops. Having spent many hours pouring over this great volume of work, I was frequently moved by some of the insights highlighted by the authors in their efforts to not only increase awareness but also to witness the anticipation of hope underscoring the very essence of those who face psychological challenge. It is so important to take stock but equally important to question and seek solutions by capitalising the best of their talents. They harness a level of expectation which in turn encourages others to engage and to lend support.

As a valuable provider of essential services it is timely therefore that IAHIP continues to challenge existing ideas, to embrace new approaches and innovations and to share the importance of these findings in today’s complex society. In bringing you this body of work in its book form I urge you to pursue meaningful debate and to question and probe existing methods and theories. By doing so you will ensure that key services and supports are provided by those that can.

I would like to express my sincere gratitude to IAHIP in particular, Kay Noonan, who has not only been so helpful and supportive but incredibly patient as well.

The purpose of this conference was to highlight the challenges faced in Keeping Psychotherapy Relevant to These Changing Times in Irish society today and by understanding and exploring how change can positively impact on the lives of others is key. I would like to take this opportunity to congratulate you on your work and to wish you all continued success in the future.

Ann Kilcoyne

Editor
IAHIP held its second Conference in the Clarion Hotel, Cork on the 4th March, 2016. The title of the conference was: “Keeping Psychotherapy relevant to these changing times”.

Building upon and learning from our 2013 Conference, a committee of seven people put together an interesting and exciting conference. Of course this would not have been possible without the generosity and hard work of the presenters. There were fourteen papers, seven workshops and seven poster presentations. The poster presentations were a new addition to the conference content. IAHIP is very conscious of encouraging student involvement in the organisation and the poster presentations enabled students who may not have completed any research before to enrich the conference with their contributions. As a way of encouraging student participation it was decided to offer a prize for the best poster. Congratulations goes to Monique Danaher for her poster, “Dead Body, Living Body’ Explorations After Sudden Death” which won the competition. We asked the conference delegates to look at the posters and talk with the presenters and vote for the entry they liked the best. You can see Monique’s poster along with all of the others on the 2016 Conference section on the IAHIP website.

Another exciting feature of the 2016 IAHIP Conference was the international interest. There were three presenters from the U.S.A. who offered two workshops: Mismeach: Courage as the Heart of the Work for Psychotherapists; Daring Therapists - Healing Shame in the Therapy Room, and one paper: Stable to Fluid: The Evolvement of Psychotherapy’s Awareness of Gender and Sexual Fluidity with Clinical Implications for our Work. We also had a Video Story Teller, Austin Adesso, from the U.S. who offered to come and record key parts of the conference for the IAHIP website. A special word of thanks to our American guests for gracing us with their presence. While IAHIP is a member of the European Association for Psychotherapy (E.A.P.) it is lovely to become known in the wider world, especially in the U.S.A.

Dermod Moore, chair of IAHIP, gave the opening speech in which he asked what a collective noun of therapists might be. He explored concepts for the Greek word Therapon and its correlation in ancient Hebrew. Therapon can mean to nurse or to treat medically. Therapia is a service; a medical treatment; it’s curing, healing, a service done to the sick; a waiting on. A therapon is an attendant or minister giving willing service. He concluded that a collective noun for psychotherapists might be a Bedlam of psychotherapists coming from Bethlem Royal Hospital in London, which was Europe’s first and only institution to specialise in mental illnesses. Bethlem, founded in 1247, was devoted to healing sick paupers. It was originally called Bethlehem and later Londoners pronounced it as Bethlem or Bedlam and so the word Bedlam!

Jean Manahan, CEO of the Irish Council for Psychotherapy gave the keynote speech which was warm, witty, informative and very encouraging of the work of IAHIP. Jean spoke about the extraordinary potential of the ‘I-Thou’ in the therapeutic relationship to create something else, where something unknown becomes known, and the potential for something magical to emerge out of that relationship.

Dermod and Jean’s keynote speeches are available on: iahip.org/conference-2016.
The papers, workshops and posters all responded to various aspects of how we might keep psychotherapy relevant to these changing times. The presentations included covered areas such as the role of nature in psychotherapy, eating disorders, endings, psychotherapy in the Irish Health Service, therapists’ experience of working in a second language, male vulnerability in the psychotherapy environment, creative use of the psychotherapy space, listening to the lessons of neuroscience, chronic pain and the role of psychotherapy to mention but a few.

The feedback from the conference participants was very positive and the fact that the conference was held in Cork invited such comments as: “Cork, a great location: thinking outside the East coast (The Pale) excellent”, “Have it in Cork each year and make it a weekend rather than a day”, “It would be wonderful if more conferences and workshops were held outside of Dublin – not always Cork either but not in Dublin all the time.

The Conference Committee and IAHIP appreciate the time people took to complete the evaluation sheets and the thought they put into doing so. We will collate the feedback and this will be used by a future conference committee when planning the next IAHIP conference.

Finally, a big thank you to the conference delegates, the presenters, the volunteers and my fellow committee members who all put so much work into the organising of the conference and to IAHIP for hosting the conference.

Kay Noonan
Conference Co-ordinator.
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Workshop: Daring Therapists - Healing Shame in the Therapy Room
by Marianne Marlow

Description of Workshop:
Although shame is a prevalent and painful emotion that arises frequently in everyday life (Dearing & Tangney, 2011), its role within the therapeutic process is often overlooked. We tend to avoid the word in common language as shame is a difficult subject to discuss. It is inherently linked to the desire to hide and conceal and is not often willingly surfaced in therapy. Therapists also inadvertently avoid discussing shame-related topics, perhaps because of discomfort with our own shame. Finally, the psychobiological impact of shame is difficult to measure. Nevertheless, shame is a ubiquitous emotion present in the therapy office and must be approached and addressed within the therapeutic relationship. Otherwise, it is given legitimacy.

One might say that we can't exorcise the demon shame until we can name it.
(Dearing & Tangney, 2011).

The research of Dr. Brené Brown provides a framework to recognize shame triggers in our clients and when countertransference occurs for us as clinicians. Therapists need guidance to help us better understand shame and to work with clients within their own experiences of shame. As therapists, we must be willing to deal with our own shame before we are able to help clients heal shame–related wounds.

This workshop explores:
- Current research on shame.
- How to recognize countertransference.
- Designing interventions to release the ‘lock-down’ of shame.
- Treating shame through a variety of techniques.
- Transforming shame in ourselves as clinicians, and with our clients.
- The link between shame, fear, and trauma.

As clinicians, we cannot effectively stand beside our clients in realms we have not explored. We must move through any personal discomfort in order to address shame directly. To assist in this critical awareness we will use Brené Brown’s metaphor of ‘the Arena’ to explore our subconscious, maladaptive, and limiting beliefs. This enables us to better serve our clients in reaching their own understanding; thus clearing the clinical field to restore connection.

Workshop Objectives:
Participants will examine—in dyads and individual experience—the phenomenon of scarcity, comparison, and shame. Using empathy and self-compassion, we will develop our awareness as clinicians while providing a clear pathway which strengthens the therapeutic alliance.

Additionally, this workshop will help participants to:
- Understand and begin to utilize the metaphor of the arena to examine the challenges associated with feeling vulnerable or with engaging in behaviors that lead to uncertainty, risk and emotional exposure.
- Utilize a shared language in the group to talk about the various components of the arena.
- Begin to understand the relationships among vulnerability, scarcity, shame, and comparison.
- Recognize how criticism and cynicism neurologically impede our willingness to be vulnerable.
- Define shame in the nervous system for themselves and their clients.
Participants will actively:

- Explore the context of the arena where personal vulnerability will start to bring to consciousness the people, messages, and expectations that lend personal and professional support to their efforts to ‘show up’ and that generate fear.
- Work with an inventory (that may be used with clients) to tease out the subconscious roadblocks to fear and shame.
- Explore their own real bravery.
- Learn their own shame triggers and subconscious remedies to those triggers.
- Explore what keeps us at the door of the arena without going in.
- Examine the role of scarcity, comparison, and shame.
- Learn the shields and healthy personal resources to overcome and live with shame – an inevitability in our nervous systems.
- Learn about the 2 remedies of shame

In summary, this highly interactive workshop will present the concept of healing shame – once we understand how shame operates in our lives, it cannot operate our lives.

*If we are brave enough, often enough, we will fall.*

(Brené Brown 2015).

This is a workshop about how to *Rise Strong*.

**Marianne Marlow** MA LMHC Daring Way facilitator – candidate, is a presenter, trainer, psychotherapist, and relationship specialist. The foundation of her work is: relationships test bravery, reveal courage, and lead to evolution. Healthy relationships rewire us dynamically inspiring us to positively influence the world! Marianne’s passion lies in assisting those daring for authentic relationships. She trains coaches, therapists, physicians, attorneys, and thought-leaders internationally in highly experiential programs and retreats. She is secretary of WMHCA and a certified Daring Way Facilitator. As a public and industry presenter, she extends her expertise by teaching personal and professional resiliency. As a master therapist, she supervises and professionally develops coaches and therapists.

**References:**

An Exploration of How Mothers Who Experience The Journey of Becoming A Psychotherapist Relate To Their Children During The Process.
by Suzanna O’Reilly

*Man is the only being who is subject to his childhood. He is that being whose childhood constantly draws him backwards.*

(Paul Ricoeur, 20th century French philosopher)

This research project asks the question, “How do mothers who experience the journey of becoming a therapist relate to their children during the process?” It explores how being a mother can impact on how a trainee makes sense of the training process. It aims to demonstrate the transformative aspect of becoming a psychotherapist and how this may impact on the trainee and also the family of the trainee. A defining condition of being human is our urgent need to understand and order the meaning of our experience, to integrate it with what we know to avoid the threat of chaos (Mezirow, 2000).

We make meaning with different dimensions of awareness and understanding and in the process of becoming a therapist, there is potential for great change. Confronted with personal therapy, process group work, experiential learning and client work, the trainee has the opportunity to re-examine belief systems and question previously held assumptions. Interpretations and opinions that may have worked for the trainee prior to the training may not do so anymore. The ethos of therapy training courses is one of self-questioning and self-monitoring and this leads the trainee to the kind of change that can impact on future decisions and ways of relating to self and others.

**Introduction to the Research Project**

The specific objectives of this research are:

- To explore the impact of training on female therapists who have children.
- To investigate how the trainee may experience being a parent during the process.
- To identify any changes in the parent–child relationship that may be attributed to the training.

**Context of the Study**

The study aims to explore the lived experience of trainees who are undergoing changes as part of their training. The study aimed to provide a descriptive window into the private perceptions of mothers training as psychotherapists. It aims to demonstrate the transformative aspect of becoming a psychotherapist and how this may impact on the trainee and also the family of the trainee.

**Experiences of Therapists in Training**

Graduate training in psychotherapy is a challenging and rewarding undertaking. The practice of training and learning psychotherapy skills requires a very personal and professional engagement. Knowing more about student’s experiences in their training process could help evade problems such as incompetence, impairment, burnout, or disillusionment (Orlinsky & Ronnestad, 2005).

Little research has explored the internal reactions that students experience as trainee therapists, even though these early experiences are understood to provide the foundation of subsequent learning. Several authors’ state that the theory and research on training novice therapists is fairly outdated (Hill & Lent, 2006).

Other authors observe psychotherapy training as an area of renewed interest (Hilsenroth *et al.*, 2006). It is evident that while the topic of training has received more attention than any other therapist
variable (Beutler et al., 2004), there is a significant gap in the literature exploring the subjective experiences of psychotherapy trainees.

**Perceptions of Psychotherapists as Parents**

Interestingly, Kohut (1977) many years ago had the occasion to analyse many adults who, as children of psychotherapists, had been negatively impacted by their parent’s tendency to overanalyse and interpret their behaviours. He states that the:

> Pathogenic effect of the parental behaviour lay in the fact that the parent’s participation in their children’s life, their claim, often correctly made, that they knew more about what their children were thinking, wishing, feeling than the children themselves, tended to interfere with the consolidation of the self of these children.

(Hohut, p.146-147).

The unwelcome intrusion in the child’s life in this manner was inappropriate and hindered the child’s own self-awareness process.

As Kohut points out, these “children became secretive and walled themselves off from being penetrated by the parental insights” (p.147). Consequently, the relationship between therapist and child became more distant. Conversely, other studies appear more positive about the experience of parenting whilst practicing as a therapist.

A tendency to become more open, thoughtful, confident, and patient as a result of a career in psychotherapy cannot help but improve the therapist’s parenting skills (Guy, 1987). It seems that psychotherapists believe this to be true of themselves. For example, 71% of those surveyed in one study indicated that they felt that their clinical practice had a positive impact on relationships with their children (Guy et al., 1987). It might be assumed that some home environments are characterised by many of the same qualities that psychotherapists attempt to provide for their clients, such as empathy, genuiness and positive regard. If this is true, certainly the children will benefit from being raised in such an environment (Rogers, 1980). Golden and Farber (1998) in their small study on whether it is indeed good for children to have a therapist as a parent discovered that being a therapist is good for one’s children as long as one’s professional skills are not applied indiscriminately. Theory and research in conjunction with the results of a small scale study (n=20), suggest that children harbour both positive and negative feelings and dislike their parent’s tendency to act like a therapist at home.

**The Challenge of the Dual Role – Therapist and Parent for the Family**

The challenge of being an authority on matters in relation to emotions, thoughts and behaviour is something that may have an effect on both the parent therapist and the child. Wallerstein (1981) suggests that therapists may well experience greater anxieties in raising children since, “We of all people have laid open intellectual claim to knowing how best to do it”. He explains how therapists may experience anxiety in the role of parent and relate to their child in an “interpretive fashion” at home. It may be “easier to know how to act when one is comfortably ensconced in the analytic drivers’ seat” (Wallerstein, 1981, p.291). The dual role of parent and therapist appears to pose a challenge. Storr (1979) expresses how the confidential aspect of a therapist’s work can leave children in the dark in relation to what exactly their parent does in a working day. There may be a shroud of mystery that is necessary in the profession. Professional discretion means that the therapist is virtually unable to discuss his (her) work with his family, who often have very little idea of what the work entails and being unable to talk about this in front of the children may increase a parent’s remoteness and make the children feel excluded (Storr, 1979, p.183).
As far as this researcher is able to determine, no studies exist that provide a more descriptive model to represent the range of student experiences. This researcher has chosen to illuminate the lived experiences of mothers training as therapists and their perceptions of how it may have impacted on their training and relationships with their children.

**Methodological Overview**

Interpretative Phenomenological Analysis (IPA) was chosen as the methodological approach for this research as it is concerned with the individual subjective narratives of the participants. The goal of phenomenological research is to arrive at the essence of the lived experience of a phenomenon (Moustakas, 1994). It was felt that IPA methodology would most accurately reflect the experiences of the mothers who are training as therapists and give them a voice in the research.

Interpretation in IPA is a form of amplification or illumination of meaning, which is cued or sparked by a close engagement with the data, and which requires creativity, reflection and critical awareness for its full development (Smith *et al.*, 2009, p.205). This form of inquiry was chosen as it creates and generates a rich base of knowledge and provides an understanding of phenomena when there is little research in an area.

IPA is always interpretative but there are different levels of interpretation. The analysis for this research study developed and progressed over time (6 weeks) to deeper levels of interpretation. Critically for IPA research, the interpretations must always be grounded in the meeting of researcher and text (Smith *et al.*, 2009, p.36). Making interpretations from the data is complex and the researcher needs the awareness that the participant’s meaning-making is first order, while the researcher’s sense-making is second order (Smith *et al.*, 2009, p.36).

**Sampling and Recruitment**

In keeping with the aims of this study, three trainee therapists who were mothers coming to the end of their training were interviewed. The criteria inclusion for this research was straightforwardly - mothers who are in the final year of psychotherapy training. Participants were chosen for recruitment from the same psychotherapy training college in Dublin because of its high standards of teaching and its emphasis on experiential learning.

**Method of Data Collection**

The data was collected about trainee therapist’s experiences of being a mother through in-depth, semi-structured interviews. The interviews each took between 40 and 50 minutes and took place in a private room in the college library. A first pilot interview was done to evaluate the clarity of the questions and no changes were made, the questions were deemed appropriate for this IPA study. Semi-Structured interviews allow flexibility in the interviewing process. It allows for the details of what the interviewee views as important in explaining and understanding events, patterns, and forms of behaviour (Bryman, 2008, p.423).

**Ethical Considerations**

Ethical considerations in terms of confidentiality, anonymity and the handling of audio and transcript materials were respected. The researcher felt that the principle of “sensitivity to context” (Yardley, 2000) was adhered to throughout this research at all times. Initially “sensitivity to context” was demonstrated in showing empathy, putting the participant at ease, recognising interactional difficulties and negotiating the intricacies of the researcher-participant interaction.
Data Analysis
The seven strong themes that emerged from the analysis were as follows:

- Mother-children relating before training and the sense of change coming to the end of training.
- Understanding self in a new way/stepping back.
- Challenges met whilst training.
- Impact of potential change on both therapist and child, how it is.
- New awareness of words/expressions/meanings.
- Looking back at the past/emotional aspects and struggles.
- Moving forward, doing things with more self-awareness.

Later, with more thorough examination across the transcripts, three master themes emerged with subordinate themes as follows:

Master Theme 1/Subordinate Themes
- Looking back with emotion
  - How it was in the past and what I didn’t know or feel.

Master Theme 2/Subordinate Themes
- Stepping back with awareness
  - Subordinate themes-Pausing to consider and
  - Relating with self and with others

Master Theme 3/Subordinate Themes
- Moving forward with wisdom
  - Subordinate themes - choosing words carefully and listening in a different way.

Key Findings
A heightened sensitivity to issues around babyhood, pregnancy, maternal feelings and parenting were explored in the context of studying psychotherapy as a mother. Additional stressors like the practicalities of managing and juggling family life around the training was explored, however it was also acknowledged that all trainees, whether mothers or not, have commitments outside the training. The personal growth experienced by the participants was varied, including a more relaxed perspective and greater awareness of self. All participants had a sense that they were moving forward with greater wisdom about themselves which allowed for a freedom to relate to their children in a more open manner. A greater appreciation of the profound impact of words was attributed to the training and this had a positive impact on family relating.

The following vignettes show the essence of the qualitative findings:

Note: Quotations are coded to identify the participant and to specify the segment of text from the relevant transcripts as follows:

Note: [P#1.p7.233-241] refers to participant one and the segment of the text is located on page 7 of the transcript at line numbers 233-241.

[P#2.p1.1-5]
I never thought really about it, to be honest with you, until I started this course. And then I started thinking, “oh my god”, all the mistakes, all the ...you know stuff I should have done and didn t do....
...having the baby, you know was hard, finding time to do the assignments, yeah so it was more the time. So! I don’t think it held me back but one thing, I could say that sometimes the whole Attachment Stuff and the whole blaming of the mother that had started to annoy me a little bit, because it is on you and the mother is always the bad person.

I think the only thing is and I’m kind of wondering is maybe the conflict between being ‘The good enough mother’ and being ‘good enough’, yeah for your clients. Because when I actually leave the baby, you know, with a child minder to go to do client work, you know, placement work and stuff like that, I did feel a bit guilty.

To be as attuned to myself as much as I’ve been attuned to others, I guess it is quite a big difference.

Hugely, yeah..., but I think it has allowed me to be much more accepting, you know of having ‘maternal instinct’, if you would call it that, or that I am allowed, I am allowed to have these feelings for my children....hmmm I don’t have to be tough all the time...(laughing).

I would imagine that it has, in the sense that my understanding ehm around their behaviours, what teenagers do, I am less likely to react at a very highly emotional level. I can now, sometimes, step back and you know, talk it through ...

You know, I think overall, my children benefitted from my training, you know and I am more present to them and more relaxed when I am with them.

Well, I’m still on the road, but one thing that I can see is that I am learning to own my own views, opinions, words.

Well, I am very conscious of words now and the power of words ... because I am very conscious of, I mean words are our tools...ehm, and the impact of words is beyond measure.

I suppose, I suppose, I am more conscious of the fact that it would be very easy for them, to push me into the role of their mother.

...the understanding of child development, looking at behavioural patterns, looking at how your children relate to themselves as much as anybody else. I have to say, it’s ehm something that I’m constantly looking at with ...awe.

Yes there are definite advantages because there is a lot of things obviously that talk about childhood development. Even in first year, we did developmental psychology and I remember a lot of the people that were not parents were completely lost in it.
Discussion
The three participants of this study having experienced pregnancy and childbirth themselves had a wealth of knowledge and experience to bring to this research. They each showed a keen interest in the research topic and also a generosity and integrity in sharing their individual thoughts and experiences within the interview process. Stern (1995) has written extensively on what he describes as “The motherhood Castellation”. He asserts that, with the birth of a baby, the mother passes into a new and unique psychic organisation and this organisation is the motherhood castellation. As a psychic organiser, this castellation will determine a new set of actions, tendencies, sensibilities, fantasies, fears and wishes (Stern, 1995, p. 171). Becoming a mother and becoming a therapist both involve periods of great change for a woman. Becoming a therapist whilst being a mother can evoke many emotions as expressed in the transcripts. Klein (2005) describes psychotherapy as a developmental process, in the same way as growing up is, and the two have features in common. A difference is that psychotherapy is remedial: it is intended to make people better, to make good some deficiency or disturbance whose roots may go back to the days of childhood (Klein, 2005, p. 381). An understanding of childhood disturbances is essential for the work of a therapist and as a mother nurturing small children at the same time, it is evident that some of the psychoanalytical literature and theories can trigger responses.

Psychologist John Bowlby was the first Attachment theorist, describing attachment as a “lasting psychological connectedness between human beings” (Bowlby, 1969). Studies in Attachment show that the earliest bonds formed by children with their caregivers have a tremendous impact that continues through life. A secure base was originally perceived as the “care-giver” to whom the child turned to when the child is distressed. Ironically, the secure base may provide a secure or insecure attachment experience depending on circumstances (Holmes, 2001).

Later, it was realised that the secure base can be seen not just as an external figure but also as a representation of security within the individual psyche. The idea of internalising a secure base is related to what in the psychoanalytic context is referred to as libidinal object constancy. This implies a stable sense of emotional connection and attachment to a particular other even when that person is not physically present (Eagle, 2003).

It is apparent across the transcripts that the participants in training have come across material that may have stimulated thoughts around their own parenting practices and their own sense of being parented.

The implications of secure base extend to adulthood as adults have an internal working model based on their earlier attachment style, which remains relatively stable over time. This model contains information about self and about others organised into schemas that apply to all relationships. If the framework from early experiences is secure, individuals are confident in regulating the ups and downs of emotional life and have high self-esteem. But if the framework is insecure, they will find it difficult to deal with stress and they may lack self-esteem. These people have difficulties in regulating emotions and are vulnerable to various psychopathologies (Gerhardt, 2004).

Further Research
Few studies have attempted to understand the transformational changes experienced by trainees, or identified which aspects of professional training programmes assist them in the process of becoming therapists. There is a scarcity of literature that taps into the “lived” experience of the trainee. There is scope for more IPA research in this area as there is a significant gap in the literature exploring the subjective experiences of the trainee therapist.
Conclusion
In conclusion, this study has provided a unique descriptive window into the private perceptions of trainee therapists who are mothers and how they relate to their children during the process.

I wish to enable the reader of this study to evaluate its transferability to persons in contexts which are more or less similar and I am interested in what light it might shed within its broader context. IPA as a creative process allowed me as researcher to give the participants a clear voice in the study and it is my pleasure to allow the reader to check the interpretations being made.

Suzanna O’Reilly, MA Psychotherapy, H. Dip Counselling, H. Dip Ed., BA (Hons) Int. Suzanna graduated from the MA in Humanistic and Integrative Psychotherapy, Dublin Business School, in 2014. She has a keen interest in the relational aspects of psychotherapy and the process of self-awareness. Suzanna trained as a secondary school teacher in UCD 1991-1996 and has taught English and Spanish at second level. Suzanna volunteered with the ISPCC from 2005-2008. She is currently a volunteer with both Aware and the Dublin Rape Crisis Centre. She has been in private practice, working in Aris Balbriggan, from 2012-2015. She has recently started her own private practice in Balbriggan as she works towards professional accreditation with IAHIP.

References:
‘Dead Body, Living Body’ Explorations after Sudden Death
by Monique Danaher

Six weeks before I was due to start my research journey, my only brother Warren was drowned. It was a horrifying, heartbreaking experience for me and I began this journey as a shattered researcher thrown into a dark underworld, a place full of frozen ghosts and old defenses.

This research project then became the vehicle through which I could explore my lived experience after Warren’s traumatic loss. This took on a deeper significance for me because of the sudden death of my sister Lorraine when I was five. My sense was that this loss was dissociated from within my family, and is a learned response for coping with traumatic loss.

While I began by using a heuristic methodology (Moustakas, 1990), it was in Romanyshyn’s imaginal research (2007) that I found the support I needed to work with the unconscious processes as part of my research. Romanyshyn’s approach makes a place for ‘Soul’ in the research process, and says, we must acknowledge that the researcher’s own wounds, her complexes, provide the connection with the topic.

The sudden loss of a sibling is a complex intrapsychic and interpersonal experience. I researched it from many different theoretical perspectives, including the body and shock, trauma, the psychological loss of the assumptive world, grief and transgenerational trauma. It is also an interpersonal experience which includes the relationship to the now deceased sibling and new family relationships.

As part of this research, I involve the voices of others by conducting research interviews on the lived experience of the sudden loss of an adult sibling.

This deeply personal self-search also brought me back to revisit again my own “dead body”, my difficulties with ‘psychosomatic indwelling’ (Winnicott, 1962:58) and my mind/body splitting as a solution to my own traumatic history and somatic memories.

My hope is that this study will provide a window into some of the challenges faced with the sudden loss of a sibling. I also wish to document a personal transformative journey following traumatic loss as a contribution to psychotherapeutic literature on the subject.

Monique Danaher is a relational and integrative psychotherapist practicing in Limerick City since 1997. She is accredited with IAHIP, ICP and she holds the European Certificate of Psychotherapy. She also works as a supervisor, trainer and group facilitator. Monique’s original training was in Biodynamic body psychotherapy and her MA focused on shock trauma. Her practice integrates developmental, relational and somatic perspectives/approaches to psycho spiritual healing. Her work reflects her deep interest in the recovery of the voice of the living body and healing the wounds of the heart. Aside from her professional career, Monique enjoys poetry and being in wild nature.

References:
‘Come Away O Human Child to the Waters and the Wild’: A Qualitative Study into the Role Nature can Play in Psychotherapy.
by Joanne Hanrahan

The innate connection between humans and the natural world has been celebrated throughout the ages. From indigenous peoples and old traditions, through philosophy, theology, poetry, mythology and art, nature’s healing properties have been embraced. Similarly at a scientific level the benefits of contact with nature have long been established. Given psychotherapy is a human science supporting psychological healing, what of the integration between psychotherapy and nature? The research study, on which the IAHIP conference presentation and this paper are based, addresses this question.

Nature and Wellbeing

Recent systematic reviews completed in different parts of the world by academics in the fields of environmental science, social work and nursing (Keniger et al., 2013; Heinsch, 2012; Hansen-Ketchum, Marck and Reutter, 2009) have evaluated the body of research on human-nature contact. Literature examined in these reviews point to the psychological, cognitive, physiological, social and spiritual benefits of interacting with nature. Research highlighting beneficial interaction, is further categorised in terms of viewing nature, being in close proximity to it and direct participation and involvement with nature.

At a European governmental and social policy level reports into ‘green care’ are receiving some attention. Extensive reports by the European research body Cooperation in Science and Technology (COST) (Sempik, Hine and Wilcox, 2010) and by UK mental health charity MIND (MIND, 2013; MIND, 2007) are favourable of interventions which improve and promote mental health through nature. The green care interventions reviewed in the above reports predominately include activities such as social and therapeutic horticulture, facilitated green exercise and wilderness therapy. Despite what seems like an obvious extension of the reports’ review, they provide little or no mention of one to one nature-related psychotherapy.

Nature and Psychotherapy

During the second half of the twentieth century a number of psychotherapeutic theorists, such as Jung (Sabini, 2002; Jung, 1963) and Frankl (1959) pointed to the psychological benefits of contact with nature. More recently, a school of psychological thought known as eco-psychology (Roszak, Gomes and Kanner, 1995) has also emerged along with corresponding writings on the concept of ‘eco-therapy’ (Buzzell and Chalquist, 2009).

The therapeutic qualities of nature recognised throughout the ages by Shamanistic healers and indigenous peoples (Abram, 1996) are now being increasingly embraced by psychotherapists. However, in mainstream psychotherapy, it would appear that the integration of nature and psychotherapy is at a fledgling stage of development. McLeod’s (2013), latest edition of the bestseller An Introduction to Counselling, now includes a new chapter on therapy in nature. Similarly the new edition of Burns’ (2014), Nature-Guided Therapy, first published in 1998 also suggests increased interest in the topic as does recently published work by Jordan (2015).

Nevertheless, there appears to be a dearth of empirical studies on the specific area of the integration of nature into psychotherapy. Analysis of the literature also points to gaps in the research. Such gaps include little direct focus on pure psychotherapy and nature, as opposed to multidisciplinary approaches to therapeutic nature work. The focus of the research in this area is also on outdoor psychotherapy as opposed to a broader integration of nature to psychotherapy.
On review of the current literature the qualitative study, on which this paper is based, was undertaken in 2015. It was completed as part of an MSc in Integrative Counselling and Psychotherapy in conjunction with the Turning Point Training Institute and DCU. The aim of the research was to explore the integration of nature into psychotherapy. This was achieved through interviewing psychotherapists who see nature as playing a significant role in their own personal process and an integral part in their clinical practice. From the reviewed literature it would appear that this is the first study to include data from a number of psychotherapists, using a mixed approach to nature integration. This paper provides a brief overview of the study and its findings.

**Method Sample and Analysis Overview**

Psychotherapists were recruited for this research through the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP) and the Irish Association for Counselling and Psychotherapy (IACP). Nine psychotherapists, practicing in three of the four provinces of Ireland with a mix of both rural and urban practices, engaged in semi-structured interviews. One of these therapists played an important role in piloting the study and the remaining eight interviews provided the data for the study. The experienced participants had integrated nature into their clinical practices in a variety of ways. Approaches to integration of nature to practice varied between participants but included outdoor sessions, outdoor homework, using natural materials in the therapy room and exploring the therapeutic value of a room with a view. It should be noted that not all or the therapists in the study engaged in outdoor one to one sessions, yet all provided very rich data on the integration of nature to practice. It is believed that the diversity in their approaches and therapeutic influences added depth to the study.

*Figure 1: Participant Theoretical Frameworks, Influences & Approaches*
A phenomenological informed Thematic Analysis, based on Braun and Clarke’s (2013; 2006) framework was chosen as the most suitable method of analysis for this data. A meticulous and embodied analysis of the data lead to the identification of themes related to the integration of nature to psychotherapy. Analysis of these themes highlight that a three way relationship between therapist, client and nature can greatly enhance therapeutic work and the awareness of the self. The analysis also draws attention to an unexpected study finding - that of the continuum between psychotherapy as a science and psychotherapy as a care of the soul and to the dissonance along that continuum.

Results
Analysis of the data in this study identified two overarching themes and five themes as shown in Fig.2

Figure 2: Thematic Map

Overarching themes organise and structure research findings and capture an idea encapsulated in a number of themes (Braun and Clarke, 2013). This research highlighted two distinctive patterns in the data and these are referred to as ‘Saints’ and ‘Scholars’.

The overarching theme of Saints should not be misunderstood as referring to religious themes. It should be interpreted in the broader sense of spirituality, creativity, symbolism meaning making and magical mystery. The story of these concepts in the data are caught in the themes ‘Within us yet beyond us’ and ‘Nature does the work’.

The overarching theme ‘Scholars’ corresponds to much of what might be described as core to clinical practice, therapist reflexivity and client process work. The themes in this category, ‘It’s not just a walk in the park’ and ‘To know ourselves’ refer to reflective theoretical practice and the deepening awareness of the client to their own psychological processes.

‘Saints’ and ‘Scholars’ also speak to the continuum between psychotherapy as a science and psychotherapy as a therapy of the soul. It addresses the dissonance along that continuum reflected in the final theme ‘That’s not quite academic’.

All five of the theme names have been taken from direct quotations in the data. The naming quotes were seen as not just important in themselves but as providing an immediate and vivid sense of what the themes are about (Braun and Clarke, 2013).
‘Within us Yet Beyond us’
This theme reflected the finding that the natural world evokes a sense of spirituality, interconnectivity, and inspires feelings of awe. Findings related to this theme included:

- The importance of feeling part of ‘something bigger’
- The fact that we are ‘beings of nature’, and not separate from nature
- Reinforcement of the shamanistic and Jungian view which identifies nature as ‘the spirit’ or spiritual (Abram, 1996; Jung, 1963).
- The external world was seen as inspiring change and transcendence in the inner world. Akin to Maslow (1962) and Hoffman, Iversen and Ortiz (2010), this research revealed the prevalence of nature inspired peak experiences.
- A link between contact with nature and the transpersonal self was highlighted and the need to “rest our souls in nature” suggested.

‘Nature Does the Work’
This theme relates to many of the intangible dimensions which nature brings to psychotherapeutic work. It addresses the finding that contact with nature not only aids the therapy process, but in some ways, can provide more to the client than the therapist can alone. Key findings associated with this theme included:

- The value of clients’ engagement with nature in supporting their integration of issues such as life and death and research suggested that learning from nature provides hope.
- Akin to findings in Adevi and Martensson (2013) and Sahlin et al., (2012), this study suggested that engaging in nature related symbolism can provide comfort and enhance meaning for many clients.
- Contact with nature can foster imagination, creativity, the element of fun and evokes the sense that anything is possible.
- The magical, mystical and numinous quality of nature was also linked to Jung’s (1968) collective unconscious and concepts such as Hollwey and Brierley’s (2014) intuitive consciousness.

‘To Know Ourselves’
‘To know ourselves’ included what might be considered as the more traditional aspects of psychological process, investigating nature’s role in areas such as emotional affect and discharge, dissociation and embodiment. Points of interest in this theme included:

- All the therapists spoke of nature’s potential to enhance positive feelings. Terms such as ‘soothed’, ‘uplifted’, ‘rewired’ and ‘rejuvenated’ were regularly used.
- Nature’s ability to ‘hold’ emotions such as rage, fear and shame was very apparent from the interviews as was the integrative healing value of cathartic releases in nature.
- The findings from this study also suggested that unconscious processes may be more freely accessed through contact with nature.
- Integration of dissociated parts may happen quicker through contact with nature with terms like “breakthrough”, “uprooting”, “fundamental switch” being used to describe nature’s role.
- This study proposes that contact with nature increases awareness of an embodied self and places great value on the visceral experience of direct contact with nature.
‘It’s Not Just a Walk in the Park’
This theme explored psychotherapeutic theory in the context of nature work and the importance of therapist experience and insight. Findings included:

- Integrating nature into psychotherapy has the potential to deepen the real or person-to-person relationship and the transpersonal relationship. It also highlighted transferential issues, such as the finding that outdoor therapy can often ‘diminish’ projections on the part of the client.
- Some clients benefit from the witnessing of an outdoor therapeutic experience while others prefer to connect with nature alone and process their experiences later in therapy.
- For some clients walking side by side may aid the development of trust with the therapist and ease disclosure, whereas for others outdoor therapy may increase fear, avoidance or trigger traumatic memories. Thus the individual client and the stage the therapy must be given consideration.

Overall, the discussion of these themes allowed for the significance of integrating nature and psychotherapy to be highlighted in relation to the spiritual, symbolic, embodied process and the dimensions it adds to practice.

‘That’s Not Quite Academic’
This final theme reflects conflicting but related aspects in the data. One being the drive to highlight nature in psychotherapy in scholarly terms and the other the need to embrace both nature and psychotherapy’s healing powers as sometimes being more of an art than a science.

While this theme highlighted some discord around integrating nature to practice, it is interesting to note that the main aspect of nature and psychotherapy integration which seemed to fuel dissonance around academia was that of the spiritual and numinous facets of this integration.

‘That’s not quite academic’ reflects the study finding of a desire among therapists, to tie nature’s integration in psychotherapy, along with its spiritual and numinous aspects, to academia. However, in contrast the second aspect of the data which developed this theme also suggested the view that the over theorising of psychotherapy should be resisted due to the fear that we have lost the ‘soul’ in psycho-therapy.

Hollwey and Brierley (2014) suggest that the numinous realm and psychological science are essential parts of our existence and need a reliable bridge to join them. This research would suggest that nature and its integration into psychotherapy may provide one such bridge between science and soul.

Integration of Themes
The exploration of each theme brings valuable insight to research. However, it is the overall integration of themes that highlights the importance of the three way relationship between therapist, nature and client. It is to this that the focus will now turn.

Jung, on writing of his experience of living in “modest harmony with nature” in Bollingen on Lake Zurich, describes his sense of “repose and renewal” and of being “most deeply myself” (1963, p.225), through connection with nature. In psychotherapeutic terms there are many aspects to the self which Jung may have been referring to. Three of the themes discussed in the research drew attention to nature’s possible role in deepening awareness of different aspects of the self. Findings suggested nature contact can help us ‘know ourselves’ through contact with unconscious aspects of the self and development of an embodied sense of self. Similarly at a spiritual level it would seem in this study that
contact with nature can lead to the experience of what Assagioli (1965) termed as the transpersonal self. An exploration of ‘Nature does the work’ adds yet another dimension to the expanded sense of self which nature may contribute to, suggesting links to Jung’s (1968) collective unconscious and concepts such as Hollwey and Brierley’s (2014) intuitive consciousness.

However, while the focus of psychotherapy is generally to deepen the awareness of the various aspects of self, in its attempts to encourage real and congruent relationships, this process is not without pain, fear, avoidance and at times, resistance to change. Similarly, and as one would expect, this struggle is also reflected across the themes in this research. While the possible positive effect of being able to reintegrate dissociated parts quicker through contact with nature is highlighted in ‘To know ourselves’, issues around fear and trauma of embodied experience were also addressed in the analysis of the research. Similarly therapist’s observations of process avoidance and fear relating to nature work were mentioned in ‘It’s not just a walk in the park’. In these cases this research would point to the direct experience of nature as expanding and deepening awareness of self. This, consequential, engagement with self, at times, may also fuel fear in relation to psychotherapeutic process work.

The skill and knowledge base of the therapist is always of paramount importance in psychotherapy to ensure the safe navigation of unconscious process. This applies to therapists across all modalities and approaches. Based on the many clear links to therapeutic process and deepening of awareness which integrating nature and psychotherapy facilitates, therapeutic skill is a highly important dynamic in the therapist nature and client relationship.

Figure 3: Therapist, Nature and Client Relationship. Awareness of self as developed through this research.
Review of Research Objectives
This research started out with three main objectives each of which was achieved and are summarised below:

1. To explore the experience of integrating nature into psychotherapy practice
This study showed that integrating nature into psychotherapy practice added many positive dimensions to clinical practice. It was found to have a deepening and enriching influence on the therapeutic relationship. This research highlighted the significance of nature as a resource to therapists, their clients and ultimately to the therapy process. As such, a therapeutic partnership including nature was found to be greatly beneficial. This is in line with much of the current literature and empirical research in this area (Jordan, 2015; Burns, 2014; Plotkin, 2013; Hasbach, 2012; Berger, 2008a; Berger and McLeod, 2006).

2. To conceptualise the theoretical links of this practice
Therapists seamlessly integrated nature into practice with mainstream approaches such as Person Centered, Psychodynamic and Cognitive Behavioural Therapy. They highlighted direct theoretical links to very common approaches such as Gestalt and Existentialism. However similar to Berger (2008a) and Davis (1998) this research also points to the fact that integrating nature into psychotherapy includes embracing creative and transpersonal modalities and a holistic approach to psychological healing.

3. To examine the therapeutic value of nature from psychotherapists’ perspective
Many facets of the therapeutic value of nature were addressed in this research. In line with much of the literature (Palsdottir et al., 2014; Adevi and Martensson, 2013; Linden and Grut, 2002) contact with nature was seen as initiating change in clients, providing comfort and meaning, fostering creativity, promoting positive affect and supporting cathartic discharge.

With the overall research objectives reviewed and key finding summarised this paper will now conclude with the study implications and recommendations.

Implications and Recommendations for Theory Development and Clinical Practice
The role of nature in embodied experience was very significant in this research. However, there would appear to be very little research on the integration of body psychotherapy approaches and nature. This presents as a potentially important area for theoretical development. Similarly this research suggested that theoretical development based on an integration of nature in approaches to trauma would warrant attention.

In terms of clinical practice this study presents useful insights to both those who have integrated nature into their therapy practice and those who may consider it. This research highlights the clear benefits of contact with nature, along with showing that this contact can enrich the psychotherapeutic process. Therefore, based on the research findings that the therapeutic benefits of integrating nature to therapy outweigh its limitations, this study would propose that psychotherapists embrace nature in practice. Clinical recommendations on such a practice include:

- Self-reflection on the part of therapists on the role nature plays in their own lives.
- A gradual examination on ways which nature may be appropriately integrated to practice.
- A client focus, with clear understanding and consideration given to the client’s needs.
- Consideration given to each individual client in relation to nature based interventions, timing of such interventions and possible drawbacks.
Recommendations from the therapists, whose experience brought this research to fruition, include seeing the ‘magic in life’, tapping in to ‘the wonder of a child’, and having ‘fun with it’. As one therapist concluded “we’re there to stimulate curiosity and get people in touch with themselves. Connected back to self”.

Joanne Hanrahan is a psychotherapist working in private practice in county Clare. She completed her psychotherapy training and MSc in Integrative Counselling and Psychotherapy with Turning Point Institute and DCU. Living by the sea, Joanne’s awareness of the therapeutic value of nature in terms of her own psychological process inspired her choice of research topic. She now integrates nature into her practice in various ways including engaging in outdoor sessions. Joanne’s background is in Guidance Counselling and, having also trained in Jungian Sand Therapy, she was highly involved in adolescent counselling and student support in schools for over seventeen years.

References:


On Being Affective and Effective – Developing Psychotherapy Provision in the Irish Health Service – Challenges and Opportunities for the Humanistic Integrative Practitioner

by Gerard O’Neill

Preamble
In Issue 73 of Inside Out this author stated that “psychotherapy is at a very exciting stage of development in terms of what the research is saying about what makes therapy effective” (O’Neill, 2014). The evaluation of psychotherapy services is a complex issue and should be underpinned by an appreciation of the factors that make psychotherapy effective. This paper outlines the content of a presentation the author gave at the IAHIP 2016 conference on the theme of being affective and effective. Part of this author’s Doctoral research focused on the introduction of a measurement instrument designed to quantify clinical change and therefore, therapeutic effectiveness, into the therapeutic space which we will return to later in the paper. The linking of findings from neurobiological research with psychoanalytic and attachment theory is beginning to provide the humanistic integrative psychotherapist with a map of both the way affect is experienced both by the client and the affective interaction between therapist and client. It is the belief of this author that affect and the way in which affect is conceptualised and managed within the process of therapy is at the heart of effective therapy.

Themes in research on the effectiveness of psychotherapy
Early efforts in psychotherapy research aimed at proving that one therapeutic approach was more effective than another. This lead to a realisation that there would have to be theoretical integration in the various therapeutic orientations (Roth and Fonagy, 1996) and to an acceptance in some quarters that no one approach was more effective than another which came to be known as the “dodo bird verdict”. The focus then shifted to identifying the effective ingredients that were common to all psychotherapy approaches and known as the common factors research. In one meta-analytic review (Hubble et al, 1999) these were identified as:

- Client/extratherapeutic factors are responsible for 40% of outcome variance
- Relationship factors or common factors are responsible for 30% of outcome variance
- Placebo, hope and expectancy contribute to 15% of outcome variance.
- Model /technique factors account for 15% of outcome.

Of interest to the humanistic integrative psychotherapist is that relationship factors and client factors together account for over 70% of outcome variance.

Bruce Wampold (2001) concluded that the person of the therapist is the biggest factor in influencing positive outcome in psychotherapy and noted the importance of a match between the theoretical perspective being offered by the therapist and the worldview of the client. He recommended that a psychotherapist should be familiar with a number of orientations and use one which most approximates to the worldview of the client. In summary, the common factors research tell us that the client, the therapist and the therapeutic alliance, in descending order, are the key factors in determining successful outcome in psychotherapy.

Research from neurobiology and psychoanalysis
Dr. Alan Schore draws on knowledge and research from a range of contexts including psychoanalytic theory, attachment theory and the neurosciences (Schore, 2003A) (Schore, 2003B) and describes therapeutic change as arising from the psychobiological attunement of the therapist’s felt sense to the
patient’s felt sense (Schore, 2007; 2012). He sees psychotherapy as the affect communicating cure with clear implications for the dominance of the cognitive paradigm for the last 30 years (2007). In a similar vein, Daniel Stern (2004) describes the affect regulation arising from the cumulative impact of repeated intersubjective “being with the other” experiences as accounting for the majority of therapeutic change. It is the view of this author that in re-affirming the primacy of affect, there is a risk of relegating the role of intellect and cognition to the sideline. As human integrative psychotherapists, we know we are thinking, feeling, embodied human beings and healthy human functioning depends on a degree of integration.

In noting Wampole’s recommendation of a fit between the theoretical perspective being offered by the therapist and the world view of the client, a more sophisticated articulation of the complexity involved in an effective therapeutic process involved is captured in the term practitioner epistemology (Polkinghorne, 1992). Experienced and expert practitioners develop a body of knowledge which is tacit through their clinical experiences and expert practice. This also involves the accommodation of previous understandings to the uniqueness of a particular clinical situation. This is arrived at through a process of “reflection in action” in the midst of the therapeutic process and “reflection on action” outside of the therapeutic process. From this perspective expert practice is a process of constantly trying to adapt the therapeutic approach to the world view of the client.

When we combine Schore and Stern, we can now say that effective psychotherapy from a bottom up perspective consists in the affect regulation arising from psychobiological attunement in the intersubjective relationship between the client and psychotherapist. From a top down perspective, effective psychotherapy involves the psychotherapist constantly trying to adapt the psychotherapeutic approach to the particular worldview of the client and their unique situation through a process of reflection in action. To help us conceptualise further what the psychotherapeutic approach might look like in practice I will turn to attachment theory and related developments.

Attachment theory
John Bowlby and Mary Ainsworth developed attachment theory from their work together in the Tavistock Clinic in London at the end of the Second World War. Attachment behaviour is a form of instinctual behavior that develops in humans and other mammals during infancy and has as its aim achieving proximity to a mother figure, the function of which is the protection from predators i.e. a goal corrected system (Bowlby, 1988) (Bowlby, 1979). Bowlby was the great formulator of theories and drew on ideas from a wide range of subjects, which included ethology and cybernetics (Bretherton, 1992). Ainsworth was the great experimentalist and devised means of testing Bowlby’s theories and the pinnacle of this development is the strange situation test. Further developments led to the classification of three universal attachment styles in Adults Types A, B & C and the Adult Attachment Interview (AAI), developed by Mary Main, as a means of assessing a particular attachment style based on the internal working model (IWM) (McKinsey and Crittenden, 2000). The concept of the IWM and goal directed systems are important in considering the application of attachment theory to psychotherapy. From an integrative psychotherapy perspective Jeremy Holmes (1993) has pointed out the similarity of the concept of the IWM to basic assumptions in Cognitive Behavioural Therapy (Beck et al, 1979) and “self-other” schemata (Horowitz, 1988).

Extended attachment theory
Extended attachment theory developed by Dorothy Heard and Brian Lake (1997) adds an additional three biological based goal corrected systems to the two systems conceptualised by Bowlby and Ainsworth and a further two systems the internal and external environment. The theory postulates these seven systems working together in a dynamic restorative process of which the aim is not just
protection from predators but to return the self to a state of well-being. They also propose a new understanding of the “self” in a subjective state and the “person” in an intersubjective state and relating to others the person retains their sense of self. Heard and Lake’s theoretical framework is called the “Theory of Attachment Based Exploratory Interest Sharing” (TABEIS). When things are going well the autonomous self is embedded in a network of relationships involved in interest sharing characterised by supportive, companionable pattern of relating rather than dominant submissive relating. Any threat that is sensed to the self triggers the restorative process involving one or more of the seven systems which remain active until a state of well being is restored. Daniel Stern has described the drive for intersubjectivity as having evolutionary status (2004). In TABEIS the optimal position for the human species is envisaged as being exploratory and survival with well-being. If we consider for a moment the idea of being exploratory and survival with well-being also having evolutionary status, this raises fundamental questions for the aims of psychotherapy and what we consider to be healthy human functioning.

**Exploratory Goal Corrected Psychotherapy**

There are many examples of the application of Bowlby and Main’s attachment theory across a range of disciplines and subject areas. In relation to its application to psychotherapy, Bowlby, in his later work, described the process of psychotherapy as the gradual unpacking of the IWM of the client, which had been shaped by suboptimal attachment conditions in their childhood. Attachment theory has also informed other approaches to psychotherapy and explicitly with mentalization (Fonagy et al, 2004) and Emotionally Focused Couple Therapy (Johnson, 2004). Exploratory Goal Corrected Psychotherapy (EGCP), developed by Dr Una McCluskey, is based on the findings from her research (McCluskey, 2005) and builds on and integrates extended attachment theory (Heard, and Lake, 1997) (Heard D, Lake B, and McCluskey, 2009). EGCP utilises “goal corrected empathic attunement” as a powerful therapeutic tool to facilitate emotional regulation in the client. *Attunement* precedes *empathy* developmentally and infants are born with the capacity to attune at a physiological level to the affect of their mother including literally the mother’s breath and tone of voice as a survival strategy (McCluskey, 2005). *Empathy* is described as a meta-cognitive activity which includes the ability to see another’s point of view, understand and resonate with their emotions and convey this to the other person in words in a way that is understandable to them.

**Summary of the evidence on effectiveness**

The review of the common factors research tells us the effective components in psychotherapy in order of importance are the client, the therapist and the therapeutic alliance. Research synthesised from neurobiology and psychoanalysis highlight therapeutic change arising from psychobiological attunement and repeated intersubjective “being with the other” experiences. This also involves the psychotherapist from a practitioner epistemological perspective adapting the therapeutic approach to the client’s worldview and the uniqueness of the client’s situation. Extended attachment theory provides a broad conceptual base for how we function as human beings and envisages a self surviving with well being as our optimal status. EGCP proposes an interactive framework with the skilful use of empathic attunement by the psychotherapist to emotionally up or down regulate the client with the self returning to being exploratory and a state of well being.

When compared with the extensive empirical base for Bowlby and Main’s attachment theory, the empirical basis for TABEIS and EGCP is still being developed. However EGCP does share the same effective therapeutic mechanisms as those identified in the summary of neurobiology and psychoanalytic research and practical application of the approach with adults is more explicit in EGCP. To synthesise all these themes we now have a meta-perspective that conceptualises the human species from a combined evolutionary and developmental perspective that envisages not just survival but survival with well being. We also have the outline of an integrated model of psychotherapy that...
combines bottom up and top down approaches to restore well being. We now turn to the challenges of providing psychotherapy in a health service environment.

Development of Practice Based Evidence & ‘Knowledge in Context’

As psychotherapy services become increasingly embedded in large organisations like the health service they are, like other disciplines, increasingly required to demonstrate effectiveness. This naturalist approach to knowledge generation which is the dominant paradigm in the health service reflects a world view which is grounded in predictability and certainty based on the assumed existence of underlying universal laws and principles with a reliance on evidence based practice to demonstrate effectiveness. In practical terms, humanistic psychotherapists working in public sector settings now find themselves regularly completing outcome measures with clients as part of the requirement to demonstrate evidence based practice. Others would argue that in a discipline like psychotherapy that deals directly with human beings, knowledge is situational and contextual (Fishman, 1999) and is co-constructed (Gergen, 1992) which is similar to the intersubjectivity of Stern (2004). How can psychotherapists negotiate this clash of cultural paradigms in their clinical practice and in other professional contexts?

John McLeod has written about the “knowledge-in-context” approach (1999) to developing professional knowledge in psychotherapy through practitioner research. I have also already discussed the concept of practitioner epistemology (Polkinghorne, 1992). The suggestion here is that humanistic integrative psychotherapists see themselves engaging in practitioner research in their practice and from this perspective, knowledge derived from their practice can be regarded as practice based evidence informed by a humanistic paradigm. In this author’s own Doctoral research (O’Neill, 2009) he investigated, in collaboration with colleagues, the impact of introducing a clinical outcome measure into a service working with adults who had experienced childhood trauma. One of the outcomes of the research was the generation of clinical guidance around the use of measures in the service and whilst the clinical context was specific, much of the professional knowledge is transferable and applicable generally.

From a more general perspective, there are also a number of arguments to be made which support the use of outcome measures as a means of improving effectiveness. Some studies suggest that one in ten clients actually get worse in therapy (Carr, 2008) and the therapist does not always spot this, so an outcome measure may have act as an alert for these clients. Depression can cloud or distort a client’s perception of progress in therapy or they can be overly pessimistic about their life in general and an outcome measure can be legitimately used to provide a measure of balance. From a practitioner epistemological perspective, when psychotherapists are being reflexive about their practice in therapy with the client and outside of therapy with their supervisor, the reflexive process can be assisted by using an outcome measure as an additional source of data.

Measuring effectiveness in psychotherapy – the broader organisational context

Measuring effectiveness in psychotherapy from an organisational perspective is best considered from a micro perspective and a macro perspective. The micro perspective begins at the level of the effective individual therapeutic interaction and the effective therapy session followed by an episode of effective therapy which includes the initial appointment and the closing session. The macro perspective includes the effective therapist, the effective supervisor and the effective psychotherapy service. This author’s own research highlighted that not only are there are different variables influencing effectiveness at the different levels but there are also different criteria and approaches for determining and measuring this effectiveness at the different levels of perspective. The micro and macro contextual understanding helped shape the approach to outcome evaluation in the following HSE counselling services that are available in the south east of Ireland.
National Counselling Service South East (NCS SE) – a specialist counselling service for adults aged 18 and over whose functioning is affected by a childhood experience of neglect, emotional, physical or sexual abuse. The NCS SE provides medium to long term therapy and there is an average of 250 referrals per year and over 3,000 counselling sessions were delivered in 2015.

Counselling in Primary Care (CIPC SE) – a generic counselling service for adults aged 18 and over with mild to moderate psychological difficulties who possess a valid medical card. CIPC is available nationally since 2013 and provides short term therapy. In the South East there is an average of 2,500 referrals per year and over 8,000 counselling sessions were delivered in 2015.

Self Harm Intervention Programme (SHIP) – a specialist counselling service for individuals aged 16 and over who are experiencing suicidal ideation or the impulse to self harm. SHIP is unique to the South East and is available regionally since 2012. Provides short to medium term therapy with an average of 800 referrals per year and over 3,000 counselling sessions were delivered in 2015.

A clinical outcome measure is routinely used in SHIP and CIPC and the counsellors and psychotherapists have successfully integrated the use of the measure into their routine practice. An external evaluation of the SHIP service completed in 2015 (Gardner et al., 2015) made a recommendation that the SHIP service should be replicated nationally also highlighted how the clinical measure used in SHIP had become an important source of data to the client and themselves as the therapist in demonstrating clinical progress. It is also now routine practice for counsellors in SHP and CIPC to include the results of the clinical outcome measure in their review of clients in case supervision particularly in complex cases.

Conclusion
This paper has mapped the ways in which a humanistic integrative psychotherapist can integrate the challenge of demonstrating effectiveness within their therapeutic practice so that completion of outcome measures does not become an empty ritual. Knowledge of the effective components in psychotherapy when combined with the skilled and sensitive use of outcome measures with clients can assist the humanistic integrative psychotherapist with being both affective and effective. This necessarily redefines the practice of humanistic integrative psychotherapy with implications for practitioners, supervisors, trainers and professional organisations.

Dr Gerard O’Neill, Director of Counselling, HSE CHO Area 5, 15-2-16. Gerard originally trained as a psychiatric nurse and has extensive experience in developing community mental health services in the NHS in the UK. He completed his Masters in Counselling at the University of Hertfordshire before returning to Ireland in the mid 1990’s. He has held the post of Director of Counselling with the HSE South East since 2000 and obtained his Doctorate in Psychotherapy from the Metanoia Institute/Middlesex University London in 2009. His Doctoral research focused on bringing a humanistic perspective to using measures in psychotherapy and he continues to have a very active role in managing and developing high quality counselling and psychotherapy services in the south east of Ireland.

References:


Enlisting the Right Brain to Find Meaning in Life
by Barbara Dowds

Meaning may be described as the beliefs, values and charged experiences round which the self becomes organised (Thompson, 2009; Dowds, 2010; Dowds, 2014). However, meaning is implicit or unconscious (Ward, 2014) and it is only when our source of meaning is attacked or lost that we become aware of deriving meaning from a particular source. For example, if we live according great value to honesty but then see dishonesty being rewarded, we may lose faith in what human beings are and find ourselves withdrawing from a particular institution or from humanity in general, as well as losing confidence in ourselves. Othello, when told that Desdemona was unfaithful to him, lamented that his ‘occupation’ was gone. His occupation had been to love his wife – ‘not wisely but too well’ – but he now believed her to be unworthy of his love. However it happens, loss of meaning is a crisis that brings awareness of the implicit values that form the foundation of the self. We become depressed when our belief paradigm is invalidated, e.g. believing that hard work will be rewarded, but finding ourselves passed over for promotion or attention. However, depression can be a crucible for generating meaning if we are willing to learn the lesson it is offering (Lewis, 2002; Rowe, 2003).

Viktor Frankl categorised values or meaning into three classes: (1) creative meaning that expands our identity; (2) experiential meaning that is about being receptive to nature, art, love and other encounters; and (3) attitudinal meaning which manifests in our stance towards limitation and suffering. But Frankl, Buber, Cottingham and others all insist that excessive concern with self-actualisation thwarts genuine meaning because a meaningful life stretches far beyond individual concerns (Yalom, 1980; Cottingham, 2003; van Deurzen-Smith, 1997). Whether we derive meaning from religious faith, helping others, creative expression, the beauty of nature, or participating in a great project, I propose that the core of meaning is about connection – with other individuals or communities, the natural world, the cosmos or with God. It is about experiencing ourselves as part of a greater web of being.

Our capacity for connection, and therefore meaning, relies on a primal, pre-relational sense of connection according to the NeuroAffective Relational Model of development (Heller and LaPierre, 2012). Trauma in the womb, at birth or during the first six months of life can affect the individual’s capacity to feel connected. Such an individual is disconnected from his own body and emotions as well as from other people. He may feel shame at existing and as if he doesn’t belong; thus life feels empty and futile.

Genuine meaning is not created - as some existentialists claim – but, being implicit, it is discovered (Ward, 2014; Yalom, 1980; van Deurzen-Smith, 1997; van Deurzen and Arnold-Baker, 2005). Our beliefs and values are primarily embodied and emotional and only secondarily cognitive. I know that poverty is evil when I feel the plight of society’s cast-offs, unprotected from the rain and wind, humiliated by having to beg for what is their right – their fundamental survival needs. Meaning is the outcome of a believing process - a way of interpreting the world within a particular believing paradigm. This believing paradigm is emergent (bottom-up neurologically speaking) and unconscious and is therefore associated with right brain functions. The left side of the brain is needed for language, order, logic and analysis; the right for body-awareness, intersubjective process and affect regulation (McGilchrist, 2009; Schore, 2010; Siegel, 2012; Carroll, 2005; Cozolino, 2010; Dowds, 2014). Allan Schore, (2010) has suggested that the conscious mind resides in the left hemisphere and the unconscious in the right. We need the right hemisphere for grounding in the reality of emotional/body responses, relationship and situational context. By contrast the left hemisphere is prone to confabulation, creating ‘plausible, but bogus, explanations for the evidence that does not fit its version
of events’ (McGilchrist, 2009, p.234). When we become stuck in excessive left hemisphere thinking we are already disengaged from living process and therefore losing meaning. As Freud (1960) said:

... the moment a man asks the question about meaning, he is sick ... By asking this question one is merely admitting to a store of unsatisfied libido to which something else must have happened, a kind of fermentation leading to sadness and depression.

To return to embodied, relating engagement with life, we must enlist the right hemisphere. In therapy this means right hemisphere to right hemisphere relating rather than verbal analysis; it may involve working with imagery, dreams, the body, creativity or the transpersonal. Even supposedly left-brain therapies are underpinned implicitly by right-brain being and relating which are merely being excluded from the explicit work. Bidden or unbidden, the body and the unconscious of client and therapist are always present in the consulting room.

This workshop will be a combination of lecture and experiential engagement for the group. Exercises will be offered to explore:

(1) Sources of meaning.
(2) The sensation of connection and its loss.
(3) Translating client left brain statements into right brain implicit feelings.

Dr Barbara Dowds MIAHIP MIACP SIACP, was educated in Trinity College Dublin and was a university senior lecturer in molecular genetics until she began to work as a psychotherapist in 2002. She taught in PCI College between 2005 and 2014, was on the editorial board of Eisteach for seven years, and is the author of Beyond the Frustrated Self (Karnac, 2014). Barbara currently has a busy private practice as therapist and supervisor, presents post-graduate training workshops and is writing her second book - on depression. For more, see www.barbaradowds.net

References:
Suicide is a major public health concern in Ireland. In 2012, there were 525 deaths by suicide (CSO, 2012). Ten people die by suicide in Ireland every week and of those, eight are men (Gartland, 2013).

This narrative study explores whether transpersonal psychotherapy, which treats the whole person, mind, body, emotions and spirit is an effective treatment for suicidal behaviour. Traditional psychotherapy approaches do not explicitly address spirituality in current treatment. If psychotherapy does not address the spiritual aspect of the person, it does not create the space for a client to connect with their inner spiritual self, which is their deepest, inner being. This study interprets and makes meaning of six therapists’ stories of their experience of the transpersonal component as treatment for suicidal clients. Narrative inquiry and a critical event approach enabled exploration of transpersonal psychotherapy from therapists’ inner emotional experience.

This study found that the transpersonal psychotherapy facilitated suicidal clients to explore their spirituality i.e. what is their meaning and purpose in life, what brings a sense of connectedness and wholeness. Transpersonal psychotherapy addresses both the spiritual and psychological health of the client and considers their suicidal behaviour from both perspectives. Transpersonal experiences in psychotherapy have transformative potential. In these moments, the therapist and client experience an expanded state of consciousness and feel a sense of presence of oneness. Such altered awareness, beyond cognitive or emotional awareness, helped clients recognise that though they are separate from they are connected to others, and part of something greater. This brought new insights to clients regarding their ambivalence toward life and death. Therapists shared how transpersonal psychotherapy facilitates clients to connect with their spiritual wisdom, which can guide clients’ choices in life and reach their full potential as a whole person or “fully embodied authenticity” (Guyer, 2010).

Treatments for suicidal behaviour are challenging. “At the deepest level, this work is of a spiritual nature” (Browne, 2013). The findings of this study suggest that transpersonal psychotherapy should be considered as a treatment for suicidal behaviour. Transpersonal psychotherapy facilitates clients to discover meaning in the life-crisis and to transcend their past and current experiences.

Hilda Cullinane was born in Dublin and died in Cork in July 2014 following a road traffic accident. She connected very easily with people and had an innate sensitivity to her own and other people’s feelings and needs. This led her to study for a Masters in Psychotherapy at Turning Point Institute and DCU from 2009 until 2013. She had a particular interest in the spiritual and transpersonal nature of Psychotherapy and supporting people with suicidal behaviour. She completed her clinical training and was continuing in practice at St. Marthas (St. James Hospital). Hilda felt she had found her true calling as a Psychotherapist having previously studied law at UCD and qualifying as a barrister.

The poster was presented by Mary Rabbitte, friend and peer of Hilda’s at TPI.

References:
The Experience of Working with Clients with Eating Disorders from the Perspective of Psychotherapists with Eating Disorder History

by Christina Galvin

Introduction

It is estimated that up to 200,000 people are affected by eating disorders (EDs) in Ireland, with 400 new cases emerging each year. EDs account for approximately 80 annual deaths (DoH, 2006). Research indicates that the longer EDs remain undiagnosed and untreated, the more difficult they are to overcome. Thus, the earlier a person seeks treatment, the greater the likelihood of physical and emotional recovery (Le Grange and Loeb, 2007). Well-trained professionals are therefore crucial to enabling people manage and overcome the effects of these disabling constellation of conditions (Wright and Hacking, 2012). Because resistance to treatment and reluctance to recover are common features of the ED experience (Halmi, 2013), psychotherapists need to be psychologically equipped to work with ED clients (Kaplan and Garfinkel, 1999). New research in the ED field indicates that therapists with personal ED history are more likely to possess enhanced understanding of the disorder alongside an increased ability to empathise with clients precisely because they have ‘been through it’ themselves (Warren et al., 2013a&b; Zerbe, 2013).

However, the risks of over-identification with clients have also been noted and the potentially deleterious effects for both parties highlighted (Warren et al., 2013a; Satir et al., 2009). Although a substantial number of those who work therapeutically with clients with ED have personal experience of ED (Williams and Havercamp, 2010; Bloomgarden, Gerstein and Moss, 2003), few studies have focused on the actual experience of psychotherapists with ED history (Rance, Moller and Douglas, 2010; Bowlby et al., 2012). Thus, little is known about how these clinicians experience the work, their work practices, motivations, views on recovery (Bowlby et al., 2012), or how they manage the dynamics of the therapeutic relationship (Williams and Havercamp, 2010; Warren et al., 2009). The present study aims to address this gap from the perspective that clinicians who have studied ED, worked with ED clients and have personal experience of ED, would appear to be an important source of insight into the process of healing. With its emphasis on the voices of psychotherapists themselves, this study is the first of its kind in Ireland.

The study aims to explore, via semi-structured interviews, the experience of working with people with EDs from the perspective of psychotherapists with ED history. By honing focus on personal experience, it seeks to examine participants’ understanding of:

- The recovery process
- Therapeutic work with ED clients
- The strengths and vulnerabilities of therapists with experiences close to that of their clients.

This topic is important because, as recent studies reveal, therapists with ED history often seek out positions in the ED psychotherapy field (Bowlby et al., 2012).

Methodology

Interpretative Phenomenological Analysis (IPA) was selected as the qualitative research methodology for this study on the basis of its utility as a tool for parsing subjective experience (Smith and Osborn, 2003). Consistent with the IPA imperative that less is more, a sample of three therapists (two women, one man) were recruited by email from the pool of professional psychotherapists listed on IACP and IAHIP websites. This allowed for detailed exploration of the individuality of participant experiences. 
Analysis reveals the very personal context informing participants’ understanding of their own histories and their approach to therapeutic work. Although unique to participants, their narratives encapsulate issues of universal resonance, of interest not only to the cohort being studied, but to the psychotherapy community generally, supervisors and laypeople.

Three broad themes emerged from the data:

1. ‘Memories of Hunger’—Making Sense of the ED Experience;
2. ‘Being Ok with Imperfection’—Recovery as Meaning-Making;
3. ‘I Just Know’—How Experience Informs Practice.

Discussion

1. ‘Memories of Hunger’—Making Sense of the ED Experience

The fact that childhood experience of ED took up such a large portion of the interviews speaks to the degree to which ED played a formative part in participants’ lives and in subsequent decisions to work as psychotherapists in this field. The suffering they endured led them to find meaning in and beyond their condition and, as a corollary, inspired ‘a personal moral imperative’ (Kiselica and Robinson, 2001, p.397) to enable clients make sense of their EDs by understanding the deeper patterns at play. Themes of transgenerational trauma (‘memories of hunger’) and mother’s issues with food permeated the narratives and formed the basis of meaning participants ascribed to their ED experience.

The notion that an individual’s behaviour and psychological development must be understood within her/his social environment is an important area of thought deriving from the traditions of community psychology and social ecology. Viewed against a history of family trauma played out within the context of a repressive wider culture, the onset of participants’ problematic relationships with food and body image make a lot more sense.

The transgenerational transmission of ‘anxious embodiment’ received moving evocation in participant narratives. For example, when Sandra was asked about her personal experience of ED, she immediately placed her issues in the context of her mother’s stories of early deprivation and trauma:

*My mother... was brought up in an orphanage and she would... have told us... that she was starving and ate out of bins and [that] they ate grass... I remember growing up on those stories around food.*

Disordered relations with food began early on for Roisin also. Even before she could speak, food was used as an instrument of control and power-struggle between the matriarchs:

*The problems began before I even had words... [My early feeding became a] battle between my grandmothers...and mother... It's just memories of hunger.*

Sean’s narrative documents the fraught nature of his relationship with his mother. He talks of learning ED behaviour from her and how the physical act of vomiting became a default method of coping:

*I remember actually thinking constantly... that this is what you do if you are upset.*

Inability to digest distress in any other way meant the ED embedded itself in physical form as a persistent somatic symptom (Orbach, 2010), in essence, becoming a surrogate identity. By his own
admission, his ED therefore signified a kind of ‘false self’. Psychoanalyst and paediatrician, D.W. Winnicott (1965) who conceived the term, theorised that in pushing forward parts of themselves that are deemed acceptable to parents at the expense of other ‘unacceptable’ aspects, children develop a counterfeit persona or defensive facade. Sean’s ‘false self’ developed around food and its denial, which became a way to deal with feelings that felt overwhelming and too unsafe to express in his family.

Desire to use one’s own past experience and awareness of pain in the service of others represents a common motivator of psychotherapists’ career decisions, a fact well-documented (Farber et al., 2005). An interpretative perspective of the experiences of participants in this study therefore construes their choice to enter the field as a way of drawing meaning from early suffering, of coming to terms with ‘memories of hunger’ and unmet needs.10

2. ‘Being Ok with Imperfection’ - Recovery as Meaning-Making

For the three participants, personal therapy and the work they do with others provide a way to reflect more deeply on the meaning of ED. Their work, fuelled by obvious altruistic intentions to help others, constitutes a way to give their lives purpose. Their accounts challenge the notion that our stories define us,11 affording instead, compelling testimony of the power of human beings to re-vision themselves.12 As psychotherapists, enabling others tap into this power has become a keystone of their lives. Frankl’s dictum (1963, p.235) that ‘suffering ceases to become suffering at the moment it finds a meaning’ resounds through participant accounts.

Among the unanticipated findings of this study were the particular meanings participants attributed to their ED experiences. For instance, Sean’s belief in the ‘necessity’ of symptoms as a ‘movement towards health’ imbues ED with meaning not found in the medical model. His compassionate approach contains within it his own ‘lived experience’ of discovering meaning in adversity (Etherington, 2000). Symptoms, for Sean, are the psyche’s way to self-regulate, neurosis an attempt at self-cure. This is very much in line with both Freudian and Jungian positions which understand the necessity of symptoms and see value and meaning in neuroses.13 From this perspective, the manifestation of neurosis has a ‘curative function’ (Leader 2011, p.70), presenting a doorway to more expansive ways of living.

Roisin’s equation of the ED experience with ‘adventure’ is arresting given ED is generally regarded as a disease. Nowadays, we understand ‘adventure’ to mean ‘a bold and risky undertaking’, or the act of daring ‘to take a chance’. However, its Latin origins, adventura, meaning ‘what must happen’, tie in with the notion of necessity, upending the presumption of luck. Divested of chance, adventure becomes rooted instead in the inevitability of fate. Understanding the necessity of symptoms in light of personal history, therefore, we may recover a sense of adventure about them, alongside the willingness to explore the physical and behavioural manifestations of pain as an idiom of the psyche seeking imaginative expression.

Embedded in conceptions of ED as ‘necessity’ and ‘adventure’, is profound acceptance. This permeates Sandra’s recovery experience also. Her openness to ‘befriend[ing]’ ED thoughts represents a relinquishing of the struggle and an acceptance of ED as part of who she is. The notion of making peace with oneself potently resonates in Sean’s narrative too:

*Recovery is not perfection—it’s kind of being ok with imperfection.*

Thus, participant recovery narratives highlight the way in which empathy and understanding have come to replace self-hatred. Awareness of the fundamental role of self-compassion as catalyst for
change permeates their work. It is this attitude of self-empathy which they strive to inspire in clients also, accompanying them on a path to self-acceptance through the exploration of meaning.

All participants’ voice impatience with the medical paradigm which they believe promotes a reified notion of recovery that bears no relation to either their own or their clients’ lived experience. Participants’ believe instead in the ‘process model’ of recovery, defined as a course without fixed destination but nevertheless leading to growth and discovery of untapped resources. Recent developments in resilience research (Masten and Obradovic, 2008) echo participants’ frustration with ‘deficit’ models of illness which problematise symptoms. Adopting a resilience-infused recovery model replaces the notion of recovery as a narrow measure against which to succeed or fail with a multidimensional approach that includes both flourishing and frailty. The issue about whether therapists with ED history should or shouldn’t work with ED clients remains contentious. In highlighting the complexity of individual recovery experience, this study calls for unprejudiced appraisal of individual suitability.

3. ‘I Just Know’ - How Experience Informs Practice

Knowing what it’s like from the inside out gives participants the confidence to integrate acceptance of their own ED history in current practice. This intuitive recognition of clients’ struggles is captured in Sandra’s cogent remark: ‘when they talk... I can explore that more ’cos I just know.’ This study finds that participants’ therapeutic style reflects that which facilitated their own recovery. Participants’ pride in ‘just knowing’ from personal experience about ED and recovery signifies a major narrative theme. This is unsurprising due to the intensity of personal investment in therapy and the degree to which therapy-motivated recovery sustains participants’ commitment to professional practice.

Stigma surrounding ED and body size/shape arose as an issue of particular concern in participant narratives. EDs are among the most highly stigmatized of all mental illnesses (Roehrig and McLean, 2010). The ignorance and lack of sensitivity with which EDs are handled by many in the health professions was a theme woven through the experience of all participants and points to lack of knowledge regarding the seriousness of EDs (Williams and Leichner, 2006). As research shows, clinicians’ stigmatising attitudes can hinder treatment progress, exacerbate symptomology (Puhl et al., 2014) and/or place a burden on sufferers to manage their condition alone (Roehrig and McLean, 2010). Sandra’s experience detailing years of lonely suffering is just one example of the pernicious human cost of stigma.

However, a countervailing influence on all participants which contributed to their recovery was their experiences of being witnessed in therapy and/or supervision. The therapy that worked enabled them feel seen and heard for who they are. In feeling that they mattered to their therapists they came to ‘matter’ to themselves (Winnicott, 1971, p.4-5). Reflecting this attitude of caring towards their clients, participants now counter their clients’ shame and internalised stigma.

Analyses indicate that while the acting out of countertransference is harmful, its management confers lasting therapeutic benefits (Hayes, Gelso and Hummel, 2011). Having effectively worked through issues surrounding their own ED experience, participants in this study are aware of and capable of managing it. Study findings are underpinned by research (Warren et al., 2013a&b) emphasising the importance of supervision to the management of countertransference in ED treatment.

Contrary to results from previous studies on psychotherapists with ED history highlighting therapists’ eagerness to stress their ‘recovered’ status (Rance, Moller and Douglas, 2010), participants in this study recognised their ongoing vulnerabilities around food and weight and were upfront about the need for continued vigilance in this regard. Roisin, for instance, was direct about her ED being a default mechanism of coping in times of stress. With respect to countertransference, she talked about
its centrality to the therapy process, the importance of continually questioning her own reactions, of assuming an exploratory stance and taking any issues arising to personal therapy and supervision. For her, these are crucial supports. While Sean’s vigilance extended to obtaining more than the required number of supervisory sessions, he accepted the inevitability of errors. This, he recognises, keeps him grounded in the knowledge of his essential fallibility, while an ability to own his mistakes validates the client’s humanity also.

Participant stories testify to the inevitability of the mutual influence of personal and professional experience. A chief finding of this research construes participants’ experience of adversity as a key agent of compassion and a catalyst for forging deep connections with clients.

**Conclusion**

The formative impact of childhood experience on participants and the impossibility of separating the influence of personal history from therapeutic work is a decisive outcome of this research. In addition, the significance to recovery of a supportive, human connection with a therapist-supervisor proves critical in participants’ experience. All participants are vociferous in their rejection of the medical model of ED treatment because of their own negative experiences with it. Exploration of personal meaning of ED proves far more valuable. A conclusive theme is the part played by meaning-making in recovery experiences and its integration in therapists’ own therapeutic practice.

The study also flags some unexpected meanings of ED. Notions of ED as ‘necessity’ and ‘adventure’ show the creative ways participants approach ED symptomology in professional practice. Additionally interesting and similar to findings elsewhere (Bowlby, 2012), is that the treatment philosophy and modality which participants utilise in client work reflects that which they experienced as helpful in their own recovery process. Participants’ methods of working offer cogent critique of conventional paternalistic methods which problematise symptoms. Another major theme of participants’ stories is the revelatory function of self-compassion in recovery. Having found therapists/supervisors to whom they ‘mattered’, participants came to matter to themselves and now integrate this insight in their client work.

On the subject of stigma towards people with EDs, the ED field has a lot to learn from research documenting how therapists’ troubled history may be seen as advantageous. Such findings underscore the results of this study suggesting that participants conceptualise their ED struggles as an essential component of their ability to be present to clients’ distress. The issue of perfectionism, widely regarded as a propellant of ED and which ironically constricts many recovery models, has led to debate about whether therapists with similar issues to their clients should or shouldn’t practise. The openness of therapists regarding continued sensitivities around food and weight represents an unforeseen and important finding. It is argued, therefore, that ready acceptance of one’s ED and the recognition of the need for management of trigger-points make therapists particularly empathic in holding equally the roles of client and therapist. As results reveal, however, maintaining such resilience is greatly dependent on habitual self-care, a central part of which must entail regular personal therapy and supervision.

Regarding ED recovery, a model reinforced by Resilience Theory offers the unique possibility of re-visioning a condition long seen as an illness of ‘deficits’. The resilience model recasts ‘illness’ as a method of adaptability, opening the possibility for consideration of the client’s protective processes as well as their innate strengths (Masten, 2011). This analysis emphasises the necessity for dispensing with narrow and unrealistic standards of recovery and to instead reframe definitions honouring the complexity of personal lives.

Precisely because they have ‘been through it’ themselves, participants bring a depth of commitment and understanding to those who suffer similarly. An appraisal of their narratives ultimately reveals
a vocational quality and a strong sense of shared humanity. Thus, instead of tackling ‘the problem’ with a toolbox of solutions, their aim is to engage the client in sifting symptoms for deeper meaning, transforming experience of pain into touchstones for spiritual growth.

**Clinical Recommendations**

Findings from this study present important recommendations for clinical practice.

1. Therapists working with ED clients must commit to taking seriously the need for regular self-care, including supervision and personal therapy.
2. Provision of specialised training for supervisors is crucial for the effective support of ED therapists (with and without personal history).
3. Countertransference and the risks of over-identification demand special attention by therapists and must be prioritised by supervisors.
4. In challenging restrictive definitions of recovery this study recommends the adoption of process and resilience models which respect individual context.
5. Training directors are uniquely placed to highlight stigma by discussing the following points with trainees:
   (a) Cultural weight bias and how this affects therapists and clients;
   (b) The stigma that surrounds the issue of recovered/recovering professionals;
   (c) Interventions to counter stigma and to support therapists;
   (d) Enduring stereotypes of ED clients as ‘difficult’, their effects on therapists/clients and how these may be challenged.

**Cristina Galvin** works as a psychotherapist in private practice, specialising in work with clients with eating disorders and trauma. She also works with the National Counselling Service and recently also at NUI Galway Student Counselling Service and Jigsaw Galway mental health support service for young people. In her therapeutic work Cristina draws on a rich background in creative arts. Fifteen years experience in action research in the public health field (HIV/addiction/trauma) took her to UK, US and Russia, where over several years she worked with people in crisis. She completed a Masters in Psychotherapy with Turning Point and DCU in 2015, is also a qualified yoga teacher and yoga therapist since 2004 and teaches yoga in Galway and surrounds.

**References:**


Endnotes

1 Yet, EDs not meeting narrowly defined criteria for a psychiatric disorder are much more widespread than those that do (Austin, 2000). Screening studies conducted both in Europe and North America have found that approximately 10% to 25% of girls and young women manifest ‘disordered eating’ patterns (Austin, 2000, p.1249). Early stage intervention and prevention measures are acknowledged as key to mitigating the likelihood of subclinical EDs progressing to more chronic and treatment-resistant forms (Le Grange and Loeb, 2007).

2 Research shows that approximately one third of therapists who treat ED clients share similar history with them, far exceeding ED rates of 0.3%-4.2% in the general population (Warren et al., 2013a; Williams and Havercamp, 2010; Barbarich, 2002).

3 This research, completed during 2014 and 2015, was undertaken as part of the MSc in Integrative Counselling and Psychotherapy at Dublin City University and Turning Point Training Institute, Dublin.

4 Consensus reigns among IPA theorists that ‘fewer participants examined at a greater depth is always preferable to a broader, shallow and simply descriptive analysis of many individuals’, such as in thematic analysis and grounded theory (Hefferon and Gil-Rodriguez, 2011, p.756; Reid, Flowers and Larkin, 2005). The ‘logic and power’ in choosing such an approach lies in the selection of ‘information-rich cases for study in-depth’ (Patton, 1990, p.169). In other words, rather than producing empirical generalisation, the sampling method places quality above quantity with the aim of generating insight and detailed understanding.

5 These themes also reflect ideas which surfaced in the process of the literature review.

6 Bronfenbrenner’s ecological model (2005, p.284) theorises that individual development is shaped by a host of ‘interacting contexts’ and so engenders a more broad-based perspective of the circumstances in which EDs arise.

7 The term, ‘anxious embodiment’, meaning body trauma, is coined by the writer, Susie Orbach, in Bodies (2010, p.10).

8 For the purposes of confidentiality, participants were each given a pseudonym.

9 In Fat is a Feminist Issue, Orbach (2006, p.105) delivers a cogent reflection on the transgenerational transmission of anxious embodiment—how the body is shaped by upbringing—which speaks directly to participants’ experience: ‘If the early distortion in the feeding relationship is attributable to the social forces present in the mother-[child] relationship, then this will be as true for our mothers as [children]... As long as patriarchal culture demands that women bring up their [children] to accept an inferior social position, the mother’s job will be fraught with tension and confusion which are often made manifest in the way mothers and [children] interact over the subject of food.’

10 In a wide-ranging analysis of the career motivations of psychotherapists, Farber et al., (2005) provide abundant evidence to show how difficult family and cultural experiences undoubtedly contribute to therapists’ choice of career. This is confirmed, indeed, by international data revealing personal distress as the factor motivating the career decisions of almost half (48%) of psychotherapists (Orlinsky and Ronnestad, 2005).

11 As White and Epston (1990), pioneers of Narrative Therapy, theorise, alternative perspectives on our lives open up the possibility of new ways of relating to our stories. In their groundbreaking work, Narrative Means to Therapeutic Ends, White and Epston (1990, p.3) explain how the organisation of our lives around specific meanings may contribute either to the survival of ‘the problem’ or to liberation from it. Drawing on social constructionism and liberation philosophy, this approach aims to replace ‘toxic’ narratives and ‘subjugating discourses’ with stories that heal and enable recovery (Neimeyer, 1998, p.144).
12The importance of the imagination to re-storying our lives and its centrifugal place in recovery is particularly salient in Roisin’s experience and is given pithy expression in the words of poet Ted Hughes: ‘what alters the imagination alters everything’ (cited in: Oswald, 2014, p.2). Roisin’s experience and her hope for clients is that therapy will radically alter their imagination. Researchers have established firm links between the processes of telling one’s story and the construction of self-identity (Giddens, 1991; Bruner, 1995; Plummer, 1995).

13Freud (1911, p.71), for instance, believed symptoms constituted ‘an attempt at recovery, a process of reconstruction.’ Jung (1976, CW 18, par. 389, p.169) similarly viewed neuroses as profoundly purposeful attempts at restitution: ‘In many cases we have to say, ‘Thank heaven he could make up his mind to be neurotic.’ Neurosis, he continues, ‘is really an attempt at self-cure, just as any physical disease is in part an attempt at self-cure... It is an attempt of the self-regulating psychic system to restore the balance...’

14In a unique study on the specific role of compassion in psychotherapy, Vivino et al., (2009, p.167) discerned that therapists were particularly able to identify with clients’ suffering ‘when memories of their own suffering were elicited’. This research demonstrates how the therapist’s practised ability to have compassion for oneself and one’s own struggles greatly facilitates extension of compassion to clients (Vivino et al., 2009)

15Johnston, Smethurst and Gowers’ (2005) study uncovered discriminatory practices among some employers. Andrea Bloomgarden, a self-identified practitioner in recovery from an ED, argues that therapists, employers and society generally must let go rigorous attitudes that demand a warped ideal of perfection as a standard for helping others. Therapists, she says, ‘are human and this [must be] admissible’ (Bloomgarden, Gerstein and Moss 2003, p.166).

16All participants work from an integrative perspective: Sandra combines CBT and person-centred therapy; Roisin takes a psychodynamic, creatively exploratory approach and Sean draws on psychodynamic and Dialectical Behavioural Therapy models.

17Data showing that ED therapists base choice of therapeutic approach on personal preference/experience rather than on research evidence has drawn criticism in the literature (von Ranson and Robinson, 2006). While familiarity with and insight into a particular brand of therapy from the perspective of therapists who have derived personal benefit from it could indeed prove positive to clients, more research is needed on situations in which this might prove advantageous/detrimental

18The fact that therapists in this study spent so much time talking about their personal ED experiences rather than their client work leads, at the very least, to queries about whose recovery is uppermost. How do clients experience participants as therapists? Without client input, it is obviously impossible to address this issue. Nevertheless, with research suggesting therapists are generally unreliable judges of clients’ experiences and exhibit tendencies towards overrating their overall effectiveness (Cooper, 2010), it is important to maintain a stance of detachment and keep in mind that what participants say in this study is one side of the story. Personal experience is not to be conflated with skill. While one can certainly enhance the other, neither therapists nor clients are served by presuming equivalence.

19Yet, there is currently a lack of data on the determinants of ‘good’ supervision which has implications for treatment quality (Schofield and Grant, 2013). The dearth of attention paid to the specific subject of countertransference in ED treatment is also concerning (Forget, Marussi and Le Corff, 2011). This study highlights the need to address both research gaps.

20In contrast to other recent IPA research with a similar cohort (Rance, Douglas and Moller, 2010), psychotherapists in this study espouse more flexible notions of recovery.

21It is only relatively recently that the particular issue of training for supervisors in the ED field has arisen as a subject meriting specific attention (Boie and Lopez, 2011). Boie and Lopez (2011) underscore the importance of supervisors being able to draw on a comprehensive framework and recommend training in the ‘integrated developmental model’ (IDM). The IDM cements the different aspects of working with ED clients and provides a schema for effectively assisting the professional development of therapists across a broad range of experience levels (Boie and Lopez, 2011). Emphasised, in particular, are the importance of facilitating open discussion of the therapist’s recovery, the values that they attach to it, as well as instances of loss of objectivity and possible relapse risks. The authors additionally recommend that when assessing the readiness of therapists to work with ED clients supervisors need to pay particular attention to therapists’ attitudes towards their own ED (Boie and Lopez, 2011).

22Addressing treatment challenges at the beginning of training may not only alleviate therapist stress (with obvious knock-on benefits for clients), but promote the retention of clinicians in the ED field (Satir, 2013; Thompson-Brenner and Westen, 2005).
Misneach: Courage as the Heart of the Work for Psychotherapists

by Caroline Burke

These changing times of economic hardship and societal dislocation greatly impact individuals: some suffer a sense of isolation and purposelessness, many strive to dig themselves out of depression and complicated grief, others experience despair in unemployment and poverty. As these raw and pain-filled stories enter the room, the therapist’s walk with the client is often a daily exercise in personal vulnerability.

“Vulnerability defines our humanity” (Jordan 2008a, p.239) and in the therapy hour this vulnerability stems from many places. When a therapist sits with a client and his/her stories, stories that—when listened to closely—stir deep within the therapists’ experience, then vulnerability is present (Jordan, 2008). This stirred vulnerability may be a result of unresolved pieces of the therapist (Garfield, 1987), an emerged shared transference-countertransference created by the client and therapist while working together in session (Gill, 1983; Green, 1975), and/or the personal feeling-style of the therapist when attending fully to clients (Holmqvist & Bengt-Ake, 1996). These stirrings arise quickly from multi-layered foundations within the therapist and are often held as deeply vulnerable.

What follows then is a two-fold vulnerability experienced on the part of the therapist: not only is the therapist vulnerable to the client, the therapist is also vulnerable to him/herself. Being authentic within the work and allowing oneself to be affected by the client’s experience requires an openness (spoken and unspoken) to the client – and concurrently, to oneself. The work requires the willingness to take a risk: risk of having one’s own personal values and conflicts stirred up within the process of wholehearted and empathic connection to the client. As a result, within the therapy hour, one finds oneself sitting vulnerable within themselves and with the client.

It is in this place of vulnerable openness where growth and change occurs. And the process of therapy - allowing the unfolding of this openness for both client and therapist - recognises that in this posture, growth occurs as well as potential for vulnerable injury (Jordan, 2008). How does a therapist navigate through these intensive experiences and tend to both the vulnerability within themselves and with their clients? What can the therapist draw upon?

Misneach! Courage! In the Irish language, “Misneach” means courage in the sense of being able to keep one’s head about them (coming from the root ‘med’ - to be measured). Misneach also implies a sense of strength, endurance, bravery and spirit in all senses of the word (Kondratiev, 2016). In English, courage comes from the Latin root ‘cor’ meaning heart. In Middle English cor (courage) was denoted as the seat of feelings (Merriam-Webster n.d.).

Other perspectives and definitions of courage are numerous and nuanced; what courage is, and what it is not. For example: courage may not necessarily be synonymous with fearlessness. The tone of Plato’s view of courage, for instance, was that it demanded a quality of thoughtfulness, as he believed that fearlessness exhibited qualities of rashness and boldness with little forethought (Plato, edited by Hamilton, 1961). More recently, in the helplessness literature (i.e. Seligman, 1974), courage was specifically named as not being the same as resistance, as it is not merely resistance to being overpowered when faced with difficult circumstances (Peterson & Seligman, 1984; Seligman, 1974). So although there are overlapping themes, for some theorists there are pieces of courage that distinguish themselves from one another.

The dialogue on the definition and experience of what courage is within the therapy hour is considerable. Alfred Adler’s concept of courage is based on social interest, with an emphasis on optimism and
caring for both clients and others in the world (Dreikurs, undated). Abraham Maslow (1963, p.119) discussed the components of courage as one strives for self-actualization as:

...a kind of daring, a going out in front all alone...

Rollo May (1975, p13) explored how one aspect of courage is a willingness to allow the unconscious to become conscious in order to bring a new order. He described courage as being essential:

...the foundation that underlines and gives reality to all other virtues and personal values.

Putman (1997) suggests that psychological courage, or the courage displayed when one encounters and faces one’s own irrational fears and anxieties, is part of the definition. For the purpose of this paper, the construct will come from various sources of literature and be defined as:

...an experience where an individual perceives a risk, overcomes fear; and is still able to be fully present to another.

(Medina, 2008).

If courage is the heart of the work and is foundational in giving rise to hope amidst vulnerability (May, 1975), how is it experienced by therapists in the therapy hour?

Although sources of courage are many, a few are mentioned here. One source of courage for the therapist comes from the client him/herself. The act of entering therapy in itself is a courageous decision as the client begins the brave processes of openness and vulnerability with the therapist. The stories told by clients often exhibit great moments of courage in the midst of intensive struggle and alone-ness. Through the client’s growth, therapists witness courage - courage that clients are initially unaware of possessing (Yalom, 2015). This adopting of courage through the client is akin to the theory of contagion - that courage itself is contagious: one ‘catches it’ from the client (Rachman, 1979). Unbeknownst to the client, they are modeling courage for the therapist as they tell their stories of suffering and demonstrate great resilience through their growth. Therapists are inspired by these models of courage (Hatcher, et al., 2012).

Therapists also find their courage by tapping into their own historic wells of resilience and hope, which are the foundations of courage (Skovholt, 2012). When therapists are stirred by a client story and experience the countertransference of tapping into their own historic experience of growth, they find courage adjacent to the experience. Courage is accessible as the therapist too has had to use it in order to work through their own stories, their own vulnerability. And the courage is summoned to be present again in the therapy hour, this time to assist the work of the client.

Feminist theory often posits that courage arises in the deeply relational and interpersonal connection that unfolds between therapist and client within the therapy process. As the intensity of the separation between self and other lessens, strength grows. Therein lies courage; it is found when isolation fades and relationship begins (Jordan, 2008a).

The literature also reports that some therapists tap into a source of spirituality and/or religion to summon courage. Therapists, although trained in the work academically, might also believe that without beseeching:

...this supreme power, I wouldn’t know where I’d be.

Seeking a supreme power or a God also increases the therapist’s courage that they are:

...heading in the right direction.  


Students in training and seasoned therapists alike are encouraged to be mindful of their courage, be knowledgeable of its source, and be aware of how their courage is both essential and manifested in their work with clients. A few questions therapists might ask themselves:

- What are the sources of my courage as a therapist?
- How do I experience the parallel process of client courage and therapist courage?
- When do I lose heart and find my courage elusive?
- What is impeding upon my use of inner courage?
- Has my courage in my work as a therapist changed from when I was a newer practitioner to now as a mid or late career practitioner?
- How can I, with my colleagues, co-create courage together as a central aspect of our work?

Courage, *misneach*, is the heart of the work with clients. This courage is found deep within the therapist’s experience, in the modeling of courage and resilience exhibited in their clients, in the creation of a relationship with the client, and in external sources of belief. Without courage, therapists may fold into the client’s despair, and, as a result, they may become defended and lose heart (Timulak, 2014). This often-scarce conversation of therapist-courage needs to be an ongoing dialogue as it is a critical component (the heart!) of meaningful therapeutic work.

**Addendum:**

*Courage*, a poem by John O’Donohue (2008) captures the essence of courage beautifully:

**For Courage**

When the light around you lessens  
And your thoughts darken until  
Your body feels fear turn  
Cold as a stone inside

When you find yourself bereft  
Of any belief in yourself  
And all you unknowingly  
Leaned on has fallen

When one voice commands  
Your whole heart,  
And it is raven dark,

Steady yourself and see  
That it is your own thinking  
That darkens your world

Search and you will find  
A diamond-thought of light,
Know that you are not alone
And that this darkness has purpose
Gradually it will school your eyes
To find the one gift your life requires
Hidden within this night-corner.

Invoke the learning
Of every suffering
You have suffered.

Close your eyes
Gather all the kindling
About your heart
To create one spark.
That is all you need
To nourish the flame
That will cleanse the dark
Of its weight of festered fear.

A new confidence will come alive
To urge you towards higher ground
Where your imagination
Will learn to engage difficulty
As its most rewarding threshold!

Caroline Burke holds a Ph.D. in counselling psychology and is a licensed psychologist in Minneapolis St Paul, Minnesota. She is both a psychotherapist as well as an instructor at the University of Minnesota. Caroline supervises students in their process of becoming therapists and she is their teacher for their core content areas as well. Caroline relishes and enjoys boasting of her Irish heritage.

References:


Research in Psychotherapy Training: Clinical Implications

by Gráinne Donohue

This research aims to look at the impact, if any, of engaging in a research project as part of a psychotherapy training. The introduction of a research module as a core part of clinical training is a relatively new phenomenon within psychotherapy training in this country. New graduates have not only designed and engaged in a piece of research, but have also been made aware of large scale clinical studies and their implications for practice. This study then aims to explore with recent graduates how this immersion into the field of psychotherapy research has impacted upon them as clinicians. Six graduates of a four year post-graduate training were interviewed on their perceptions of research prior to commencing modules, their experience of the research process and finally the impact they felt it has had on them as practitioners. The overall ability to integrate this fundamental aspect of training will be looked at alongside the challenges involved with conducting and completing a research project on the self.

While much as been written about training from numerous perspectives, there is little in the literature about how being engaged in research affects a student’s overall training experience. This research in particular will pay attention to understanding the benefits, synergies, conflicts, and tensions in combining research with such aspects of psychotherapy training as personal therapy, case studies, supervision, classes and college life.

Dr. Gráinne Donohue Ph.D, MA (Psych) has over fifteen years experience in the mental health profession. She completed her doctoral studies in the School of Medicine and Medical Sciences, UCD, specialising in a psychoanalytic understanding of loss and dementia. She was awarded a research grant from the International Psychoanalytic Association and subsequently became a Research Fellow. She currently works clinically in the area of psychosis and lectures in the Department of Psychotherapy at DBS and UCD. She is a member of the Association of Psychoanalysis and Psychotherapy in Ireland and the Society for Psychotherapy Research.
Call to Action: Humanistic Psychotherapy with Gender Nonconforming Clients
by Meredith A. Martyr

We are all artists and performers; consistently chipping away and perfecting how we want the world to perceive us. Whether we are aware of it or not, we are performing in a variety of roles in the world around us. The roles shift in and out of place throughout our lifetime, sometimes the pieces fit easily together and other times, they do not. As practitioners, have two important roles with clients: first, we assist in how clients conceptualise their various identities and second, we offer an authentic connection based upon the pillars of humanistic psychotherapy; respect, unconditional positive regard and trust.

Gender Nonconforming Individuals
Gender nonconformity as an identity that is often times misunderstood. A common misconception is the differentiation between sex and gender identity. It is assumed by most individuals that gender identity is consistent with the sex assigned to a person at birth (Bethea & McCollum, 2013). This may or may not be the case. Gender identity is an individual’s inherent belief of being a girl, woman, or female, a boy, a man, or male, an alternative gender, or a blend of male and female (Bethea & McCollum, 2013; Institute of Medicine, 2011). The thought of gender commonly brings up a dichotomous dynamic that is consistently represented in general society. Goods, media, etc. are marketed as for boys or girls, men or woman, without any representation of individuals who do not fit perfectly into these roles. But what comes of this dichotomy? What is to be done of the people who cannot fit into these narrow roles? How do we as practitioners facilitate purpose and connection in these moments of distress?

Humanistic Psychotherapy and Gender Nonconforming Individuals
At the broad and holistic perspective, gender performance and identity is intrinsically tied to how we exist as individuals. How do we want to view ourselves? What are the systems that are blocking us from fully accepting and loving who we are? How do we want others to see us? How do we come to accept who we are at our most intrinsic and honest level? Humanistic psychotherapy provides a foundational perspective for practitioners working with gender nonconforming individuals. A pillar of humanistic psychotherapy work is being inclusive of all experiences a person may bring into the room with them. This is common knowledge amongst humanistic practitioners, however this may be a radical notion to gender nonconforming individuals who may have never experienced such respect, unconditional trust and an encouragement of self-empowerment. Cultures where gender nonconforming individuals were visible and/or had common respect for their identities were weakened by colonialism and systematic inequity (Nanda, 1999). They often feel secluded and forced to cope with the stigma of gender nonconformity in isolation thereby increasing their mental health distress (Fredriksen-Goldsen et al., 2014; Singh et al., 2011). This is where the strength of humanistic psychotherapy lies – in the connection to the human existence. What we as humans often suffer from is the lack of we-ness, the hope that our distress may not be experienced in isolation, but in company with others. Practitioners may offer this connection and present-focused approach that is consistently missing in this population.

Processes of Humanistic Psychotherapy and Gender Nonconforming Individuals
Carl Rogers (1961) emphasises the importance of the three interconnected core conditions of humanistic psychotherapy: congruence, empathy and unconditional positive regard. Rogers (1961) believed that if a practitioner exemplifies all three of these core conditions while working with any individual, then clients will be more willing to accept and express themselves without fear of retaliation. All three of these pillars weave in and out of each other in order to provide a sturdy tapestry based upon the utmost core principle of humanistic psychotherapy: the healing power of the therapeutic relationship.

Congruence can be understood as the ability to be transparent with clients and to relate to them through an
authentic approach. The medical model and approach to defining gender has historically been perceived by the gender nonconforming community as hurtful, damaging, and oppressive. We as practitioners have the choice to operate from a place of honesty and authenticity in order to cultivate safety with this population.

Unconditional positive regard is the capacity for the practitioner to attentively listen without judgment and to offer the utmost acceptance of who the client is in their full entirety. Gender nonconforming clients are often coping with an intersection of multiple identities (i.e. spirituality, ethnicity, socioeconomic status, etc.) that lead to mental health distress (Daley et al., 2008). Humanistic practitioners provide a space of acceptance, which may lead to the client feeling fully integrated in the various identities they bring.

Empathy, the most popular of humanistic psychotherapy’s core conditions, is defined as the practitioner’s practice to fully convey their appreciation and accurate reading of the client’s experiences and emotions. The power of empathy cannot be overstated nor overlooked in our profession. Empathy can be conveyed in a variety of verbal and non-verbal behaviors, however for gender nonconforming clients this may come through in validating notions of systemic oppression, gender-based violence, etc. Empathy must not only be conveyed in the immediacy of the here-and-now, but also being aware of and supporting the client’s journey of naming their unique experiences of subjugation and stigma.

Our Call to Practice
As a young practitioner-in-training, I often find myself sitting alone in my office in awe of the weight people bear. How do we as humans carry the weight day in and day out? Humanistic psychotherapy provides a foundational philosophical base for practitioners to operate from when working with populations who have been systemically subjugated, particularly with the gender nonconforming population. The connections made through empathic understanding, unconditional positive regard, and congruence provide a therapeutic relationship with the means to access the emotional connection that the gender nonconforming population has historically been denied. We as practitioners are movers-and-shakers. We are the change-makers, on the bridge between what society is doing and what society is capable of. We do this through our extension of humanistic practice and our commitment to advocate for our clients through providing unconditionally supportive mental health practice. I challenge all practitioners to consider our role as advocates for gender conforming clients through incorporating our humanistic approaches in a culturally aware, individualistic, and respectful manner.

Meredith A. Martyr is a PhD student in counselling psychology at the University of Minnesota in Minneapolis, Minnesota, U.S.A. She completed both her BA in English literature and gender, women, & sexuality studies in 2010 and her MA in counselling & student personnel psychology in 2013 at the University of Minnesota. Martyr’s research interests include sexual violence prevention, gender identity construction, human sexuality and clinical supervision. Her clinical interests are LGBT psychology, identity development, trauma, sexual violence and psychoeducation with college students regarding mental health, sexual violence and bystander intervention.

References:
When Words are not Enough: Listening to the Lessons of Neuroscience and Bringing Creativity into the Psychotherapy Space  
by Eileen Prendiville

The environment shapes neurobiological development (Perry, 2006) and attachment formation; a creative neurosequential approach to psychotherapy maximises potential for healing and promotes new neurological development by attending to what we know about neuroscience, interpersonal neurobiology, and the biology of both attachment and arousal. There are different approaches to psychotherapy: top-down models that focus on cognition and are often primarily focused on the use of verbal language, and bottom-up models that attend to the central role of physiological elements and the two-way system of brain-body communication (Perry, 2006 Prendiville, in press).

Both left and right hemispheres of the brain are involved in healing. When these are working in partnership, processing is facilitated. The right hemisphere is dominant in the early years of life. It is sensory based, creative, processes social emotional experiences, does not rely on verbal language, and is significantly involved in the regulation of emotion and self-regulation (Cozolino, 2010; Porges, 2011: 138-140). The fact that this hemisphere is predominantly activated when recalling both early and disturbing memories (van der Kolk, 2003: 308) provides a strong rationale for the use of right brain activities when processing unresolved trauma and modifying embodied, implicit memories.

The left hemisphere is linked to language, logic and more linear thinking. The term ‘speechless terror’ is used to explain how, during traumatic experiences, the language centre (Broca’s area) is deactivated and the limbic system is activated. In the face of overwhelming experiences, we are unable to give narrative to our immediate experiences (van der Kolk, 1996). ‘Instead we are left with a more primitive sensory and somatic level of processing that does not facilitate us in being able to coherently understand and transfer the experience to long term memory’ (Prendiville, 2014:94). Such memories are instead stored in the somatic and visual areas of the brain. Most psychotherapists have experience of traumatized clients struggling with presenting a coherent narrative of their unprocessed traumatic memories.

An understanding of interpersonal neurobiology, trauma and healing suggest that talk therapy may not lead to full recovery: it is beneficial to incorporate expressive arts into psychotherapy and pay attention to the physiological impact of trauma (e.g. Gantt & Tinnin, 2009; Gaskill & Perry, 2014; Green & Drewes, 2014; Malchiodi, 2014; Malchiodi & Crenshaw, 2014). In discussing the stress response, Perry and Pate (1994) state that talking cannot translate into changes in the midbrain or the brain stem, the very areas that mediate a range of physiological, hyper-reactivity, behavioral impulsivity, hypervigilance, anxiety, emotional ability and sleep problems. The key to neurosequentially informed therapeutic intervention is to remember that the stress response systems originate in the brainstem and diencephalon. As long as these systems are poorly regulated and dysfunctional, they will disrupt and dysregulate the higher parts of the brain. Perry (2006: 38-39) proposes that even the best cognitive-behavioral, insight-oriented, or even affect-based interventions will fail if the brainstem is poorly regulated.

In recent years, it has become widely recognized that therapists need to take account of neurobiological evidence when planning developmentally appropriate and sequential interventions when working psychotherapeutically with clients throughout the lifespan (Gaskill & Perry, 2014). An individual treatment plan will seek to match the therapeutic activities to the physiological needs, developmental stage, and interests of the client while taking account of the neurobiology of stress and trauma (Prendiville, in press; Prendiville & Howard, in press).
Hierarchal Development
During the early years, the brain develops at a rapid rate. This slows down as we grow and mature. The neural system becoming organized from the more primitive lower (brainstem and midbrain) to more sophisticated higher (limbic system and cortical) regions, developing from the spinal column in a hierarchal bottom to top movement. All sensory information enters via the brainstem. Perry (2006) explains how neurons and neural systems are designed to change in accordance with experience - the ‘use it or lose it’ principle. Some systems are more responsive to change than others – the more complex higher brain regions are easier to change than the lower regions. We can learn new telephone numbers (cognitive function) more easily than we can change our capacity to self-soothe (lower brain regions).

Early developmental trauma, and stressful intrauterine experiences, impact negatively on both neural development and the interconnected functions of the nervous system. The resulting lack of smooth integration contributes to difficulties in regulation and a compromised stress response system. When an individual is in a state of alarm, the frontal cortex (the thinking brain), and the limbic system (the emotional brain) shut down. Only the lower brain areas are activated and the individual will struggle with:

- Establishing a feeling of safety;
- Processing incoming information;
- Successfully engaging with others;
- Recognizing emotional states;
- Self-regulating;
- Organizing their thinking. (Prendiville, in press)

The Stress Response: Fight – Flight – Freeze
The vagus nerves, a family of nerves originating in the brain stem, regulate the survival processes of fight, flight and freeze (Porges, 2011). Stress responses cause physiological changes (e.g. raising or lowering) in blood pressure, heart rate, temperature, breathing, digestion, metabolism, muscle tone, pain threshold, hormonal, and chemical balance. Our bodies are equipped to respond adaptively to danger by either fighting, fleeing or freezing. None of these is intrinsically better or worse that others. What is significant is the situation itself, the options available to the person, and their developmental status. Prior experiences may also be relevant. An adaptive response commonly includes elements of hyperarousal (mobilization for defence – fight or flight), and elements of hypoarousal and dissociation (freeze and surrender) as the dangerous event progresses. Fighting and fleeing (hyperarousal) are action-oriented responses that focus attention on the critical components in the external world and options to engage with it defensively. These are governed by the sympathetic nervous system. This causes an increase in heart rate, muscle tone and rate of respiration, and a change in cognition as the focus of attention is narrowed to elements linked to survival. Freezing (hypoarousal) has an inward focus and attention is drawn to the internal world as a way of reducing awareness of (avoiding) the situation in which one finds oneself. The activation of the parasympathetic nervous system causes a decrease in heart rate, muscle tone and rate of respiration, and a numbing of responsiveness, depersonalization, and a shift into robotic responses. Fighting or fleeing is not possible if you are immobilized or otherwise incapable of escaping an intolerable situation characterized by pain, terror and helplessness. Young children have less capacity to fight or flee than adolescents or adults therefore compliance and dissociation is a common component of the response to childhood trauma. The more anxious the person feels, the quicker they will move from anxious to threatened, and from threatened to terrorized. If sufficiently terrorized, the ‘freezing’ may escalate into complete dissociation and even fainting. With each shift, the higher brain regions go further off-line and the lower brain regions predominate. When terror takes over, the brainstem is the predominant (autonomic) regulating brain...
Keeping Psychotherapy Relevant to These Changing Times - 2016

region thus severely compromising the capacity to react, provide emotional responses, and think. Fear states are clearly linked to cognitive impairment: if a fear state is persistent, this impairment can interfere with all areas of life.

Perry (2001) cautions that if the stress response is activated for a prolonged period, the neural system mediating this response will be disrupted and it can become a persistently activated state. The amygdala becomes set to fire constantly and the ability to evaluate level of danger is reduced, leaving the individual in a state of dysregulation without capacity to self-soothe. Perry (2008: 93) defines trauma as:

An experience or pattern of experiences which activate the stress-response systems in such an extreme or prolonged fashion as to cause alterations in the regulation and functioning of these systems.

Those who experience persistent states of hyperarousal have a compromised ability to evaluate stimuli accurately in terms of the threat it comprises; their orbitofrontal cortex is unlikely to be fully available for stimulus discrimination, learning and problem solving (van der Kolk, 2003: 307). When this occurs, arousal state is governed by the more primitive parts of the brain rather than being responsive to the here and now. Stress related physiological states reduce each individual’s capacity to connect with higher, more rational responses, and bad situations quickly deteriorate unless help with regulation is available or utilized (Prendiville, in press).

A Neurosequential Approach to Therapy
Therapy will be more effective if the client is regulated at the beginning of each therapy session, and remains regulated throughout the session. Many clients have difficulties with self-soothing and will benefit from co-regulatory interventions that assist them in this regard (activities to regulate the lower brain). Knowledge of interpersonal neurobiology (Schore, 2002) provides guidance in this area. A longer-term goal for those prone to hyper- or hypo-arousal will be to broaden their window of tolerance for emotional distress, enabling them to remain regulated even in novel or adverse circumstances (Prendiville, in press; Prendiville & Howard, in press).

A neurosequential approach to therapy begins with the least complex brain area and moves sequentially through the more complex regions; brainstem first, then midbrain, then limbic, then cortex. Attention is paid to the functions associated with each region (i.e. regulation of arousal, sleep and fear states, somatosensory integration, emotional regulation, concrete and abstract thought) and the type of interventions that best address each area of dysfunction (massage, rhythm, movement, sensation, animal-assisted therapy, play, art, drama, storytelling etc) (Perry, 2006; Prendiville, in press; Prendiville & Howard, in press).

Clinical decision-making is informed by a knowledge of neurosequential development and a framework for conceptualizing how the particular client is impacted by any poorly developed brain region/s. For example, a client struggling with regulation (e.g. following trauma or early neglect) may be well served by embodiment activities and rhythmic approaches that target the brainstem. Similar decisions will be made throughout each session and therapy process – all the time guided by the needs and wisdom of the client.

The experiential workshop at the IAHIP conference elaborates on this area and allows participants an opportunity to engage with creative approaches with relevance to clients throughout the lifespan in a developmentally appropriate, sequential manner.
Eileen Prendiville is the Course Director for the MA Creative Psychotherapy and Play Therapy at Ireland’s Children’s Therapy Centre. She is heavily involved in providing play therapy and creative psychotherapy training, both nationally and internationally. She devised ‘The Therapeutic Touchstone’, an innovative approach for use when working with vulnerable and dependent clients, and co-authored *Play Therapy Today: Contemporary Practice for Individuals, Groups and Parents*. Her next book, *Creative Psychotherapy: Applying the Principles of Neurobiology to Play and Expressive Arts-Based Practice* is due to be published in October 2016.

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“I Get Butterflies” A Mother’s Emotional Response to the Relationship with her Child: An Investigation into the Interactions that Cause an Emotive Response
by Deirdre Evans

The current research study asks the question “What is the mother’s emotional response to the relationship with her child?” The Oxford English Dictionary (2011) gives the definition of ‘emotions’ as ‘a strong feeling deriving from one’s circumstances, mood, or relationships with others’. The word ‘relationship’, is defined as ‘the way in which two or more people or things are connected, or the state of being connected’ (Oxford University Press, 2011). Much of the existing research into the connection between mother and child (e.g. Schore, 2007; Balbernie, 2001; Seigel, 1999) focuses on the emotional influence the relationship has on the child in the dyad. What of the mother’s response to her child? How does the child affect her? Using the methods of a focus group and a case study, the current research dissertation addresses these questions. The study finds that a mother’s state is intensely influenced by interactions with her child; that there are indeed a number of emotional patterns that the mother exhibits in response to her child.

Deirdre Evans is an accredited psychotherapist with the IAHIP, with a keen interest in the mental health of women. Since graduating with first class honours in 2011, she maintained her focus on the mother’s experience of the attachment relationship, by working with a charity whose clients suffer from post-natal depression. Deirdre now works in private practice in Dublin City Counselling and Therapy Centre, as well as in Swords, North County Dublin.

Her email for correspondence is Deirdre.p.evans@gmail.com

To read more about the current study, please visit the following link: http://esource.dbs.ie/handle/10788/288

References:
Big Boys Don’t Cry: A Qualitative Exploration of Male Vulnerability in the Psychotherapy Environment
by Darren Reid.

Supervisors: Dr. Mary Rabbitte, Dr. Mary Kelly

Abstract:
Male vulnerability has been shown to have a role in how men try to avoid disclosure and help seeking behaviour. Male suicide attempts have been linked to non-disclosure of distress, not seeking help and not wanting to appear vulnerable. In Ireland men are more likely to kill themselves and less likely to seek help than women. However, there seems to be little or no research on male vulnerability. This research explored what role male vulnerability has in relation to psychotherapy and male help seeking behaviours. The primary aim was to gain an understanding of how men view and relate to their own vulnerability and how this in turn affects their experience of psychotherapy. The research used in-depth interviews to collect data from participants, who were trainee psychotherapists with a minimum of 20+ individual therapy hours. The data was analysed using Thematic Analysis. Findings show how men view their vulnerability is largely related to their adherence to their masculine norm, where men who adhered to their gender norm, struggled to experience their vulnerability. A positive experience of being vulnerable in psychotherapy relied heavily on the therapeutic alliance between the participants and their therapist. By being vulnerable, the participants reported an increase in self-compassion and self-acceptance, greater emotional tolerance and a feeling of being more real and authentic. These research findings could form the basis for further studies on men and vulnerability and contribute to learning in how men relate to their vulnerability in psychotherapy.

Background to the Research
To date very little research has been carried out on vulnerability directly. Brown (2006) found that one of the key elements in a person’s ability to overcome shame lay in their ability to be vulnerable. She states that a person’s ability to experience vulnerability was a very important precursor to change. While her study was in-depth, its primary focus was on women in America and overcoming shame.

There are indications that vulnerability plays a role in how men try to avoid disclosure and seeking help. In researching Irishmen who had attempted to kill themselves, (Cleary 2012) found that a major theme was ‘non-disclosure’. She attributes this to them not wanting to feel or appear vulnerable. This point is in line with research on how men in Ireland are more likely to kill themselves and less likely to seek help than women (National Office for Suicide Prevention, 2013, Health Service Executive, 2007, Begley et al., 2004b, Departments of Public Health, 2001).

Aim and Objectives
The aim of this research was to explore male client’s experience of being vulnerable in a psychotherapeutic setting. In seeking to gain an understanding of men’s experience of being vulnerable, the researcher hoped to add to the body of knowledge on the lived experience of being vulnerable in front of a psychotherapist. It is hoped by the researcher that the findings in this research can be used to inform policy and/or aid further research.

The objectives of the research in examining male vulnerability were:

- Explore how men define vulnerability.
- Gain an understanding of the male experience of vulnerability in psychotherapy.
- Understand how the experience of being vulnerable during the therapeutic process related to the client achieving their therapeutic goals.
- Add to the body of knowledge regarding the male experience of being vulnerable and how it relates to their mental health.
Literature
Gender and the gender role appears to have a direct relation to men’s help seeking behaviour (Mahalik and Burns, 2011, Steinfeldt et al., 2009 Levant et al., 2011). According to Mahalik and Burns (2011) this is partially to do with the different socialisation that men and women receive. Men are encouraged to take greater personal risks. In addition to greater risk taking, men’s gender role also promotes emotional stoicism, physical toughness, and autonomy, all of which goes against seeking help (Way et al., 2014).

According to Addis et al., (2010) masculinity is an ambiguous, fluid, social construct, that encourages being emotionally restrictive and rejecting anything that might be perceived as feminine or homosexual (Connell & Messerschmidt, 2005, Hyde et al., 2008, Proctor, 2008, Gillon 2008).

Graef et al., (2010) found that men who held beliefs about male emotional restrictiveness were far more likely to have negative attitudes to counselling. Vogel et al., (2011) found that men viewed counselling services in conflict with the traditional masculine role.

While men have a much higher suicide rate they are also disproportionately less likely than women to engage with mental-health services (Sweet, 2012, Stack, 2000, Addis and Mahalik, 2003). One reason for this disparity of suicide rates and help seeking in Irish men is that men fear disclosing and speaking about their distress (Cleary, 2012, O’Brien et al., 2005, Begly et al., 2004a).

It is well established that men cry less frequently and less intensely than women (Santiago-Menendez and Campbell, 2013, Goodey, 1997, Mathell et al., 2001, Cusack et al., 2006, Vingerhoets et al., 2000). Yet despite this, Vingerhoets et al. (2000) states that these gender differences are not found in babies.

Shame is frequently associated with vulnerability in the literature (Brown, 2006, Platt and Freyd, 2015, Gilson, 2013). Whereas Brown (2006) states that being vulnerable can help a person build a resilience to shame, Gilson (2013) argues that being vulnerable can actually lead to a person feeling shame.

From the review of the literature the main limitations observed were the lack of research on vulnerability in relation to both men and women. The lack of qualitative studies in the area and the binary nature of the research on gender.

Research Participants
The participants were all recruited from the student body of Turning Point Institute, from 2nd and 3rd year students. By limiting the selection criteria to 2nd and 3rd year students the researcher ensured the following inclusion criteria:

- Participants were over 18 years of age.
- Participants were in on-going psychotherapy.
- Participants had successfully completed 1 year of psychotherapy training.

Having completed the first year of training the participants had at least a minimum of 20 hours’ psychotherapy (a requirement to passing 1st year) and thus obtained a sufficient experience of being a client.
Research Design Methodology

Based on the literature and the aims of this research a qualitative study was proposed using semi-structured interviews with male psychotherapy students (Robson, 2002, Creswell, 2013, McLeod, 2013, Braun and Clarke, 2013, Willig and Stainton-Rogers, 2007).

A thematic analysis was used to analyse the collected data. Thematic Analysis is a method that comprises of identifying, examining and recording patterns in the collected research data. This method has been widely used and is well recognised in the field of psychology and psychotherapy research.

This study followed the stages of thematic analysis as outlined by Braun and Clarke (2006):

1. Familiarisation with the data;
2. Initial coding generation;
3. Searching for themes based on the initial coding;
4. Review of the themes;
5. Theme definition and labelling;

Steps 3, 4, 5 and 6 all become cyclical and iterative enabling the extraction of themes from the data.

Data Analysis Map

The steps outlined in analysing the research data are displayed in the fig below:

![Data Analysis Map](image)

Research Findings

The data analysis identified one overarching theme, four main themes and five sub-themes.
The overarching theme, the themes and the sub-themes from the data analysis are as follows:

<table>
<thead>
<tr>
<th>Overarching Theme</th>
<th>Themes</th>
<th>Sub-Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lock Down</td>
<td>Rejection Avoidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shame</td>
</tr>
<tr>
<td></td>
<td>Coping Mechanisms</td>
<td>Unable to Run</td>
</tr>
<tr>
<td></td>
<td>Struggle</td>
<td>Opening Up</td>
</tr>
<tr>
<td></td>
<td>Compassion &amp; Acceptance</td>
<td>Being Seen</td>
</tr>
</tbody>
</table>

**Figure. 2 Overarching theme, themes and sub themes**

The relationship between the overarching theme, themes and sub-themes are represented below.

**Figure. 3 Thematic Map**

**Theme 1: Lock Down**

The main finding from *Lock Down* and its sub-themes are that the participant’s defined vulnerability as a weakness related to gender. They linked shame to this feeling of weakness and not being good enough. In addition, they felt that if they did express their vulnerability that it would lead to them being rejected. Because of this, the participants locked down the parts of themselves that they felt were vulnerable.
It is interesting to note the individual codes that are linked to *Lock Down* and their number of citations as shown in the following figure.

![Graph showing citations for different codes related to lock down](image)

From the data analysis it shows that the main cause of lock down is related to gender. This aligns with research, as the codes *vulnerability is weak* and *expressing emotion* are associated with the male gender role (Connell and Messerschmidt, 2005, Hyde *et al.*, 2008).

**Theme 2: Coping Mechanisms**
The main finding from the theme *Coping Mechanisms* is the participants developed various ways of coping to enable them to lock down their vulnerability. While all the participants describe how they used coping mechanisms, the type of coping mechanisms appears to vary.

The following figure shows how many times each coping mechanisms were cited.

![Graph showing citations for different coping mechanisms](image)

**Theme 3: Struggle**
The main finding from *Struggle* and its sub-themes can be summarised as how the opposing forces within the participants, try to both keep their vulnerability hidden and allow it to be seen. It involves the reduced use of coping mechanisms and the eventual opening up.

The theme of *struggle* occurs most commonly in the findings. It appears almost twice as much as
the next highest theme, *lock down* and 40% of all code in the transcripts was associated with it. This is a reflection of how significant the theme of *struggle* is in describing the participant’s experience of being vulnerable and relates directly to the research aim to gain an understanding of the male experience of vulnerability in psychotherapy.

The following figure shows the most common codes in the theme *struggle* and how often they occurred in the data:

![Chart showing codes and their frequency in the struggle theme]

**Theme 4: Compassion and Acceptance**
The findings from the theme *Compassion and Acceptance* and its sub-theme *Being Seen* are that by allowing the experience of vulnerability, the participants in turn experienced an increase in self-compassion and self-acceptance. This theme has one sub-theme, *Being Seen* which appears to be an integral part of the experience, namely the therapeutic role. *Being Seen* is directly related to how the participants experience being vulnerable in relation to another person.

The following figure shows the most common codes in the theme *Compassion and Acceptance*.

![Chart showing codes and their frequency in the compassion and acceptance theme]

For the participants, being vulnerable was in conflict with their gender role scripts. Part of the process of being vulnerable was going against their gender role. By doing this, the analysis has shown that the participants felt more authentic and real. They experienced an increase in their ability to tolerate difficult emotions. In addition to this, their perception of vulnerability appears to have changed.
However wherein participants viewed vulnerability as a negative and a weakness, they now view it as a positive and a strength.

**Conclusion**

**How do men define vulnerability?**

How vulnerability is viewed by men, appears to be related to how much they adhere to their masculine gender role. Before starting therapy, the participants described how they rejected their vulnerability in order to maintain the appearance of being what Vandello *et al.* (2008) describes as real men. The participants managed to enforce the rejection of their vulnerability using the dual sticks of shame and fear of rejection.

The participants of this study described how they felt shame around being vulnerable and in addition how if they were vulnerable it would result in them being rejected.

Going against their socialised masculine gender role, the men in this study were being more true to themselves and resulted in a change to how they perceive their vulnerability. They no longer described it as a negative and a weakness and instead described it as a positive and a strength. It is interesting to note the fluidity in the relationship between men and their vulnerability. They went from associating vulnerability with shame and rejection to instead seeing their vulnerability as an authentic part of them that was a strength.

It is unclear how much of the participant’s transformation is a result of changes to their vulnerability, or to a reduction in their adherence to the masculine gender role. The findings from this research suggest that the change occurs within how men relate to their vulnerability and in turn how they by extension relate to themselves. At different stages the participants described vulnerability as a negative and as a positive. This implies that their vulnerability is actually neither negative nor positive, but instead just a feeling and depending on how men relate to it can result in a negative or positive experience.

**How do men experience vulnerability in psychotherapy?**

For the men in this study the experience of getting in touch with their vulnerability appears to be a very difficult task. Considering how their idea of themselves as men is closely linked with them not being vulnerable, it is safe to conclude that being vulnerable was a challenge to their identity as men.

The research shows how the participants developed coping mechanisms in order to manage their vulnerability. In addition to this the most popular coping mechanisms also appeared to reinforce their sense of being real men. For the participants this took the form of alcohol consumption, playing sport or working hard, all of which they felt resulted in a positive reflection of them as men.

This shows the complexity of working with men in psychotherapy around issues linked to their adherence to masculine norms. For the participants an important step in getting in contact with their vulnerability was to overcome these coping mechanisms. This resulted in an increase in anxiety for the participants.

Having trust and feeling safe in the therapeutic alliance appears to be an essential component for the participants. This enabled them to be vulnerable and to allow themselves to open up. The participants describe how being really seen and emotionally held by their therapist was key for them. Emotions and emotional expression appears to be integral to this part of the participant’s experience. As vulnerability is a feeling that comprises of emotions (Manstead *et al.*, 2004), it is understandable then that the experience of getting in touch with vulnerability would also involve getting in touch
with emotions. For a lot of the participants this involved crying. According to (Bowlby, 1988), crying is one of the most powerful manifestations of emotion, that is designed to communicate distress and elicit caregiving responses. For the participants, what was essential in their journey to being vulnerable, was not just being able to elicit caregiving responses but for their therapist to respond in an emotionally appropriate manner. This appears to not just validate the participant’s vulnerable experience but also enabled them to better accept and regulate their own vulnerability.

**How did being vulnerable relate to the client’s therapeutic goals?**

By being vulnerable the participants of this study reported a number of positive changes. The results show how the participants experienced an increase in their levels of self-compassion and self-acceptance.

When the participants described their experience of vulnerability before they came to therapy, one of the common experiences was feeling shame. After being in therapy for over a year, when the participants described their experience of vulnerability, shame was no longer prevalent in the findings. What was prevalent in the findings was an increase in the participant’s levels of self-compassion. This is in keeping with research by Reilly *et al.* (2014) who found that men with high levels of self-compassion had lower levels of shame.

In addition to this the participants also describe how their experience of therapy and vulnerability resulted in them feeling more authentic and real.

The research indicates that being able to accept their vulnerability, coincided with the participant’s ability to tolerate emotions. Especially emotions that they would have initially viewed as being in conflict with their gender role. The participants related how the process of expressing difficult emotions resulted in them being able to better manage those emotions.

**Add to the body of knowledge regarding male vulnerability**

The participants reported a greater ability to tolerate emotions they would have described as difficult. This would indicate that men’s ability to be vulnerable plays an important role in their help seeking behaviour.

For the participants getting to the point where they could experience their vulnerability was an extremely difficult process. Their relationship to their therapist was identified as being key for them in being able to fully experience their vulnerability.

In addition to this, by being vulnerable, the participants appeared to gain something that transcends what can be captured in research themes, codes and data, as illustrated in the quote below:

*“I had to stand up with the little boy as a grown man and embrace it all and finally give a face and a name to it... and I think... that definitely changed my life forever.”* (Interview: Tom).

**Limitations of this Study**

One of the main limitations of the study is in relation to the participant population. All the men are training to be psychotherapists in the same training institute. This makes it especially difficult to mitigate for the impact being educated in the same psychological stand point will have on how the participants relate to certain concepts like vulnerability.

In addition, the researcher was also trained in the same training institute. However there was no prior relationship with any of the participants. While their shared identity may have enabled the participants to speak more openly, the differences in progression (Researcher 4th year, Participants 2nd and 3rd years) may have created a power dynamic.
Another limitation of the study is that it was a point in time study. This point in time for the participants was anywhere from half way through second year to the end of third year. While the data produced in this study was very rich, it did only capture the participant’s views at one specific time during their journey.

Finally, due to the lack of similar research on male vulnerability and the relatively small sample size of this research, it is difficult to gauge to what degree the findings are idiosyncratic or robust.

Darren Reid is a qualified Humanistic and Integrative Psychotherapist, a graduate of Turning Point Training Institute and Dublin City University. He completed his Masters studying male vulnerability in psychotherapy. Darren has worked for the past several years in Mental Health with organisations such as University College Dublin (UCD), Newlands Institute for Counselling, Personal Counselling Centre Naas and the Samaritans. Darren currently operates a private practice in both Naas and Carlow. www.carlowpsychotherapy.ie

References:


But, as we are bone, so are we dream,  
as we are ash, so are we seed.  
I know a place  
where poets and painters trace the faces of God,  
and within a leaf, the other side of the moon.  
It is that space between skin and bone,  
I call “Life”.

~ Neil Frederick Sharpe

Introduction

The National Human Genome Research Institute states advances in genomic science “allow us to read nature’s complete genetic blueprint for building a human being” (NHGRI, 2013). However, Todres, Galvin and Holloway (2009) suggest that to fully understand what it means to be human one must uphold the uniqueness of the human being. They argue that scientific advances, while radically improving the health of the population, have neglected the place of subjectivity and the sense of Self, both of which are essential to a deeper understanding of health and well-being.

Individuals who have inherited a mutated gene are known as genetic carriers and these genetic mutations put individuals and their children at risk of disease (Capelli et al, 2009). New information on current or future health has profound implications for our internal experience as efforts are made to integrate a genetic diagnosis (McDaniel, 2005). Targum (1981) describes genetic disease as intrinsically human and emphasises the human suffering when faced with our own vulnerability.

Awareness of genetic risk triggers emotions that significantly impact on one’s quality of life (Esplen, Hunter and Kash, 2012). While a psychological approach to genetic counselling has evolved, research identifies significant challenges for counsellors and patients, raising questions of whether carriers are being met in their efforts to manage the emotional impact of their diagnosis (Biesecker, 1998; Capelli et al., 1999; Petersen, 1999).

Despite these considerations, there is a paucity of research from the field of psychotherapy into the experiences of carriers. This study addresses the disparity through an Interpretative Phenomenological Analysis (IPA) on narratives from semi-structured interviews with three women diagnosed as fragile X premutation carriers (FX carriers). Using an Object Relations framework to explore the themes emerging from the participants’ internalised experiences, the study illuminates how a genetic diagnosis might manifest in the psyche.

The study builds on research from health psychology, highlighting the psychosocial impact of a genetic diagnosis, and supports mounting evidence of the relevance of IPA for understanding illness:

…with a move away from a simple biomedical model of disease and illness, where an observable bodily process is held to map onto a predictable illness experience in a fairly simple way, there has come an increasing recognition of the constructed nature of illness. (Brocki and Wearden, 2006, p.88).
In 1991, researchers identified a genetic mutation, known as the Fragile X Mental Retardation 1 (FMR1) on the X chromosome (Verkerk et al. as cited in Abrams et al. 2012). The FMR1 gene had the propensity to fully mutate causing the neurodevelopmental disorder fragile X syndrome (FXS). Clinicians were initially concerned with the fully mutated FMR1 gene causing FXS as FX carriers were thought to be asymptomatic (www.fragilex.org). However, recent research implicates the FMR1 gene as the single-gene cause of a family of fragile X disorders (FXD) of which FX carriers are at increased risk of developing (Tassone, Hagerman and Hagerman, 2014).

The aim of the study is to offer a deeper understanding of the nature of genetic illness by exploring participants’ perceptions and interpretations of their FX carrier status. By investigating how participants manage the risks of their genetic inheritance, the study upholds the significance of the lived experience as relevant to generating new insights into genetic disease.

Literature Review

Due to the absence of qualitative studies on the implicit meaning of an FX carrier diagnosis, studies from health psychology and genetic medicine are explored alongside articles concerning psychotherapeutic interventions in Medical Genetics. Issues around genetic testing and genetic counselling are identified as significant to an understanding of individuals confronting genetic disease. To understand how a diagnosis of FX might manifest in the psyche, Object Relations literature is reviewed.

Studies investigating the psychosocial impact of FX genetic testing identified anxiety, depression, guilt, responsibility, and feelings of loss among the participants (Anido, Carlson, Taft and Sherman, 2005; McConkie-Rosell, Spiridigliozzi, Sullivan, Dawson and Lachiewicz, 2000). Medical research into FX carriers reports females, in particular, are at an increased risk of mood and psychiatric disorders such as anxiety, depression and difficulties in social functioning (Lachiewicz et al 2010; Tassone, Hagerman and Hagerman, 2014).

Uncertainty around genetic risk encourages inaccurate risk perception, heightening emotional distress (Lerman, Croyle, Tercyak and Hamann, 2002; Sharpe and Carter, 2006). Targum (1981) suggests parents’ experience of their child’s genetic diagnosis is traumatic wherein denial, and projection of anger onto spouses and medical staff, is the first attempt made to manage feelings of loss and hopelessness. He stresses the importance of successfully mourning the loss of the idealized child.

Sharpe and Carter (2006) argue the emotional responses triggered from the process of genetic testing “impairs the communication, understanding and retention of information” (p.53). Targum (1981) adds anxiety provoked by a genetic diagnosis inhibits the individual’s capacity to be psychological, impeding the goals of genetic counselling.

Capelli et al. (2009) report that some genetic counsellors feel inadequately trained regarding the psychological aspects of their role. Evans (2006) maintains it is possible for genetic counsellors, using non-directiveness, to recognise clients’ psychological complexities and to facilitate autonomous decision-making when confronting genetic risk. However, Petersen (1999) notes the concept of non-directiveness is debated among genetic counsellors, who argue that it is an ideal impossible to uphold given the value-laden medical information being presented.

Fragile X Syndrome (FXS) is considered to be the most common single-gene cause of inherited intellectual and developmental disability and autism (Hagerman, Rivera and Hagerman, 2008).

Fragile X Disorders (FXD) include a late-onset neurodegenerative disorder fragile X tremor ataxia syndrome (FXTAS), characterized by severe tremor, gait ataxia and cognitive decline; and a condition known as primary ovarian insufficiency (FXPOI) which leads to infertility and menopause before the age of 40 (Abrams et al. (2012).
Object Relations theory holds the ‘Self’ needing to feel connected and understood in a world that makes sense. The psyche is presented as a self-organising dynamic entity constructing itself, using defences, to create a sense of coherency when disruption is experienced. The Self relates to internal representations, known as internal objects, which are feelings towards or fantasies of early external relationships (Jacobs, 2010).

For Klein (1959), the development of the Self centres on the interplay of inner and outer worlds where projection and introjection operate in tandem as psychic defences. Klein’s (1946) two stages of development are the paranoid-schizoid position and the depressive position. The former is characterized by persecutory anxiety and splitting processes where the infant manages disruptions, such as separation, by splitting the experience into total goodness and total badness. In this way, a sense of Self begins where feelings of loss are mitigated. The latter depressive position is characterised by the infant’s ability to integrate good and bad in the same object where loss is recognised and grief replaces anger.

Fairbairn (1946) claims if the connection with the caregiver is broken, in the form of abandonment, the infant experiences a ‘primary trauma’. The relationship, on which the infant is wholly dependent, is preserved by relocating the traumatic experience inside and splitting it into a tolerable ideal-object, representing how we like others to be all of the time, and an intolerable bad-object consisting of the exciting-object representing the aspect of the Other we yearn for and the rejecting-object, representing the aspect that has abandoned us. Attached to the exciting-object is the aspect of the Self, representing intense neediness and attached to the rejecting-object is the aspect of the Self, contemptuous of this neediness. While the child continues to relate to the external object, creating a sense of security, the internal object-relating intensifies where guilt and shame operate within the child who has become ‘bad’ (Fairbairn, 1943).

Freud (1917) described the states of mourning and melancholia that arise in response to the experience of loss. Mourning is time-limited and its function is to detach the survivor’s hope and memories from the beloved lost-object. When healthy mourning is complete, the original lost-object has been abandoned in death and the libido has been displaced onto another object allowing energy to be reinvested in life and the ego to remain intact. By comparison, the melancholic experiences the same lack of interest in life, however there is an added lowering of self-regard. The insults and criticisms directed at the Self are meant for the lost-object who has been internalised. Here, the melancholic identifies entirely with the lost object.

Anxiety and depression are often pathologised wherein these symptoms are understood to have a definite organic aetiology and are classified as separate psychiatric illnesses. According to Leader (2008) they are appropriate human responses encompassing a deep sense of fear, and cannot be fully understood without the acknowledgement of unconscious processing of loss.

Genetic illness is often experienced as a trauma which affects the Self deeply. Previous studies highlight anxiety, depression, loss and guilt experienced by FX carriers. Despite this, there is a paucity of research in relation to the implicit meaning women have made of their FX carrier status. Research on the psychological support available to carriers suggests genetic counsellors struggle to contain the emotional impact of a diagnosis. Object Relations theory frames emotional difficulties experienced in adult life in light of early development of the Self, paying particular attention to the degree to which the psyche uses defences to manage the anxieties brought about by a traumatic experience.
Methodology
Todres, Galvin and Holloway (2009) argue valuable information elicited by qualitative studies be used to inform and expand the healthcare service which often reduces the body to biological processes, resulting in a loss of meaning for the patient. Thus, a qualitative approach using IPA was used to elicit nuanced analyses of individual narratives of three women: Catherine, Sarah and Laura. Although it was not specified in the inclusion criteria, each participant is a mother of a child diagnosed with FXS. This study used semi-structured interviews comprised of thirteen questions. The questions were framed broadly and openly so participants’ perceptions, previously unexpressed, were allowed a voice. Approval for the research proposal was granted by the Department of Psychotherapy, Ethics Committee at Dublin Business School in April 2014.

Findings
Three themes emerging from the interview transcripts offer a psychotherapeutic understanding of the experiences of female FX carriers and are examined below:

Suspended in The Unknown
Participants were unfamiliar with FXS during initial investigations into their childrens’ developmental delays. Shock and denial permeates each experience of what they describe as abrupt and unexpected diagnoses in their children. A further sense of uncertainty manifests throughout the participants’ interaction within the medical framework as they struggle to make sense of their new genetic information.

Participants’ interaction within the medical framework suggests the trauma of diagnosis was compounded by an experience of being left in a fearful state of unknowing. Laura describes the emotional impact of a lack of medical responsiveness and communicates a sense of helplessness, which left her in a state of fearful uncertainty. Similarly, Catherine believes lengthy waiting lists prolonged her anxiety. She describes the impact of numerous appointments as if on a journey without any sense of direction. Her portrayal of the clinical setting illustrates her deeply felt sense of isolation, as if frozen in trauma and suspended in space and time.

Fragile X: A Threatening Presence
The meaningless dynamic of the unknown created a sense of fear which facilitated a mental representation of FX as a Threatening Presence. FX was construed as a sinister presence, lurking in the background and capable of launching an unexpected attack on their families. FX, with its capacity to devastate, threatened survival and evoked feelings of loss in each participant.

The place occupied by FX in the participants’ inner world became more threatening than the medical threat posed by the unstable gene. Catherine confirms the medical risks of FXD are more manageable than her anxiety. She states that FX robbed her of the son she hoped for. However, her intense feelings motivated her to work for a FX charity. Painful feelings of loss are evoked for Sarah. Upon learning of her son’s diagnosis, she felt as though someone had died yet she knows her son is alive.

Primitive Defenses
Defenses against the anxiety arising from the turbulent diagnosis is seen in varying ways across the interviews. The strength of regression sees Catherine split her experience of others, and herself into good and bad. This is particularly evident as she projects her intolerable feelings onto a medical system she feels is entirely bad. Laura, on the other hand, continues to relate to a medical system she finds satisfactory, while introjecting the frustrations of that same system. Sarah’s denial is evident throughout.
Catherine defines herself as a split subject by making the distinction between the good dominant gene inherited from her Spanish father and the bad FX gene inherited from her Irish mother. She is intolerant of any vulnerability in herself or others which she views as ‘bad’. Her feelings of fear, anger and guilt encourage a reorganisation as if to take up combat against the medical system.

On the other hand, Laura describes the impact of her son’s diagnosis as not having affected her relationship with her husband. Likewise, with her father, from whom she inherited the gene, the status quo has remained and they rarely talk about FX. Although she had spoken of a fragmented medical system with its long delays and lack of information, she aims her frustration away from the system towards herself so she can manage day-to-day. Her self-reproach is evident as she feels she could have done more for her daughter.

Sarah’s defense had been to deny her son’s diagnosis in the hope it would go away. She struggles to understand her feelings of grief around her son’s diagnosis, all the time referring to it as the final nail in the coffin and at the same time denying any impact of her own diagnosis. Sarah deflects all questions around her diagnosis to her son’s diagnosis, presenting it as having a greater impact. However, two weeks after the interview had taken place, Sarah called the researcher to say from the moment she was diagnosed she no longer felt the presence of her father who had died when she was seven (from whom she inherited the FX gene) and to whom she had felt deeply connected through prayer. She expressed disbelief that he would allow FX to affect her and expressed shock when she could no longer feel his presence.

Discussion

Findings, which illuminate the participants’ journey from diagnosis, correlate with Targum’s (1981) research that a genetic diagnosis is experienced as traumatic. From an Object Relations perspective, the unresponsiveness of a caregiver (the medical system) is experienced as further trauma, instilling a level of fear profoundly affecting the psyche. Catherine’s and Laura’s accounts of lengthy waiting lists illustrate this sense of fear and anxiety and a defensive organisation is constructed. Catherine’s feelings of isolation and disconnect gives weight to the importance of the narrative in the illness experience, as reflected by Todres, Galvin and Holloway (2009):

*To be human is to be on a journey...we move through time meaningfully and do not exist in a vacuum; to be human is to be connected to a sense of continuity...the meaningfulness of a person’s journey can either be supported or lost* (p.72-73).

While the findings are consistent with medical research identifying anxiety in FX carriers (Lachiewicz et al 2010; Tassone, Hagerman and Hagerman, 2014), this study offers another paradigm by which the anxiety experienced by FX carriers may be understood.

The sense of threat evoked by the inner engagement with FX as a Threatening Presence stirred up unbearable anxiety within the participants and fits with Klein’s (1946) paranoid-schizoid position. Klein (1946) asserts that anxiety is central to our being and therefore the anxiety stirred from internal conflicts may be more frightening than the fear encountered from external perils.

Targum (1981) describes feelings of loss as common to parents’ experiences of their child’s diagnosis; this is consistent with the findings. Separation from the lost-object by way of mourning allows the individual to move on and to reinvest their energies in other activities (Freud, 1917), as is seen with Catherine’s attempts to integrate her loss through charity work. However, Sarah’s feelings of loss are implicitly, rather than explicitly, known to her. Her experience correlates to Freud’s (1917) state of melancholia wherein the person who grieves is unsure of who or what is being mourned. Significantly,
Sarah’s diagnosis evoked feelings of the earlier loss of her father. Upon receiving her diagnosis, her father (the lost-object) with whom she remained identified with in prayer (Freud, 1917), suddenly disappeared. The researcher proposes that, aged seven, she may not have successfully mourned her father and the internalised trauma of her loss allowed her to continue relating to an idealised spiritual father (Fairbairn, 1946). When he failed her by not protecting her against FX her repressed feelings were reawakened and his death was realised.

The findings identified across the interviews are consistent with Object Relations theory in that the trauma of a genetic diagnosis gave rise to the use of primitive defense mechanisms of denial, splitting, projection and introjection. Targum (1981) notes denial is most often used to defend against the intense anxieties which arise out of the feelings of loss. The use of denial is most evident in Sarah’s experience through the mechanism of repression where she denied the impact of her own diagnosis as it was connected to emotions previously disavowed. For Catherine and Laura, these mechanisms are evident in their management of the anxiety experienced within the intersubjective framework of the medical system.

According to Fairbairn (1943), “it is better to be a sinner in a world ruled by God than to live in a world ruled by the devil” (p.67). This is consistent with Laura’s introjection of the trauma which sees her relate to a ‘satisfactory’ medical system. The same may be said of her familial relationships in which nothing seems to have changed despite the disruption of the diagnosis.

The findings identify Catherine as projecting intense anxieties onto a system that is failing her. The gene is internalised as a threatening bad-object and as a fragile, vulnerable and Irish bad-object. Catherine’s inner life holds many powerful emotions and the study identifies feelings of guilt and persecutory anxiety as she questions if she is doing enough for her daughter. Catherine’s disdain of her own vulnerability and of others’ vulnerability is consistent with Fairbairn’s (1946) process of the internal split in the schizoid position where part of the ego attached to the rejecting-object fears vulnerability (as cited in Gomez, 1997).

The study highlighted a parallel process of projection within society. While describing a difficult consultation in a former ‘mental hospital’, a potent mix of medical and historical factors are observed wherein the institution holds the shame projected from a society fearing being less abled. Catherine expresses her anger when feeling shame suggesting her feelings not only arose from her own bad-objects but from shame disavowed by society (Sinason, 1992 as cited in Gomez, 1997) and experienced through ‘projective identification’ (Klein, 1946).

**Conclusion**

This study examines the implicit meaning that three women have made of their experience as FX carriers. Due to the dearth of literature from the field of psychotherapy, the researcher drew on literature from genetic medicine and health psychology. McDaniel (2005) describes the confrontation with genetic illness as a profoundly human encounter and the experience of a diagnosis in a child is experienced as traumatic for parents (Targum, 1981). Research identifies challenges in genetic counselling which raises fundamental questions of whether carriers are contained in their efforts to manage the anxieties arising out of this new genetic information (Capelli et al., 2009).

To develop a deeper understanding of the emotions experienced by those confronting genetic illness (Anido, Carlson, Taft and Sherman, 2005; McConkie-Rosell, Spiridigliozzi, Sullivan, Dawson and Lachiewicz, 2000; Tassone, Hagerman and Hagerman, 2014) literature from Object Relations theorists (Klein, 1946; Fairbairn, 1946 and Freud, 1917) are discussed in respect of the findings of the study and illustrate how a genetic diagnosis manifests in the adult psyche.
For all participants, their child’s diagnosis was experienced as traumatic. By exploring how they have managed and contained the impact of this trauma, the study highlighted a difficult journey within an unresponsive medical framework adding to their fear and anxiety. The study found the inner engagement with FX as a mental representation became more threatening than the external threat and feelings of loss identified in all interviews. The study suggests anxiety from a genetic diagnosis cannot be fully understood without the unconscious processing of the experience of loss. Lastly, in an effort to manage the anxieties arising out of their experiences, a regression to primitive defences is identified across the interviews.

The study recommends additional psychotherapeutic support in the clinical setting for those confronting genetic illness and further research using other psychotherapy frameworks to explore the experiences of genetic carriers.

Tania Kacperski graduated from The Queens University of Belfast with a B.A in German & Sociology. Tania completed an M.A in Psychotherapy at Dublin Business School in November 2015 and has worked as the administrator for the Irish Council for Psychotherapy since July 2014.

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Love Others As You Love Thyself: Psychotherapy, Mindfulness And The Spiritual Dimension – A Pathway Towards Integration
by Donna Curtin

Introduction
In recent years the teaching of meditation practices has adopted a secular form which does not necessitate adherence to religious and cultural beliefs Hart, (2004); Duerr (2004); Kabat-Zinn (1996); Santorelli (1999). As an existential psychotherapist and a mindfulness teacher, for me mindfulness practices have become a practical way to maintain, sustain, nurture and fine tune inner connectedness. The philosophy underpinning existential psychotherapy also aims at inner connectedness and rests in the belief that it is not possible to work exclusively in one sphere and neglect all other aspects of self. Existential philosophy recognizes the interdependence and connection of all parts within a greater whole. Van Deurzen-Smith (1998) reminds us that all human experience whether, physical, social, personal or spiritual is interrelated and that these four dimensions are all interlinked. This paper is grounded in a holistic world-view of ‘being-in-the-world’ physically, socially, privately and more particularly ‘spiritually’ and is anchored in Van Deurzen-Smith’s (1998) existential four world framework. Mindfulness is taught not as a technique but as a ‘way of being’, a way of experiencing what is present from moment to moment.

Kabat-Zinn, (1996) teaches us that mindfulness is cultivated daily, regardless of circumstances, and practiced for its own sake as a ‘path’ or a ‘way’, in the spirit of the consciousness disciplines. In this paper I will reflect on how the experience of partaking in the Mindfulness Based Stress Reduction Programme (MBSR) and becoming an MBSR Instructor influenced my personal, professional and spiritual life. From my experience, it is my belief that the cultivation of mindfulness through regular practice can provide a possible pathway for the modern day psychotherapist to holistically and inclusively integrate the spiritual dimension in their work.

Spirituality

Elkins et al (1988) coming from the humanistic phenomenological viewpoint define spirituality as:

“Spirituality which comes from the Latin spiritus, meaning ‘breath of life’ is a way of being and experiencing that comes through awareness of a transcendent dimension and that is characterized by certain identifiable values in regard to self, others, nature, life and whatever one considers to be the Ultimate.”

(Elkins et al. 1988, p.10)

This is not a creed but a way of experiencing, not something to ‘believe in’ but a way to live life. The transcendental dimension indicates that spirituality can include altered states of consciousness.

Celtic Spirituality

Spirituality is considered the ancestral heritage of Celtic civilisation, their world is always “latently and actively spiritual” O’Donohue, (1997, p.81). In Celtic civilisation there was no barrier between soul and body, each was natural to each other and spirituality was enjoyed as something lyrical and sensuous. There was no negative splitting of dualistic Christian morality that later did so much damage to these two lovely and enfolded presences. For the Celts the depth of spiritual presence was activated through language and experienced through the senses. “Language itself had power to cause events and to divine events yet to happen”, O’Donohue (1997, p.81). “Spirituality is the art of Transfiguration” O’Donohue (1997, p.83) not forced into any predetermined shape but as attention to the inner rhythm of our days and lives. This definition blends perfectly into the practice of mindfulness where “This attention brings a new awareness of our own human and divine presence”, O’Donohue (1997, p.83).

An awareness of something bigger than us, of feeling connected to everything. O’Donohue (1997)
reminds us that it is far more creative to work with the idea of mindfulness rather than with the idea of will, too often people try to change their lives by forcing it into shape by using the Will. In other words the mind thinks up the plan and then too often Will forces our lives into that shape. This way of approaching the sacredness of one’s own presence is externalist and violent and can bring you falsely outside yourself and disconnected from your authentic self, as O’Donohue (1997, p.83) observes: “You can perish in the famine of your own making” and advises “if you attend to yourself and work to come into your own presence, you will find exactly the right rhythm for your life.

He suggests the use of the senses as “generous pathways to bring you home” (O’Donohue, 1997, p.84).

By mindfully meditating on the senses it enables us to connect with and notice what is actually present. The great philosophers admit, that to a large degree, all knowledge comes through the senses and I too believe a transfiguration of your life can be achieved through attention to your senses. The senses can guide us towards the deep inner world of our hearts and practising attunement to the wisdom of the senses is a simple and informal way to embody mindfulness. I have become aware that, as I engage in a more mindful way of living, my use of mindfulness language has increased in my therapy space. All the principles of existential psychotherapy are present in my therapeutic practice but the mindful language which I now use is, I believe, much more accessible to my clients.

**Spiritual Development**

Meditative practices provide the opportunity to see into one’s own nature, where blind spots fall away and can inspire fresh insight and clarity as well as true joy and gratitude. In monastic settings and on retreat, the discovery and experience of awareness is facilitated by the peaceful environment. However, in my experience switching to the eastern model of spiritual development through meditative practices does not always endure through everyday personal life and can, at times, have relatively little impact. Traditionally in Asian cultures it was a viable option to live purely as the impersonal universal, where the religious context was provided and honoured and supported through spiritual retreat and placed no emphasis on the development of the individual.

As an Irish existential psychotherapist committed to mindful personal and professional development, a wife, a mother of teenagers, a daughter, a colleague and a friend I find it can be challenging to integrate and embody these practices into my everyday life world. Living an ‘other-worldly’ life with little personal contact with people may be possible for yogis and sadhus in Asia and for closed orders of monks and nuns in Christian western culture but for the ordinary citizen to integrate and embody these practices into their life of everyday earning a living, raising a family, engaging in relationships, paying a mortgage can be difficult. While many people feel the benefit of mindfulness practices and retreats, very often, within a short period of time, they are usually back in their old habits, patterns and limiting structures. Welwood (2000) warns that the hard truth is that spiritual realization is relatively easy compared to actualizing it. Welwood (2000) reminds us of the devastating consequences, we have seen in recent times in many spiritual communities where personal lives have been neglected in pursuit of impersonal spiritual realization. Neglecting this aspect of experience, he claims, leads to inner denial: “The divine is within each person. For too long we have believed the divine to be outside of us and that has created cynicism, emptiness and negativity”, O’Donohue, (1997, p.84:85).

Over time I have learned that regular practice and attending retreats annually is a loving and nourishing way to develop and cultivate presence. Much personal processing and awareness happens on retreat in a gentle safe holding environment. I find myself drawn more and more towards cultivating the embodiment of mindfulness practice itself. Bringing home from retreat, fresh insights and inspiration...
which weaves its way into my personal life and my therapy practice. Through practicing mindful living, I have discovered the trustworthiness of whatever arises in the present moment to guide me in the right direction. In a therapy session this translates into my guiding the client into moment to moment awareness of what’s happening in the mind-body, with trust, patience and often silence as we both witness whatever arises. There is a knowing and a confidence that the truth will reveal itself. My spiritual journey is consciously remembering to be mindful in my movements, actions and words. Learning to ‘walk the walk’, practicing as a ‘way-of-being’, contemplative living, a spiritual practice in and of itself.

Contemplative Living
Miller (1994) points out that contemplation involves the development of compassionate attention. In our world today our attention is scattered in a multitude of directions through technology, our lifestyles and the media. Krishnamurti (1969) referred to the experience of contemplation when he said:

> When you look totally you will give your whole attention, your whole being, everything of yourself, your eyes, your ears, your nerves. You will attend with complete self-abandonment. Miller (1994, p.31).

In fragmented consciousness we are pushed and pulled by the outside world; from contemplative awareness we see things as they are in the here and now when we experience a sacred moment, we don’t need anything else, everything is seen as sacred, as holy. It is the “I-thou” that Buber (1923) refers to in being in relationship with self and with another human being. The experience is satisfying in and of itself; we become totally attuned to what is happening in the moment. Contemplation in Merton’s (2003) view is reconnecting with the fundamental unity of life, which he identifies as the Source. This Source is the unity that underlies all life and also known as God in Christianity, Allah in Islam, the Tao, in Taoism, the Brahman in Hinduism, the realm of the invisible for Plato the collective unconscious for Jung and the implicate order for Bohm.

Mindfulness Practice Research
Recently there has been a great deal of research into the connection between consciousness and the brain. Searle (1993) claims that both the physical and non-physical processes are involved in complete consciousness. For phenomenologists, body and mind are seen as different aspects of the same experience – the experience of one always implying the experience of the other.

According to a study by Davidson and Lutz (2008) regions of the brain involved with empathetic responses are impacted through the practice of meditation. There is a growing body of research indicating that regular meditation can have a dramatic effect on brain function. Shapiro, Brown & Astin (2008), claim that the practice of meditation fosters psychological wellbeing and supports important affective and interpersonal capacities. Nataraja (2008) refers to a study in 2004 when a Mindfulness Based Stress Reduction Programme, run over an eight week period, showed significant improvement in participants emotional and social functioning as well as their health and vitality. While mindfulness comes from the Buddhist tradition, the Mindfulness Based Stress Reduction Programme is taught in a secular way to include people of all traditions. Generally speaking, meditation can elicit profound benefits in terms of physical, psychological, emotional and spiritual wellbeing. Shapiro, Brown & Astin (2008) assert that while the techniques of different types of meditation may differ, they all focus on training attention and awareness so that people become more finely attuned to events and experiences in the present moment and cultivating a meditation practice becomes a way of life.
Shapiro, Carlson, Astin & Freedman (2006) established that mindfulness meditation involves three core elements; intention, attention and attitude. Intention involves consciously and purposefully noticing the present moment and when attention has become distracted regulating attention back to the focus of the mindfulness meditation. Attention, often described as observation of the ‘bare facts’ (Brown, Ryan & Creswell, 2007), is then placed on a particular object i.e. the body, the breath etc. Attitude, the third core element; is an open, non-judgement and accepting frame of mind brought to the meditative practice, where we learn to be present to whatever arises in our field of awareness in a nonreactive way. This process provides an opportunity to notice phenomena as they arise and then we can choose if and how to respond rather than to engage with old and often destructive habitual patterns of reacting. For the mindful psychotherapist this practice is characterized by patience and trusting the right action will become apparent. Therapy requires good timing.


Conceptual Framework

The existential-phenomenological approach to human experience does not separate mind and body. Cohn (1997) claims the separation of mind from body is an intellectual speculation rather than a true reflection of human experience. Boss (1979) reminds us that man’s somatic aspect is actually inseparable from his being-in-the-world and stresses the embodiment of all perception and interaction, “It is through my body that I understand people, as it is through my body that I perceive ‘things’” Merleau-Ponty (1962, p.186). Husser (1960) points out the incompleteness of Descartes famous statement ‘I think therefore I am’ (Husser, 1960), cited in Cohn (1997, p.10). Heidegger (1962) expresses this mutual involvement of mind and world as ‘Being-in-the-world’ which is also ‘Being-in-the-body’. Historically, emotions have been dismissed and viewed with suspicion and contempt and treated as ‘other’ and separate from us (Cohn, 1997). From Plato onwards these ‘passions’ have been viewed as man’s lower nature, a classic form of Western dualistic thinking, where the emotions are seen as alien and primitive. Welwood (2000) suggests that in the act of treating emotions as ‘other’ we grant them power over us and goes on to claim that acting (emotions) out or indeed suppressing emotions can cause even further suffering. By not allowing emotions to be experienced just as they are, we reinforce the alienation of our experience of emotions further.

The Existential Four World Framework

Existential psychotherapy like mindfulness encourages present moment awareness, the process of ‘staying with’ emotions and sensations without getting lost in analysis and attachments, but encouraging the sensing of the full experience for what it is. In eastern traditions it is considered essential to have a firm foundation in meditation practice where the confusion of the emotions may become transformed into seeing things as they are.

The traditional threefold existential dimensions used by existential psychotherapists for exploring existence are commonly known as Umwelt, Mitwelt and Eigenwelt; Binswanger (1946), Boss (1963). The Umwelt describes the instinctual behaviour of the person in the natural world with its physical and biological dimension ‘being-in-the-body’. The Mitwelt describes the public world with its social dimension of human relationships where the person is likely to behave in a learnt cultured manner ‘being-in-relationship’. The Eigenwelt describes the private world, where a person is likely to have a sense of identity and ownership. It is the psychological dimension of intimate and personal
experience; ‘Being-with-my inner self’ (different authors have translated these terms with differences in understanding and underlying concepts). Van Deurzen-Smith (1998) has expanded these three dimensions (physical, social and personal) to include a fourth dimension, a spiritual dimension which she denotes as Uberwelt. This fourth aspect describes the spiritual dimension of beliefs and aspirations or ideal world where the person is likely to refer to values beyond herself. Frankl (1964) shares his wisdom when he says a whole new meaning to life with a sense of purpose, vitality and passion can be instilled when we rise to the challenges of our own ideals. The interdependence of the four basic dimensions of human existence from existential philosophy frame this paper in the exploration of mindfulness as a pathway towards integration.

**Integrating The Four Worlds With Mindfulness Practice**

The existential approach advocates returning to the practice of letting one’s ideals shape one’s life and not being motivated by the socially created ones. Van Deurzen-Smith (1998) advocates an encouragement of expansion into new territory rather than labelling characteristics and qualities which can be restricting and limiting. Existential therapists explore the implicit ideological (or spiritual) outlook of the client in a gentle attempt to urge the client to uncover and see their own true values. Here we are presented with the opportunity to discover and reevaluate old ideals which may have been buried and hidden from the way we have adapted to public world values. Many clients experience great relief when they discover their own true values (spirituality) and how they have lost touch with them. Often a new sense of independence and confidence is rediscovered in their ability to become the directors of their own lives. Can mindfulness practice facilitate the process that existential psychotherapists refer to, namely can we integrate all four worlds, especially the spiritual world through practicing mindfulness meditation?

**Conclusion**

Both mindfulness practice and existential psychotherapy encourage us to open ourselves to the experience of reality to ‘what is’, and in the process, to let go of our assumptions which separate us from ‘what is’. Meditation practice strengthens and nourishes the ability to pay attention, to stay fully present and to trust the therapy process as it unfolds.

I have discovered that by anchoring my work in Van Deursen’s four world framework and incorporating mindfulness practices using the language of mindfulness in my therapeutic practice, I can integrate the spiritual dimension of experience in therapy. I facilitate the client to focus on and become aware of the senses. In this way whenever the client struggles with staying connected, gentle mindful interventions are offered to support the client to reconnect with the thread of experience that leads them into deeper levels of awareness.

As an existential psychotherapist and a mindfulness instructor for many years I now ask the following questions: How mindful are psychotherapists in their psychotherapy practice? Do they remain open to the spiritual dimension in their practice? Can they foster presence, by staying with inner experience and facilitate the client to do the same? Do they actively cultivate, develop and nurture presence?

Today, during my experiential workshop I am inviting psychotherapists to experience a guided mindfulness meditation, anchored in the four worlds and focusing on the senses. I invite them to observe and experience life as it is unfolding, trusting their divine presence (spiritual dimension) to take them where they need to go. I invite my colleagues to approach the practice with an attitude of openness, acceptance and in a nonjudgmental compassionate way. I offer the opportunity to be nourished and informed by life itself, to trust the experience of simply being present to whatever arises.
Donna Curtin MIAHIP is a humanistic & integrative psychotherapist based in Limerick, Ireland. She is also an MBSR Instructor and runs mindfulness programmes and workshops with Mindfulness Journey. A member of the first cohort of Master’s Degree students of Humanistic & Integrative Psychotherapy at University of Limerick in 1999 under the directorship of Gerry Meyers, Maggie Tierney and Tom Geary. Donna trained with Dr. Jon Kabat-Zinn of the Center for Mindfulness, UMASS and is currently a PhD student researching Psychotherapy & Mindfulness. Email: mindfulnessjourney@gmail.com; website: www.mindfulnessjourney.ie

References:
An Exploration of the Place of Psychotherapy in the Treatment of Schizophrenia in Ireland
by Nicola Harrison

The purpose of this research is to explore the place if any, of psychotherapy in the treatment of schizophrenia within the mental health services. Firstly, this study aims to understand the participant’s perspective of their role in the assessment and process of treating schizophrenia. This study will attempt to explore the professional’s opinion of psychotherapy as a form of treatment of schizophrenia. The health professional’s understanding of the experience of schizophrenia from their patient’s perspective will be examined. Finally, this study endeavours to understand the reasons behind the advancement or lack of advancement in the use of psychotherapy in the process of treating a diagnosis of schizophrenia.

The main sources of experience and opinion will be gathered from five psychiatrists actively working within the mental health services. The aims of this study require a research strategy within the qualitative paradigm. Semi-structured interviews will be used to carry out data collection, followed by the use of thematic analysis to analyse the data.

The findings will provide an insight into this area of research from an Irish context. This research endeavours to gain greater insight into the reasons behind the mental health services’ hesitation to fully embrace psychotherapy as a form of treatment in the patient’s recovery. It is hoped that the psychiatrists’ perspectives will provide in-depth insight into the process of treatment thus far and the future that psychotherapy may have in the process of recovery.

Nicola Harrison is a trainee Integrative Psychotherapist and is currently completing an M.A. in Psychotherapy. She also holds a M.A. in Addiction studies. She practices in a centre in Kildare.
“All changed, changed utterly: A terrible beauty is born”.
An Exploration on the Effects of Suicidality on Experienced Irish Clinicians
by Heather Moore¹

Abstract
Background: Emerging research coming from the person-centred and psychodynamic traditions in the past 15 years have examined the traumatic dimension of suicidal behaviour on clinicians. However, there is limited empirical literature on the impact of suicidality on Irish psychotherapists. In Ireland, it is estimated that 500 citizens die by suicide each year, while approximately 11,000 accident and emergency admissions are the consequence of suicide attempts.

Aim: This elicits the question, how does suicide prevention impact Irish mental health professionals who work solely with these vulnerable populations?

Method: In this article, the process of interpretative phenomenological analysis (IPA) was applied to the narratives of seven experienced therapists.

Findings: The Irish Poet W.B. Yeats coined the famous refrain ‘All changed, changed utterly, a terrible beauty is born’ in his poem ‘Easter 1916’ (as cited in Martin, 1989, p.176-177). This quote aptly encapsulates the reality of seven experienced Irish psychotherapists who work exclusively in the field of suicide prevention. Three salient superordinate themes emerged: 1) Overworking; 2) All changed, changed utterly/identity disruption; 3) A terrible beauty is born/A spiritual practice.

Discussion: Clinicians were ‘changed, changed utterly’ with identity disruption evident in their self, bodies, intimate relationships and professional identity. ‘A terrible beauty was born’ was demonstrated in the overarching theme of the restorative nature of client engagement in the life of the therapist. This was particularly evident in humanistic practitioners, who where acutely aware of their own sublimation of melancholia.

Conclusion: Most striking across all seven transcripts was the mix of the corrosive nature of suicide prevention on the self of the therapist, combined with unparalleled opportunities for personal growth and spiritual reformulation.

Key words: Suicide, vicarious trauma, resilience, burnout, melancholia

Introduction
To face death is a terrifying feat for humanity. Despite contemporary British research examining the traumatic impact of suicidal behaviour on clinicians, Dr Ella Arensman (personal communication, 2015), director of the National Suicide Research Foundation of Ireland, reports that there is scant attention on the effects of suicidality on Irish psychotherapists (Moore & Donohue, 2016). Arguably, the risk of suicidal behaviour is common across many Irish clinical situations and could potentially be regarded as ‘an occupational hazard’² (Foley & Kelly, 2007). This paper aims to examine in-depth how accredited ³ ⁴ psychotherapists in Ireland, who predominantly treat suicidal clients, are affected.

¹Corresponding Author: heddymoore@gmail.com
²The decriminalisation of suicide in Ireland in 1993, followed by the establishment of the Irish National Task Force on Suicide in 1995, has resulted in the proliferation of preventative programs.
³Irish Association for Counselling and Psychotherapy
⁴Irish Association of Humanistic Integrative Psychotherapists
Literature Review

Vicarious Trauma

Over the past 20 years, the psychotherapeutic community are in agreement that working with suicidal clients can have detrimental effects on the clinician (Pearlman & Saakvitne, 1995; Reeves, 2010). Many high-risk clients present with histories of attachment traumata, sexual abuse, self-injurious behaviours and psychological sequelae as evidenced in borderline processes (Paris, 2007). These intense interpersonal transactions can result in dire professional and personal consequences causing disruption to the therapists’ sense of self, sense of other, and worldview (Trippany, White Kress & Wilcoxon, 2004). Contemporary suicidologists stress that irrespective of maturity, or orientation, there is an emotional and somatic toll, highlighting how clinicians can be hampered with doubts personally and professionally for years to come (Moerman, 2012). The Irish researcher Egan (2006) stipulates that clinicians who work with clients employing immature defenses may be more prone to clients ‘getting under their skin’, where it becomes difficult to discern mine from thine (Vaillant, 1992, p.59). Widely represented in psychoanalytic literature is the containing property of the mother’s skin, which facilitates an internalisation of soothing experiences for her infant (Bick, 1986; Turp, 2007).

Historically, Pearlman and Saakvitne (1995) posited that these particular countertransferral responses set the stage for vicarious trauma (VT), like a contagious disease the process of therapy can infect the other with shame, guilt, impotency and helplessness. Correspondingly, Freudenberger (1980) declared unrealistic expectations of the self as critical in contributing to burnout. When therapists do not understand that some clinical dilemmas are unsolvable, they may doubt their meaningful contribution. This can lead to a more dehumanised approach that serves to protect against emotional attachments with clients (Menzies-Lyth, 1988).

Vicarious Resilience

Clinical explorations into vicarious trauma have uncovered an inverse phenomenon defined as vicarious resilience (VR). Hernández and colleagues (2010) concede that vicarious trauma and vicarious resilience though initiated by trauma are natural phenomena, with one counterbalancing the other. The developing literature on VR espouses that witnessing the vanquishing of tragedy in the client, permanently alters the practitioner’s inner world in terms of worldview, beliefs, and spirituality due to the empathic link. Fundamentally, working in this psychotherapeutic domain has the power to wound and to heal.

Methodology

Reflexive statement

At the time of this inquiry I was a psychotherapeutic student in a clinic that offered short-term therapy (15 sessions) to suicide-vulnerable clients. I marvelled at my experienced colleagues working 16-20 hours in suicide prevention. I wholeheartedly believe in the containing properties of supervision and I wondered how therapists coped with the time-limited sessions when dealing with the complexity of suicidality.

The sample

The final sample was purposive consisting of seven female accredited therapists working in an agency devoted to suicide prevention (Smith, Flowers & Larkin, 2009). Three were person-centred, three trained as humanistic practitioners, and one respondent originated from a rational emotive orientation (Table 1). Despite having analytic roots, burnout is rarely studied from this viewpoint. The Lacanian theorists, Vanheule and Verhaeghe (2005) elucidate that there is a strong link between burnout, professional identity and intersubjective experiences.

There were no master therapists (10 years or more) in the sample.
Table 1

<table>
<thead>
<tr>
<th>Code</th>
<th>Age range</th>
<th>Years in Centre</th>
<th>Years as therapist</th>
<th>Years Accred.</th>
<th>Accred. Body</th>
<th>Hrs. per Wk</th>
<th>Orientation</th>
<th>Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>40-55</td>
<td>6 yrs</td>
<td>8 yrs</td>
<td>3 yrs</td>
<td>IAHIP</td>
<td>16 clients &amp; 4 assess</td>
<td>Humanistic Integrative</td>
<td>Dip.</td>
</tr>
<tr>
<td>PB</td>
<td>40-55</td>
<td>4 yrs</td>
<td>7 yrs</td>
<td>3 yrs</td>
<td>IACP</td>
<td>16 clients &amp; 4 assess</td>
<td>REBT</td>
<td>Dip.</td>
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<td>PC</td>
<td>40-55</td>
<td>5 yrs</td>
<td>5 yrs</td>
<td>1.5 yrs</td>
<td>IACP</td>
<td>16 clients &amp; 4 assess</td>
<td>Person Centred</td>
<td>Degree</td>
</tr>
<tr>
<td>PD</td>
<td>40-55</td>
<td>4 yrs</td>
<td>5.5 yrs</td>
<td>2.5 yrs</td>
<td>ACPC</td>
<td>12 clients</td>
<td>Person Centred</td>
<td>Degree</td>
</tr>
<tr>
<td>PE</td>
<td>40-55</td>
<td>5 yrs</td>
<td>8 yrs</td>
<td>3 yrs</td>
<td>IACP</td>
<td>8 clients</td>
<td>Person Centred</td>
<td>Degree</td>
</tr>
<tr>
<td>PF</td>
<td>40-55</td>
<td>5 yrs</td>
<td>8 yrs</td>
<td>3 yrs</td>
<td>IACP &amp; PSI</td>
<td>15 clients</td>
<td>Humanistic Integrative</td>
<td>Degree &amp; Msc</td>
</tr>
<tr>
<td>PG</td>
<td>40-55</td>
<td>6 yrs</td>
<td>7 yrs</td>
<td>4 yrs</td>
<td>IAHIP</td>
<td>12 clients 13 supervision</td>
<td>Humanistic Integrative</td>
<td>Degree</td>
</tr>
</tbody>
</table>

Data collection methods
The primary research method was the narrative approach and data was collected through in-depth, open-ended interviews lasting approximately 45 minutes. Tape-recorded interviews provided conversations in their actual original form and yielded valuable transcripts later for analysis.

Interpretive Phenomenological Analysis
In investigating other forms of data analysis, Interpretive Phenomenological Analysis (IPA) was chosen as its philosophy and methodology correlated well to the line of this inquiry. This empathic exploration of issues is fundamental to the ethical rigour needed concerning therapist’s treatment of suicidal clientele (Smith & Osborn, 2003). IPA involves a ‘double hermeneutic’ (Smith, 2004, p.53) analysis in which the researcher tries to interpret the participant’s ‘sense-making’ practice (ibid.). This implies that IPA is firmly embedded in the participant’s dialogue, with direct quotes and metaphors used liberally to substantiate findings and inform master themes (ibid).

Data analysis
Thereafter, each interview was analysed using the IPA steps delineated by Smith and Osborn (2003). A painstaking case-by-case analysis of each transcript occurred, with manual transcribing and coding being employed to develop an intimate acquaintance with the data (ibid.).7 When identifying master

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7Interview A was printed out, and blank pages were attached to each page. No restrictions were placed as observations, annotations, associations and the participant’s descriptive words were written on adjoined pages. Subsequently, refined observations from Interview A were copied onto a separate page. The same procedure was employed for Interview B and so on.
themes, the researcher attempted to ‘imagine a magnet with some of the themes pulling others in and helping to make sense of them’ (Smith & Eatough, 2006, p. 335). Importantly, superordinate themes were not only selected on prevalence, but on the depth of passages, which richly-illustrated the themes (Smith et al. 2009).

Findings
Three superordinate themes, each containing three subordinate themes were identified: Overworking; all changed, changed utterly/identity disruption; and A terrible beauty is born/a spiritual practice – see Table 2.

<table>
<thead>
<tr>
<th>SUPERORDINATE THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overworking</td>
</tr>
<tr>
<td>2. All Changed,</td>
</tr>
<tr>
<td>Changed Utterly/</td>
</tr>
<tr>
<td>Identity Disruption</td>
</tr>
<tr>
<td>3. A Terrible Beauty</td>
</tr>
<tr>
<td>is Born/</td>
</tr>
<tr>
<td>A Spiritual Practice</td>
</tr>
</tbody>
</table>

- i) Working under a death threat 110%
- ii) Under my skin
- iii) Holding the Therapist Hostage

- i) Disruption to the Self
- ii) Disruption to Other-Intimacy
- iii) Disruption to Professional Identity

- i) The Agapean Mission
- ii) Community of Believers
- iii) Regeneration

*Overworking*
All therapists described being ‘overworked’ by providing extra therapeutic sessions, between-session phone calls and were consumed by the client after hours. Therefore, additional ‘therapeutic accommodations’ (Goldblatt, 2008, p.98) are demanded of therapists working with this unique client population. Cathy encapsulates the feelings of many when she articulated:

> Sometimes, sitting in that despair can be really, really difficult...I just say to them, drop the coffin.

Encouraging the client to ‘drop the coffin’, the transitional object of self-death, engulfs the clinician with anxiety as considerable energy is expended in enticing the client to ‘stay in this universe’.

The researcher noted that all practitioners described how they symbolically separated work from home by showering, as a means to metaphorically disinfect themselves from interactions. Like an infectious disease, individuals often transmit their contagion to the therapist who brings the client home (Vaillant, 1992). Their ‘overworking’ highlighted the complexity of the cases, as well as the ambivalence inherent to the suicidal threat (Paris, 2007). The researcher interpreted the client’s ability to get under the therapist’s skin, as explaining this phenomenon.
All changed, changed utterly/identity disruption

Given the life and death nature of this work, a notable theme was the transformation of the therapist’s inner landscape. The trauma of suicide can be heard to impact the clinician on three levels: Disruptions to the self, other-intimacy, and professional identity.

Disruption to the self

Denise reflects how it is impossible to engage in these therapies and remain unchanged:

*My worldview has changed profoundly. I certainly don’t view the world as positively as I would have before...because I realise that actually a lot of people have very, very difficult lives, and that might sound really bad...but...I’m not sure I think the world is such a great place...it’s not a safe place.*

Sandra’s excerpt stood out as she honestly describes the ramifications of being a helpless witness (Weingarten, 2003) to countless disturbing narratives:

*So now I just say you don’t need all the details, whether it’s sexual abuse or rape or taking your own life so that helps me to manage that bit better. In the beginning, I had people telling me graphic details about sexual abuse...and I would have to try and blank that stuff out.*

This striking extract is reminiscent of how dissociation in the therapist, results in diminished attunement, which can re-traumatise clients (Herman, 1992). Burnout characterised by depersonalisation (Vanheule & Verhaeghe, 2005) is explicit in Helen’s quote:

*You hear this negative story and that story and there is a part of me now that is cutting off actually that stuff...I get compassion fatigue and I don’t want to know about starving children in Africa...I just cut it out of my life, and it’s my way of coping.*

Helen uses the signifier *cut* in order to cope, which is fascinating as her work involves self-harming clients. Again Helen relates how a completed suicide combined with a personal loss impacted her ominously at a somatic level:

*A couple of months later I was diagnosed with a very under-active thyroid gland. I was extremely tired and they didn’t know what was wrong with me...and I had to actually resign from my full-time job...I put a lot of energy into my work...I think that 20 hours of suicide a week is too much.*

The researcher was aware that the diagnosis of an under-active thyroid gland is located in the neck region and her client suicided by hanging.

Disruption to Other-intimacy

An overarching theme was how vicarious trauma travelled beyond the therapeutic space into the personal arena. Participants revealed a disruptive sense of safety that translated into hyper-vigilance around their children (Egan, 2006). Martina expands how her intimate bonds suffer emotional depletion:

*I feel like I have given 110% to my clients...and I really have to struggle to have something left for home and I’m very conscious of that...I might have just enough left for my kids...but by the time it gets to my husband like...O God! ...I have nothing left to give you [Laughs].*
Denise dramatically emphasises her decision to not have children:

_Since working with suicidality... I don't really want to be a parent, because I work with so many kids...dealing with the ins and outs of parents and...I don't know if I want to bring a child up in this world...that might seem mad, but I guess it has profoundly impacted me._

Essentially, the client’s suicidality is communicated here, where the death instinct can destroy the extension of the therapist-self in deciding not to bring forth life (Bion, 1959).

**Disruption to professional identity**

Four out of the seven respondents had lost a client to suicide. A resounding theme was the fracturing of the professional ego ideal and fear of letting down the organisation. Tara gravely discusses how her naïveté was usurped, subjecting the professional self to recrimination and doubt:

_You go in thinking that it's never going to happen to you and when it does happen...you feel you have let everyone down...you question the work, you question do you want to be in this type of work? Am I suitable for this work? And it opens up the vulnerable side that's there in the work as well._

Helen expresses how this impairment to her professional ability resulted in a lack of desire to counsel high-risk individuals. However, the image of a wounded warrior who goes back into battle came to mind:

_It made me wonder, ‘Am I able to continue in this kind of work? Can I do this?’ And you know what, it actually made me stronger...and made me think, ‘Hang this...it just makes me want to go in there and fight back...’_

The researcher noted her ‘Freudian slip’ (italicised above) might belie hidden anger concerning the client’s death by asphyxiation.

**A terrible beauty is born/A spiritual practice**

The most striking phenomenological characteristic was that despite suicidal prevention being a harrowing experience, interviewees describe their job as a ‘blessing’, a ‘gift’ and a ‘privilege’. Unquestionably, in the Irish post-Christian context, therapy has replaced the void that religion once filled (Weatherill, 2004). Denise’s quotation encapsulates the _agapean_ principle and a positive addictive metaphor is used to exemplify this idea:

_In the organisation it’s almost like you get a love transfusion...you get it straight into your veins and you bring it over and put it into theirs [clients] and you keep sending it to them. I think that’s the biggest change that can happen. They actually start to kind of...love themselves a bit..._

Nonetheless, there was a strong ethos conveyed by all participants that they could only do this work because they operate as a strong, specialised community (Anderson, 2013). All transcripts emanated a sense of fulfilment in the practitioners’ developmental journey:

_I made a suicidal attempt in my past...I often say this to clients...the gift that comes from a suicide attempt is that we can really get life; we can really begin living._

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8(From the Greek word ‘agape’ meaning God’s unconditional love)
Furthermore, Tara recognises that bearing witness to her client’s growth has elicited healing in relation to the self:

*I think it has made me...like me a little bit more...and to recognise that...I am not perfect ok...nor will I be perfect, but that there is goodness in me, and I know that would be wasted if I didn’t share it. And it’s a privilege to do that. It came out of painful things...and that’s one thing I can share with my clients.*

**Discussion**

Increased interest and over-absorption with clients were consistent phenomena throughout the transcripts, which corresponds with analytic investigations (Birtchnell, 1983; Briggs *et al*., 2012; Goldblatt, 2008). The confines of time-limited therapy intensified stress in all participants; these findings explicitly state how a robust continuity of care is required with suicidal clients.

Accordingly, five participants described the need for purification of their bodies. Therefore, attending to the countertransference responses and what is being held in the skin is vital in order to comprehend the impact of the suicidal condition (Turp, 2007). Additionally, Meltzer’s (1994) concept of adhesive identification explains how clients superficially stick to the therapist’s skin surface as a defense against separation.

It is well documented that the psychotherapeutic engagement with traumatised clients can shatter the clinician’s interpretation of reality (Trippany *et al*., 2004; Reeves, 2010) and the same findings were found in this study. Therapists were altered in relationship to the self, to others, as well as in their professional capacity (Moerman, 2012). Persistent exposure to suicidal narratives wrought a sense of affective numbing, protecting the therapist from active client involvement (Menzies-Lyth, 1988).

Suicide attacks the body of the client, and four participants expressed how suicide prevention impacted their body-self, in the form of terrifying dreams and somatic sensations. Unmetabolised loss around the death of a client to hanging resulted in an under-active thyroid gland that left Helen without vitality. These findings add to contemporary clinical research that countertransference can be expressed through the arousal of spontaneous somatic sensations (Egan, Booth & Trimble, 2010).

Psychotherapy is a dialectical process requiring, in a Winnicottian (1971) sense, the mirroring of the client. Participants in this study maintained a sense of self by withdrawing from family and friends; hence interpersonal bankruptcy ensued (Vanheule & Verhaeghe, 2005). Moreover, VT was detected in a form of over-protectiveness around one’s children (Egan, 2006). Although examples were not discovered in the professional literature, it could be interpreted that the participant who decided not to have children, was in some way succumbing to the death instinct, (Bion, 1959). In reviewing the participants’ reactions to client self-murder, a salient finding was the splintering of the professional ego ideal, which is consistent with psychodynamic case studies (Anderson, 2013; Rycroft, 2005).

A compelling discovery was the manner in which participants conceptualised their clinical practice as a spiritual endeavour, and this was clearly demonstrated in therapists from the humanistic tradition. Respondents who openly expressed their own melancholia as being a conscious motivation for entering this work conveyed a deep appreciation for what Wosket (1999) called their ‘internal client’ (p.48). Wosket (1999) describes the ‘internal client’ as part of the therapist that continues to develop and receive healing as a result of deep engagement with clients. A conspicuous element was the participants’ zeal for their work and how religious terminology was used to describe their ‘vocation’ (Cathy) in high-risk psychotherapy. It is noteworthy that humanistic writers have long addressed these spiritual qualities of communion, presence and the sacred as intrinsic to the therapeutic relationship.
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A resounding finding was the extent to which organisational factors played in the well-being of the present sample (Voss Horrell et al., 2011). Contrasting with the current literature on the support of supervision as a protective dynamic in combating VT (Egan, 2006), this sample categorically emphasised the containment from each other (Anderson, 2013).

The phenomenological characteristic concerning the regeneration of the self was attested by all participants and is widely reflected in thanatology studies (Mayan, Morse & Eldershaw, 2006). Humanistically trained participants transcended personal tragedies and their work with suicidal clients, into a state of spiritual awakening. Knafo (2004) asserts that the humanistic approach to trauma has always involved an intimate confrontation with one’s own mortality, enhancing creative and transcendent shifts in consciousness.

**Limitations to the study**

This inquiry offers one interpretation of the data and does not claim exclusivity from other possible interpretations that may have transposed.

**Conclusion**

The present study highlights how the talking cure as the ‘love transfusion’ (Denise) or love cure educates us to the life-promoting attributes of attachment, containment and psychic holding. Conversely, it teaches us that the perversion of these properties can manifest as lethal deadliness, or a nameless dread, which can destroy the human spirit (Seager, 2008). An overarching conclusion that can be tentatively drawn from the findings is the restorative nature of client engagement in the life of the therapist. Freud (1917) understood the problem of suicide as a problem of relatedness. Therefore, the treatment of suicide involves a new form of dyadic relatedness as engendered in the therapeutic couple. In conclusion, the words of Wosket (1999) succinctly describe this process:

> A therapist uses themselves and in as far as they are able to become a resonating chamber for the client's emotions. Congruence and compassion open the way to the therapist's primary instrument of healing: the personal vulnerability of his own trembling self. (p. 214)

**Heather Moore** MA (Psychotherapy) is a psychotherapist in private practice working with adults, adolescents and couples in Dublin city. She is a core trainer on the Masters programme in psychodynamic theory and practice in Dublin Business School. Heather is an accredited member of the Irish Association for Humanistic Integrative Psychotherapy (IAHIP) and of the Irish Association for Counselling and Psychotherapy (IACP). It was her work in an Irish mental health centre that solely counselled teenagers and adults struggling with suicidal ideation that influenced her to research into the impact of this particular work on Irish clinicians.

**Department of Psychotherapy & Counselling, Dublin Business School, Ireland**

To access the full paper, follow the link below:


**References:**


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**Tables:**

Table 1 The sample of participants
Table 2 The master themes and their categories
A Psychotherapeutic Exploration of Endings
by Laura Harris

Introduction
The ending stage in psychotherapy remained relatively unacknowledged in the emergence of psychoanalysis, most notably the near absence of the topic in Freud’s work (Orgel, 2000). Much of the existing literature is concerned with the client’s experience in ending. Some literature and studies on the therapist’s emotional response in ending with clients exists, however it remains limited and largely addressed within the psychoanalytic tradition. The general consensus on the silence held by Psychoanalysis on the topic is a reluctance to acknowledge and engage in the therapist’s potential emotional experience that can be generated during the ending process (Novick, 1997). It is widely agreed that the ending process for the client is a time when old conflicts can re-emerge, new conflicts and oedipal vulnerabilities are activated, and trauma can re-surface with great intensity, accelerated by the impending separation (Freud, 1937; Loewald, 1962; Novick, 1997).

Central to the ending process are the most challenging and fundamental human issues yielding a powerful stage of the therapeutic process. It is replete with the issues and processes of separation, loss, mourning and mortality (Frank, 1999; Junkers, 2013). There is increased tendency to regress back into difficult emotional positions, with a greater use of primitive defenses against separation and the feelings that accompany it (Schafer, 2002). According to some studies, the therapist experiences the processes of separation, loss and mourning, along with the reactivation of early painful experiences, most notably oedipal conflicts, narcissistic needs and transference neurosis. For example, Judith Viorst (1982), in a study on the emotional impact of the loss of a client on the therapist, showed that therapists experience similar emotions and use of defenses as clients (Goodyear, 1981). In a more recent study, Fragkiadaki and Strauss (2012) found that much emotion is generated in the therapist and focusing on the client can contribute to neglecting the therapist’s own experiences. The therapist participates with her or his own history of loss and separations, which may still be painful, unresolved and present in the inter-subjective space. They argue that exploring the therapist’s emotional response is necessary (Fragkiadaki et al., 2012). This research seeks to add to the existing literature and draw further attention to the psychotherapist’s experience of ending with clients.

Methodology
This study explores the psychotherapist’s understanding of their experiences of endings; both with clients and in the psychotherapist’s own personal and social world.

The focus primarily rests upon how the psychotherapist’s history of endings could be restimulated and how it could impinge on the ending process with clients. Three practicing clinicians were purposively selected and through semi-structured interviews offered experiences and insights into the phenomenon of ending. This qualitative study was conducted through an Interpretative Phenomenological Analysis to allow for optimal possibilities to explore the participant’s unfolding experiences and understandings. Three themes emerged and are presented in this paper. Pseudonyms are assigned to protect the participant’s identities.
Themes
The Space to End or Not; The Psychotherapist’s History
The research found that ending with clients could trigger much deep-seated painful experiences for the psychotherapist that can in turn affect the ending space for clients. For Martin, the potency of ending with his client resulted in a prolonged drawn-out ending. In the following extract, Martin illustrates how ‘old wounds’ are re-activated in ending with his client:

… what’s being avoided really is the depth of his [client] depression and of how difficult it is to just sit with the depression … it was unbearable to stay with it so the paradox is that we would never get to an ending unless we both found a way me primarily so that he could have some experience of his feelings being tolerated (laughs) …

To end it was necessary for the client to experience his unbearable depressive feelings, felt and tolerated by the other. Martin discloses his own experience of depression and offers some earlier life experience that refers to the loss of the primary object:

… I am aware of my own depression so I think my own depression probably em influences how I attach, or don’t attach …

… my mother was alcoholic an active alcoholic until she died and em my my default position was trying to save her and eh never quite succeeding …

An ending is at risk of being shortened or prolonged in psychotherapy, if the therapist’s early loss of the primary object, oedipal conflicts, separation anxiety, castration, narcissistic needs or defenses are aroused (Orgel, 2000 and Davies, 2005). The expression of the therapist’s emotional reaction is necessary to allow effective working through of the significantly important material emerging during the ending process (Novick, 1997). The findings indicate that old conflicts concerning Martin’s own experience with depression, attachment and possibly the loss of the primary object remerged. The ending process elicits the most formidable anxieties and conflicts in the therapist (Novick, 1997).

For another participant the threat and danger of stimulating difficult past experiences of endings was subject to increased risk during the ending process. In her approach to ending with clients Siobhan appeared to defend against old conflicts by managing the ending with clients. Psychoanalyst and

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Years as a Therapist</th>
<th>Years Accredited</th>
<th>Accrediting Body</th>
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<tr>
<td>Martin</td>
<td>60 - 75</td>
<td>20</td>
<td>20</td>
<td>ICP</td>
</tr>
<tr>
<td>Siobhan</td>
<td>30 - 45</td>
<td>12</td>
<td>9</td>
<td>ICP</td>
</tr>
<tr>
<td>Angela</td>
<td>45 - 60</td>
<td>16</td>
<td>14</td>
<td>ICP</td>
</tr>
</tbody>
</table>
author Gabriele Junkers (2013) proposes that the therapist may fear the opening of old wounds that were considered healed, and possibly even mastered. Themes of safety, preparation, openness, and honesty in ending with clients were repeatedly expressed and evidently significant for Siobhan. In the following extracts, Siobhan describes her approach to ending with clients and her own past experiences of leaving:

... I would be very open about endings I would mention at the beginning that ideally it is not an abrupt one ...

... t’was always a threatening or it was a big explosion a big argument ya know a big fuss people going em so that I think there was always the threat of somebody was leaving somewhere ... so maybe that’s why I am as em drawn for the endings to be safe for people

... I do make it clear and honest and I think quite safe there’s no like pulling the rug out from under ... helping them to prepare for the finishing which was never something I would have been at the receiving end of in my own life

The participant’s earlier experiences of ‘leave taking’ carry a sense of danger, punishment and even death. The descriptions portray how deeply vulnerable the experiences of leaving were for Siobhan. The findings also suggest that these experiences could be re-activated quite easily in the ending with clients, particularly an abrupt ending. The inter-subjective space during the ending process is potentially prone to the psychotherapist’s personal history of losses and separations, often unresolved and persistent (Fragkiadaki et al., 2012).

The Presence of Death
A sense of death, loss and mourning permeate the ending process (Cooper, 2009; Loewald, 1962). Endings with clients can bring the psychotherapist into greater contact with a sense of mortality. Martin used the expected death of his father and the untimely death of his mother to illustrate his understanding of planned and sudden endings:

... the contrast between the two [deaths] was and one was an ending to an actual process the other was a shock a trauma ...

Martin referred to sudden death as a trauma and this suggests the deep impact of sudden endings in psychotherapy. The unresolved feelings that the psychotherapist can be left with following a sudden ending are comparable to those feelings after a sudden death (Salberg, 2009 and Schlesinger, 2005).

The challenge of engaging with issues of death and one’s own mortality can pervade the ending process both covertly and overtly. Siobhan shared a very sensitive and deeply challenging ending with a client who was very ill. Siobhan was asked by her client to visit him in intensive care a week before he died:

... now he was in intensive care he was hooked up and everything and em I sat with him for about an hour ... when I was leaving I had a very strong feeling I wouldn’t see him again but the other part of me kicked in and I said sure I’ll see you again in our sessions and he said do you think so and I said I do and I lied.
Siobhan’s facial expression and tone of voice were suggestively confessional and guilty, in revealing that she had lied. The difficulty of ending and death can rest in the re-awakening of anxiety of annihilation (Klein, 1949) when confronted with one’s own limitations and transience during termination (Junkers, 2013). The phrases ‘tubes and wires’ and ‘sticking on the gloves’ in the following extract further highlight the threat and closeness of death and Siobhan’s possible need to cover up in the ending:

... I saw him surrounded by all the tubes and wires he was in intensive care ya know I had to stick on the gloves, and all of that ...

The Researcher’s Experience of Exploring Endings
Each interview proved diverse and valuable in offering further understanding of certain aspects of endings that were played out in the interviews and particularly during the ending of the interview.

(i) ‘An Ending Man’
In the interview with Martin time and finality are explored through the experience of the recent death of his relative John and reveal issues that are presently concerning him. According to the psychoanalyst Judy Kantrowitz (2002), analysis can evoke a feeling of endless time and an ending process can draw out awareness of time and finality. Martin is entering a later stage of life in which ending appears prevalent for him, particularly the ending of his career as a psychotherapist:

It’s its all around yes its part of me now and that’s it an ending man that’s that’s it, there’s a guy in the hospital a Filipino nurse who was really intrigued with John … because of the age … he couldn’t get over that it was actually this man in the bed was a hundred years old ya know … and then going out the door … he just said out really loud CENTURY MAN ya know he was he was relating to this human being who was a century old ya know

... yea I’m an Ending Man and I’ve I’ve never thought of it that way ...

The experience at termination compels one to reflect on one’s life and the fragility of one’s existence (Yalom, 1980). ‘An Ending Man’ seemed to be a summing up of Martin’s sense of self as he participates in the ending process of a stage in his life. The psychotherapist can remain safeguarded by the role that creates both an illusion of timelessness and of escaping illness and aging (eg. Pinsky, 2002; Junkers, 2013). However, aging can force the individual to surrender a fantasy of immortality (Martin Teising as cited in Junkers, 2013). The interviewee considers the defying attitude and intense attachment to life of his dying relative:

... (John) he’d a very strong life force… he’d get this evidence of this absolute attachment to to to living and life ...

... I’d say he got a taken by surprise because I’d say he saw himself living, yea probably living forever … cause he was having an experience as if he would live forever ya know

The phrase ‘live forever’ was spoken quietly and contemplatively and with a sense that Martin was alone in the room. The experience that Martin was alone at certain times during the interview reflects the supplementary role of the interview to his process.

(ii) The Risk of Regression
Safety, preparation, and openness are significant in the process of ending with clients for Siobhan. The
considerable focus on safety and openness drew attention to the possibility that this was a way that Siobhan could defend against her own experiences of endings that were very threatening. Siobhan used the word ‘haunts’ to describe the client’s experience after an abrupt ending:

I say if you end abruptly your left with that unclosed piece ... and that that haunts him not me but that haunts them ...

The use of the word ‘haunts’ suggests the client could be really burdened by an abrupt ending. However, it would be difficult to know how a client feels following an abrupt ending and thus the word ‘haunts’ could possibly belong to the interviewee’s own internal experience around such endings. It could suggest that something about an abrupt ending is persistently present for the interviewee that is unable to rest.

There was something reflexive about the subject of abrupt ending, in the ending of our interview that became staggered. On reaching the end of the interview, I thanked Siobhan. Subsequently, I felt unsettled by the interviewee’s response as if it had finished too soon for her or that she was taken by surprise:

That’s great, thanks very much (Interviewer)
That’s it? (Siobhan)

The audio recorder was switched off, however the conversation continued and Siobhan suggested switching the recorder back on. I felt that there had been a felt sense of an abrupt ending for the interviewee and this resulted in a hesitation to end.

Much of the literature (e.g. Ferraro & Garella, 2009) addresses the topic of regression for the client but remains relatively silent on the possible regressive experiences of the psychotherapist during endings with clients. The therapist is also vulnerable to experiencing regression during the ending process with clients and adopts defenses to ward off any risk of regression. Authors Ellen Pinsky (2002) and Arnold Modell (1991) capture the difficulty for the therapist in experiencing deep and difficult realities in a context that is not ordinary life for the therapist. Transference and counter-transference both manage and potentially disguise this difficulty for the therapist (Modell, 1991). The role of the therapist created by the profession can deprive the therapist of true feelings (Pinsky, 2002).

(iii) A Sense of Illusion, Disappointment and Trespassing
The theme of safety in managing the ending with clients reappeared during the interview with Angela. In managing the ending, Angela described her desire to put as much safety around the client’s process in the form of a container before he or she moves out into the world. In the following extracts Angela describes images of safety when a client is ending that give an illusion of wrapping up the client’s process in a soft cushioned container:

... chicks emerging from the eggs, and routing from the safety of the egg, to under the wings of the mother ...

... that there is as much of a safety put put ya know as much of a container put around their process as allows them to move out into their world in a safer way...

This image of managing the ending had the illusion that the client departs with their process almost untouchable, invulnerable and more manageable than it actually may be. There was a strong impression
during the interview that Angela’s own process was tightly secured and out of reach and possibly representative of her way of managing her own process, both in ending and in general. The participant refers to ambivalent attachment but speaks about it almost outside of herself and with caution:

... I really keep an eye out for ambivalent attachment even so I’m not thinking of any particular one but I certainly could be aware of that in a in a that it could be quite easy for me, to collude with a client in their ambivalence around the ending.

The extent of the safely contained process generates questions on the experience for the client in the event that life becomes difficult again. Within the psychoanalytic literature, following the termination phase is the post-termination phase, which can be experienced as an unsafe and destabilising period even after good-enough psychotherapy (Craigie, 2009). If an unexpected persistence of inner conflict and pain reemerge following an ending in a therapeutic relationship, this can leave the client feeling disappointed with the therapeutic process (Craigie, 2002). Such a securely contained ending may be difficult to achieve, with endings and processes often too complex to be so neatly packed up.

**Conclusion**

The study shows evidence that the psychotherapist’s history and personal experiences of ending can impact on the ending process with clients and can potentially be harmful. Whilst there are a couple of studies on the emotional responses of the therapist and on counter-transference based enactments during the ending process, greater research could be allocated to the actual impingements of the psychotherapist’s experiences of ending on the ending process with clients. Death poses another acutely challenging and concerning issue in ending for the therapist. Ending with clients can remind the therapist of time, limitations and mortality that can discourage the therapist from fully engaging with endings. Furthermore, the research found that there was a particular focus on safety in the ending process with clients. It indicates that managing endings, particularly through creating safety, could be a way of managing ending for the therapist and defending against past experiences of ending. The management of ending proves particularly useful for the therapist in defending against the re-emergence of old conflicts and would suggest the necessity for further exploration into how endings are managed. The psychotherapist’s emotional experience during the ending process warrants greater research, understanding, openness and acceptance.


**References:**


Psychotherapeutic Exploration of the Impact of Working on Multidisciplinary Teams in Psycho-oncology

by Milena Sobesto

Cancer is described as the defining plague of today’s generation (Mukherjee, 2011). The diagnosis of cancer calls for a huge change in one’s life. The cancer patient must adapt to life-threatening experiences such as: chemotherapy, surgery, radiation, and constant waiting for the results of tests.

Multidisciplinary teams in psycho-oncology have provided support of doctors, nurses, occupational therapists, speech therapists, physiotherapists etc., as well as psychologists and psychotherapists (Wise, et al, 2013). Psycho-oncology is a field that highlights the crucial need for supporting people affected by cancer, in other words it pays more attention to the human side of patient care (Dolbeault, et al, 1999).

This research therefore will look at the work of different professions in cancer care from a psychotherapeutic perspective. It is set to gain better understanding of individual experiences and the impact this type of work has on the professionals working on multidisciplinary teams in psycho-oncology. This paper will also try to establish why there is such a small number of psychotherapists working in the field of psycho-oncology. Is it because of the nature of the work, where people are dying of cancer, which impacts on the professionals working in this area, or is it to do with the risk of compassion fatigue?

Professionals working in psycho-oncology try to provide the best care possible for the cancer patient while at the same time protect themselves from experiencing burnout. It is a fact that Irish National Cancer Control Programme (NCCP) has brought huge reorganisation in provision of improved care as well as better outcomes for patients diagnosed with cancer. There has been an improvement in providing specialist cancer centres which tackle early detection treatment and supports. Shannon (2012) underlines that there is still a significant amount of work to be done in this area. ‘The statistics show that because of the ageing population in Ireland the increase of people developing cancer will raise up to 100% over the coming decade’ (Shannon, 2012). Therefore with the growing number of patients there will be a need for an increase in the number of professionals tackling the psychosocial needs of cancer patients.

Milena Sobesto is a Polish national born in Krakow. She moved to Ireland 10 years ago with her family. She has a background in Childcare and has close connections with Barretstown camp for children and families affected by cancer. Thanks to Barretstown, Milena became interested in psycho-oncology and aspects related to working on multidisciplinary teams in psycho-oncology departments. She completed Higher Diploma in Counselling and Psychotherapy and hopes to graduate with MA in Psychotherapy from Dublin Business School in November 2016. Milena is a student member of IAHIP and she hopes to contribute to research around Humanistic and Integrative Psychotherapy in the future.

References:
The Experience of Family Therapists Working in a Second Language: An Interpretative Phenomenological Analysis

by Claudia Harke

The art and the beauty of therapy is in creating a space where things can be said that are so countercultural, and occasionally so challenging that people would never accept them in any other context.

(Smith, 2011)

Introduction

This study aimed to gain an in-depth understanding of Family Therapists’ individual experience of working in a second language using an Interpretative Phenomenological Analysis (IPA). The focus was on therapists working in Ireland in English as their second language. Accredited Systemic Psychotherapists were interviewed about their experience of working and interacting bilingually in a different culture.

Speaking at least one foreign language has become a relevant topic in a time of globalisation where it is common for people to travel to different countries and form international relationships. The English language in particular is a global language as it has developed a special role that is recognised in every country (Crystal, 2012). The profession of psychotherapy is affected by these factors, as the client base becomes more international and therapists increasingly work abroad. This qualitative study was carried out as part of a Master’s Degree in Systemic Psychotherapy. The idea and interest for it arose from the researcher’s own experience of having trained as a Family Therapist in Ireland, with English as a second language.

The Sample

The participants taking part in the study were four women. All four were born and grew up in countries on the European continent where they all had studied to degree level. In their early twenties they moved to Ireland where they studied Systemic Psychotherapy. All participants currently work therapeutically in English rather than their native language.

Data Collection and Analysis

A semi-structured interview schedule was developed. This was informed by relevant literature and discussions with a supervisor. The schedule was used flexibly in order to allow probing of unanticipated areas that emerged.

Each interview was first analysed in-depth individually. Each recording was listened to and the transcript read multiple times. A table with three margins was used to analyse the transcripts. While the middle-margin contained the raw data, exploratory comments describing initial thoughts about the content were made in the right margin. Each transcript was then re-read and the left margin used to note emergent themes, drawing on both the transcript and the initial analyses. Each interview was analysed in this way until all four interviews had been analysed to this level (Smith et al., 2009). Emergent themes were then listed chronologically and moved around to form super-ordinate themes. The next stage involved looking for patterns across cases. This was achieved by drawing up a list of themes for the group, and clustering these into master themes.

Findings

Four master themes emerged from the analysis of the semi-structured interviews. The themes and related subthemes were as follows:

- Similarities and differences (unfamiliar communication rules; internalised systemic terminology; relationship to native language; a sense of switching)
• Possibilities for self-experience and reflexivity (retaining of self; expectations of self; how others perceive me; my coping mechanism)
• Unique therapeutic learnings and understandings (language in systemic therapy; connection through collaboration)
• A privilege that enriches and challenges – ambivalent emotions (a complicated, confusing and frustrating struggle; an enriching privilege)

**Master Theme A: Similarities and differences**

All participants described feelings of difference but sameness in the way they perceived a foreign language in a foreign country and culture. Those feelings were not entirely limited to the aspect of unfamiliarity in a different country. They also appeared within the home culture context and the participants’ self-perception.

In some way all participants had experienced “unfamiliar communication rules” in connection to speaking a second language within their work context in Ireland:

> The way we interact with each other is different ... For example, we don't call people by their first names.

In the participant’s culture, using a person’s first name, for example, when not knowing people well produces a “Very significant false feeling of closeness.”

For some of the participants, once they adjusted to the foreign rules, the rules of their home country became unfamiliar to them:

> ... you go back to your family ... and the discourse and the communication patterns and rules, they're all different ... you're expected to function in a communication system that's very different to [your] current communication system and [your] professional communication system.

In addition to the unfamiliar communication rules, participants spoke about how having trained and worked in English made them “internalise the systemic terminology” in that language which made it difficult to translate those professional terms into their native language. Subsequently, their native language as a professional communication tool started to lose its function:

> It was actually harder for me because I had internalised all the core concepts of Psychotherapy in English.

All participants had something to say about their “relationship to their native language”. One participant described that her native language was connected to a feeling of competency in her clinical work. She described it as less likely to question herself when speaking her native language:

> ... when you're speaking your own language ... when you're doing clinical work, ... I never felt ‘I don't know how to ask this question?’, ‘Have I used the right word?’, while when you're working in your second language you're always questioning ... it situates you outside your zone of competence.

All participants agreed on having “a sense of switching”, in relation to their first and second languages or their home and foreign identities. The native and second language were seen as:

> ... mixed up together.
Switching seemed to have two meanings: the switching from native to second language and the switching from personal to therapist persona:

*Like when I had my therapist persona, I wanted to speak in English. When that persona changes I mean native language thinking can take over very easily.*

**Possibilities for self-experience and reflexivity**
The second master theme draws upon the ways in which the participating therapists saw their individual experiences of working in a second language as an opportunity for self-experience and reflexivity. It is connected to the first master theme insofar as difference and sameness might have caused the participants to be self-conscious and therefore made them analyse who they were, who they would like to be, what others may have thought of them and their ways of coping with the experience.

All participants spoke in some form about a need of “retaining a stable and consistent self”.

They saw the process of accepting their own foreign accents as a sign of difference within the Irish culture which brought about raw emotions that, if not worked through, could potentially reflect in sessions:

*... if I am comfortable with who I am and what I am, that reflects in the session. If I am uncomfortable with my accent or being foreign that will reflect in the session. So I had to do work on myself and accept that I will always have an accent.*

Together with “retaining a self” came “the expectations of self” and how the participants thought people in the Irish culture perceived them. They were used to having a wide spread vocabulary in their native languages which held a certain status in their culture. Being left without this unlimited amount of vocabulary in a second language made them wonder if they still came across as competent:

*I’m used to ... using very rich and very varied vocabulary ... it would also be a sign of your level of education ... in English I have bits of it.*

Self-expectations of feeling competent were challenged even more by entering the world of Psychotherapy in a second language:

*Up until I started the systemic therapy I was feeling very competent but that changed with the systemic training. I was very challenged. Everything I knew. Everything I thought I knew. I was thinking that my systemic thinking wasn’t good enough or wasn’t exactly what they were looking for. So that was very painful for me.*

The participants wondered about how other people, like colleagues or clients, perceived them. Coming from different cultures and having grown up with different native languages, the participants stated that Irish colleagues and clients would perceive them as “more straight forward”:

*... and when I write some recommendations they would often say like; oh you know, you’re straight to the point.” Or, “I think they would see me as somebody who voices things ...” or “I think they would say I’m curious and that I’m not afraid of asking the questions.*

In addition to trying to retain a sense of self, struggling with expectations of themselves and wondering how others may perceive them, the theme of “coping strategies” ran through the interviews. A stronger awareness of other people’s reactions, as well as cultural and language differences stood out as coping strategies:
I’d say that I’m more aware. I mean, for me if I feel that I need to say something I will still say it. It’s that I’m more aware of how people can react to it.” Or “I think you’re definitely a lot more aware of cultural differences, language differences, … you become more aware of how you do things in comparison to how things are being done in the language or in the country you live in.

It was described that coping with difference is through connecting and relating to it by being aware of it in the first place:

You kind of have to pay attention to people’s needs and how they communicate them…. To me there are no options otherwise you can’t relate to anyone and no one can relate to you.

Unique therapeutic learnings and understandings
While the first two master themes were quite general in relation to systemic work and the second language, this third master theme is more specific. Here, participants spoke specifically about the use of “language in Family Therapy” training with the focus on the live supervision part of the training and therefore about working with families in a systemic manner. It was explained that language, in terms of accents, was the main struggle:

I noticed that the issue of me being a foreigner in training became a problem …. Not because of the culture but because I was not familiar with these groups in Ireland and in the Irish society. So the accent was different, the way to address was different; the expressions were something that I had not heard before.

“Connection through collaboration” looked at how systemic therapists working in a second language deal with situations where language gaps could become a problem. This aspect was brought up by all therapists in a slightly different way. However, the underlying theme for all of them was to deal with the situation through collaboration with the client.

Participants spoke about being able to connect with a client through emotion regardless of the language:

... the emotions are not primal to language so for me I connect emotionally with a person regardless of their language.

Checking in with clients and getting their perception of a session seemed to have become an important tool for the non-native therapists. It was acknowledged that there might be a limit to asking clients those type of questions and about holding a thought for longer, reflecting – even if it was until the following session – and then deciding whether or not it would be useful to ask:

If an expression doesn’t make sense I will ask them to say it in a different way. In different words. But there’s also a limit to how many times you can ask someone to say something.” And “... after a session and I thought ‘oh when I was asking that question I wonder did they hear it in a more directive or in a different way?’ and I could go back the following week and say ‘You know I was wondering because I’m from a different culture did we actually have the same explanation for that word...

A privilege that enriches and challenges – ambivalent emotions
The fourth and last master theme draws upon the ambivalent emotions and meanings the experience of working in a second language seems to have had for all four therapists.
“A complicated, confusing and frustrating struggle” addresses the challenging side of working in a second language. The participants acknowledge that they struggled understanding the new language but did not give up:

... I had those gaps where I could not simply understand what was said from the content. So that was a difficult component that I had to simply deal with and make the best out of it.

The ambivalent emotions became clear as the experience was described as both frustrating and as “an enriching privilege”:

At the same time though, I used to find it very frustrating sometimes when people would say ‘Oh your English is so good’ because I found it a bit patronising almost .... Although it is a privilege at the same time ... you won’t ever quite get it right because it’s not your first language. So it’s both…”

One participant thought that while the experience may be difficult there are pros that come with it for personal and professional development:

... you know difference is always enriching. So I think that that’s a great positive. Whatever I require from this culture as well is enriching for me as a person and hence as a therapist.

The positives a participant drew from it were that working in a second language can be a liberation and a privilege for a therapist with regards being oftentimes allowed to not get things quite right but also to ask questions:

I think the permission to ask things in a way that maybe, yeah, so it is definitely a privilege and if you get it wrong and you’re misunderstood it gives you also that permission to not get things right as well.

Discussion
The findings showed that for the participants the psychotherapy training in particular highlighted the significance of working in a second language. It gave them a taste of reality and while it “was painful until the end. It clicked later on”. Therefore, for the participants, their training was a crucial part of their experience of becoming therapists and inseparable from their style as therapists later on. “The training dominates. That’s the bottom line. Regardless of client, of practice, of language”.

This study provides a contribution to an understanding of the experience of family therapists who work in a second language, and appears to be the first study to have been conducted from the bilingual therapist’s point of view (searches of the literature up to 2014 showed that there were no published IPA studies conducted on this topic previously). Other qualitative studies in this area used samples of either bilingual client’s experiences of therapy (Greenson, 1950; Buxbaum, 1949) or client’s experiences of bilingual therapists (e.g. Bowker & Richards, 2004; Burck, 2005; Rosenblum, 2011). Searches of the literature indicate that there is a gap in the qualitative research into therapist’s experiences in general. Aside from the need for a great deal more research into Family Therapists’ and Psychotherapists’ experiences, it would be interesting to re-analyse the study with male therapists. The ideas for future research could be endless. It would be great to learn more about:

- Irish Family Therapists’/Psychotherapists’ perspective of working in a second language.
- Irish Family Therapists’/Psychotherapists’ perception of studying with foreign students/working with foreign colleagues.
• The nature of Family Therapy (Psychotherapy) training programmes in other countries.
• Trainers and Supervisor’s ideas on working and teaching multi and cross-culturally.

Conclusion
Past, present or future – Psychotherapy will always be relevant and will remain a profession that has the skill and need to adjust to cultural and social changes. Psychotherapy may not have been as international in the past but there certainly is a need for multilingual therapists and curiosity more than ever in current times.

While this study has shown how working in a second language for Therapists may be a challenge at times, it also showed how therapeutic training can contribute in approaching this challenge in a resourceful way and turn it into an enriching and precious experience. The phrase “Working in a second language” cannot be restricted to doing actual client work. It emerged that this was only a fraction of the topic. The experience in itself turned out to be much richer than the study title. “It’s about finding the best balance for each therapist … how they can be the best therapist they could be in a second language”.

The full and detailed version of the thesis on which this paper was based is available for download at the following URL: http://www.claudiaharke.ie/thesis.pdf

Claudia Harke qualified as a Rehabilitation Psychologist in Germany, her country of origin, where she worked in the fields of Paediatrics and Rehabilitation. In 2009, she moved to Ireland and subsequently graduated with a Master’s Degree in (Systemic) Psychotherapy from University College Dublin and the Mater Hospital in 2015. The conference paper she presented was drawn from the research for her Master’s thesis which developed from her interest in working cross-culturally and bilingually. Claudia currently works as a Family Therapist in Dublin.

Email for correspondence: claudia.harke@gmail.com

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The More Things Change...
*by Michele O’Brien*

**Introduction**
The study explores the experience of five supervisors; an enquiry through the lens of Supervision into the title of the conference, ‘Keeping Psychotherapy Relevant to these Changing Times’. This paper is an attempt to summarise the findings and to address the impact of these changing times on the practice of Psychotherapy and on us as supervisors.

Each supervisor came from different training orientations and modalities; work from different philosophical stances and theory bases; they each have their own individual style. They are utterly authentic and congruent with themselves and who they are as people. Together they have over 140 years of experience. Each maintains a practice that includes psychotherapy and supervision. All were or have been involved in the training of therapists and the supervision of supervisors. These conversations were transcribed and emerging themes were extrapolated. The study asked the question ‘How do you keep Psychotherapy relevant to these changing times?’ Quotes in *italics* are taken directly from the transcripts.

**Frames of Reference**
The following definitions and understanding of terms is the lens through which the analysis was viewed:

**Psychotherapy**
Browne (2013, p.531) sees the term psychotherapy, coming from the Greek, *therapeia*, meaning to treat, to attend on, to service. The former, to treat, is more readily understood outside of psychotherapy circles. It has its origins in the medical model. The sense of psychotherapy used throughout this paper is from the latter; to be of service and to attend to.

**Humanistic and Integrative Psychotherapy**
The view of Humanistic and Integrative Psychotherapy that I use is from IAHIP ethics, which emphasises the autonomous and self-regulatory qualities of the person, who has the ability to go beyond themselves and realise their true nature. Based on a phenomenological view, importance is on experience and meaningful contact between persons, (IAHIP, 2016).

**Supervision**
I use a definition of supervision adapted from Carroll and Gilbert (2011): a collaborative learning space used by supervisees to reflect on all aspects of their work, where they receive formal and informal feedback on that work and where the welfare of clients and the quality of the service they receive is central.

**Relevant**
The Latin root of the word is *velare*: to unveil, to reveal. I am using the following definition as a starting point:

Closely connected or appropriate to what is being done or considered: appropriate to the current time, period, or circumstances; of contemporary interest, (OUP, 2016)

As the interview process developed an evolution in my own understanding of the word relevant took place; it came to have a significance of a dynamic process, not static; something alive, vital and creative.
Context
Irish society is changing; we are living in a postmodern culture; a different world with a different set of pressures. During the last number of years we have experienced a great deal of social change; economic, state and religious. There has been a seismic shift in attitudes to gender, relationships, family and sexuality. Many issues once seen as taboo have become dinner table conversations. We are experiencing multicultural mix in society and a huge dependence on social media and IT, and other impacts of globalisation. The assumptions and structures that were so known to us are being challenged. What was once a relatively stable experience of life is now in a state of flux, as sense and meaning is made of this precipitous shift.

Seeing a counsellor has become normal practice; people are accessing therapy in greater numbers, not exclusively private practice. The nature of how clients’ access therapy has changed; availability is more across the board; short term counselling can be accessed through primary care and the voluntary sector. What is the impact of this on psychotherapy as a practice? According to one interviewee:

*Psychotherapy could be seen as another facility for people to avail of.... maybe other resources have narrowed, or aren’t available and .... Psychotherapy then becomes a particular route for people.*

Is psychotherapy always the correct approach? A supervisor suggested that a longer period of assessment was taking place, which addresses this question and also to establish the root of what the client was actually seeking help for. Seeing beyond the context, another commented: “*their pain is to do with what their circumstances have brought them in touch with*”. Is the context global or particular?

Whilst it is worth remembering the different stages that accredited psychotherapists and supervisors have gone through as professionals; trainee, pre-accredited and accredited, more experienced and so on; supervisors taking part in the study were noticing a difference in the presentation of some supervisees. In general, more of an academic approach, more fluency around theory which they felt was to the detriment of the experiential and personal development; a lack in presence, deep listening and empathy.

Emerging Themes
In considering keeping psychotherapy relevant, four strands emerged from the supervisor interviews. I grouped them in the following way: Relational and Attunement; Refinement and Pluralism; Continuous Professional and Personal Development; Ethics and Quality Control. These groupings are merely a way to discuss the salient ideas raised. There are clearly overlaps, interconnections, and grey areas.

Relational and Attunement
Despite these changing times, supervisors are still focusing on the relational; a satisfying and mutual relationship which is the basis for healing. Linked with the dance of attunement; being able to deeply attend to and respond to the other, makes this partnership a very powerful element. Importance was also placed on the centrality on empathy; congruence and unconditional positive regard; though this central and essential core has been enhanced and deepened by continuous learning and reflective practice, becoming a clear supportive and embodied internal structure.

In attuning to their clients, qualities of the therapist themselves became important; respect, depth and compassion; curious and passionate. By being present and having the capacity to facilitate deep listening. For a client to experience being held and being heard, interventions are required to be nuanced, precise and relevant thus deepening the potential for connection.
A creative approach with a non-imposing curiosity and enquiry was important, both at the contracting stage and throughout the therapeutic relationship. Negotiation was required in order to establish a mutual working alliance, the context for therapy and to establish the client requirements. One interviewee described a “sensing and experiencing of the other” to inform this process. According to Cooper et al (2013, p.67), there is within the person a dynamic between autonomy and interrelatedness; the individual and the relational. To keep it relevant means to hold all of this, the relational and the ability to attune to the underlying.

Refinement and Pluralism
Refinement, as a process of enhancing and tweaking was another theme that addressed relevancy to these changing times, along with and being opposite to, what I refer to as pluralism; the coexistence of two or more states. Both are pertinent in the particular of the therapeutic alliance and also in the bigger picture of the client’s world. Importance was placed on using skills and interventions in refining and researching in the moment, and on a continual practice of sifting out. This depth awareness, of being fully awake, in turn, becomes the therapist’s gateway of refining understanding of the other at many levels. “Knowing enough to need to know more, this ironically becomes a kind of endless deeper knowing”, was how one supervisor described it. This realised depth of compassion becomes a container for meaning and vice versa. The therapist is thus, dynamic, vital and alert using enquiry and curiosity with humility and tenacity. One participant described it as “adapting to meet client without losing essence of self”; the therapist unafraid to grapple and be curious, to get to ‘know’. To get to the root of the clients concern, nested in their particular context, the interrelationship between field and figure; the ability to sit with difference and tolerate the experience is vital. It is easy to understand the world of the client whose view is similar to our own; however, a supervisor spoke of the importance of having cultural sensitivity; a broad cultural awareness and a sense of unconscious bias in values, beliefs and perception.

Continuous Professional and Personal Development
All supervisors in the study are actively engaged in a continual process of philosophical/theological/transpersonal/spiritual reflection and learning; resulting in a practice that is relevant, vital and alive. This dynamic framework has become an underpinning resource for their unique understanding of human existence. Each was embodied in a core practice of meaning making, which one described as “peer support for the heart”. Another: “holding the bigger picture makes individual work more potent – you open up to those larger levels of awareness and you are also opening up to more support and a sense of your place in a part of something bigger”.

For expansion and enhancement any new learning has to be tweaked, synthesised and integrated into a core footing. Practitioners are then nested in a larger perspective and as such, become the resource for ‘being with”; for sitting with the mystery of the clients world, sitting in the edge of the unknown. In keeping it relevant, the limiting nature of approaching the work of psychotherapy from theory alone was named and the huge value placed on personal development. Empathy cannot be simply taught and learned, it has to come from within as an authentic experience. Coming home to self as a source for this is crucial. Limitation is both a reality and a starting point. One supervisor sets the backdrop of their work as “the limiting notion of our living and dying”, and described being in a cyclical process of ‘composing and decomposing’. Another described the paradoxical movement of “unpacking the essence in me that gives meaning to life and it is through that meaning of life I can do the unpacking and find the essence of the other”.

Ethics and Quality Control
Throughout this document themes are interchangeable between psychotherapy and the supervision of psychotherapy. This fourth strand however, is weighted more in the actual role of supervision.
The importance of good reflective practice was continually named as a way of keeping it relevant. A commitment is required of the supervisor to sit in the tension between growth and development versus evaluation and assessing; being robust enough, engaging flexibility and curiosity with a willingness to risk rupture in the supervisory relationship, in service of client.

There is an onus to keep it relevant through the dual functions of ethical sensitivity and the monitoring of quality control. There is also an importance placed on the value of the supervisor’s antenna, especially in relation to duty of care to the client and the quality and relevancy of the service they receive. It is relevant, “to the extent that people find it helpful”, as one supervisor commented.

Awareness of being caught in the undertow of transference and countertransference is essential. It could be the unconscious pull of suffering or pain of human existence; of being pulled into the external landscape of the other; a dance or tussle between field and figure. The ability to sit in discomfort without being pulled in by unconscious material as yet unrevealed, or by the seduction of material that at any moment can seem more immediate, and carrying urgency. There is a requirement of supervisor to be in moment by moment decision making; in the tension between following and staying with or risking rupture; a continual process of sharpening the figure.

**Emerging Model**

The most profound tone communicated to me by the practitioners, was an overriding sense of the sacredness and nobility of being involved in this intimate relationship called psychotherapy. Listening to their wisdom and experience, a deep backdrop was forming. I noted how much they worked from their own essence; free and unencumbered. A thesis was starting to emerge of two main propositions. A healthy working tension between firstly, the responsibility toward the client in the therapeutic dyad; including relational, attunement, refinement and pluralism; and secondly, the personal and professional responsibility of the supervisor for their own unceasing development and that of their supervisees; which largely happens outside of the therapy relationship.

My sense of relevant is an embodied grounded stance in the shifting sands, feet firmly planted, finding traction in the waters of these changing times; an internalised supportive structure which does not limit and constrain. Remaining true to their unique essential framework becomes a resource that supports the therapist/supervisor to stay in a process of constant negotiating and grappling so as to attune and ease in to a deepening connection with the other. By being themselves, having true compassion and being in relationship with their own vulnerability lends a freedom and an authentic willingness to understand human suffering. One example is of a therapist/supervisor who has gone beyond their own hyper vigilance and traumatic experience which has been transformed into an acute alertness or antenna. This grants a critical meeting with the other, the tension between the important versus urgent is ever present. To attend by attuning, not just to follow the urgent, but to use that as the window to see beyond the immediate pull of the undertow. To work at this level requires the creation of an empathic space and the freedom to sit in the mystery of any unconscious process.

To keep the essential relevance of psychotherapy, we need to ensure that the approach is integrated and, I would argue, not merely eclectic, that is jumping to the latest without examination or reflection. New research, theories and models are emerging all the time. They can be of best value when they are refined, assimilated and built into existing essential principles, modalities and philosophies. Critical reflection on action is the process of a continual critiquing or testing self against theory. This craft of a continuous process of learning and development in turn cultivates a deepening of process and integration of new learning, tested against existing beliefs, perceptions and behaviours. This then cultivates reflection in action, moment by moment.
Good quality supervision is essential in keeping psychotherapy relevant to these changing times. Supervision as a model of collaboration and lifelong learning can address the tension between theoretical knowledge and process; espoused learning versus experiential, translatable into action and changed practice (Carroll, 1996, 2014). We cannot teach empathy, it has to be learned through experience so that it becomes authentic and flowing; a part of us. It involves examining practice reflectively and reflexively, which creates a reformulation of existing assumptions to “permit a more inclusive, discriminating, permeable, and integrative perspective” (Mezirow, 2011, p.9).

Conclusion

Although the context of society may have shifted the same human needs, dilemmas and crises exist beneath. Paradoxically, the context of these changing times could be turned on its head. The consideration is one of emphasis; it is dependent on individual stance, attitude and frame of reference; the individual world view of the therapist and supervisor. Ultimately, keeping it relevant is to see the context as field, and as the door to the particular human suffering and struggle of the other.

There is a relationship between the level of personal responsibility (individualism) and the holding environment. We have become a ‘procedural’ led world, which has less time for the relational; we have become disconnected. In fact, it is possible that the procedural is in danger of making pathology of natural human suffering. Is it too simple to say that previously held structures gave us a construction for understanding the struggle of what it is to be human, and in pursuit of new ideals they have consequently been rebuffed? Therefore, to keep it relevant, there is an importance vested in therapy to hold an authentic solid presence which makes itself available to the client to explore their own structures of meaning making. Transformation comes through this interconnectedness; negotiation and grappling with difference to find meaning and understanding not unlike the negotiation and struggle of mother and baby in forming attachment. Presence and compassion are the source from which to attune; to meet the client where they are and to understand their world view.

Have we reached another paradigm of consciousness where in effect, it seems that we are facing an ‘adolescent pull’ in our new postmodern culture? “Fix it. Fix me.” I feel that as therapists and supervisors we need not to become ‘collusive parents’; to allow the client to find their own sense of themselves. This is similar to that of early attachment where mother and child grapple and struggle; negotiate to hone the bond. The difference you could say, at the adolescence stage, is that the struggle is concerned not with me and mother but is more concerned about me and wider society. It also involves much more ‘conscious knowing’. We as therapists/supervisors can appeal to this, whilst holding vulnerability in perspective. We have to assist people to be in the world, therefore, it is utterly vital that as therapists and supervisors we need to remain countercultural; to continually be aware of where we are getting caught up in fear and urgency of the context. At one level, this may seem as though we are not ‘doing anything’, however this is the irony. It is important to cultivate an atmosphere that ‘sees beyond’; that does not react but rather considers and responds. We need to be deepening, broadening and continually integrating the person centred themes; that we focus on relationship rather than technique and develop an ‘authentic encounter stance’.

How do we do this? We remain real, robust and clear whilst at the same time able to sit in a posture of understanding and compassion and not get pulled in. From the experience of the study, I feel that we need to be operating out of a spacious and integrated, theoretical, philosophical and spiritual framework. This comes from and is maintained by an on-going practice or discipline; to ‘chew over’, reflect on and synthesise our experience.

‘Plus ça change plus c’est la même chose’
Michele O’Brien is an IAHIP accredited Psychotherapist and Supervisor. She completed her psychotherapy training with Dublin Counselling and Therapy Centre in 2002. She has a Masters (Hons) in Supervisory Practice, from Milltown Institute. She maintains a private practice in Kenmare, Co Kerry, which has been home to her for the past 25 years. Based in the Stone Arch Centre, Michele’s interest is in exploring the transformative and restorative aspects of Supervision. She recently undertook a thematic analysis exploring Supervision and Psychotherapy: Keeping it Relevant to these Changing Times.

She can be contacted at 0872564189; www.micheleobrien.ie; michele@micheleobrien.ie

References:

Chronic Pain and the Role of Psychotherapy

by Mary Peyton

Kate
Kate arrives for her session. She has been looking at her issues around her adoption and today she limps into the room and sits in the chair. It is obvious that there is a problem with her foot but she minimises this. I find myself drawn into a collusion with her dismissal and we speak of her early experiences which have been occupying her thoughts since our last session, but my attention is pulled back to her foot which she is not moving. I say to her that I notice her left foot is still and she tells me that she had tripped on her way to her session but it was fine, just a bit sore. She goes on to speak of her fantasies and fears around her birth mother but my attention is still gripped by her foot. I ask her if we might pay some attention to her foot that appears to have been injured. She reluctantly agrees and says she has work that evening which involves her being on her feet and now she notices that it is painful and swollen. She is able to move it but it hurts. I ask her to stand and when she attempts to place her left foot flat on the floor, she is unable to weight-bear. I think to myself that she has probably broken a bone and that it requires attention. She reluctantly agrees that it probably would be wise to go to the Accident and Emergency Department. The subsequent confirmation of a fracture and her ability to dismiss both the injury and the pain, offered us a metaphor for her disconnection from her early psychological pain/fracture and indeed herself, including the difficulties she constantly experienced around taking care of herself at a practical level.

Human beings have a complex relationship with pain. Pain is a multidimensional, complex, and unpleasant experience with emotional, cognitive, affective, behavioural and sensory components (Manchikanti et al., 2002). Pain is a subjective experience. There are survivors and prisoners. The Pain in Europe Study carried out in (Fricker, 2003) demonstrated that one in five people in Ireland suffer from chronic pain with some people enduring it for up to 20 years (Breivik et al., 2006). A more recent study looking at the prevalence, impact and cost of chronic pain in Ireland (Raftery et al., 2011) demonstrated an even higher prevalence figure of 35 percent.

The Function of Pain
Imagine if we felt no pain! When a person is born with congenital insensitivity to pain, their life expectancy in 50% of cases is only 3 years, with a maximum age expectancy of between 25 and 30 years. This condition is characterised by the ability to feel sensations of pressure, sharp and dull, hot and cold but not pain (Nagasako et al., 2003). Pain signals damage. Most of us are familiar with the damage we can do when we have had local anaesthesia for the purposes of dental work. When the local anaesthetic wears off, we are only too aware of the pain of the numerous bites we have inflicted upon our cheeks while the signal for damage was immobilized. Pain is protective and helps us survive. It tells us that something is wrong, and calls our attention to it. It is part of a vital warning system. The experience of acute pain is adaptive and signals the need for rest and recuperation.

Chronic pain however is defined as pain that serves no biological function, lasts longer than the typical healing time, is not responsive to traditional treatments and lasts longer than six months. It has many detrimental consequences for the individual including psychological distress, social isolation, employment difficulties, and relationship problems. For most people there are no outward signs of chronic pain, which further increases their difficulties. They look normal and are expected to behave as if nothing is wrong.

The syndrome of chronic pain appears with the words psychogenic, psychosomatic, somatoform attached to it. Unfortunately, somehow these words diminish rather than credit the crucial importance of the psyche. Medicine looks at pain through biological mechanical eyes, investigates it looking for structural and microscopic causes and treats it with analgesics, surgery and physical interventions
such as physiotherapy. It acknowledges the psychological component, but in a way that can often leave the patient feeling abandoned, wronged or simply wrong. The dualistic model is still very much alive, and body/mind unity is given lip service when it should actually be central.

From a biological perspective, physiological needs are basic in understanding the body; from a totally different perspective of humanistic theory, potentials for experiencing are basic in understanding the human body. Physiological and humanistic constructs bear no hierarchical relationship toward one another; each set enjoys independent integrity. (Mahrer, 1978)

**The Biology of Pain**

The body has pain receptors present in the skin and internal organs, which when stimulated, send signals to the brain which then recognizes what part of the body is in pain and what type of pain is being felt. There are two pathways for pain fibres, one to locate the pain and the other to alert us to pain. The majority of the latter pain fibres terminate in an area called the reticular activation system, a part of the brain that activates the entire nervous system, arousing us from sleep, alerting us to danger, and causing us to take defensive or aversive reactions.

Neuroscience “one of the contemporary glamour specialties of research medicine” (Sarno, 2008), offers further insight into the biological mechanisms of chronic pain but again is sometimes misguided in confusing correlation with causation. What neuroscience has taught us about pain is that when an individual feels pain, many areas of the brain are activated, including the amygdala (involved in recognizing threat) and frontal cortex (involved in our cognitions and meaning making). This can lead to a person with chronic pain feeling hyper vigilant and stressed, with all the ensuing consequences. Another phenomenon has also been recognized in individuals with chronic pain and it is the phenomenon of recruitment of areas not initially involved in the sensation of pain. This is called central sensitization and it results in allodynia and hyperalgesia. **Allodynia** is pain, usually on the skin, caused by something that would not normally cause pain such as light touch, and **hyperalgesia** is an increased response to a painful stimulus. Therefore, the chronicity of pain in itself can bring about changes to the experience of pain.

We can thus see how pain and stress are related, the amygdala influencing the hypothalamic-pituitary-axis, causing it to secrete stress hormones and increasing stress chemicals in the body. What is missing here is the psyche and its part of the story. Pain has a story to tell with a history and context for each person.

**Chronic Pain**

When we look at pain purely through biological eyes, there is much that is missed. Of course, there is a time when it is appropriate to do exactly that, for example with my client Kate, but even there, had we limited our curiosity in that manner that would have done her a disfavor. How else might her body have had to speak in order to bring her into connection with herself had the metaphor of the communication been overlooked and that opportunity missed? And her story was of acute pain.

When pain is chronic, a purely mechanistic biological approach is patently insufficient. It ignores the mind body relationship, and the emotional component in pain. Chronic pain can be met with jaded eyes. Indeed, even psychotherapists, despite their theoretical frameworks, may shy away from working with pain particularly musculoskeletal pain. The therapist’s own defensive countertransference may be activated, perhaps seeing pain as an inevitable consequence of injury, aging or illness (Anderson & Sherman, 2013).

Many studies have demonstrated that adverse experiences during childhood such as physical or sexual abuse may well be possible risk factors for the later development and persistence of chronic pain in
adulthood (Linton, 2002; Davis et al., 2005; Sachs-Ericsson et al., 2009). Sarno (2008) would also claim that pain, particularly chronic pain, can be a defense against emotion, and it so distracts the person that the source may never be uncovered unless the mind body connection is made. Luyten & Van Houdenhove (2013) argue that current treatment research has overlooked growing insights in relation to the central role of attachment and stress regulation in chronic pain and has proposed an integrative, specific and staged treatment approach with attachment and mentalisation at its core. He hypothesizes that individuals with chronic pain can switch from a chronic state of “overdrive” in the hypothalamic-pituitary-adrenal axis, which is activated in stress, to a state of “underdrive” leading to what he calls a “bio-psychological crash.” This manifests as profound lethargy, fatigability, loss of concentration, increased sensitivity to pain and stress. In his research, improvements in symptoms correlated with changes in emotional processing i.e. the expression, acknowledgment and acceptance of emotions and emotional distress.

**Chronic Pain and Attachment**

Pain is a stress making experience. Attachment and stress regulation are intimately related (Sbarra & Hazan, 2008). As human beings, we are wired to seek proximity to attachment figures when we are stressed (Bowlby, 1969). If securely attached, proximity seeking leads to down regulation of stress. The hormone oxytocin plays a role in attachment behaviour. It is also vital in relation to an individual’s capacity for mentalisation, i.e. the capacity to interpret oneself and others in terms of mental states, in other words to ascribe intentions and meaning to human behaviour. Oxytocin levels are high in new mothers, enabling the bonding necessary between mother and baby. Individuals who are securely attached have a greater capacity to mentalise. (Fonagy et al., 2002) This capacity to mentalise is maintained even when severely stressed, and therefore the individual is able to remain open and reflective even when stressed, leading to increased capacity for intimacy in relationship (Fredrickson, 2001; Mikulincer & Shaver, 2007).

Individuals who are insecurely attached however, use different strategies when faced with stress. Anxiously attached individuals rely on emotion-focused coping and avoidant individuals rely on distancing coping. The former frantically pursue others for support, demonstrating demanding and claiming behaviour. This is associated with physiological stress and again uses up high levels of energy. There may well also be negative consequences in relation to the very relationships they seek to offer them support. The latter (avoidant) project an image of independence and strength and may appear to be coping well, when in fact deep down they are severely distressed. The energy required to maintain this is high. The avoidant breaks down in the face of severe, persistent stressors and the individual experiences feelings of insecurity, heightened reactivation of negative self-representations with concomitant high levels of stress.

Research has shown that chronic pain patients’ coping styles influence evaluations made about them by others, and of course, the evaluators’ gender and own attachment characteristics have an important influence on such evaluations (Baily et al., 2012). When an individual demonstrates attachment avoidance, this was associated with lower ratings of perceived deservingness of support and desirability as a friend. Thus, the individual with avoidant attachment can find him/herself isolated and alone. One study was carried out using the Social Communication Model of Pain (Craig, 2009). This model was developed as a framework for understanding the many interpersonal factors affecting pain and pain management. Interpersonal factors include the characteristics both of the individual with pain and the person they are relating to. Therefore awareness by the therapist of the attachment dyad is important, as it offers information in relation to possible unconscious early attachment issues which will play out in the therapy.

**Regulation of Stress**

Denying or fighting symptoms prolongs stress. With prolonged stress, there are neurobiological
consequences. For example, Le Doux (1996) speaks of the loss of dendrites in the nerve, which means less connectivity and less neurogenesis. In addition, there is little scope for reflectiveness while high levels of stress continue (Fonagy & Luyten, 2009). And yet, what is required is that reflectiveness is fostered by the therapist. This may be further complicated by the individual maintaining a split relationship with their symptoms. The pain may be seen as an attacking other, evoking fear and helplessness. Pain is seen as “the enemy”. Where this is the case, there is little capacity for exploration of inner mental states and again the therapist has to hold this potential space for the client.

The Task of the Therapist
As therapists, we are comfortable working with the recognition that emotional conflicts, repression and disavowal have an impact on body structure. The presence of physical pain is less comfortable, contributed to no doubt by the medicalization of pain, a framework that can get in the way of working therapeutically with pain. In addition, the primal experience of pain is inevitably activated within the therapist, and the therapist needs to be aware of his/her own relationship with pain.

John
John has not had a restful sleep for months because of pain. His pain is everywhere, in his muscles, joints and skin, which feels like it is on fire. His pain consumes him. He has a diagnosis of chronic pain, has had a multitude of investigations, has tried various medications but is more frightened by their side effects than he is of the pain. To the outside world, he looks like he is managing life well and is successful. In reality, he lives his life in agony. He knows that he was sexually abused when he was a boy and that the physical pain he is now experiencing is related to that experience but cannot really connect the two.

With a client such as John, the work of the psychotherapist is to help the individual translate the painful language of the body into the language of the intense debilitating psyche that created it in the first place. This is no easy task. When a client presents in chronic pain, its immediacy can fill the room to the exclusion of other possible areas of focus. It can catch us as therapists. It demands attention and at the same time, there is an overwhelming desire to be rid of it, an unenviable position to be caught in for both therapist and client. How do we work with this intense conflict? And what of the client whose resistance to working with pain presents as a conviction that there is a biological reason for pain, despite investigations yielding nothing? This may manifest as a projective identification where the therapist finds themselves feeling utterly helpless as they grapple with their client’s conviction of a medical diagnosis which has just not been found yet. It may also represent a denial on the client’s part of what lies beneath.

Having a framework to work from is vital. Seeing pain as a psychobiological entity, as a language that is being used by the client to speak some truth that is not able to emerge in any other way, offers us a way to hold the client while the story is told. Pain is a way of using somatic imagery to tell a story. Holding the possibility that pain contains primary intolerable affective states of which the client is not conscious is crucial. Pain can on the one hand offer the opportunity for the client to speak and seek help and on the other keep the person distanced from these intolerable unbearable feelings. If we hold the position that pain is a distress signal, we can help the person decipher this signal and look for the source/meaning internally. Even when the signal is screaming, we have to have the capacity to help the person look around at what else is going on. Or in the words of Bollas (1994), we need to provide a receptive space “for the arrival of news from within the self.” What other sensations, feelings, emotions, images, are present or indeed absent? How might dreams be informing us of the deeper meanings of the pain? Gently encouraging a curiosity in the person, holding fast when the storm peaks as it will repeatedly, staying present in the despair, allows a space for the client to connect with themselves at a deep level so that the metaphor can unfold and the relationship with and experience of pain can change.
The reality of the individual’s suffering must be received and reflected by the therapist in order that room is created for thinking around the symptoms, particularly where there is little or no connection to psychological factors. It is through inner connection that feelings are recognized and expressed, stress is diminished, and an alternative meaningful view of self is created. This is the beginning of recovery. To this end, the ability of the therapist to offer a receptive space, to be aware of and track their countertransference and digest it, is a necessary precondition for the client, in time, to be able to listen to and hear the story of their pain.

Mary Peyton works as an Integrative and Humanistic psychotherapist in private practice and is an accredited Supervisor with IAHIP. She studied Medicine in UCD and has a Fellowship in Anaesthesia from the Faculty of Anaesthesia, Royal College of Surgeons in Ireland.

References:
A Mixed Methods Investigation of Stress, Compassion Fatigue and Satisfaction, Governed by Self-Care Strategies, for Integrative Irish Psychotherapists: This Too Shall Pass.
by Shane Gallagher

Seventy six integrative Irish psychotherapists (N=76) completed an on-line questionnaire. Information was collected on demographics, participation in several self-care strategies (y/n), and on total consistent time dedicated to self-care strategies per month. Measures for stress, compassion fatigue and satisfaction were also completed. The statistical analysis indicated that client hours per month significantly predicted stress scores, to a negative moderate amount and that academic qualifications significantly predicted burn out scores, to a positive minimal amount, no other significant predictive correlations were found. However, a profile plot indicated an inverse correlation between mean perceived stress scores and the amount of self-care strategies used, for therapists in private practice. Qualitative analysis indicated the uniqueness of self-care strategies employed. Both methodologies highlighted areas of interest and concern including, access to Irish participant therapist populations, stigma/labelling associated with negative concepts and the importance of self-awareness and good supervision.

Previous research and literature in this area, is somewhat paradoxical and contradictory, as a result of overlapping concepts, inconsistent population sampling and other methodological limitations (Craig & Sprang, 2010; Kadambi & Ennis, 2004). Previous research has approached the subject through the concepts of stress, burnout, vicarious trauma, secondary traumatic stress, compassion fatigue, vicarious resilience and compassion satisfaction. Much of the earlier research has focused on the dangers and negative consequences for the therapist (Figley, 1995; McCann & Pearlman, 1990; Smith & Moss, 2009). Some of the later research has tended to focus on possible vicarious resilience/growth or compassion satisfaction (Craig & Sprang, 2010; Hernández, Engstrom & Gangsei, 2010). This research attempted to overcome problems associated with previous research, through purposive sampling of participants (N=76) (accredited members of IAHIP), a focus on stress, compassion fatigue, compassion satisfaction and self-care strategies and the use of the most validated scales for the measurement of these concepts. This research question is important, as the knowledge of the impact of these factors not only informs the profession, but sets the basis for strategies, training and practice, that could aid in prevention and ensure a minimisation of negative effect (Bright & Harrison, 2013).

Concepts under investigation
Stress is a subjective experience and what counts as a stressor, differs for each individual, similarly, coping strategies used by individuals are also widely variant (Lazurus, 1966). Research has shown that individual characteristics affect the ability of individuals to cope with stressful situations (Kozak, Strelau, & Miles, 2005); similarly environmental factors, from a very young age, have been shown to effect an individual’s ability to regulate stress levels (Schore, 2003, 2014). Stress would appear to have its roots in the flight, fight or freeze response (Schore, 2014). Psychological theories have perceived stress occurring as a result of cognitive assessment that resources (coping mechanisms) are unable to meet demands (stressors) (Lazarus & Folkman, 1984b).

Burnout is generally considered to be influenced by work related variables, as a result of organisational impediments and conditions (Maslach & Leiter, 2008; O’Connor & McQuaid, 2013). Factors associated with the antecedents of burnout include, increased workload, limited support (social and work related), role conflict, ambiguity and personal characteristics of the individual (Maslach, Schaufelli & Leiter, 2001; Wilkerson & Bellini, 2006).
Stamm (2010) has indicated that secondary traumatic stress is one half of compassion fatigue (the other being burnout) and is related to carers treating individuals, who have suffered primary stress and trauma. According to Stamm (ibid) this results in the therapist being traumatised by the experiences of the client.

The following factors have been shown to effect therapist’s wellbeing:

**Work related:**
Personal supervision (O’Connor & McQuaid, 2013), peer support and supervision (Thompson, 2003), diverse caseload (Chrestman, 1995), clear boundaries (Neuman & Gamble, 1995), clinical experience (Sheehy & Friedlander, 2009), trauma history (Linley & Joseph, 2007), workload (O’Connor & McQuaid, 2013), negative/positive work support (Saakvitne & Pearlman, 1996), ongoing training and education (Linley & Joseph, 2007).

**Personal-related:**
Healthy lifestyles (exercise, diet, holidays/breaks) (O’Connor & McQuaid, 2013), spirituality (religious or mindfulness/meditation) (Christopher & Maris, 2010), social support (Linley & Joseph, 2007), awareness, balance and connection (ABC) (awareness of self, balance of lifestyle and connection with people/nature) (Figley, 2002), personal therapy (O’Connor & McQuaid, 2013), the bond of the therapeutic relationship (Linley & Joseph, 2007).

According to Stamm (2010) compassion satisfaction occurs as a result of the therapist being able to do their work in an efficacious manner, to assist clients/colleagues, to facilitate a better quality of life for clients or to ameliorate suffering in the other.

Consistently, the quantitative studies that have been conducted on negative concepts have failed to identify high levels of symptomologies among participants (Arvay & Uhlemann, 1996; Baird & Jenkins, 2003; Kadambi & Truscott, 2003). This lack of verification has primarily been attributed to under reporting by participants (due to stigma, labelling) (Elwood, Matt, Lohr & Galovski, 2010; O’Connor & McQuaid, 2013). However, previous research has also indicated that perceived stress, burnout and secondary traumatic stress, are preventable, and transient conditions rather than fixed (Hayes, 2013; O’Connor & McQuaid, 2013).

**Participants and Procedure**
The sample for this study consists of seventy-six (N = 76), (Gender F/M = 61/15, 4:1), (Age 35-44 = 10, 13%; 45-54 = 23, 30%; 55-64 = 37, 49%; 65-74 = 6, 8%), accredited integrative psychotherapists in Ireland. The sample consists of accredited members of the ‘Irish Association of Humanistic and Integrative Psychotherapy’ (IAHIP, 2015).

Having received approval from the Dublin Business School ethics committee, an ad was posted in the IAHIP weekly classifieds inviting participation from accredited therapists. A survey weblink was contained in this advertisement, unfortunately only ten responses were received. Accordingly, a follow up e-mail was issued to 408 therapists and centres, which resulted in a further 66 responses (response rate 16.18%). All ethical guidelines were adhered to, in these communications.

**Method**
Raw data was imported from the on line questionnaire, for eighty-one therapists (N = 81). The data was then cleaned, excesses removed, this included the removal of five incomplete participants, this left data for 76 (N=76) participants. Interestingly, of the five incomplete participants, four stopped...
completing the survey at the exact same question, the first one related to self-care strategies. The edited data was analysed using the statistical package for the social sciences (S.P.S.S.) (Kinnear & Gray, 2007). Demographics were collected on age, gender, relationship status, self-care strategies, self-care hours p.m., average client hours per month (p.m.), average personal therapy p.m., average personal supervision p.m., organisational or private practice, specialist or general practice, academic qualifications and willingness to participate in a one hour interview. Two pre-existing established measures were also used, the ‘Perceived Stress Scale’ (PSS-10) (Cohen, Kamarck & Marmelstein, 1983), and the ‘Professional Quality of Life Scale’ (ProQol - V) (Stamm, 2010). A series of standard multiple regression analyses were carried out, to test the predictive value of several predictor variables, on single criterion variables. Predictor variables were average self-care hours per month, average personal therapy hours per month, academic qualifications, therapist years accredited and average client hours per month. Criterion variables used were perceived stress scores, burnout scores, secondary traumatic stress scores and compassion satisfaction scores. In accordance with the rules for sample size (Stephens, 1996, p.72), fifteen subjects are required for each predictor variable.

From a qualitative perspective, three accredited integrative therapists were selected to participate in interviews, in keeping with current recommendations (Smith, Flower & Larkin, 2009; Smith & Osborn, 2008). Interviewees were selected, based on their indication of willingness to participate and on those who scored highest in the burnout scale. Individuals selected scored fifteenth, twentieth and twenty-seventh highest respectively in burnout scores. Interviews were conducted in a semi-structured format (Smith, Flowers and Larkin, 2009). Data was then analysed, using transcripts and notes taken shortly after each interview, using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, Larkin, 2009).

Results
Descriptive Statistics:

<table>
<thead>
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<th>Therapist employment in Public or Private Sector</th>
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</thead>
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<td>Public</td>
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<tr>
<td>Private</td>
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<tr>
<td>Totals</td>
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</tbody>
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**Table i:** Descriptive statistics for private/public sector, indicating frequency and percentages.

<table>
<thead>
<tr>
<th>Therapist in full-time/part-time employment</th>
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<tr>
<td><strong>Employment as therapist</strong></td>
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<tr>
<td>Full-time</td>
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<tr>
<td>Part-time</td>
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<tr>
<td>Totals</td>
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**Table ii:** Descriptive statistics for full/part-time employment, indicating frequency and percentages.
**Therapist Practice**

<table>
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<tr>
<th>Type of practice</th>
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<th>Percentage %</th>
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<tr>
<td>Specialised</td>
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<td>15</td>
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<tr>
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<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table iii:** Descriptive statistics for general/specialised practice, indicating frequency and percentages.

**Meditation**

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>38</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>50</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table iv:** Descriptive statistics for meditation, indicating frequency and percentages.

**Mindfulness**

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49</td>
<td>65</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table v:** Descriptive statistics for mindfulness, indicating frequency and percentages.

**Breathing exercises**

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42</td>
<td>55</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>45</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table vi:** Descriptive statistics for mindfulness, indicating frequency and percentages.

**Physical exercise**

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56</td>
<td>74</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table vii:** Descriptive statistics for physical exercise, indicating frequency and percentages.
### Social/Peer support

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>65</td>
<td>85</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table viii:** Descriptive statistics for social/peer support, indicating frequency and percentages.

### Willingness to participate in interview

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table ix:** Descriptive statistics for interview participation, indicating frequency and percentages.

### Number of self-care strategies practiced

<table>
<thead>
<tr>
<th>Number strategies</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>One</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Two</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Three</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Four</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>Five</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table x:** Descriptive statistics for number of self-care strategies, indicating frequency and percentages.

### Descriptive statistics for continuous variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of responses</th>
<th>Min. Score</th>
<th>Max. Score</th>
<th>Mean Score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years accredited</td>
<td>76</td>
<td>1</td>
<td>35</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Client hours p.m.</td>
<td>76</td>
<td>2</td>
<td>100</td>
<td>38</td>
<td>22</td>
</tr>
<tr>
<td>P. Therapy hours p.m.</td>
<td>76</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Supervision hours p.m.</td>
<td>76</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Self-care hours p.m.</td>
<td>76</td>
<td>0</td>
<td>60</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>P.S.S.</td>
<td>76</td>
<td>0</td>
<td>24</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Burnout</td>
<td>72</td>
<td>28</td>
<td>52</td>
<td>37</td>
<td>6</td>
</tr>
<tr>
<td>S.T.S.</td>
<td>72</td>
<td>36</td>
<td>67</td>
<td>49</td>
<td>8</td>
</tr>
<tr>
<td>C.S.</td>
<td>72</td>
<td>35</td>
<td>61</td>
<td>50</td>
<td>7</td>
</tr>
</tbody>
</table>

**Table xi:** Descriptive statistics for scale data, indicating number of responses, minimum maximum scores, mean scores and standard deviation.
An analysis of raw scores for all continuous variables was also carried out. This analysis indicated the following points of interest: for perceived stress, \((N = 76)\), range = 0 – 24 (mean = 12.29, \(SD = 5.34\)), no high values. However, eight participants (9%) scored under five, with one scoring zero, this appears unlikely, and may indicate underreporting or choosing the right (consciously or unconsciously), rather than the real answer. Four participants \((N = 4)\) who completed all other sections of the questionnaire did not complete the ProQol. No extreme scores were recorded for burnout, \((N = 72)\), range = 28 – 52 (mean = 36.75, \(SD = 6.23\)). Range of score for secondary traumatic stress \((N = 72)\), 36 – 67 (mean = 48.75, \(SD = 7.55\)), twelve participants (17%) scored above 57, indicating high \((12 \geq 57)\) levels (Stamm, 2010). Range of scores for compassion satisfaction \((N = 72)\), 35 – 61 (mean = 49.83, \(SD = 6.69\)), twelve participants (17%) scored above 57, indicating high levels \((12 \geq 57)\) (ibid). The individuals who scored high for secondary traumatic stress, were not all the same as those that scored high on compassion satisfaction. Range of scores for self-care hours per month \((N = 76)\), 0 – 60 (mean = 18.05, \(SD = 13.75\)), 13 (17%) participants indicated under 5 hours \((13 < 5)\), with one indicating 0, this also appears unlikely and may point to a problem with the options provided for self-care strategies and measurement, based on total hours per month.

**Inferential statistics:**

Client hours per month significantly predicted perceived stress scores to a negative moderate amount \((\beta = -.319, p = .012)\). This indicates that client hrs/mth ↑ = stress scores ↓. This may indicate a validation of their abilities, as a result of the number of client hours per month. Academic qualifications significantly predicted burnout scores, to a minimal positive amount \((\beta = .282, p = .022)\), indicating that, academic qualifications ↑ = burnout scores ↑. This result makes little sense from the perspective of previous research, which indicates that education and professional development act as moderators against negative concepts (Linley & Joseph, 2007; Follette, Polusay & Millbeck, 1994; O’Connor & McQuaid, 2013). It should be noted that this result was minimal. However, this result and the fact that no other significant predictive correlations were discovered, within the statistical analysis, contrary to previous research, may point to a problem with the sample size.

However, an analysis of a profile plot (Graph i), depicting marginal means for perceived stress, governed by number of self-care strategies employed and private or public employment, demonstrates some interesting results. In the private sector graph line, mean perceived stress scores drop dramatically, as the number of self-care strategies increases. In the public sector graph line, mean perceived stress scores also decrease as the number of self-care strategies increase, with a slight increase from two to three strategies. This would seem to indicate that the amount of self-care strategies employed has a positive effect on perceived stress levels.
**Figure i:** Profile plot depicting marginal means for perceived stress, governed by number of self-care strategy groupings and private or public employment.

**Other graphs of interest:**

**Figure ii:** Bar graph depicting count of participants for relationship status.
Figure iii: Bar graph indicating count of participants, for different academic qualifications categories.

Qualitative:
As a result of the interviews conducted, the transcription of same, and the IPA analysis of the data, the following findings came to light.

Frequencies of key words:

<table>
<thead>
<tr>
<th></th>
<th>Burnout</th>
<th>Stress</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona</td>
<td>0</td>
<td>51</td>
<td>4</td>
</tr>
<tr>
<td>Mary</td>
<td>2</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Anne</td>
<td>1</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>86</td>
<td>7</td>
</tr>
</tbody>
</table>

Table xii: Frequency of repetition of key words, within transcripts, governed by interviewees.

The analysis of frequency of key words, within each transcript, indicated that the word burnout only appeared three times. This supports the assertion by previous research, that burnout is perceived as stigmatising and labelling (Elwood, Matt, Lohr & Galovski, 2010; Fahy, 2007; Figley, 1995; O’Connor & McQuaid, 2013). In contrast, the word stress occurred eighty-six times, which indicates its acceptable nature. The word satisfaction only occurred seven times, however, a review of the transcripts indicates that other words with similar meaning (i.e. happiness, joy), were also used.

Analysis of themes:
As a result of the use of interpretative phenomenological analysis, the understated superordinate and subordinate themes were uncovered.
Stress and compassion fatigue:
This analysis indicated that Stress would appear to be the acceptable face of psychotherapist’s distress. The transcripts are rife with multiple references, whether retrospective, extreme, acute or chronic. Each interviewee elucidated the difficulties associated with complex clients, though individually these were different for each one, indicating the individuality of each therapist (Chrestman, 1995). One issue, which came up very strongly, was control, which was indicated very strongly by Fiona “So I was working in the public service and I wanted more control over my life I guess.”….. 5(A) “So being in control also meant you had control of your costs, but I imagine it would be stressful.”….. 7(D) “These are the things that actually matter to me, you know, and I can pick and choose the work I do.”….. 8(C) “So no again I think because I am in control of my work I don’t have to really spend time worrying about what I should do.” and to a slightly lesser degree by the other interviewees. This is in keeping with previous research, on stress (Petrosky & Birkimer, 1991) and this may represent one of the catalysts for burnout and chronic stress (Maslach & Leiter, 2008; O’Connor & McQuaid, 2013).

Burnout, in contrast, represents a lack, a lack of inclusion in the dialogue and a lack of acceptance. This may represent the lack that therapists feel in association with the concept, this is demonstrated very strongly by Fiona’s only speaking about it off record, the other two interviewees made some reference to it, but always in a defended way. This is supported in previous research by reference to stigma/labelling associated with these extreme negative concepts (Linley & Joseph, 2007; Follette, Polusay & Millbeck, 1994; O’Connor & McQuaid, 2013). Secondary traumatic stress was also spoken about very openly in the transcripts, and the role of transference and counter-transference (Freud, 1912).

Compassion satisfaction:
Internal factors or therapist as individual, was considered to strongly moderate stress and other negative concepts. The roles of awareness, experience, self-esteem, self-development, internal supervisors (Casement, 1990) were shown to impact, not just on the negatives, but on the positives as well. Therapists must be aware of their own processes, their own limits, their own individual stressors (which are unique to the individual) and utilise strategies to compensate. With regard to external factors, the importance of client balance, client change, organisational support and the effects of a lack in any of these areas was strongly emphasised, in keeping with previous research (Sheehy & Friedlander, 2009; O’Connor & McQuaid, 2013).
Self-care:
The important role played by supervision, in supporting therapists and the security and secure base (Bowlby, 1988) which it provides, was very evident from the transcripts. The role of supervision, its emphasis and impact on all three interviewees, was emphatic, which is supported by previous research (Linley & Joseph, 2007; O’Connor & McQuaid, 2013) and making it, perhaps, the front line of defence against negative factors. In keeping with previous research (Linley & Joseph, 2007; O’Connor & McQuaid, 2013; Thompson, 2003), personal/group therapy, peer support and social support all rated highly. However, there was one proviso, that when these supports were going badly, this combines to accentuate other negative factors in the interviewee’s lives. Interestingly, self-care strategies were unique for each interviewee, one valued holidays and alone time, one massage and gardening and one utilised running, yoga and meditation. All three acknowledged the positive effects of strategies like meditation and mindfulness, but admitted to being inconsistent in their practice. Accordingly, it is maintained that individual therapists compensate for their own process (through awareness) and adapt their self-care, to what is considered necessary, for their own self-maintenance.

One matter of further interest was the strong statement, interpreted as a plea, by one of the interviewees. Mary’s request for it to be acknowledged “that it’s okay, to be not okay”. This was seen as an affirmation of previous statements (Figley, 2002; O’Connor & McQuaid, 2013), as regards the negative concepts and stigma/labelling (ibid).

Co-operative:
The quantitative statistical analysis demonstrated a lack of high scores, for burnout/stress, this was confirmed by the qualitative analysis. However, due to the rich nature of qualitative analysis it was able to demonstrate retrospective incidents of chronic stress or burnout, in the past lived experience of the interviewees. This further confirmed the transient and treatable nature of such conditions. Further the qualitative analysis demonstrated stigma/labelling attached to such concepts, as asserted by previous research (ibid). This may indicate elements of underreporting, which is supported quantitatively by participants not completing certain sections of the questionnaire and low scoring on certain measures (PSS).

Discussion
This research has generated strong, quantitative and qualitative baseline data, in relation to integrative psychotherapists in Ireland. More diverse self-care strategies were utilised by participants than was reflected in the options given, this should be addressed in future research, along with measurement of individual strategies (hrs/mth) rather than a single measure of total hours per month.

Graph i indicated the effectiveness of self-care strategies on stress. Confirmation of perceptions of stigma/labelling were also found and Mary’s plea, perhaps, highlights this strongest. A plea that representative bodies, supervisors and peers should take on board.

Although only weak support was found for predictive correlations, one of the possible reasons for this is tentative sample size. Generally speaking quantitative research requires a minimum of 100-120 participants and this is not aided by a lack of access to therapist populations. IAHIP’s access route, though laudable, was not effective, as is evidenced by this research. Perhaps organisations such as IAHIP and IACP, IPAA and ICP can assist in establishing such access. Such an access route would enable therapists to indicate which areas of research they consider important (through their participation). A second benefit is that this access route would open a two-way avenue of access, where the results of such research could be circulated back to participating therapists. However, in the interim I would entreat all psychotherapists, given the importance of research, to participate in as much as they are able.
Shane Gallagher, is a 52 year old retired member of An Garda Síochána. He has a B.A. in Psychology (2010) and is currently a member of the Psychological Society of Ireland (MPSI). He has an M.A. in Psychotherapy (2015) and is currently a pre-accredited associate member of IAHIP. Some areas of interest: stress, anxiety, attachment, depression, grief, bi-polar, autism spectrum, mindfulness, meditation and impact of early childhood experiences on adult character formations.

References:


**Perception of the Value of Psychotherapy in the Late Diagnosis of Dyslexia**

*by Yvonne Cunningham*

**Introduction**

The study of Savery and Wilson (2012) confirmed that stories from adult students with dyslexia were not commonly heard and in their qualitative narrative analysis approach the positive impact of identification and self-awareness of their participants’ dyslexia was highlighted alongside the educational supports received. A case study in this area of research investigating the interaction between dyslexia and its secondary emotional problems was reported in 1990 (Migden, 1990). This study reported the psychodynamic therapy treatment of a thirty-three year old male alongside educational supports and the impact of emotional problems on educational efforts as well as the development of emotional problems related to the client’s learning problems. A body of work by Alexander-Passe (2006, 2008, 2010 and 2015) and Kong (2012) examines the links between dyslexia and mental health and draws links between psychological and emotional issues and a diagnosis of dyslexia. Kong’s 2012 study with chiropractic students who were diagnosed with dyslexia when completing a Masters level programme discovered themes of Distress, Self-Doubt, Embarrassment, Frustration, Relief, Confidence and Motivation upon late diagnosis. Coping Strategies and Emotional and Behavioural Defences are engaged when dyslexia is not diagnosed or students are struggling (Alexander-Passe, 2010). The role of psychotherapy or the experiences of adults with dyslexia in psychotherapy have not been further explored and therefore this study is timely in furthering these findings.

The overall aim of the study was to gain insight into the experience of those diagnosed late with dyslexia either during their education or in their adult lives of the psychotherapy experience. Participants’ perceptions of the value of psychotherapy after a late diagnosis of dyslexia was explored as a significant gap existed in the literature in relation to understanding the themes explored in psychotherapy post a late dyslexia diagnosis and the psychotherapy experiences of participants.

In the context of this gap the objectives of this study were:

i. To identify if any common themes emerge in participants’ diagnosis that would lead them to seek psychotherapy related to their educational and psychological experience including the emotional effects.

ii. To explore participants’ perception of the value and efficacy of psychotherapy.

iii. To provide further insight into the supports required by adults with dyslexia to the present support services e.g. psychological support alongside educational supports, based on the experiences and testimony of the participants.

**Methodology**

A decision to use a qualitative research approach was taken to capture the lived experience of the participants (Braun and Clarke, 2013).

Research methodologies were investigated within the qualitative research paradigm. Thematic Analysis (TA) was chosen as the method for identifying themes and patterns of meaning as the method
focuses on the participants’ viewpoint, in this case how they experienced psychotherapy post dyslexia diagnosis and how they made sense of their experiences (Braun and Clarke, 2006).

Six participants, four male and two female were interviewed using semi-structured interview to outline their experiences of psychotherapy after a late dyslexia diagnosis. Participants were recruited via agencies that have links with adult education and dyslexia such as the National Adult Literacy Agency (NALA), Educational and Training Boards, (ETBs), The Dyslexia Association of Ireland (DAI) and student support departments in third-level educational institutes.

Results
Four main themes of Empathy, Frustration, Emotional and Behavioural Defences and Self Belief, Acceptance and Efficacy were identified with recognised overarching themes of Therapeutic Relationship and Coping Strategies were represented throughout the interview data. The use of Thematic Analysis allowed the experiences of the participants to be expressed through the themes and to further the general understanding of the lived experiences of the late diagnosed dyslexic adult population.

Empathy emerged as a major theme in the current study findings. A lack of empathy and recognition of literacy difficulties by adults in their lives namely their teachers and parents was uniformly described by the six participants of the study. From the testimony of the participants, it may be suggested that the empathy maintained in the therapy sessions, may been developmentally reparative and the ‘holding’, ‘being seen’ and consistency of support (‘my rock’) through difficulties in the therapeutic process and the life generally contributed to the overall therapeutic experience and progress of the client participants confirming the observations and findings within the research literature on Empathy.

Acceptance of Diagnosis, Labelling and Stigma
There are mixed findings in the research literature relating to dyslexia and the concepts of labelling and stigma. Some findings are that the stigma in relation to experienced difficulties in literacy are already present prior to diagnosis (Riddick, 2000) whereas others found that the stigma and exclusion from particular social groups commence after diagnosis (Rice & Brooks, 2004, Lisle, 2011, Elliot & Place, 2012). In the current study, five of the six participants interviewed were relatively open about their diagnosis of dyslexia. The sixth participant was in a teaching role in school and was very wary about disclosing her diagnosed dyslexia to anyone outside her family including her peers or initially in the counselling context.

Importance of Diagnosis
There are some findings in the data collected from all the participants in this study which stand in contrast to the findings in the research literature. Some reservations in the research literature about the necessity or wisdom of diagnosis stems from the difficulty in diagnosing dyslexia and it is proposed that a remediatory literacy strategy should be implemented for all those who experience literacy difficulties rather than placing an emphasis on assessment and diagnosis (Rice & Brooks, 2004). The participants in this study however, emphatically and without direct questioning on the topic, stressed how important receiving a diagnosis of dyslexia had been in their lives describing it as a turning point or framework upon which to position their self-understanding and awareness. This is a significant finding because it further informs the debate on the necessity for a specific diagnosis of dyslexia for those with literacy difficulties and the importance attributed to the diagnosis by those who receive it.

Not only was the fact of being diagnosed as dyslexic essential to the study participants but also the fact that in their cases they had been diagnosed at a later stage in life. All six participants had left post primary education by the time they were diagnosed as dyslexic. The participants lamented the lost
time and experienced personal and educational difficulties that arose from the late dyslexia diagnosis. The educational difficulties included the requirement to study Irish and other languages without any reasonable accommodations in state examinations.

A person’s concept of self comes from within and is based on a person’s thoughts, perceptions, beliefs, feelings and actions (Branden, 1994). Academic achievement has been strongly linked to self esteem within the research literature (Bandura, 1990; Swalander, 2006). All participants were aware of difference and difficulties from a young age and without the correct information related to their educational difficulties, a ‘false self’ was constructed which included incorrect information (‘lazy’, ‘stupid’) (Ryan, 2004) and engaged defence mechanisms (Alexander-Passe, 2010).

Branden’s concept of a ‘continuous loop’ (Branden, 1994) was borne out consistently in the participants’ testimony in this study confirming that it is difficult for those with dyslexia to develop a positive sense of self. Data in the case of all the participants confirmed previous findings that low-self-esteem affects performance and low performance affects self-esteem. The concept of self is also influenced by the views and values of others (Branden, 1994; Jerald, 2007). All the participants revealed that the feedback received from teachers had a significant impact on their self concept. This was not necessarily about remarks related to their educational performance alone but also how the participants felt they were perceived as children within the classroom by their teachers.

All participants also referred to their peer group in the interviews. The data reflected their awareness of themselves and their abilities compared to others whether this was explicitly or implicitly confirmed. Hehir’s (2007) finding that social barriers are constructed due to learning difficulties was corroborated however it was unclear from the present data whether this was due to their exclusion by others or a decision made by the participants themselves as to where they fitted in socially.

All six participants also referred to their self-perception from the perspective of home in both how they believed they were seen by their parents and siblings. Parental expectations varied and the participants were very clear on how they perceived themselves within this framework. Family circumstances including large families, bereavements, single parenthood and addiction in the family were assigned as part of the reasons the five of the participants felt unseen in their academic difficulties and this required process in psychotherapy.

After school, both in work and third level education a continuance of feeling unseen, inner-conflict or needing to stay beneath the radar was described by all the study participants. Those who attended colleges or adult literacy courses after diagnosis described how peer support was important in accepting their diagnosis and sense of self, (Tanner, 2009). In the negative, participants described lack of job satisfaction due to menial work and the pull of addiction and crime leading them further away from aligning themselves to their true selves or to achieving their potential.

The participants described the process in moving towards an integrated self through the work they did in psychotherapy. The stages outlined in acceptance of a learning disability (Higgins et al, 2002) were broadly mirrored in the testimony of the participants. Awareness is the first step in the integration of this new information and again participants confirmed that receiving a diagnosis of dyslexia was essential to their self-knowledge. There was acknowledgement amongst the participants, however, that receiving their diagnosis was an initial step and the information in turn needed to be integrated into their life narrative. The participants in turn described how they had worked through the stages of 2) acceptance of labelling, 3) understanding and negotiation of their learning difficulty, 4) compartmentalisation and 5) transformation (Higgins et al, 2002). This process was supported in counselling as the participants worked through what the diagnosis meant to them, helping them to gain further understanding of self.
It is not suggested in the data from this study that moving from one stage to the next was a linear process with the participants describing the work in therapy as hard and painful and the process took time sometimes moving forwards and sometimes taking backwards steps. Adjusting their self-concept and self-esteem in accordance with their dyslexia diagnosis was a difficult process. It appeared that as their lived experience and the reality of their situation became more aligned with the truth of their diagnosis, that self-acceptance and transformation became more permanent. This is in keeping with the findings in previous research literature that to develop a positive self-concept alongside a dyslexia diagnosis that both acceptance and understanding is required (Logan, 2009, Alexander-Passe, 2010). The concept of the ‘Deceitful Dyslexic’ is explored in Nile’s recently published novelette (2015) highlighting the energy required, persistent stress and failing to achieve potential that accompanies masking dyslexic traits. Attendance at counselling alongside the diagnosis and acceptance profile according to Nile not only can lead to a freedom in self-acceptance but can translate to a ripple effect in the wider life experience of the person involved e.g. in relationships, further education, job promotion etc. A significant part of the transformation occurred when the locus of control (Rotter, 1966) was gradually altered from external to internal through therapy and with a new sense of self, the participants began to steer their own lives. This was in contrast to earlier reports of poor self-reflection and a sense of life ‘happening to them’ rather than playing an active part in their own lives. The participants also reported a more authentic relationship in general with family members, parents, siblings and children and a change in friendships now that they were in tune with their real self.

Emotional and Behavioural Defences
A model of Dyslexia Defence Mechanisms was outlined by Alexander-Passe (2010, pp.145-149) and refers to both Emotional and Behavioural Defence Mechanisms. Alexander-Passe identified that the perception of the person with dyslexia of the challenge before them leads either to 1) The development of a coping strategy which is seen as more positive and leading towards personal growth or 2) The development of an emotional or behavioural defence which can be self-protective in the short-term but more debilitating the longer it progresses (Alexander-Passe, 2010; Aldwin, 2000). The current data revealed the participants using the terminology of emotional and behavioural defences. Developing awareness of their coping strategies, emotional and behavioural defences were reported as a large component of the work in the participants’ counselling sessions. ‘Masking’ their true selves was reported; emotional or behavioural defences were projected while inside feelings of being ‘vulnerable’, ‘numb’, ‘dead’ or ‘confused’ were described. An inability to connect authentically or express themselves to others was also expressed. Alwin (2000) highlighted that although coping strategies and emotional and behavioural defences can be transient in relation to a stressful situation, they can become habitual or entrenched particularly in the case of dyslexia when literacy skills are called on many times hourly in the educational setting and in the wider world.

Strengths of the Study
This study focuses on the participants’ psychotherapy experience post a late dyslexia diagnosis. The use of Thematic Analysis, allows specific characteristics and viewpoints to be given emphasis that may not be captured using an alternative research method (Willig, 2013). The aim of this study is to explore the psychotherapy experience from the client’s perspective of those who have a late diagnosis of dyslexia. While studies identify the commonly reported associated psychological and emotional issues associated with a dyslexia diagnosis (Alexander-Passe, 2010; Kong, 2012; Tanner, 2009), this study allows further insight into the client’s perspective in addressing their psychological issues in therapy associated with the late diagnosis of dyslexia. The client’s perspective of exploring the main themes arising in psychotherapy has broken new territory in research and provides insight for not only others who may have a late diagnosis of dyslexia in the future but also for associated professionals.

The previous experience of the participants in a therapeutic setting allowed them to access their
process readily despite the research quality of the interview and they gave a strength and depth of testimony which surpassed a fact-based account. Therefore, the data collected is authentic, holistic and well-considered adding to the legitimacy of the participants’ experience.

Limitations of the Study
In an extension of the reported experience of the research participants, no data was recorded as to the exact nature of the counselling or psychotherapy that the participants had attended or the leanings or qualifications of their therapists as this was not specifically asked by the researcher or reported by the clients. It is therefore not possible to gain insight from the present data as to the effectiveness of differing methodologies.

The participants of the study varied in age from their twenties to their fifties and therefore it is a long time since they participated in primary or secondary education. While their experiences may correspond to the experiences of those of a similar age, the findings of the current study may not be applicable to the experiences of a younger population due to increased awareness and changes within the Irish education system.

Recommendations for Clinical Practice
Considering the relatively high prevalence of dyslexia in the general population (8%-10%), both the literature (Tanner, 2009; Grande; 2006; Alexander-Passe, 2010, 2012) and findings of this study highlight the need for knowledge of the characteristics associated with a dyslexia diagnosis related not only to the practicalities of literacy skills but also associated stress, anxiety, shame, impact on the development of behavioural and emotional coping styles and self-esteem, self-belief and self-efficacy. One participant clearly stated that when the therapist produced introductory paperwork on commencement of therapy, the action created an immediate barrier due to her shame and fear of disclosure. Awareness is also relevant in therapies where written activities maybe required e.g. CBT or where homework such as journaling is recommended. It is important for therapists to be mindful that while some clients may be forthcoming about their dyslexia diagnosis, some may have a diagnosis of dyslexia of which they have attained a personal acceptance but dislike to disclose fearing shame or misunderstanding. Therefore, therapists should be perceptive to the possibility of their client having dyslexia and develop their client intake and literacy based interventions accordingly.

In the initial planning of this research study, a more streamlined study of participants attending psychotherapy as a direct result of their late diagnosis was envisaged and the issues that arose from a late diagnosis processed within the psychotherapy sessions. A more complex landscape, however, of the adult experience of a late dyslexia diagnosis emerged with many issues of the educational, emotional and behavioural impacts identified by the participants commencing from their earliest memories of school. All participants acknowledged the benefits of psychotherapy with some initial issues around disclosure to the therapist highlighted by one female participant. The participants reflected on the time taken to develop self awareness, self-belief and self-acceptance and that the empathy and holding within the therapeutic relationship supported them in expressing and discharging their frustration and dismantling emotional and behavioural defences to return to a “real” or “true” self. The double layer of difficulties was acknowledged by the majority of the participants and this was expressed that “a lack of education” was at the root of their difficulties. A common theme became apparent in the development of escape mechanisms; inner-conflict and frustration at an early age as a result of feeling external feedback did not integrate with their internal sense of selves. A lack of attunement and empathy coupled with undiagnosed dyslexia resulted in protective escape mechanisms being engaged. These in turn had generalised and through psychotherapy the participants began to realise that the coping mechanisms were limiting, prohibitive and had become redundant as they endeavoured to live whole-heartedly and in accordance with their true selves.
Yvonne Cunningham is a Humanistic and Integrative Psychotherapist, Registered Educational Psychologist and Primary Teacher who works in private practice in Galway. Yvonne has a particular interest in the psychological and emotional effects of learning difficulties. Yvonne specialises in assessment, therapy and training and works in these ways with those diagnosed with learning difficulties of all ages, their families and associated professionals.

References:
A Psychotherapeutic Exploration of the Presenting Issues of Irish Women Post Abortion
by Bevin Herbert

In an Irish context, the issue of abortion has been one of the most divisively debated topics over the last thirty years or more. Successive governments have avoided enacting legislation despite a shift in public opinion, a number of legal rulings and more recently, criticism from the United Nations and European Courts. Ireland is company to some fifty other countries where abortion is totally or almost completely prohibited, many of these are in the developing world. The debate portrayed in media circles in Ireland tends to emphasise the extremities of the opposing sides, resulting in an often polarised debate with one side ‘pro-life’ and the other ‘pro-choice.’ What seems least attended to, is the individual woman at the heart of the situation and this is the central focus of this study.

There are a multitude of studies and research on the psychological effects of abortion on women, but few that specifically relate to Irish women. The aim of this study is to gain a more insightful understanding of the Irish woman’s subjective experience, particularly considering the issues of stigma, culture, travel to another country and societal attitudes that may affect her. The language of choice used when discussing abortion is often inappropriate in its black and white terminology, the choice to terminate a pregnancy is affected by many aspects of a woman’s life. A report from the Crisis Pregnancy Agency reviewed the literature on the psychological effects of abortion on women and highlighted the lack of research into this issue for Irish women (Fine-Davis, 2007). This research topic emerged in response to the existing but limited recommendations for exploration into this area. With this in mind the objectives of this research are to extend knowledge and understanding of the issues that present for Irish women post abortion and gain insight into the lived experiences of these women. To consider the implications of the societal influence that is specific to Irish women and its impact on their experience. Finally this deeper consideration would then contribute to existing theory by deepening our understanding from a psychotherapeutic perspective.

Bevin Herbert is a qualified psychotherapist having achieved a First Class Honours Degree in Psychotherapy in 2013. Bevin is furthering her studies and is currently completing a Masters in Psychotherapy and Counselling in Dublin Business School. Bevin has also worked in Human Resources for twenty years and is currently managing Human Resources and Communications in Dublin Fire Brigade. She is also part of the Critical Incident Stress Management team for Dublin Fire Brigade. She currently resides in Dublin.

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Widening Our Lens – Towards a New Model of Psychotherapy
by Monica Haughey

Irish society has undergone huge changes since the inception of the profession of psychotherapy, and alongside this there have been developments in our understanding of how our minds work, and there has been a growth in the areas of positive psychology and in our knowledge of the power of our thought process. This paper aims to identify some of these changes and considers how we might respond to them not only in our own practices but also in our training institutions.

Societal Changes
One central change has been the ongoing collapse and transformation of many of the old structures and institutions whether it be that of the church, the banks, schools, charitable bodies and government bodies. There have been scandals around sexual abuse, mishandling of money and in general the misuse of power has been challenged in our society and no stone has been left unturned. There have been enquiries, exposures and tribunals all seeking to challenge old methods and structures. For those who are interested in astrology, this is explained by the fact that Pluto has been in Capricorn since 2008 and thus a huge and profound structural shift has been taking place.

Authority has been challenged and is no longer an automatic right. When I grew up in the 1960’s and 70’s in Ireland we didn't challenge the “powers that be”, whether it was the church, teacher, or your parents at home. I can remember seeing my brothers who were altar boys get slapped on the altar and, when I raised it at home, I was silenced and I quickly learned that I had said something considered to be inappropriate. There was no support for me to challenge this priest and my family were not going to cause trouble either. This was, of course, representative of society at the time and there were much more severe examples of the abuse of power in the church and throughout the wider society. The status quo was generally one of acceptance, resignation and a belief that really we had very little control over our own destiny. An in-depth analysis of this culture is not within the remit of this paper, other than to say we had a history of colonialism and oppression by church and state.

Whilst we may still not have arrived at the pure, transparent and inclusive society we would like, and there are still ongoing changes, we are in my view more empowered in terms of people having a voice, finding ways to demonstrate their dissatisfaction, and challenging authority and ongoing corruption. In schools, parents demand to be more involved. Those working in institutions are acutely aware that they are in the public eye and need to be mindful of their actions and how they treat residents. Institutions seek to be more accountable and society is demanding this. Society has been and is being “cleaned out”. The new paradigm is one of empowerment and participation, and increasingly people are seeking to develop greater agency and control over their own lives. There is more openness to how mind, body and spirit are connected and I am continually amazed and encouraged by how yoga classes, pilates classes and mindfulness classes are in such demand. People are breathing into their heart chakras, practising visualisation and thinking positive thoughts and really wanting support to effect change in themselves and to keep themselves well.

Developments in Neuroscience
One of the key developments that has impacted on psychotherapy is the area of neuroscience, as it allows us as therapists to provide an explanation of how therapy works. The field of neuroscience shows that all our thoughts, feelings, memories and sensations can be attributed to the neuron cells in our brain passing messages along synapses or neural pathways. We know that when neurons connect they form a bond and we tend to get into habits of passing messages along well used pathways. But these neuro pathways in the brain can be changed and the brain is in fact a dynamic structure rather than a fixed one. Throughout our lifespan new neural pathways can be developed and new neurons
can be built and our brains can rewire themselves and psychotherapy can effect this kind of change. Neuroscience also gives us an understanding of trauma and the role of therapy. Cozolino (2015), in his recent publication *Why Therapy Works* explains that many of our human issues which are brought to therapy have arisen because of how we process utilising different aspects of our brain. When our brain needs to react quickly to alert us to potential dangers, it is our fast primitive/reptilian brain that is called in to play rather than our slower part of the brain in the frontal cortex, which helps us to plan, reason and negotiate. Early painful childhood experiences, especially, can be difficult to integrate and are traumatic as we process much in early life through our fast, reptilian brain. Our frontal cortex which can plan, reason and negotiate social relationships only develops later. These early experiences can wreak havoc on our world view and make us feel unsafe. Cozolino (2015) argues that a good therapist can utilise the basic human need for connection, be a positive parental figure and help clients calm their over-active primitive brain response, uncover unconscious patterns of thought and behaviour, and alter the neural patterns to create healthier functioning. Neuroscience demonstrates that we can change and that our tendency to repeat behaviours can be modified. It is also interesting to note that it explains that we all have a predisposition to focusing on the negative as our brains evolved with a requirement to be alert to what was fear-inducing rather than situations causing us to feel relaxed and well.

**Positive Psychology**

Positive psychology makes a huge contribution to the field of wellness and can be described as the study of happiness. Seligman (2003), one of the founders of Positive Psychology, believes that happiness has to be more than the absence of misery and that psychotherapy needs a whole set of other skills that are about more than delving into our issues and releasing the pain. He believes that we need to learn and to teach the skills of being a happy and how to live well. Positive psychology focuses on wellness and provides us with concrete ideas, scientifically proven, to promote and maintain wellness. Seligman believes that whilst pain and suffering addressed in therapy is important we have gone too far. Acknowledging pain and suffering are important but we all still need to be able to find meaning, experience gratitude and be happy. Skills of being happy need to be grafted on to our in depth work with clients.

Key concepts in the area of positive psychology concern themselves with helping people maximise their potential, to find ways to engage with their highest strengths and also to seek to find ways to find meaning and to connect with a bigger purpose. Seligman has done extensive studies on how our strengths correlate with happiness, and interestingly noted that our capacity to love and be loved have the highest statistical correlation with life satisfaction and happiness. He promotes expressing gratitude and caring for others as activities that will really make us feel better and reduce depression.

**Mindfulness**

There has been a huge surge in interest in mindfulness and there is widespread recognition of how powerful the practice can be, whether as an everyday practice to support our well being, or one specifically geared to help us manage pain, illness, or a particular psychological issue. Mindfulness is now in the “ether” and people inherently seem to understand its value in this fast-paced, post-religious society we live in. Many psychotherapists further their training by studying mindfulness and are aware of the value for their clients in terms of increased sense of well-being. Studies such as Davidson, R.J. *et al* (2004) demonstrate that those who regularly practice mindfulness are happier and more contented than average as it can enhance the area of the brain associated with happiness and compassion. Mindfulness can assist us in managing and living in greater harmony with our minds. We can learn to observe our minds and Buddhist teacher Yongey Rinpoche (2007) describes that the “mind is a kind of constantly evolving occurrence arising through the interaction of neurological habits and the unpredictable elements of immediate experience.” Mindfulness is an approach to help us become aware of this and to develop a relationship with ourselves.
Consciousness Creates Reality

Our thoughts, awareness and intentions all influence not only how we perceive but also our reality. Physicists now acknowledge that there is an observer effect and this was acknowledged in the 1930’s by pioneering physicist Sir James Jeans (1930) who wrote “the steam of knowledge is heading towards a non mechanical reality; the universe begins to look like more a great thought than like a great thing”. Many people are embracing this way of understanding reality and it has been popularised by the best selling film and book by Byrne, R. (2006), *The Secret*. Essentially they promote the views “be careful what you wish for”, that we are co-creators of our own reality and we have much more choice than we realise, if we practice affirmations and expect good things to happen they will, that our thoughts are more powerful than we realise.

The biologist Bruce Lipton in his book *The Biology of Belief* (2005) demonstrates his then controversial discovery that the energy from our thoughts influences our very cells and that essentially our bodies can be changed as we re-train our thinking. This concept is I believe a view that is being incorporated with very little effort into current main stream thinking. He believes we have been programmed to feel powerless especially in the area of health and spirituality and that we are entering a new era which is based on love rather than fear and that increasingly we can shape our lives to be more healthy, loving and fulfilled by taking control of our thought patterns.

What are the Implications of all of These Changes?

In some sense psychotherapy fits beautifully into this new paradigm in that our core values embody personal responsibility, cultivating awareness and supporting the client to take better charge of their own lives.

More Empowered Clients

In my view clients will and must be more empowered in coming to therapy. No longer do they come to a psychotherapist who is a “blank canvas” as it is likely that they have looked us up online and got some background. We need to ensure that the information they find is the information we wish them to find! It will be helpful if are able to articulate clearly what we do and how it has been shown to work. We will be competing with other therapies in that there are many people offering different forms of healing and so we will need to be able to identify clearly what we are offering and perhaps what the benefits are likely to be. We will also be competing with offers of instant healing online something like “Heal your Inner Critic” in just 10 minutes per day for 14 days, and podcasts and YouTube videos on how to have a happier life.

As we have been steadily and at times dramatically clearing out old structures and outworn viewpoints, it is likely that more clients will be preparing to move forward more and do less of looking back. This is clearly an optimistic and perhaps controversial statement and may not rest well with everyone, but as a society we have done a lot of healing and whilst there are still hurts and injustices it is important we can support clients in moving on and building health. This is not to say that there are still of course clients who will need in-depth healing due to early traumas, or help to deal with serious life issues, but that our context has changed and is changing.

Value of Both Short Term and Long Term Work

Neuroscience gives us a framework to understand the changes that can occur in our clients’ lives and can be used to support both short-term work and more long term. Cozolino (2015) is not categorical about the length of therapy nor the type of therapy and instead focuses on what we seek to achieve as therapists: a good relationship that clients can feel safe enough to let go misperceptions of themselves and try out new behaviours to assist them in healing.
Long term therapy may be vital for unconscious, deep-seated issues but shorter term interventions can make an impact if there are issues that rely on explicit memories that are in our conscious mind. Whatever we repeatedly sense, feel and think will slowly sculpt our neural structure. Ivey and Zalaquett (2011) also argue that we can feel and think differently by focussing using our rational mind and they caution against focus on negative issues and reinforcing these brain circuits and instead suggest we use our rational, frontal cortex to focus on positives and strengths and that this can overcome the negatives.

Role of Positive Thinking
Writers such as Ward and Stokes (2014) argue that if we practice visualisations and expressing positive emotion we will eventually feel positive and will change the brain chemistry. Solution focused therapy was developed by Steve De Shazer in the 1980’s and offers a helpful way for a client to really see and imagine their way forward in their lives. He suggests we use the “miracle question” which could be in the form of:

If a miracle were to happen and you woke up tomorrow morning and your life had been transformed in a positive way, what would have happened, how would you feel?

This kind of enquiry encourages our client to become their own expert and begin to seek ways to make their lives better themselves. It’s not a new approach but could be helpful if we are seeking to offer a more short-term focussed intervention.

The implications of the thesis that our thoughts create our reality are far reaching and the extent to which we can integrate this into our work with clients would depend on both the client and therapist.

Energy Work
Techniques such as ‘tapping’, that work directly with energy, are already being practiced by some psychotherapists in their work with clients. This is a technique that is based on the principles of ancient acupressure and modern psychology and in a very practical way is used to heal any negative emotions or physical pain. The method used is that of tapping with your fingertips on specific meridian points of your body including your hands, temples, forehead, etc., while focusing on negative emotions or physical sensations. Advocates argue that when we combine this technique with vocally speaking affirmations and positive words, our nervous system can become calmer and our bodies can be brought back to balance. David Feinstein, a well recognised clinical psychologist from the John Hopkins University School of Medicine has done extensive research on how the process works and how our nervous system can be de-activated and undesired responses can be uncoupled from the triggers, providing you with greater ease and freedom to live your life more effectively and joyfully. He argues that one of the strengths of this approach is that it is fast and precise and that “right there in the moment, the entire landscape of the brain is changing around the issue that the person is thinking about.”

Homeopathy
Whilst some clients may be on anti-depressants or some form of medication prescribed by their medical practitioner, there is an increasing awareness of other “complementary” healing interventions. One such approach is homeopathy and this is working at an energetic level and can very safely and effectively support our work as psychotherapists. Homeopathy views illness as something which ‘arises’ when the individual is out of balance on either a physical, mental, emotional or spiritual level. Homeopathy is a very deep medicine which can effect us on these different levels. It can be used effectively in conjunction with psychotherapy and there are already psychotherapists offering this in addition to their practice of psychotherapy.
Eco Psychotherapy
Psychotherapy may embrace broad-based therapists such as those who practice eco-psychotherapy and who have a strong belief in the healing power of nature. Theodore Roszak (2001) states:

*Other therapies seek to heal the alienation between person and person, person and family, person and society. Eco-psychology seeks to heal the more fundamental alienation between the recently created urban psyche and the age-old natural environment.*

Dublin based David Staunton describes himself as an eco-psychotherapist and his approach is to include, explore and restore the human-to-nature connection as well as the human-to-human relationship. He meets clients initially indoors but if they wish will then subsequently meet them outdoors.

Conclusion
As I have already discussed, we practice in a society that is rapidly changing. Our clients are and will be increasingly seeking out a variety of approaches to feeling well. We need to ensure our professionalism and standards of practice in psychotherapy. However, there are a myriad of influences on clients’ wellness. The positive psychology movement argues that by expressing gratitude and caring for others we can feel better. But the “be careful what you wish for” approach, espoused by thinkers such as those in The Secret (2006), take this further in that the underlying belief is that we can change our external reality with our thoughts. We can’t be seen to be woolly or esoteric in our approaches. Alongside this, in my view clients are increasingly aware that their thoughts can change their reality. At the moment, society does seem ready to accept the positive psychology contributions around how we can improve our well-being. However, the concept that we can change our external environment may not still be a fully credible proposal for therapy to embrace. Does our profession need to maintain a conservatism to ensure credibility?

The therapeutic relationship has always been of paramount importance and in my view will continue to be. In particular, therapist qualities of authenticity, transparency and courage as always will continue to be highly prized. However, I do believe it is important that we seek to acknowledge and support our clients in their strengths and in moving forward in their lives.

In my own practice, I enquire at the outset whether the client wishes to engage in short term or longer term work with me. I am clear that both have a role. I also am very open to other aspects of the client’s well-being such as exercise, diet and whether they may benefit from practices to support them such as yoga or mindfulness. Generally they are bringing this up in our conversations. I am interested in other interventions to support energetic shifts such as homeopathy and in my own direct experience have found this to be a very helpful addition to the psychotherapy process.

It is an exciting time for psychotherapy. Our values of empowerment and client self-determination fit beautifully within this new paradigm in society but we must ensure we stay open to societal changes in building wellness and seek to incorporate these changes into our practices.

Monica Haughey is an experienced psychotherapist of almost 20 years and supervisor since 2008. She has a small private practice and alongside this does short term counselling for EAP provider, Carecall. Her other work is as a trainer with organisations in the public and private sector around cultivating wellness in the workplace, managing change and communication skills. She is increasingly interested in ways to develop and broaden her psychotherapy practice and transfer some of the core values and skills from the therapy room to work place settings. Alongside this she is passionate about food as a means to wellness and has written two recipe books and founded ‘The Good Food Initiative’.
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