Inside Out

No. 100. Summer 2023. €7.00

The Irish Journal for Humanistic and Integrative Psychotherapy

We should sit in the unknowing and be open to what happens:
Spirit in the Session

Invest in your future self:
Mindcrafting: How to mentor your ageing mind

Dreams are always a creation, not a replay:
Dreams – Making neural connections

CONTRIBUTIONS FOR NEXT ISSUE:
Articles (1500-3000 words), book, workshop or film reviews (500-1000 words), readers' letters or comments, and contributions for *The Space* for the next issue of ***Inside Out*** should be sent by email attachment no later than **1st September 2023** to **insideoutjournal@iahip.org**.

Formatting Requirements can be found on the *Inside Out* Section at www.iahip.org. All articles may be subject to editing. Anyone wishing to discuss ideas for contributions may contact any member of the Editorial Board.

ADVERTISING:
To enquire about advertising in ***Inside Out*** please contact the IAHIP office (info@iahip.org, +353 (1) 284 1665). Advertisements for the next issue are to be submitted no later than **1st of September 2023** to the IAHIP office or online at http://iahip.org/payments. *Advertisements must be typeset and provided in PDF or Word format.* Further guidance on submitting an advertisement is given towards the back of the journal and on the Inside Out section at www.iahip.org.

Rates: Full page (14cm x 20.5cm): €230;
Half-page (14cm x 10cm): €115.

Inclusion of an advertisement does not imply endorsement by *Inside Out* or IAHIP, and the Editorial Board reserves the right to use discretion in relation to all advertisements received as to their suitability for publication in our journal.

Printed by Opus Print, Dublin. Tel: 01 405 7815

EDITORIAL

Welcome to the summer edition of *Inside Out* for 2023. As ever we have a wide variety of articles in this issue and we hope you will find them interesting and thought provoking and perhaps an inspiration and support for your work.

In an ever changing and seemingly crisis filled world, we are called to be adaptive and courageous in response to the challenges we face. We are not long after the turmoil of a global pandemic, the spectre of the effects of climate change seem more and more present to us, and now there are people raising the alarm for the potential harms of AI as it gets ever more sophisticated. And they are just the chart toppers!

In various ways the articles in this issue talk to this theme. We have articles that speak to the issue of ageing and eldering by Martina Breen and Dr Declan Lyons, pertinent now as our populations ages; an article on doing therapy in nature by Maeve Peoples, a response to pressures from the Covid-19 pandemic; and a book review on working with sex workers which may challenge internally held prejudices. There is also an article by Prof Windy Dryden on naming (and legitimising) therapy that may last for only one session.

We also have articles on dreams, creative supervision, the place of spirituality in therapy, all providing metaphorical food for the journey.

Therapy, of course, encourages us and our clients to take space to reflect and explore important and fundamental issues. Matthew Henson grapples with the fundamental question of how therapy works, never an easy one to answer. While Mary Spring, playfully explores how things sometimes work against us on the way to therapy!

And what about a possible addition to the *DSM*? Read the article by Seán Ó Tarpaigh to find out more. It is a thought provoking, tongue-in-cheek piece that will make you reflect, not only about the merits of the *DSM*, but also about the effects of greed on all of us.

And that is not all, throughout the issue there are poems, book reviews, an account of being an IAHIP volunteer, a flash fiction about anxiety and dissociation, and news of a memorial library in memory of Mary Paula Walsh.

We want to make the journal relevant, topical and interesting, so if you have a topic that you feel needs to written about and given attention, please consider submitting an article to us for future editions.

Finally, the editorial board would like to thank Jamie O'Crowley for his contribution to the board. Jamie is moving on due to other commitments after nearly 3 years with the board and he has been a valued member whom we will be sorry to lose. We wish him all the best.

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.

Spirit in the session

by Margaret Brady

There's a thread you follow. It goes among things that change. But it doesn't change.

(Stafford, 2014)

Psychotherapy as a profession tends to attract those of us who have an interest in the deeper questions of life. Whether this manifests in philosophical, scientific or spiritual form, many of us have chosen this profession because we have a sense that there's more to life. We want to swim in the depths of meaning rather than skate along the surface, and when a client seems to be testing those deeper waters, we get excited at the prospect of undertaking that exploration with them.

However, talking to therapists about spiritual issues that arise in their client work, there is often a sense of discomfort, a sense of 'I'd love to explore this but I don't know how' or 'I don't feel qualified' or 'how can I go there without imposing my own beliefs on the client?' In this article, I'll offer some thoughts that might help to open up this area, to take away some of the anxiety and enable us to welcome our clients' spiritual selves – along with the rest of them – into the session.

Part of the perceived difficulty in working with spiritual issues arises from the conflation of religion and spirituality. One way of understanding the difference between the two is that spirituality is our *direct experience* and *inner belief* around something greater than ourselves. Religion, on the other hand, describes the *structures* and *practices* we put in place to help us make sense of spirituality – an outer expression of spirituality which often occurs in prescribed ways and in prescribed settings. For some people, religion and spirituality are the same, but this is not true for everyone. Some people have a deep sense of the spiritual without ever engaging with a formal religion, while others may be outwardly observant but have no personal sense of spirituality.

What is spirituality?

David Elkins and his colleagues at Pepperdine University came up with a very detailed definition of spirituality as a multidimensional construct consisting of nine major components (which I have paraphrased here from Elkins et al., 1988). They found that spirituality involves:

1. A belief in something more than we can see – which may be a personal God, a higher self, a transcendent dimension, etc.
2. A belief that life is meaningful, and that the existential void can be filled with an authentic life. This will look different for all of us – what is it that gives your life meaning? What gets you up in the morning?
3. A belief that each person has a vocation or calling, something that makes them feel really inspired and fulfilled (this is often confused in our society with a profession, but they are not the same).
4. A belief that life is infused with sacredness and the spiritual person can experience awe, reverence and wonder even in non-religious settings – we know that many people find this in nature, or in music, or in relationship.
5. Challenging material values, that ultimate satisfaction is to be found not in material things but in things of the spirit.
6. Interconnection and altruism – having a sense that we are all connected, being affected by the pain and suffering of others, and having a sense of social justice.
7. Idealism, having a vision of a better world and a desire to bring it about.
8. Awareness of the tragic, that pain, suffering and death are part of life and give it colour and shade.
9. That being spiritual changes all aspects of who we are and how we live.

This study is referenced a lot in the literature on spirituality and psychotherapy, and what is helpful about it is that it is not religion-specific. None of these qualities are exclusive to any one tradition, but each speaks to the human experience, and so shows how we might be doing spiritual work with clients without ever mentioning the word spirit.

We can easily ask our clients about their values, how connected they feel, where they feel awe, or joy or inspiration, what gives their life meaning. I remember working with a client who was an outspoken atheist; over the course of the therapy he moved from a place of disconnection, fear and meaninglessness to a lived sense of love and connection, of creating meaning and significance and finding the courage to follow his dreams. It wasn't a religious journey, but it was a profoundly spiritual one.

How spirituality shows up

Sometimes a therapist finds themselves working with spiritual or religious issues because their clients keep presenting with them – and the range of issues can be very broad. In my own practice, spiritual and/or religious issues that have emerged include loss of faith, lack of meaning in life, fear of death, rage at a patriarchal church, clerical sexual abuse, desire to integrate mystical experiences, wishing to connect with nature and develop an eco-spiritual practice, curiosity about mindfulness, and existential terror following a psychedelic drug experience.

Sometimes, spirituality shows up as the presenting issue, and sometimes it manifests as a peripheral issue. For example, 'spiritual bypassing', a phrase coined by the late American therapist John Welwood, describes what happens when a person tries to skip over the painful emotional work of healing and go straight to a place of 'I forgive everything and it's all perfect because I am so spiritual' (Welwood, n.d.) It's an attempt to escape pain which is very understandable but ultimately fruitless. Another example is 'spiritual narcissism' (Vonk, 2021), where a person believes that the normal rules don't apply to

them because they are spiritual and therefore special (the cliché of the person who starts meditating and stops paying child support…).

Spirituality as a resource

Of course, we should not forget that sometimes spirituality shows up in extremely positive ways for people – as an incredible source of inner strength and support, as well as external community and support in times of hardship. A Gallup & Lindsay national poll taken in the USA in 1999 found that 80% of people said they prayed when faced with a problem or crisis. A similar and perhaps particularly Irish example might involve the numbers of novenas said for Leaving Certificate students each June as the state exams loom.

Research has shown that spiritual and religious practices can help people with mental health problems. In a 2001 study of more than 400 people with serious mental illness in the Los Angeles area, over 80% reported that they used some sort of religious belief or practice to help them cope with their symptoms and daily problems. They had used this strategy for an average of 16 years, so it was something they found to be of long-term benefit (Tepper et al., 2001).

Hefti et al. (2011) also found religious coping to be highly prevalent among patients with psychiatric disorders in Switzerland. Their surveys indicated that 70–80% used religious or spiritual beliefs and activities to cope with daily difficulties and frustrations. Religion helped patients to enhance emotional adjustment and to maintain hope, purpose and meaning. They also found that it helped patients in reframing problems, and persevering in the face of psychosocial stressors.

Benefits for therapists

Similar results have been found in studies of psychotherapists - in particular, spiritual practices such as prayer and mindfulness have been shown to reduce burnout and compassion fatigue in the profession (Case 2001; Giles, 2012; Rodriguez, 2016; Pong, 2022). We know that mindfulness enhances our ability to self-regulate, which is just as crucial for us as for our clients. Several studies also suggest that spiritual practice promotes empathy among therapists (Shapiro, Schwartz, & Bonner, 1998; Aiken, 2006; Wang, 2007).

Mindfulness meditation practice and self-reported mindfulness have been found to directly correlate with cognitive flexibility and attentional functioning (Moore and Malinowski, 2009). Mindfulness practice can also help therapists to be more attentive to the therapy process, more comfortable with silence, and more attuned with themselves and their clients (Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008).

It is essential that any therapist proposing to work with clients around spirituality should have, at the very least, tried out the practices they are recommending and asked themselves the ‘big questions’ that commonly arise. Self-awareness is crucial here; we cannot accompany our clients through territory we have never explored ourselves.

Creating a safe space

If you are open to exploring these subjects with clients but they just never arise, it’s worth considering whether you might be unconsciously shutting your clients down. How do you respond when your client mentions such a theme? Spirituality is an area of extreme sensitivity for many clients who may be afraid of being judged negatively as naïve, superstitious or stupid if they mention them. Even if clients are prepared to admit, for example, that they practice mindfulness (which is quite mainstream at the

moment), they might be embarrassed to admit that they believe in angels, or consult tarot cards, or other practices for which they feel people might laugh at them. Similarly, younger clients might be reluctant to admit that they pray or go to religious services if this is unfashionable in their peer group.

A simple and non-judgemental way to explore your client's religious and spiritual life is simply to include a question on your intake form: 'Do you have a spiritual or religious path that is important to you?' If the answer is no, you can move on unless the client wants to talk about that 'no'; if the answer is yes, it's easy to ask, 'Can you tell me a little more about that?' By indicating in an opening session that this is a safe subject to raise with you, you have created space for a discussion that may show up at any point later in the therapy.

Diversity issues

Most often, if a client speaks about spiritual issues, they do so in the context of their own particular tradition, and this can be intimidating for therapists who might not be familiar with that tradition.

The spectrum of religious and spiritual belief is vast, even in a relatively small society such as Ireland. Even the Pastafarians (not a misprint, and worth Googling) hit the headlines recently when they objected to their exclusion from an interfaith event in Dublin (Bourke, 2023). And as with other issues that arise in a diverse society, it's important for psychotherapists to be sensitive to and informed about religious and spiritual diversity.

ASERVIC (The Association for Spiritual, Ethical and Religious Values in Counselling) is a group that is part of the American Counselling Association. It has published a list of 14 competencies (2009) for therapists dealing with spiritual and religious issues. It's worth reviewing by Irish therapists as a way to self-check and see where further learning might be beneficial. For the sake of brevity, the competencies are summarised under the following headings:

Culture and Worldview

Therapists should be able to describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism. They should recognise that the client's beliefs about spirituality and/or religion are central to their worldview and can influence psychosocial functioning.

Therapist Self-Awareness

Therapists should actively explore their own attitudes, beliefs, and values about spirituality and/or religion and should continuously evaluate the influence of those attitudes, beliefs and values on the client and the therapy process. Therapists should recognise the limits of their understanding of the client's spiritual and/or religious perspective and should seek information, resources and experts for consultation and referral where necessary.

Human and Spiritual Development

Therapists should be able to describe and apply various models of spiritual and/or religious development and their relationship to human development. (One such model, that of Ken Wilber, is addressed below.)

Communication

Therapists should respond to client communications about spirituality and/or religion with acceptance and sensitivity. They should use concepts that are consistent with and acceptable to the client's

spiritual and/or religious perspectives. They should be able to recognise spiritual and/or religious themes in client communication and be able to address these when therapeutically relevant.

Assessment, Diagnosis and Treatment
During intake and assessment, therapists should try to understand a client's spiritual and/or religious perspective. They should recognise that the client's spiritual and/or religious perspectives can (a) enhance well-being; (b) contribute to problems; and/or (c) exacerbate symptoms.

Therapists should try to set goals with the client that are consistent with their spiritual and/or religious perspectives, and should be able to (a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and (b) use spiritual and/or religious practices as techniques when appropriate and acceptable to the client.

Finally, therapists should be able to therapeutically apply theory and current research supporting the inclusion of a client's spiritual beliefs and practices in their work.

Not 'What' but 'How'
Although it is important to engage with what it is a person believes, to me, what a person believes is not nearly as important as the way in which they believe it. This is where the subject of transpersonal psychology really comes into its own and provides therapists with both a model and language for engaging with personal and spiritual growth that can help clients of any tradition or none.

In 1977, the American philosopher Ken Wilber posed the question of whether all the world's wisdom traditions were actually trying to describe the same process of spiritual development in different ways. He took every model of psychological and spiritual growth he could find and synthesised them into a complex developmental model of human consciousness, with 24 stages ranging from pre-personal consciousness (such as that of a baby that has no concept of itself as separate from the mother) to the highest levels of transpersonal non-dual awareness exemplified by figures such as Jesus or Buddha (Wilber, 1997). Wilber's work is fascinating, but beyond the scope of this article. However, John Rowan, the British psychotherapist, adapted Wilber's model and drew out the parts that he felt were relevant to the work of psychotherapy (Rowan, 2005). His adapted model has an elegant simplicity that is far easier to understand; simply put, he shows how the work of therapy applies to the various stages of consciousness.

The task of **pre-personal** consciousness is the development of the individual ego. When the baby is born, all is one. As it grows, the child must learn to separate, to learn who it is apart from the mother. This is the realm of pre-and perinatal psychology, as well as theories of child development.

When this developmental task is complete, the person has a sense of themselves as an individual – they enter the realm of the **personal**, which is the realm of most traditional psychology and psychotherapy. The task of this realm is to become a well-functioning, responsible adult, to achieve mental and emotional maturity. Many people are happy to live out their lives here, but some find themselves asking questions like 'Is this all there is?' These are the people who find themselves drawn towards the **transpersonal**, which can be understood as 'beyond the personal'.

Rowan describes a number of stages in the transpersonal and at the risk of over-simplification, I will outline them briefly, bearing in mind that progress through the stages of consciousness is not linear, and certainly not a one-time journey. It is also important to note that this model is an integrative one:

each stage includes and expands upon the learnings of earlier stages, rather than leaving them behind.

Centaur consciousness: The existential level

The **Centaur** stage is the entry point to the transpersonal and can be described as aligning with humanistic or existential psychology. A person at this level of consciousness is fully and wonderfully themselves. They may be what Maslow (1962/2022) describes as a 'self-actualiser', engaged with existential questions of life, death and meaning, and following their passions and skills in ways that might amaze other people. Maslow described several traits shared by self-actualising people, which have recently been developed further by American psychologist Scott Barry Kaufman (2022). Traits include:

- **Appreciation** - even of simple things.
- **Acceptance** - responding to self, others and life with good humour and tolerance.
- **Authenticity** - true to themselves, rather than trying to be what others want.
- **Equanimity** - able to remain calm and true to themselves even in difficult situations.
- **Purpose** - most of Maslow's subjects were focused on a 'mission' or life's work outside themselves.
- **Realism** - self-actualisers can judge situations well and are quick to spot inauthenticity.
- **Humanitarianism** - caring about others and humanity as a whole. Able to form deep loving relationships.
- **Moral sense** - clear on their values and able to live by them. Not depending on others for their views and opinions.
- **Creativity** - not just in terms of producing art, but in how they live.
- **Peak experiences.**

At the Centaur stage, a person's consciousness is still firmly rooted in the sense of themselves as an individual. They may, however, occasionally transcend this through peak experiences, those moments described by Maslow when the sense of self evaporates and is replaced by a sense of wellness and oneness with all beings. All of Maslow's subjects reported frequent peak experiences, leading him to hypothesise that there was something beyond self-actualisation. The peak experiences reported by his subjects are similar to mystical and religious experiences reported in various spiritual traditions. Having fully inhabited the individual self, they were transcending, or moving beyond it into a sense of identification or oneness with something greater.

As a spiritual stage, this may be completely atheistic – and I am reminded of my atheist client who did such wonderful work in coming to inhabit his true self and creating a meaningful life. There may be a letting go or disillusionment of old ways of thinking and believing and perhaps the beginning of something new.

Subtle consciousness: The soul level

The next transpersonal level is called the **Subtle** – this is the level of the soul. This is the level of the imaginal world, where we work with things like symbols and dreams and myth and intuition. On this level we learn to trust non-linear knowing. In terms of psychotherapy, this level aligns very well with Jungian work, or perhaps with psychosynthesis.

This is the level at which we have a really deep experience of living from the soul, or the higher self, and there may be experiences of bliss, development of compassion and so on. We might become

quite serious about a meditation practice or spiritual path and feel an excitement about that, a sense of progression. The language of this level is imagination, so we could use tools like visualisation, or active imagination e.g. creating an imaginal dialogue with the wise self. We can explore symbols and archetypes, or work with dreams. Working with dreams in my practice, I'm always amazed at how quickly they can help clients get to the heart of the therapeutic issue. Work at this level is about surrendering the rational mind and opening to inner wisdom.

Causal consciousness: The non-dual level

The **Causal** (non-dual) level is where we give up the archetypes and all our concepts of God or spirituality. Writers like Eckhart Tolle (2001) or Ram Dass (1971) describe this kind of non-dual awareness. Entering this level of consciousness might mean a letting go, finding that the symbols and forms that once inspired us no longer speak to us in quite the same way. If we explore the teachings of the Christian mystics like Meister Eckhart, who said 'I pray God to rid me of God' (Rohr, 2015), we can see that this is a recurring theme. Eckhart is praying that he will be able to transcend his limited conceptions of the divine. There is a formless consciousness here, what the Buddhists call Samadhi.

On a practical level, Rowan asks whether therapy is possible at a non-dual level – if there is no self, what do therapists have to work with? He has a point. Someone who is tapping into this level of consciousness will not be coming to you with the typical therapy issues; probably the main thing a therapist can do for a person at this level is to simply be with them and hold a safe space for them, and that might be all they need.

Ultimate consciousness

Finally, the **Ultimate** – what Buddhists call the void. It is God as the great mystery, perfect unity with the divine. I mention it merely to complete the overview, because my guess is that most of us have never met anyone at this level of consciousness, and if we did, they certainly wouldn't need therapy.

I find the whole Wilber/Rowan model useful in terms of providing a framework, but when we talk about the transpersonal for the purposes of therapy, we are normally talking about the Centaur (Existential) level, the Subtle (Soul) level and occasionally the Causal (non-dual) level.

If we look at the whole circle, we can see how people can engage with spirituality and religion from any of these levels of consciousness – from an authoritarian God who will punish us if we disobey, to rational disbelief, to perhaps a questioning based on experience and then onto a deeper experience of spirituality that grows from within rather than being imposed from outside. Simply put, it is a progression from fear to love that applies regardless of which tradition a person follows. For a therapist, the ability to locate a client on this spectrum of consciousness is just as important when engaging with spirituality as is information about whichever tradition they may follow.

John Rowan (1998, p. 108) says that the essential element of transpersonal therapy is the therapist's state of being – rather than having a tool-chest of techniques, we should sit in the unknowing and be open to what happens. And I think he's probably right, though it can be a whole life's practice to be able to sit in the unknowing, to get comfortable with the mystery. I will close with a quote from Mary Oliver, one of my favourite nature mystics:

Let me keep my distance, always, from those
who think they have the answers.

Let me keep company always with those who say
"Look!" and laugh in astonishment,
and bow their heads.

(Oliver, 2010)

As therapists, may we always retain that wisdom and humility - to be surprised, to laugh at our own astonishment, and to bow our heads in the face of mystery.

Margaret Brady MIAHIP is a psychotherapist, spiritual companion and workshop facilitator based in Dublin 6. For more information see www.margaretbrady.ie

References

Aiken, G. A. (2006). The potential effect of mindfulness meditation on the cultivation of empathy in psychotherapy: A qualitative inquiry. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 67*(4-B), 2212.

ASERVIC: Competencies for working with spirituality. (2009).
https://aservic.org/spiritual-and-religious-competencies/

Bourke, S. (2023, March 8). 'Former Lord Mayor of Dublin Hazel Chu insists that she does not discriminate against Church of the Flying Spaghetti Monster'. *Irish Independent*. https://www.independent.ie/news/former-lord-mayor-of-dublin-hazel-chu-insists-that-she-does-not-discriminate-against-church-of-the-flying-spaghetti-monster/42375864.html on 28/04/2023

Case, P. W. (2001). Spiritual coping and well-functioning among psychologists. *Journal of Psychology & Theology, 29*(1), 29-41.

Elkins, D. N., Hedstrom, L. J., Hughes, L. L., Leaf, J. A., & Saunders, C. (1988). Towards a humanistic-phenomenological spirituality. *Journal of Humanistic Psychology, 28*(4), 5-18. http://dx.doi.org/10.1177/0022167888284002

Giles, J.H. (2012). The role of spirituality in therapist self-care: an exploration of students' beliefs and practices (MSc Thesis) https://library.ndsu.edu/ir/handle/10365/26665

Hefti, R. (2011). Integrating religion and spirituality into mental health care, psychiatry and psychotherapy. Religions, 2, 611-627. http://dx.doi.org/10.3390/rel2040611

Kaufman, S. B. (2022). *Transcend: The new science of self-actualisation.* Sheldon Press.

Maslow, A.H. (1962/2022). *Towards a psychology of being.* Wilder Publications.

Moore A, Malinowski P. (2009). Meditation, mindfulness and cognitive flexibility. *Consciousness and Cognition, 18*(1):176-86. doi: 10.1016/j.concog.2008.12.008.

Newsome, S., Christopher, J.C., Dahlen, P. & Christopher, S. (2006). Teaching counselors self-care through mindfulness practices. *Teachers College Record 108*(9):1881-1900 DOI:10.1111/j.1467-9620.2006.00766.x

Oliver, M. (2010). Mysteries, yes. In *Evidence.* Beacon Press.

Pargament, K. L. (2011). *Spiritually integrated psychotherapy.* Guilford Press.

Pong, H. (2022). The correlation between spiritual well-being and burnout of teachers. *Religions* 13: 760. https://doi.org/10.3390/rel13080760

Ram Dass. (1971). *Be here now.* Crown Publications.

Rodrigues, M.F., Nardi, A.E., Levitan, M. (2016). Mindfulness in mood and anxiety disorders: a review of the literature. *Trends in Psychiatry and Psychotherapy 39*(3):207-215. doi: 10.1590/2237-6089-2016-0051. Epub 2017 Jul 31.

Rohr, R. (2015, July 16). *Daily meditation*. Centre for Action and Contemplation. https://cac.org/daily-meditations/meister-eckhart-part-ii-2015-07-16/.

Rowan, J. (2005). *The transpersonal* (2nd Ed). Routledge.

Schure, M. B., Christopher, J., & Christopher, S. (2008). Mind-body medicine and the art of self-care: Teaching mindfulness to counseling students through yoga, meditation, and qigong. *Journal of Counseling & Development, 86*(1), 47–56. https://doi.org/10.1002/j.1556-6678.2008.tb00625.x

Shapiro, S. L., Schwartz, G. E., & Bonner, G. (1998). Effects of mindfulness-based stress reduction on medical and premedical students. *Journal of Behavioral Medicine, 21*(6), 581–599. https://doi.org/10.1023/A:1018700829825

Stafford, W. (2014). The way it is. In *Ask me: 100 essential poems.* Graywolf Press.

Tepper, L., Rogers, S.A., Coleman, E.M. & Malony, H.N. (2001). The prevalence of religious coping among persons with persistent mental illness. Psychiatric Services 52(5): 660-5. doi: 10.1176/appi.ps.52.5.660. (Cited in Pargament).

Tolle, E. (2001). *The power of now.* Hodder & Stoughton.

Vonk, R. (2021). Spiritual narcissism: How the ego hijacks spiritual development. *Psychology Today Blog*. Accessed from https://www.psychologytoday.com/ie/blog/spiritual-narcissism/202101/spiritual-narcissism on 29/04/2023.

Wang, S. J. (2007). Mindfulness meditation: Its personal and professional impact on psychotherapists. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 67*(7-B), 4122.

Welwood, J. (n.d.) On spiritual bypassing and relationship. Accessed from https://www.scienceandnonduality.com/article/on-spiritual-bypassing-and-relationship on 29/04/2023

Wilber, K. (1997). An integral theory of consciousness*. Journal of Consciousness Studies,* 4 (1), 72-92.

What's in a name? What to call therapy where a client may come once

by Windy Dryden

In 1990, an Israeli psychologist, Moshe Talmon, published a book that would herald a way of working with people therapeutically and would challenge conventional ways of thinking about therapy and how it is normally practised. Talmon was not the first to write about working with people who often only attend one session. Indeed, Sigmund Freud wrote about times when he was asked to consult with someone when he was on vacation and was able to help them in one session (e.g., Freud & Breuer, 1895).

Therapists, in general, are very suspicious when it transpires that a client has only come once. Data from agencies across the world indicate that the most frequent number of sessions clients have is '1'. (e.g., Brown & Jones, 2005; Hoyt & Talmon, 2014). This is formally known as the 'mode'. Therapists refer to the client as having 'dropped-out' of treatment or having terminated therapy 'prematurely'. However, these somewhat pejorative remarks are decidedly from the therapist's perspective. While not wishing to deny the fact that, in some cases, a person deciding not to return for a second therapy session indicates dissatisfaction with the first session, research and service data show that clients who decide to come once are often satisfied with the help they have received in the first (and only) session and decide not to seek further help. These data are more pronounced when this form of therapy delivery is planned and contracted, that is where the therapist and client agree to meet to help the client get what they came for in that one session on the understanding that more help is available to the client on request.

This way of working with people challenges perceived therapeutic wisdom such as 'it takes time to forge a good therapeutic relationship which cannot be done in one session'. See Dryden (2022) for a discussion of this and other ways in which this mode of therapy delivery challenges more conventional ways of thinking about therapy. Another challenge is posed by what to call this mode of therapy delivery.

In this article, I will consider the issues one faces when deciding what to call therapy where the intent is to help the person in one session but where more help is available. I will review the two names currently used: Single-Session Therapy (SST) and One-At-A-Time Therapy (OAATT), and explain my reservations about them. Then I will explain why I prefer the term ONEplus Therapy.

Single-Session Therapy

Whenever I give a training workshop on single-session therapy, I emphasise that the purpose of SST is for the therapist and client to work together to see if they can help the client meet their stated wants from the session while acknowledging that more help is available to the client if requested. However, people continue to hear that the nature of single-session therapy is that it provides therapy lasting one session only. They sometimes refer to this as 'one-off' therapy. These people then argue that in SST, we restrict help offered to people and only offer them one session when they want more. This is decidedly not the case.

However, the difficulty here is that single-session therapy *can* last for one session only. This occurs when the client states in advance that this is all they want, and the therapist concurs with this. Yet, single-session therapy can *also* refer to the situation mentioned above, where it can be one session but involves additional help. Jeffrey Young (2018) acknowledges the difficulties inherent in the term 'single-session therapy' but argues for its retention because it has 'shock' value – it interests and challenges therapists new to this mode of therapy delivery. I understand this viewpoint, but as 'clarity' is one of the central principles of this mode of therapy delivery, there should be, in my opinion, a description of this way of working with people that is clear and accurate. Given the ambiguity surrounding the term 'single-session therapy', my approach is to look for a different, unambiguous descriptive term.

One-At-A-Time Therapy

Michael Hoyt (2011) introduced the term 'one at a time' to refer to SST. Hoyt et al. (2018) state that this term describes the situation where "therapy takes place one contact at a time, and one contact may be all the time that is needed" (p. 5). However, particularly in university and college counselling services in the United Kingdom, 'One-At-A-Time Therapy' (OAATT) has been used to describe a situation where students can only book one session at a time and in some services, what has been referred to as a 'purposeful pause' has been imposed so that students have to wait for a period, often two weeks before they can make another appointment. More formally here, at the end of the session, clients are asked to engage in a process called 'reflect-digest-act-let time pass-decide' where they are encouraged to reflect on their learning from the session, to digest it (meaning to make connections with other relevant areas of their life), to act on their reflections and digested learning and to see what happens before they decide whether or not to seek more help. I have no objection to this when it is proposed as *one* way forward after the session. My objection is that it is the *only* way forward for clients after the session. This practice reflects the situation in other agencies where clients are told that they will be contacted two weeks (for example) after their single session and asked how they are getting on and to see if they require further help. Therefore, one-at-a-time therapy excludes the possibility of the client deciding to make another appointment to see a therapist at the end of their single session. While this makes sense from an organisational perspective, it appears to be at variance with a central principle of this way of working with clients where the client is the principal decision-maker.

ONEplus Therapy

Given that I have reservations concerning the terms 'single-session therapy' and 'one-at-a-time therapy', what do I suggest instead? I have decided to call the mode of therapy delivery 'ONEplus Therapy' (see Dryden, 2023). I have capitalised the word 'ONE' because it indicates it is a principal objective of this way of working to help the person with what they have come for by the end of the session. The word 'plus' is attached to the word 'ONE' without a space to indicate that more help is available to the client on request and that this is an integral part of the delivery mode. Unlike 'One-at-a-time therapy', 'ONEplus Therapy' does not restrict *when* the person can access further help should they decide to do so. Also, the person can access any form of therapy delivery offered by the agency or practitioner. If they request a form of help not provided by the above, then, if possible, a suitable external referral is made.

In addition, given the dual nature of this way of working (let's help you in one session/more help is available), the term 'ONEplus Therapy' does not suggest that only one session is offered to the client, which, in the minds of many, is suggested by the term 'single-session therapy'. I hope that the term 'ONEplus Therapy' clarifies the essence of what we try to do in offering this mode of therapy delivery.

This is to offer therapy where the therapist and client contract to meet for a session of therapy and work together to help the client to achieve their stated wants from that session on the understanding that further help is available to the client on request**.**

An earlier version of this piece appeared in Dryden (2023).

Windy Dryden is Emeritus Professor of Psychotherapeutic Studies at Goldsmiths University of London. His goal is to disseminate SST/ONEplus Therapy. His latest book is *ONEplus Therapy: Helping People at the Point of Need.*

References

Brown, G.S., & Jones, E.R. (2005). Implementing a feedback system in a managed care environment: What are patients teaching us? *Journal of Clinical Psychology, 61,* 187-198.

Dryden, W. (2022). *Single-session therapy: Responses to frequently asked questions.* Routledge.

Dryden, W. (2023). *ONEplus therapy: Helping people at the point of need.* Onlinevents Publications.

Freud, S. & Breuer, J. (1895). *Studien über hysterie.* Deuticke.

Hoyt, M. F. (2011). Foreword. In A. Slive & M. Bobele (Eds.), *When one hour is all you have: Effective therapy for walk-in clients* (pp. xix – xv). Zeig, Tucker, & Theisen.

Hoyt, M. F., Bobele, M., Slive, A., Young, J. & Talmon, M. (Eds.). (2018). *Single-session therapy by walk-in or appointment: Administrative, clinical, and supervisory aspects of one-at-a-time services.* Routledge.

Hoyt, M. F. & Talmon, M. F. (2014). What the literature says: An annotated bibliography. In M. F. Hoyt & M. Talmon (Eds.), *Capturing the moment: Single session therapy and walk-in services* (pp. 487-516). Crown House Publishing.

Talmon, M. (1990). *Single session therapy: Maximising the effect of the first (and often only) therapeutic encounter.* Jossey-Bass.

Young, J. (2018). SST: The misunderstood gift that keeps on giving. In M. F. Hoyt, M. Bobele, A. Slive, J. Young & M. Talmon (Eds.), *Single-session therapy by walk-in or appointment: Administrative, clinical, and supervisory aspects of one-at-a-time services* (pp. 40–58). Routledge.

Ashe House
balance. heal. transform.

Centre for MindBody Integration

Mindful Self-Compassion (MSC) 5 day Residential Intensive with Anne Kirwan
Certified MSC Teacher

September 3rd at 4.00pm-September 8th, 2023, at 1.00pm

Come Join me at Ballyvaloo Retreat and Conference Centre, County Wexford

Learn to use the core practices of self-compassion so that it is possible to love others without losing yourself.

This intensive training offers you a unique opportunity to immerse yourself in the key practices of mindful self-compassion, based on the research and work of the founders Kristin Neff and Chris Germer. Learn how powerful and transformative mindful self-compassion is, while staying at relaxing single ensuite accommodation, nourished by freshly prepared vegetarian food and a beautiful 11 km beach!

This somatic and experiential intensive is particularly suited to counsellors, psychotherapists, psychologists, and ALL mental health professionals to enhance and deepen your personal and professional understanding of self-compassion.

CPD Hours: 30 Hours Awarded

Special IAHIP Reader Offer - €75 off All Inclusive Fee. Quote IAHIP75 on Application Form

For Further Information, 2022 MSC Testimonials, Registration and Payment Process:

https://ashehouse.ie/bookings/residential-mindful-self-compassion-5-day-intensive-course/
www.ashehouse.ie
info@ashehouse.ie
018437359 or 0872054524

A modest proposal regarding DSM 5

by Seán Ó Tarpaigh

As therapists we tend to treat the *DSM* (2013), and diagnosis generally, with a degree of caution, if not downright scepticism. The origins, history, and methodology of the *DSM* all give rise to serious questions about its efficacy and application in many of our therapeutic settings. Concerns are not confined to the psychotherapy profession but can also be found among the psychiatric community and literature (Frances, 2013; Baca-Garcia et al., 2007).

Amongst the concerns often raised regarding the DSM methodology are, for example, the dangers of cultural biases, and labelling (Honos-Webb & Leitner, 2001). Also much discussed are conflicts of interests amongst the authors of the *DSM* (Greenberg, 2012). Researchers Cosgrove and Krimsky (2012) found that 69% of the *DSM-5* task force members report having ties to the pharmaceutical industry. A particular concern for therapists is that of over-diagnosis or the pathologising of natural responses to the everyday challenges of life (Frances, 2010). This latter point is particularly evident in the latest addition which includes a diagnosis of "Prolonged Grief Disorder" in the *DSM 5-TR* (2022, pp. 322-27). This appears to pathologise grief if, after just one year the sufferer displays "intense yearning" for, and "preoccupation" with the deceased (p. 324). Our own response and those of our clients might lead us to question the usefulness of this kind of diagnosis. One year seems oddly arbitrary, if not meaningless, to anyone who has lost a loved one. Grief is complex and unique to each individual and circumstance. Death is permanent and can, among other things, upend our sense of time and our sense of security and stability. Intense yearning and/or preoccupation may very reasonably continue for an extended even indefinite period if, for instance the bereaved is elderly, or the deceased is a child, or has been a victim of violence. However, this pathologising may make more sense when seen in an American context, where, amongst other considerations, the pressure to diagnose equals insurance cover equals sales of medications equals profits for insurance providers, physicians, and pharmaceutical companies. One does not have to be overly cynical to imagine that such a system of interconnections could, at least in part, lead to over-diagnosis.

Having said all this it may come as a surprise that I wish here to suggest yet another addition to the latest *DSM* edition. It seems to me a glaring omission that if we are to label "prolonged grief" as a psychiatric disorder, there is surely a place for many other human emotions and behaviours which could merit inclusion. Take for example that most pernicious human behaviour which we know as greed - prolonged greed, obscene greed, insane greed, most especially in the teeth of the present-day existential threat of climate collapse. If one were to watch an individual atop a giant sequoia tree, sawing happily at the supporting branch, without regard to their safety or very survival, we would surely think such an individual merited inclusion in any diagnostic of mental disorders.

I humbly present, therefore, my modest proposal for the inclusion of what I will refer to as CAD, Compulsive Acquisition Disorder® (aka Easter Island Syndrome) as would be formatted in the DSM:

Compulsive Acquisition Disorder (CAD)
CAD is a mental disorder characterised by persistent and excessive acquisition of possessions and/or money regardless of need. The individual experiences an intense urge or desire to acquire ever more cash, goods, property, status, power, or experiences. This is done regardless of consequences to others or society in general. There is no point of satiety.

Diagnostic criteria

A. Recurrent and persistent, excessive acquisition of possessions, money, and property etc. beyond what is reasonable.
B. The excessive acquisition is continued regardless of consequences to others and is often achieved by questionable and risky practices.
C. The symptoms cause clinically significant impairment in social, romantic, familial, and occupational relationships. The primary attachment is not to people but to possessions, money and/or status.
D. The symptoms are not better explained by another mental disorder (e.g. hoarding disorder, obsessive-compulsive disorder).

Specifiers

Specify if:

- With good insight
- With poor insight
- With absent insight/delusional beliefs
- With focus on status and power
- With reclusive or secretive tendencies

Specify if:

- Episodic: Symptoms present for less than 1 year
- Persistent: Symptoms present for 1 year or more

Diagnostic Features

Individuals with CAD experience a persistent, irresistible urge to acquire possessions, power, money, debt, without any thought given to the actual needs of the individual or consequences to others. The acquisition of items can be through multiple means such as buying, trading, deceit, or obtaining for free. The items, money or assets acquired sometimes result in the accumulation and manipulation of debt and the resulting stress can dominate daily activities, relationships, and functioning. Individuals with CAD may experience no feelings of distress or shame about their behaviour or its consequences to others, yet they feel righteous and entitled to continue to accumulate. They may attempt to hide their behaviour from themselves and others with tokens of charitable activities which may often profit them in extraneous ways, particularly outward status. They will often involve themselves in power structures, especially the political system which they will manipulate for their personal aggrandisement and power.

Prevalence

CAD is an increasingly common disorder in the more privileged echelons of society.

Studies suggest that it affects around 1% of the general population but exceeds 90% of the hyper-affluent, powerful, and non-domiciled cohort of the population. It is important to note that CAD occurs along a spectrum and that most of the population may have some degree of CAD which can also have adverse effects at various points along this spectrum.

Development and Course

CAD typically begins in adolescence, with symptoms persisting into adulthood. The disorder generally worsens over time, with an increasing accumulation of possessions, money, assets and/or debt, along with ever more illicit dealings and activities. This usually leads to greater interference with daily life and relationships.

Specify if:

- Inherited
- Self-generated

Comorbidities

CAD often has comorbidity with personality disorders especially Cluster B (Narcissistic, Histrionic, and Antisocial) disorders and with OCD personality disorder (Cluster C).

Differential Diagnosis

CAD needs to be differentiated from other mental disorders that may present with similar symptoms, such as:

- Hoarding Disorder
- Obsessive-Compulsive Disorder
- Substance Use Disorders
- Addiction Disorders

Treatment

CAD is very resistant to treatment. The sufferer is often unaware, in denial, or delusional regarding there being an issue at all and will be very dismissive of the very idea of therapeutic intervention. Typically, there is a strong sense of entitlement and lack of shame or morality. Relational therapies are dismissed as they are seen as a threat to defences against deeper insecurities which lie at the heart of the disorder. This also happens with somatic approaches. Cognitive-behavioural therapy focuses on developing strategies to resist urges to acquire yet more possessions, money, status etc. CBT may help by heightening awareness of the consequences of such behaviour. Treatment may involve medication, such as anti-depressants, to reduce impulsivity. Family therapy may be useful in improving social support and by increasing awareness of others impacted by the compulsive acquisition behaviour, thus breaking through the delusional bulwark of the sufferer to reveal the often-catastrophic consequences of the behaviour to family and society.

Conclusion

I am sure we can all think of well-known individuals and groups (cads!) throughout the world who qualify for a CAD diagnosis: billionaire royals who hide their wealth and use their influence to avoid taxes (Evans & Pegg, 2021); billionaire owners of pharmaceutical companies happy to make ever more profits on the back of utter misery for thousands of vulnerable individuals (Keefe, 2021); oligarchs and political leaders heedlessly destroying irreparable natural environments to hoard even more billions in a society and ecosystem collapsing under the weight of greed, or compulsive acquisition. All of these and more will not, at present, find a DSM diagnosis. This is a particular disorder that urgently requires recognition, for how can we offer a treatment if we haven't even given it a name and a nosology?

I will leave the last word to Shakespeare, who as so often was ahead of the curve with a diagnosis of unrestrained greed, its development, and its consequences which I hereby term Compulsive Acquisition Disorder, CAD. ®

Then everything includes itself in power,
Power into will, will into appetite;
And appetite, a universal wolf,
(So doubly seconded with will and power),
Must make perforce a universal prey,
And last eat up himself.

Shakespeare (1997) Troilus and Cressida I iii 119-124

Seán Ó Tarpaigh MSc is a Gestalt psychotherapist and graduate of the Metanoia Institute, London. He has trained in EMDR, Internal Family Systems and practices mindfulness-based approaches. Having worked in London's Priory Hospital, he now has a private practice in Monkstown, Dublin. He previously worked as a professional actor and director and Irish language translator.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Baca-Garcia, E., Perez-Rodriguez, M.M., Basurte-Villamor, I., Fernandez del Moral, A.L., Jimenez-Arriero, M.A., Gonzalez de Rivera, J.L, Siaz-Ruiz, J., and Oquendo, M.A. (2007). Diagnostic stability of psychiatric disorders in clinical practice. *The British Journal of Psychiatry. 190* (3): 210–216. doi: 10.1192/bjp.bp.106.024026.

Cosgrove, L. & Krimsky, S. (2012). A comparison of *DSM*-IV and *DSM*-5 panel members' financial associations with industry: A pernicious problem persists. *PLoS Med, 9*(3): e1001190. https://doi.org/10.1371/journal.pmed.1001190

Evans, R. & Pegg, D. (2021, February 7) *Revealed: Queen lobbied for change in law to hide her private wealth.* The Guardian. https://www.theguardian.com/uk-news/2021/feb/07/revealed-queen-lobbied-for-change-in-law-to-hide-her-private-wealth

Frances, A.J. (2010, June 2). *Psychiatric Fads and Overdiagnosis*. Psychology Today. https://www.psychologytoday.com/us/blog/dsm5-in-distress/201006/psychiatric-fads-and-overdiagnosis https://en.wikipedia.org/wiki/Allen_Frances

Frances, A. (2013, August 13). *The New Crisis in Confidence in Psychiatric Diagnosis.* Annals of Internal Medicine. https://doi.org/10.7326/0003-4819-159-3-201308060-00655

Greenberg. G. (2012, January 12). *The D.S.M.'s Troubled Revision.* The New York Times. https://www.nytimes.com/2012/01/30/opinion/the-dsms-troubled-revision.html

Honos-Webb, H. & Leitner, L.M. (2001). How Using the DSM Causes Damage: A Client's Report. *Journal of Humanistic Psychology*, *41* (4): 36–56. https://doi.org/10.1177/00221678014140

Keefe, P. R. (2021) *Empire of Pain*. Doubleday.

Shakespeare W, The History of Troilus and Cressida, The Riverside Shakespeare 2nd.ed. Edited by Dean Johnson, Houghton Mifflin Company, Boston and New York, 1997 pp.477-532

Using imagery as a resource in clinical supervision

by Claire Colreavy Donnelly

I believe the use of imagination, creativity and image is a foundational ingredient of psychotherapeutic work. This is true, whether we are specifically trained in a creative psychotherapeutic medium, or work as verbal psychotherapists. As psychotherapists, the process of mentalisation, which is essential, is based on our ability to imagine and conceptualise what is happening internally for others, as well as ourselves. A questioning mind is an essential characteristic of a curious, interested, and attuned psychotherapist.

Lou Cozolino (2023), posed an intriguing and provocative question in a recent online training: "What are you protecting yourself from when you do therapy?" When I do therapy (and clinical supervision), I protect myself from a life without meaning! His question catapulted my imagination into a rich exploration of all the years of memories of sessions together with clients and therapists where we sought meaning for the challenges, pain, and adversity that life brings. Without my imagination and a creative approach that helps spark my clients' and supervisees' imagination, it would be impossible to develop alternative strategies or ways of looking to reframe life's opportunities for learning, meaning and growth.

As I wrote about elsewhere, I make a distinction between the use of embodied imagery and diagrammatic imagery in therapeutic work (Colreavy Donnelly, 2017). In Jonah Hill's documentary film 'Stutz' (2022) about his relationship with his psychiatrist, Stutz creates diagrammatic images for his clients which illustrate psychological tools that they can use as therapeutic reminders for growth. These images, although very powerful, have a different quality to them because they come from the imagination of someone else and are passed on to the client or therapist as generic messages for life. However, something unique and special happens when the therapist encourages the client, or the supervisor encourages the supervisee to enter their own imagination and be open to what emerges specifically for them.

I also write about it elsewhere, (Colreavy Donnelly, 2017), the notion that within our unconscious are deeply personal and profound messages that can emerge as images for our understanding and healing in the form of what I call our own *Image Medication*. This concept, when shared with patients, appeared very helpful when I worked in a psychiatric hospital where they were used to being fed generic prescriptions for their mental health difficulties. As we worked together, I consistently encouraged them to learn to trust what emerged through their imaginations as communications from their unconscious in the same way as suggesting that their symptoms might also be a way that their mind and body communicates with them.

In order to help clients become more flexible in their approach to life's challenges, we need to develop our own imaginative capacities in order to invite them into a creative space of "what ifs" and "as ifs". When we want supervisees to become more flexible in their approach or understanding of their clients' experience, we also need to encourage them to use a more experimental thought process and play with ideas about possible meanings, underlying behaviour and relational dynamics. Some

people find this easier than others. Can we imagine what we have not yet experienced? Yes. This is the space of daydream and reverie which we found easier to access in childhood. Unfortunately, as we mature and become conditioned for living up to, or down to, society's expectations of us, we can lose our capacity to imagine and dream of alternatives. Creativity and play are hard to access if we are feeling dysregulated or evaluated in any way, so it is imperative for therapists, and in turn supervisors, to create a safe space where clients or supervisees can become freer to lean into creative possibilities, without feeling judged. If we take on the role of supervision with a heavy hand of criticism, policing the profession with rights and wrongs without empowering therapists to work through the subtleties of context and encouraging them to take responsibility for clinical judgements that value process as much as outcome, we create a closed system where imagination cannot flourish.

The use of imagery, whether imagined or projected into an artwork, is a vital aspect of my clinical supervision with therapists working within a variety of private practice, social care, education, or health care settings. In creating space in supervision for accessing the world of their own and our shared imagination I invite supervisees to engage with images for a range of reasons. I will describe this approach and explore the reasons why inviting therapists into an imaginative space of reverie can deepen their understanding of therapeutic work. The use of imagery can highlight their countertransference and enrich their understanding of their clients. It can also, in the form of visualisations, help resource them in a sustainable way for managing vicarious trauma. I will illustrate how important our relationship to image is in working as therapists, supervisees and supervisors.

Whether working with play therapists, creative arts therapists, creative psychotherapists, or therapists new to working creatively, my suggestion is to work imagistically, to open up new insights, access untapped areas of information, engage in live intrapersonal and interpersonal discourse, and keep the work fresh. There is no emphasis on creative skill with this approach, just an openness to be playful and a curiosity to tap into creative dialogue together and subsequently to develop the supervisor's internal creative supervisor.

Creative supervision consists of developing a safe, honest space where we can both play collaboratively with imaginative possibilities around the potential meaning underlying client symptoms, we can decipher the impact of our countertransference, we can explore latent parallel processes and we can encourage the therapist's awareness of somatic information which they carry over from their client and which they have yet to become conscious of.

The reasons why working with image in supervision as idea or artwork is effective are:

- The therapist's imagery which explores their countertransference may help us attune to their clients' experience and choose the direction they may need to follow with their future treatment plan.
- Being open to whatever spontaneously emerges in our imagination when thinking on the therapeutic dance we engage in with our clients can help us access underlying relational content; mapping intersubjectivity and help us become aware of shared unconscious processes - 'we swim in the same psychic sea.' (Jung, 1960).
- Creatively projecting out the 'side effects' or impact of vicarious trauma that therapists carry from the work can help them unburden physically, energetically, and psychodynamically.
- Engaging in the visualisation of powerful imagery can act as a spiritually rich resource to prevent therapist burnout and create professional sustainability.

Imagery around countertransference

I encourage supervisees to work creatively by asking them what image they have of their client. This might be a symbolic image – "She seems like a drooping flower with no soil" or a memory of a significant action or behaviour the client made during a session that has stayed with them - "He kept biting his hand when talking about his father as if trying not to say something…" Both these kinds of images can offer helpful information in understanding the client's process. With the first image, I may ask "What might the picture need?" To which the therapist could reply "Some roots, a healthy environment." The task is then to help the therapist explore with the client whether developing "some roots" or "healthy environment" in life might be personally significant and a direction to go in. With the last example, the crystalised memory of the client biting their hand may have some significance around the father son relationship and is worth initiating a dialogue compassionately and with curiosity. Both therapeutic interventions would be done in a speculative and collaborative way, in tandem with case conceptualisation and developing a space to creatively explore possible meanings.

Sometimes one of my tasks in supervision is to help the supervisee trust that they are a sensitive instrument which can, when finely tuned, or attuned, pick up vast amounts of information about the client's process. Again, Cozolino talked about *shuttling*, when the therapist acts as a kind of antenna through his mind and body, opening a channel that is porous, receiving information, "shuttling to attention and then to our internal process." (Cozolino, 2023). This kind of information gathering can be processed after the session through creative supervision. I also model that the client will engage in what they find relevant from therapist's reflection of them and if the therapist's sensitivity or pacing is off, this then becomes more content to explore creatively in supervision.

Sometimes in supervision I mirror facially, or through body work, the image the supervisee has embodied when they describe a client in a difficult session. They seem unaware that they may have absorbed an aspect of their client until they see it reflected back to them and when this lands, they appear to gain some insight into the client and their process. If a supervisee, in a charged session, is unsure whether they have read a client's behaviour appropriately, I ask them to embody the client and when I reflect back, they seem to access a space to observe without the stress of responding in session. Something lands with them in terms of being able to press pause and they feel more confident with what may be going on psychodynamically. "Ah, I hadn't thought of this, or in this way", can be a typical response.

Figure 1

Figure 1 is an image I created when I worked with a young man with a brain tumour. The sadness I felt in my heart and body whilst working with him called for me to create an image in response to my sense of helplessness. Whilst working with him I would hold this in mind to sustain me in staying attuned to his experience and present to him. The image seemed to hold a clue as to how I should continue to stay hopeful in his therapy. It felt like a direction I needed to hold onto. This was my visual amulet that influenced the treatment approach which I used with him – "stay hopeful and move towards the light". I encourage supervisees to manifest that which feels latent to them, something they can't quite articulate but are aware is there. I invite them to make an actual image or speak about what emerges in their imagination when channeling the client or reflecting on sessions. This appears to be a way of accessing

how our unconscious meets theirs and is very helpful in naming and exploring countertransference issues in a gentle and insightful way.

Creative projection

I consistently encourage supervisees to develop a practice of projecting out whatever they may be left with following a difficult session. This can be a creative projection in terms of an abstract painting, drawing or sculpture of colour, shape, texture or have a movement associated with it. This can help the therapist shed or metabolise some affect that the client may have projected onto them. It can also help them process and digest what may have been transferred or displaced onto them by helping them objectify and release energetically and in a concrete way the content of the session. I have found that this practice not only encourages dialogue with their internal supervisor but can also help prevent therapist burnout. Having some way of processing and projecting out what we absorb from clients is an essential tool and underestimated in my opinion. I have witnessed experienced therapists concerned by how much they carry from their clients and believing that they are doing something wrong. "Surely, with all my experience, I shouldn't be so sensitive to the intensity of my client's trauma?" I respond by saying that I would be more concerned with them if they were not moved, touched or affected by their client's pain. I cite the seminal work of Isobel Menzies (1960) which explored organisational and professional defences when working with trauma and anxiety. The key is in having a way to process what we absorb from our clients, not in defending ourselves against being touched by them.

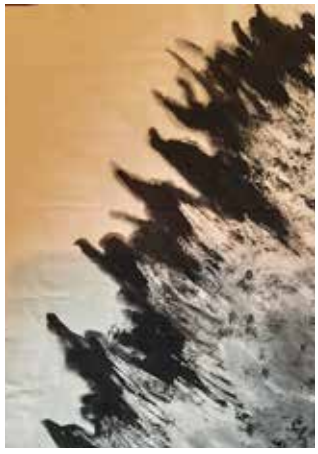


Figure 2

When thinking about a young, deeply traumatised and depressed client at the start of my own therapeutic career, I remember how weighed down I felt with the heaviness of his trauma and depression. I found it hard to breathe in sessions and when he'd leave, I felt there was nowhere to go but just to withstand his projections and my feelings of helplessness in witnessing his own. I created the image in figure 2 after one of his sessions and felt a little relief in externalising my sense of impending dread. Objectifying the effect he had on me and my own affect seemed to help me sustain the work. I held onto part of an image he had created, torn off and discarded. It was a light source. Keeping this and connecting it in my imagination with my own dark image, seemed to help me hold onto a sense of hope for him by investing in a symbolic narrative that manifested a kind of aesthetic alchemy.

Mapping the therapeutic dance

Exploring with the supervisee the image they have of the kind of dance they are engaged in with the client can be very revealing. This might be a drawn, painted, small world (a technique which uses figurines or natural objects to describe a mental image), embodied or conceptual image but all can be a powerful reflection on the client's or therapist's attachment schema. Trish Banks (2022), in her online course *Creative Practice for Self-supervision,* explores interesting psychodynamic parallels between her own countertransference and what may be going on with the client's process by reflecting on her own artwork after a session.

It can also be interesting to wonder whether the dynamic between therapist and client is recreated in the supervisory relationship by collaboratively engaging in the live here and now dance that is created in supervision. When supervising supervisors, this imaginative venture can reap interesting results.

Visualisation of powerful imagery

Figure 3.

When faced with a supervisee heavily carrying the responsibility of a client's pain, trauma, or search for meaning, I invite them (whatever their religious or spiritual bent) into a world of imagery which can resource them personally and professionally. I offer a personal image which has sustained me through my own therapeutic practice. It begins with grounding and deepening my breath, then tapping into my imagination to call upon a greater source of energy and wisdom. An image emerges for me, a little like figure 3, of a bright source, a web of golden filigree with myself, my supervisee and their client being safely held, supported by a loving matrix. I see myself both connected to and channeling this life force in my work. This image, which emerged spontaneously very early in my career has always provided much comfort and support to sustain me through my therapeutic and supervisory practice. When together we have ethically managed known risk factors, exhausted all avenues of support, and I know they have been a good enough therapist, I encourage my supervisee to spiritually offer the client and their pain over to something greater and wiser. I invite my supervisees to source their own image which will sustain them through dark times when working with vulnerable suicidal or bereaved clients. Their own image will have much more power than one prescribed by me, but I offer this as my example.

No doubt, this process reflects my deep connection with Spirit, Soul, God, Chi or Life force. Whatever our spiritual beliefs, as humanistic therapists we are sustained by the notion that our human pain creates opportunities for personal growth once we find facilitating environments to support our journey. As organisms if we can just move towards the light we can flourish through adversity. Making real our beliefs in terms of meditation practices which focus on symbolic imagery provides a map for why we do what we do and how we can sustain ourselves and our clients in this very taxing but meaningful work.

In conclusion, my belief in using imagery in therapy and supervision sustains my energy and passion for the work. It helps me connect to and trust the language and wisdom of my own unconscious as a doorway into a collective unconscious, a bigger power. It helps me imagine maps for my practice and navigate potential approaches. Throughout my career when I've encouraged clients and therapists to open up to connecting with the language of their own unconscious I have witnessed them growing in awareness, trusting themselves more and becoming more flexible in their personal and professional lives.

Claire Colreavy Donnelly, MIACAT, MIAHIP, SIAHIP, MICP**,** has worked as a community artist, youth counsellor, art psychotherapist, clinical supervisor, and arts therapy trainer. Her clinical experience

includes working within adult psychiatry, UK CAMHS, an adolescent in-patient unit, Áthas, a community mental health disability project, within primary and secondary schools and in private practice in her studios in Kildare since 2003. She also provides creative clinical supervision. She has published articles, book chapters and conference presentations related to her psychotherapy work.

References

Banks, T. (2022). *Creative practice for self supervision* [online course]. Therapy Academy. https://therapyacademy.ie/details/online/1134

Colreavy Donnelly, C. (2010). The importance of image in the creative arts therapies.*Inside Out,*Summer 2010.

Colreavy Donnelly, C. (2017). Art in psychotherapy: The healing power of images. In Howard, J. and Prendiville, E. (Eds.), *Creative Psychotherapy: Applying the principles of neurobiology to play and expressive arts-based practice* (Chapter 8). Routledge.

Cozolino, L. (2023). *The making of a therapist, online course* [online course]. PCPSI. https://pcpsi.ie/product/the-making-of-a-therapist-with-dr-lou-cozolino-recording/

Jung, C.G. (1933). *Modern man in search of a soul*. Kegan Paul.

Menzies, I.E.P. (1960). A case-study in the functioning of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital. *Human Relations*, *13*(2), 95-121.

Hill, J. (Director). (2022). *Stutz documentary* [Film]. Netflix.

Requiem for the end of a good day's work

Ger Murphy

So it ended,
So many years, so many tears,
souvenirs of trauma, tragedy and transformation.
I have listened since my twenties, understood since my thirties and felt since my forties.
By then the encased soul was stirring, thawing, coming to life.
Finally ready to meet the broken hearted,
Gilding the slow art of suffering.
The relief of waking up settled me to the task these past decades,
opening me to the dark art of good company.
I have grieved with the grieving, raged with the raped, and prayed with the unredeemed.
I have been father, teacher, brother, witness, friend.
I have been well used ,
well paid, and well loved.
I found my place.
I learned to be whole hearted, open hearted, and fun.
I offered presence, pity and poems as we mulched personal madness into village medicine,
Love and wisdom drawing us on to heal the pain of separation, and soften the stories of lack.
We have been faithful to our task of coaxing shy soul into blessing.
Soon gratitude trumps greed, imagination flowers and the erotic is reborn.
Then soul called time, to be out of time, no longer on time, having a good time and not limited to this time.
Thank you for what we shared, for what was bared, how we cared for this great unfolding, the bringing through of life's desire, living itself through us.
Thank you, thank me and thank the mystery.

Ger Murphy has worked as a psychotherapist for 35 years, was a founder of *Inside Out* and ICP and IAHIP, ran a psychotherapy training at Institute of Creative Counselling and Psychotherapy for 25 years, and continues to practice, and offer company to those seeking development individually and in groups. Ger has now paused his psychotherapy practice so as to allow "a fallow field" so he can allow space to discern his next offering. He can be contacted at germurphyster@gmail.com and at www.iccp.ie.

Life as an IAHIP committee volunteer

by Rachel Somers

My first introduction to committee work started on the Supervision Accreditation Committee in 2011. I'd been invited by a friend who I had trained with back in 2002 with The Tivoli Institute. Having just had my second child, I was trying to restart my private practice after my maternity leave and was delighted to be invited into such an experienced and supportive group, supporting fellow supervisors in their journeys to get accredited. I had experienced my private practice to be exceptionally isolating. As psychotherapists, we don't belong to a profession where we can go home and talk about what we have heard at work or are holding in our bodies from a day of client work. To be part of this committee which met regularly, albeit to speak to all things supervision, was initially an opportunity for me to link in with other like-minded therapists as well as catching up and staying connected with those I had lost contact with.

There was no doubt I had to get my head around a lot. There were forms, checklists, bye laws and procedures to become familiar with. It all felt quite daunting. There was a settling in period to observe, take everything in and ask questions. The committee members were all so supportive and advised me to take my time and that the information would land. That it did. Over the three years I volunteered I'd become secretary and really looked forward to our meetings. What I really enjoyed was how much I learnt in such a short period of time. Having qualified as a supervisor in 2009, I was new in my accreditation, but being part of this committee supported my work and my supervisees tremendously. If I didn't know something, I knew someone who did and the path was clear to lift the phone, email, or ask at a meeting itself. The committee not only processed and supported supervisors toward their accreditation, we also developed a supervisor forum and created more events for IAHIP supervisors to meet and learn more as well as contributing to important changes in criteria and standards within IAHIP.

Another important learning for me was how I became very aware of my own position as a supervisee. Being on this committee, I had learnt about the support I should have been getting from my own supervisor and the support I wasn't getting. It was within this committee that I gained the strength

to challenge my own supervisory relationship. This helped me break away from that which was so comfortable and easy, I hadn't realised my learning had ceased. As an IAHIP volunteer I was supported. My committee peers helped me to break from what was no longer acceptable for me. I discovered that being part of an organisation, guiding professionals toward a professional standard, meant I could no longer accept blurred boundaries and unprofessional behaviour that gave the perception of perfection but adhered to nothing like it.

Since then, as a supervisor, I have worked with many supervisees from differing training institutes and professional accrediting bodies. Committee work alerted me to the varying standards for the profession. It also informed me in terms of who I choose to work with and who may not be the best match.

I missed being part of the committee when I was no longer volunteering for IAHIP. Being a young mother of two stretched my resources so much, that in 2014 I took a break, knowing I would at some stage return to volunteering. I missed my committee members and I felt out of the loop not only regarding support from like-minded professionals, but also in the work itself. It felt like hard work having to keep up to date with changes or just relying on my supervision to keep me focussed on the ever-changing developments in the world of psychotherapy and supervision.

Five years ago I was invited, again by the same friend I had trained with, to join the Accreditation Committee. I had since had another child, and I craved to be back involved at the grass roots of the organisation. I thought, what did I know about accreditation? I had become accredited in 2004 under the now defunct Bye Law 10, a much simpler experience compared with what applicants have to go through today. I had been grandparented into the European Association of Psychotherapy (EAP), again a simpler process then, and when I looked into the newer Bye Law 11, I felt slightly inadequate as the criteria required now is so much higher than my core training could ever meet back in 2002.

The Accreditation Committee were lovely (still are) and I was welcomed in 2019 by a supporting chairperson and secretary who oversaw the general running of procedures, meetings, and processing of applications. I had no idea when I started that the accreditation committee played a huge part in advising and supporting the standards within IAHIP. Each committee runs into each other I discovered. We consulted with the Ethics Committee when we discovered applicants who may have been unsupported in their training and first years in practice. We connected with the Psychotherapy Training Course Recognition Committee (PTCRC), when applications highlighted discrepancies in standards within recognised training colleges, and the Supervision Committee often met with us to maintain support and make sure everyone was singing off the same hymn sheet as regards standards and meeting EAP criteria.

I had a few meetings under my belt in March 2020 when lockdown happened. This was a massive challenge to the committee. A self-confessed slow burner, it has always taken me a while to feel settled and confident in the knowledge needed. Not only had I agreed to be secretary (again), but I felt like I was still getting used to the forms, documents and bye laws, specifically Bye Law 11, which sets out the committee work. The work of the committee came as a nice distraction from the monotony of lockdown. I home schooled my three children, Zoom called my clients and supervisees and kept busy with committee work. No one knew what Zoom was before the Covid-19 pandemic, but it soon became our main communicator for IAHIP committee work.

The work of the Accreditation Committee did not stop during lockdown. Nor did any of the work on other committees, working groups or the Governing Body. We continued to work and process applications online and on Zoom. We kept in contact with other committees and working groups and I believe this connection to colleagues, some of whom had now become friends, kept me sane in the unpredictable present we were now living in. Some members had become sick, really sick. Some were losing family and friends. Some volunteers were vulnerable, living alone and cocooning and still volunteering for IAHIP. We supported each other, listened to each other, and came together, bringing the IAHIP family closer and unified in the work at hand.

Don't get me wrong, there were/are definite times we have not been one big happy family. Some meetings went on until 10/11 o'clock at night. Fights were had about online hours and Covid clinical client hours, supervision hours and personal therapy applicable during phase 1 training. Personalities clashed regarding changing standards all while managing our own homes and fears within them. While processing of applications for accreditation slowed down, we continued working together for all members which signified the care, commitment, and tremendous passion all IAHIP committees, working groups and volunteers had and still have today.

Personality is alive and kicking within the organisation. Reactions can be large and challenging to manage at times. I see this as a reflection of the work we do and the *grá* each volunteer member has for the profession and IAHIP itself. This has challenged me now, not allowing me to sit back. Disagreements can happen, personalities can oppose each other. However, we are all humanistic and integrative psychotherapists at the end of the day and share a connected experience. The IAHIP criteria set for our own psychotherapeutic experience and journey means that we all get and understand this passion and the energy attached to the work. Our humanness, vulnerability and fragility at times, connect us and allow us to support each other.

A thick skin has been required. In different circles I have heard murmurings that the Accreditation Committee can make it deliberately hard for those going through the accreditation process. This has felt hurtful to the committee, whose energy and time given to all applicants and their supervisors, supporting them through the process which has been unwavering, whether they complete to being successful, or unsuccessful in their applications. Speaking for myself, I have only ever had one main focus in my role on the committee, that is, to help and support applicants in the process of accreditation within the standards outlined by Bye Law 11. It is upsetting to me that the committee can be blamed for upholding a standard developed by previous governing bodies and committees, set out years before our current volunteers became actively involved. The Accreditation Committee upholds the current bye law as it currently exists. As a volunteer, reaction, projection and blame can cut and wound. The energy it takes to respond to this can be a real force which has interfered with some volunteers staying on committees.

Despite this, I have had, and continue to have, so much fun working within IAHIP. I laugh so much with my fellow volunteers, and the office staff. Our Christmas parties have been especially memorable where we have let our hair down and made great connection to each other. Lunch breaks have also been a great opportunity to link in and check in with each other in all our processes, both personal and professional. I have laughed so hard, and after three children, my pelvic floor has been compromised on several occasions. I have also cried when I felt vulnerable with people I feel safe and supported around. I have thought at times, what am I doing here? And definitely wobbled once or ten times.

Nevertheless, it has never impacted enough for me to stop the work as an IAHIP volunteer. If anything, it has enhanced the work and camaraderie within the team. It is a team, in my opinion working together for the membership and for you, the valued and respected member.

There's a perception right now that IAHIP is in its last few years, that it will no longer be needed once CORU comes in. I disagree completely. CORU will be the regulating body, when it eventually happens. I don't see IAHIP disappearing, if anything it will come into its own in continuing to support our members in their work, in maintaining the standards everyone has worked so hard to achieve for psychotherapy in Ireland, especially regarding supervision, which won't be regulated by CORU. I see IAHIP moving forward in a new role of support and further training for its membership, lessening the isolation we can all experience at times and strengthening the humanistic and integrative tradition for psychotherapists in Ireland.

There is no doubt that some view IAHIP as elitist and exhibiting some form of professional snobbery. Speaking to this now, I would rather engage in a professional supporting body who recognises my training and experience and includes its members in upholding this standard, and not relating to how many credits I've accumulated or a box ticking exercise. My clients and supervisees do not see my credits or how many boxes I tick. They see the person, my experience, and my ability to sit and hold the space, how I listen, how I don't tell them what to do or tell them what direction to go next, or that I even know better than them. Working on a committee and most recently the Governing Body as a representative for the Accreditation Committee, has done nothing except enhance my work and my own growth as a person and as a humanistic and integrative psychotherapist.

This year is the 30th Anniversary of IAHIP. The founding members created this organisation for us humanistic and integrative psychotherapists coming behind them, also seeking support and to help maintain and uphold the professionalism and standards we all work under. I am overwhelmingly grateful to them, my trainers, supervisors, colleagues, peers, and the friends I have met and worked with throughout my IAHIP experience. In gratitude for the work done before my time, I continue to give back as they had once done. They devoted their time, energy, passion and *grá* so that we could be guided in the humanistic and integrative tradition. Is it now time for you to give back?

Rachel Somers graduated from The Tivoli Institute in 2002. She became accredited with IAHIP in 2005 and has worked with a number of organisations since then as a psychotherapist, supervisor, lecturer and tutor. Rachel is also an accredited supervisor and a qualified EMDR therapist. She set up her private practice, Somers Psychotherapy in Clondalkin Village in 2012. She has a special interest in upholding standards within the Psychotherapeutic Community through her involvement with IAHIP. Rachel is currently Accreditation Secretary and Representative on the Governing Body since 2021.

The journey of conscious ageing: Reflections and insights from a psychotherapist

by Martina Breen

Ireland, like many other developed countries, is experiencing an ageing population, with people living longer than ever before. The Central Statistics Office (CSO) figures predict that those aged 65 years and over will increase significantly: from 629,800 in 2016 to almost 1.6 million by 2051(CSO, 2017). This evolving ageing population presents new challenges and opportunities for us as a nation. The Irish Government's *Positive Ageing Strategy* has the following as its vision:

> *Ireland will be a society for all ages that celebrates and prepares properly for individual and population ageing. It will enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential. It will promote and respect older people's engagement in economic, social, cultural, community and family life and foster better solidarity between generations. It will be a society in which the equality, independence, participation, care, self-fulfilment and dignity of older people are pursued at all times.*
>
> (Department of Health, 2013)

The Irish initiatives, such as Healthy Ireland and Age Friendly Ireland, emphasise preventive health measures, social participation, and well-being. These approaches to healthy ageing align with the wisdom shared in books like *Tuesdays with Morrie* by Mitch Albom (2017) and *Age-ing to Sage-ing* by Reb Zalman (Schachter-Shalomi & Miller, 2014). These approaches recognise the importance of creating age-friendly environments, which resonate with the profound lessons imparted by Morrie

Schwartz in *Tuesdays with Morrie*. and the value of inner growth, personal transformation, and a sense of community in the ageing process, depicted in the book *Age-ing to Sage-ing*.

Age-ing to Sage-ing encourages us to engage ourselves in the second half of life to become a "wise elder" by means of practice and opening ourselves to our "inner life" in a way that we probably were not able to do earlier in life. Reb Zalman poses the question of why should we live beyond the time of begetting and raising our children? He goes on to state: "If we do live longer, then nature must have a task. There must be a purpose. The purpose is to hothouse consciousness, generation by generation; so that the older generation can transmit something to the younger." (Schachter-Shalomi & Miller, 2014, Chapter 1). Rather than allowing yourself to just grow old – you can make a decision to enter a new life stage and consciously age. So, whilst ageing is a natural process that involves physical changes and a gradual decline in physical abilities, *Sage-ing*, on the other hand, is an intentional approach to ageing that involves actively seeking out opportunities for growth and transformation in the second half of life. It's about getting older with intentionality, resilience, and grace. It involves not only addressing the physical and mental aspects of ageing, but also the spiritual aspects such as finding meaning and purpose in the lives we have lived, as well as exploring and visioning the time we have left. Through this work, we learn what it is to redefine what it means to be an elder in today's world. Rather than viewing ageing as a period of decline and loss, it is time to look at our process of ageing as a time of growth, wisdom, and personal transformation.

For the past number of years, I have been actively engaged in the work of conscious ageing and have been using some of the great resources to support individuals and professionals in this work. Sage-ing International (https://www.sage-ing.org), a non-profit organisation, which has taken Schachter-Shalomi's work and offers training and resources, internationally to support individuals navigate the ageing process with greater ease and grace. This is done in a simple format through 'Wisdom Circles' and they offer Certified Sage-ing Leadership Training, CSL. One of Sage-ing International's wisdom quotes is: "The first half of life is constructing personality; The Second half of life is deconstructing the personality!"

Sine qua non of Sage-ing (Adapted from *Age-ing to Sage-ing*)

- To have a willingness to deal with life completion and to face the denial of ageing.
- To come to terms with your mortality.
- To acquire the skills for working on the inside by practising journal writing, meditation, imaginal exercises
- To pay attention to your body, feelings, mind and spirit
- To give a real hearing to the inner voices, allowing all the minorities within you to have a voice.
- To begin to do life repair:
    - In health;
    - In practical matters with wills and testaments;
    - In relationships and between generations;
    - By reaching into the past and offering release and healing;
    - Through forgiveness work with release from vindictiveness;
    - By finding the pearls in the anxious memories.

- To do the philosophical homework by raising questions about the purpose and meaning of your life.
- To serve as an elder to others: as a guide, mentor and agent of healing and reconciliation on behalf of the planet, the nation and the family by being a wisdom keeper.
- To prepare for a serene death.

To become an adult, we need to let go of being an adolescent. To become an elder, we need to have completed our adulting. Elderhood is a new phase of life, given to us by the grace of longevity. There is a newfound freedom in embracing our age and ageing consciously. By modelling conscious ageing and embodying its principles in our own lives we can inspire our clients to do the same and create a more compassionate and fulfilling world for ourselves and others.

Ron Pevny (2014), author of *Conscious Living, Conscious Ageing: Embrace and Savour your Next Chapter*, offers a guidebook for those who are interested in exploring the ageing process with awareness, curiosity, and purpose. A previous Vision Quest Leader, he writes extensively around the personal and spiritual growth that occurs as we age. This growth is not necessarily a given; it requires a deliberate effort to engage with our own ageing process and to cultivate qualities like self-awareness, resilience, and wisdom.

According to Pevny, conscious eldering involves several key practices. One is self-reflection, which involves taking time to reflect on our life experiences, our values, and our goals for the future. Another is community-building, which involves connecting with others who share our interests and values, and who can support us on our journey of conscious ageing. A third practice is service, which involves using our skills and experience to make a positive impact in our communities and the world at large. The book advocates that through engageing with our own ageing process consciously and intentionally we can create a meaningful and rewarding next chapter of our lives.

Suffice to say that most of us are aware that ageing can come with emotional challenges such as grief, anxiety, or depression, along with significant life transitions such as retirement, changes in health, loss of sense of meaning and purpose in life, or loss of loved ones. Not all people ageing suffer with these, but many do. Psychotherapy can play a crucial role in supporting individuals to consciously age in a challenging world by supporting individuals navigate these transitions, process associated emotions, and develop coping strategies to adapt effectively.

But it is also true that, as therapists, *we* also need to become wise elders in this challenging world if we are to support our peers! We need to cultivate the very qualities and skills in our own lives that are essential for effective psychotherapy. These skills include the ability to hold space for our own pain and suffering, have healthy coping skills, and strategies for maintaining well-being, to have a sense of self-compassion, empathy, perspective-taking, and the ability to make wise decisions and to understand the interconnectedness of these domains that promotes overall well-being and conscious ageing. We may consider that we already possess all of these qualities with our professional qualification, but are we practicing these qualities with ourselves as we age?

The cultural narrative often focuses on youth, and the value of experience and wisdom is overlooked and many older adults have negative beliefs about ageing, such as feeling that they are less valued or less capable as they get older. However, the elders are the ones who have lived through the ups

and downs of life, accumulated a wealth of knowledge, and gained invaluable insights that can guide society through these challenging times. They possess a level of wisdom that can only be acquired through years of life experience, and it is this wisdom that is needed in the lives of our young people today.

The need for wise elderhood in our current world of crisis cannot be overstated. The elders of any community possess a unique set of skills, knowledge, and wisdom that can guide us towards a better future. It is time for us to acknowledge, not only, the value of the elders, but to endeavour to become one ourselves. As psychotherapists, it is important that we become conscious elders ourselves in order to better support conscious ageing in our clients. As psychotherapists, we are in a unique position to model conscious ageing for our clients. By embodying the principles of conscious ageing in our own lives, we can inspire our clients to do the same. We can continue to grow and develop, not just as professionals, but as ageing human beings in a world where ageing and elderhood as a stage of life, are often ignored and under-appreciated. In modern society the value of elders has been diminished, and their voices silenced. It is time for us to acknowledge the value of the elders. Only then will we value ourselves as elders and truly harness the power of wisdom to create a more just, equitable, and sustainable world for all.

Martina Breen M.A. is a Gestalt Psychotherapist, Supervisor, Spiritual Director and a Certified Sage-ing Leader (CSL) She works as an Integrative Health Specialist with VHI, along with a private practice and facilitating programmes on conscious living, ageing and dying. She is co-facilitating a retreat on conscious eldering with Ron Pevny in Kilteggan, Wicklow in September this year. She can be contacted at martinasbreen@gmail.com

References

Albom, M. (2017). *Tuesdays with Morrie*. Sphere.

Central Statistics Office (2017). *Population and labour force projections 2107-2051*. CSO. https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2017-2051/populationprojectionsresults/

Cohen, G. (2005). *The mature mind: The positive power of the ageing brain.* Basic Books.

Department of Health. (2013). *The national positive ageing strategy*. Department of Health https://www.gov.ie/en/publication/737780-national-positive-ageing-strategy/

Pevny, R. (2014*). Conscious living, conscious ageing: Embrace and savor your next chapter*. Atria.

Schachter-Shalomi, Z & Miller, R. S. (2014). *Age-ing to sage-ing: A revolutionary approach to growing older.* Hachette Book Group.

Mindcrafting: How to mentor your ageing mind

by Declan Lyons, Deirdre Hussey, and Sinead O'Sullivan

Later life is frequently seen as a time of entitlement and an opportunity to reap rewards and translate the gains of well lived years into an annuity of quality living. After long years of working or child-rearing the retiree is presumably entitled to abundant leisure, an ample or at least an adequate pension and discounts or subsides such as free travel or a TV licence, not to mention good health and access to quality public services when required.

Expectations and reality tend to collide frequently in life though and old age is no different. Most of the privileges associated with the age of "pensionhood" are in reality poor compensations for the devalued status of older people, who have struggled to emerge from the crisis of Covid-19 and rebuild networks and social connections. The pandemic brought into focus layers of vulnerability from loneliness and isolation to the growing role of technology for the execution of many aspects of daily living tasks, leading to frustration and alienation from a disconnected world that not even serial vaccination could render safer or more inviting.

The notion that older people have anything useful to contribute to society is seldom entertained and because we fear our own demise intensely, indicators of the often cosmetic aspects of ageing worry many who perceive unwanted reminders of our own mortality. The morale and status of older people is frequently devalued, even scorned, when many of the older generation are devoid of power or gainful employment, as older workers are rarely perceived as useful in a volatile and changing gig economy. Society tends thus to distance itself from older people whether by failing to support older people's independence through adequate home care - thereby leading to institutionalisation in nursing homes, or by dismissing and stereotyping all older people as being a burden or decrepit, dependent and infirm. The age stratification of society also runs very deep and contact between generations may be driven by obligation rather than a desire to learn from the other.

Older people often sadly collude with this stereotype and gracefully withdraw from many areas of life to make way for younger blood, but by doing so are they putting the dividend of their extra years of life expectancy at risk? Meanwhile, the years available to us continue to grow as humans have effectively doubled average life expectancy over the last 200 years which represents a great triumph for humanity as a whole.

Survival of the wisest

There is little doubt that older persons experience scapegoating for many of society's ills such as hospital overcrowding or scarce social welfare provision and additionally may have to endure multiple losses that can accompany later life. Whether this is a decline in physical health, sensory impairments, the death of long-time friends or the loss of role and status since retirement and diminishing physical attractiveness - these losses may be encountered simultaneously and seem to validate the statement "getting old is not for sissies". Some older people resort to melancholy and complaint in response to these insults on their selfhood and in revenge for society's efforts to render an entire section of the population irrelevant and invisible.

It does not take too much of an imaginative stretch to see how these losses stack up and accumulate, each threatening to chip away at our psychological defences and self-image. Mental illnesses such as major depressive disorder not infrequently affect older people in the context of this extreme discouragement and such ensuing depression threatens to strip away quality of life, not just from the individual but also from those closest to them. Compulsory retirement also threatens the sense of purpose and meaning that we are primed to extract from life at all ages, never mind to deny the person an appropriate level of cognitive stimulation and challenge, crucial to staving off dementia and memory and cognitive decline.

While acknowledging the reality that later life can be a testing time, in writing the book *Mindcrafting* (Lyons, 2022) we wanted to showcase the benefits of continued activity and engagement and consequently the sense of meaning and pleasure that is attainable in later years. Opportunities for full participation by older people in society depend on their ability to remain hopeful and at the same time accepting of change and loss with grace and determination. It is still possible to thrive despite the presence of illness (which is neither inevitable nor untreatable) and older people have demonstrable depths of resilience that have seen them survive many crises and struggles as they flexibly adapt to stressors and changing circumstances. No illness or loss of function however should be accepted as a normal part of ageing. The demonstration of continued zeal to reach out and try new things (even 'the dreaded technology') that might improve their lives and above all to remain enthusiastic and committed, is for many the secret sauce of successful ageing.

The key emotional and psychological needs

Despite all the fears of and efforts to fight off the ageing process, on many levels remarkably little changes as we grow older. We are not evicted from our bodies, nor from our passions and interests and most people still feel largely the same on the inside, even if the exterior wall paint is cracking a little. Key components of human happiness are quite simple and they are something to do, something to look forward to and someone to love. If these and other key emotional and psychological needs are met and balanced in a healthy way, it is my view that much emotional and psychological distress and even clinical depression is either absent or significantly reduced in intensity.

Throughout the book *Mindcrafting* (Lyons, 2022) we refer to the set of organising ideas known as the Human Givens originally devised by Joe Griffin and Ivan Tyrrell in the 1990s (2013). The Human Givens approach has provided clinically useful list of human needs that are frankly directly applicable to many situations, whether the relevant issues relate to status, legitimacy or autonomy. This framework is a useful and practically applicable description of how humans function in terms of meeting key emotional needs and how our innate resources such as intuition, memory and enhanced awareness to name but a few, are deployed in meeting these needs. As a clinician working with older people, I have found that patients relate well to the therapeutic explanations and language of this approach which promotes insight and engagement, and this sets the scene for behaviour change and breaking of patterns. Meeting our universal emotional needs healthily and sustainably, such as the need for autonomy and status, among many others which may be especially imperilled during later years, is akin to living off a well- balanced diet for the mind. In fact, this foundation of needs and resource awareness is a sound basis for flourishing in old age - not just for individuals - but also for wider society. If older people could begin to appreciate that many of their higher order brain abilities such as reason,

empathy skills and intuition actually improve with age, they may regain the confidence to stave off loneliness and isolation through active reconnection with and involvement in their communities.

Invest in your future self

As humans we tend to think of our future selves as different people and combined with a tendency to underestimate the pace at which time passes, we may be suddenly disorientated when confronted with the reality of our chronological score. Rarely do we creatively plan for our later years, our personal evolution and becoming – instead, denial, distraction and indulgence in youthful fantasy tends to prevail. Yet this stance may be abruptly shattered, and we can suddenly be confronted with reality as we realise all that we love and cherish and even our own existence is finite. This may happen when we are politely offered a seat on a bus or a train or finding ourselves meeting criteria to be admitted to under "geriatric" services in hospital, or even the shock of a health event when all those assumptions we had about our bodies standing up to years of punishment are finally imploded.

All is not lost, however, and old age does not have to be equated with inevitable disability and disease. Nor are our later years invariably fraught with grief and the stress of ageing. Older people can recover from many acute illnesses, in reality just as well as younger people, when given adequate time to do so. The development of many specialist services for older persons is all about restoring independence and optimal functioning through intensive rehabilitation and the bringing together of expertise from many healthcare disciplines. Sophisticated, person-centred healthcare, of which older people as a group are the main beneficiaries, will increasingly reduce disability and morbidity. Altered lifestyles and habits such as healthy eating, movement and exercise even undertaken in later life can significantly improve one's quality of life. Appropriately adapted technology will allow greater independence for an older generation who will be able to 'age in place' rather than be admitted to a continuing care facility. There will be ever increasing future research about the forms of intellectual stimulation that will be relevant in relation to improving brain neuroplasticity, with all the potential to delay or prevent memory loss and even dementia.

Older people are an increasingly diverse, heterogenous grouping in society and will look for role models and desirable reflections of their own potential in contemporary culture, to challenge any growing invisibility imposed upon them by younger cohorts. Older people will realise their considerable economic leverage as one of the great untapped markets of the twenty first century and will use this to design services, supports and experiences tailored to their own needs as they recast the third act of their lives as a time of opportunity, potential and personal reinvention. Their ability over many years to selflessly contribute to the welfare of others and to identify with fairness, equity and justice will be an important moral resource for the next generation, and consequently many have justifiably benefitted from universal state supports and entitlements which sadly are increasingly eroded in many economies. Although ageing involves a variety of processes, namely biological, psychological and social, the ultimate challenge is to move away from overcoming the inherent nature of old age and its association with death, and to transcend any infirmity through our attitude, our behaviour and especially our social institutions.

Charter for action

In essence the idea that motivated the book *Mindcrafting* (Lyons, 2022) was to encourage older people to take controlled risks in their lives rather than adopting a safety-first approach, to continue to view

their lives as an adventure and to commit to see what was around the next corner by remaining interested, enthusiastic and engaged in as many aspects of life as possible. Setbacks in the form of illness and loss are inevitable to some extent but for those who struggle to define themselves in the absence of a career and paid employment, over identification with illness and disability can block the attributes of resilience and wisdom which allow us to retain good humour and interest in other human beings. Even as the curtain closes, the example of dignity and tenacity that older people can display is of inestimable value to the next generation. Stoicism can be the very essence of survival during the ups and downs of life and older people, by definition, have cultivated this in spades, but guarding and maintaining independence is equally key to that positive self-perception as a competent and responsible adult, as opposed to being a dependent and helpless object that has to accept exclusion and marginalisation. The search for meaning and the meeting of key emotional needs, against a backdrop of an affirming social environment and the recasting of the idea of community, are surely the best ways to ensure our elders can squeeze every last drop out of life.

Dr Declan Lyons is a Consultant Psychiatrist at St. Patrick's Mental Health Services, James's St, Dublin 8, and Clinical Associate Professor in Psychiatry at Trinity College Dublin.

Dr Deirdre Hussey is a Registrar in Psychiatry at St Patrick's Mental Health Services Dublin.

Dr Sinead O'Sullivan is a Registrar in Psychiatry at St Patrick's Mental Health Services Dublin.

References

Griffin, J. & Tyrrell, I. (2013) *Human Givens – the new approach to emotional health and clear thinking.* HG Publishing

Lyons, D. (2022) *Mindcrafting: How to mentor your ageing mind.* Beehive Books.

Dreams – Making neural connections

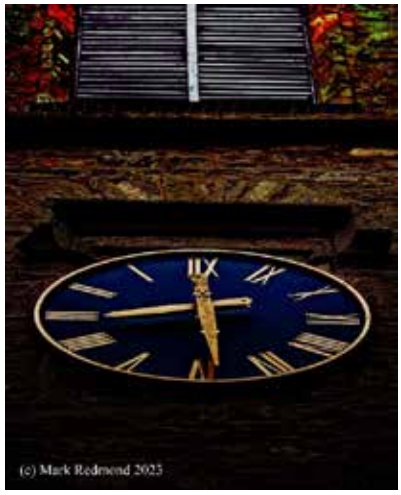
by Mark Redmond

At completion of my training as a psychotherapist my dissertation was an exploration of recurring dreams and trauma (Redmond, 2012) and I have since found it useful when working with clients' dreams in my psychotherapy practice. Three themes of interest emerged from the dissertation: firstly, dreaming has an integrative function that tempers disturbing emotional responses to new experiences. Dreams achieve this by connecting the new emotional concern to similar emotional experiences in the dreamer's past, thereby making the new experience familiar and less disturbing. A second theme is the concept of boundary thickness and dreaming, and a third, the recurring dream continuum. What follows is an updated and abridged version of these dissertation themes.

Sleep is important (Killgore, 2010; Walker, 2009) and sleep debt can lead to health problems (Bayon et al., 2014; Spiegel et al., 1999; van Cauter et al., 2007). There is ongoing debate on the psychological function of dreaming (Domhoff, 2017; Hobson & Schredl, 2011); still, there are many dream function hypothesises in the literature, including: Freudian (1953 [1900]); Jungian (2002); Adaption to Stress (Koulack, 1993; Stewart & Koulack, 1993); Threat Simulation Theory (Revonsuo, 2000; 2015); Activation Input Neuro-modulation (AIM) Model (Hobson et al., 2000); Continuity Hypothesis (Schredl, 2003; Schredl & Hofmann, 2003); Protoconsciousness Theory (Hobson, 2009); Problem Solving (Barrett, 1993, 2007, 2017; Cartwright, 1974); Control Mastery Theory (Gazzillo et al., 2020) and Human Self-domestication (Blagrove & Lockheart, 2022).

The hypothesis of interest here is that dreams are a mental function that conceptualise unprocessed emotional experiences (Cartwright et al., 2006; Cartwright, 2010; Domhoff, 1993, 2000, 2011, 2017; Hartmann, 1996a, 1996b, 1999, 2001, 2010a, 2010b, 2013, 2014) – a function which Cartwright (2010) and Hartmann (2014) suggest goes on day and night. Cartwright's (2010) 24-hour mind hypothesis states that when awake, processing is via normal conscious mental activity, moving to the processing of preconscious material with less motor activity during non-REM sleep, and then deeper for unconscious processing in REM sleep. A normal sleep night would include several such non-REM and REM cycle iterations striving for emotional homeostasis. Hartmann (2014) posits a "focused-waking-thought-to-dreaming continuum" (p. 31). Dreams make connections in neural networks more broadly than waking consciousness and are not random but guided by the dominant emotional concern of the individual. The dream's "central image" (p. 11) contextualises this dominant emotion and provides an explanatory "picture metaphor" (p. 49). Metaphor is what occurs more naturally as one moves away from reductionist structured rapid processing mental activity of focused-waking-thought to the broader and more systemic realms of reverie and dreaming. Aside from night terrors, dreams are always "a creation, not a replay" (p. 23), and are "not a consolidation of memory. Rather, dreaming 'weaves in' and integrates new material into existing memory, guided by emotion" (p. 24). Cartwright (2010) beautifully captures these different modes of mental functioning metaphorically with her statement "we speak prose while awake and poetry in sleep" (p. 157).

Physical illnesses are also sources of emotional concern and dreams often portray these vividly with picture metaphor. The dreaming mind is more sensitive in this respect and "appear to pick up or notice small disturbances the waking mind has not noticed" (Hartmann, 2001, p. 52) – a view supported by Fiss (1993). Fiss's (1993) Signal Detection Model posits that dreams in general are more responsive than the waking mind to "low-level stimuli" and "Poetzl phenomenon" (p. 407). Barrett (1993; 2007; 2017) and Cartwright (1974; 2010) suggest that the unconscious mind is in general a better problem solver than the conscious mind.



Boundary thickness and dreams

People are different physically, behaviourally, and mentally, and some people live their lives more 'dreamily' than others. Considering Hartmann's (2014) focused-waking-thought-to-dreaming continuum there are some people who live their lives more in focused-waking-thought and others more at the day-dreaming/dreaming end of the continuum. Hartmann and Kunzendorf (2006) and Hartmann (2014) coined the term 'thick and thin boundary' to differentiate these personality types. Thick boundary types are very solid, well organised and have a sharp focus, able to concentrate on one thing while ignoring others. They are well defended, may seem rigid and are sometimes referred to as 'thick-skinned'. At the other extreme, individuals are especially sensitive, open, or vulnerable. In their minds things are relatively fluid. They experience thoughts and feelings (often many different ones) at the same time. Such people have particularly thin boundaries. Most of us are in between or may have thick boundaries in some ways and thin in others. The Boundary Questionnaire (BQ) (Hartmann, 2001; 2013) examines the quantitative aspects of boundaries and though not a useful measure to assess personality, it does show that boundary thinness is highly correlated with the measure, "openness to experience" and "people who score thin on the boundary scale score unusually open on that measure" (Hartmann, 2001, p. 223). The BQ also indicates a significant correlation between thinness of boundaries and dream recall frequency. Certain definable groups who scored 'thicker' than average (naval officers, lawyers) tended to report very few dreams. Conversely those scoring 'thinner' (artists, musicians) report more dreams than average. Thin boundary individuals are generally life-long sufferers of nightmares that usually do not have a single acute traumatic source in childhood. Though they are empathic and creative in a positive sense, as children they were also oversensitive and vulnerable "Traumas that might have seemed minor to others had a great impact on those people" (Hartmann, 2001, p. 49).

Dream continua

Domhoff (1993; 2000) posits that there is a considerable amount of dream content that is repetitive for each individual and suggests a continuum for these dreams based on what he calls the "repetition principle" (Domhoff, 2000, p. 1), "To the degree that the experience is gradually assimilated, to that degree the dreams decrease in frequency and become altered in content" (p. 4). Hartmann (2001) and Terr (1990) also support the idea of a repetition continuum of the intensity of emotional concerns repeatedly contextualised in dreams. These diverse continua are shown in Figure 1.

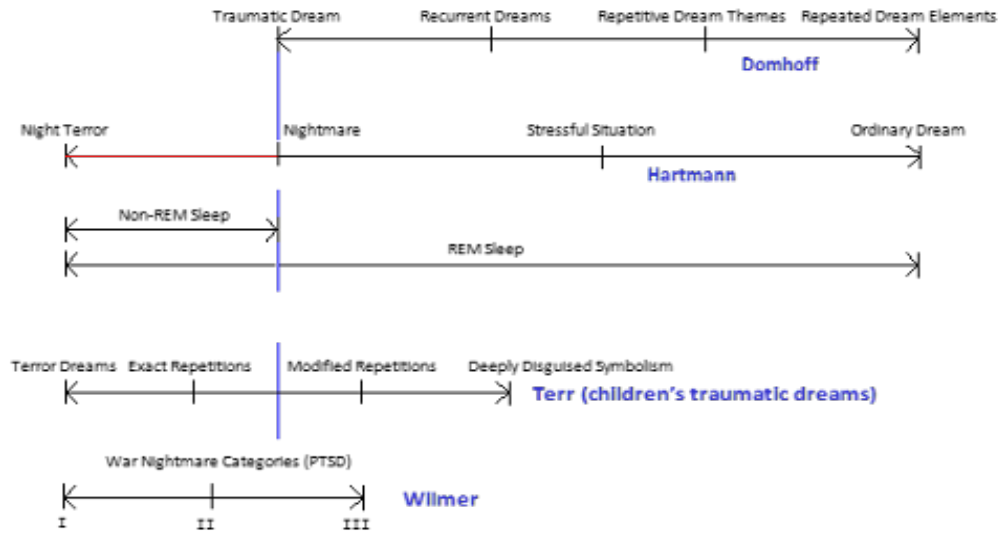


Figure 1: Dream Continua

1. Night terrors

These are not included on the Domhoff (2000) continuum, however Hartmann (1996b; 1999) and Terr (1990) differentiate them from traumatic dreams/nightmares. Night terrors usually occur (but not always) in slow wave sleep during early non-REM phases. They are not true nightmares; rather they are memory intrusions or flashbacks occurring in sleep which are usually an exact replica of the original traumatic experience (Hartmann, 1996b). In children, they are associated with "intense autonomic discharge, palpitations, sweating and a "glassy-eyed," panic-stricken stare" (Stoddard et al., 1996, p. 32). Wilmer's (1996) categories I and II war nightmares seem to fit at this end of the continuum as shown in Figure 1. It requires severe horrific events to trigger these dreams, and Hartmann (1996b) unexpectedly found that sufferers "did not have very thin boundaries found in those with life-long nightmares" (p. 112). These dreams fail to make connections in neural networks (Hartmann, 1996b); nevertheless, Wilmer (1996) calls his war nightmares "healing nightmares", which would indicate connection-making capability. Pressmann et al. (1995) cite an interesting case of a patient with sleep apnoea causing night terrors; however one could pose the question: which is the cause and which is the effect?

2. Traumatic dreams / nightmares

These occur mainly in REM phases, and are a major symptom of PTSD which portray traumatic events in emotional detail and horror (Domhoff, 2000). However, Hartmann (1996b) argues that dreams on this level of the continuum are never an exact replica of the original traumatic experience since they generally contain an important metaphoric change to represent the original terror.

3. Recurrent dreams

These most often begin in childhood and adolescence with few reported to begin in adulthood. The affective tone is reported to be negative with regular themes of being attacked or chased. They are reported to begin at times of stress, but rarely does the content reflect the stressful situation directly i.e., images are more metaphoric. Not all

subjects are able to link the onset of recurrent dreams to current stressful events which signals that the event is sometimes forgotten or repressed by thin boundary individuals, however Duval et al. (2013) warn not to immediately conclude that such dreams point to repressed childhood trauma.

4. Recurring themes

The symbols and metaphors that appear in these dreams are more variable and bizarre but when a long dream series is examined, clear recurring themes emerge. These repetitive themes are generally linked to more minor current emotional stressors or with residues of repressed childhood trauma.

5. Repeated dream elements

The dreams found at the lower end of the continuum are more random and the emotional pre-occupation very difficult to establish. However, Hall and Van De Castle's Quantitative Content Analysis System (1966, as cited in Domhoff, 2000) shows that preoccupations can be uncovered by constructing carefully defined categories for settings, objects, emotions, character, activities, and social interactions, and then tabulating frequencies for each of these categories.

Studies and reviews

Brown and Donderi's (1986) study (n=67) explored the links between recurrent dreamers and their self-reported well-being, and found that recurrent dreamers reported lower well-being scores than non-recurrent or past recurrent dreamers. Cartwright's (1996) study of divorcing couples (n=70) found that those who, in the early days of the divorce, reported more dreams about their spouses coped better one year later, on various measures (e.g., depression), than those who did not have such dreams. An assessment by Zadra (1996) finds "support for the validity and the heuristic value of Domhoff's (1993) repetition continuum" (p. 242). The cessation of a recurrent dream is associated with an elevation in self-reported levels of well-being and changes in dream patterns may be important indicators of how well people are adapting to their life circumstances (Zadra, 1996), thus highlighting the importance of examining series of dreams instead of focusing solely on individual dreams. A sample of Hartmann's own dream research include studies before and after the 2001 New York twin tower terror attacks (Hartmann & Basile, 2003) (n=16) and (Hartmann & Brezler, 2008) (n=44). Hartmann and Brezler (2008) conclude that:

> The power of the central imagery of the dream is related to the power of the underlying emotion or emotional state. And the study supports the idea that the dream image is an emotionally guided construction or creation, not a replay of waking experience.
>
> (Hartmann & Brezler, 2008, p. 217)

Fox et al.'s (2013) review which compared functional neuroimaging and first-person content reports, found that "dreaming can be understood as an "intensified" version of waking mind-wandering" (p. 1). The waking-to-dream continuum is further supported by a review by Scarpelli et al. (2019) which concludes that "emotional regulation and dreaming share similar neurobiological bases suggesting that the amygdala, hippocampus and mPFC operate in a sort of continuum between wakefulness and REM sleep" (p. 9). Studies by Sterpendich et al. (2020) conclude that "emotions in dreams and wakefulness engage similar neural substrates and substantiate a link between emotional processes occurring during sleep and emotional brain functions during wakefulness" (p. 840). Margherita et al.'s, (2021) study (n=1095) during the Covid-19 lockdown in Italy supports the adaptive

function of dreaming and their "results confirmed the function of dreams to work through traumatic experiences, whether the dreams are recalled or not" (p. 383).

Conclusion

Good sleep habits with or without dreams are essential for well-being. Dreams, when they occur, are functional whether they are remembered or not. Dreams contextualise unprocessed emotions, helping to weave in new experiences into existing memory, thereby building a meaningful emotional memory system at the core of the Self. Dreams use metaphor which is hyper-connective when making connections in neural networks since metaphor views boundaries between neural nodes more loosely. In contrast, focused-waking-thought uses serial logic and checks neural nodes more tightly when making connections; i.e., more precise matches are needed. The intensity of emotions contextualised in dreams can follow a continuum, thus highlighting the utility of examining dreams as a series rather than focusing on individual dreams in isolation. Change in emotional intensity in repetitive dreams can indicate change in well-being not obvious to the waking mind.

Mark Redmond MIAHIP, Dip. Counselling & Psychotherapy, MSc (Loss and Bereavement), BTech. Mark works in private practice in south Wexford and in cancer support. He likes working with dreams/nightmares and can be contacted at info@markredmond.ie.

References

Barrett, D. (1993). The "committee of sleep": A study of dream incubation for problem solving. *Dreaming*, *3*(2), 115-122. https://doi.org/10.1037/h0094375

Barrett, D. (2007). An evolutionary theory of dreams and problem-solving. In D. Barrett & P. McNamara (Eds.), *The New Science of Dreaming, Volume III: Cultural and Theoretical Perspectives* (pp. 133-154). Praeger/Greenwood.

Barrett, D. (2017). Dreams and creative problem-solving. *Annals of the New York Academy of Sciences*, *1406*(1), 64-67. https://doi.org/10.1111/nyas.13412

Bayon, V., Leger, D., Gomez-Merino, D., Vecchierini, M.-F., & Chennaoui, M. (2014). Sleep debt and obesity. *Annals of Medicine*, *46*(5), 264-272. https://doi.org/10.3109/07853890.2014.931103

Blagrove, M., & Lockheart, J. (2022). Dream-sharing and human self-domestication. *International Journal of Dream Research*, *15*(1), 86-94. https://doi.org/10.11588/ijodr.2022.1.83442

Brown, R. J., & Donderi, D. C. (1986). Dream content and self-reported well-being among recurrent dreamers, past-recurrent dreamers, and nonrecurrent dreamers. *Journal of Personality and Social Psychology*, *50*(3), 612–623. https://doi.org/10.1037/0022-3514.50.3.612

Cartwright, R., Agargun, M. Y., Kirkby, J., & Friedman, J. K. (2006). Relation of dreams to waking concerns. *Psychiatry Research*, *141*(3), 261-270. https://doi.org/10.1016/j.psychres.2005.05.013

Cartwright, R. D. (1974). Problem solving: waking and dreaming. *Journal of Abnormal Psychology*, *83*(4), 451–455. https://doi.org/10.1037/h0036811

Cartwright, R. D. (1996). Dreams and Adaption to Divorce. In D. Barrett (Ed.), *Trauma and Dreams* (pp. 179-185).

Cartwright, R. D. (2010). *The twenty-four hour mind: The role of sleep and dreaming in our emotional lives*. Oxford University Press.

Domhoff, G. W. (1993). The repetition of dreams and dream elements: A possible clue to a function of dreams. In A. Moffitt, M. Kramer, & R. Hoffmann (Eds.), *The functions of dreaming* (pp. 293-320). State University of New York Press.

Domhoff, G. W. (2000). *The repetition principle in dreams: Is it a possible clue to a function of dreams*. Retrieved 08th April, 2023 from https://dreams.ucsc.edu/Library/domhoff_2000b.html

Domhoff, G. W. (2011). Dreams are embodied simulations that dramatize conceptions and concerns. *International Journal of Dream Research, 4*(2), 50-62. https://doi.org/10.11588/ijodr.2011.2.9137

Domhoff, G. W. (2017). The invasion of the concept snatchers: The origins, distortions, and future of the continuity hypothesis. *Dreaming*, *27*(1), 14-39. https://doi.org/10.1037/drm0000047

Duval, M., McDuff, P., & Zadra, A. (2013). Nightmare Frequency, Nightmare Distress, and Psychopathology in Female Victims of Childhood Maltreatment. *The Journal of Nervous and Mental Disease*, *201*(9), 767-772. https://doi.org/10.1097/NMD.0b013e3182a214a1

Fiss, H. (1993). The "royal road" to the unconscious revisited: A signal detection model of dream function. In A. Moffitt, M. Kramer, & R. Hoffmann (Eds.), *The functions of dreaming* (pp. 381-418). State University of New York Press.

Fox, K. C., Nijeboer, S., Solomonova, E., Domhoff, G. W., & Christoff, K. (2013). Dreaming as mind wandering: evidence from functional neuroimaging and first-person content reports. *Frontiers in Human Neuroscience*, *7*(1), 1-18. https://doi.org/10.3389/fnhum.2013.00412

Freud, S. (1953 [1900]). *The Interpretation of Dreams* (Standard vols. 4&5 ed.). The Hogarth Press.

Gazzillo, F., Silberschatz, G., Fimiani, R., De Luca, E., & Bush, M. (2020). Dreaming and adaptation: The perspective of control-mastery theory. *Psychoanalytic Psychology*, *37*(3), 185-198. https://doi.org/10.1037/pap0000252

Hall, C., & Van De Castle, R. (1966). *The Content Analysis of Dreams*. Appleton-Century-Crofts.

Hartmann, E. (1996a). Outline for a theory on the nature and functions of dreaming. *Dreaming*, *6*(2), 147-170. https://doi.org/10.1037/h0094452

Hartmann, E. (1996b). Who develops PTSD nightmares and who dosen't. In D. Barrett (Ed.), *Trauma and Dreams* (pp. 100-113).

Hartmann, E. (1999). The nightmare is the most useful dream. *Sleep and Hypnosis*, *1*(4), 199-203. https://www.sleepandhypnosis.org/ing/abstract.aspx?MkID=33

Hartmann, E. (2001). *Dreams and Nightmares*. Persues Publishing.

Hartmann, E. (2010a). The dream always makes new connections: the dream is a creation, not a replay. *Sleep Medicine Clinics*, *5*(2), 241-248. https://doi.org/10.1016/j.jsmc.2010.01.009

Hartmann, E. (2010b). Meteorite or gemstone? Dreaming as one end of a continuum of functioning: Implications for research and for the use of dreams in therapy and self-knowledge. *Dreaming*, *20*(3), 149-168. https://doi.org/10.1037/a0020575

Hartmann, E. (2013). *Website: Ernest Hartmann: Selected Papers to 2013*. Ernest Hartmann. Retrieved 1st May, 2023 from https://ernesthartmann.com/

Hartmann, E. (2014). *The nature and functions of dreaming*. Oxford University Press Oxford.

Hartmann, E., & Basile, R. (2003). Dream Imagery Becomes More Intense After 9/11/01. *Dreaming*, *13*(2), 61-66. https://doi.org/10.1023/A:1023398924124

Hartmann, E., & Brezler, T. (2008). A Systematic Change in Dreams after 9/11/01. *Sleep*, *31*(2), 213-218. https://doi.org/10.1093/sleep/31.2.213

Hartmann, E., & Kunzendorf, R. G. (2006). Boundaries and Dreams. *Imagination, Cognition and Personality*, *26*(1), 101-115. https://doi.org/10.2190/hk76-038k-407m-8670

Hobson, A., & Schredl, M. (2011). The continuity and discontinuity between waking and dreaming:

A dialogue between Michael Schredl and Allan Hobson concerning the adequacy and completeness of these notions. *International Journal of Dream Research*, *4*(1), 3-7. https://doi.org/10.11588/ijodr.2011.1.9087

Hobson, J. A. (2009). REM sleep and dreaming: towards a theory of protoconsciousness. *Nature Reviews Neuroscience*, *10*(11), 803-813. https://doi.org/10.1038/nrn2716

Hobson, J. A., Pace-Schott, E. F., & Stickgold, R. (2000). Dreaming and the brain: Toward a cognitive neuroscience of conscious states. *Behavioral and Brain Sciences*, *23*(6), 793-842. https://doi.org/10.1017/S0140525X00003976

Jung, C. G. (2002). *Dreams*. Routledge Classics.

Killgore, W. D. (2010). Effects of sleep deprivation on cognition. *Progress in brain research*, *185*(1), 105-129. https://doi.org/10.1016/B978-0-444-53702-7.00007-5

Koulack, D. (1993). Dreams and Adaption to Contemporary Stress. In A. Moffitt, M. Kramer, & R. Hoffmann (Eds.), *The functions of dreaming* (pp. 321-340). State University of New York Press.

Margherita, G., Gargiulo, A., Lemmo, D., Fante, C., Filosa, M., Manari, T., Lenzo, V., Quattropani, M. C., Vegni, E., Borghi, L., Castelnuovo, G., Cattivelli, R., Saita, E., Franceschini, C., & Musetti, A. (2021). Are we dreaming or are we awake? A quali–quantitative analysis of dream narratives and dreaming process during the COVID-19 pandemic. *Dreaming*, *31*(4), 373-387. https://doi.org/10.1037/drm0000180

Pressman, M. R., Meyer, T. J., Kendrick-Mohamed, J., Figueroa, W. G., Greenspon, L. W., & Peterson, D. D. (1995). Night Terrors in an Adult Precipitated by Sleep Apnea. *Sleep*, *18*(9), 773-775. https://doi.org/10.1093/sleep/18.9.773

Redmond, M. (2012). *The Use of Recurring Dreams in Healing Trauma* [unpublished dissertation]. Dublin Counselling and Therapy Centre.

Revonsuo, A. (2000). The reinterpretation of dreams: An evolutionary hypothesis of the function of dreaming. *Behavioral and Brain Sciences*, *23*(6), 877-901. https://doi.org/10.1017/S0140525X00004015

Revonsuo, A., Tuominen, J., & Valli, K. (2015). The Avatars in the Machine: Dreaming as a Simulation of Social Reality. In T. K. Metzinger & J. M. Windt (Eds.), *Open MIND*. MIND Group. https://doi.org/10.15502/9783958570375

Scarpelli, S., Bartolacci, C., D'Atri, A., Gorgoni, M., & De Gennaro, L. (2019). The Functional Role of Dreaming in Emotional Processes [Review]. *Frontiers in psychology*, *10*(1), 1-16. https://doi.org/10.3389/fpsyg.2019.00459

Schredl, M. (2003). Continuity between waking and dreaming: A proposal for a mathematical model. *Sleep and Hypnosis*, *5*(1), 26-39. https://www.sleepandhypnosis.org/ing/abstract.aspx?MkID=111

Schredl, M., & Hofmann, F. (2003). Continuity between waking activities and dream activities. *Consciousness and cognition*, *12*(2), 298-308. https://doi.org/10.1016/S1053-8100(02)00072-7

Spiegel, K., Leproult, R., & Van Cauter, E. (1999). Impact of sleep debt on metabolic and endocrine function. *The Lancet*, *354*(9188), 1435-1439. https://doi.org/10.1016/S0140-6736(99)01376-8

Sterpenich, V., Perogamvros, L., Tononi, G., & Schwartz, S. (2020). Fear in dreams and in wakefulness: Evidence for day/night affective homeostasis. *Human Brain Mapping*, *41*(3), 840-850. https://doi.org/10.1002/hbm.24843

Stewart, D. W., & Koulack, D. (1993). The function of dreams in adaptation to stress over time. *Dreaming*, *3*(4), 259–268. https://doi.org/10.1037/h0094384

Stoddard, F. J., Chedekel, D. S., & Shakun, L. (1996). Dreams and Nightmares of Burned Children. In D. Barrett (Ed.), *Trauma and Dreams* (pp. 25-45). Harvard University Press.

Terr, L. (1990). *Too Scared to Cry: How Trauma Affects Children and Ultimately Us All*. Basic Books.

van Cauter, E., Holmbäck, U., Knutson, K., Leproult, R., Miller, A., Nedeltcheva, A., Pannain, S., Penev, P., Tasali, E., & Spiegel, K. (2007). Impact of Sleep and Sleep Loss on Neuroendocrine and Metabolic Function. *Hormone Research in Paediatrics*, *67*(Suppl. 1), 2-9. https://doi.org/10.1159/000097543

Walker, M. P. (2009). The Role of Sleep in Cognition and Emotion. *Annals of the New York Academy of Sciences*, *1156*(1), 168-197. https://doi.org/10.1111/j.1749-6632.2009.04416.x

Wilmer, H. A. (1996). The Healing Nightmare: War Dreams of Vietnam Veterans. In D. Barrett (Ed.), *Trauma and Dreams* (pp. 85-99). Harvard University Press.

Zadra, A. L. (1996). Recurrent Dreams: Their Relation to Life Events. In D. Barrett (Ed.), *Trauma and Dreams* (pp. 231-247). Harvard University Press.

Not your typical therapy session

by Maeve Peoples

"If you go down in the woods today, you're sure of a big surprise…" (Kennedy, 1932)

We amble up the forestry path. The sun is shining, but there's a cold sharp breeze, the kind that can be quite cutting. The evergreen trees provide plenty of shelter. I'm thankful for this today.

This walk isn't about getting steps in or exercising. No, this walk is different.

"What do you mean, you do therapy in the woods?" a prospective client asks. I'm comfortable with this question now, although I wasn't always. In particular when I first started out.

The pandemic changed everything. This included how I worked as a psychotherapist. No longer was I able to meet clients in the office. We were all too scared of what we didn't understand. I tried to adapt to online therapy with my clients. While I found that it worked for some, it didn't work for everyone. I'm still trying to understand why that is. But as we all know, just like therapy itself, there is no one prescriptive formula that works for everyone.

Ask anyone what a psychotherapist's office might look like, and most people will think about Freud and his infamous couch. A client lying across it with the man himself sitting at the end writing notes. The couch now resides in London, free from the burden of dreams, traumas and phobias. It was recently restored, continuing the cultural legacy of Freud's work.

So what does a psychotherapy space need? Bookshelves with psychology and psychotherapy texts.

A desk, at which to write notes. Objets d'art. Paintings on the wall. Qualifications, framed and hung. A box of tissues. Chairs placed at just the correct distance apart. Personal, but not too personal. A professional tone. What does this space tell a prospective client about the therapist? What is the therapist, consciously or unconsciously, relaying about themselves?

Working therapeutically outside of an office space wasn't something that my fellow students and I had explored in my psychotherapy training. Indeed, very little time was spent on discussing what a therapeutic space might, or should, look like. I remember there being some discussion around whether the client or the therapist should sit closer to the door. Safer for the therapist, a chance to get out if things turned sour. Or, a feeling of safety for the client, knowing they were closer to the exit. Symbolic of their ability to hold some control over what was happening in the therapy session.

So what to do? I needed an alternative to the office space. So I took a risk. I'd never heard of people doing therapy in the woods. I didn't know what that might look like. But I knew that I had to think differently and I needed to address the problem in a creative way. I also knew I had to adapt to how the world was changing. Psychotherapy is changing. That's certainly true for me.

I call it Walk & Talk. It's not exactly a highly original title, but I'm sure that you get the point. But that's exactly what it is. We walk. And we talk. Sometimes we stop. We look. Tree stumps provide seating if we feel the need to rest. Up in the hills it's possible to breathe in the clean fresh air. We can connect with the seasons and with the environment around us. Nature is grounding. No matter what the weather, the time of year, or the day, these woods can teach us and restore us.

Research suggests living near green spaces and spending time in nature can improve mental health (Capaldi, 2014). GP's in Scotland started prescribing time outdoors in nature before the pandemic (Frumkin et al., 2017). Scientists are still trying to figure out why it works, but the leading theory is that spending time in nature reduces stress.

Barcelona, a city with one of the highest populations and traffic densities in Europe, has implemented a plan to create more green spaces. The thinking behind this is to improve the health of more than 30,000 people, and thus reduce the use of antidepressants. According to research, this will save up to €45m annually in costs associated with mental health issues (Yañez et al., 2022).

Professor Shane O'Mara, author of *In praise of walking: The new science of how we walk and why it is good for us*, says "Research shows that walking facilitates feeling better even when you expect the opposite" (In praise of walking book steps up, 2020).

Walking has many benefits for both the body and mind. It helps to protect and repair organs that have been subject to stresses and strains. It's good for the gut, helping the passage of food through the intestines. Walking is also associated with improved creativity, improved mood, and the general sharpening of our thinking (O'Mara, 2018).

So, on our Walk & Talks, we meander. We pause to take a few deep belly breaths. We notice our surroundings. We hear the birds. We feel the sunshine on our skin.

We walk side by side. You and I. At the same time. We walk the path, go on this journey together. If you stop, I stop too. If you walk quickly, I might deliberately slow my pace. Or I might keep up. As part of the therapeutic process, depending on what you as a client need, I can adjust our pace. We bring our entire body to the session. Our movements, our body language. Just like bringing our attention to

the landscape that surrounds us, we bring our attention to the inner landscape of our body. We do this as we walk.

Walking in the woods allows us to learn how to stop. To pause for a moment. To be still and to breathe. To begin to understand that we have a choice. Learning not to impulsively do the same thing over again and again. To develop and understand that working this way can be a transformative experience by allowing the client to simply pause and breathe. To pause and not feel that they need to fill the space.

To linger and listen. A background of human existence far off in the distance, a rumbling of an engine. Pigeons cooing. Leaves rustling. The water from the nearby stream. To smell the earth, nature, the outside world. Smell the resin from the trees. To feel the wind pulling past my face. To feel my toes wrapped in my woolly socks. The rough pebbles under my boots. The cuff of my jacket on my wrists. To taste the coffee I had before I started work.

And then to notice that I am breathing. I am alive. I am experiencing. I am connecting to my internal world, I am supported by the external environment.

To be aware of the impact of this pause, this stillness. We can begin to know ourselves more deeply. To connect with our deeper selves. To be allowed to respect ourselves. A space to permit and embrace anything that may emerge from within.

From both peers and clients I hear similar questions. What do you do if you meet someone? What if it rains? Does it work as well as therapy in an office? Is it be dangerous? How do you keep track of time? This last one is definitely a question from a therapist.

If we meet someone, we smile and say hello. Sometimes we will briefly pass the time of day with them, perhaps commenting on the weather or the steepness of the hill. Our lives are full of constant interruptions. How we deal with these interruptions in therapy may resonate with how we deal with them in real life.

As an aside, I do wonder what the regular dog walkers that I meet think of me. They see me two or three times a week, with different people, of different ages. Perhaps they just think that I'm quite sociable!

If it rains, we feel it on our skin. Perhaps we take shelter under the boughs of a nearby tree. I have even been known to jump in the puddles. The sun shone on me yesterday. Five minutes later, I could feel and hear hail stones hitting my jacket. Each offer equal value while we walk. As with life, we note what is happening, and we resume our journey.

We live in Ireland. It rains here, that's just part of life in this country. For me, outdoor clothing is essential. But it's not mandatory. What you wear is up to you. As the Scandinavians say "there's no such thing as bad weather, there's only bad clothing".

My father always had an uncanny knack of guessing the time accurately. I'm not sure if I've inherited that particular skill or not but I seem to instinctively know when to retrace our steps. How far to walk before we turn back. If we take the loop walk, at a decent pace it takes 40 minutes, so I know I have time to stop and do a grounding piece, or to take a few minutes to pause and sit on the bridge and listen to the water as I listen to you.

This way of being a therapist, in nature, sits well for me. The up side of that for the people I walk with is they are getting a genuine me, a comfortable me, a me not trying to be something which I'm not.

As for danger; engaging in therapy certainly is daunting, and I hope never dangerous! But it's definitely not and never will be, a teddy bears' picnic!

Psychotherapy is changing. It was forced to. In all its disciplines, be they online, face to face in a room, or outdoors.

Maeve Peoples is a fully accredited psychotherapist, Maeve brings her compassion and her ability to create a space that is both safe and nurturing for her clients. Part of this journey is adapting to the changing needs of clients, either face to face, or online. Maeve offers Walk & Talk therapy in the woods near her home. She can be contacted at maeve.peoples@icloud.com

References

Capaldi C.A., Dopko R.L., Zelenski J.M. (2014). The relationship between nature connectedness and happiness: a meta-analysis. *Front Psychol*. 5:976. https://doi.org/10.3389/fpsyg.2014.00976

Frumkin H., Bratman G.N., Breslow S.J., Cochran B., Kahn P.H. Jr, Lawler J.J., Levin P.S., Tandon P.S., Varanasi U., Wolf K.L., Wood S.A. (2017). Nature contact and human health: A research agenda. *Environ Health Perspect*., *125*(7): 075001. https://doi.org/10.1289/EHP1663.

In praise of walking book steps up. (2020, February 14). In praise of walking book steps up. *A mindful walker*. https://www.amindfulwalker.com/in-praise-of-walking/

Kennedy, J. (1032) Teddy bears picnic [Song]

O'Mara, S. (2108, October 14). In praise of walking – My new book. *Shane O'Mara brains, behaviour, organisations*. https://www.shaneomara.com/2018/10/14/in-praise-of-walking-my-new-book/

Yañez, D.V., Barboza, E.P., Cirach, M., Daher, C., Nieuwenhuijsen, M., & Mueller, N. (2022). An urban green space intervention with benefits for mental health: A health impact assessment of the Barcelona "Eixos Verds" Plan. *Environment International.* 174:107880. https://doi.org/10.1016/j.envint.2023.107880

Everyone can sing

by Anne Colgan

Did you know that only between 2% and 5% of people in the world's population are tone deaf? (Sachs, 2008; Peretz & Vuvan, 2017; Singwise, 2020). So, if between 98% and 95% of people can sing, why do so many people call themselves non-singers? One of the main reasons I have come across in my research is that they were told they could not sing by someone not qualified to do so. What often followed that declaration was a sense of shame and of not being good enough. They became the outsiders, not the chosen ones. Trauma can also cause loss of voice as can lack of support: for instance, when boys' voices are changing at puberty. This shaming can affect your speaking voice and cause lack of confidence and poor self-esteem. Your sound is unique to you; no one can tell you that you don't have a voice of your own.

When I would mention that I was a singer a large percentage of people of all ages would say to me "I wish I could sing; I was told I can't sing". This percentage was much higher than 5%; it was more like 20%. Many years ago, someone said to me, "I wish I could sing a song". To which I said without thinking much, "I'll teach you". Thus began my journey of exploring (what happened that) some people thought they could not sing and what could be done to reverse that belief.

I sent out an invitation to people who thought they could not sing to come and work with me to see if they had a voice. Some could sing already and wanted to have a better relationship with their voice. The majority of those who responded thought they could not sing. Two years later the "non-singers" became singers. Two have joined choirs, something they thought they could never do and one singer has a voice capable of singing opera. This experience for me was mind blowing and humbling. I admire their courage and perseverance throughout the process. There was laughter and tears as can happen when you discover and re-discover something you think you don't have.

Singing is good for you mentally, physically and emotionally. When you combine the frequency you create when singing with intent it brings about healing. Not only that, I have experienced great joy and ecstasy when singing and I want others to feel the same. I began my research in 2015 and I decided I wanted to tell everyone about what I had discovered. In 2019 I began to write my book *Everyone Can Sing* which I self-published in February 2023.

I incorporate voicework in my psychotherapy practice and I also work with people who want to learn how to sing, which entails breathwork and the mechanics of singing. Many people will have stopped singing because of a traumatic event in their lives. They tell me they have lost their voice. When I work with clients who have those experiences the combination of psychotherapy and creative voice work can heal and restore the voice. I am glad I have written the book so that more people can have access to learning about singing and how it supported me in my life.

The names of the clients in the book have been changed to protect their identity and written permission has been granted to Anne to write and speak about their experiences.

Anne Colgan is a psychotherapist and supervisor, a member of IAHIP and EAP, a singer and workshop facilitator of "The Experiential Creative Voice Workshop". She is a former Chair of ICP and former Vice Chair of IAHIP. Her websites are www.everyonecansing.ie and www.thehavengroup.ie

References

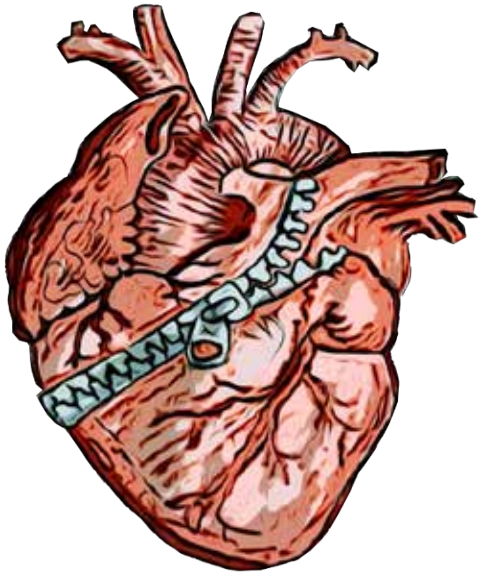
Peretz, I. & Vuvan, D.T. Prevalence of congenital amusia. *European Journal of Human Genetics* (2017) 25, 625–630

Sachs, O. (2008) *Musicophilia*. Vintage

Singwise.com (2020) Tone Deafness (Amusia) and Other Causes of Persistent Pitch Problems https://www.singwise.com/articles/tone-deafness-amusia-and-other-causes-of-persistent-pitch-problems

On secrets of the heart and psychotherapy: A short reflection

by Matthew Henson



Teccam explains there are two types of secrets. There are secrets of the mouth and secrets of the heart.

Most secrets are secrets of the mouth. Gossip shared and small scandals whispered. These secrets long to be let loose upon the world. A secret of the mouth is like a stone in your boot. At first you're barely aware of it. Then it grows irritating, then intolerable. Secrets of the mouth grow larger the longer you keep them, swelling until they press against your lips. They fight to be let free.

Secrets of the heart are different. They are private and painful, and we want nothing more than to hide them from the world. They do not swell and press against the mouth. They live in the heart, and the longer they are kept, the heavier they become.

Teccam claims it is better to have a mouthful of poison than a secret of the heart. Any fool will spit out poison, he says, but we hoard these painful treasures. We swallow hard against them every day, forcing them deep inside us. There they sit, growing heavier, festering. Given enough time, they cannot help but crush the heart that holds them…

Quibble all you like, Teccam understood the shape of the world.

(Rothfuss, 2021)

On theory and poetry

Over the last 20 or so years in practice, in my quiet moments and as is my wont, considerable time has been given over to pondering what it is that I offer as an existential psychotherapist. During that time my understanding has developed, shifted, matured, become increasingly nuanced and both more sophisticated and, paradoxically, simplified. However, in all that time, I am yet to find a succinct *theoretical* definition which encompasses the whole range of my psychotherapy practice in a way that can be understood through abstract description and without direct experience. "How does therapy work?" is still the initial session question I least like being asked. Not because I don't know the answer, nor because I don't like answering it, but because so much depends upon what the person sitting in the 'client' chair brings to the equation, which makes it an almost impossible question to answer prospectively. The best succinct answer I have is that existential therapy might be thought of as the by-

product of a process of phenomenological exploration, which will (hopefully and usually does) make sense retrospectively. An answer that is probably meaningless to anyone who isn't already well-versed in philosophers such as Martin Heidegger and Maurice Merleau-Ponty; an answer which is less than useless to someone who really just wants reassurance that a therapist can help them with whatever troubles brought them to therapy.

Of course, there are many different scientific and other philosophical bases for psychotherapy, some of which can be fused through technical eclecticism or contiguous integration, and some which are incommensurable with others. The *theoretical* objectives of psychotherapy are many, varied and ever-evolving. Noting just a few: from making the unconscious conscious, to replacing dysfunctional thought processes with functional ones, to reattuning neuroception, to reducing post-traumatic symptoms through bilateral eye movement, many different scientific objectives are cited under the heading 'psychotherapy'. We are a disparate profession and all the richer for it.

As a slight aside, CORU should not be envied in its current task to formulate a definition which at once unifies the many strands of *psychotherapy* and demarcates it as something distinctly different from *counselling*. We have known for some time that the difference between psychotherapist and counsellor will most likely be established through educational achievements, QQI (2014) levels 9 and 8 respectively, but the professional practice differences (what actually happens in the room) between psychotherapy and counselling, have yet to be determined. We have had draft national psychotherapy *education* awards standards for nearly a decade (QQI, 2014), but in the intervening period we are still waiting for national psychotherapy professional *practice* standards.

In the absence of a unifying theoretical definition, and until such time as national practice standards are agreed upon, we might prefer *prosaic* or *poetic* definitions. Over the years, I have acquired quite a collection of these and, when I first heard Rothfuss (2012) in audiobook format, I found what might be another wonderfully poetic definition of psychotherapy; one of my favourites. From Rothfuss, we might infer that:

Psychotherapy is a place for secrets of the heart,

or rather, psychotherapy is a place where secrets of the heart might be spoken, either to release them before they crush the heart that holds them, or to allow the healing of a heart already so crushed.

Of course, this definition requires nothing of the person attending therapy; the sharing of secrets is neither obligatory nor an outcome measure of therapeutic success. Many people will and do experience hugely positive therapeutic outcomes without ever going near any secrets of any kind. There is no dictate for clients to fulfil. Rather, this definition can be conceived as an intentional goal of the therapist, to contribute to the co-creation of a therapeutic space which is safe enough for clients to disclose their secrets of the heart, *should they wish*.

On secrets of the heart as challenge

It would be extraneous to debate here whether there are in reality, *any* absolute safe spaces in the world (including therapy), or indeed whether there *should be* any absolute safe spaces (including therapy) when we consider 'hate speech' for example, or disclosures of abusive / criminal behaviour. A safe therapeutic space, for the purposes of this reflection, does not refer to the safety afforded when we are 'amongst friends'; the type of safety required for the sharing of politically, morally, ethically and/or legally dubious thoughts, feelings, and behaviours. Secrets which might get us into trouble

with others, a boss, a spouse, the gardai, the church, the taxman, are often *secrets of the mouth*. Of course, many people bring such private matters to therapy and seek assurance that the therapist will keep these secrets 'confidential'. This level of confidentiality is not unique; it is shared across many professions where the personal affairs of the client should not be gossiped about nor communicated to others. In Rothfuss' fantasy world, the secret of the heart carried by Kvothe, the main protagonist, relates not to his later life antics, which he has no difficulty sharing, but his early life trauma. In my experience, the same is true in the real-life stories of people who enter therapist consulting rooms. The transgressions which might result in negative consequences should they become public knowledge, are usually not the things people find most difficult to talk about in therapy. Often, the things that are most difficult to even disclose, let alone discuss, relate to traumatic experiences and / or emotions; matters which might never attract any external sanction.

In a reflection published in the *Irish Journal for Humanistic and Integrative Psychotherapy*, I am not going to list the many ways emotional trauma occurs, how to identify trauma when it presents or how to work therapeutically with it; we are all experts in the field, even those of us who don't have the words "trauma informed" on our certification. Instead, I will offer only a gentle reminder that trauma attracts shame like a magnet attracts iron filings and talking about traumatic experiences, as well as often being necessary for healing, is often also re-traumatising. The greater the initial trauma (and any subsequent re-trauma), the greater the shame, the greater the need to keep secret, the greater the need for *therapeutic safety*.

In the past decade or so, the historical stigma associated with psychotherapy has pretty much dissolved. Today, people are usually just as happy to be seen in a psychotherapy waiting room as they are to be seen at a GP surgery. Confidentiality today is not quite so much about hiding the fact that someone is **whispers** "*going to counselling*". It is easy to achieve the safety required for people to share their private affairs with a psychotherapist, as they might with a GP, a solicitor, an accountant, and for this to be written into professional codes of conduct. It is another thing altogether, once someone is in the therapy space, to achieve the safety required for the sharing of secrets of the heart, these most painful and most deeply hoarded traumatic treasures. Secrets of the heart require *next-level* safety and it is this requirement that perhaps sets psychotherapy (and counselling, maybe?) aside from other professional relationships.

And of course, therapeutic safety does not begin and end with confidentiality. The many boundaries we hold with, and for, our clients all contribute to therapeutic safety; that probably goes without saying. The same is true for the codes of ethics we embrace, implicitly and explicitly, through membership of accrediting bodies. We avoid dual relationships, for example, (particularly the personal kind) not only to protect our clients from potential problematic power dynamics within the secondary relationship, but also to protect the integrity of the primary relationship, to protect the integrity of the therapeutic space itself. Secrets of the heart need to stay in the therapeutic space, they cannot subsequently be taken to the pub, the tennis club, the boardroom or the bedroom; this is why we forsake the possibility of other personal or business relationships once we embark upon a therapeutic alliance. *Everything we do*, professionally as psychotherapists, from the maintenance of 'hard boundaries', to the ongoing development and refinement of our interpersonal and relational 'soft skill-set'; from our efforts to ensure calm, quiet and interruption-free physical and online spaces, to the meditations and practices we use to clear our emotional energy between sessions; from reading and writing books and journal articles, to attending CPD workshops; from supervision, to our own personal therapy; from those

judgement calls about when to say nothing, to those judgement calls about when to make personal disclosures; *everything*, one way or another, assists us to co-create spaces that might be safe enough for secrets of the heart.

It follows that if we are not striving at all times to co-create this level of safety, then perhaps we are not practising psychotherapy at all?

On secrets of the heart as reward

> *You go rummaging around in other people's lives. You hear rumours and go digging for the painful truth beneath the lovely lies. You believe you have a right to these things. But you don't… When someone tells you a piece of their life, they're giving you a gift, not granting you your due.*
>
> *Patrick Rothfuss, The Wise Man's Fear*

Whilst the market value of psychotherapy is perhaps quite far behind some other professions with comparable knowledge base and skills-set requirements, there are of course, many non-monetary rewards. Secrets of the heart are top of my list. Alongside my own direct experience, I have learned more about the world through listening to the people I am honoured and privileged to call *my clients*, than I have through any other means. I love books, movies, songs, and these, together with much less loved sources of information such as, newspapers, documentaries and social media, are all great places to learn about life. But I learn most from the real conversations I have with real people, when real life experiences are shared through the simple act of talking and listening in spaces that are safe enough for secrets of the heart.

Our clients pay us money for therapy, and at the same time they reward us with the gift of stories of their lives. Through these gifts, we get to see the world as it truly is, not as a series of abstract concepts, but at a visceral, ontological, and deeply meaningful level. What it means to be *human*, what it means to be *alive*, what it means to *be in the world*; the shape of the world as it is actually experienced through embodied felt senses, is never revealed more fully, nor at greater relational depth, than when a secret of the heart is shared. We have no right to these treasures; we strive to earn them, and it is *always* a privilege when we succeed.

Secrets of the heart are both the challenge and the reward of psychotherapy.

Concluding thought

It occurs to me that whatever future direction our evolving scientific knowledge base and our regulatory bodies take us in, psychotherapy might always be defined as *a place for secrets of the heart*. Or, for those who favour more technical descriptors, perhaps we can at least agree that a space safe enough for secrets of the heart is inherently safe enough for any form of psychotherapy, however we choose to define it.

Acknowledgements

Thank you, Patrick Rothfuss, for the first two King Killer Chronicles. Please publish the third.

Thank you, Indra Henson, for the image of a zipped heart. Your (he)artwork just gets better!

Most importantly, thank you to everyone who has shared a secret of the heart in my therapy room. My life has been enriched by each and every one.

Matthew Henson is an existential psychotherapist, psychotherapy trainer and group facilitator in private practice. He is based in Kinsale (and online). He is a fan of the fantasy novel genre and a fan of Patrick Rothfuss in particular. www.matthewhenson.ie

References

Quality and Qualifications Ireland (2014) Awards Standards – Counselling and Psychotherapy, Retrieved 1 June 2023 from https://www.qqi.ie/sites/default/files/2021-12/counselling-and-psychotherapy-qqi-award-standards-2014.pdf

Rothfuss, P. (2012) *The Wise Man's Fear* (R. Degas, Narr.) Audible. https://www.audible.co.uk/pd/The-Wise-Mans-Fear-Audiobook/B007Q36VFC?qid=1684270761&sr=1-3&ref=a_search_c3_lProduct_1_3&pf_rd_p=c6e316b8-14da-418d-8f91-b3cad83c5183&pf_rd_r=CF6SVHQ9BV596Q5WGSER&pageLoadId=XBhLq2UXV7W0GnvX&

The Gods and Goddesses are against me!

by Mary Spring

Personal therapy could be likened to a long and winding road. Often times, you might say, it's a long and winding and very testing road. And that's before I even enter the room. Traversing the pedestrian-unfriendly road infrastructures of Galway city and trying to negotiate its bewildering light systems frequently makes this journey a harrowing event. I have been knocked down by a marauding cyclist who saw nothing untoward with cycling like crazy on a footpath. Hit from behind, this incident subsequently necessitated two shoulder surgeries and has resulted in me being more fearful than fearless when out and about.

Other challenges have befallen me. You might not believe this but on one occasion I was walking through town on my way to personal therapy when a bird, from on high, shat on my head. Though not necessarily prompting an existential crisis, I was, nonetheless, randomly shat on. Seriously. My head. No one else's, as far as I could note. Not in the habit of screaming or shrieking, never mind squealing, I felt the uncomfortable wet plop, and silently wept and died inside. Quickly bypassing Supermac's which was on my doorstep, I dived into a nearby hotel's rest room. There I gained a sense of feigned composure and equilibrium and continued on my way to my weekly session.

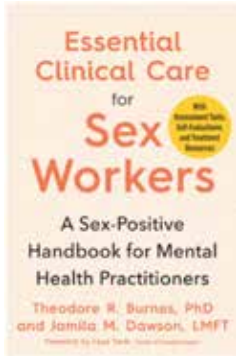
The long and winding road to therapy has presented other challenges. In early January, a few years ago, I reached the entrance to the therapist's room, only to find that the outer gate was not just closed but also locked. I can only describe this experience as the equivalent of the straw breaking the camel's back. The symbolism of a locked gate was not lost on me. Feeling my anger acutely roused, I sent a brusque four-worded text message to the therapist: "Outer gate is locked". Once I got into the room I was really upset, angry and hurt and, undoubtedly, threading on older shut doors in my life. On another day, I tripped and fell while ascending the stairs to the therapist's room. My takeaway coffee went everywhere and I felt like a very young helpless child and a proper idiot as the therapist dried up the spillage with a magically acquired mop. Though it can be a useful prop, I have now decided never, ever again to bring a cup of coffee into the session. I have lovely childhood memories of coffee, invariably Maxwell House or Nescafe, being made by my mother – granules and sugar were creamily pasted together with a spoon of water and then the cup was filled to the brim with boiling milk. It was a latte before coffee became an art form in the '90s. Now, however, a modern-day latte cannot be enjoyed while in a therapy session, particularly if it might spill over beforehand while climbing the stairs. It's not the same as having a cuppa up the town with my almond milk latte-drinking buddy Art, though perhaps that's what I might have been looking for on the occasions I brought a cuppa with me into therapy – something friendly, cosy and comfortable, or perhaps even something older and more familial and rooted in the dining room of my childhood home.

On returning to my parked car from another session, I once saw that my car had been clamped. Relieved of €120 I could only conclude that the gods and the goddesses were and continue to be against me. I'm certain of it. Added to these experiences have been the near weekly battles with westerly winds and gales that blow in from the nearby Atlantic. I have buried in bins at least five umbrellas rendered useless. Such are the landmines I have occasionally walked through before and, indeed, after a therapy session.

And even within the hour-long session, things sometimes go haywire and moments are encountered, moments I can only describe as weird. Strange things happen. One Monday, a sheet of vertical blinds, positioned as in a phalanx, collapsed as I spoke. Two sets of eyebrows arched in unison. Was this a sign of something ominous or something positively symbolic and instructive? Was light coming in to the work? Was my well-honed defensive shield dropping away as I entered more and more into a trusting therapeutic relationship. My water bottle has spilled over. More symbolism perhaps of necessary spillage, of opening flood gates, of releasing tightly contained aspects of my life.

I since have googled to see who the god or goddess of therapy is, and the ancient Greek god Asclepius, with his serpent-entwined staff and his impressive CV seems to fit the bill. I have it on good authority that he was the son of Apollo and Coronis and that the centaur Chiron taught him the art of healing. I'm seriously thinking of making contact with Asclepius. The name Asclepius is a bit of a mouthful and I could see myself tripping over its pronunciation. I'm wondering does he use a shortened form – *Clepi? Assee? Pius? Pi?* We need to talk, however. I continue to believe that I have been rather hard done by. The gods and the goddesses seem to be against me, don't you think?

Mary Spring is an accredited psychotherapist with IACP. She has a private practice in Galway city and is a tutor/lecturer with ICPPD.



Book review: Essential clinical care for sex workers: A sex-positive handbook for mental health practitioners

by Theodore R. Burnes PhD and Jamilla M. Dawson LMFT

ISBN:9781623276808

Reviewed by William Pattengill

Whether or not you expect to be providing psychotherapy or counselling services to sex workers, I believe this book is still worth our attention because of how it challenges us to re-examine our personal and professional attitudes toward not only sex work (since 1978 the preferred term for prostitution, street walking, etc.) but sexuality itself.

Although the authors are writing specifically about the U.S., the issues presented may be more pronounced in Ireland due to the robust historical influence of the Catholic Church. The authors introduce the terms “erotophobia”, “whoreophobia” and “sex-negative” to describe the sociocultural prejudices against any non-procreative sexual activity, to which they attribute the chronic avoidance of social services by sex workers, including mental health counselling. Many of the sex workers interviewed claim that their would-be therapists often reveal that same prejudice and unintentionally drive them away.

In researching for a local perspective, I found that there are reportedly only two sex workers operating in Ireland for every 10,000 citizens (ProCon.org, n.d.). I suspect this may not be very accurate for at least two reasons: one is the need for privacy in the face of the pervasive social stigma and legal issues, and the other is the recent proliferation of virtual and remote sex work opportunities that may have given a boost to those numbers as well as providing a greater shield of anonymity. By comparison, the figures reported for the U.S. are 31 and for Russia 200 per 10,000 (ProCon.org, n.d.).

Another example of the attitudes under review by the authors is what they call the “whoreocracy”, the hierarchy that sex workers have been boxed into based on their working environments and numbers of clients. Those who work “in-house” such as escorts and “massage parlour” staff, whose higher prices require fewer clients per week, are seen as superior to those “on the street”, to those who need to hide their true identities, and at the low end, those trading sex for drugs. The industry has changed radically with the advent of digital media, obscuring the aforementioned status markers, and affording a greater level of safety and privacy for providers of video and phone sex.

Nevertheless, it is still a profession with a higher level of danger than most, despite the Irish government’s best intentions. We are currently operating under what is called the Nordic system, which in 2017 superseded the 1993 law that prohibited both the provision of sexual services and the

sale of/payment for sex. Things Nordic tend to have a progressive and humane connotation, but in this case, legalising the sale of sex but criminalising the purchase has unintended downsides. A structural error was to conflate domestic sex workers with illegally imported "trafficked" workers, treating both as exploited victims, which might be only partially accurate. Though offering sex for sale is technically legal, there are many easy ways to fall afoul of the law in the process.

A second downside was the prohibition of "brothels" which by definition are any place where two or more sex workers are doing business, including a shared apartment. The result of this is the loss of safety in numbers and oversight provided by shared accommodations, and the requirement that sex workers be alone with clients creates the potential for physical endangerment. Meanwhile, the Gardaí have shown their own tendencies to disapprove of sex work by assaulting one in five workers, according to a report of a study by the University of Limerick and funded by the Department of Justice (Raleigh, 2022). Furthermore, the Amnesty International Report of 2022/2023 states that ". . .the disregard shown for the safety of sex workers (in Ireland) through continued criminalisation of aspects of sex work places the workers at a high risk of abuse and violence including rape, and are less able to trust Gardaí" (Amnesty International, 2023). The criminalised "aspects" in question are "brothels," and the payments for sex, both of which force sex workers to be alone with clients and thus out of range of any protection that might be afforded by law enforcement.

We can see that there are many reasons why a sex worker might seek out counselling or other support, but there are equally plentiful reasons why they are reluctant to avail themselves of that resource. The authors begin their book with an account of these obstacles that have grown out of old prejudices and lack of education. They maintain that there is an enduring misconception that people (mostly women) either enter the field due to a troubled or traumatic childhood, or are traumatised by the work itself. The other aspect of this belief is that the sex worker is always wishing for a way out and would prefer any other lifestyle. The presence of these misconceptions in the mental health profession is all too apparent to many potential sex worker clients, resulting in the clients being seen as victims when they may conversely feel empowered and fulfilled by their work and less like the stereotypical wayward soul in need of salvation.

Therapists working under the above misconceptions may focus on sex work itself as the source of whatever malaise the client is experiencing, missing the presence of underlying stressors such as the occupational hazards of stigma, harassment, or threats of violence, as well as basic family, economic, or health concerns. The authors invite the reader to review their own feelings about this type of work and attitudes about what constitutes "healthy" or acceptable sexual activity. Lack of graduate-level sex education and the retention of old conservative "family values" may hinder clinicians in their attempts to meet the needs of the contemporary sex worker, as outdated stereotypes of "fallen women" may still be present. This situation has not been helped by what the authors see as historically faulty research methods used for studies of sex workers' mental health even in recent years, contaminated by "erotophobia", "sex-negativity", and patriarchal attitudes.

Current economic conditions provide an increased incentive for younger people to consider sex work as a viable primary or secondary source of income: higher costs of housing, education and resulting student loans, the relative safety and anonymity of virtual/remote work, and the increase in popularity of online porn. This is the new reality, whereas it once was believed that drug and/or alcohol addiction or low self-esteem were the main contributing factors. However, the stressors that often arise, and the perceived lack of mental health options, can result in those same harmful behaviours.

The book includes some sociological exploration of how sex work in the U.S. is impacted by critical race theory, feminism, and white male privilege, and it appears that those issues may also be present in this country. Searching the internet to get a sense of the resources available to Ireland's sex worker community, I found a far different picture than what the authors were painting in their *Essential clinical care* project, with its references to empowerment and fulfilment. Most of the advocacy groups and support services here seem to be based on the belief that their service users are exploited, downtrodden, and desperate to escape dependence on selling their bodies. That may be due to the high percentage of undocumented and trafficked foreigners who have been coerced into the trade against their will or better judgement, with few other options for survival.

The only available statistics I found, which again may be currently inaccurate, claimed that only six per cent of our sex workers were Irish citizens, and only eight per cent were registered with a GP. Of the remaining great majority, about one third were listed as Brazilian, and another third as Roma, and most of the emigrants reported difficulty with the English language (UCD, 2021). There are many organisations tasked with providing services to this diverse community, and most are concerned with findings ways for their clients to transition out of sex work in order to save their physical and emotional health. This reality was corroborated by a recent study conducted by the University College of Dublin, the Sexual Exploitation Research Project and Womens' Health Services, entitled "Confronting the Harm". From my reading of the preface to the study, the concept of an empowered and fulfilled sex worker was nowhere to be found.

Possibly the authors of *Essential Clinical Care* are idealising their American subjects' potential for fulfillment in pursuit of a feminist ideal. The wide range of support services available to sex workers in the U.S. might imply acceptance or at least tolerance of sex work, but the authors do not acknowledge the gathering gloom of recent trends threatening many of the freedoms that once defined progressive American culture, such as legal restrictions to abortion access and banning books from school libraries.

Nevertheless, their recommendations for clinical care are appropriate for workers on both sides of the Atlantic, administered with a heavy dose of "Woke" awareness with a capital W. The authors introduce us to the types of sex work that may be encountered, a historical perspective of its place in mental health practice, the need for self-examination of one's own attitudes toward the subject, a guide to assessment, conceptualising treatment, and clinical interventions and process. The use of vignettes of personal and professional experiences brings theory into clearer focus. Their hope is that readers will come away with the tools that equip them to "reframe and shift our understanding" of the whole phenomenon of sex-for-pay, and to become "change makers" in our professional and social communities. Having shed our ingrained prejudices, we can become advocates for sex workers by confronting "whoreophobic" comments or attitudes among our colleagues, supervisees, friends, and family members. Most of all, in their own practices, therapists can begin to correct the harm done to sex workers by their profession.

These concluding remarks seem better suited to a society where sex workers can hope for a life of "empowerment and fulfilment" in their careers and receive the same benefit from therapy as other members of the community, with their clinicians able to refrain from blaming their work for most of their problems. At present, the current work environment in Ireland seems to provide little opportunity for much of the hopes described above to come to fruition, so the authors' calls for increased awareness, tolerance, and support are even more urgent.

William Pattengill is a member of the editorial board and an occasional contributor to Inside Out. After retiring from the home renovation business, he has enjoyed the opportunity to return to his roots as a journalist.

References

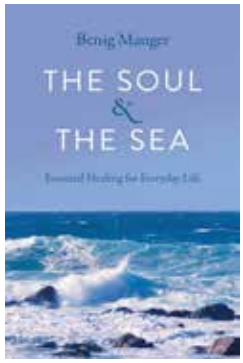
Amnesty International (2023) *Amnesty International Report 2022*
https://www.amnesty.ie/annual-report-2022/

BeyondExploitation (n.d.)
https://www.beyondexploitation.ie

ProCon.org (n.d.) *How many prostitutes are there in the United States and other countries?* https://prostitution.procon.org/questions/how-many-prostitutes-are-in-the-united-states-and-the-rest-of-the-world/

Raleigh, David (2022, Aug. 25). *One in five sex workers sexually exploited by Gardai, report finds* BreakingNews.ie
https://www.breakingnews.ie/ireland/sex-worker-face-discriminatory-behaviour-from-Gardai-report-finds-1354712.html

UCD (2021) *Confronting the harm - Ireland.* https://www.ucd.ie/geary/static/publications/Confronting_the_Harm.pdf



Book Review: The Soul & The Sea: Essential Healing for Everyday Life

by Benig Mauger

ISBN: 1803411279

Reviewed by Ursula Somerville

I am pleased to write this review of Benig Mauger's new book *The Soul & The Sea: Essential Healing for Everyday Life*. Benig has been a good friend of this journal *Inside Out* in the past and most recently she delivered an online workshop as part of our (IAHIP) series of regional meetings in June 2022.

This book has personal, Jungian, and spiritual aspects, coming from within Benig and contained within 215 pages. Benig's unique style of writing invites the reader to lean into the story and visit the "rooms" she cleverly offers. "Rooms" which allow the reader to rest a while and ruminate in the memories which come to visit. It would be useful to have beside you a pen and paper to record your own creativity that will open up within you.

As I read the *Soul and the Sea*: *Essential Healing for Everyday Life* there is a real ethereal felt-sense for me because of how it is written and I was instantly brought to a soulful place as I settled into the beautifully presented book. Lovingly placed between the covers, which is sea blue and has a spray of waves on it, there is an invitation for the reader to engage with the author and you want to know more. Benig tells us she wrote this book while in lockdown in the early days of Covid 19 in her "soul home" in Connemara on the Wild Atlantic Way. It looks back on her life as a woman who was born to love, and she weaves in both Jungian depth psychology and spirituality to help bring to life her experiences as a loving woman and as a therapist. She uses inspirational quotes from Rumi, and Rainer Maria Rilke, and Mary Oliver. Perhaps, most importantly, she introduces us to her spiritual master, Sai Maa, as she describes her influences on her and, in part, dedicates the book to her.

She tells us, early on, that "… healing was not simply a matter of will… I understood the mystical nature of transformation and healing" (p. 1). This sets the tone of the book, and she deftly brings us through coloured "rooms", each colour representing a healing nature: the red room, the pink room, the blue room, the rose room, the green room, the purple room. The room I wanted to remain in was the green room which starts out with nature and the Soul. This section opens with a beautiful quote from Heraclitus: "You could never arrive at the limits of the Soul, no matter how many roads you travelled, so deep is its mystery" (p. 113). Once in the green room, Benig is accompanied by the Earth Goddess who tells her: "Write about creativity; write about renewal and new life, write about how deep is our soul" (p. 112). In this room we visit our complexes and Benig asks us to "trek our soul" (p. 120). By this she means be creative and do not be led astray by a strong ego, rather, go to the deep sense of self. In the green room she introduces us to "inner archetypes" (p. 120) which may get in our own way and

names them as “Victim, Prostitute, Child and Saboteur” (p. 123). I understand, from Benig’s writings, that we must not be afraid of meeting these archetypes if we can become creative. Before we leave the green room, we will have been exploring a “healing from within” (p. 126) and, to augment the creative side of healing and transformation, she offers a “workbook and exercises” section which help us “change our patterns” (p. 128).

I have highlighted just some of the “rooms” but there are also rooms for birth, life and death, all of which are powerful testaments to our living experience. I would certainly encourage reading this book as it will open your creative side and much more besides. For such a small book there is a wealth of resources in it for everyday living, as both a human and a psychotherapist.

Ursula Somerville, MIAHIP, SIAHIP, is a psychotherapist and clinical supervisor who aligns herself with the teachings of Carl Jung and has completed an MA in Art, Psyche and Creative Imagination.

An introduction to The Mary Paula Walsh Library

by Kay Conroy

There is a charcoal portrait of Dublin's first chief librarian in the archive of the National Gallery.

The portrait is of Róisín Walsh. Róisín Walsh was a feminist, republican, educationalist, linguist and one of the world's first female head librarians.

She was born in Co. Tyrone in 1889, educated at St. Louis Convent Monaghan, Dominican Convent Eccles Street, UCD and Cambridge. She lectured in English and Irish, was involved in the nationalist independent movement, lectured on Irish language folklore and culture across Europe and America and was appointed chief national librarian in Dublin in 1931.

Her motto "Revolution by Education" promoted changing Irish society through education and the diffusion of knowledge. She believed there could be "no progress until the people have been educated first."

As the chief librarian she ensured access to books by expanding all library services nationally, especially for those who could not afford the privilege of education at the time.

She encouraged books in Irish and by Irish authors and developed and expanded libraries in Inchicore, Drumcondra, Phibsborough and Ringsend in the socially expanding city of Dublin in the 1930s.

The Portrait of Róisín Walsh, now in the archive of the National Gallery, is by Seán O'Sullivan and it was presented to the National Gallery by her niece Mary Paula Walsh in 2017. Mary Paula died in April of 2017. She was co-founder of Turning Point and as a pioneering social scientist and psychotherapist, she followed closely in the innovative and visionary footsteps of her Aunt Róisín.

This new library – internal to Turning Point – is to be named *The Mary Paula Walsh Library* in memory of both her and Róisín Walsh's pioneering leadership, initiatives and legacy. All of us depend on the knowledge and the experience of others. All of us are richer for the local, national and international works, texts, thoughts, information, writings, and narratives throughout all disciplines. That is how we connect and learn and expand.

The development of *The Mary Paula Walsh Library* is an investment in social, intellectual and emotional progression. This is one of the central objectives of how Mary Paula Walsh and I imagined and developed Turning Point in 1986 to what it is today. In the preface to her book, *Living after a Death,* Mary Paula writes of the hope that her book can become a companion to those who might feel the weight of grief and despair following a death. Such a hope parallels both the core of Turning Point™ and the aim of this new library. The library is where all students can find a route to knowledge and be free to explore and understand a sense of themselves. Reading brings a personal world and the world of others alive in the mind of the reader.

The Mary Paula Walsh Library is to be a companion to all students and readers, developing their personal journeys before they accompany others on their journey towards individual healing.

As C. S. Lewis was told by one of his students, “We read to know that we are not alone.”

All the journeys of life are to be found in libraries.

They are all there.

In a million forms.

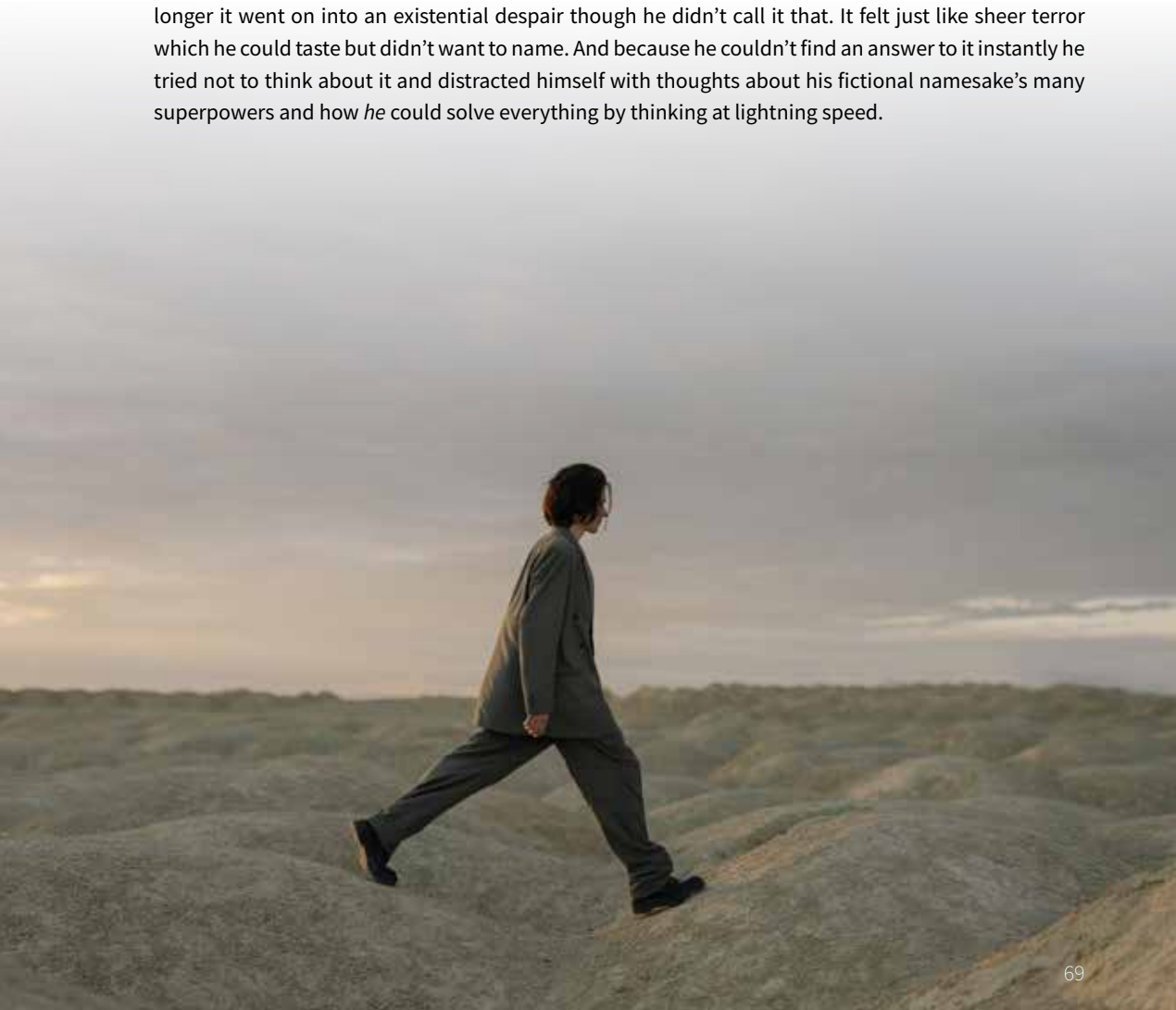
The Mary Paula Walsh Library is for all students of Turning Point and beyond.

Mary Paula Walsh
1941-2017

Flash fiction

by Paul Daly

Always in a hurry to do things he had long ago picked up the nickname, Flash. He wore his assumed moniker like a cape, reveling in feats of alacrity whenever he was in company, driven by a nervous energy that propelled him to answer questions before they were half asked, talk at breakneck speed, order the first round before the others had sat down and walk everywhere as if he were in a race. He always seemed to be running away from life, from people, from his past, from his future, from the present moment. When he was alone at home it was a different story. Then he was plain Peter, his superpowers discarded like a costume. But he didn't really relax even at home. When he looked in the mirror to shave it was a furtive glance as if he were afraid of what he would see. He wasn't out to impress or to escape anyone so his actions were less frenetic but the radio or TV were always on and he regularly scanned the news headlines on his phone to see if some new disaster had occurred. In those rare moments when there was extended silence like when there was a power cut or his phone died and he couldn't immediately find a charger he felt a vague dissatisfaction which sharpened the longer it went on into an existential despair though he didn't call it that. It felt just like sheer terror which he could taste but didn't want to name. And because he couldn't find an answer to it instantly he tried not to think about it and distracted himself with thoughts about his fictional namesake's many superpowers and how *he* could solve everything by thinking at lightning speed.



INSIDE OUT

The Irish Journal for Humanistic and Integrative Psychotherapy

Ordering *Inside Out*

Inside Out is published three times a year and is delivered free to members of the Irish Association of Humanistic and Integrative Psychotherapy. Non-members are welcome to subscribe to Inside Out or to purchase individual issues. Members may also purchase additional copies of journal issues. Each journal issue costs €7.

To place an order please visit the IAHIP website at https://iahip.org/inside-out

Advertising with *Inside Out*

To enquire about advertising with ***Inside Out*** please contact the IAHIP Office by email at admin@iahip.org or by phone at (01) 284 1665

Advertisements may be submitted and paid for online at http://iahip.org/payments

Further information about rates, deadlines and formatting requirements are available at https://iahip.org/inside-out

Information for Contributors

For information on formatting requirements and guidelines please visit:
https://iahip.org/inside-out

The Space...

New Beginnings

On the first day
you said
let's go easy.

On the second
you said
that sounds hard.

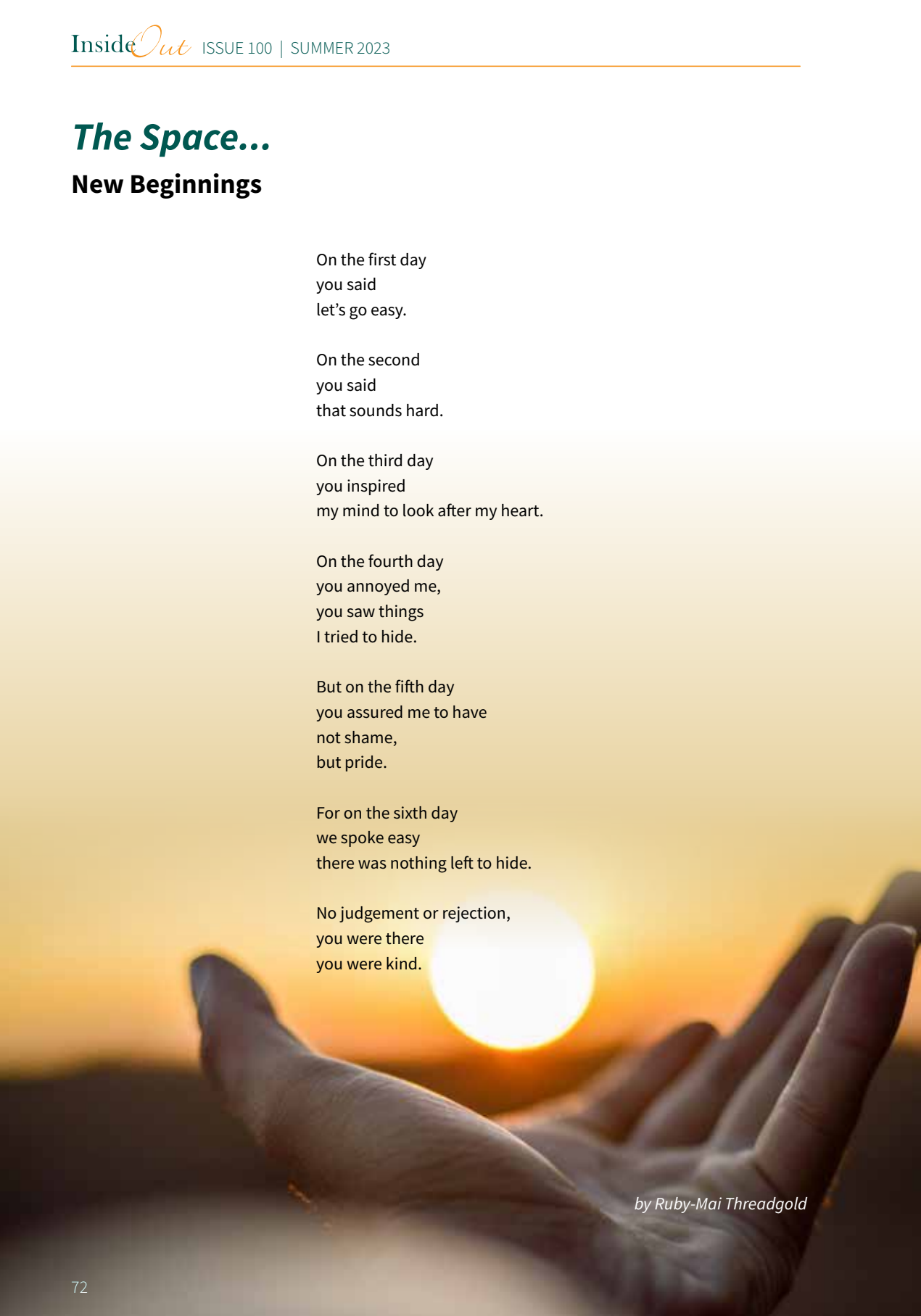
On the third day
you inspired
my mind to look after my heart.

On the fourth day
you annoyed me,
you saw things
I tried to hide.

But on the fifth day
you assured me to have
not shame,
but pride.

For on the sixth day
we spoke easy
there was nothing left to hide.

No judgement or rejection,
you were there
you were kind.



by Ruby-Mai Threadgold

OCT 14 - 15 2023

CASTLETROY PARK HOTEL
Limerick

Gestalt Institute of Ireland
Irish Gestalt Centre

GESTALT INSTITUTE OF IRELAND CONFERENCE

MOVING SENSING FEELING BODIES

Renewing Hope in a Fracturing World

A conference that seeks to gather a community of practitioners to explore forms of vitality that are of our embodied relational situations, full of possibility in a world of uncertainty.

Keynote Speakers:
Peter Philippson
Eliat Aram
Larysa Didkovska
Billy Desmond
Peri Mackintosh

and live online contributions from

Margherita Spagnuolo Lobb
and **Richard Hycner**

Early Bird Rate Available up to end June
Full Fee: €260 | Student: €240

Registration from 1st July 2023
Full Fee: €290 | Student: €260

www.gestalt-institute-of-ireland-conference.org

ISSN 0791-7325

InsideOut

IAHIP Irish Association of Humanistic and Integrative Psychotherapy

40 Northumberland Ave, Dun Laoghaire, Co. Dublin