Inside Out

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Surviving the storm:
Postnatal anxiety and depression in a pandemic

Beyond the window of tolerance:
The impact of early hospital experiences

Silent Voices:
Ending the silence on parental alcohol misuse

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EDITORIAL

Our readers will not be surprised that much of this issue features the varying ways our contributors have responded to the repercussions of the ongoing pandemic-spawned "global anxiety."

This anxiety is perhaps most acutely experienced in homelessness and Editorial Board member Paul Daly explores the issue of therapy with homeless people, noting the lack of research on the subject from a humanistic perspective. To help remedy this missing dimension, he provides an existential overview based on interviews with three therapists working with homeless people and the available existential therapy literature.

Trauma can result from domestic strife as chronicled in Daniel Cleary's exploration of the challenges faced by the therapist dealing with the related abuse and its collateral damage, not only within the family but also to the therapist. He addresses the possibility of "moral distress" and challenges to one's values, and as we hear not often enough, the importance of self-care.

A possible catalyst for early trauma that receives little attention is the subject of Colm O'Connell's "Early hospital experiences and long-term effects" in which he looks at how these events can leave lasting impressions.

Marion Rackard also addresses early trauma, highlighting her work with the Silent Voices initiative and the HSE to raise awareness of the effects of parental alcohol abuse.

Ethical issues are the subject of "Doing right when things aren't right". This thought-provoking work by Mike Hackett and Niall Bulfin investigates issues arising from the distancing requirements that have disrupted traditional practice, and how we must adapt to these circumstances. The authors remind us of the need to balance the welfare of client and therapist as we engage in both the new remote platform and the revised protocols of face-to-face meetings.

In "Green shoots," her reflection on the spiritual challenges of the pandemic, Nicky Flood suggests that it offers *"an opportunity to reset, rethink, and remaster our own lives."* The ongoing restriction of both our work and personal lives is the subject of Maria Moran's look at "Remote connection and communion," as well as Brian Gillen's "Self-love in the time of Covid." He draws parallels between the individual sufferer and society at large, with a message of hope for finding silver linings beyond the darkness. Lastly, in "Surviving the storm," Sheena King chronicles her harrowing ordeal with post-natal depression and the isolation forced on us all by the pandemic, and offers sympathy to the sisterhood of new mothers with a similar plight.

On the lighter side, we find in Ger Murphy's article on the use of poetry in psychotherapy many inspiring examples of how poems can become a *"wonderful companion for clients going though many different life events."* He addresses the theoretical underpinnings of this approach and includes practical accounts of its benefits to his own clients and how poetry can be a "medicine which allows the person to sink more deeply into their own inner experience." And if you're seeking your own "medicine", this issue also presents reflective poetry from John Bourke.

The issue closes with Paul Daly's "Kidney Sisters", a brief account of a relationship which sprang out of the gift of a transplant and which Paul wishes to dedicate to his late wife Trisha. In closing, the Board wants to extend our deepest sympathy to Paul for his sudden loss.

JOURNAL ETHOS

Inside Out is the journal of the membership of the Irish Association of Humanistic and Integrative Psychotherapy. Our journal is devoted to inspiring the sharing of ideas amongst those within and around the psychotherapy community. We invite submissions that articulate and explore the profession and heart of psychotherapy. Our aim is to embody the humanistic value of developing authentic relationships. *Inside Out* supports diversity and welcomes into dialogue all cultural, religious, social, racial and gender identities. Our aspiration is to inform, inspire, open dialogue and widen debate. In giving readers space for their voices, we aim to facilitate diverse strands of thought and feeling that might open, develop, unfold and intertwine.

Self-love in the time of Covid: the mental health challenges of a global pandemic

by Brian Gillen

> *Nothing in this world was more difficult than love.*
>
> (Garcia Márquez, 1989: 295)

One of the major reasons people first present for psychotherapy or counselling is that a difficult event or crisis occurs in their life. It has often just happened, is still happening or is about to happen, and the anxiety, depression or emotional disturbance associated with this experience is too much for them to bear on their own. As we know, it can be hugely beneficial when someone reaches out and shares their problems and struggles in a professional therapeutic setting. However, a paradox often exists when they do so in the midst of a life crisis.

While it may take a bolt out of the blue to motivate a client to seek help, the suddenness, shock and overwhelming nature of their experience can actually hinder them from being able to fully process it or reveal its true purpose and meaning in their life. It may also create or reinforce an overly simplistic belief that the event itself was 'bad' or 'negative' (and therefore should be forgotten or avoided), rather than something from which one might derive positive insight and experience. As a result, the opportunity to nurture and enhance their overall mental health and find a more sustainable and resilient way of coping, irrespective of what life throws up, can get lost.

During the therapy process, a client, say Greta or Greg, may gradually discover that it wasn't the difficult life event itself, rather the negative, traumatic or overwhelming emotional reaction they had towards it, which posed the greatest problem. That Buddhist proverb – 'pain is inevitable, suffering is optional' is apt here. The sense of not being prepared nor able for the sudden, painful experience can undermine a person's self-confidence and create untold anxiety, causing them to suffer much more than any crisis warrants. On a deeper level yet, it also raises the question for each individual, 'do I know myself as well as I thought?'

Further along the journey of therapy, should they choose to stick with it, Greta or Greg may ultimately come to realise that the original life crisis or so-called bad event had a completely different meaning and purpose - to reveal to them deeper truths about themselves and shine a light on the paramount importance of their self-relationship.

Covid-19 society

Following more than a year of disruption and anxiety in the general populace over the global coronavirus pandemic, we as a nation may not be that dissimilar to a shocked or confused individual picking up the phone for the first time to call a therapist or counsellor. We may not know explicitly what we need or why we need it, but somehow implicitly we feel there has to be more to this frightfully difficult event (and how we are experiencing it), than meets the eye. The Covid crisis and its impact have focused minds, made us more curious and aware of our state in life, and more invested in how it will all turn out. However, as with any existential life crisis, the temptation in society has been to cover over the cracks and move on quickly from the event, rather than stopping to consider its true impact, particularly on our wider mental health and wellbeing.

The national conversation, conducted mainly through political discourse and the mass media (even more so during Covid restrictions as casual face-to-face social chatter was uniquely hampered) was predominantly focused on the health and socio-economic consequences of the pandemic. The physical health impact, especially for those in older age cohorts or with underlying health conditions; the knock-on restrictions and delays in routine healthcare services and treatments; the economic uncertainty and hardship from job losses and business closures, education, childcare and special needs resources disruption; social isolation and separation; and the upsurge in numbers of deaths.

With the message came the method, how to keep the populace engaged and interested in the midst of much personal sacrifice and growing Covid fatigue. Specialist concepts and jargon adopted from the corporate and medical worlds (flatten the curve, lockdown, super-spreader, asymptomatic, aerosols, antibodies) made us all feel a little more knowledgeable and possibly in control of events. Maps showing county-by-county compliance league tables, a Covid Olympics if you will, kept us on our marks. Epidemiological statistics and ratios, charted in large colourful graphs, told us that the most important number was now a letter called 'R'. Pictures of microscopic invading 'mutants' and 'variants' kept us in a collective thrall, like a dystopian sci-fi movie.

As well as being informative and entertaining, there was a social cohesion dividend. Popular media played a quasi-emotional role in helping to discharge the pent-up needs, frustrations and feelings of its captive audience: impatience with the slow pace of society reopening; restlessness at the curbs imposed on travel and movement; frustration with changes and delays in the vaccine rollout; unholy outrage at individuals or cohorts deriving any unfair advantage such as showing up maskless to a large funeral, hiding out at a local shebeen, having a house hooley, jumping the vaccine queue or skipping the quarantine hotel. It also provided some much-needed hope in the form of the now infamous 'not all heroes wear capes' recognition of our healthcare and frontline workers. Accentuating this positive and the various spontaneous acts of kindness and charity breaking out in the outbreak made us feel we were indeed, 'all in this together'.

The real pandemic

The national conversation may have acknowledged and lamented the 'mental health effects' of the pandemic too; however it has failed to grasp the true gravity and extent of this. Not unlike a new therapy client, eager for quick solutions to longstanding complex problems, we risk ending up with shallow fragments of truth in the absence of a more organic, deeper dig into our mental state during and following this crisis. Maybe we are quietly petrified from discovering that our struggle with our self-relationship is in fact the real pandemic event. Covid and all the uncertainty, confusion and change it represents has been a catalyst for this, challenging and exposing our already fragile mental health.

The past year-and-a-half has burgeoned a deep and profound struggle within each of us - a pandemic of individual existential self-doubt and angst, sometimes questioning the meaning and purpose of who we are, and sometimes the world itself. In the new normal there has been a sadly unavoidable, life-and-death imperative not to be physically close to each other, not to touch each other and not to hold each other. Apart from being counterintuitive and countercultural, this experience has seemed unnatural and emotionally limiting for many people. It may well have traumatised and confused the normal functioning of mind, body and soul and potentially disrupted and damaged families, friendships and relationships.

Added to this, the old reliable fixes and solutions people often depend on to solve or distract from

life's problems, like supermarket flour and toilet rolls in the early lockdown, became limited or ran out completely. The inability to plan ahead or focus on the future laid bare an incapacity to live or be content in the moment, here and now. Greater home isolation and confinement revealed the already fractured nature of some relationships, put under further duress and resulting in an escalation of domestic violence and fallout. The lack of social and recreational outlets uncovered a deeper struggle with self-contentment, self-reliance or simply being with myself. The inability to flex our economic muscle too, for example buying nice clothes, changing the car, taking a foreign holiday or moving house, exposed the weakness in our inner psychological muscle if you will - namely the ability to draw self-esteem, self-worth and value primarily from within ourselves and our relationships rather than from our external possessions, achievements or image.

Every cloud

There are those who already know much of this and have been on a journey towards self-knowledge and self-love long before Covid struck. They perhaps have an advantage in an upside-down world finally revealing itself so emphatically. As with Noah's Ark they have been secretly planning for years how to cope and survive a global disaster, just by living quietly and securely within their means and within themselves, building their inner psychological lifeboat.

There are also those who previously lived life on the edge, insecurely attached to external, worldly distractions to create some form of balance or happiness within. Having had many of those options taken away, they were left silently scrambling to hold on or to find any meaning in the crisis. Some, no doubt, doubled down on previous behaviours, partying harder, stressing harder, depressing and oppressing harder - their inner mood pendulum swinging longer and wider in a context of diminishing returns. But some may have taken the tide at the flood and started to take back control of their lives, realigning their relationship with self. In a time of adversity and chaos, they might well have stumbled upon their greatest opportunity yet to find some love, peace and joy in life.

This may be the silver lining to the Covid cloud. Just as the virus respects no boundaries or borders in its spread, so too its opportunities are equal, universal and potentially life changing. There is an opportunity for everybody, in the face of such shared turbulence and adversity, to lose their minds and come to their senses, as Perls advised, to reset and reconnect with themselves - with who they are and what they want in life (Perls, Hefferline, Goodman, 1994: 127). There is now full and unfettered permission *not* to go buy that mid-life crisis sports car or face lift, snort that dodgy line of cocaine or project all that suppressed anger and disappointment onto the partner or kids. Rather, this is permission to slow down and live 'the examined life' like never before. Permission to love again perhaps?

Doing whatever we need to truly 'stay safe' as the newfound social gesture extols, grants you and me full permission to be more compassionate, kind and loving to ourselves. It can be given to myself by myself, but it will be supported and enhanced by many in society - other folk who are similarly trying to 'hold firm', remain grounded and love themselves too. Such self-agency and empowerment for each one could bring untold mental health benefits for the many. Take the example of work and our relationship with it. Perhaps starting to really appreciate the value of a job or role, or that once bemoaned long commute to work, which possibly only ever served to expose one's inability to be alone or bored in a good way. Realising, like Scrooge the morning after, what we wouldn't do for another chance at that life now rather than the kitchen-cum-diner-cum-bedroom-cum-office, since occupied and endured relentlessly. The pandemic and its associated disruptions and restrictions

can be a catalyst for positive change and reconnection with what really matters in life, a life less complicated and more simple.

Connecting with our 'inner child' is a therapeutic idea relevant to this simplification and permission process. The more Greta or Greg can see the innocence and vulnerability of that small child part of themselves, the more they will be compassionate and understanding towards all of self, including their needs as an adult. The plight of today's children can be a very useful reminder or model for this. With education, games and social activities having been limited or halted during Covid, and the added economic and social pressures brought to bear on families and communities, perhaps the greatest emotional toll of all has been on our young adults and children. With society reopening, let's hope that they bounce back without too many long-term emotional scars or injuries, the worst 'long-Covid' imaginable.

What is essential?

Staying with childhood things for a moment, that classic children's book *The Little Prince* has this little gem among many in its pages: *"it's only with the heart that one can see rightly, what's essential is invisible to the eye"* (de Saint Exupéry, 1974: 33). The emerging post-Covid era is an opportunity for us all to do things differently this time round, to see with the heart not the head. During the clamour of pandemic protocols and directives regarding 'essential' services, jobs or travel, we may have missed the most essential 'essential' of all - our core mental health and self-relationship. And just as the definition of what was essential in a lockdown is very contextual (e.g. travelling certain distances was prohibited, but allowed on compassionate grounds) being good to myself, minding myself, and loving myself is the most prescient and essential focus any one could possibly have during or following a crisis. It's a body, heart and head balancing act that therapists have been promoting and encouraging with every Greta and Greg since therapy began.

Indeed, much of this new reckoning will play out in an upsurge in demand for psychotherapy, counselling and mental health services in the coming months and years. Thankfully such professions and services were generally deemed as essential during the crisis. The challenge now is not merely to keep that nominal designation but to strengthen and improve it. Having moved out of the eye of the Covid storm, humanity will need help to process and heal our individual and communal trauma. But like good therapy, why stop there? We need to proactively facilitate people in society to continue the process, to carry on working on themselves and become much more self-aware and resilient for the longer term. Otherwise, the negative impacts of the pandemic, like generational trauma, will not only linger but continue to fester for years to come. Worse still, we will have missed a once in a generation opportunity to transform the ordinary mental health and wellbeing of our people.

Society, politics and media has already started to drive home the post-Covid message of economic, social and institutional reinvestment and rebuilding, and of course this is important. However, rebuilding and investing in the psychic, emotional and mental health of the nation is much more essential, and not just in the short term. In order to do this we need to see past societal, political and media narratives, and prioritise our mental health and deeper psychological and emotional needs. Psychotherapy, counselling and the health and social care professions in general can be at the forefront of this new moment.

Positive mental health and wellbeing is founded on love of self, and love of each other (in that order - you cannot fully experience the latter without the former). It requires time, patience and understanding, all of which have been under enormous pressure in the pandemic (arguably much

more than economic and monetary means and resources). The crisis has exposed the delicate inner psychological fabric of our lives and our fragile relationship with ourselves and others. Ironically, in a time of great societal strain, stress and change in the world, we need to know, trust and love our innermost self even more. In our hearts we know this. Deep down every Greta or Greg wants this.

Like any crisis, we should respect the pandemic and learn to live alongside it, but we should not let it determine us, our lives or what we truly need. If anything, let us use this time as permission to get back to our primary purpose in life - to know and love ourselves - with or without Covid. Let us not wait for the end of the pandemic or indeed the emergence of another crisis to begin the journey back to self and self-love.

Brian Gillen is a psychodynamic psychotherapist and the Director of LifeChange Psychotherapy & Counselling in Dublin. He has been a Regional Organiser for IAHIP and is Chairperson of the CORU Counsellors and Psychotherapists Registration Board.

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Psychotherapy with homeless people: some learnings from the literature

by Paul Daly

> *Poor naked wretches, wheresoe'er you are,*
> *That bide the pelting of this pitiless storm,*
> *How shall your houseless heads and unfed sides,*
> *Your looped and windowed raggedness, defend you*
> *From seasons such as these? O, I have ta'en*
> *Too little care of this. Take physic, pomp,*
> *Expose thyself to feel what wretches feel,*
> *That thou mayst shake the superflux to them*
> *And show the heavens more just.*
>
> (Shakespeare, 1608/1997, 3.4.28-36).

Much of Shakespeare's language is hugely resonant and often anticipates the later insights of psychotherapy. King Lear's empathic feelings for the homeless of his time are spoken in the middle of an imaginative world in which many aspects are simultaneously internal and external. The storm that rages is in Lear's mind as much as on the heath, and the window-like holes in the clothes, the "*houseless heads*" and the nakedness of the destitute, which Lear is seeing for the first time, speak of psychic vulnerability as much as exposure to the elements. *King Lear* is a play about the gradual stripping away of a human being's accommodations. Shortly after the words spoken above Lear says to Poor Tom, "*Unaccommodated man is no more but such a poor, bare, forked animal as thou art*" (Shakespeare, 1608/1997, 3.4.105-106). Lear's own head is "*houseless*" and the shelter he seeks - as with many homeless people today - is not just a physical dwelling but the shelter of love and understanding (Seager, 2011). Although the words "*wretch*" and "*thy*" are from a different era, the idea behind Lear's invitation to himself to "*expose thyself to feel what wretches feel…and show the heavens more just*" (Shakespeare, 1608/1997, 3.4.34-36) could be seen in the self-talk of someone today working with vulnerable homeless people on the street.

The insight that some homeless people experience psychic vulnerabilities and psychological distress is not new. We see this in literature and in personal observation. In the largely autobiographical *Down and Out in Paris and London,* George Orwell (1933: 204) describes "*tramps*" as "*the most docile, broken-spirited creatures imaginable*". More recently John Healy's (1988/2008: 1) visceral autobiography of alcohol addiction and homelessness begins ominously, "*My father didn't look like he would harm anyone*." Within a few sentences the six-year-old is being violently assaulted by his father (Healy, 1988/2008). There is a sense in this book that if people are not traumatised before they are homeless, they become so because of it:

> *Skippering is illegal; also rough. Some skippers are fair; most are bad. One feature common to both - they are all lousy. It is hard to describe to a clean and healthy person just how uncomfortable and degrading it is to share your clothes with a load of parasites: apart from the terrible irritation there is the nasty feeling of self-contempt. Fights break out in the night; the police come in, nick you or throw you out, depending on their mood; any nutcase can walk in, burn the place down*

> *while you're in a drunken stupor. You try to sleep in the attic with the birds but end up in the basement with the rats.*
>
> (Healy, 1988/2008: 161-162)

Structural narratives are outside the scope of this article which is about psychotherapy with homeless people, but it is worthwhile to note Declerk's (2006: 162) observation that the unfortunate situation of the homeless

> *is compounded by the insidious sadism of a society - our society - that needs to punish those who live on its fringes, and which to this end, ensures that the health and welfare provisions made for the homeless are structurally inadequate.*

How homelessness is thought of shapes how we respond to it. Homelessness is a multidimensional reality with socio-economic, familial, psychological, and health aspects. There is a limited but rich body of psychotherapy literature on psychotherapy with homeless people which I discovered when doing research for my Masters thesis in 2017, and in this article I would like to outline it and reflect on what may be missing.

It has long been recognised that some homeless people, in addition to requiring housing, have needs also for psychotherapy or psychiatric services. The Programme for the Homeless Mental Health Service in Dublin, which was set up in 1979, may have been the first consultant psychiatrist-led service of its kind in the world (The College of Psychiatry of Ireland, 2011) and it currently engages homeless people with "*severe and enduring mental health difficulties*" (Case Management Guidebook, n.d.). A 2012 study of a Dublin homeless hostel found a very high prevalence of mental disorders: 81.6% (Prinsloo, Parr & Fenton, 2012). Voluntary agencies such as the Dublin Simon Community provide counselling services for homeless people and their most recent annual report (2020: 15) states that in 2019 clients received 2,850 hours of one-to-one counselling and mental health support from the Sure Steps counselling service.

Such services are perhaps a recognition that homelessness can come about for reasons other than structural factors such as a lack of affordable housing, poverty, unemployment or high rents (Focus Ireland, n.d.) and it may originate through "*an inability to be at home, to feel some connectivity through house, neighbourhood and wider community*" (Robinson, 2001: 5). Writing about homeless services in England, Martin Seager (2011: 183) states:

> *When it comes to tackling homelessness we act as if 'getting a roof over a person's head' was more important than what is going on inside their head and as if the physical shelter provided by the roof was more important than any psychological shelter that might be provided under that roof from the relationships formed between that person and the others who live there.*

Seager (2011: 184) goes on to state that the approach to homelessness is too often "*mind blind*", focusing on the necessary aspects of bricks and mortar, food, medicine, skills and finance but not helping people meet their "*universal psychological and spiritual needs*" to be loved, listened to, belong, achieve, have meaning and hope.

Researchers have conceptualised aspects of homelessness in a number of different ways. One of the ways human beings make sense of experience is through narratives which are like threads which weave together certain privileged events and experiences (Morgan, 2000). The dominant narratives we tell

ourselves shape our lives and relationships with other people and many of these narratives occur at the same time and are influenced by the cultures we live in (Morgan, 2000). While poverty, unemployment, social welfare and health provisions and lack of available and affordable accommodation are major factors in homelessness, there is a lot of research which links homelessness to psychological factors (Seager, 2011; Campbell, 2006; Finfgeld-Connett, 2010; Fischer and Breakey, 1991; Goodman, Saxe and Harvey, 1991). I would like to outline the narratives of homelessness in the psychotherapy literature in the hope that looking at the various related and often overlapping therapeutic themes will add to a greater understanding and prompt us to ask what else needs to be included.

Homelessness as lack of containment

O'Connor (2003: 115) outlines the concept of containment as described by Klein and Bion: the child's anxieties are projected into mother who detoxifies them and gives them back to the child in a more palatable form. Each person's first home is not a house but "*the mind of one's mother*" (O'Connor, 2003: 121). This experience of a containing object is eventually internalised so that the child is able to go through a process of self-reflection which helps him or her to tolerate experiences of absence - though containment from others is always needed to some extent (O'Connor, 2003: 116). When containment does not happen or happens to a lesser extent the result is an uncertainty about the world; the child may avoid interactions where anxiety arises, reject the very act of containment or turn to external sources of comfort (O'Connor, 2003: 119). In addition, it may happen that the child is used as a container for the unwanted feelings of his or her parents and O'Connor draws the analogy that homeless people "*become the victims of a collective projection of all that is unpleasant and unsavoury*" and they may come to enact this role (O'Connor, 2003: 118). For O'Connor (2003: 120) the experience of containment and the experience of being at home are parallel and therefore to be without a home is also to be without a sense of belonging and safety: home is defined by one's relationships and one's emotional connectedness. Some people put up with chronic homelessness because it is a reflection of their internal experience of rejection and disconnection; others seek more intense containments such as prison or drugs (O'Connor, 2003: 122-123).

Campbell (2006) describes Rey's concept of the claustro-agoraphobia dilemma, which Campbell states is intrinsic to both homelessness and to borderline disorders. This is where the person feels shut in when in an enclosed space and afraid and abandoned when in the open spaces of the streets. Campbell (2006) cites Rey's insight that the characteristic occupation of doorways by homeless people stands for an inability to make choices. The doorways become an intermediary space between the 'inner' sense of persecution and the hostile 'external' world where their restricted ability for self-reflection is expressed in their wish to make sense of themselves through other people's responses, drawing passers-by and support workers into fleeting encounters (Campbell, 2006, para 21).

Brown et al. (2011) write about a pilot project which made up to 25 psychodynamic psychotherapy sessions available to chronically excluded people in 12 different locations across London. The clients at times put up a fierce resistance to psychotherapy: they engaged with psychotherapeutic thinking but they would not enter the therapist's room, lingering in the doorway, the park, the garden, the corridor, the ward instead (Brown et al., 2011). Behind this resistance appeared to be an anxiety for some about being taken over and obliterated, recalling histories of neglect and abuse, and the doorway was the only place they felt safe (Brown et al., 2011). There were challenges in these border spaces for both therapist and client: lack of privacy, interruptions, poor weather, frequent uninvited spectators, difficulties hearing and focusing (Brown et al., 2011: 315).

Homelessness as psychological 'unhousedness' and psycho-social dis-memberment

Scanlon & Adlam (2006: 10) posit that some homeless people - in a similar way to those with personality disorders - are "*psychologically 'unhoused' and psycho-socially 'dis-membered'*". Homeless people with a personality disorder may have a deep sense of not being at home in their body or mind and experience painful unbearable feelings, and Scanlon and Adlam (2006) ask how someone who feels continually empty in their internal space would feel secure in the external space of a house. The authors cite Bateman and Fonagy who link this emptiness to lack of success in establishing a secure attachment, and they state that "*in ordinary development the experience of 'home' is linked to the experience of one's self being housed in others', usually parents' minds*" (Scanlon & Adlam, 2006: 11). The personality-disordered homeless client seeks to refrain from "'*being inside' anything*" while at the same time wishing to be known and "*inside the mind of others*" (Scanlon & Adlam, 2006: 11).

Homelessness as broken attachment

Seager (2011) claims that broken attachments are one of the contributing factors to chronic homelessness and that long term rough sleepers may well be still searching for their first secure attachment in their lives. Smolen (2001) writes that when working with homeless children and parents there must be a clear focus on the early attachment relationships of both the child and the parents.

Homelessness as failure of self-care

While socially oriented theories see homelessness in structural terms, chronic homelessness can also be seen as involving a profound failure of self-care. Brown's (2015) experience as a psychotherapist working with the homeless is that failure to care for one's body may repeat scenarios of early neglect or abuse and this is often communicated through disturbances in relation to dirt and smell. Failure of self-care comes from a traumatised relationship between the person and his or her body in the first instance (Brown, 2015). Brown (2015: 37) cites Lemma's observation that "*the body never ceases to signal the relationship with the mother*". Odours, which are unconfined and which unavoidably cross boundaries, prevent us from ignoring the homeless person's distressed mind and neglected body (Brown, 2015).

Seager (2011) sees long term rough sleeping as indicating an almost complete disregard of the value of the self. Sleeping rough and refusing shelter, particularly in the winter months, comprises serious self-neglect but it is often naively seen as a *"lifestyle choice"* (Seager, 2011: 185).

Homelessness as trauma

There is a lot of research on homeless people and trauma. Early developmental trauma including abuse, neglect, and attachment disruption are part of the narrative for many homeless people (Hopper, Bassuk & Olivet, 2009). For some people, adult domestic violence is the catalyst to homelessness and because homeless people are traumatised, they find it difficult to cope with the many obstacles they encounter or to escape homelessness (Hopper, Bassuk & Olivet, 2009). Goodman et al. (1991) claim that homelessness itself is a risk factor for psychological trauma because the loss of one's home can be a severe stressor, the conditions of shelter may result in trauma and many homeless people, in particular women, become homeless after experiencing sexual and physical abuse. Felix (2004) states that homeless people have experienced a high incidence of trauma and violence during childhood.

Homelessness as addiction

The most prevalent disorders found in a Dublin homeless hostel were "*Alcohol Dependence (23.7%), Opioid Dependence and Major Depressive Disorder (both 18.4%), Opioid Abuse and Alcohol-Induced*

Depression (both 7.9%)" (Prinsloo, Parr, & Fenton, 2012: 22). The connection between homelessness and addiction has been made by Fisher and Breakey who as far back as 1991 stated that the research evidence consistently supports the high prevalence of alcohol, drug and mental disorders among homeless people.

Homelessness as unconscious familiarity with the street

Farrell (2010: 243-251) argues that there are three main dynamics which cause people to continue to be chronically homeless even when housing becomes available: an unconscious gravitation towards the familiar homeless environment; difficulty with situations which are structured; and an adjusting to being homeless. The unconscious tendency to gravitate towards the familiar is an example of Freud's repetition compulsion (Farrell, 2010: 244). Some homeless people may gravitate to life on the familiar streets in the same way that people in abusive relationships keep returning to violent situations and there may be unconscious resistance to leaving this way of life (Farrell, 2010: 244-245).

Homelessness as breakdown

Volunteering first with an initially small homeless project (now called Project H.O.M.E.) in Philadelphia, Luepnitz (2015: 152) was struck by the situation of those who appeared psychically unable to live indoors and with the agreement of the project leader recruited psychoanalysts - now 14 in number - for the "*deep work*" that was needed. Luepnitz (2020) conceptualises three psychological categories of homelessness which reflect "*increasing levels of trauma and dysfunction*": First, homelessness can be an "*expression of breakdown*" where "*one's resources have been exhausted*". Second, following Brown (2019), it can be "a *defense against breakdown*". Third, following Winnicott (1963), homelessness can be "an expression of the breakdown that occurred in infancy, but was not experienced". In her earlier work Luepnitz (2015) highlights the idea that the breakdown one fears most has, in Winnicott's words "*already happened, near the beginning of the individual's life*", and the patient needs "*to experience this past thing for the first time in the present—that is to say, in the transference*" (Luepnitz, 2015: 157). Luepnitz (2015: 159) writes of her way of doing psychoanalysis with homeless people: "*We show up. We bear witness and make ourselves vulnerable to the dread, the aggression, the deadness of the patient's inner world—without abandonment or retaliation*."

Homelessness as nameless feeling of dread

The Lacanian psychoanalyst Harper (1999: 84) states that for the homeless person on the street there is little difference between the public and private spheres and no sense of sanctuary or home. To describe this traumatic space Harper (1999: 84-85) invokes Bion's "*nameless feeling of dread*", Winnicott's "*state of endlessly falling*" and Klein's "*pure presence without absence, a lack of lack*".

Homelessness and survival

Researchers coming from diverse disciplines focus on the narrative of survival. The resiliency and survival skills of homeless adolescents tend to decrease over time which may be due to the constant challenges faced (Lee, Liang, Rotheram-Borus, & Milburn, 2011). Roebuck & Roebuck (2016) found that young homeless people positively adapt in the light of the adversity they experience. Strategies for survival among homeless teenagers and young adults are diverse (Hein, 2011) and include socially approved and disapproved activities (Ferguson et al., 2011: 401).

Homelessness and resilience

Most research on homeless people has "*focused on the problems faced by this vulnerable group*" but a study of 87 homeless and ex-homeless people in London explored their resilience (Smith et al., 2008: 2).

Factors that enhanced resilience included being able to establish meaningful contact with their families and/or integrate in the wider community, opportunities for engaging in the creative arts and learning, and welfare workers who listened patiently, empathetically and non-judgementally (Smith et al, 2007: 20).

Limitations of narratives

The available narratives on any given subject, while often offering valuable insights, are also necessarily limited. In the case of the above narratives, they are conceptualisations of some aspects of people who are homeless and there is no space in this article to describe the unique human beings involved or the compassionate therapies that the therapist-researchers engage in. We know from other sources such as news media (e.g. Irish Times, 2015) and the annual reports of homeless charities (e.g. Dublin Simon Community, 2020) of the resilience, resourcefulness, creativity and solidarity of many homeless people. However, this is generally not reflected in the psychotherapy literature. Moreover, there is very little, if any, academic research on this work which comes from an explicitly humanistic perspective. Humanistic psychotherapies share a broad set of values and philosophical assumptions (McLeod, 2014) which incorporate relational, experiential, existential and phenomenological approaches (Cain, Keenan and Rubin, 2016). They emphasise the benefits of relational connection and support, emotional expression and processing, the movement towards authentic being, focus on the self and self-concept, discovering a sense of meaning and purpose and the cultivation of the capacity for freedom and choice (Cain, Keenan and Rubin, 2015). One such is existential psychotherapy.

The existential dimension of homelessness

In research for my Masters thesis in 2017, I interviewed three psychotherapists working with long-term homeless clients. I had expected that the findings would mirror the mainly psychodynamic narratives of the literature. Instead, I discovered that the themes that emerged were existential. The stark facts of existence are faced most clearly by homeless people: being isolated and estranged from society, experiencing meaninglessness and anxiety, having no place of one's own or sense of place, facing danger and death. In *Waiting for Godot* (1956) Samuel Beckett's "*existential tramps*" (Gold, 1988) have achieved iconic status, becoming an identifiable narrative of those without a place and anxiously waiting for meaning. Given the situation of the homeless, it is surprising that the existential dimension is almost completely absent from the literature on psychotherapy with homeless people. The only peer-reviewed research discovered was that by Sumerlin and Bundrick (1997: 1304, 1311) who write that "*existential anxiety is poignant for homeless people as they struggle to find food, clothing, and shelter every day*" and they note that insufficient attention has been paid to "*the existential dilemma of the homeless*". Eustace (2014: 136, 159) interviewed six homeless people in Dublin for her doctoral thesis and her conclusion is that "*homelessness can be viewed as a profoundly boring, deeply anxious existence characterised by the breakdown of caring relationships with self or others*". I have identified below some themes from existential psychotherapy which emerged out of my research. These themes reframe or expand some of the above narratives and I have outlined them below as they are expressed in general psychotherapy literature.

Existential anxiety

It has been said that the characteristic mood of human beings today is anxiety (Collonello, 1999). Existential psychotherapy goes further: from this perspective anxiety is a given of existence (Iacovou and Weixel-Dixon, 2015: 52). Anxiety is not just one feeling among others: it is an ontological characteristic of human beings, rooted in our existence (May, 1958: 50): *"Anxiety is the experience of the threat of imminent non-being", the "most painful and basic threat which any being can suffer, for it is the threat of loss of existence itself" (May, 1958: 50, 52).*

For Spinelli this anxiety is about "*the fragility of human existence*" (Du Plock and Fisher, 2005: 73). Tillich views neurotic anxiety as a distraction from and an evasion of existential anxiety (van Deurzen and Kenward, 2005: 7). May (1958: 52) looks at both sides of existential anxiety which he characterises as a condition where "s*ome potentiality is present, some new possibility of being, threatened by non-being*". Existential writers value such anxiety because "*it marks the start of our openness to the human condition*" and it is "*the necessary counterpart of being truly alive*" (van Deurzen and Kenward, 2005: 7). Existential therapy strives to help people to find the courage to face life and death resolutely (van Deurzen, 2012: 48). Cooper and Adams (2005: 84-85) strike a cautionary note in relation to translating existential philosophical insights into clinical practice, emphasising the importance of respecting clients' defences about death, and that therapists need to be aware of their own death-related issues so as not to impose them on clients and, importantly too, appreciating the brightness of life, as well as anxiety about death.

Not-at-home-ness

It is interesting that one of the key terms in the existential lexicon is Heidegger's not-at-home-ness or *Unheimlichkeit* (van Deurzen and Kenward, 2005: 209). In this form of anxiety, the person feels homeless but this feeling of homelessness is "*a fundamental state of Being, which corresponds to the intrinsic temporary nature of human existence*" (van Deurzen and Kenward, 2005: 209). The sense of "*homelessness, feeling lost and deprived of human relationships is the metaphysical condition of modern humanity*" (Collonello, 1999: 41). The feeling of "*not-at-homeness*" may lead the person to engage in "*metaphysical questioning*" because it calls on each of us to consider "*our actual state of Being rather than hide in the They*" (van Deurzen and Kenward, 2005: 209).

Alienation and isolation

In existential psychotherapy there are four kinds of estrangement or alienation: "*from oneself, from others, from the world and from God*" (van Deurzen and Kenward, 2005: 2-3). Whereas hysteria was the "*typical*" kind of psychic problem in Freud's day, the schizoid state is the problem of today where therapists see many persons who are "*detached, unrelated, lacking in affect, tending towards depersonalisation, and covering up their problems by means of intellectualisation and technical formulations*" (May, 1958: 56). For Yalom (1980: 355) existential isolation is the "*unbridgeable gulf between oneself and any other being*" but, paradoxically, he is still able to say of psychotherapy that "*it is the relationship that heals*" (401).

Freedom

Freedom is perhaps the quintessential existentialist theme. The Christian existentialist, Kierkegaard, said that "*anxiety is the dizziness of freedom*" (van Deurzen and Kenward, 2005: 6). Macquarrie (1972: 177) states that for Kierkegaard freedom and existence are indistinguishable: "*One does not first exist and then become free: rather, to be human is already to be free*." If the human being did not have some freedom to fulfil a new potentiality, he or she would not experience anxiety (May, 1958: 52). People surrender freedom in order to escape this unbearable anxiety (Goldstein, as cited in May, 1958: 52). For Yalom and Josselson (2014: 274) freedom refers to the fact that the human being is responsible for and the author of his or her own world, own life design and own choices and actions.

Meaning and meaninglessness

For Frankl the person's most basic motivation is to find meaning in life (Cooper, 2003: 53). Frankl (1946/2004: 131) sees the loss of meaning as an existential vacuum which is "*the mass neurosis of the present time*" which can impel people to turn to addictions and compulsions to fill their existential

void (Cooper, 2003: 53-54). For du Plock and Fisher (2005: 75-76), a client's dysfunctional behaviour is meaningful because it serves to defend against anxiety and cannot be left behind until that which is defended against is addressed. Baumeister (1991: 56) views the human being as having four basic needs for meaning: purpose, value, efficacy and self-worth; and when these are not satisfied people show distress.

Conclusion

I have presented here an outline of some therapy narratives of homelessness, noting the lack of research from a humanistic perspective and offering some existential themes as an extra perspective to view the situation of homeless clients. While existential psychotherapy is often most associated with the more challenging aspects of life such as anxiety (van Deurzen, 2012) and despair (Binswanger, 1958), it also focuses on joy (van Deurzen and Kenward, 2005), the deep relatedness of 'I and Thou' rather than 'I-It' (Buber, 1937), potentiality (May, 1958), meaning (Frankl, 1946/2004), authenticity (Cooper, 2003; Pollard, 2005; van Deurzen, 2012), embodiment (Dreyfus, 1996) and sex (Barker, 2011). These themes could be unpacked usefully in relation to homelessness but there is no space to do this here. Nowadays, therapists are all integrative to a greater or lesser extent and being pragmatic, combine elements from a number of different therapeutic orientations, depending on how useful they are for the client. Existential therapy is one of a number of therapeutic perspectives which a therapist can include in working with homeless or indeed any clients. By having an existential dimension, the big picture is included - values, meaning or lack of meaning, purpose, freedom, choice, responsibility, authenticity, the four worlds of physical, personal, social and spiritual (van Deurzen, 2012) - and these are brought into clear focus by considering both the fragility of existence and its possibilities. Because each of the existential themes apply equally to therapist and client, the approach is less likely to be othering and more likely to be truly humanistic.

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The lasting presence of early hospital experiences

by Colm O'Connell

The experience of surgery is odd at any age: the loss of consciousness, the potential for overwhelming pain, the unfamiliar environment of hospital and professional medics, and perhaps the unusually fraught relationship dynamics with caregivers. Add to this mix the early stage of psychological development implied by childhood plus the highly adaptive nature of children in this phase, and what results is a crucible of experience, something that can crystallise the immediate responses into habits perhaps shaping a lifetime of future experience.

In this piece, I am using some of my own early hospitalisation experience and academic research to propose Early Childhood Experience of Surgery and Hospitalisation (ECESH) as a prototypical event that can result in character formation - a phenotype of experience, to borrow a term more commonly used in biology (to describe a category of thing malleable by its environment). The experience and subsequent meaning-making can result in long-term beliefs and behaviours, often beneath the level of conscious awareness. No doubt, the uncovering of the subtle impact of my own surgery in childhood played a part in my choosing to research the similar experience of others as part of my Masters dissertation. This impact (subtle and not so subtle) is often overlooked as a source of struggle or defence in therapy, as evidenced in the cases below.

Integrative psychology and psychotherapy are especially well matched to investigate the complexity of interactions and consequences in such experiences. And as a corollary, this class of karmic event also provides a useful case study encompassing the lived experience, environment, the unconscious, the arising of awareness and the elapse of time to affirm the value of integrative perspectives. This discussion does not extend to the possible effects of the birth experience itself, although that too has potential for exploration.

Many psychotherapy modalities might offer an apparently replete perspective on ECESH. For example, psychoanalysis might suggest an interpretation around the young psyche struggling to survive and choosing to split or repress any future association with that which was terrifying at a young age. Attachment theory might look at the important bond of safety between child and caregiver and how such a bond was stressed and perhaps misshaped as a consequence. Somatic approaches can feel into the physiological overwhelm and perhaps the need to re-regulate what once seemed unsurvivable. Whether these disparate perspectives can be reconciled, or whether such an endeavour is even a necessary ideal from a therapeutic perspective is somewhat of a philosophical question. There are of course newer modalities, for example Janina Fisher's trauma model which seeks to make a useful blend of these somatic and psychodynamic perspectives (Fisher, 2017).

There are also new perspectives coming from interdisciplinary work that seek to blend the physical and social sciences into informative new models (such as neuroscience and mindfulness, to pick a popular example). Yet other approaches such as gestalt or integral psychology allow these disparate impressions to be held in mind and gracefully utilise the acceptance and humility of ignorance. Such integrative approaches are capable of holding these apparently independent perspectives together. Yet in allowing that integration, one chooses pragmatically to leave aside a neat theoretical synthesis

of such perspectives. In practice, it is an example of what the poet John Keats called *Negative Capability*: to hold two paradoxical ideas in mind together without discomfort - a disposition well suited to integrative therapy ('Negative Capability', 2010).

Interviews around the hospital experience

In my research interviews (O'Connell, 2020) with three people who had an ECESH, each one was able to recognise the repetition of a pattern in their present day lives that was at least partially initiated back in their childhood hospital/surgery episode. For one subject her forgotten difficult postoperative separation as a toddler from her mother is speculated as originating in an attachment style lived out in a clinging relationship pattern in adult relationships. For another participant, the memory of his highly anxious mother and contrastingly reassuring calm medical team at the start of an excruciating appendicitis episode informed his adult relational style of helping others survive painful experiences. From my own experience, I wonder about the impact of the surgeon's cutting and sewing which I experienced at the age of three months (possibly without anaesthetic, which was common as infants were thought not to experience pain) on my own attachment style and connection with caregivers.

There is substantial medical research into accidental awareness during surgery itself, which can be one aspect of ECESH. Research in this area displays an enormously wide range of accidental awareness, from more than 1 in 100 (Andrade et al., 2008) to 1 in 142,000 (Pandit et al., 2014). Pandit et al. (2014) in their study review of cohorts that did have post-operative recall of events reported a high prevalence (41% of participants) suffering consequences of moderate or severe long term psychological sequelae. Andrade et al. (2008) also suggest that the incidence of awareness in children can be eight times that of adults, measured by post-operative recall, while others have questioned if current methods are sufficient to catch or track these phenomena (Davidson, 2007; Russell, 2016). One can only wonder at the many unspoken meanings carried forward from such liminal experiences.

The silent past

Psychoanalyst Paul Renn offers a relevant modern marriage of neurobiological, psychoanalytical and psychodynamic research in his perfectly titled work *The Silent Past and The Invisible Present* (2012). Renn's book summarises an evolution in thinking on what Freud had called the dynamic unconscious and its content of repressed awareness (or the overlapping class of implicit memories) of what was once consciously known, to encompass preverbal experience and learning related to Bollas' *"unthought known"* and Stern's *"unfathomable experience"* (Renn, 2012:16). Renn also details the *"neural Darwinism"* of memory, in that meaning is being re-constructed and evolved anew with each recollection of an event (Renn, 2012: 18). The participants in my own research displayed something which I termed *memory dissonance* whereby memories of the ECESH were recalled yet actively discredited in an ongoing present-day process. In discussing the effects of early trauma on childhood development, Renn references research by Lyons-Ruth et al. (1999) on the intersubjective attachment systems where "*subtle"* aspects of the relationship seemed to be involved, rather than gross abuse, neglect or abandonment (21). This supports the proposition that experiences such as ECESH can be formative even below the level of what would be considered traumatic. I was interested to note in my own research study that the meaning-making of the three participants mainly referenced the relationship dynamics and consequences of the experience, rather than any transpersonal meaning with which my own experience seems somewhat imbued.

In terms of character styles or traits and how they are engendered, Johnson (1994) has put forward a well-regarded psychoanalytic and somatic theory of styles, which may derive from the inevitable

difficulty which arises when the environment does not meet the expectations of a child. He utilises a model of character development that goes through the following five stages: 1) self-confirmation; 2) negative environmental response; 3) organismic reaction; 4) self-negation; and 5) adjustment process. It is in the responses selected in stages 4 and 5 that a character style (or the lesser tendency of a character trait) is developed, according to this model. For ECESH, it can be imagined that stages 2 to 4 may be compressed into a very short intense timeline. These inner conflicts are dealt with in whatever way works for the child (splitting or repression for example).

Other depictions

There are quite a few examples of ECESH that arise in the psychotherapeutic literature (though none that assembles them together, as far as I can tell). Erskine's (2015: 62-70) in his *Relations Patterns, Therapeutic Presence* contains a relevant case study in early hospitalisation. "Kay" is a 54-year-old woman suffering from a sense of loneliness and anger at feelings of being controlled by others. Erskine is her third therapist, and a significant unfolding in the therapy room happens by the opportune appearance of a spider climbing up and down a thread from the ceiling above. Initially thrilled, and then withdrawing, Kay remarks that a spider had been her only friend while she had lived in an iron lung for two years from two to four years of age. Kay had never thought to mention this to previous therapists or in a full year of work prior with Erskine, assuming it would be of no interest to anyone (as had been her relational experience in hospital). Erskine describes the ensuing work as a slow patient dyadic re-regulation of Kay's present day experience, which unconsciously communicated her implicit (pre-verbal and never verbalised) memories of the hospitalisation experience and her unmet (non-memory) relational needs. Erskine frames in-depth psychotherapy as a raising into consciousness of what was heretofore an unconscious relational need (or needs), even as the person persists in suffering the lack of that relational satisfaction which was previously unknown to themselves.

Another example appears with therapist Annie Rogers, in her absorbing memoir-cum-case-study, *A Shining Affliction* (1997) which narrates her troubling experience of coming to terms with an invasive early childhood medical procedure which surfaces in a parallel process to her engagement with a child client in therapy.

In a wide-ranging case study and literature review, Riordan et al. (2017) discuss the successful treatment, via play therapy and Somatic Experiencing, of "Little Bill", a 30-month-old toddler, who underwent two surgical procedures which resulted in restraint trauma and tonic immobility. Thereafter he showed signs of disorganised attachment towards his mother and shortly after was given a childhood PTSD diagnosis. The case study outlines a protocol that allowed the toddler to achieve dyadic completion, being the re-installing of a feeling of soothing and safety from his mother via iterated play scenarios that included physically running to the mother, an action that was traumatically truncated in the second surgical experience.

The normalcy of significant dysregulation

American psychiatrist Lenore Terr has written a number of illuminating studies on trauma and its (sometimes surprising) etiology in children and adolescents. To contrast with a previous group study on trauma arising from a very public mass kidnapping event, Terr performed a randomised interview-based study of 25 children and adolescents not known to have any shared trauma, focusing around life expectations and connection to any significant discrete episode they recollected (Terr, 1983). The interviewees reported a range of experiences such as witnessing a brother and father having an accident, being hospitalised after a car accident, being hit by a ladder, fainting following a fright, or

witnessing an earthquake. In 15 of the children these experiences occurred without it resulting in any serious difficulty, per Terr's interview impressions.

But in ten cases Terr found that the severe fright or trauma was carried forward, resulting in a limited life view, even though none of these children would have had any previously acknowledged developmental or mental health issue. That is a significantly large proportion of 40% carrying a pathology or psychic trauma (per Terr's impression) from such normal (although shocking) events. Terr (2013) suggests that this limitation is carried forward when a child spontaneously creates an interpretation in the moments after an event, which can install a bias to recognise "omens", often mistakenly, for future experience. I suggest that ECESH can also be a source for such subtle hidden interpretations and biases.

The desire for self-regulation

What these instances have in common is the experience of overwhelm, where one or both of the child's physiological and interpersonal systems are stretched beyond their usual bounds to such a degree that they don't return back to stasis in the normal manner. They are beyond *"the window of tolerance"* (Siegel, 2015). There is a residue of adaptation, though perhaps not conscious, which alters the windows of perception going forward. There is evidence in the cases discussed here of that early adaptation and the later use of others (either in therapy or relationship or both) to repeat and repair the dysregulating overwhelm experience with a co-created repetition that has the opportunity (though not necessarily the guarantee) of co-regulation. It may in fact be what they seek out (perhaps unconsciously) in the therapeutic process.

The research points to such experiences and consequent limiting adaptations often being held in the body, beyond conscious recall, expressed in somatic symptoms (such as chronic pain or skin conditions) or dreams. It is most notable that these events rarely surfaced with the individual's first therapist, often overlooked by both parties, only to surface somewhat serendipitously in later work. While some of these cases include other sources of ongoing trauma, the evidence for psychic impairment from a single shock related to overwhelming physical pain is considerable (Riordan et al., 2017; Rogers, 1995).

In my own research interviews, it was possible to pick up the desire for repetition of some relational dynamic around the ECESH in the therapeutic relationships of the participants. The previous dysregulating relational circumstances (the overwhelm of physical pain around surgery, or caregivers unable to provide comfort post-surgery) was occasionally able to be held, examined and reframed in therapy such that the underlying subconscious need was met and psychic energy freed up, decades after the initial *psychic insult*.

Final discharge

On leaving hospital one is *discharged* and is considered as no longer requiring ongoing care - yet I contend that not everything may be appropriately discharged at that point, and that ECESH can be a source of significant psychic struggle which may persist into adulthood through somatic symptoms, have an influence on attachment style and on personal narrative and identity. It appears often overlooked as a source of struggle or defence by client and therapist.

The process of dealing with a discrete overwhelming episode such as ECESH serves as a "simplified" model of the unconscious and awareness writ large. It contains the elements of (neurological) development and growing capability, challenge to the autonomic nervous system, self-regulation and co-regulation (via others), somatic memory, and the slow evolution of meaning that is possible with increased awareness.

It seems evident that it is simply not possible to have the capacity to process such challenges at a young age, and that the opportunity for integration arises with maturity, (therapeutic) assistance and perhaps no small amount of good fortune. There may be much to be learnt by inquiring into the dynamics of early childhood surgeries and hospitalisations and the adaptations that persist, perhaps unhelpfully in the present day.

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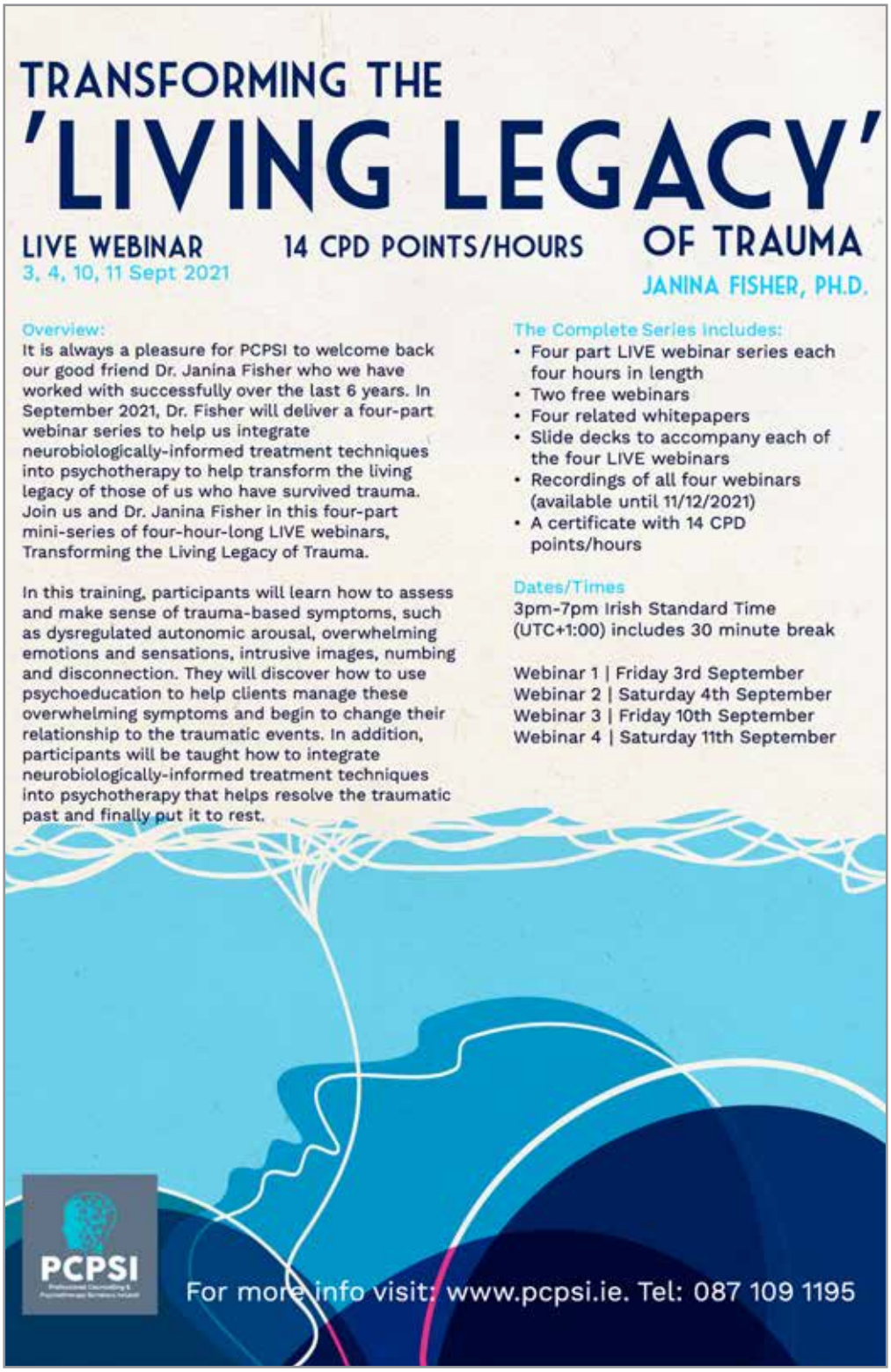
TRANSFORMING THE
'LIVING LEGACY'
OF TRAUMA
LIVE WEBINAR
3, 4, 10, 11 Sept 2021
14 CPD POINTS/HOURS
JANINA FISHER, PH.D.
Overview:
It is always a pleasure for PCPSI to welcome back our good friend Dr. Janina Fisher who we have worked with successfully over the last 6 years. In September 2021, Dr. Fisher will deliver a four-part webinar series to help us integrate neurobiologically-informed treatment techniques into psychotherapy to help transform the living legacy of those of us who have survived trauma. Join us and Dr. Janina Fisher in this four-part mini-series of four-hour-long LIVE webinars, Transforming the Living Legacy of Trauma.
In this training, participants will learn how to assess and make sense of trauma-based symptoms, such as dysregulated autonomic arousal, overwhelming emotions and sensations, intrusive images, numbing and disconnection. They will discover how to use psychoeducation to help clients manage these overwhelming symptoms and begin to change their relationship to the traumatic events. In addition, participants will be taught how to integrate neurobiologically-informed treatment techniques into psychotherapy that helps resolve the traumatic past and finally put it to rest.
The Complete Series Includes:
• Four part LIVE webinar series each four hours in length
• Two free webinars
• Four related whitepapers
• Slide decks to accompany each of the four LIVE webinars
• Recordings of all four webinars (available until 11/12/2021)
• A certificate with 14 CPD points/hours
Dates/Times
3pm-7pm Irish Standard Time (UTC+1:00) includes 30 minute break
Webinar 1 | Friday 3rd September
Webinar 2 | Saturday 4th September
Webinar 3 | Friday 10th September
Webinar 4 | Saturday 11th September
PCPSI
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Green Shoots

by Nicky Flood

Our hearts have been cracked open. We have been starkly reminded of the fragility and brevity of life. The existential perspective sees death as an inescapable boundary to life and when kept in our awareness, can add a tension and urgency that enriches life with more meaning, inspiring an impetus to take charge of our lives. In many ways the beauty of life is within the limitation of death - without death, life would lose some of its intensity. Our ability to direct our lives is facilitated by our inherent personal freedom – freedom to desire, choose, act and most importantly, to change.

Freedom implies a level of choice and within its expression lies concomitant anxiety, responsibility and guilt. The anxiety of making a choice from a finitude of options; the responsibility of ensuring it comes to fruition; and the guilt of possibly abandoning or betraying oneself by that choice. Guilt is the dark shadow of freedom - the guilt of having wronged oneself or forfeited one's own potentialities; it is a transgression against the self. Choice also implies accountability – accountability for the self, one's destiny, and the creation of one's own world. Our identity is formed by a lifetime of innumerable choices made and others relinquished.

Once we can accept the responsibility involved in creating our own world, we come to the realisation that we alone hold the power to alter our life predicament. Existential anxiety and guilt are important signposts towards what is omitted or absent in one's life. Yet our propensity towards shielding ourselves from the anxiety and responsibility of choice can result in a flight from freedom, an inauthentic way of living and the denial of our own possibilities and opportunities for the future.

Anxiety, responsibility and guilt provide constructive insights to own, utilise and act on one's inherent potentialities and freedom of will. These existential anxieties act as a mentor or guide. They are a call to action – the action of courageously engaging with and committing to living a more impassioned, authentic life with wisdom and integrity. Buried in the tangled labyrinth of guilt and anxiety is fertile ground where green shoots are waiting to be born. We have a once-in-a-generation opportunity to reset, rethink and remaster our own lives as we move forward in this new and better world. Our hearts have been cracked open, but in the words of Leonard Cohen (1992, 1:36) "*that's how the light gets in*".

Nicky Flood has just completed an MA in Humanistic and Integrative psychotherapy with DBS and is working towards IAHIP accreditation.

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Doing right when things aren't right: Ethical perspectives on face-to-face counselling and psychotherapy practice during a pandemic

by Mike Hackett MIACP & Niall Bulfin MIAHIP

Never, never be afraid to do what's right, especially if the well-being of a person or animal is at stake. Society's punishments are small compared to the wounds we inflict on our soul when we look the other way – Anon.

Doing the right thing is difficult. Personal values, morals, societal norms, professional standards and cultural imperatives shape each and every endeavour we undertake as we go about our work as therapists. Being a therapist is challenging. Often, we must balance our personal motivations (earning a living, doing meaningful work, self-care) with the needs of clients (urgency of care, holding suffering, being emotionally available), professional body guidelines (ethical compliance, maintaining standards, gatekeepers of the profession) and the professional context in which we operate (landlords and rent demands, placements and the curricula of training institutions). This is challenging enough under 'normal' circumstances, but what happens when faced with an extraordinary global event such as the ongoing Covid-19 global pandemic? How do we manage all of the above factors when we, our clients, our profession and indeed our society are gravely impacted due to a profound existential threat? How do we figure out what the right thing is when normality has to be profoundly readjusted? How do we do the right thing when our livelihoods are impacted? How do we know what is the right thing when such a situation is unprecedented and we cannot rely on answers from wise elders like supervisors and our professional bodies – because they too are faced with profound uncertainty and the same threat as ourselves. As every therapist in the country grapples with the question of how to provide therapy during a pandemic, this reflective piece explores these themes with a view to providing therapists with reflective anchors from which they can formulate responses to the challenges the pandemic presents and hopefully, be better equipped to 'do the right thing'.

Is there a 'right thing'?

We feel it important at this point to comment on our term - 'right thing'. Here, we are not implying that there is an objective truth, a certainty of knowing or an absolutely quantifiable outcome, rather to acknowledge the ambiguity and uncertainty inherent in ethical discernment. By 'right thing', we ultimately mean, *that which we are willing to live with, faithful in the knowledge that life is risk and that noble intent is no guarantee of good outcome*.

What is the 'right thing'?

Perhaps the most difficult question of all is the question 'What is the right thing to do?' as it inevitably creates a myriad of further questions, ambiguity and uncertainty. Many additional questions arise beneath such an apparently simple question. The right thing for whom? Is doing nothing right? How do I measure the impact of the action? How do I identify the best choice when presented with a range of 'right' options? What 'sacred cows' of our professional values may need to be sacrificed in order to do the right thing? Are we willing to change? What are the limits to our willingness to 'do the right thing' when faced with a collapse of our practice, pressure from clients to work face-to-face, requirements of training courses and compliance with legal and public health guidance?

This difficult prospect was, as Ireland began its first national lockdown on 29th March 2020, echoed in the minds of many in Irish society and perhaps in particular, in the minds of those who have a duty of care to others. Counselling and psychotherapy are action-oriented endeavours and as with any action, they have *circumstances*, *contexts*, *consequences* and *outcomes*.

Circumstances, contexts, consequences and outcomes

As the impact of Covid-19 began to sweep the globe with infection rates increasing, many therapists and clients were faced with the prospect of moving from traditional face-to-face settings to an online therapeutic space. This resulted in a necessary journey to chart a course through an online world of technology and therapy platforms which contain video, payment, scheduling and records management in a single service. In a few short months, the *circumstances* of counselling changed. Therapists and clients struggled with isolation due to the stay-at-home order, fear of infection, the impact of news and social media on wellbeing and the presenting problems of clients being amplified by the pandemic. The *contexts* changed. Therapists had to encroach on a boundary of home/work by creating a space and navigating with family/partners also working from home, they had to suddenly upskill technology competencies, and for many this seemed like a task well beyond their ordinary skilfulness and expertise. Many resisted the potential altogether, citing a range of challenges, some preferential (I don't want to work online), some practical (I don't have training/equipment/broadband), some professional (the way I work doesn't suit online) etc. This likely reflected the inevitable shock and variety of responses which accompany a global pandemic as therapists and clients alike struggled with the existential, emotional and self-care challenges such a situation represents.

Further *consequences* ensued. During the pandemic, student therapists lost placements and access to clients, many clients lost their therapists, many wise elders retired or withdrew from working and yet more struggled from loss of income and their self-employed status, leaving them vulnerable to financial hardship. If all of this were not enough, the *outcomes* changed. For those therapists and clients, who due to the great leveller a pandemic represents, became ill or died, pre-pandemic focus of therapy shifted to themes of shock, tragedy, grief and the impact of the failed rituals of mourning as funerals were severely curtailed. The stories of all those affected, lay or professional, were often reduced to private narratives of profound existential suffering.

In light of these circumstances, contexts, consequences and outcomes, many assumptions about the way we previously operated as therapists needed to be revisited, with numerous changes to the therapeutic contract requiring explicit revision. Specifically, therapy being a mostly face-to-face endeavour meant that therapists used to have control over the therapeutic environment (seating, light, heat, minimising distractions etc.), providing a confidential physical space and in-person emotional containment, features all critical to maximising the conditions for process. In the new online context, sessions in beds and bedrooms, at kitchen tables, in garden sheds, in cars and in some cases while walking on beaches or in woodlands all required sensitive management and careful negotiation. Broadband drop-outs, network contention issues, physical interruptions (deliveries, pets, children, etc.), client disinhibition, eating, smoking, consumption of beverages during session and a host of previously accepted norms of in-session behaviour required careful, sensitive re-negotiation. It would appear that perhaps for many therapists the ethical concern of 'informed consent' became singular focus in the attempt to maintain therapeutic continuity in very difficult shared circumstances.

Further, our attention to ethics came into even sharper focus after the first lockdown when restrictions began to ease in May of 2020, when another crucial evaluation was required: the decision as to whether to return to face-to-face work in the context of an active pandemic.

From lockdown to the resumption of face-to-face therapy

Following lobbying by a number of Irish counselling and psychotherapy representative bodies, counselling and psychotherapy was identified as an *essential service* under the umbrella banner of Social Care. However, the announcement explicitly states that the designation of counselling/psychotherapy "*which is an essential service*" was limited by the inclusion of the words "(***for essential cases***)" (IACP, 2020; IAHIP, 2020; emphasis added). Further, RTE news reported on 29th March 2020, that, as part of its classification of Human Health and Social Work activities included *"paramedical and* ***essential*** *therapy activities"* [emphasis added]. However, the guidelines for therapists to apply when considering a return to face-to-face work completely omit the requirement for a resumption to be for *"essential cases"*, emphasising instead public health and safety measures rather than protocols for assessing whether or not therapy cases were actually essential. The second and third lockdowns have not altered this position as therapists and clients are caught up in cycles of face-to-face, online, face-to-face, online and for some, with a focus on health and safety measures (cleaning, ventilating, social distancing, screening and mask-wearing), an otherwise resumption of therapy as normal. This, in the face of viral mutation and increased transmissibility (the UK strain is estimated to be 70% more transmissible than that circulating in March 2020).

It might then be reasonable to consider that in the absence of explicit guidance, the ultimate determinant of good practice is to revert to ethical principles. In particular, for counselling and psychotherapy, these might include the principles of non-malfeasance, beneficence, autonomy, justice and self-care.

Ethical principles in action

So, how do we apply the ethical principles which guide our work under 'normal' circumstance at an extraordinary time such as a global pandemic? Perhaps it is worth reflecting on each in order to build a foundation for ethical decision-making or 'doing the right thing'.

Non-malfeasance: the principle of doing no harm. Typically this is extended to doing no harm to the client but in the context of a pandemic, reciprocally, to the therapist who themselves remains as vulnerable as the client.

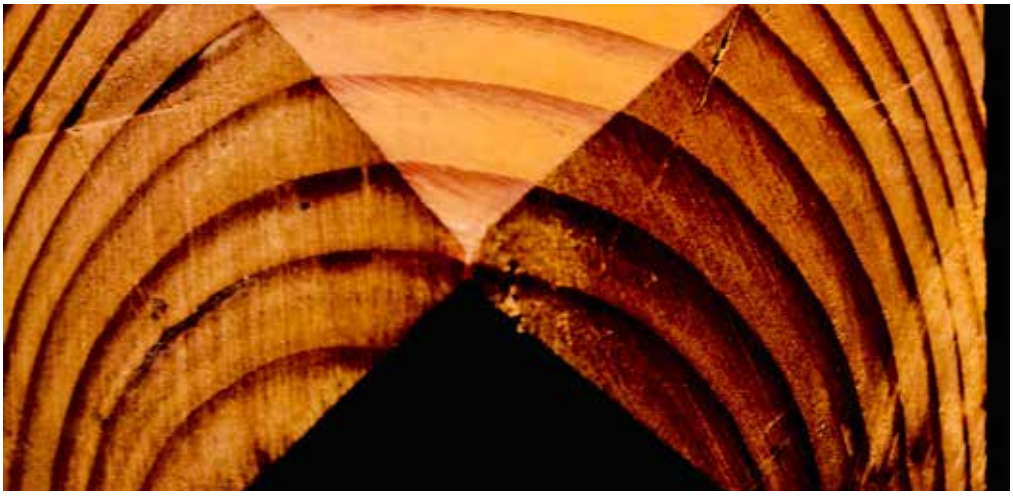
Beneficence: the principle of actively contributing to client wellbeing. Doing no harm is insufficient in this principle, as therapists are called to consider how to enhance the wellbeing of clients. In this case, therapists too should be included as the potential transmission from in-session contact not only has an immediate impact on them, but every one of their close contacts and the close contacts of their clients.

Autonomy: respecting the right of client self-determination in the expression of their life choices. During a pandemic we are moved to consider the difference between a client expressing a preference for face-to-face therapy and our professional role to assess whether or not face-to-face therapy is *essential* in line with public health guidance and the law.

Justice: treating clients with honesty and fairness. Here, we must weigh individual choice with the consequences of those choices more broadly. Can we honestly say that therapy is a safe space with a virulent and pervasive virus in our communities? Should we become ill with Covid-19 following a week of face-to-face client work, our obligation to inform clients of our positive Covid-19 test result may shatter the safety of the therapeutic space. Is it societally acceptable just to consider only the client's preference (or our own) for face-to-face work when we are advised to reduce our contacts with others, and not in fact increase them?

And finally, the principle of *self-care*; our obligation to protect and monitor our own wellbeing sufficient to working effectively with our clients. How do we reconcile the need to safeguard our financial wellbeing with the risk of clients disengaging from therapy should online work be rejected by them as a therapeutic option?

These reflective anchors provide an initial orientation to some of the questions which require serious and diligent consideration. By casting a reflective light into the shadow of face-to-face work during a pandemic we can satisfy ourselves that we have carefully, considerately and ethically reaffirmed our obligations to ourselves, our clients, our profession and our society. We can stand proud over our decisions congruently and compassionately, balancing our own wellbeing and livelihoods. With this in mind, we offer the following reflective model to support you in navigating a resumption of face-to-face therapy.



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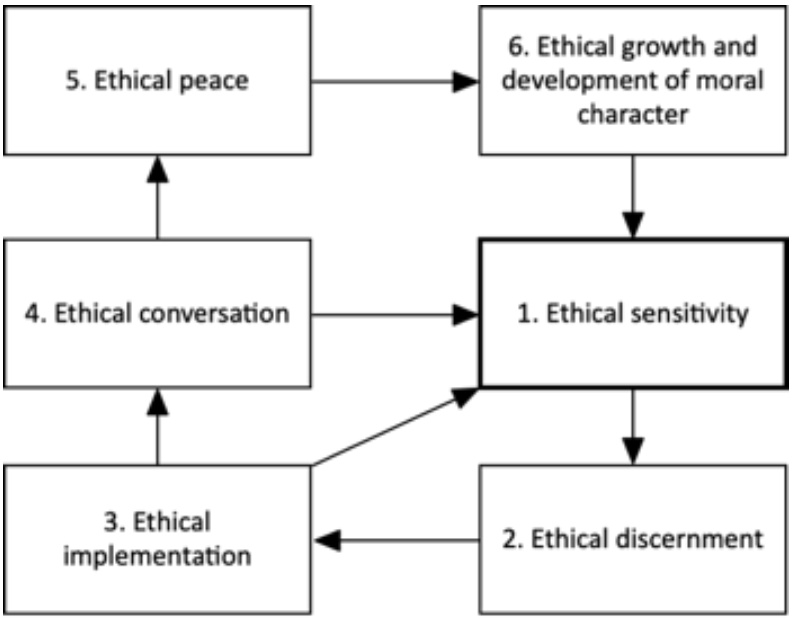
Working through the dilemma, ethics in action

Therapists work to 'do the right thing' all the time. Our intentions are noble, considerate and fundamentally client-centred, sometimes even to the detriment of our own wellbeing! That's how far we are willing to go for others. We do our best, employing compassion, empathy and kindness, and mobilise all of that to enhance client wellbeing. Our work is difficult, dealing with abuse, neglect, trauma, depression, anxiety, loss, grief, typically all the things others avoid. Our work often goes unnoticed and underappreciated, silent heroes battling the myriad causes of human suffering. Despite all of this, at extraordinary times like these, our noble intentions are no guarantee of successful outcomes, especially when it comes with the threat of serious illness or death posed by Covid-19.

Therefore, we believe that the decision to work face-to-face is not simply one of observing public health guidance, but constitutes an important ethical dilemma. Historically, we as a profession have never faced an ethical dilemma in which the therapist could infect the client with a virulent and highly transmissible disease despite reasonable precautions taken, especially when we have received no training in these preventative measures.

Perhaps the most familiar ethical decision making model is that of Michael Carroll's and Elizabeth Shaw's six stage model of ethical maturity. A short summary is provided here:



Components in Ethical Maturity (Carroll & Shaw, 2013)

1. *Ethical sensitivity*: an awareness of our own values, our professional standards, public health guidance, of the potential for harm in these contexts, the consequences of that harm and the impact of both our behaviour and our initial intentions.

2. *Ethical discernment*: diligent reflection balancing emotional awareness, problem solving and arriving at potential ethical decisions.

3. *Ethical implementation*: understanding what might block me from acting, what might support me, and thinking through how to implement my decisions.

4. *Ethical conversation*: thinking about how I might defend my decision, how I present my decisions to my clients, my peers, my supervisor, my profession and to wider society – I connect these to the prior principles.

5. *Ethical peace:* I can live with the decision I've made and actions I've taken in exercising my free will and accountability, using my support networks, watching for changes to base assumptions, managing the limits of my decisions, learning from the process and letting go of that which I cannot control.

6. *Ethical growth:* using my reflective ability to further enhance my self-knowledge (my values, my morals etc.) and to become more ethically sensitive and attuned.

With that in mind then, how might we thoroughly reflect on the dilemma at hand? To do this, we might apply the model above in the case of two therapists. As you consider these two therapists, we invite you to consider – which do you consider most compelling and why?

Ethical Component	Therapist A	Therapist B
Ethical sensitivity	Clients need therapy. Therapists need clients. Clients have preferences for engaging with therapy, therapists have preferences for providing therapy. Preferences are not the same as needs. Some preferences are needs. Not all needs are preferences. How do I know the difference when my decision may represent serious harm to my client, myself, our respective families and wider society? How do I balance my needs with those of my clients especially if rejecting client preferences costs me my practice? Do I want to adapt to a safe alternative (e.g. working online)? Is a safe alternative appropriate for some clients (e.g. clients with no guarantee to privacy)? What level of risk am I willing to accept? What level of risk is my client willing to accept? In either of us accepting risk, we may be transferring risk to others (e.g. a client takes a bus to therapy thereby coming into contact with others).	Clients need therapy. My livelihood is to provide therapy. My clients prefer face-to-face therapy. I prefer face-to-face therapy. I think I can take adequate precautions and rely on clients' agreements to not come to therapy when feeling ill or having been notified of being a close contact of someone who is ill. I don't have the technical knowledge or skill to adapt online work. My way of working is not compatible with working online. If I am willing to take the risk, and if my client, aware of risks, chooses to work face-to-face, I believe that is in the spirit of respecting autonomy. My work has been deemed an 'essential service'. I therefore have permission to work face-to-face. I am not responsible for the choices my client makes outside of therapy.
Ethical discernment	I value reducing risk to as close to zero as possible, especially the risk of physical harm. I place this above my financial wellbeing, above the survival of my practice. I value the 'safe space' therapy represents by accepting the trade-off between potential interruptions/privacy for clients and the risk to physical health or death. Can my client and I explore solutions to create 'virtual safe spaces' and adapt to interruptions, limitations, constraints imposed by going online? I choose the anxiety of navigating the world of therapy online over the anxiety of Coronavirus in the therapy room. I want to honour the spirit of public health guidelines by limiting close contacts over my ability to work face-to-face due to my designation as an 'essential worker'.	If I put in place adequate steps, compliant with public health and health and safety guidelines, I see no reason not to offer face-to-face sessions. For some of my clients, face-to-face therapy is essential as they have no space at home which is private/confidential. I am in the office anyway for those essential clients so it makes sense to extend face-to-face to clients before and after that essential session. Online therapy isn't as good/effective as face-to-face therapy. I don't have the technical skills to provide an alternative to face-to-face therapy. I don't have access to technology/broadband sufficient to provide a good online experience.

Ethical decision	As a result of weighing the above, understanding my values, considering alternatives and having balanced the various risks involved, I have decided to offer my clients therapy via phone/online only. This reduces our physical risk of harm to zero. We can both build from here and negotiate ways to address technical and space issues which might be a barrier to us working online (e.g. sessions from their car, after children have gone to bed, use of headphones, etc.). I accept the risk of the impact to my practice if clients refuse the offer of online therapy thereby honouring their autonomy and will seek ways to advertise my online practice. I will resume face-to-face therapy when three conditions are met: a) Covid is not circulating in the community (or when herd immunity is achieved), b) a viable, effective and safe vaccine has been administered to myself and each of my clients and c) there is a safe and effective treatment for Covid which renders Covid as a serious but non-fatal disease.	Having looked at the variables above, I conclude that providing face-to-face therapy, though not zero risk, is sufficiently mitigated by my enforcing the following: a) myself and my clients are temperature checked on arrival to my practice, b) I do a close-contact screening before each session, c) the chairs in the room are more than 2m away, d) I do not handle cash, e) we both wear masks, f) windows are open and g) there is a Perspex screen between the client and me. I deem these precautions adequate as they are in line with best practice guidance from public health officials.
Ethical conversation	I have taken steps to discuss my thinking and my feelings with my partner, two peers, my supervisor and a friend who trains student therapists. I encouraged each to engage critically with my decision so that I could uncover any biases or values unconscious to my current thinking.	I spoke to my supervisor in our last face-to-face session and took a full hour to discuss my thinking. My supervisor felt that my protocol was similar to his and seemed to meet current guidance. He did recommend that I review the situation in three months.
Ethical peace	I feel that I have done the best I can to respect ethical principles of beneficence and non-malfeasance, respecting autonomy and the potential impact on my clients who chose not to move online (removing themselves from therapeutic support) and myself (the impact to my practice).	I have followed all the guidance, kept my practice going, provided a safe space for my clients and have put significant effort and investment into reducing risk as much as possible.
Ethical growth	Since my decision, news that a new strain of the virus is 70% more transmissible and potentially 30% more severe has affirmed my prior decision. Though a vaccine is becoming available, I will need to carefully consider in collaboration with my clients about resuming face-to-face work when the other conditions are sufficiently met to justify the non-zero risk to physical harm.	We have been working well face-to-face for the last four months so my decision to remain stands. There is no evidence that the news of a new, more transmissible strain would constitute additional risk to the protocols I have in place. I will however respect clients' decisions and monitor closely as we move from lockdown to lockdown.

A practical framework for working face-to-face during Covid-19

Whilst recognising that 'doing the right thing' is a complex endeavour and one which can lead to feelings of ambiguity and uncertainty, our obligation is to act ethically. For many therapists (and indeed perhaps for many clients) and for a myriad of reasons, face-to-face therapy will be the outcome of ethical discernment. Considering the real and not the ideal then, we offer further anchors of reflection in order to help professionals address the greater than zero risk of working this way. For this, we propose the following framework;

Step	Task	Example or consideration
1. Identify a narrow and well-defined list of candidate 'essential therapy' categories	Assess each client individually against these categories	• Clients who are experiencing domestic abuse in the home • Clients with high suicidal ideation • Etc.
	Validate clinical judgement with your supervisor / peers	
	Ensure you collaborate with clients on the outcomes of assessment as to whether therapy will be online or in-person	
	Document the assessment, validation and ultimate decision in your case notes	
2. Engage your risk reduction protocols	Health & Safety protocols	Sanitising, masking, distancing, airflow, Perspex barriers, cashless, no waiting room, breaks between sessions, temperature checks, risk assessment etc.
	Therapy protocols	• Check that your insurance provider is covering you for face-to-face work during the pandemic • Consider how you will manage confidentiality should you or your client become ill and need to participate in contact tracing or be identified as a close contact • Consider how you will handle withdrawing from practice should you become ill • Consider the boundaries of access to personal bank details or other ePayment methods when not handling cash • Ensure adequate before and after session time to effect health and safety protocols • Ensure your Professional Will is up to date • Re-evaluate the assumptions which led to face-to-face work as more information is available from public health and professional bodies
3. Accept those risks which cannot be mitigated	Ensure clients are informed about the risks when choosing face-to-face work - update your contract and your notes	
	Validate accepted risks with your supervisor	
	Review each client situation on an ongoing basis to evaluate if face-to-face is still 'essential therapy' using ethical models rather than on the basis of permissibility or habit	

Conclusion

Being on guard for ethical issues can be challenging in the best of circumstances. Working ethically during a global event like a pandemic brings many new challenges which require diligent and thoughtful reflection. In a very real sense, our ordinary outward obligations (towards clients) are amplified by an equally powerful need to consider inward obligations (towards ourselves) and indeed careful consideration of the wider familial and societal impact of our decisions. Discerning the difference between preferences and needs offers a first step toward ethical decision making. Having access to a well-established method for ethical practice, coupled with new protocols in light of present

circumstances, may offer therapists confidence in their professional practice, personal conscience, client care and societal obligations as good citizens. We hope that this reflective piece in some small way offers fellow professionals practical support, professional inflection points and reflective anchors which assist them in entering bravely into the territory of 'doing the right thing' when things just aren't right.

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The flesh became word and we dwelt amongst it: The use of poetry in psychotherapy

by Ger Murphy

It is said that we have two births: our physical birth, and the first time we are spoken of, that moment when we enter the realm of culture, when we are thought of as somebody's son or daughter, part of a clan or orphaned from one.

This birth into culture is linked strongly to our birth into language; we are held by language and in a real sense we are made by language, so the flesh can be seen to become word and in this becoming lies much of our suffering and also the possibility of redemption. When we can speak words which express us, lead us and give access to our deepest yearnings, we feel more human, more connected and somehow more at peace with the world even when this peace is peace with deep suffering.

It is through the word that we engage most powerfully in the realm of relationality. While touch and body expression speak intimately from and of our deep interiority, language draws us out into a realm of shared expression with the exquisite possibility of our being understood by another and also of being missed/forgotten/misjudged. The realm of language invites us to risk our narcissistic ego ideal, take our life into our hands (or our words) and set sail on the open sea of communication in the hope of the intimacy of meeting another and being formed anew in the miracle of conversation.

Poetry is a particular kind of language and has long been known as the language of the soul. It is no wonder then that poetry can be seen as a helpful tool in psychotherapeutic practice. In this piece I want to speak to the use of poetry in practice, outline some theoretical underpinnings, and offer a glimpse of specific uses of poetry in the clinical setting. The use of poems in practice settings offers a tool where the client can work with a poem for a variety of purposes. A suitable poem can be a wonderful companion for clients going through many different life events, from working with grief and loss to accompanying the client through various developmental changes and to using poems as a form of bodywork.

Many people's past experience of poetry is from the classroom where the object was to learn a poem or to understand the author's intention and to offer a critique of the style and construction of a poem. For many, this experience was a challenging one where concepts of success and failure made poetry-speaking a secondary aspect. An attempt to dismantle and understand the construction of a poem can be satisfying, but can also be a reductionist approach which misses the spirit of the poem and depends too heavily on the rational mind. Poetry has ever been a spoken engagement with posture, breath, eye contact, tone and cadence all going to make a unique offering of every poem spoken through a particular voice/body. This is hugely different from reading a poem from a page.

In the work of which I speak the poem is used differently. The poem is seen as a 'medicine' which allows the person to sink more deeply into their own inner experience. The listening is also undertaken differently. The aim is not to understand and critique the poem but to listen with the heart and allow it

to open and affect us. The poetic word is a crafted word where the deepest personal experiences can be shared as they weave through the broadest existential issues in a way that offers the listener an entry point to their own experience. It is not prescriptive and does not taste of self-indulgence, even in its privacy and revelation. This is a high expectation, but a gift to the world when it is achieved.

The poem as companion during challenging times can be a real support, and the specific medicine of a poem can call the person back to a place of opening to and witnessing their experience. The invitation which a suitable poem can offer is one which allows the client and ourselves the opportunity to see that most experiences we encounter have been met before, thus allowing us to realise that our issues have a universal, as well as a particular dimension. Perhaps this is one of the great paradoxes of our lives where we struggle to hold both the deeply personal and the existential and collective expressions of our days.

For example, a client going through a strong grief experience can be greatly helped by Rilke's poem "Pushing Through":

> *It is possible that I am pushing through solid rock*
> *In flintlike layers,*
> *As the ore lies, alone.*
> *I am such a long way in I see no way through, and no space…*
>
> (Rilke, 2014: 161)

Poetry offers a fine connecting possibility between the silent body and the culturally civilised spoken word that give clients many clues to the directions possible in their own unfolding while offering them scaffolding in times of turmoil and change.

Mary Oliver's poem "The Journey" has been a companion to many clients coming through dark times:

> *One day you finally knew*
> *what you had to do, and began,*
> *though the voices around you*
> *kept shouting*
> *their bad advice--…*
>
> (Oliver, 2004: 79)

These two examples give only a glimpse at the breadth of poems which speak to particular life processes and can remind the client of their struggle and possible growth gateways through their experience.

Similarly, the Mark Nepo poem "Adrift" has helped many clients in times of great loss and change:

> *Everything is beautiful and I am so sad.*
> *This is how the heart makes a duet of*
> *wonder and grief.*
>
> (Nepo, 2000: 100)

A poem given to a client to work with can also be a very useful form of bodywork and can highlight patterns of holding and structure. For a useful introduction to character structure which is a framework which I am using, see *Eastern Body Western Mind* by Anodea Judith (2004) which draws on the work of Wilhelm Reich and Alexander Lowen (the founders of body psychotherapy).

How a client embodies a poem in speaking it can be very telling. The constriction and blocks in the body energy are evident as someone speaks a poem. There can then be many creative ways to work with the client in this regard, and as they more fully absorb the poem and allow it to live inside them, they can get many hints as to the areas of their body which can be more fully and vibrantly inhabited. How the poem is communicated also lets both psychotherapist and client feel the opening to intimate connection which the client can allow and this often speaks loudly of the relation to presence and connection in the client's world outside of the therapeutic space.

Different poems can shine a light on different aspects of the person. Poems such as Seamus Heaney's "Digging" allow a focus on their relation to their own root chakra and ground or earth element:

> *Between my finger and my thumb*
> *The squat pin rest; snug as a gun.*
> *Under my window, a clean rasping sound*
> *When the spade sinks into gravelly ground:*
> *My father, digging. I look down…*
>
> (Heaney, 2019: 136)

Schizoid issues are uncovered in the work where the individual has had to develop a schizoid type character structure and not fully enter the body due to early developmental challenges in the womb and in early life. The client's relation to the earth and to their own grounding on it are revealed both in a symbolic and a physical sense with the poem acting as a guide to becoming more embodied and earthed.

Another poem which speaks of this theme is Mary O'Donnell's "Return to Clay":

> *It is not hard.*
> *Go west or south, north,*
> *east if you wish. Take*
> *the swift path to the soil,*
> *in boots or killer heels,*
> *dungarees or velvet. The garments*
> *are irrelevant, merely*
> *a beautiful counterpoint*
> *to the moment when you sniff*
> *the air, realise your pores*
> *have filled with the smell of clay…*
>
> (O'Donnell, 2018: 189)

Poems of this type can alert us to what is missing in our presence in life, for example, how we keep ourselves separated from the earth element in our lives with the losses that entails to our relationships with ourselves, others, and nature.

The issues and challenges of the oral stage of infancy can be vividly brought to light as someone works with the poem "Love after Love" by Derek Walcott. In taking this poem into themselves, the client can encounter issues regarding self-esteem and also issues related to their feeling life, their sense of fullness or lack in their belly area, or second chakra/water element. To fully engage with the element one has to tolerate pleasure and sensual experience, and the issues that are often buried due to past conditioning or trauma can emerge, as well as the presence of the 'self-critic' who appears when self-

love becomes a possibility. Opening to self-love and the challenge of a benign sense of self-esteem is a major issue for many clients with issues of a second chakra or oral nature.

The time will come
when, with elation,
you will greet yourself arriving
at your own door, in your own mirror,
and each will smile at the other's welcome

(Walcott, 2009: 39)

The challenges inherent in tolerating and embracing our feeling nature, and also our lacks and hungers, is strongly present and awakened by poems like this.

Poems like "I Will Not Die An Unlived Life", by Dawna Markova are useful in relation to the subsequent developmental challenge of self-assertion versus shame, or so-called masochistic character or endure-type as Judith refers to it.

I will not die an unlived life.
I will not live in fear
of falling or catching fire.
I choose to inhabit my days, ***...***

(Markova, 2000: 68)

This can bring into focus the client's issues regarding self-assertion, or will-related issues. Many clients who have had their will thwarted in toddler stage and beyond and who have had to armour themselves against shame and humiliation, thereby developing a masochistic type character structure, benefit from the stretch which a poem like this offers them where they are encouraged to fully experience meeting the power of their own will and the defences against this. This refers to the fire element of the person. To dare to celebrate the separate identity, to stand out, is often a risk for such individuals where it can be more comfortable to hide in self-abasement and hold a subdued and stubborn approach to life. So, to speak the lines *"I will not die an unlived life, nor live in fear of falling or catching fire"* are often experienced as a stretch for the self burdened by shame, and can bring great liberation when the shackles of such shame are cast off, allowing the grief to flow and be followed by a greater sense of self possession.

Finally, there are many poems that can help work with the phallic/narcissistic or hysteric character process where deep relation and surrender to relationship are key themes in the work with a particular client. Developmentally, such clients can come to therapy unable to let go into a relationship fully when their early experience meant that offering their love safely was compromised, leaving them with specific defences in this regard. This fourth chakra, or heart chakra corresponds with the air element of the client.

Marie Howe's poem "Annunciation" offers great opportunities in working with these issues:

Even if I don't see it again—nor ever feel it
I know it is—and that if once it hailed me
it ever does—
and so it is myself I want to turn in that direction…

(Howe, 1998: 101)

This brief introduction to the use of poems to elucidate particular character issues is of course merely

pointing to the fact that particular poems can be chosen to work with, where the medicine of the poem can be an elixir for the particular themes with which the client is engaged. The character structure map developed by Wilhelm Reich as he built on the developmental schema outlined by Sigmund Freud, and further developed by David Boadella and Anodea Judith is very useful in providing a view of where development has been impaired and where growth can be focused.

With the work on these four elements—Earth, Water, Fire and Air—and the corresponding chakras, we can have a rounded schema to explore the potential and the blocks in the individual and how best they can pursue their growth and healing. Suitable poems can be valuable tools for growth, and can be a creative and fun way to explore how we can fully open to living.

A poem often operates as a transitional object, or self-soothing structure, and I have noticed recently through the Covid-19 challenge that many clients are finding support and nourishment in this way by having a few lines of a favourite poem with them through their days and nights. For example, the first stanza of the Stanley Kunitz poem "The Layers" is evocative for many just now:

> *I have walked through many lives,*
> *some of them my own,*
> *and I am not who I was though some principle of being*
> *abides, from which I struggle not to stray…*
>
> (Kunitz, 2003: 28)

To draw us back to what it is, that *"principle of being from which I struggle not to stray"* can offer us a fine meditation to strengthen us in challenging times.

Clients may themselves have a poem which has particular relevance for them, and if so, they are encouraged to bring this to therapy and to work with it. The process of learning a poem or 'writing it on our bones' can be so revealing in what we remember and forget. It is useful to see Kim Rosen's book *Saved by a Poem* (2009) to explore in depth the process of engaging with a poem.

Finally, there are many poems that can support the deep therapeutic endeavour of coming to acceptance of life as we find it, and confronting our resistances and narcissistic holdings, but one that I employ is Rumi's "Undressing".

> *Learn the alchemy*
> *true human beings know.*
> *The moment you accept*
> *what troubles you have been given,*
> *the door opens…*
>
> (Rumi, 2006: 94)

I hope I have pointed to the possibility of this kind of poetry work being significantly different from our normal engagement with poetry. Poetry offers a creative path to personal development in a psychotherapeutic context. We could say that in fact this is an embodied practice where Tantra meets Shamanism. By this, I mean that the opening to the ecstatic or the more-than-personal realm through a body practice, which is foundational to the Tantric tradition, can meet the grounded practice of meeting spirit in nature through the elements, which is basic to Shamanism. These two practices can come together as we engage mindfully with poetry, so we are changed by this deep alchemy. How this practice can live within a psychotherapeutic engagement is an ongoing and creative question which I continue to hold.

Seeing this poetry work as a form of bodywork can open us to the possibilities in it as a part of psychotherapeutic practice. Using the tri-focused matrix outlined above we can look at ourselves and our clients along the lines of the three foci:

1. What character structure seems most present in the person before us? And then what is the core existential question to be grappled with?
2. What chakra seems to require more or less energy activation?
3. What element from the four elements of earth/water/fire/air is most pertinent to the individual's development?

Using these questions, we can begin to build a focused bodywork practice that helps the individual build strength, resilience and surrender in their approach to life.

I find the use of David Boadella's guidance for bodywork practice in his book *Lifestreams* (2015) useful here also. Boadella focuses on three dimensions of contact as key to developing focused bodywork practice: these are centering, grounding and facing. I find working with how someone embodies a poem using these three dimensions to be most valuable as they offer good guidance as to how we might experiment with the poem, speaking in creative ways that offer a stretch to the character-structured way in which we speak, move, breathe and are embodied.

Having lenses of this kind strongly potentiates our work with poetry and I wish you well as you deepen your engagement with poetry for yourself and possibly your clients.

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Surviving the storm – A personal account of postnatal depression and anxiety in a pandemic

by Sheena King

As we all know, March 2020 marked the end of 'normal' life as we knew it. The frightening reality of the Covid-19 global pandemic seeped into our daily lives and brought with it global anxiety. My existing anxieties as a pregnant young woman preparing for her first child were elevated to new levels. Among these many fears, one in particular caused me the most distress. I was terrified about the possibility of having to go through my first ever experience of childbirth alone. I began to realise that the birthing experience I hoped for was in jeopardy and I worried every single day about how I would be able to tackle this great unknown without the emotional support of my husband. The World Health Organisation (WHO) gave clear recommendations that pregnant women should not be denied the support of a birth companion. After all, *"…pregnancy is not put on pause in a pandemic, and neither are fundamental human rights. A woman's experience of childbirth is as important as her clinical care"* (Tuncalp, 2020). Despite this, the emotional health and welfare of many expectant mothers have been severely compromised by Covid restrictions.

As the sun rose on the morning of Friday 1st May 2020, my husband waited nervously in his van outside our local hospital for over three hours while I was being informed that our little human was showing signs of making an appearance a week earlier than planned. Thankfully, he was permitted to join me in the delivery suite and that evening, we welcomed a beautiful healthy baby boy. No words could convey the joy of meeting our little man for the first time, and I could not imagine experiencing this life-changing event alone. My heart breaks for all those women in Ireland and across the world in the past year who have gone through labour and/or childbirth without the emotional support of their birth partner. I also feel a deep sadness for each woman who attends antenatal scans alone, particularly those experiencing health concerns and those parents who experience foetal losses or complications.

In the three hours immediately after giving birth, we soaked up every moment together as a family of three before my husband had to leave us. Even though I was prepared for the reality that I would spend the next three days without seeing any family member, this was still a very lonely and frightening experience at times. I was physically and emotionally shell-shocked and exhausted. As a new mammy, I was also terrified leaving my baby unattended for even five minutes. I had no idea what was 'the norm' in a maternity ward and just minutes after my tearful farewell to my husband that first night, I innocently asked a night nurse if it was possible for her to keep an eye on the baby for a minute while I used the bathroom (a scary event in itself!) Her response was one of disgust: "Oh no, we don't do that, we have too much to be doing. You'll have to just leave him there". I felt embarrassed for my ignorance and I felt stupid for being frightened to leave my three-hour-old baby alone even for a few moments. For the following 24 hours, as I revelled in the awe and overwhelming love I felt for my beautiful boy, I was also hit by recurring shock waves of isolation, sadness, loneliness, fear and helplessness that felt unbearable at times. Even though I received care and support from some lovely maternity staff, I longed for my husband and my own mother. I needed to be held, reassured and nurtured by those closest to me.

Our deserted village

They say it takes a village to raise a child. I now can see why. I imagine I am not alone in my experience of feeling overwhelmed in the first few days and weeks of becoming a mother. I trudged through the muddy waters of new parenthood as best I could, taking one day at a time, one feed at a time, one sleepless night at a time. Also, like so many other new mothers, I attempted to breastfeed my little boy. I lasted five weeks before conceding that it was too detrimental to my physical and mental health and that of my family. Of course, we had some wonderful and joyful experiences in those first few weeks as a family of three, and I remember feeling immense pride for this little human that I had created. Like millions of other new mothers, I got used to surviving on minimal sleep and began to settle into my new identity as a parent. We also purchased our first home during this time and moved house with a seven-week-old baby. We did most of this without the hands-on support of any family and friends. The only person to enter our home in our first five weeks as parents was our public health nurse, whose visits were restricted to 15 minutes contact and the rest on the phone sitting in our driveway.

I feel sadness that I did not have my village around me as I tried to adjust to parenthood. I wasn't able to access the support and nurture that my mother wanted to give to her only daughter at this special but vulnerable time. My little boy's grandparents were not able to hold him and experience those magical moments. By following public health guidelines, we sadly experienced disconnect and distance at a time where we needed to feel held by those who loved us. The feelings of isolation, loneliness and helplessness that I had felt during my hospital stay often resurfaced during this fourth trimester, but it wasn't until my son was four months old that these feelings became stronger.

The storm

For as long as I can remember, I knew I wanted to someday be a mother. I didn't realise that it was going to be so hard and that I would feel so awful in it. For six months, I felt like I was in a tiny wooden boat alone at sea during a massive storm, being constantly hit by huge waves that battered me from all directions. These waves proved relentless at times, slowly breaking me into tiny broken pieces *(see picture: 'The Storm').* Most days I felt weak, worn away, broken and helpless. I was physically and mentally exhausted like never before. I was deeply depressed while at the same time experiencing anxiety in the form of restlessness and rage that I had never experienced before. My limbic brain was in the driving seat and it was speeding out of control.

'The Storm' by Sheena King

Like so many people, I put a brave face on as a defence mechanism. I didn't feel brave enough to let others close to me into my inner world for fear of judgement or pity. Each time I looked in the mirror I

was filled with loathing and disgust. I saw a complete failure as a person and as a mammy. I questioned myself almost every minute of every day. Why couldn't I get my child to sleep through the night? How come my friends seemed to be managing and I wasn't? Why was I so angry with everything? With every day and night that passed, I was running out of energy and strength to fight back the storm waves that crashed against me from all directions.

Somewhere inside me however, I had a courage and strength that kept me going even if it was barely existent some days. Even though I felt blessed every single day to have a beautiful, healthy child and a loving family around me, I grieved for so many lost parts of myself. I grieved for my freedom, my hobbies and the loss of the bubbly energetic young woman with whom I had become friends over the past thirty odd years. I grieved for my pre-pregnancy body and I also grieved my pre-Covid life. I grieved for human contact with my support village instead of seeing their faces on the screen of my phone. I grieved for coffee dates with friends, visits to extended families, strolls around shopping centres with my buggy. I felt disconnected from the world around me and I grieved all the hugs that I desperately needed.

Name it to tame it

Despite my years of training and experience in the field of therapy and mental health, I naively thought that I would never be one of 'those women' who experienced postnatal depression. Maybe my awareness of depression and anxiety would somehow give me immunity against them? Thankfully, I had the ongoing wisdom and support of my therapist who witnessed the storm in which I was drowning. With her help, I was slowly able to give this storm a name. This was a turning point in my journey, and even though it took me over a week to find the courage to schedule an appointment with my GP to explore the idea of medication, I started to see that perhaps this storm might someday pass. It was eye-opening for me to learn that my experience is more common than people even realise, and I was not alone in my experience.

Throughout this journey, I have also found some resolution in naming the lack of support that I and so many recent new mothers have received. I have needed to name my anger, frustration and disappointment at falling prey to the impact of Covid but also the gaps that already exist in our country's public health system. In my experience, a mother suffering with postnatal depression and/or anxiety can feel completely lost and disconnected. I felt emotionally paralysed in a state of fear and overwhelm and there were times when I felt I could not reach out for help. I needed more check-ins from my public health professionals, and I needed more support as a first-time mother in a pandemic. I felt forgotten and isolated at a time when I needed to feel supported. My husband ended up being the sole witness to my grief, loss, torment and turmoil and I feel a deep sadness that he endured so much. I was lost at sea in my broken boat and even though I knew he was nearby desperately trying to help me, I was out of his reach.

I imagine that there are so many new mothers in my position who do not have the support of a loving partner or family. There are those who, for various reasons, do not have the support of their own counsellor. There are mothers who are separated from their families and friends by land and oceans and continents. I can only imagine how many of these women may be trying to survive their own storms right now. In my eyes, they are all true warriors.

After the storm comes the sun

In her poem *'The Storm',* Lupita Almaraz Aguilar reminds us that despite the loss and the damage caused by the storm,

…murky waters will clear
Don't underestimate nature
The thunder will roll but then fade
Sun will come sooner or later

(Almaraz Aguilar, 2020)

Now that my storm has passed, I have been able to appreciate the gifts that this experience has given me. Despite the isolation and disconnection which Covid gave us, it also allowed us some breathing space to adjust to life as new parents. Months of cocooning gave me uninterrupted time to get to know my little boy without the pressure of having to entertain guests or organise babysitters. And while I longed for the opportunity to squeeze my post-partum body into a figure-hugging dress and hit the dancefloor at friends' weddings, I thoroughly enjoyed spending the past year wearing yoga pants and tracksuit tops almost every day of the week!

My use of the storm metaphor is one that was central in my work with my dear supervisor Bridget Breen who passed away suddenly in April 2020. I would like to think that on my darkest days at sea, she was somewhere nearby sending me strength and courage. I am also forever grateful to my own therapist who has held a space in her heart for me when I felt like no one could help me. She battled through the storm with me, she kept me afloat and she helped me to see that the storm would eventually pass. As a therapist myself, my experience this past year has given me the gift of a deeper awareness and appreciation for our profession. As therapists, we have the privilege of helping others when they are battling their own storms. We are often that little ray of hope and light on their darkest days.

I am so thankful that my husband stayed by my side through this frightening journey of mine. There were times where my husband was in the middle of the deep dark sea with me, and we battled the storm together. There were other times where he stood at the shore, desperate and unable to reach me. He has always been and continues to be my rock, my silent hero and my best friend. There are so many partners like him in similar positions, and as helpless as they may feel at times, they are a gift. They are often the little ray of light that comes through the storm clouds on those darkest days.

'After the Storm' by Sheena King

The greatest gift of all that I have received from this past year is my beautiful little boy. He has helped me to reach depths of my soul that I have never imagined. Victor Frankl spoke of how mankind is inherently motivated to endure and survive suffering when there is love. He said that *". . . love is the ultimate and the highest goal to which man can aspire."* (Frankl, 1959: 37). As frightening as my experience of postnatal depression and anxiety has been, my love for my little boy has been my anchor in the storm. Part of me died and was washed away in that storm. But the part of me that remains has been transformed into a

stronger human being. I am reminded of the following excerpt which I came across in recent years.

> *. . . and once the storm is over, you won't remember how you made it through, how you managed to survive. You won't even be sure, in fact, whether the storm is really over. But one thing is certain. When you come out of the storm you won't be the same person who walked in. That's what this storm's all about.*
>
> (Murakami, 2005: p.4)

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Remote connection and communion: One psychotherapist's experience of learning during the pandemic

by Maria Moran

> *"The failure to communicate is frustration. The failure to commune is despair."*
>
> (Finley, 1978: 92)

Over the past year our style of connection and our sense of disconnection has been tried and tested on every front. The Covid pandemic, by its nature, has rendered everyday life difficult for all of us but for many, their lives were filled with deep fear, great suffering and loss. As psychotherapists, besides the trials of life in a pandemic, we have been challenged professionally to find new ways of sustaining our connection with our clients in order to facilitate their work. The focus for this paper is to share my journey over the past year as I adjusted to the necessary changes that had to be made in order to facilitate my clients. I will share some experiences and reflections on the challenges this year has offered me and how this experience may open new horizons post-pandemic.

Connection

As psychotherapists, particularly within the humanistic and integrative ethos, the quality of our work is dependent on the depth of connection we can make with our clients. It is my belief that this deep connection, for so many troubled people, offers a sense of acceptance that can help overcome the damage of wounded hearts and minds. The basic human need to have our personal story witnessed by another is paramount for the healing process, and in our work it is vital that we strive to offer that sacred space for our clients. One of the essential properties for good connection depends on the quality of our 'presence' in the therapy room. Here we have all our senses available to us and as communication depends not just on what we say (in fact this is deemed to be a very small percentage of the message we relay) but largely on our body language, the surroundings we offer and the provision of good clear boundaries etc., are important. So what happened when we went 'remote'? I will attempt to describe my experience of the past year and what I am learning about the process of psychotherapy through it.

Remote psychotherapy

Last March, because of the dangers of Covid, and like so many others, I began to offer my services over the telephone or using video calls. Probably because of the remoteness of my location, most people opted for telephone sessions, as reliable internet connection (despite all the advertisement to the contrary) has not arrived in some rural settings yet. I will speak therefore of my experience of how I managed to navigate from live sessions (with all the human senses available to me and my client), to remote work where we were connecting bereft of sight, touch (so strange not to welcome anyone without being able to look into their eyes and shake their hand), smell and lastly taste (which to my mind was the only sense that didn't seem to offer a challenge as such). In other words, I felt enormously deprived of the energetic contact I had grown to expect in my workplace.

I remember how I moved into this way of functioning professionally with reservations and misgivings. I imagine that the tension in my own body as I leaned into the phone in an attempt to be more present to my client, added to the exhaustion I felt at the end of each day. My whole being took some time

to traverse this new territory and to learn to accept that it is possible to do good work under these conditions. With time and experience of this way of working, I now trust that the depth of work does not need to be compromised for most of my clients, (although I believe that a certain number of clients would do better in live sessions).

Initially, especially with clients I had never met previously, I felt a sense of disempowerment within my being (similar to the experience of attempting to read a document without the use of my spectacles). I was conscious of my reliance on picking up the physical energy and body language of my client in the room. These were the well tested dependable tools I used as a way and means of understanding my client and what lay hidden between the words and in the physical space between us. I have always listened to my own body language and that of my client during face-to-face sessions and I saw the energetic space between us as a deep well of understanding and insight which, when gently stirred, has the ability to rouse the spirit of adventure and risk-taking within both of us. This had become such an intuitive and trusted way of connecting in my work, I was taken aback by its absence. For some weeks, the perceived lack of this space in remote work was a distraction for me and added to my exhaustion as I tried harder. I sometimes felt clumsy and disoriented.

Something new

Gradually, as I accepted that this remote way of working was different, I relaxed a bit and found myself being prompted inwardly with ideas, images and symbols of possible interventions that I didn't really trust in this arena. I wondered at the value or consequences of sharing these random promptings with my client but unlike the face-to-face encounter, when I had an energetic insight, now I doubted the validity of sharing this 'inspiration' – what was its source?

As I became more familiar with these 'promptings' and the frequency of them increased, I found myself arriving at a place where, very tentatively at first, I dared to trust them or at least to risk using them. These inward nudges led me to enquire about something that wasn't clearly connected to what my client was speaking about but the intervention did bring the work on a very useful and interesting diversion; (similar to my felt sense of non-verbal communication within a face-to-face session but not the same). At first, I may have wondered with my client in such a subtle way that it was too faint to be heard. But as my confidence increased, I became a little braver and discovered a sense of connectivity and sometimes communion that was emerging. These interventions were not by any means earth-shattering but had a quality of offering the client another path to explore which bore much fruit. For example, a client who was struggling to find a focus for her work for some weeks, on this particular day was very subdued. When I asked her gently what was happening for her, she just said "I'm blank"; a question came into my mind at that moment straight out of the blue and I didn't understand its significance but I decided to risk asking her; her response brought her to life and she now discovered what was important for her to explore and this yielded a rich harvest.

Of course, occurrences such as these don't occur at every session, but the incidence of these promptings feels significant. The nature of these interventions, while similar to the body sensations I attend to when in the same room with my client, are experienced differently in the remote situation. It is more a silent but audible prompt that has nothing to do with me but somehow it is found useful for the client. It feels as if the energetic communication is able to cross the divide during these remote sessions in a way I never expected. It is something that I watch for very carefully during my sessions now and while I am still not able to articulate how this compensation of physical presence is being bridged, my sense is that it is spiritual in nature.

Human connecting

I have always been interested in and reflective of the varied ways we have of connecting, attaching, bonding (and indeed distancing) one with another as human beings, whether individually or in groups, big or small. I had been working as a psychotherapist for some years before I first took up the study of theology in a serious way. Believe me, the necessity to keep those worlds separate as I moved between the two disciplines was quite a chore at the time. In my experience there seemed to be a distance between followers of these two disciplines based on suspicion and fear. What I discovered during my studies was that the same wisdom was spoken in both disciplines, just using different languages.

Ancestral connection

One area of exploration I engaged in was on the nature of our relationship with our ancestors. I explored this through psychotherapeutic and spiritual understandings using a Christian lens. Ancestral healing looks at how the energy of unfinished business of the ancestors is handed down through the generations, deeply impacting the lives of the present generation. The work of ancestral healing is to address these issues, whether they be issues of injustice perpetrated on the person(s) concerned or suffered by them. When a member of the family line steps forward to deal with the issue, even if it took place many generations before, the energy is cleared and healing happens for all the family (whether they are aware or not that the brave family member has taken on this work for the family). Of course, this is a phenomenon that has been observed world over since time immemorial and is an integral part of many traditional cultures and belief systems. I was reminded of this study as I pondered on the question of connection and remembered how easily the psychotherapeutic and Christian understandings spoke to each other, albeit in different languages. I feel this previous area of exploration speaks to the current topic of this article and with this in mind, I will offer a few thoughts through the mystical lens.

Mystical connection

From a spiritual perspective I will draw in the teachings of a well-known mystic of the last century called Thomas Merton. James Finlay, in his book entitled *Merton's Palace of Nowhere*, offers a perspective of Merton's understanding of the difference between communication and communion as two fundamentally different modes of knowing:

> *Communication is logical, quantitative and practical in its application. It is a linear form of human intercourse in which each piece of information is given one at a time and leads up to some particular conclusion. Mathematics is the language par excellence of communication. And computers are the champions of mathematical language. Computers are able to communicate vast quantities of usable, verifiable data that is unaffected by subjective thought and feeling. We could not live without this one-dimensional mode of knowing. But, of itself, it lacks the power to convey the deepest hopes and yearnings of human existence.*
>
> (Finley, 1978: 91)

These *"deepest hopes and yearnings of human existence"*, when not met in the lives of our clients, often become a source of unhappiness and the focus of our work in the psychotherapeutic setting.

Of communion Merton says:

> *It is something that the deepest ground of our being cries out for, and it is something for which a lifetime of striving would not be enough. In the Book of Acts [8:28-40] we read of the eunuch riding along in his carriage reading the Book of Isaiah. He is approached by Philip, who asks him if he*

> *understands what he is reading. The eunuch responds by saying, "How can I, unless some man shows me?" Philip climbs into the carriage, speaks to him, and the eunuch finds not information but communion with God. He responds not by taking notes but by going down into the water to be baptized. Philip's words came to the eunuch not in the form of information but as symbols evoking an encounter with God. Religious language may not be logical, but it is always symbolic. It is always a symbol, a promise of the communion the disciple longs to discover. The purpose of the symbol is not to convey information but to open unknown depths of awareness enabling the disciple to come upon his own center, his own ontological roots in a mystery of being that transcends his individual ego.*
>
> *The words themselves evoke occasions of this communion, which is a mode of knowing not wholly available to what can be communicated in quantitative, verifiable terms. Words are to communion what the sky is to the stars. The sky does not own the stars, nor contain them like coins held securely in a pouch. Rather the sky is the matrix in which the stars appear…*
>
> (Finley, 1978: 92-93)

These profound moments that we are privileged to witness as we sit with our clients, those 'Philip' moments, are the moments of communion, the source of which come through us but not of us. In my early practice, although I always made space for the spiritual experience, it was not something that I spoke about openly. Probably the idea of spirituality and religion were too intertwined in the Irish context at the time and it felt like dangerous terrain. I do not believe that I am alone in our profession in feeling this reticence when it comes to sharing spiritual experience with another during our work. I wonder why this may be?

Psychotherapeutic connection

Moving from mystical to psychological language, let us draw on voices from our own profession. Carl Rogers and Brian Thorne were two voices that impressed me deeply during my training years in psychotherapy and their recognition of the relationship as being an essential element in the quality of interaction that occurs between the two parties impressed me hugely. I will quote an excerpt of Brian Thorne's journey of discovering the importance of the gift of 'tenderness', as he termed his sense of deep interrelatedness of the human spirit and its facilitation of the psychotherapeutic journey. His courage, as expressed below, encouraged me to explore this aspect of our work:

> *One day, however, for I know not what reason, I decided to throw such caution to the winds. I suppose at some level I reminded myself that I was not a counsellor in the analytic tradition but someone who believed in the fundamental trustworthiness of human beings and that this category included myself. I knew that I was an experienced responsible counsellor and that I was committed to my client's wellbeing. My own congruence - the outcome of the discipline of my chosen therapeutic approach - was revealing to me a strong sense of being intimately involved in a profound level with someone with whom I apparently had little in common. I decided to trust that feeling, however mysterious or inexplicable and to hold onto it rather than to dismiss it or treat it with the usual circumspection. The result of that decision has been far-reaching, for I discovered that my trust in this sense of profound interrelatedness (and it usually happens unpredictably) gives access to a world which seems outside of space and time and where it is possible for both my client and me to relate without fear and with astonishing clarity of perception…. It is clear to me now that the decision to trust the feeling of interrelatedness was the first step towards a willingness on my part to acknowledge my spiritual experience of reality.*
>
> (Thorne, 1999: 38)

While Thorne wrote these words back in the last century, it is still an area of exploration in the present time. Very recently, I came across an article in the *Journal of the American Psychological Association* (2020). I will quote:

> *Abstract: The importance of relational processes during psychotherapy and psychoanalysis has long been emphasized. Theoretical and empirical investigations have focused mostly on episodes in which the therapeutic relationship is taken over by transference, leads to enactments, or suffers ruptures, and much less on understanding the role of positive relational episodes in the change process during psychotherapy. Episodes of the latter type, conceptualized as Authentic Relational Moments (ARMs), are core experiences in the patient's implicit* relational *learning in psychotherapy*.
>
> (Békés & Hoffman, 2020: 1051)

The article goes on to speak of the core aspects of ARMs being authenticity, understanding and witnessing. "*ARMs occur when the connection is especially strong and genuine between patient and therapist, allowing the dyad to arrive at a symbolic relational space where they connect deeply and authentically"* (Békés & Hoffman, 2020: 1052). While this is an interesting description, the authors indicate their intention of researching this concept in an empirical study. (I feel doubtful that avenue will bear fruit if they are in the zone of subjective experience and communion.)

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Communion and personhood

"Listen with the ear of your heart" (Holzherr, 2016) was the instruction St Benedict gave to his monks back in the sixth century in the prologue to The Rule. "*An intensive listening or careful hearing should correspond to this call. The heart must incline itself to that which is heard… a basic attitude of humility. …the rule is directed at the whole person, body and soul."* (Holzherr, 2016:10). This is the disposition and quality of listening required of us in order to enter our personhood. Human personhood is not the same as speaking of one's personality. It is, rather, about speaking of one's relationality. As human persons, we have the capacity for creativity and this requires that we engage with the faculty of our imagination as distinct from logical or cognitive thought. It might be really important to be careful not to exclude this possibility when sitting with our clients. The power and the use of symbols in our work is familiar to us all. Jung has left us an impressive legacy on the subject. But for now, I will give Merton the last word as he speaks of symbols and communion:

> *Traditionally, the value of the symbol is precisely in its apparent uselessness as a means of simple communication. It is ordered toward communion, not to communication. Because it is*

> *not an efficient mode of communicating information, the symbol can achieve a higher purpose of going beyond practicality and purpose, beyond cause and effect. Instead of establishing a new contact by a meeting of minds in the sharing of news, the symbol tells nothing new: it revives our awareness of what we already know, and deepens our awareness. What is 'new' in the symbol is the ever new discovery of a new depth and a new actuality in what is and always has been. . . . The function of the symbol is to manifest a union that already exists but is not fully realised. The symbol awakens awareness or restores it. Therefore it does not aim at communication but at communion. Communion is the awareness of participation in an ontological reality.*
>
> (Finley, 1978: 93)

Conclusion

> *Had I not been awake I would have missed it,*
> *It came and went so unexpectedly*
> *And almost it seemed dangerously,*
> *Returning like an animal to the house,*
> *A courier blast that there and then*
> *Lapsed ordinary. But not ever*
> *After. And not now.*
>
> (Heaney, 2011)

In our work as psychotherapists, the words or symbols that spontaneously emerge at times, the unbidden images, should we listen to their prompting, may be more important to share with our clients than we can imagine. To say I'm surprised to have realised a much deeper awareness of this communion through telephone work with clients is an understatement. I feel excited at the possibility of extending my service to reach potential clients who cannot reach me in our traditional setting of the therapy room. Having had this experience of telephone and video calls, I now feel more ready and confident to actively offer psychotherapy to those who are confined to their homes for various reasons but would like the opportunity of engaging at this level. I will now do so, confident that I can offer them all that I can offer my face-to-face clients. I hope this will be the case for many therapists moving forward.

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The River

by John Bourke

Every time I walk along that way
You are there,
Like a faithful friend.
Your sounds washing over me
Remembering, reminding, beckoning
The soft unfurling of my soul.

A home
From the incessant growl of being locked in;
I have accepted and adapted,
Bent low my head and borne
The pain, and gotten on with it,
And gotten on with it!
But now a beautiful anger rises in me
Screaming at the grief and hurt
And senseless loss…

And still,
Every time I walk along that way
You are there,
Like a faithful friend.
Your sounds now cradling my cries
Returning, smiling, beckoning
The soft unfurling of my soul.

John Bourke *is in training to become a psychotherapist, at present undertaking the MA in Psychotherapy in DBS. John has a particular interest in Integral Psychotherapy.*

Self-care of the therapist working with traumatised clients of domestic abuse when dealing with moral distress

by Daniel Cleary

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Domestic abuse can be described as a multi-faceted problem, and the people involved are from all social classes and positions (Gadomski et al., 2001; Hamlin, 1991; Mann, 2000; Sokoloff & Dupont, 2005). Studies involving domestic abuse have been carried out by many different researchers in various disciplines, including medicine, psychology, and social science (Ansari & Boyle, 2017; Chang et al., 2014; Gill et al., 2012). In these studies, as well as the practicality of working with victims and perpetrators experiencing domestic abuse, there arise different challenges, both for the people involved directly with the domestic abuse, and for the people working in this area, the domestic abuse therapists/practitioners. The author sees his work as a psychotherapist being performed in this context, and when faced with moral distress while working with traumatised clients, the need for self- care becomes evident.

Domestic abuse

Domestic abuse is gender neutral. It includes all genders, races, ages and sexual orientations (Alejo, 2014: 82). Men and women can be the perpetrators or victims in heterosexual or same-sex relationships. In 2013, the World Health Organisation identified violence against women and their children as a human rights issue (WHO, 2013). Women's Aid (2019) describes domestic abuse "*as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence*." In most cases it is perpetrated by a partner or ex-partner but can also be perpetrated by a family member or someone involved as a carer in the life of the family. Also, in most cases it is experienced by women and is perpetrated by men. Most female and male victims of domestic violence do not report their experiences of domestic violence (Watson & Parsons, 2005).

The impact on the domestic abuse therapist.

Working with victims of domestic abuse requires the therapist to be able to have a multifaceted response and trauma informed care and practice, in order not to re-traumatise victims (Alejo, 2014). The therapist will have to listen to and deal with the different impacts of domestic abuse on the family, especially on the victims. Cohen and Collens tell us that individuals who are working with traumatised clients can experience "*secondary traumatic stress*" and "*vicarious trauma*" in the context of trauma work (2013: 3). The therapist may also have to hear about the children who experience domestic abuse in their homes, and its impact when their parents are in a domestic abuse relationship (Carpenter & Stacks, 2009). The therapist may also encounter the perpetrator of the abuse and work with that person with a view to the perpetrator accepting responsibility for what they have done, as well as the

therapist listening to the details of what has happened (Iliffe & Steed, 2000). The therapist will always have a focus on protecting the victims, including the children, as this is central to the work (Skyner, & Waters, 1999). The therapist will also be engaged in the work of change for/with the perpetrator of abuse, if the perpetrators are willing to engage in this work (Bowen, 2011). The therapist may have to address legal issues in their work, particularly in the area of child protection. This could involve the therapist being involved with Tusla, social workers who work in child protection, and the therapist may also have to be involved in the legal system in Ireland (Holt, 2011). Cohen and Collens (2013) draw our attention to an aspect of trauma work that is not often explored or researched, which is the "*potential positive changes that emerge from trauma work*" (3). Another possible impact on the therapist is that of moral distress. According to Cherny et al., moral distress "*can produce feelings of frustration, anger and anxiety, and of having been devalued and marginalised*" (2015: 254). The impact of moral distress on the therapist can be destructive and can result in the therapist, according to Cherny et al., having nightmares, headaches or possibly depression (2015). These authors go on to say that moral distress can have the impact of the therapist being/choosing to be isolated and also threaten the "*self-worth*" of the therapist (254). Moral distress can also "*have the impact of burnout*" on the therapist and "*has been identified as a major risk factor*" for people leaving their work. These authors tell us that a therapist could end up with *"moral residue"* due to a perceived sense of "*seriously compromising*" themselves or allowing themselves to be *"seriously compromised"* and if this re-occurs can lead to an impact on the practitioner's "*self-worth*" (254).

Understanding a traumatised client.

Trauma can appear and be understood in different ways; Herman (1992) describes trauma as an affliction of being powerless, where the victim is in a state of being helpless. In addition, this is the experience that the person has, when everyday ordinary systems of care that give that person a sense of control, connection and meaning are also overwhelmed. Herman also informs us that any traumatic events are extraordinary because they overwhelm the ordinary interactions of the person with their everyday environment. Herman (1992) also said that people who have endured any kind of difficult/horrendous events will suffer from some expected psychological distress or trauma. He tells us that there is a wide range of traumatic disorders and these can go from the effects of a single, one-off overwhelming event to the more "*complicated effects of prolonged and repeated abuse*" (2), as in the case of domestic abuse. When it comes to domestic abuse and to the victim in the situation, Herman says that the victim (the woman) who has been given some kind of diagnosis, especially a severe personality disorder, has been generally failed in the recognition of the impact of "*victimisation*" (2). Herman (2001) also tells us that "*trauma is the result of the bodily system being flooded, with the result that the body's self-defence system becomes disorganised*" (122). For him, these are the responses or parts/aspects that a person had in their normal day-to-day responses to danger that were useful or beneficial to the person and are now always in "*an altered and exaggerated state*" (122), even though the event or danger has long passed. Berclaz (2009), when referring to Herman's understanding of trauma, says that traumatic events can involve anything from threats to life, to threats to a person's autonomy and self-determination over their own body, or a close encounter with violence and/or death. A person who has these experiences is confronted with the "*extremities of helplessness and terror and evoke the responses of catastrophe*" (28). According to Nijenhuis & van der Hart (2011), the word trauma means wound or injury. From this perspective, we must see the traumatic event as "*a psychobiological wound*" (417) and not an event. This psychobiological wound is understood as something that has come about because of "*psychological, biological, social, and other environmental factors*" (417). Van der Kolk (2015) informs us that trauma is specifically an event and that it overwhelms

the person's central nervous system, altering the way in which that person processes and recalls the memories of the event(s). Van der Kolk (2015) states the following;

> *Traumatised people chronically feel unsafe inside their bodies: The past is alive in the form of gnawing interior discomfort. Their bodies are constantly bombarded by visceral warning signs; in an attempt to control these processes, they often become expert at ignoring their gut feelings and in numbing awareness of what is played out inside. They learn to hide from their selves*.
>
> (van der Kolk 2015: 97)

Van der Kolk (2015) also tells us that trauma for the person is not just about what happened in that event in the past; it is also about what is left for that person because of that traumatic event, and this is the pain, horror, and fear that is now living inside of the body.

Trauma and domestic abuse

The impact of domestic abuse on victims can be short or long term. Victims of domestic abuse are at an increased risk for many chronic health problems, health risk behaviours and mental health issues (Macy, Ferron & Crosby, 2009). The therapist will, in their work, hear all the experiences of the family, adults and children. Domestic abuse impacts the overall 'quality of life' for a victim (Hanson et al., 2010). The traumatic impact on adult victims who experience domestic abuse depends on different factors, and these include the person's response to trauma/stress, age, frequency, and the severity of abuse (SafeIreland, 2020; Watson & Parsons, 2005: 105-122). Some victims will display criteria associated with Post Traumatic Stress Disorder (PTSD), and others will exhibit resilient responses. Traumatic responses often are different because individuals react differently to trauma. The obvious impact on victims is physical injury, life threatening injuries or death (Karakurt et al., 2017). Other impacts include the psychological/emotional injury (stalking, threats, harassment, coercive control, isolation, intimidation etc.); also, there are common emotional and spiritual effects of domestic abuse which include: hopelessness, feeling unworthy, apprehension, chronic stress, being discouraged about the future, inability to trust, fear of intimacy, questioning and doubting spiritual faith and feeling unmotivated. The destruction of personal property and family property, and the threat of same have a negative psychological and emotional impact on victims. The impact of domestic abuse can also include economic and financial factors or technologically facilitated factors (Al-Alosi. 2017). The abuse can affect a person's parenting capacity, identity and parental role (Cort & Cline, 2017). Victims suffer negative social effects from domestic abuse, and the therapist will also hear about how the abuse has harmed family bonds and family relationships (Meyer, 2017). Children also experience domestic violence with all their senses, and it negatively impacts their everyday functioning, and even their very being. It is understood that children are acutely aware of and impacted by domestic abuse (Devaney, 2015).

Moral distress

The idea of, and need for understanding, 'moral distress' with professionals has its origins in nursing ethics in the 1970s and 1980s. During this period, ethics faculties in America "*recognised that nurses and nursing students displayed a strong interest in the study of ethics*" (Jameton, 2013: 297). Hamric et al. (2012) tell us that "*moral distress is increasingly recognised as an important problem that threatens the integrity of health care providers and health care systems*" (1), and they go on to say that there are very few reliable and valid measures of moral distress in use, and this would include everyday practices for professionals, as well as in research. Austin (2012) tells us that moral distress is used to refer to *"experiences of frustration and failure arising from struggles to fulfil the moral obligations*

of professionals"; she goes on to say that "we need to pay attention to these experiences" (28). Moral distress/moral problems are described as common experiences with complex phenomenon (Jameton, 2013; Hanna, 2004). These common experiences happen for individuals and for societies "*when individuals have clear moral judgments about societal practices but have difficulty in finding a venue in which to express concerns*" (Jameton, 2013: 297). But there is a difficulty with having a "*clear complete definition*" in spite of these moral distresses/problems being experienced by professionals worldwide (Hanna, 2004: 73). Some authors who suggest that moral distress is understood by how it arises i.e., a professional struggling to make a decision because of what the organisation they work for demands, or what society looks for. Sunderland et al. (2010), however, understand it to mean the "*particular phenomenon of moral distress,"* or "*feelings of helplessness to act in accordance with one's moral values due to systemic or institutional constraints*" (78). Camp & Sadler (2019) tell us that moral distress happens when a professional chooses an ethical response to the moral distress, but for whatever reason, cannot do it. Cherny et al. (2015) tell us that professionals who experience moral distress do so when they are asked to "*carry out acts that run contrary to their moral compass*" (246). Perhaps a more helpful understanding of moral distress comes from Russell (2012) when she says that "*The term 'moral distress' is not a word, but rather a phrase that is often given different meanings by different literature*" (15). Russell (2012) tells us that when it comes to understanding moral distress, looking at its common use in the literature is insightful, and tells us that "*four comprehensive attributes were formulated to describe moral distress: negative feelings, powerlessness, conflicting loyalties, and uncertainty*" (23).

Self-care

Professionals in any/all caring professions run the risk of experiencing stress, burnout and exhaustion (Bressi & Vaden 2017), secondary or vicarious trauma (Bober & Regher 2006), and/or compassionate fatigue (Sansbury, Graves & Scott, 2015). Wise et al., (2012) tell us that professionals who are committed to caring for others may neglect having a balance between "*caring for our clients and caring for ourselves*" (487- 488). They go on to say that they understand self-care as *"enhancing positive well-being"*. Self-care for social workers, according to Bloomquist et al., (2015), is the way in which these professionals will be able to "*protect*" themselves "*against the many stressors*" (293) of their profession. Self-care can also be understood by practicing actions that are intentional and done on purpose by people and organisations, and these actions can contribute to the wellness of the professional and reduce their stress (Alkema, Linton, & Davies, 2008). Two ways in which a therapist working with traumatised clients can practise self-care is by using their values and/or the values of the organisation they may be working with, and also by attending supervision.

Values

Organisations have different values and use these in showing the vision and mission that they have. These organisations ask the people involved in the organisation to commit to these values so as to engage in the work of the organisation. For some organisations, the focus is on 'how' you do what you do so that the clients will experience and see their values at work. Values according to Mowles (2008) create the conditions for solidarity among staff. Mowles goes on to say that values "*are emergent and intensely social phenomena that arise daily between people engaged in a collective enterprise*" (5). Values and beliefs can also be used in an organisation so as to enable an individual, group or management to make ethical decisions (McEwan, 2001). Bissett (2014) tell us that if there is congruence between the therapists' values and their perceptions of organisational values, then there is the possibility that the practitioner will experience job satisfaction, work engagement, inclusion and resilience.

Supervision

Berger & Quiros (2014) tell us that supervision for those who work with traumatised clients is *"designed to enhance the knowledge and skills of practitioners who provide this service"* and they go on to say that supervision will "*foster the professional and personal growth of practitioners and enhance their mastery of trauma-informed care*" (296). The role of the supervisor is to support the therapist emotionally, modelling ethical, safe practice, and promoting effective practice interventions which would need to be informed by evidence-based theory and research (British Psychological Society, 2007). Many involved in different aspects of social care, social work, therapy and/or counselling believe that supervision is necessary for them professionally as well as for good self-care. This self-care in supervision is so that the therapist will be able to find meaning in the work that they do and so that they will have resilience and allow themselves to be open to the potential of transformation (Thompson et al, 2011: 159).

Conclusion

In a family where domestic abuse is an issue and everyday reality, all members will experience and be impacted by traumatic events. These traumatic experiences will have a long-lasting effect on the person, even if the experience was a one-off event. Therapists working in the area of domestic abuse then will need to be aware of the possible situations and experiences they will find themselves working within, in order that they can best address and work with those involved to ensure safety for the family and themselves as therapists. In their work as therapists in this area, they may find themselves addressing moral dilemmas and trying to work with and manage these as they go about working with their clients. The tendency here is to experience moral distress, whereby the therapists may find themselves unable to continue to work with traumatised clients. Therapists will need to be able to avail of appropriate self-care in order to be able to address any issues that arise, and they will need to be aware of issues like stress, burnout, vicarious trauma, secondary trauma, compassion fatigue, supervision and the values of self and/or the organisation.

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Silent Voices – ending the silence on parental problem alcohol use

by Marion Rackard, IAHIP, ACI

"I am 65 years of age and still carry the scars of my childhood surrounded by alcohol."

"The hardest part was the never-ending repeated sense of crushing disappointment when one of my parents was drunk again. In one way, I came to expect it but it never stopped being disappointing or painful; there's always a small amount of hope that you cling on to when you have a parent with alcoholism."

"When our parents drank, we were left to our own devices. From a very early age, we had to assume total responsibility to feed ourselves, manage finances, manage chaotic parents, get to school."

These testimonies - from people who grew up in homes where one or both parents drank to excess - give voice to the trauma that such an experience can have, lasting long into adulthood and causing untold damage.

There is now a wealth of research that tells us growing up in a home where a parent has a problem with alcohol is an adverse childhood experience (ACE) that can have devastating consequences, disrupting the child's development, severing a family's emotional bonds and giving rise to lifelong implications for physical and mental health (Felitti et al., 1998; Ashton et al., 2016; Beliis et al., 2014). In Ireland, independent research finds that up to one in six children live in a home with parental problem alcohol use. This demonstrates that it is a whole of population concern that spans all social classes.

In real terms, one in six means it is likely that more than 200,000 children in Ireland are living with the traumatic circumstances of a childhood where parental problem alcohol use is a frequent event. It is further estimated that there are around 400,000 people in Ireland today who are adult children of alcohol-impacted families. Taken together that is 600,000 people – 12% of the population.

Silent Voices

Given the huge numbers of people being harmed from this preventable trauma, Alcohol Action Ireland (AAI), the national independent advocate for reducing alcohol harm, has in recent years begun campaigning on the issue and in January 2019 launched the *Silent Voices* initiative (Alcohol Action Ireland, 2019). It has been fostered by three individuals who experienced parental problem alcohol use – Carol Fawsitt, Barbara Whelan and this article's author, Marion Rackard.

Silent Voices aims to break the silence by highlighting the figures and research – and people's personal stories. Awareness needs to be raised among a wide range of audiences from the public, to politicians, to the media, educators and anyone who works with vulnerable children and families. Fergal Keane (BBC Africa Editor and Author) was the guest speaker at the launch of *Silent Voices* and spoke about his experience with the issue (Alcohol Action Ireland, 2021a).

Since the initiative launched AAI has:

- Established a platform, *Shared Voices*, where adult children can share their experiences anonymously. Recently two of these stories were animated (Alcohol Action Ireland, 2021b) which gives an illustration of some of the trauma experienced. If you have clients who might wish to share their stories anonymously on the platform this can be done at the website https://alcoholireland.ie/silent-voices/shared-voices/.
- Held workshops and meetings with a range of interested organisations and individuals. From this we developed our manifesto of strategic actions (Alcohol Action Ireland, 2021c) needed to address the issues in this area.
- Carried out public talks to raise awareness within the therapeutic community, such as an Aware talk (Alcohol Action Ireland, 2021d) given by co-founder Barbara Whelan and two others (Alcohol Action Ireland, 2021e) given by co-founder Marion Rackard (IAHIP, ACI) and addiction counsellor Austin Prior.
- Collaborated with academics from University College Cork to explore the experiences of ACOAs as indicated in the *Shared Voices* and with other interviewees.
- Expanded this research work into a detailed paper around education (Alcohol Action Ireland, 2021f).
- Met with senior government ministers and policy makers.
- Advocated for the introduction of better data sharing between police and schools to provide immediate support for children who have experienced domestic violence.
- Garnered significant media coverage of this issue with over 100 items in national and regional media as well as the dedicated *Silent Voices* social media handle and launched a podcast (Alcohol Action Ireland, 2021g) featuring the founders of the initiative discussing the campaign.

However, despite all of this, much more needs to be done. As well as grassroots and NGO work, Government should provide funding so that all agencies that work with children and families become trauma-informed. This would mean that professionals in front-line services and counsellors are adequately equipped to deal with the issues that stem from adversity in childhood and can recognise children affected by parental problem alcohol use.

Educators, too, are very well placed to identify children experiencing hidden harm. The provision of specific training in relation to adverse children experiences (ACEs) should be examined at teacher training level, and at all levels of professional development – from teachers to principals to education welfare officers.

Silent Voices would also like to see robust, comprehensive and consistent data gathered in appropriate settings, for example in mental health, child and family, education, homeless and criminal justice settings. This will identify the numbers of children and adults affected by this issue and will inform policy and service provision. Public discourse/debate on the right to a childhood free from alcohol harm should take place, and children should have their voices heard in relation to the impact of alcohol on their lives.

Covid impact

This issue has become even more pressing since the Covid pandemic lockdowns of the past year and a half. We know that Ireland's alcohol users substituted most of their drinking from regulated licensed premises to consumption in the home. And we know that homes with children have seen an increase in at-home drinking with data from the Central Statistics Office showing that 27 per cent of households with children reported an increase in alcohol consumption (CSO, 2020). A survey carried out by Mental Health Ireland also found that one in five parents home schooling said their alcohol consumption has increased during Covid-19 (Mental Health Ireland, 2021).

Couple this with reports that in 2020, there was an 87% increase in the number of domestic violence cases dealt with by the Director of Public Prosecutions (DPP) and we can see the very real dangers facing children and families (RTE, 2021).

Although alcohol should not be used an excuse for a perpetrator of domestic abuse, research clearly shows that domestic abuse is higher among women whose partners consume alcohol (Wilson et al., 2017) and that alcohol use increases the occurrence and severity of domestic violence (Graham et al., 2011).

Tackling the issue

Knowing all of this, there must be responses at all levels of society. We know with ambitious thinking and leadership, change can happen. For example, our nearest neighbours Scotland have a national training plan in place to ensure that all frontline workers can recognise and deal with psychological trauma (NHS, 2019). Police, social workers and nurses were among the staff to benefit from the plan, which is being rolled out to all frontline workers.

AAI knows from contact with services that all kinds of professionals, at all levels, are crying out for training on this issue and for more cross-agency collaboration. Not everyone needs to be an expert or be able to provide a response, but people want to know how to recognise trauma and help children and adult children heal from the wounds of past or current traumas.

Personal experience

As an IAHIP member and supervisor, I have encountered adult children of parental problem alcohol use as clients with varied presentations: depression; anxiety; relationship conflicts/breakdown; parenting worries; obsessive-compulsive disorder; substance use; eating disorders. All of these conditions highlight an undertone of buried shame; fear; hurt; rejection; loneliness; grief. As someone who grew up with parental problem alcohol use myself and having experienced therapy myself for many years, I have regularly felt that this group of clients was largely ignored in the research literature and certainly within counselling trainings. This is why I became a co-founder of *Silent Voices*.

Parental problem alcohol/drug use impacts on family communications and interactions determining the quality of relationships which shapes the contours of each member's life. It often brings a heavy pain and burden, resulting in hurt, confusion and grief that can consume the human soul across generations, as can be seen in the quotes at the start of this article.

I look forward to joining with colleagues who share a similar interest in the adult/child impact of this subject in contributing to this journal and other outlets on a range of topics, which will shine a light on the struggles and challenges faced by this group. Please contact us if you are a therapist who is

interested in providing counselling to this group of clients. We are interested in having contact with therapists working with these clients to build capacity and deepen understanding of the range of impacts and the counselling interventions that are of most benefit.

Upcoming public event on 18 October 2021 with Dr Stephanie Brown, internationally recognised expert on the treatment of alcoholics, adult children of alcoholics and all addicts and their families, based on her research defining a developmental process of active addiction and recovery. Podcast with Dr Brown for therapists also to be released prior to the event.

Web	alcoholireland.ie/campaigns/silent-voices/
email	silentvoices@alcoholactionireland.ie(marionrackard7@gmail.com)
Social media	@IrelandSilent

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The Space...

Kidney Sisters

For Trisha

The last thing I remember before I was wheeled into the operating theatre in Beaumont was a nurse saying that another woman had received the other kidney from the donor and she was doing well. When I came to hours later my bed had been placed in ICU next to the other woman whose name was Iris. I'm from Raheny and she was from a rural part of Galway and twenty years older than me. Iris was a grandmother while my children were young but we had an immediate affinity. It was like as if we each were pregnant with one of a pair of twins. But these twins wouldn't be getting any bigger and would be in us for years… hopefully. And *they* were keeping *us* alive, instead of the other way around. Out of an enormous act of generosity somebody had decided to donate their vital organs, which lived on in us, enabling us to live longer, and I felt hugely grateful. Iris and I swopped stories about hospitals and births and husbands and children. Even when we left hospital to go to our different homes we still kept in touch. 'Kidney sisters' is my what one of my boys called us. I used to ring Iris every couple of months. I think I felt anxious about how she was doing and how her kidney was working. And when I heard she was going through setbacks I felt afraid it was going to happen to me too. But it never did. My kidney seemed to be special and my consultant told me my readings were exceptional. I felt a bit guilty about that sometimes. But gradually over the years Iris and I stopped contacting each other. And I often forgot that I even had a transplant.

Paul Daly is an IAHIP accredited psychotherapist working in private practice and community-based therapy in Dublin.

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