

The Irish

Journal of Counselling and Psychotherapy

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- Working with Transgender People
- Fertility: What the statistics do not measure
- Therapy in the 21st Century. A pimped profession?
- Something Larger: On sharing therapeutic case notes with children and young people

Look Again

The logo for the Irish Association for Counselling and Psychotherapy (iacp) features a stylized orange and yellow circular icon to the left of the lowercase letters 'iacp' in a blue, sans-serif font.

Irish Association for Counselling and Psychotherapy

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Our Title

In Autumn 2017, our title changed from "Éisteach" to "The Irish Journal of Counselling and Psychotherapy" or "IJCP" for short.

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Each issue of IJCP is planned well in advance of the publication date and some issues are themed. If you are interested in submitting an article for consideration, responding to the Therapist's Dilemma or wish to contribute a book or workshop review or Letter to the Editor, please see 'Guidelines for Submitting Articles' on the IACP website, www.iacp.ie.

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From the Editor:

Content



Dear Colleagues,

In counselling and psychotherapy we learn to “look again”. Our first glance can be reactive, reductive, unseeing or prejudiced and we know the risks of acting out of such places with clients. Even if our first instincts are accurate, it pays to spend longer trying to verify them. Looking again, where we make the effort, helps us to engage, to explore, to appreciate or to re-imagine. “Respicere” the Latin verb “to look again” is at the very root of “respect” – a core value of our profession.

In this, our summer edition, we make the effort to engage and explore with the transgender community to understand what they want of us as counsellors. Ms Terri O’Sullivan of Cork Counselling Services worked closely with TENI - the Transgender Equality Network Ireland (TENI) who seek to improve conditions and advance the rights and equality of trans people and their families. The resulting article aims to support us working with transgender clients to provide informed and sensitive care. It looks to bring us up to speed with terminology and guidelines from the transgender client’s perspective.

Our second paper looks again at fertility, and specifically the struggles and anguish experienced by those facing fertility issues. Esther O’Neill encourages us to explore beyond the coldly captured and high level statistics to appreciate a myriad of unique and often complex client experiences that may lie underneath. It can be easy to overlook fertility issues that are subtle and unannounced to the world, yet cause turmoil in hearts that are hidden to the undiscerning first glance.

Sheila Peelo, in our third article, takes another look at the provision of subcontracted “brief counselling to the workplace” through independent providers. Her exploration leads to strong and passionate criticism, and to a stark warning against the pimping of the counsellor and the exploitation of our profession. She makes the case that therapeutic care is being stripped back to something which is commercially attractive and divorced from its therapeutic roots. She sees dangers where others may not, and even if we disagree, we all gain by the engagement.

For many counsellors, our first take on writing client notes may be one of duty, ethical compliance and

effort. In our fourth article, Mike Moss charmingly re-imagines the writing of client notes. His article is an attempt to focus on how writing therapeutic notes and offering to share them can be an integral part of the therapeutic experience (instead of a left-over) and may become part of the healing process for clients.

We hope these articles will provoke you to change perspective, to re-imagine, to look again and to enjoy your work.

Before we sign off, a Call to Action! If you are an IACP accredited counsellor or psychotherapist and have an ethical or professional dilemma, we want to hear from you! Is there some aspect of your work about which you would like to solicit input from the wider IACP community? Perhaps you are questioning social media use or online counselling? Maybe the past or the future of our profession, concerns you? Maybe you are wondering when to disclose or not disclose or maybe you are struggling with an issue relating to professional boundaries or confidentiality that challenges your own moral standing or internal values? This is an opportunity to have your thoughts aired for input, feedback and maybe even guidance or support. If you would like to see your thoughts published (anonymously or attributed) in a future issue of the Irish Journal of Counselling and Psychotherapy (IJCP), please forward it by email to ijcp@iacp.ie We look forward to hearing from you.

In the meantime, we wish you a really good summer.

Hugh Morley

Academic Article

Working with Transgender People

This article is written by the Transgender Equality Network Ireland (TENI) in conjunction with Ms. Terri O’Sullivan of Cork Counselling Services. It received input from the HSE and was sponsored in 2018 by a grant from the Community Foundation for Ireland. There is a useful glossary at the back of this article.



“The expression of gender characteristics, including identities that are not stereotypically associated with one’s assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative.”

World Professional Association of Transgender Health (WPATH)

Introduction

This article is intended to support counsellors working with transgender people and their families to provide informed and sensitive care to their clients.

Transgender people are individuals whose gender identity or gender expression is different from the sex assigned at birth. Gender identity is the internal sense of being male or female, neither or both.

We all have a gender identity. Some transgender people may medically transition and undergo hormone

replacement therapy and/or surgery to align their bodies with their gender identity.

Transgender people have a variety of needs relating to their healthcare including access to mental health, medical transition and primary care services that are sensitive to their identities and experience.

Terminology

A **transgender person** is an individual whose gender identity and/or gender expression differs from the sex assigned to them at birth. This term

can include diverse gender identities such as: transsexual, transgender, crossdresser, genderqueer, non-binary, gender variant or differently gendered people.

Not all individuals with identities that are considered part of the transgender umbrella will refer to themselves as transgender. For some, this may be because they identify with a particular term (such as transsexual or genderqueer) which they feel more precisely describes their identity. Others may feel that their experience is a medical or temporary condition and not an identity (for example they feel they have gender dysphoria but are not transgender). In reality there are many identities under the trans umbrella.

On the other hand, some people who undergo gender-transition may not identify as transgender and may request that they are referred to in the gender that they identify as. Therefore, it is always good to ask the client how they identify, as this validates their identity, which may facilitate a therapeutic relationship with their counsellor. Counsellors will already be familiar with how human beings struggle with being categorised by others as opposed to identifying themselves.

Gender nonconformity refers to the extent to which a person’s gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex

assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only some gender non-conforming people experience gender dysphoria at some point in their lives. In the current Irish context a diagnosis of “gender dysphoria” (by a Psychiatrist) is in practice required to access hormones or surgery through the public healthcare system. According to the Diagnostic and Statistical Manual V (which psychiatrists use), people who experience intense, persistent gender conflict can be given the diagnosis of “gender dysphoria” (American Psychiatric Association, 2013).

The Prevalence of Transgender People in Ireland

The prevalence of transgender people in Ireland is difficult to estimate as there is no official collection of this data. GIRES, a UK-based organisation, estimates that 1% of individuals may experience some degree of gender variance or non-conformity and approximately 0.2% may undergo transition (Reed, 2011).

In a recent study, researchers from the Department of Endocrinology in St. Columille’s Hospital (SCH), Loughlinstown, Dublin reviewed the medical records of 218 patients and estimated prevalence of gender dysphoria at 1:10,154 male-to-female (MTF) and 1:27,668 female-to-male (FTM) individuals in the Irish population (Judge et al, 2014). However, these figures only include individuals seeking medical services from SCH and exclude those who are seeking treatment elsewhere or who do not medically transition. Nonetheless, the researchers suggest that the number of patients accessing services is steadily rising. This is particularly true for children and adolescents. Specialist gender identity services internationally have observed increases in referral rates of adolescents in recent years (Aitken

“Issues that emerge in psychotherapy with transgender people are the same ones that emerge for anyone else, issues of self and self-in-relation, autonomy and connection, identity and intimacy”

(Fraser, 2009, p. 127)

et al, 2015, Kaltiala-Heino et al, 2015).

Your Role as Counsellor

There are a myriad of reasons why any client comes for counselling and it is important not to assume that transgender clients are coming to counselling to discuss gender issues. However many transgender clients will present for counselling with particular concerns related to their gender identity or gender expression, or these may arise during the course of counselling. It is important that counsellors working with transgender clients seek to create and promote clinical practice that is inclusive, affirming, and supportive of clients with varying gender identities and expressions.

Being well-educated and sensitive to transgender issues enhances the likelihood of creating a trusting and authentic relationship with the client and impacts on clients’ positive experience of counselling (Bensen, 2013). This document aims to assist counsellors in becoming aware of and understanding transgender issues, and aims to help with the provision of effective and affirmative counselling for transgender people. This document is not a substitute for training. Counsellors should be aware that Transgender Equality Network Ireland (TENI) currently provide effective training in this area to various sectors in Ireland including the HSE.

Below are some of the issues for

which a transgender client may seek support in counselling:

- Experience of gender dysphoria
- Confusion about gender identity or concept of their own gender
- Exploring or changing to a new gender expression
- Wanting help in finding ways to express their gender identity physically and socially
- Transitioning physically and requiring psychological support in doing so
- Requiring support around the use of physical and medical interventions
- Depression, anxiety, self-harm, suicidal ideation or attempts as a result of gender dysphoria or transgender related issues
- Experience of stigma, discrimination, violence, and related trauma experiences
- Internalised transphobia
- Seeking referral for medical interventions
- Navigating changes in family
- Navigating social transition and every-day life
- Resilience

Mental Health of Transgender People

There is a high incidence of suicide, self-harm and depression amongst transgender people. Delays in accessing essential health-related support to enable social and/or physical transitioning can exacerbate these risks.

In 2013, TENI published *Speaking from the Margins*, the largest study of transgender people in Ireland (N=164), which found:

- High levels of suicidal ideation with a lifetime prevalence of 78% thinking about ending their lives. Forty percent of those with suicidal ideation had made at least one attempt, with 8% of these attempts being in the previous year.
- A substantial number of the participants reported having self-harmed at some point in their lives (44%), with 6% currently self-harming.
- Common experiences of stress (83%), depression (82%) and anxiety (73%) were reported.

The report also found that transition had a positive impact on a transgender person's mental health, with 75% of participants reporting they felt that their mental health had improved, compared to 6% who felt it was worse since transition. The positive impact was even more significant in terms of suicidal thoughts and behaviour; with the majority of respondents reporting that they thought about or attempted suicide less after transition. It was reported that 81% thought about or attempted suicide more before transition, and only 4% doing so after transition (McNeil et al, 2013).

Whilst as counsellors we may frequently be presented with issues of suicidal ideation, self-harm, stress, depression and anxiety it is important to recognise the prevalence of these issues within this particular community and the intensity of suffering a transgender client is likely to be experiencing, or have experienced. This suffering is thought to be related to negative social attitudes and societal

misunderstandings rather than identifying as transgender per se.

Guidelines for Working with Transgender Clients

The American Psychological Association published Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (2015). These guidelines are a useful resource (see References). Below are a number of points that are informed by this document and are of relevance to counsellors working with transgender clients.

Non-binary view of gender identity and expression

- In many cultures gender is seen as a binary construct. It is assumed you are either male or female and that your gender identity matches your sex assigned at birth. However research has shown that there is a range of gender identities and gender expressions that go beyond the male – female binary.
- The reality for transgender people is that their gender identity differs at varying degrees to the sex assigned at birth and may be experienced or expressed outside of this binary.
- A non-binary view of gender, and the understanding that gender expression can differ to sex assigned at birth, is essential to the provision of affirmative counselling to transgender clients.
- This also involves moving beyond a binary view of transgender, recognising that not every transition is either male-to-female or female-to-male. Clients may identify as neither man nor woman, a blend of man and woman, or a unique gender identity.

- Further, gender identity can develop and vary over the lifespan.

Distinction between gender identity and sexual orientation

- The sexual orientation of transgender clients is a separate identity to that of their gender identity and should never be presumed or assumed.
- As gender-variance is often assumed to be evidence of homosexuality, clients who are confused about gender identity issues may actually describe their feelings in terms of confusion about their sexual orientation.
- Due to lack of knowledge and confusion regarding their gender identity and sexual attraction etc. transgender people may assume they are gay, lesbian, bisexual or queer which may prevent their awareness of their transgender identity.

Non-pathological viewpoint

- It is fundamental that counsellors recognise that gender nonconformity and gender dysphoria is not a pathology in itself. It is a natural expression of human development and experience. However, people can experience significant distress as a result of gender dysphoria and social discrimination.
- Having respect for a client's gender identity enhances a transgender client's experience of counselling/psychotherapy.

Acknowledgement of stigma and discrimination

- Counsellors should be aware of the impact of stigma, prejudice, discrimination, and violence on the health and well-being of

transgender clients.

- Discrimination and anti-trans prejudice can be experienced from the subtle to the severe. Areas of discrimination include, but are not limited to, in education, employment and the workplace, access to social services etc.
- Transgender people who hold multiple marginalized identities are more vulnerable to discrimination and acts of violence or other bias motivated crimes against them.

Awareness of own competence in working with gender identity issues.

- A lack of knowledge of and training in gender identity and gender expression issues can hinder the effectiveness of counselling (Rachlin, 2002).
- An openness to identifying gaps in our knowledge and a willingness to educate ourselves is crucial. Whilst it can be helpful and necessary to ask our clients in an open and respectful manner about their experience, it is also the counsellor's responsibility to educate themselves with regards to working with transgender people. This prevents our clients from spending their time in therapy educating their counsellor.
- Counsellors educating themselves includes:
 - Understanding the unique issues that transgender clients face
 - Being familiar / current with the language used by transgender clients to refer to gender identity
 - Knowing what resources, referrals and processes are available

- Understanding the historical, political and cultural background of transgender people.
- Being educated in transgender related issues and the language used allows us to be authentic, respectful and attuned when relating to our clients in regards to the intricacies of gender identity.
- Seeking consultations with counsellors and psychotherapists who have expertise in working with transgender clients can be useful. As can accessing the resources available on www.teni.ie or attending training provided by TENI.
- Reflecting on the ethical issue of competence, and recognising both the boundaries of our competence and limits of our expertise is essential for safeguarding our clients.

Awareness of own gender identity related attitudes and their impact on the therapeutic relationship.

- In order to prevent further prejudice towards our clients and to ensure the development of the therapeutic relationship we need to identify our own gender identities, biases and expectations.
- Questions for counsellors to honestly ask themselves include:
 - What are your fears and prejudices in working with transgender clients?
 - What are the gaps in your acceptance of transgender clients?
 - What assumptions do you make about gender, gender development and gender expression?
 - How comfortable are you working with a transgender client?

- Becoming aware of and challenging our own prejudices will allow us to recognise how our beliefs may be influencing the therapeutic process and help to prevent our unconscious collusion with the client's own internalised transphobia (Milrod, 2000).
- Transference and countertransference will need to be brought to clinical supervision in order to safeguard the client and the therapeutic relationship.
- As we have an ethical responsibility to avoid harming our clients it is necessary to monitor are we able to work with this client in a way that meets their best interest or is there need to refer to another counsellor?

Guidelines by Client Profile

The profile of the client may impact how you as a counsellor work with the client. Below you will find details about some of the more specific issues to be aware of when counselling adult transgender people, children and young transgender people and family members of transgender people.

A. Adults

- When beginning to work with a transgender client discuss the name and pronoun they, and you, would like to be addressed by. This may be an ongoing conversation.
- Access to bathrooms and feelings regarding safety in your work building should be addressed.
- Issues of confidentiality need also to be discussed. Ensuring that time is given to discussing how you and

your service will safeguard the client's confidentiality, what their preferred means of correspondence from you or your service is and what data is stored in relation to them may help ease a transgender client's concerns around confidentiality and privacy.

- Psychoeducation can be an important role of the counsellor. A client may be experiencing considerable confusion and anxiety about their experience. The counsellor may need to provide information about transgender identities to help them understand the discordance they are experiencing. They may also need to assist the client in distinguishing between issues of sexual orientation and gender identity.
 - Counselling can be lengthy as the client works to sort out their own transgender needs, balancing these with needs of family, back and forth for many years. Disclosure issues may also continue throughout the lifespan with the establishment of new relationships (friends, co-workers, partners, etc.)
 - Fostering self-acceptance and providing validation is an important role of the counsellor, as is helping the client enhance their resilience and coping skills when dealing with painful experiences. The emerging, authentic self may be very vulnerable (Bockting, Knudson, Goldberg, 2006).
 - Developmental tasks that were previously disrupted or put on hold because of gender dysphoria are often taken up once comfort with one's gender identity has been achieved (Bockting, Knudson, Goldberg, 2006). For many, this includes the development of sexual and intimate relationship. Issues relating to sexual identity, intimacy, sexual functioning, safe sex, relationships etc. may need to be explored in counselling.
 - Grief and loss are common experiences of transgender people, even after social or physical transitioning has occurred. This may include a loss of work as well as rejection by family, friends, and community. There may also be a feeling of loss of direction, loss of time, or a mourning for the idealised image of the self before surgery.
 - Clients who have been much focused on surgery to the exclusion of other life goals may need support to explore other directions in their lives once the long sought after surgery has been achieved (Bockting, Knudson, Goldberg, 2006).
 - There are power differentials inherent in every counselling relationship. Consider the impact of gender and cisgender related privileges on the therapeutic relationship (Hund & Thomas, 2015). As transgender people are often the victims of oppression we need to consider how we help to empower our clients and in what ways might we be disempowering them?
- B. Children and Young People¹**
- The gender developmental stage of a transgender child is likely to determine the emotional and psychological challenges that they experience (Brill & Pepper, 2008). As a child begins to become more aware of the external world and society's expectations, gender dysphoria may begin to develop, heightening at puberty.
 - During the ages of 5 and 7 a child begins to realise that their gender is not going to change, and may experience embarrassment as they receive cues from family and society that gender variant behaviour is wrong.
 - From 9 to 12 the child is likely to begin to experience puberty and may feel that their body is betraying their true self. Increased awareness of the external world's expectations serves to heighten distress. Some may reject what is their preferred gender in order to conform. Depression and self-destructive or harming behaviours may be seen at this point (Bernhall & Coolhart, 2012).
 - During adolescence the young person may feel like they are going through the wrong puberty. Experience of social anxiety, depression and withdrawal risk increases. As the body develops, aversion to it or part of it and a dissociation or experience of a disembodied self can emerge (Fraser, 2009).
 - Not all children and young people who are experiencing gender non-conformity will persist in a transgender identity into adulthood (American Psychological Association, 2015)

¹This information is for educational purposes only, counselling a transgender child is complex and requires specific training and awareness. Please refer to your professional accreditation organisation.

Providing effective counselling to children and young people can involve:

- Working with a young person to explore their feelings and allowing them a space to explore their gender expression.
- Helping the young person towards self-acceptance. The client may decide to relate in their preferred gender, thus providing an opportunity for the young person to authentically relate in their preferred gender (Fraser, 2009). Reinforcing this authentic self and providing empathy and compassion for it is critical.
- Providing education and information about gender identity issues to the client and their family.
- The possible need for referral for a formal diagnosis of “gender dysphoria” in order to have access to future hormone treatment (after the age of 16 in Ireland) / hormone suppressants (following the required number of assessments).
- The provision of information regarding community services and support groups for the young person and their family which can help alleviate feelings of isolation (Bernhall & Coolhart, 2012). See resources list.
- Helping the young person and their family in navigating the school systems.

C. Families

- It is important that parents are encouraged to accept ambiguity in gender identity as their child or adolescent develops and explores their gender identity, and that the importance of not pathologising

“Cognitively, families need to mourn and reconcile changes to the family identity. Therapists can help families to validate emotions, increase social support and provide accurate information on Transgenderism.” (Zamboni, 2006)

the gender expression of their child is understood (Barrow, 2014). It may also be necessary to help prepare the family for potential negative reactions and prejudice from society as a result of their child or siblings social or physical transitioning.

- There are community and social supports available to families. TransParenCi is a peer support group for parents and family members of trans people, which was formed and facilitated by TENI staff. These groups hold monthly meetings in Dublin, Cork, Waterford and Kerry. They also run residential weekends. They can link families with other family members who have had similar experiences for a phone conversation and support (See resource section or www.teni.ie).
- Significant others, family members, or friends may come to counselling to address their own concerns relating to a loved one’s disclosure of being transgender or the impact of transgender issues on their relationship over time. In some cases, they may participate in family or relationship counselling as part of a transgender person’s, or their own, therapeutic process (Bockting, Knudson, Goldberg, 2006). ☺

Resources

Health Services

Health Service Executive

Phone: (056) 77 84100

Website: www.hse.ie

Address: Primary Care Unit, Lacken, Dublin Road, Kilkenny.

National Groups

BeLong To Youth Services

Provides support for LGBT youth 13-24.

Phone: 01 670 6223

Website: www.belongto.org

Address: Parliament House, 13 Parliament Street, Dublin 2, Ireland

Transgender Equality Network Ireland (TENI)

Phone: 01 873 3575

Email: info@teni.ie

Website: www.teni.ie

Address: Unit 2, 4 Ellis Quay, Dublin 7, Ireland

Transgender peer support groups exist across Ireland. See www.teni.ie for more information.

Family Support

Gender Identity Family Support Line (TENI & LGBT Ireland)

Every Sunday 6pm - 9pm

Phone: 01 907 37 07

TransParenCi- National family support group for transgender people

Email: transparencigroup@gmail.com or office@teni.ie

International

Gender Identity Research and Education Society (GIRES)

Phone: 01372 801554

Email: info@gires.org.uk

Website: www.gires.org.uk

World Professional Association for Transgender Health (WPATH)

Email: wpath@wpath.org

Website: <http://www.wpath.org/>

GLOSSARY

Cisgender: A non-trans person (i.e. a person whose gender identity and gender expression is aligned with their sex).

Crossdresser: A person who wears items of clothing commonly associated with the opposite sex.

Gender dysphoria: Refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only some gender non-conforming people experience gender dysphoria at some point in their lives.

Gender expression: The external manifestation of a person's gender identity. Gender can be expressed through mannerisms, grooming, physical characteristics, social interactions and speech patterns.

Gender fluid: Is a non-binary gender identity. Gender fluid individuals experience different gender identities at different times. A gender fluid person's gender identity can be multiple genders at once, then switch to none at all, or move between single gender identities. Some gender fluid people regularly move between only a few specific genders, perhaps as few as two.

Gender identity: Refers to a person's deeply-felt identification as male, female, or some other gender. This may or may not correspond to the sex they were assigned at birth.

Gender nonconformity: Refers to the extent

to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.

Gender queer: Is a non-binary gender identity.

Gender variant: People whose gender identity and/or gender expression is different from traditional or stereotypical expectations of how a man or woman 'should' appear or behave.

Non-binary: Refers to gender identities that fall outside the gender binary of male or female. This includes individuals whose gender identity is neither exclusively male nor female, a combination of male and female or between or beyond genders. Similar to the usage of transgender, people under the non-binary umbrella may describe themselves using one or more of a wide variety of terms such as: gender fluid, genderqueer, etc.

Sex: The designation of a person at birth as male or female based on their anatomy (genitalia and/or reproductive organs) or biology (chromosomes and/or hormones).

Transgender person: Refers to a person whose gender identity and/or gender expression differs from the sex assigned to them at birth. This term can include diverse gender identities such as: transsexual, transgender, transvestite, non-binary, and gender variant or differently gendered people.

Trans man: A person who was assigned female at birth but who lives as a man or identifies as male. Some trans men make physical changes

through hormones or surgery; others do not.

Trans woman: A person who was assigned male at birth but who lives as a woman or identifies as female. Some trans women make physical changes through hormones or surgery; others do not.

Transphobia: The fear, dislike or hatred of people who are trans or are perceived to challenge conventional gender categories or 'norms' of male or female. Transphobia can result in individual and institutional discrimination, prejudice and violence against trans or gender variant people. **Internalised transphobia** is discomfort with one's own transgender feelings or identity as a result of internalising society's normative gender expectations.

Transition: A process through which some transgender people begin to live as the gender with which they identify, rather than the one assigned at birth. Transition might include social, physical or legal changes such as coming out to family, friends, co-workers and others; changing one's appearance; changing one's name, pronoun and sex designation on legal documents (e.g. driving licence or passport); and medical intervention (e.g. through hormones or surgery).

Transsexual: Transsexual is generally considered a subset of transgender, but some transsexual people reject the label of transgender

For a more complete glossary of transgender terms please visit www.teni.ie/trans_terms.

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Practitioner Perspective

Fertility: What the statistics do not measure

By Esther O'Neill



The lives of those affected by difficulties with fertility are often coldly captured and represented by percentages and statistics, sorely neglecting the struggles and anguish that those facing fertility issues experience.

It is also likely that in the minds of many, these statistics are most often associated with the story of a couple. Isolated are the lives and hearts of those who may also be in turmoil as a result of issues relating to fertility. For example: the woman who had once hoped to have children but who has now entered menopause; the person who, due to medical or health reasons, will never conceive their own biological child; or those who are not in a relationship and who fear that the opportunity to have children is slipping away from them.

Some weeks you are grief stricken. How do you face the world when you are grief stricken by a loss that is not seen by so many?

Each story is unique and complex beyond words. However, what each person is likely to have shared is the discovery of how intense emotions and feelings related to fertility can be, and how impermeable these emotions and feelings are to rational thought.

Other people's stories of heartache around fertility often draws me back to my own years of struggles with fertility.

The loss of a loved one can be compassionately understood by many, but the loss of the baby that you have not yet welcomed into the world, or not yet conceived,

or perhaps are *never* likely to conceive, is often a loss that is carried privately and with grave sadness due to the lack of compassion and understanding by the outside world.

Never. How painfully impossible it feels to confront or contemplate that word.

Some weeks you are grief stricken. How do you face the world when you are grief stricken by a loss that is not seen by so many?

Another Christmas passes, a new year begins. A birthday approaches, another bitter sweet date on the calendar goes unnoticed. The birth of someone else's baby arrives to celebrate, and still you remain in limbo. You console yourself by saying it will all be different for the next new year, because it has to be, because surely you can't survive another year feeling like this.

This is the perpetual loss those experiencing fertility issues face.

Your heart sinks as your period arrives unapologetically and you feel so foolish for having ever hoped and dreamt that this could be the month where it all changes.

Your body is like an infuriating stranger, completely shut off from what you long for, and no matter how much you protest or the great lengths that you go to, it carries on oblivious to your pleas.

Anger steadily and silently rises with every story that is recounted to you about the woman who just stopped trying to conceive and it became as simple as that to become pregnant. How isolating it is for your pain and circumstances to be so sorely misunderstood.

Lives change, families are built. You standstill.

In your darker moments you search for the answer to what you have done to deserve this

The only wisdom I can impart is to wholeheartedly encourage you to recognise the importance of caring for your emotional needs and the health of your mind as you face this epic battle. Create the space and quiet within your life to care for yourself and to listen to your heart. From there you will find your way.

pain? Your greatest vulnerabilities and your darkest wounds are put forward as some sort of cruel and deserving rationale.

There are days when the intensity of these emotions are like a deep, powerful sea living just below the surface that at any point could turn into a tsunami wave ready to take you down.

To cope with this sea of emotion, you employ coping mechanisms. Sometimes these coping mechanisms are your blind spots. Sometimes you are very aware that you use them. Yet, to challenge you to let go of these survival strategies without giving you anything in return, is to elicit a state of panic that isolates you even further and causes you to cling to them more fiercely for fear that you may be left destitute and shattered without them. Each person on this path faces unique and painful questions.

- How does a person lift themselves up when they are at what feels like their lowest point and summon the immense courage, energy, and strength required to embark upon another round of fertility treatment?
- How does someone trust the

future when it continues to arrive and pass and offer no reprieve?

- How does a person allow themselves to risk experiencing another miscarriage when their greatest joy was so abruptly turned into their greatest sorrow?
- How does someone begin to grieve for a future that they have not known, but that they always expected would one day be theirs?

This piece of writing is not concluded with a simple answer to these great struggles. The answer for each individual and each couple facing this battle is as unique as each person is in this world.

The only wisdom I can impart is to wholeheartedly encourage you to recognise the importance of caring for your emotional needs and the health of your mind as you face this epic battle. Create the space and quiet within your life to care for yourself and to listen to your heart. From there you will find your way.

I am grateful to a counsellor who provided me with the greatest support within my time of greatest pain. She created the conditions within the therapeutic space to welcome and hold all of my irrationally, my overflowing pot of emotions, my misplaced anger, my projections, my loneliness, my loss. From there I found my way. 

Esther O'Neil

Esther O'Neill is a psychotherapist and counsellor in private practice in Meath. Find out more about her practice Present Moment and view more mental health related articles and resources by visiting her website www.presentmoment.ie.

Practitioner Perspective

Therapy in the 21st Century. A pimped profession?

By Sheila J Peelo



Introduction

In this article, the author reflects on how short-term counselling has changed in the 21st century. The article focuses on the widespread provision of brief counselling in society and looks at how the market place has changed both the practice of counselling and the persona of the counsellor as a result. It suggests that brief therapy has been repackaged

as a specific intervention and tradeable commodity. Originating in the author's personal experience of dealing with independent counselling providers, the article goes on to question the new form of counselling which is available to the population and whether this represents change for the better. It concludes that the persona of the counsellor has largely been transformed into a 'method

delivery person' and pimped out to industry to deliver a 'commodity'. Finally, the author urges the profession not to collude with the undermining of counselling in this way.

There is no doubt that the practice of counselling and psychotherapy has undergone change over the years. Indeed, it would be improbable for the profession not to continue to develop, transform and alter over time and in response to society generally. However, not all change is good nor indeed growth promoting. When change shifts our viewing lens it also obscures other things from awareness and at times away from what is valuable. Recently, I have begun to wonder whether counselling has become just an 'intervention', driven from its philosophical roots as an interpersonal experience. If so, how have practitioners likewise been altered by this progress, if at all? In reflecting on this here, I use counselling as a generic term for therapy, counselling, psychology and psychotherapy and confine my ideas to the provision of short-term counselling.

The counselling relationship appears to be a tripartite one guided less by core values than by what sells and promises an outcome.

Some time ago I inquired about doing private therapy work with brief counselling providers. During an extensive search, I discovered a thriving counselling market, much of it available via the workplace or through independent providers. A huge section of the population can access brief counselling cost free. While it seems that counselling is thriving, I pondered the changes I noticed since I first trained. The abundance of large-scale counselling providers has reshaped counselling as an intervention and a practice whose governance is uncertain. The counselling relationship appears to be a tripartite one guided less by core values than by what sells and promises an outcome.

The Counselling Package

Very recently, I contacted such a provider to inquire about freelance work. I was responded to rapidly. The application process was detailed, demanding quality standards of practice and seemed quite impressive. I knew of the organisation's calibre and reputation and felt happy about registering as a possible provider. What took me by surprise, however, was the rate of pay which was below the normal trading rate for counselling generally. When I regretfully turned down their offer because I thought it not adequate nor reasonable, the response I received was even more puzzling. I was clearly and pointedly informed that the provider had very strict governance criteria and their rate of pay was fixed. My training, experience and qualifications were similar to the clinical manager I dealt with and yet this did not appear to be of value, in fact it seemed to be invisible. It made me question what was valuable to the provider. I wondered too if obscuring experience might allow

The 50-minute intervention could also be said to have greater appeal to management, thereby making it an attractive service. However, the '50-minute intervention' is also the product of commercialism and an ideology of outsourcing, rather than a natural evolution of counselling practice.

this provider to poach that very experience surreptitiously.

What's experience got to do with it?

What did this response convey to me with more than 20 years' experience in the public and private sectors as a psychologist, counsellor, psychotherapist and teacher? From one perspective, it might suggest that experience is irrelevant, the novice and veteran are to be equally rewarded. It might convey that the veteran adds no value, brings nothing extra. In business, industry and public service however, experience is routinely rewarded in terms of pay. Indeed, rewarding people adequately is a question of justice, something enshrined in the Universal Declaration of Human Rights and a powerful workplace motivator. Then again it could be argued that a 50-minute counselling session is what the provider costs and then sells to industry. The person of the practitioner is only important in as much as they can meet baseline criteria to deliver that product. More than baseline experience is not necessary to do the job. The fixed rate reflects the necessary and (and apparently) sufficient requirements for brief counselling interventions.

When that is broken down a little though there seems to be a built-in contradiction to that way of selling counselling. On the one hand, providers of counselling construe human beings as

constantly learning, developing, improving and excelling but at the same time, the reward offered the counsellor reflects a person who is static and one dimensional. Now that is a difficult position to defend, because to reward people financially at a fixed baseline rate only, is to disregard their ordinary tendency towards development. The very purpose of a counselling intervention is to help people to change and grow. I suggest that this contradiction, is very likely to have an influence on the overall impact of the work. It could indeed become a block to thinking within the counselling environment, and ultimately adversely affect the aim of client change.

The 50-minute intervention

Yet another viewpoint suggests that the counselling provider organisations furnish private practitioners with a regular and reliable income without the responsibilities of being an employee. There are certain advantages to working externally to organisations: greater anonymity for the client, greater distance from the influence of organisation culture, greater ability to resist competing demands (Torun 2015). The freelancer is arguably better insulated from the destructive influence of the organisation's culture (Shea and Bond 1997), something which could affect the delivery of the commodity. The 50-minute intervention could also be said to have greater appeal to management, thereby making

it an attractive service. However, the '50-minute intervention' is also the product of commercialism and an ideology of outsourcing, rather than a natural evolution of counselling practice. The stripping back of therapeutic care to something which is commercially attractive, value for money, accessible and effective has also shifted it away from its roots in counselling.

Outsourcing may well benefit many enterprises and services in several ways, not least in financial savings. Eliminating waste and improving efficiency may well be the rationale but are also trendy. Despite its benefits, outsourcing is a form of 'splitting', and something which has its own consequences for the organisation's consciousness and development. What was originally outsourced was a function + a person, however what is often bought back is a function. The counselling 'commodity' i.e. the 50-minute session, cannot so easily be divorced from the person of the 'deliverer'. The ethical principles upon which counselling is based are human values; being trustworthy, promoting wellbeing, avoiding harm, and respecting the client's right to be self-governing. These values are at the core of all counselling practice, regardless of worldview or style, and help to create a climate where something can change for the client **for the better**. This means that the 50-minute session relies essentially on a particular kind of relationship, a counselling one. The practitioner is not contingent to the commodity, but an essential interdependent part of the process. From my experience with some of these providers, what is at issue is a specific kind of 50-minute session and that is what is bought. It is

Accredited counsellors are 'pimped out' to industry, often for a reduced fee which can ignore experience and training. When the fee is then fixed for business reasons, then the whole basis of therapeutic practice is undermined.

essentially prescriptive. Though this is not entirely unusual in some forms of therapy, in my view it is problematic because practice can become a counsellor centred activity.

The commodity

Recently I have begun to reflect on this 'commodity' and how it has influenced the way counselling is practiced and taught in the 21st century.

As I see it, the 'commodity' is what is often traded, backed by research, showing it effective and helpful (McLeod 2010, Collins et al 2012). With the commercial emphasis on the commodity and its benefits, the relational aspect of counselling, and what I consider its central therapeutic value, is side-lined. The interpersonal experience has become contingent to the delivery of the commodity. The person of the counsellor is altered in such a business contract to an 'adequately skilled delivery person'. In such a scenario, accredited counsellors are 'pimped out' to industry, often for a reduced fee which can ignore experience and training. When the fee is then fixed for business reasons, then the whole basis of therapeutic practice is undermined.

Repackaged counselling

I argue that counselling has become an attractive and lucrative commodity, which easily trades on current ideas about mental health and wellbeing,

improved productivity and prompt intervention and prevention. When dismantled from a public health system or from corporate services and then managed by the enterprising private sector, counselling has been repackaged. It has become a valuable means of generating much needed cash for hard strapped public health sector providers. Strategically, such counselling tends towards a results-centric and management focused activity which, I believe, can compromise client agency. When the client only learns the solutions prescriptively, the method becomes the central focus of counselling and agency can be undermined (Peelo 2016). If the profession is not promoting client agency but rather the illusion of agency, then counselling itself has lost its way.

There are many influences on a results-centric counselling approach, not least of which are ideologies of 'evidence-based practice' and 'outsourcing'. Safeguarding, risk assessment, responding to actual threats as well as positive approaches to psychology have also influenced the way counselling is taught, practiced and regulated. Doing and producing are valued because they fit with the brief intervention model of counselling and, I argue, can misunderstand 'being with' or 'containing' the client in emotional distress.

Creating victims

Of course, brief approaches also move us all away from the

pain of experiencing the world. If the counsellor is 'pimped out' to the client, then valuing has already been violated and this will be felt at a system level. The counselling environment may then be changed and become a tension ground for control of the space and agenda. Subtle imposing or direct advice giving will become the method rather than human relationship skills. Replacing being with doing may relieve clients of the frustration of powerlessness but it also reinforces the idea that we are victims of our own misfortunes, something Walklate, (2006) refers to as the 'responsibilisation' narrative. It allows us the illusion that we can control adversities which may well rob us of our 'agency' as human beings. Agentic people are not just problem solvers but, crucially, they actively reflect, self-reflect and can change their whole meaning making when necessary. Therefore, counselling needs to respond to clients from that position if it is to create a meaningful climate of change for the client.

'Doing', though, as part of a counselling relationship and client choice, is growth promoting and evidence of agency. Joseph (2013) tells us that when people feel valued, they are more likely to be open and honest in the counselling room, grounding change in values. Such change, not imposed because of another agenda, is change that supports the emotional and psychological wellbeing of the client and is agentic. It is the value placed in the human interaction, the life-enhancing counselling relationship and the respect for autonomy which builds client personal growth. It is the integration of conditions which cultivate change with a focus on outcomes that

Where mindfulness is offered as a way of living and working, it provides an opportunity to reflect on values and what it is that brings meaning to one's life

enable change 'for the better'. The primacy of the counselling relationship is about empowering the client with a sense of self-government within a social context, and that does not exclude action or doing. What is emphasised however is client agency rather than counsellor method.

Time-limited counselling is a very valuable social resource. It can be used flexibly as a gatekeeping activity, to help clients move forward, seek further help and find support. It has some reliable scientific support as useful and helpful. Therefore, it has the potential to be a transforming experience rather than a method which is blind to human agency. It is therefore important that the profession itself, educators, regulators, and decision makers do not contribute to the pimping of the counsellor in any way by being silent on the commercial changes taking place that affect the status of counselling professionals. If we close our eyes to the pimping of counselling, then we ourselves run the risk of undermining it in the long term. ☺

Sheila J Peelo

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Practitioner Perspective

Something Larger: On sharing therapeutic case notes with children and young people

By Mike Moss



How often do we think of our clients out with the sessions and out with supervision? I am imagining we don't think of them all the time, but there will be times we may have a sense of them, or a memory from a session. How we experience being in relationship with children and young people may not only be from our contact in the room. This article is an attempt to focus on how writing therapeutic notes and offering to share them can be an integral part of the therapeutic experience and may become part of the healing process.

They also record a story of the relationship. My original training was in Youth & Community Work and then I trained in Solution Focused and Systemic Family Therapy, Integrative Counselling and Person Centred Therapy, and have benefitted from all these approaches. I am now a counsellor and psychotherapist for children and young people at West Lothian Council in Scotland.

Therapists' sharing their thoughts in written form with clients is common in solution focused and systemic approaches and narrative therapy and

feels similar to my writing and sharing case notes with children and young people. The term *therapeutic letters* can be attributed to White & Epston (1990) 'Narrative means to therapeutic ends' who describe writing letters as a way to document and privilege peoples lived experiences by offering hope and the possibilities of change, and consider they are an extension of the therapy session. Letters are generally appreciated by clients and have contributed to positive outcomes in therapy.

I always clarify any notes I write are from my perspective only and children and young people can read them or I can read them if they want. One young person liked to call the notes the story of her journey. Another young person suggested we read previous notes at random at times, trusting what emerged would be beneficial in some way.

Therapeutic notes are never written during the session as this could be a distraction and perhaps create an unnecessary power imbalance. I write as soon as I can afterwards which feels crucial to the integrity of the work. There can be a gap between the end of session and finding enough time, particularly if I have to see other children and young people soon afterwards, and I have to find space to tune back in to the session. Some children and young

people may not be interested in the notes and never read them and I accept this; however the process of writing notes informs my practice and focus on the work. They also create a unique record to help recall the session. There will be changes between sessions and I give space for this to emerge however reading previous session's notes can be a good way of re-connecting where we left off. They can also create a familiar container for some children and young people, and don't seem to get in the way of the flow.

Many children and young people have said they feel really heard this way, sometimes for the first time, and welcome an account of the previous session which I believe contributes towards creating a deeper relationship. The notes are kept in a client file and stored in a secure place and can only be accessed by myself and my manager and will be shredded after a number of years.

Epston (1994) describes therapeutic letters as being '*organically intertwined*' with the counselling session and Fox (2003) writes about what he calls '*therapeutic documents*' and believes letters record particular knowledge, encourage preferred stories and contribute to the rite of passage accompanying the end of work together. Moules (2003) finds there is a powerful influence in therapeutic writing and claims words can be read by people with their '*spirits and their bodies*' and are an extension of the therapeutic relationship when attentive and reflective of the work.

I believe there is a similar process in my attempt to convey meaning and understanding in writing case notes. A typical reflection after a counselling session in school with Crystal

I believe writing notes from a position of honouring the client's potential can help empower children and young people.

16yrs (not her real name) is written as follows:

It was good to see Crystal today. She seemed quieter than usual. I asked how things are for her just now. She told me she was 'raging' with her mum. We talked about how the arguments seem to be getting worse and how she feels the only thing she can do is go to her room and cut herself. Crystal said she still loves her mum but feels treated unfairly. This session felt a bit different from last week, and I mentioned this. I also noticed how Crystal seemed to feel angry when she talked about her mum. I mentioned how she seemed both angry and sad at times and I also heard her say that she loved her mum too. In writing these notes I am now wondering how it is for Crystal to have these big feelings she describes as making her f.... crazy at times, and how it feels important she is starting to trust herself to talk about them in the session. I look forward to seeing her next week.

My reflection here is on some of the words and mood and tone of the session from my experience of Crystal, and also wondering what it might be like for her. In the example above I try to keep Crystal in mind throughout, and believe the notes reflect my continuing attempts to maintain Rogers core conditions of '*congruence, empathy and unconditional positive regard*'. I also experience a powerful intention towards wellbeing when writing. In trying to explain this

further I can only offer a tentative description. When I am in the process of writing case notes the core conditions appear to still be active in me and there is a sense of being with the child or young person in both a real and imagined way. Moules (2003) describes an '*alchemy that occurs when tones are in harmony*', which seems to fit my intention to help, and it is as if I am in contact with a grander potential for growth in a deeper and more profound way.

At the end of our work together Crystal found the case notes helpful. She said she felt *important* because someone had really listened to her and cared enough to write about her without judgement, and she had experienced someone who trusted her to trust herself.

I believe writing notes from a position of honouring the client's potential can help empower children and young people. Pyle (2006) observes that the most important part of communicating in written form may be to help the client '*mine their own resources and knowledge*' to reveal their own strengths to themselves.

As mentioned earlier children and young people may not be interested in hearing about the previous session and it feels important the notes themselves do not become a focus of the work. Not every case note appears to contribute something when read back. However I believe having time for reflection is important in terms of the direction of the work, and could offer more than we know. It is as if the notes expand the quality of the relationship which may be felt in the work, and we can trust its direction. I once worked with a boy who seemed very unsettled at the beginning of our work

together. After each session I would write case notes and the following week offer to read them back to him. This felt like a way of containing our relationship and appeared to help. As the work progressed, reading back the case notes became less of a feature and at times unnecessary, as he eventually became able to just bring himself and 'we experienced what emerged in these moments.' Moss, M. (2018).

In Rogers essay on 'The Foundations of the Person Centred Approach' (1980) he talks quite openly about what he discovered when he was at his best as a group facilitator and therapist and writes:

...I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me...then whatever I do seems to be full of healing. At those moments it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes part of something larger. Profound growth and healing and energy are present.

I understand Rogers is commenting on his particular experience during direct work with others, yet his awareness may also lead us to appreciate what could be experienced beyond the session. This 'something larger' may be an indication of a wider energetic field and perhaps this field could be utilised in times of reflection and writing case notes. Also being able to attend to this possibility in supervision may even help us discover more in our work.

In an article *The Fifth Wave: beyond the mainstream* (2018) I imagined that what we are all

This 'something larger' may be an indication of a wider energetic field and perhaps this field could be utilised in times of reflection and writing case notes.

seeking may be found inside ourselves and the potential for this may be present in therapist and client and also in the direction of the therapeutic relationship and that there may be a 'directional presence' towards growth and change. William Bloom (2011) writes about a 'holding field' in therapy and believes there may be an energy connecting all things. I agree this is a possibility and wonder if this energy could be set in motion by the core conditions being experienced by the client and also active beyond the session.

And finally, there is a short visualisation exercise I sometimes do on my own where I imagine building a fire outdoors and invite all the children and young people I am working with to join me. Sometimes previous clients attend too and all are welcome. I greet everyone who appears and we sit around the fire in a circle. Some bring sticks and help light the fire and some sit quietly. There is some humour and a general flow of wellbeing and connection. I usually notice who comes to sit beside whom and how they get on with each other and there are some wonderful surprises at times.

I know this is an imaginary exercise and it feels almost dreamlike, however it seems to enhance my actual relationships in some way. It just feels important we can meet like this in another world that may

hold therapeutic possibilities. I understand this meeting takes place in my thoughts and I only ever invite the visualisation as a way of connecting to my own sense of the work; however it feels there is an additional part of the therapeutic relationship that is helped to grow in some way.. Perhaps we are all connected in ways we do not yet understand and it may be worth thinking about. ☺

Mike Moss

Mike Moss is employed as a counsellor and psychotherapist for children & young people by West Lothian Council, Scotland. He also has a small private practice offering supervision in Edinburgh. He has had articles published and has presented at national and international conferences and offers workshops to counsellors and psychotherapists. He can be contacted at mike.moss@outlook.com

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Book Review

Title: *When Shame Begets Shame – How Narcissists Hurt and Shame Their Victims.*
 Author: *Christine Louis de Canonville*
 Published: 2018
 Reviewed by: *Annette Murphy*

This is the author's second book on this topic and with her extensive personal and professional experience and all her research she puts forward an explanation as to how those individuals who have been brutalised at the hand of a caregiver (not always a parent), develop into a narcissist or co-narcissist (victim), these terms are explained in her book.

An insight is given into how the narcissists' superiority is juxtaposed to an inferiority complex that harbours unconscious feelings of low-self-esteem and inadequacy. I know this, but when I meet a narcissist, this can be forgotten and for good reason, yet reading it I did feel some sympathy for these individuals. However, as I read on and was reminded of how they protect themselves by projecting their shame onto their co-narcissists for their own survival, this sympathy did diminish. The book describes the full impact of this behaviour on the co-narcissist and this is corroborated through the author's generosity in sharing her own experiences, especially around the abuse at the hands of her brother. I do admire her complete honesty in her writing, but also appreciate that it is also part of her journey. The author does highlight the unconscious behaviours the co-narcissists use in order to survive the violent psychological, emotional and physical abuse heaped on them by their pathological narcissists. She stresses the importance of our understanding how these develop so that we can support clients through their journey of healing.

The book is comprehensive in that it gives a deep understanding of the world in which both the narcissist and the co-narcissist live. The author also writes about how we can work with co-narcissists, stating the importance of setting boundaries and how we approach the shame they carry, the importance of this

is emphasised. The author does question if Western style therapy can support clients through the spiritual stage of their journey and this is as a result of her own personal experience and having completed this very specific training. She found that this brought her true healing and helped her become her 'True, Authentic Self'. Some clinicians may disagree with this, but with her level of experience I do not feel in a position to dispute this.

The issue of whether narcissists can be treated is addressed by differentiating three types. With the "classical" type it is possible to a degree but they are very manipulative and this makes the work difficult. With the "malignant" type, it is highly unlikely they will not attend, and the same is true for the "psychopath"

The author has written this book for both non-professionals and professionals. She states that there is repetition of information in every chapter on purpose, so the reader can dip in and out of a chapter as they require. I can see the benefit of reading the introduction and then deciding which chapter one wishes to read. It is also stated clearly the author's reasons for editing her book herself. I do appreciate this and understand her reasoning behind it, but as a reader, I do think it would really enhance this very informative and worthwhile book if there was



some tighter editing.

In reading this book, I can hear how passionately the author wants the pain of the co-narcissist to be heard and she is being a true advocate for them in trying to highlight the necessary changes required in the Legal System, that psychological abuse be recognised as the violent abusive action it is. I shall continue to use this book in my work, as it is an essential reminder of how shame plagues clients.

Book available in PDF format from the author's website www.narcissisticbehaviour.net/when-shame-begets-shame

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Book Review

Title: *Yes to Health! No to Drugs!*
 Author: *Alice McLoughlin*
 Published: 2017
 ISBN: 978-1976092497
 Reviewed by: *Dr Ellen Kelly*

In this short book - 37 pages including illustrations - the author aims to inform primary school children about the dangers of drugs and alcohol as well as the benefits of avoiding drug use and of waiting until early adulthood before beginning to drink. With a long and rich history as a counsellor helping people of all ages with alcohol and drug related problems, as well as a history of being invited into primary schools to speak with sixth class pupils about this area, Alice McLoughlin is very well placed to write such a book. My interest in reviewing this book stems from many years of working with young people in the HSE addiction service.

The writing style is immediately informal and engaging, addressing the child reader as 'you' which draws him/her into the text. The author wastes no time in getting to the heart of the matter – What is a drug? – and her description is simple and clear. She manages to encompass a wealth of information in a few short paragraphs, ranging from different forms of drugs, legal and illegal drugs, drug sellers and the very clear message that all drugs are dangerous. She offers an excellent description of alcohol:

Alcohol is a sedative drug, a depressant, which means that it gradually puts the brain to sleep and causes the drinker to become drowsy and to have difficulty walking and talking. Alcohol is the most commonly used drug in Ireland and causes more problems than any other drug.

While the message to avoid taking drugs altogether is clear throughout, the author offers advice on healthy ways to drink alcohol as an adult, including not drinking alone and drinking as part of another activity such as a meal or a celebration. However, she's in danger of pushing her message too far when she turns her attention to Ireland's heavy drinking

culture and appeals to her young readership - as part of 'a new generation of Irish people' - to 'help to create a new image of Ireland' by drinking only small amounts of alcohol.

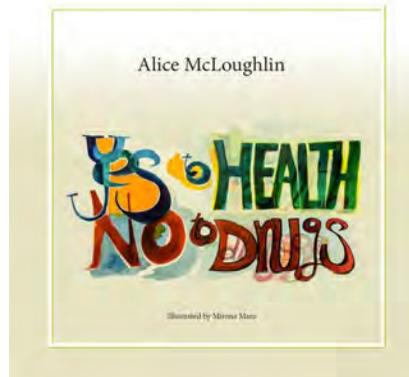
At the core of this book the author addresses the challenges and pressures of growing up, while calling on young people to 'learn how to be yourself and say how you really feel'. She explains how using alcohol or drugs to feel better and to boost confidence stops a person from learning good social skills. She has a list of reasons why young people drink and use drugs ranging from curiosity to coping with painful feelings.

A central theme of the book is that all feelings change and pass and that young people should allow themselves to feel their negative emotions, in the knowledge that they are a normal part of life, and to talk to someone about them rather than 'avoiding them with alcohol and drugs'. The consequences of drinking and drug taking are discussed and death features largely here with information on road accidents, suicide and other accidental drug/alcohol related deaths. The most sobering fact I found in this is that 'up to a third of deaths from

drowning in Ireland are alcohol-related' – information I think that many people would not be aware of.

This book can be read by children themselves – it is captivatingly illustrated and the informal tone and simple use of language makes for an easy, yet informative read. It is an appropriate resource for parents and teachers to use in a discursive way with children. For those working therapeutically with young people it could also be an aid, imparting as it does a specific knowledge.

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