Éisteach

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Progress Requires Change

- When I Am No Longer Among the Trees
- Agents of Change: The Person or the Pill?
- Has The Time Come To Resurface 'The Royal Road To The Unconscious'?
- The Research-Engaged Therapist: Why Counsellors Need to Embrace Systematic Investigation

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Irish Association for Counselling and Psychotherapy

Contents

Editorial Board:
Donna Bacon, Eithne Doherty, Áine Egan, Cóilín Ó Braonáin (Chair), Maureen Raymond-McKay, Antoinette Stanbridge

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Our Title
The word Éisteach means 'attentive in listening' (Irish-English Dictionary, Irish Texts Society, 1927). Therefore, 'duine éisteach' would be 'a person who listens attentively.'

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Each issue of Éisteach 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 'Author's Guidelines' on the IACP website, www.iacp.ie.

From the Editor:

Dear Colleagues,

I am delighted to share with you this year's autumn edition of Eisteach, a journal that has transformed considerably during my time on the committee. These progressive changes have been informed by you, our readers and as always I'm sure you will be pleased with the breadth of topics to digest. This array of subjects presents interesting arguments for each of us to consider.
The four articles highlight the calibre of therapists within our field, each providing something unique; from sharing empirical knowledge and both clinical and personal experience, to offering stimulating suggestions on how we as a profession can continue to develop and expand.

The arrival of a new Eisteach edition through your letterbox usually signifies another reliable season change. As mentioned, its contents also illustrate new adjustments and developments in its design as well as fresh information and articles, all of which remind us that everything is transient. What is permanent is that nothing is so. It is from this standpoint that Judith King describes her personal experience of loss, its process and the life lessons that can be gained from such. This beautifully written piece denotes an existential perspective on how to embrace the inevitabilities of life. It is her mindful approach to such shifts that portray an empowering sense of graceful surrender and acceptance. She eloquently describes the fruitful outcome of this approach; her ability to bask in the opportunities these shifts propose.

As therapists, we are unified in our hope for our clients' improvement from their status quo. But what is it exactly that facilitates this progress? Dr. Francis Mc Givern fosters reflection on whom or what the agent of change is through his presentation of the contrasting perspectives of two key authors; Peter Kramer and Thomas Szasz. On one side of the coin exists the argument for the biologically determined and treated psychopathologies. On the other, the opinion that socially undesirable traits have become pathologised and thus require elimination through medication. What position will you take? Irrespective of your individual choice, Mc Givern appeals for an ongoing dialogue on the direction of our profession. Discern whether you believe in the pill or the person as the catalyst for change and commence this professional discussion.

A guaranteed occurrence in our clients' lives is that they dream, yet research reports that such events are not a major focus of therapy. In our third article, Mike Hackett raises intriguing questions on the reasons for this and challenges this current position with the provision of evidence on the therapeutic benefits of dream work. He shares both his personal and professional knowledge and experience as well as weaving clinical examples through an evidence-based dream work model. Hackett offers useful pointers on how to begin developing the skill of tending to your dreams which will no doubt have you scribbling away at your bedside.

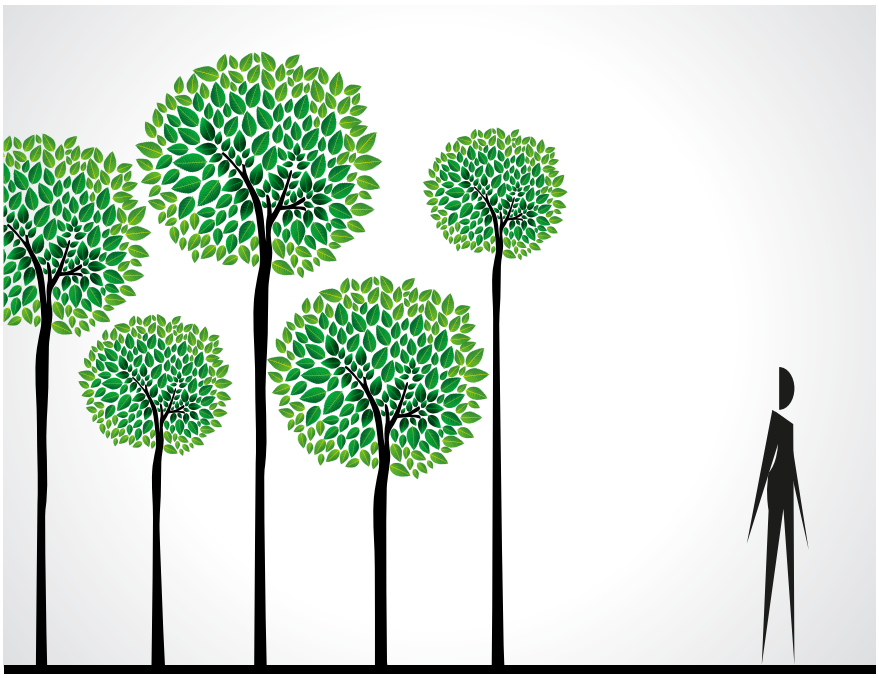
The debate about research, or lack thereof in our field, is one currently on the tips of many a professional tongue. Do we need it as a profession? Are we willing? Do we have the capabilities and training? Will it have an impact? In his article, Dr. Cóilín Ó Braonáin paves a way for research to become both accessible and rewarding for our profession. He builds a persuasive case for our needs as therapists to engage in research. The advantages of such are outlined, ranging from informing our practise to sustaining it. Leading by example, he shares insightful information gathered from his own research examining the existing attitudes of Irish therapists towards research. Current rates of those prepared to conduct research and barriers to such are reported. This piece is sure to galvanise the research debate and is well worth a look!

Wishing you all an enjoyable read and continued success in the coming months.

Donna Bacon, MIACP

When I Am No Longer Among the Trees

by Judith King



When I am among the trees,
especially the willows and the honey locust,
equally the beech, the oaks and the pines,
they give off such hints of gladness,
I would almost say that they save me, and daily.

I am so distant from the hope of myself,
in which I have goodness, and discernment,
and never hurry through the world
but walk slowly, and bow often.

Around me the trees stir in their leaves
and call out, "Stay awhile."
The light flows from their branches.

And they call again, "It's simple," they say,
"and you too have come
into the world to do this, to go easy, to be filled
with light, and to shine."

Mary Oliver (2006)

When I am no longer among the trees

I would almost say that they save me, and daily.

For over seven years I have lived among the trees.vSome of the first visitors to our top floor apartment home called this 'our tree house' soon after a move here in 2006. I was not displeased for the trees were what drew me here. In an instantaneous visualization, upon my first visit, I could see myself sitting here in the morning light, disciple to their fecundity, strength and beauty - this was enough for me to end the search for a new home and sign the papers. Not a secluded rural landscape, as you might imagine, but rather a long, narrow site, boundaried at one end by a row of eucalyptus, a kind of sound barrier from the traffic flow on the M11 and on the other by a fast flowing tidal river called the Dargle, on the nearby bank of which grew a row of magnificent trees. On the outer edge of Bray town this peaceful habitat of river and mature trees was a chance cross-fertilization of history, economics and someone else's sensibilities to the trees.

Local history suggests that this estate was first owned by a French Huguenot family who had immigrated here. Planting native trees was common practice among the more wealthy of Ireland's landowners, one dating back to the first "Planters" as they were called. These early colonisers were "gifted" with the lands of the indigenous people from the 1600's onwards. 'For the House of the Planter is

known by the trees', as Austin Clarke says in his evocative poem, 'The Planter's Daughter'. In the property boom of the late 1990's, developers bought the site, leveled the old estate house and the first round of old trees and then built a tasteful development of apartments across variously styled buildings. In a competitive market the mature trees and their ambiance of stability and pastoral peace were no doubt an impressive selling point.

In the early months of 2014, it was decided by the powers at be, that in order to build adequate flood defenses, all the mature trees at the riverside end of the development must be cut down. In the intervening years these trees had become like family, the ones who see you first thing in the morning, dishevelled and sleepy-eyed. Saved from our morning grumpiness, the trees seem ever able to offer a bright 'Good Morning'. Returning from a spell away it is as if they extend a twigged 'Welcome Home'. They play with the light of sunrise and spill forward dappling dances upon our living room floor as I gather myself to begin my morning round.

Many times, I have idly mused that in truth I need no mantra nor breathing visualization here to help me meditate, for if I were simply to sit and observe the trees, I would learn all the secrets of life. And in the wake of their imminent demise my musings are no longer so idle and out of my deep gratitude for these beautiful, living beings, I believe I owe it to them to attempt to record and communicate some of that they have taught me.

'Everything flows, nothing stands still'. *Heraclitus*

One of my little refrains in the early months of living here, when new visitors and family would come visit, was to say with glee that we now get to watch the seasons "up close and personal". My 'Council of Tree Elders', as I began to call them, included thirteen Beech and two Scot's Pine. The deciduous Beech submit obediently to the seasonal cycle, surrendering so gracefully and beautifully to each major and minor movement of the four cycles of the year. The abundant verdant green canopies of summer are lush and generous and become the play world to all manner of creature, winged beauties like chaffinches, jays and blue tits, gymnastic squirrels and manifold four, eight and hundred-legged insects.

In autumn the Elders became as 'Indian princes' (Allingham, 1973) resplendent in their robes of gold, red and ochre. Each leaf was tenderly released to the gentle autumnal air or sometimes I have been blessed enough to be showered in gold rustle which seemed to have waited for me to stroll beneath; the dry crunch under my feet added that familiar October acoustic to many a morning stroll.

Winter demanded that the Elders were pared back to the vulnerability of their naked form. Caught in the low sky November light, beech bark is a translucent grey, smooth to touch unlike the russet warmth of the more textured bark of the Scot's Pine. Straining forever heavenward, Beech raise their limbs in praise and prayer. Some of the branches had a particularly feminine grace like the raised arms of a dancer in legato. When the greyness of winter intensifies in late December, and I lay on my yoga mat trying to stretch my stiff body into a next pose, the evergreen umbrella of the scot's pine would offer me a gift of remembered green to nourish my wintered eyes.

The Elders resisted the intensity of spring's call until each leaf bud was swollen full of potentiality, protected by a little sheath of brown ensuring it was ready for the great unfurling. The buds of the upper branches were the first to swell I discovered, as if, like us, consciousness leading to growth and change must first begin in the head and slowly move down the trunk in order to become manifest in and from the body. Like a child on an Easter egg hunt I would eagerly search out the twigs to find the ones where the first Spring leaves were unfurling. It is difficult to find words adequate enough to describe the colour of that early green. So I will not try, save to say that when tree after tree opened into this early fullness, the outdoors and indoors were aglow in a kind of virginal "viriditas", (Hildegard of Bingen's word for the 'greening power of God', the vital, invigorating life force). A delay in the start date of the flood defense works last Spring allowed me to experience this virginal greening of my world one last precious time. Obedient to the end and being their 'Beechselves' to the very end, they generously offered us the exuberance of a new spring anyway, despite their imminent demise and then weeks later yielded with their reliable grace to the even greater cycle of life.

Perhaps never before in human history has there been such pressure to deny and attempt to circumvent the impact of the macro seasonal life-cycle of our own being – childhood into adolescence is frequently rushed and pushed; adolescence into adulthood is delayed and resisted; the beauty and vitality of human skin, hair and limbs, enjoyed by us in our late teens and twenties is still sought after by us in mid-life. We are seduced by the mirage of anti-aging serum or the disfigurement of surgical procedure. In Western cultures almost none of us are immune to this pressure. Daily I

stood in front of these Elders who seemed to say, in stark contrast:

> 'Surrender to the process, embrace what is natural, allow all to unfold, each season has in its own intrinsic beauty, your laughter lines and greying crown are the necessary outer wintering so that your inner world of soul and spirit may truly silence the demands of ego and image; untethered, you can surrender down into the deep sap of the life force, the eternal spring and offer yourself to the alchemist who seeks there the transformation of your soul'.

Stillness

Some mornings the Beech and Pine stood in such complete stillness that I feared I might have interrupted the Elders in their meditation. For this stillness was not just an absence of wind but something much more intensely embodied. The nature scientists tell us that all things, even the most sedentary, are actually vibrating with a discernible resonance. When the Elders were 'meditating', the stillness they embodied was captivating. Entranced, I use to seek some kind of entrainment to my own vibrations. I pray I may have by now internalized something of this quality of stillness for when I witnessed it, it called me to silence, to my knees. On the morning Dart commute to the city many passengers close their eyes for the duration, but those taking advantage of the journey time to do their morning meditation are a set apart because their bodies transfigure somewhat into this kind of alert stillness.

Groundedness and flexibility

Storm winds unnerve me. I find it difficult to be at ease when their energy dominates the skies and the surrounding air. They shake things around and rustle feathers. After they visit, you find upturned old pots and tools, yours and strays, lying around the yard. But the Elders knew this wind dance so well. They showed me how they had mastered a critical balance between grounded roots and upper body flexibility. They swayed and swirled when "*Brother Wind* " was high and unpredictable and they rustled and sashayed when he was in a more playful, gentle mood. What an important movement for all of us to practice - this easy blend of rootedness and flexibility, buffeted as we invariably are by the winds of time and happenstance.

Reverence for the Sacred

In paying this tribute of gratitude to the Tree Elders in whose shadow I've dwelt these last few years, I cannot but consider the consistently strong presence of trees in sacred texts across every religious tradition. From the great cedars of Lebanon in the Judaic Scriptures to the fig tree under which Siddhartha became enlightened, trees have been the means or the location of many a sacred encounter. Moses came upon the burning bush and took off his shoes for it was holy ground; Zaccheus hid in the sycamore but responded to Jesus' invitation to come down and be host for the evening; the Greek priests of Dedonis lay on the earth and listened to the whispers of the oak trees. Groves of oak trees were also considered sacred in the Celtic tradition and were the place of Druidic ritual. The ultimate paradox, perhaps, of the Christian tradition, is how the cross of wood, upon which Jesus of Nazareth was crucified, became the tree of life. I note this connection between the trees and this revered tradition of sacred encounter because of the contemporary call to 'the awesome awakening to the divine evoked by our experience of the natural world' of which the great ecologist and cultural historian Tom Berry speaks (Berry, 2006). 'The natural world is both the primary source of religious understanding' he adds, 'and is the primary religious community'. He draws our attention to 'the remarkable economics of the Earth, whereby the vast numbers of living species provide habitat and nourishment for each other in an ever-renewing cycle of seasonal transformations' (Berry, 2006). Sitting quietly at home over those years I heard the layers of sweet music – the tweeting twitter of the small birds, the more raucous caw-caw of the crow, the muffled squawk of the ducks in the river as she flows gurgling ceaselessly and rapidly towards the Irish Sea. Now and again I would see the great heron take flight with that breath-taking wingspan, soaring upriver and at other times I would see him seated proudly and gracefully on the river's edge or in one of its low streamed pools, searching for prey or just contemplating. I recognize that my home viewing point is in itself a representation of the destructive patterns we humans have been imposing on such natural habitats. These residential buildings have been built, no doubt, with too much concrete too close to the river's edge. Now the plan is to replace the natural riverbank with a concrete wall to protect the concrete buildings. The Management Company of the complex sold the plan by repeating the assurance of the hundred-year guarantee that comes with anything concrete! Japanese Architect *Kengo Kuma* (Kennington Steer, 2014) begs to differ when he says:

> The essence of 'weak architecture' is to ensure harmony between a building and its environment. Nature may

> appear calm and tranquil, but actually it is much more powerful than anything we are capable of making ... Architecture cannot resist the strength of nature so it needs to find ways of coexisting with it.

After the first meeting at which the plans for these new flood defenses were unveiled, I returned to my apartment and sat in my living room and looked out at the Elders. It was dusk. 'Will anyone plead our cause?' They seemed to whisper. Did I betray the Elders by not doggedly fighting for their survival? I asked myself. I painfully admit that in the end I surrendered quietly to the intensity of the belittling of my first feeble attempts at defending the trees. I spoke about how difficult I would find it to be party to a decision to kill living beings much older than I, with yet several decades remaining in their natural life cycle. When I detach from my actual participation in the Earth community, and assume the superior role as one of the "governors of nature" (Berry, 2006), I too see the logic –"the first round of 'hard architecture' (to use Kuma's phrasing from above), home now to hundreds of residents, including us, is already in place and now we have to create river banks with equivalently hard architecture for protection".

One Last Lesson

When the countdown began towards the then inevitable chainsaw days, I heard no condemnation from the Elders. 'Neither do we condemn you' they seemed to say to me. Rather, in the echoes of their pounding fall to earth I knew they would teach me one more lesson. In the end we must all face our mortality, live up to our death. Can I mirror the generous fecundity of the Elders? Can I hear their final whispers of wisdom?

> 'Give shelter to the smaller, more vulnerable ones; surrender to the cycles of nature; have faith - 'this too will pass, all shall be well and all manner of thing shall be well'; be patient and endure; yield your fruit *and* seed in due season; stay grounded but be willing to dance; accept your role in the great Earth community; give gratitude daily for being a part of it all'.

I walked among the Elders one last time in the days before the felling and touched each one tenderly and laid my full body weight against one great trunk, what might be called a begging for forgiveness. A kind of grief entered our relationship. Current and old losses in my own life story rippled out like the rings of the 'soon-to-be-exposed' internal tree trunks. Most painful perhaps is the incremental grieving in relation to my Mother, who is being quietly shelled by the slow-burn destructiveness of Alzheimer's disease, herself a great old tree of 82. And in writing these reflections I have remembered that my childhood garden was boundaried by a similar row of trees, which were felled to widen the road when I was about four or five years old.

In a more innocent time young couples, who used the natural world to find places in which to spend some private time together, used to etch heart-shapes on the bark of trees, pierced by Cupid's arrow and with their own initials carved at either end. And as I bade farewell to the Elders, I prayed that their teachings might be etched upon my heart. I call to mind the words of Cecil Day Lewis, (quoted by one of my students recently), in his poem, 'Walking Away - For Sean' (Day Lewis, 1962)

> 'I have had worse partings but none that so gnaws at my mind still'.

Judith King

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Judith King

Judith King is an accredited Psychotherapist with both IACP and IAHIP and a qualified Supervisor with a private practice in Bray, Co. Wicklow. She also teaches on the four-year Post Graduate Programme in the Dublin Counselling & Therapy Centre, Gardiner Street, Dublin 1. In addition she is a long-experienced Group Facilitator and she founded Integrative Facilitation in 2014 as a means of providing advanced training for Facilitators who wish to enhance further their competence with groups. Some of this Advanced Facilitator Training is offered at The Sanctuary in Stanhope Street, Dublin 1, where Judith also leads meditation courses. An abiding life interest for Judith is the continual search to find ever more satisfying and creative ways to nourish deeply our embodied soul journey as we navigate this 'one, wild, precious life'. Judith can be contacted by email at mjudithking@gmail.com.

Agents of Change: The Person or the Pill?

by Dr. Francis McGivern

"Psychotherapeutic drugs have the power to remap the mental landscape" (Kramer, 1997, p.209), to make the mentally ill well again, to make those who would be otherwise inhibited outgoing, and to make those with low self-esteem re-evaluate themselves in a more positive light. From another paradigm, however, this 'power' can be construed as "the business of psychiatry [manifesting as] coercion, [and] not cure"(Szasz, 2007, p. xxiii).

Introduction

With the ever encroaching influence of psychopharmaceuticals upon our profession, it is incumbent upon us as ethical practitioners to begin to question both the level of healthy dialoguing that is taking place between the psychological and medical professions that ensures best practice for the service user, as well as the position we as a profession take in relation to what constitutes psychopathology or 'disorder'.

This paper endeavours to develop a framework for reflection upon these issues through exploration of each thesis posited by psychiatrists Peter Kramer and Thomas Szasz in their publications 'Listening to Prozac' and 'The Medicalization of Everyday Life' respectively. Although Kramer's book is now almost twenty years old, both publications nonetheless still have much to offer in provoking debate around the morality of medicalisation, and the prescription of drugs with the intent of transforming the 'self'.

First, the most obvious but perhaps most salient parallel between the two authors is the high regard each demonstrates towards the psychological wellbeing of the individual. Both also acknowledge the capacity an individual has for change. The divergence begins to occur when reflecting upon what or who is the *agent* of change.

The Power of the Pill

With the advent of the antidepressant drug Prozac towards the end of the 1980s, Kramer observed a substantial minority of his patients 'transforming' and becoming 'better than well'. On one of his earliest occasions to prescribe prozac in response to a patient's tendency toward melancholy and compulsiveness, Kramer noted improvement in the patient's level of creativity, vitality, optimism, procrastination, memory and concentration.

> *Altogether Sam became less bristling, had fewer rough edges…The style he had nurtured and defended for years now seemed not a part of him but an illness. What he had touted as independence of spirit was a biological tic (Kramer, 1997, p. x).*

Kramer cites another of his patients attending him during the introduction of prozac, who despite no longer displaying overt signs of depression at a clinically significant level, maintained a degree of fragility particularly with regard to romantic relationships. Two weeks after prescribing her prozac she reported no longer feeling weary but relaxed, more hopeful, energetic, confident, she was laughing more, felt more satisfied and assertive at work, and significantly she was no longer drawn to destructive relationships and was looking forward to dating again. Having experienced such a dramatic change in herself in such a short period of time, Kramer's patient

now believed that she had been depressed *all* of her life and for the first time was completely clear headed.

> *If her self destructiveness with men and her fragility at work disappeared in response to a biological treatment, they must be biologically encoded. Her biological constitution seems to have determined her social failures (Kramer, 1997, p.18).*

Psychotherapy over a period of time Kramer claims, would have facilitated both of these patients gaining insight into the influence of their early childhood experiences on how they related to others in adulthood. Prozac, however, not only appeared to bypass this therapeutic work but *altered* personality in a way that psychotherapy possibly could *never* do. This pharmacological 'self-actualisation' manifested itself so dramatically that Kramer questions whether the medication had in some way eradicated a 'false' self and replaced it with a 'true' self. Thus, 'cosmetic psychopharmacology', medicating often in the absence of a clinical presentation to improve aspects of personality, appears to be the central agent of change according to Kramer.

Demedicalisation and the Power within the Person

In contrast, Szasz (2007) strongly advocates an alternative viewpoint in which the individual himself is the only *real* agent of change by which he holds personal responsibility for how he thinks, feels, and behaves. He has choices and he consequently makes decisions independent of his neurobiological environment. Szasz asserts that the notion of a 'false' self is tantamount to a 'mentally ill' diagnosis, a 'disease' of the brain, the result of which deprives the individual of free will. Construing specific behaviours and personality traits that society disfavour – low mood, social anxiety, shyness, low self worth, poor interpersonal skills, pessimism, diverse human sexual appetites, delusions - within the parameters of the medical model and creates what Szasz describes as a medicalisation of everyday life. In short, medicalisation occurs whenever a problem or disorder is treated from a medical perspective. As a result, many habits, behaviours, and 'ways of being' once assumed to exist within the 'normal' spectrum have now been diagnosed as diseases, not because of scientific advancement as one might expect but rather in response to cultural, societal, and political influences.

A fundamental difference between the two authors is their view of 'mental illness'. Szasz believes that 'illness' or 'disease' in its purest form signifies an abnormal biological condition of the *body*. He offers the ideas of Oxford philosopher Gilbert Ryle who suggests that since the mind is not an object, like the body, it is erroneous to associate it with illness/disease. Moreover, the "diseased mind" or "mental illness" is a metaphor, but psychiatry has applied the term 'disease' and 'illness' *literally* to the workings of the mind. Szasz' thesis is that at autopsy, a diseased *brain* can be detected and observed but a 'diseased' *mind* cannot. Thus, rational deduction would suggest that it does not exist.

By exploring demedicalisation, that is, the opposite of medicalisation, one may develop a deeper appreciation for the paradoxical lack of medical rigour involved within this continuum. Until recently for example, masturbation and homosexuality were considered diseases (Szasz, 2007). That is, they were considered abnormal conditions that required medical intervention. Masturbation has been variously defined as a sin, an immoral weakness, and as an illness during the 19th century. However, it moved along the continuum towards demedicalisation following sexologists Masters and Johnson normalising masturbation as well as the Kinsey report finding that over ninety percent of men masturbated (Conrad, 2007).

This pharmacological 'self-actualisation' manifested itself so dramatically that Kramer questions whether the medication had in some way eradicated a 'false' self and replaced it with a 'true' self.

Despite private sexual conduct between consenting adult men being decriminalised in Britain in 1967, treatments to eradicate the 'condition' of homosexuality were most widespread during the 1960s and early 1970s. Homosexuality was removed from ICD-10 (international classification of diseases) in 1992 (Smith et al., 2004), not due to it having been

Construing specific behaviours and personality traits that society disfavour – low mood, social anxiety, shyness, low self worth, poor interpersonal skills, pessimism, diverse human sexual appetites, delusions - within the parameters of the medical model and creates what Szasz describes as a medicalisation of everyday life.

'cured' out of existence but rather due to its demedicalisation. So something that was once classified as a mental illness or disease was abolished by psychiatry as a result of social pressure from the homosexual lobby rather than as a result of advancement in medicine.

Another example of the fluidity that appears to be in force along the medicalisation-demedicalisation continuum is the case of Graham Young, the 'Tea-Cup Murderer' whom, after poisoning several people was diagnosed initially with a mental illness and sent to Broadmoor. One psychiatrist offered a diagnosis of schizophrenia, whilst another offered a diagnosis of 'neurotically engendered psychopathic disorder' (Bowden, 1996). Poisoning several others on his release caused a re-evaluation of his conduct towards the demedicalised end of the continuum, being viewed now as a criminal rather than as a patient. He was convicted of multiple murders and sent to prison. Thus, if masturbation, homosexuality, schizophrenia or psychopathic disorder can be demedicalised, it stands to reason according to Szasz, that the existence of other diagnoses within ICD and DSM are questionable at best.

> *Whatever aspect of psychiatry psychiatrists claim is not medicalization, is not medicalization only if it deals with proven disease, in which case it belongs to neurology, neuroanatomy, neurophysiology, neurochemistry, neuropharmacology, neurosurgery, not psychiatry" (Szasz, 2007, p.xx).*

Biological Models of Psychological Disorder

Drawing attention again to the presentations of both Kramer's patients explored earlier, Szasz would presumably argue that 'treating' these individuals for obsessive-compulsive *disorder*, depression or any other mood *disorder*, or for interpersonal difficulties or challenges brought about by personality is "medicalization running amok" (Szasz, 2007, p.xxiii). However, Kramer might also argue that much of the evidence he cites in support of psychiatric intervention is gleaned from those working within pure or mainstream medicine who have an interest in human behaviour. Kindling and stress models of mood disorder for example, both have something to offer Kramer believes, in the understanding of the aetiology of not only major depression but near-normal depressive states also.

The kindling model is drawn from the work of neurosurgeons in the 1960s who "kindled" seizures in animals and found that less and less stimulation was required over time to generate them, to a point where they were happening spontaneously. Robert Post, a psychiatrist and biologist was interested in the similarities in presentation between these epileptic seizures in animals and the rapid-cycling of bipolar affective disorder in patients. As in kindled epilepsy, Post observed in his patients ever-decreasing time periods between episodes of mania and depression, increasing symptom severity, and significantly, decreasing levels of stimuli required over time for the onset of cycling to occur. Support for Post's model was strengthened with the superior response of bipolar patients to Tegretol, an anticonvulsant medication in comparison to the standard prescription lithium. Kramer's interest here leads him to hypothesize that trauma, the initial stimulus, causes specific parts of the brain to change at a cellular level and that this 'rewiring' in turn causes an ever-increasing sensitivity to external stimuli and consequently mental illness. This 'functional autonomy', that is, a response that lives on despite the cessation of the cause, Kramer claims makes a good argument for biological intervention. 'Stress hormones' such as epinephrine and cortisol have also been identified as possibly influencing the course of depression. A hormone produced in the adrenal glands, cortisol, similar to depression, has been found to affect mood, appetite, sleep, and physical movement. The substance in the brain responsible for releasing this hormone, corticotrophin-releasing factor has been found to be at an elevated level in stress studies using animals.

In essence, Kramer posits strong support in favour of a stress-depression model whereby individuals with low self-esteem, rejection-sensitivity, or even minor depression who experience further stressors are at great risk of developing a kind of 'kindled' disorder. Again, Kramer consequently supports early *preventative* biological intervention in order to avert the supposed inevitable danger to mental health.

> *Living with the sort of personality style that leads to repeated social failure may, beyond the pain caused to self and others, entail health risks (Kramer, 1997, p.125).*

Medicalisation from 'Above'

Surely, life's vicissitudes, its joys and sorrows, its traumas and triumphs make us who we are and equally who we are influences the course our life takes. Timidity, sensitivity, introversion, low self-esteem – all 'ways of being' that society is inconvenienced by. In fact Kramer (1997) himself expresses concerns about his sense that society strongly advocates one interpersonal style over others, having observed how his medicated patients now functioned better and crucially were more 'flexible'. Hyperthymia, a cluster of personality traits including optimism, drive, charisma, and confidence, could be viewed as a valuable asset in the world of business. Kramer reflects upon how attractive it could be to prescribe prozac ad hoc to an individual lacking these traits, in reaction to the competitive business world in which they operate. He describes a kind of 'diagnostic bracket creep', that is, defining less and less severe mood states as pathological, in order to meet both societal demands and fit the ever-expanding list of drugs the pharmaceutical industry produces that claim to iron out 'creases' within our personalities. Kramer's ethical dilemma here seems to reflect in part, one of the fundamental concerns Szasz has with psychiatry, that is, 'medicalisation from above'.

Szasz claims that 'medicalisation from above', from a position of power, is strongly rooted within psychiatry from its inception and functions primarily to maintain control within society and to meet economical, moral, and political interests. On reflecting upon what he calls 'pharmacologic self-actualisation', Kramer claims that *we* as a society "will have to decide how comfortable we are with using chemicals to modify personality in useful, attractive ways" (1997, p.15). Szasz' contention is that whilst Kramer denotes "we" to imply all members of society to include the lay person, psychiatry to this day promotes a power imbalance in which the lay person assumes the subordinate role of 'patient' who is denied the right to be consulted on any matter regarding his own welfare and completely bereft of any decision-making ability regarding the implications of psychopharmacological intervention (other than non-compliance).

Kramer regularly employs terminology such as 'illness', 'cure', and 'allowing' the patient, all words that arguably serve to maintain the inequitable dynamic that surrounds doctor and patient roles. He inadvertently offers an illustration of this power dynamic when he describes his realisation that a depressed college student patient to whom he prescribed an antidepressant, was anxious during the subsequent meeting not as a result of an amphetamine-like side effect but due to his fear of Kramer's reaction to learning he had chosen not to take the medication. Kramer had initially assumed that his patient's anxiety had a solely biological basis warranting additional pharmacotherapy in order to be suppressed. Whilst he offers alternative (psychoanalytic) explanations for the origins of the student's anxiety, this case example begs the question, is the patient's role to obey those in authority and the doctor's role to suppress the lived experience of the patient?

On reflecting upon power in relation to diagnoses, Kramer defines depression for example, in what could be regarded as quite a restrictive and uncompromising manner, that is, as "a relapsing and recurring illness" (1997, p.5)… and as "a progressive, probably lifelong disorder…[requiring]… early and prolonged intervention" (1997, p.114). Szasz contends that this description of depression as a mental illness is a recent

He describes a kind of 'diagnostic bracket creep', that is, defining less and less severe mood states as pathological, in order to meet both societal demands and fit the ever-expanding list of drugs the pharmaceutical industry produces that claim to iron out 'creases' within our personalities.

phenomenon that has manifested in medical parlance as '*having depression*', whilst heretofore individuals merely '*felt*' depressed or '*were*' depressed. This point is echoed by authors Aine Tubridy a medical psychotherapist, and the late Michael Corry a psychiatrist, who call for depression to be viewed as a form of disillusionment due to particular unmet human needs rather than be classified in medical terms such as chemical, clinical, endogenous or even reactive (Corry & Tubridy, 2001). The psychiatric establishment's classification of alcoholism as a mental disease whilst other common addictions remain outside the realm of clinical nosology is yet another case in point according to Szasz of how psychiatry has developed considerable political pulling power. Thus, he sees the exclusion of addiction to nicotine, what he calls 'nicotinism', from the classification of diseases system as a reflection of the shift in psychiatry from being *descriptive* or scientific, more toward being *prescriptive* or manipulating and swaying social policy.

Conclusion

Kramer appears to echo many of the ethical concerns cited by Szasz. For instance, he has concerns regarding the attraction psychopharmacology poses as an 'opiate for the masses' ensuring political conformity. He acknowledges that biological treatment of the rejection-sensitive individual constitutes a manipulating of personality. Furthermore, he has reservations about prescribing to adolescents who are not yet fully physically developed and questions informed consent regarding the costs and benefits to pharmacotherapy. In contrast to Szasz, however, Kramer suggests that medicine and psychiatry are in the business of enhancing *normal* functioning *as well as* treatment of illness – rogaine for the treatment of male pattern baldness, dermatological treatment for adolescent acne, plastic surgery to enhance self esteem, oestrogen for the treatment of menopause, and sedative treatment for sleep difficulties in older adults – all examples of interventions for otherwise normal human phenomena. Thus, regardless of the medical ethicists various concerns, Kramer holds to his belief that the observed transformative effect psychopharmacology has had on his patients is evidence enough for its efficacy in the treatment of normal and abnormal issues. Szasz vehemently supports the individual's right to be 'ill', the right to remain in their struggle, but also the right to choose to seek support from mental health workers within a fully informed, consenting, and collaborative environment. Szasz laments society's loss of democracy as it meanders more towards a 'pharmacracy' in which psychiatry will police and *rescue* people from the 'dangers' of their low self esteem and sensitivity to such a point that our biggest fear will be to live. It appears that psychopharmacology *does* have a place in supporting fully informed consenting individuals through difficult periods in their lives, yet significant challenges still remain regarding evaluating to whom, under what circumstances, how much, and for how long medication should be prescribed. Furthermore, with the publication of the DSM-V it is imperative that we accelerate the debate on the direction our profession is being taken, evidently toward 'diagnostic bracket creep'.

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Dr. Francis McGivern

Dr. Francis McGivern is a counselling psychologist registered with the psychological society of Ireland. He also holds a Doctorate in psychotherapy with a research focus on the personal impact of uncompleted suicide on partners. He works part time as a college counsellor at Dundalk Institute of Technology and has a private practice in a multidisciplinary health centre. He can be contacted via www.louthcounselling.com

Has The Time Come To Resurface 'The Royal Road To The Unconscious':

Reflections, Research and The Case For Embracing Dream Work in Clinical Practice and Therapist Development.

by Mike Hackett

If one advances confidently in the direction of one's dreams, and endeavours to live the life which one has imagined, one will meet with a success unexpected in common hours.

Henry David Thoreau (1817 - 1862)

Introduction

Today, dreaming seems as elusive as it was when man was first roused by this nocturnal phenomenon. In my 25 years working with dreams, I have observed the study of this phenomenon broaden from an anthropological special interest and early psychological theory into the fields of biology, neurology, chemistry and evolutionary science, applied psychology and beyond. Indeed, within the field of counselling psychology there now exists a branch of science dedicated to the study of dreams, culminating in 2004 with the arrival of the American Psychological Association's first multidisciplinary journal publication devoted specifically to dreams. It is within this scientific exploration that the questions 'do dreams have a psychological function' and 'how can they be used to support client growth and development' still remain central to the study of dreams. Moreover, as an accredited therapist and dream worker, I have been fascinated by the questions of how can attending to our own dreams be used for our own personal development, supervision and within our families and communities? In my experience, the subject of dreams is an enormously rich area of study and practice, so my focus in this article will be to build a short case, with an example, for attending to your dreams and how they can support both your personal and professional growth and that of your clients'.

Heller (2013) highlights how current sleep science has established that we spend one third of our lives asleep, and between twenty and twenty-five percent of our sleeping lives dreaming. More often than not however, we tend to report not having dreamed at all, being aware that we have dreamed but not being able to recall them, or only recalling vague, distant

fragments of our night-time visitors (Heller, 2013). Contrastingly in my life and my practice, I tend to hear reports of the vivid, anxious and fearful memories of our nightmares, which for some, when they take root in our nightly rest, can unravel the most ordinarily resilient lives.

Despite the potential for dreams to be positive or negative, I observe that the majority of people I speak to about dreams are curious about the meaning of the dreams they can remember. Furthermore, they are eager for them to be decoded in order to understand something new about themselves or their life situation. How many times on a train, Luas, bus, in a queue, at a social event, a coffee shop or other public space has your ear tuned in to someone saying 'I had an amazing dream last night' and proceed to tell their company all about it! Dreams leak into the waking world in this way, just as they occupy us at night when the committee of sleep meets to agree the agenda of our night's work.

In exploring the frequency of the occurrence of dream work in psychotherapy "According to several surveys, most therapists reported that they attend to dreams at least occasionally, although dreams were rarely a major focus of therapy" (Hill, 2010). The same research however says that despite this occasional attention to dreams "[those therapists report]…they had spent about 5% of therapy time working on these dreams". This elicits some interesting questions: Why so little time (only 5%) attending to dreams? What training have therapists had to work effectively with dreams? Have therapists a solid foundation in dream ethics to inform their dream tending with clients (in other words, tending to their dreams as a gardener would tend to his plants)? Is their dream tending with clients informed by the latest research in the field? For those therapists who do not attend to the dreams of their clients, what rich avenues of therapeutic work remain unexplored? Finally, in line with Yalom's (2010) questioning of whether we can take our client's farther than we've gone ourselves, could it be that it is difficult to dream tend with a client if the therapist hasn't tended to their own dreams?

Dreams support the therapeutic process

Much of the literature on the clinical utility and effectiveness of using dreams in therapy consists of case reports and descriptive studies. Pesant and Zadra (2004) have compiled a synthesis of clinical observations and found typically three distinct types of improvements present in the application of dream work in therapy: a) client insights – also described as enhanced client self-knowledge, self-understanding or self-awareness, b) increased involvement of the client in the therapeutic process and c) a better understanding of client dynamics and clinical progress e.g. transference and counter transference (see example later).

In support of the improvement in client insight, Murgatroyd (1985, p.97) argues that dreams can "be developed for understanding ones feelings". He postulates that by re-enacting the dream in the present, by taking responsibility for every character, symbol and event in the dream as an aspect of the dreamer (employing Perls' projection hypothesis) the therapist can facilitate a movement into awareness of the dreamer's emotional state and their thoughts about themselves. Thus he notes, "by reliving the dream, and acting it out in consciousness, the person is able to 'get in touch with' or examine their feelings more directly" (Murgatroyd, 1985, p.97).

In addition, Pesant and Zadra (2004) went on to categorise the ways in which the client's experience in therapy can be supported using dreams:

- *Connection – to uncover some patterns in one's existence or some links between different aspects of one's experience;*
- *Suddenness – an affective reaction of surprise, as if things fell into place in one's mind;*
- *Metaphorical vision – to see oneself in a new light; and,*
- *Newness – the sense of having discovered something that was not previously known.*

In relation to the second improvement of increased involvement in the therapeutic process from employing dream work in therapy, Heaton, Hill, Petersen, Rochlen and Zack (1998, p.115) found that "clients rated session outcome higher, got involved more quickly in therapy, gained more dream insight, and kept fewer secrets". Peasant and Zadra (2004, p.498) also suggest that clients may "be less reluctant to discuss disturbing issues when these are approached through dream exploration, partly because dreams are often seen as not being real, and a safer distance exists between the client and the material evoked by the dream". For

According to several surveys, most therapists reported that they attend to dreams at least occasionally, although dreams were rarely a major focus of therapy

example, the use of dream work has been especially effective for war veterans who would otherwise find it difficult to explore the impact of combat experiences (Cohen, 1999). This highlights how the dream can be held in the room, without it overwhelming the client and potentially sabotaging the work.

With regard to the third improvement of developing a better understanding of clinical progress, dreams can be used to uncover therapeutic issues like transference and the relationship dynamics between therapist and client. Clients find it difficult to deal with their feelings toward a therapist, especially if these feelings are seen to be negative or critical of a person who is actually trying to help them (Hill, 2004). In one pivotal session, my client brought a dream where he saw me as the mythical figure Atlas – holding the weight of the world on my shoulders. He mentioned this in passing almost as a joke, but I suggested that we explore this dream sequence further. This was achieved by employing Hill's Three Stage Cognitive Experiential Model which is a modern, scientifically tested method for working with dreams (Hill, 2004). It involves an immediate exploration of content, symbols, feelings and situations of the dream gaining insight into the links to the client's waking life and presenting issues. From this, tangible actions can be formed which can be implemented in the life of the client. By using the dream as a vehicle, the client was able to explore the image of me as a super human being carrying the world on his shoulders, dutifully without complaint. This allowed him gain insight into the connection between feelings he had toward his father (who he saw as being able to 'hold up any burden') and myself carrying his burdens, compared to how he saw himself; inadequate and powerless (his presenting issue), resulting in him feeling inadequate to us both. These insights formed the action to therapeutically focus on this critical parental relationship and its affects on him in his life.

Similarly, the therapist can gain key insights by using his own dreams to reveal particular aspects of the relationship with the client. For example, Woskett (1999, p.207) describes how her own dreams "often provide clues to my unacknowledged responses to clients [I dream of] or the unexpressed dynamic between us".

Dream work can be taught to clients for use outside of therapy

In my experience, dream work, unlike other therapeutic tools e.g. the empty chair from Gestalt, or Free Association from Psychoanalysis, is not dependent on the presence of a therapist but rather can be taught as a therapeutic tool for the client's use outside of therapy. I have found that equipping the client with such a method provides an extra resource for them to gain rich insights into their current life situation. Particular therapists and academics have developed tools, methods and processes in support of client empowerment by study and self-analysis of dream material (Zack in Hill 2004; Van De Castle 1994; Cushway & Sewell, 2013). Hill (2004, p.xi) puts it most eloquently by exercising poetic license on a classic saying "If you give a person a dream interpretation, she will feel enlightened for a day, but if you teach her to explore her own dreams, she will have a source of inner wisdom for a life-time".

Scientific evidence on the efficacy of dream work

"Romantic psychology, with its focus on introspective investigation of the mind's mysteries, was the province of writers and poets; but by the end of the nineteenth century, it had given way to a philosophy of science which venerated empirical observation and looked askance at anything speculative" (Freud, 1900, p.vii). As the development of psychology progressed from the romantic 19th century, to the analytic 20th century, the study of dreams have similarly undergone a rebirth in the last 50 years. Today, the scientific study of dreams has taken root in a number of ways; the creation of the International Association for the Study of Dreams (IASD); the publication of a code of ethics for those working with dreams (accessible on IASD website); and the quarterly publication by the American Psychological Association of 'Dreaming'.

In particular, one key contributor to contemporary dream work is Dr. Clara Hill of the University of

Maryland USA. Hill and her team have not only created Hill's Three Stage Cognitive Experiential Model, but have also conducted dozens of peer-reviewed studies dedicated to the efficacy of dream work (each of the many studies is enumerated in the appendix of her 2004 publication "*Dream Work in Therapy: Facilitating Exploration, Insight, and Action: Facilitating Exploration, Insight and Action*").

Perhaps the most impressive findings which have been replicated across ten studies found "that dream interpretation resulted in client ratings of session process (quality of sessions, insight and understanding) that were about one standard deviation higher, than for therapy not involving dream interpretation" (Hill, 2004, p.15). Further, Hill also found that "people with positive attitudes towards dreams expressed more interest in participating and gained more from dream interpretation than people who had more negative attitudes to dreams" (Hill, 2004, p.15).

Finally, with regard to the usefulness of dreams to enhance client's existential and spiritual growth, Davis (in Hill, 2004) notes that modest effects have been found on "measures of symptomatology and interpersonal functioning and that changes in existential well-being and spiritual insight occurred" (p. 149).

Dreams for personal development

Perhaps an illustration of how I use my own dreams in my personal development may help demonstrate the power of dreams in revealing something outside of my current awareness and thus signpost what I need to do in life.

> I am somewhere strange, it is dark and I feel vulnerable. I notice in my hand, a tooth, then all of my teeth start falling out. I wake feeling embarrassed.

I begin by looking at the images and the feelings in sequence (the Exploration stage of Hill's Model);

> The situation of the dream (somewhere strange) orientates me to my current life situation – life seems strange. I am in the dark and can't see anything other than my hand. My hand is what I use to hold things. One of my teeth is in my hand. My tooth is what I use to chew. All of my teeth fall out, I imagine my grandmothers face – her face shape totally changed when she took out her false teeth. Her face looked sunken.

Next, I develop a narrative from the loose story and the associations from the dream (combining the Insight and Action stage of Hill's Model).

> My life at the moment feels strange, I am in the dark about my current situation. I need to hold on though. I need to chew on the situation or I will lose face.

Thus you can see how, while this dream snippet appears at first to be highly symbolic and confusing, when worked through associatively, it reveals my current life situation and also, what I need to do as well as the potential impact if I don't attend to my own dreaming advice!

By reliving the dream, and acting it out in consciousness, the person is able to 'get in touch with' or examine their feelings more directly.

What we need to re-pave 'The Royal Road'

The following steps are a good beginning in engaging with dreams and working with them in personal and professional contexts.

1. First start recalling and recording your dreams. How? Here are a few suggestions:
   a. Each night, before sleep, express your intent to remember your dreams when you wake.
   b. When you do wake, stay perfectly still in your sleeping position and gently let your mind wander to what feelings, images you are feeling/remembering.
   c. Let those expand naturally. But if you can only grab a few snippets, and a feeling or two, that's fine.
   d. When you have something of the dream, write what you do recall down using pen and paper (which you keep handy beside your bed).
   e. Ask yourself what do the images, symbols etc. you remember represent for you and write those associations over the symbols, images etc. Repeat through the dream.
   f. Beginning at the start, re-read the dream but instead, substitute in the associations for images, symbols etc. creating a new narrative from the dream.
2. Bring the dream to personal therapy or hold it for your own personal development, listening

to the message of the dream and what it says about your current life situation.

3. Next, take a course in dream work (staying away from dream dictionaries and symbol databases) or join a dream group.
4. Introduce dream work to your clients and express your openness to work with their dreams should they wish to bring them. Ensure you you have undertaken some training and are familiar with the IASD Dream work Code of Ethics.

Keep up to date with the latest in dream research by reading 'Dreaming' the Journal for the study of dreams.

Conclusion

My own journey into my inner world of dreams and nightmares has been travelled over 25 years. As a therapist working with dreams in the therapy room, I am always surprised at how, despite initial trepidation, clients embrace working with their dreams and have reported significant insights into their therapeutic process. Having developed and built dream training programmes and facilitated dream groups, I am awed and profoundly moved by the shifts which accompany the experience of the meaning and significance of a dream connecting deeply with a participant. I dearly wish that all therapists could experience this profound, moving and at times unsettling, but always insightful and authentic, moment of connection with their inner world, conveyed in such a unique way though the vehicle of dreams. And perhaps, with a little curiosity, faith and a spirit of adventurous travel, we can all re-pave that 'Royal Road', creating a super-highway into deeper self-understanding and enrichment of our own lives and the lives of our clients.

Use of dream work has been especially effective for war veterans who would otherwise find it difficult to explore the impact of combat experiences

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Mike Hackett PMP ARCHTI MIACP

B.Sc. (Hons) Counselling & Psychotherapy, Dip. Couns., Advanced Dip. Supervision.

Mike works as an accredited therapist and supervisor in private practice, is a lecturer with PCI College and has recently qualified as a counselling supervisor. He is a passionate oneironaught (dream traveller) and is the facilitator of the Dublin Dream Appreciation Group. He is a member and patron of the International Assoication for the Study of Dreams and has developed training programmes for the effective, evidence based application of dreams in private practice.

Mike would be delighted to hear from you by email to; info@introspectcounselling.com

The Research-Engaged Therapist: Why Counsellors Need to Embrace Systematic Investigation

by Dr. Cóilín Ó Braonáin

Introduction

For most people the mere mention of 'research' triggers their eyes to glaze over, brain activity to shut down, and it precipitates a quick retreat into a Homeresque state of mindless bliss. But before you reach for a can of Duff, read a few more paragraphs and see if I can paint a more inspiring canvas of the need for research in counselling and psychotherapy. So, why does research matter? Firstly, the results of research help to inform practice, for example, research has over the decades helped provide definitive proof of the effectiveness of therapy (Cooper, 2008; Lambert, Masters & Ogles, 1991). Also, new psychotherapeutic approaches have been developed empirically, for example, cognitive behavioural therapy and brief solution-focussed therapy (Beck, 1976; De Shazer & Dolan, 2007; Skinner, 1974).

Secondly, the publication of research is a reliable and accessible way to share knowledge, and gain new insights, all of which informs practice and can increase the effectiveness of treatment (McLeod, 2013). Most research adds just a little to the body of knowledge, but occasionally substantial advances are made. Kuhn argued that 'normal science' involves working within a particular paradigm and within that paradigm changes are incremental or innovative, but that occasionally a paradigm shift occurs, causing a radical change in understanding (Howard & Myers, 1991). An example was Freud's introduction of the concept of the unconscious mind as the hidden motivation for much of human behaviour. Prior to Freud, behaviour was largely seen as the product of a religious 'good vs. evil' tension, with the lower social classes assumed to be more susceptible to the temptations of the devil. Freud's ideas were, therefore, both revolutionary and egalitarian (Freud, 1920).

However, there are also pragmatic reasons to take another look at research. In a market which is becoming increasingly crowded with newly qualified therapists, an ever greater number of clients will also need to present for treatment in order to maintain the livelihoods of a growing profession. However, not all those in a position to refer clients do so with enthusiasm. Some general practitioners (GP's), health insurance companies and the

Health Services Executive (HSE) have mixed feelings concerning the efficacy of counselling and psychotherapy (Culliton, 2014). For example, one study reports that only 10-20% of those reporting to GP's who need counselling will get a referral (McHugh, Brennan, Galligan, McGonagle & Byrne, 2013). [For a comprehensive review of GP referral issues see (Ward, 2014)]. Indeed, it seems that 'it does not convince the public at large for counsellors to assert that, in their personal experience, most clients gain a great deal from therapy' (McLeod, 2013, p.5; Stratton & McDonald, 2012). If personal endorsement is not enough, perhaps what is needed is a more substantive Irish-based body of objective knowledge concerning the effectiveness of therapy? But, is 'scientific' knowledge more valuable than personal experience, and what exactly is knowledge anyway?

The Nature of Knowledge

Information can be divided into four types of knowledge, or ways of knowing (McLeod, 2013). Personal knowledge refers to the understanding derived from our direct experience of the world, including our emotional experience and one's way of making sense of the world (Jarvis, 2010). Practical knowledge refers to skills learned over time, whereas theoretical knowledge is comprised of ideas of concepts which allow people to describe and explain current events leading to predictions of what may happen in the future. For example, the Donegal postman's approach to weather forecasting is based on his theory that nature somehow knows what type of summer is coming and that flora and fauna signal that knowledge through a change in behaviour. Theories give rise, in turn, to research knowledge, which is gained from testing the predictions of theories in a systematic way. Research knowledge allows us to expand our understanding by drawing on the wisdom of many people, a process which casts light on our own personal experiential knowledge, which is always quite limited, relatively speaking (Cooper, 2008).

However, regardless of the type of knowledge involved, accepted 'facts' sometimes turn out to be untrue, such as the medieval belief that the earth was at the centre of the universe, so how can we be sure what to believe? According to Popper, and broadly agreed in the scientific world, scientific truths must be falsifiable, that is, it must be possible to devise an experiment or argument which allows for the possibility of a claim being found to be either true or false (Popper, 2005). The demand for testability of psycho-therapeutic interventions caused proponents of Freud's psychoanalysis some difficulty. How can the ego, id or superego be tested? How can the unconscious mind be measured? Skinner (1974) and others, of course, shouted loudly that psychoanalysis was unscientific, untestable and he suggested quite persuasively that we should forget about the mind and focus on behaviour instead. Behaviour can be observed directly, and modified without any need for speculation concerning the mind. Currently, Cognitive Behavioural Therapy and Solution-Focused Brief Therapy are in vogue, in part, because they produce observable results which can be verified through research methods (HSE, 2015).

This paper does not mean to imply that any doubt exists about the effectiveness of other therapies, although initial outcome studies found unfavourable results concerning psychotherapy. For example, in an early meta-analysis Eysenck (1952) concluded that 'the figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder' (p. 323). Since then, at least '60,000 academic papers have been published on counselling and psychotherapy research' (Cooper, 2008, p.9). At this point, any doubt about the effectiveness of therapy as opposed to no treatment has been banished, at least in academic and counselling circles. Indeed, the 'evidence for the effectiveness of psychotherapy is overwhelming' (Carr, 2007, p.20).

Nonetheless, who has not (perhaps often) been on the receiving end of a 'counselling is a load of rubbish,' monologue by the all-knowing self-righteous? Given the reluctance of some GP's to refer (Ward, 2014), it is clear that the existing evidence alone is not enough to convince those who remain dubious. Perhaps we Irish are somewhat doubtful of British and American research and need to see the facts as they are on our own hallowed ground? [Some Irish research already exists (Carr, 2007, HSE, 2015, McHugh, 2013)]. Bizarrely, in spite of the existing evidence, it does indeed seem that more research is needed, and that Irish research might be convincing if conducted on a large scale and if the results

were disseminated in a savvy user-friendly way. And who better to conduct that research than counsellors and psychotherapists who are in regular contact with the client population?

Current Attitudes Towards Research

The opening line of this paper suggested that 'eyes glaze over' at the mention of research. The astute reader may have noticed that the claim was not referenced, and indeed the view expressed was no more than the personal opinion of the author. Like most people, the author is convinced that his views are correct, but are they? In 2013, the IACP surveyed members on a range of topics including members' views on research, and the results seemed to contradict the pessimistic opening claim of this article. According to that study, during counselling and psychotherapy training 64% of respondents undertook training in research, and 57% had been engaged in carrying out research (Ryan, 2013). A belief that research helped to improve client outcomes was shared by 78% of respondents. Overall, the attitude to research seemed very positive. However, 43% also said that 'I don't want to disseminate my research in any way,' which seemed odd. A lot of work goes into any research project, so it didn't make sense that so many would engage in research and not publish, as the report implied. The report suggested that a lack of confidence might account for this anomaly (Ryan, 2013), but the current author wondered if the research referred to by members was actually student research completed for the purpose of meeting a training requirement. The question that consequently arose was, How many therapists engage in research once qualified?

The author decided to put the exhortation to 'do research' into practice in order to answer that question. A questionnaire was empirically derived, which collected biographical data, qualification, practice information, and both attitudes towards and experience with research. The survey was piloted with five IACP members, and some adjustments were made. Participants were invited using a random cluster sampling method. That is, five participants were randomly sampled from each of the IACP member counties or city districts using a web-based random number generator (randomnumbergenerator.intemodino.com). In the event that a member had no email listed, the next person on the list was substituted. A 30 question survey was circulated using the surveymonkey.com software to 200 IACP members. Fifty four responses were received, representing a response rate of 27%.

In comparison to the 2013 survey mentioned above (Ryan), this survey found that 77% of respondents had a research module included in their counselling training (of those, 76% had 30 hours or less training in research). As part of their training, 75% conducted research, but only 18% had done any research since training. When asked if they had done research *outside of college, but not published, only 13% said 'Yes.' These figures suggest that the 2013 figures showing that members had conducted research, but didn't want to publish (43%) were referring largely to student assignments.* The true figure for psychotherapists conducting research as practitioners seem to be much lower at 13%.

The reasons given for not conducting research are informative. Forty percent stated that a lack of time was the reason, while 23% cited a lack of funding to support research. A further 25% were concerned about possible mathematical, statistical and other 'complications.' Seven percent felt that research could not capture the therapeutic experience and the remaining answers cited various reasons such as a lack of confidence. Interestingly, a majority (91%) cited either time, money or technical challenges as a reason for avoiding research, although 50% also cited some doubts as to their competence to conduct research.

Concerning the suggested necessity to convince stakeholders that counselling and psychotherapy work, 38% reported an increase in the number of clients asking questions about the effectiveness of therapy, while 23% of respondents had the experience of a GP refusing to refer patients to counselling, which adds support to the argument that more research is needed in order to satisfy stakeholders that counselling is legitimate and effective. Of 14 qualitative responses to the question as to why GP's did not refer, the majority of GP's either felt competent themselves to counsel patients or lacked confidence in psychotherapy.

Eighty-seven percent of respondents felt that research

was relevant to their practices, and when asked if they would be interested in doing research in their own practices 31% said 'Yes,' and 44% replied 'Maybe,' meaning that 75% of respondents are potential researchers! However, when asked to draw a comparison between collecting data and analysing data, 58% were unsure about data analysis. But, when asked 'How likely are you to engage in research if a simple online method were made available for you to use? - 44% were very likely, 22% somewhat likely, and 20% likely giving a total of 86% of the sample who, given support, may be future researchers in counselling and psychotherapy.

The validity of the current survey was based upon a sample of 200 members from the 2223 IACP members listed on the IACP website. A 90% confidence interval (the likelihood that the findings represent the views of the membership as a whole) was used and the number of people who responded was 54. The margin of error was 12%.

Limitations of the Survey

One limitation of the study was its brevity (30 questions). A more comprehensive survey would have elicited additional relevant information. For example, a question which was overlooked might have enquired as to any tension between GP's and therapists who disapproved of medications, an issue known to exist for some (Blackburn, 1995). The response rate was low enough to lead to a high margin of error (12%); a more acceptable margin of error would be 6% - 8%.

Discussion

It is encouraging to see that so many IACP members value research and see exploration as being relevant to their own practices. It was also heartening to discover that a large number of therapists would consider doing research if a simple method was made available online (McDonnell, Stratton, Butler & Cape, 2012). Such a method could be comprised of a simple screening questionnaire such as the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM, n.d.). The CORE – OM is a 34 item measure, which assesses clients on four dimensions, i.e. a) subjective well-being, b) problems/symptoms, c) life/social functioning, and d) risk/harm. The CORE, which is in the public domain, could be directly accessed by clients online, and completed at the outset of therapy and again at the close of treatment. The data could be centrally analysed relieving the individual therapist of a need to engage with statistics. Such an approach, if applied nationwide, would result in very decisive results due to a large sample size, which would give outcomes considerable statistical power.

Apart from the question of therapy effectiveness and the need to convince sceptics of its value, there are other topical counselling issues which would benefit from further research in an Irish context. The experience of those clients who don't improve or even get worse needs more attention (Bates, 2006, Cooper, 2008). It is reported 'that about 1 in 10 clients deteriorate following therapy and that marginalized clients with particularly troublesome disorders and negative attitudes to psychotherapy are vulnerable to dropping out of psychotherapy and deterioration' (Carr, 2007, p.31). Another old chestnut which still hasn't been resolved is the question: Do psychotherapeutic modalities differ in the types of difficulties to which they are best suited? (Roth & Fonagy, 2005). And of course the current trend towards (sometimes very) brief therapy needs further clarification regarding its effectiveness (McHugh & al., 2013).

Furthermore, an area of interest touched upon in this survey, was that of the research training received by students while studying counselling and psychotherapy. The norm appears to be that trainees receive 30 hours of training or less. One wonders if that is enough or do students need greater attention given to research, to include perhaps some training in statistics?

Conclusion

It seems, given the increasing demands of stakeholders for reassurance that therapy is effective, that counsellors and psychotherapists can no longer rely on exhortation and testimonial as a means of convincing the unpersuaded. In addition, an ever increasing number of newly qualified counsellors will result in too many fish sharing the same small pool of clients. In order for counselling to remain a viable profession, the number of people availing of counselling needs to keep pace with the number of therapists. In short, the psychotherapy field needs to evolve with the changing times and

adapt to circumstances. If the public was awash with Irish-based research evidence that dispelled doubts over therapy effectiveness, it seems likely that utilisation of counselling services would increase significantly. And who better to conduct that research than ourselves? If you've made it this far go get yourself a can of Duff. You have earned it!.

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Dr. Cóilín Ó Braonáin

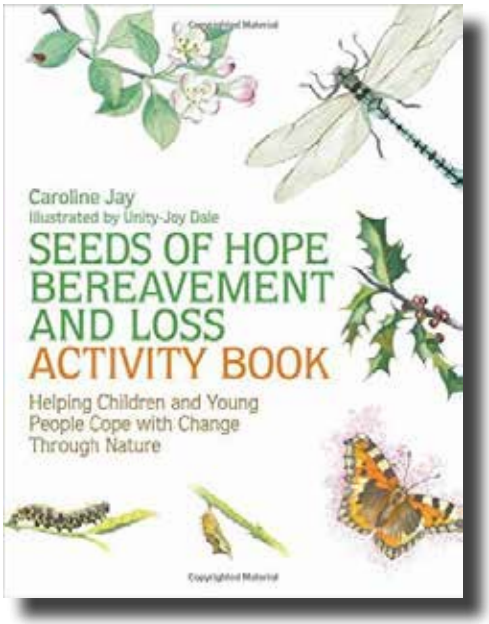
Dr. Cóilín Ó Braonáin Reg.Psychol., Ps.S.I. has been practising psychotherapy and psychology in Limerick and the Mid-West of Ireland for 15 years. He works with adults, adolescents and children using a variety of psychological therapies.

He holds a Bachelor's Degree (magna cum lauda) in Psychology and Philosophy from Marquette University in Wisconsin, USA. A Master's degree in Humanistic and Integrative Psychotherapy (1st) was awarded by the University of Limerick. More recently Cóilín earned a doctorate in Developmental Psychology at Mary Immaculate College, Limerick. Other courses completed include a Certificate in Play Therapy from the Children's Therapy Centre in Westmeath, and a certificate in Filial Play Coaching from Play Therapy Ireland. Cóilín is a professional accredited member of the Irish Association of Counselling and Psychotherapy (IACP).

Book Review

Title:	*Seeds of Hope Bereavement and Loss Activity Book; Helping Children and Young People Cope with Change through Nature*
Author:	Caroline Jay
Published:	October 2014
ISBN:	978-1849055468
Reviewed by:	Gayle Kearney, Child and Adolescent Psychotherapist, Play Therapist

This is a beautifully illustrated practical activity book to help children and young people cope with change and loss. It was written by Caroline Jay the founder of Seeds of Hope Children's Garden charity. The book was illustrated by Unity-Joy Dale who is an artist and creative therapist. Caroline Jay has extensive experience working with those who have experienced loss.



This book is aimed at children over the age of 5 years old and is applicable for those up to adolescence, and beyond in my opinion. It is written to be appropriate for use with individuals and groups. There is a proportional emphasis on using the activities within the school setting. The central message is that change and loss are part of the natural cycle of life.

In recent years the understanding of the healing and transformative value of nature has come to the fore again. This book certainly builds on this re-emergence. It offers plenty of activities and activity prompts on the theme of transition and change. It facilitates the sharing of experience s and encourages social support through activities such as making a Memory and Loss Tree, and a Feelings Tree. Furthermore it provides lots of opportunities for learning and meaning making to be generalised by outdoor activities such as finding creatures and plants.

A real strength of this activity book is its use of metaphor and symbols. These appeal to the natural play-language of children, whilst also offering a strategy to engage young people. Through personalised projections and storytelling, children and young people are empowered to explore the often polarised and juxtaposition of happy memories and painful losses. They are enabled to explore the fabric of their experiences and of life. This is in essence a path towards healing and transformation.

The book includes information about loss and bereavement. It provides information about how children of different ages can react to death. It also offers guidance on how to support children and young people's coping in primary and secondary school settings. This information is plain and simple. It is helpful for parent readers or those with a basic familiarity with the area.

This book is full of useful activities that can make the focus accessible for a broad range of clients in a variety of settings. The style of writing is easy to read and the length of each chapter encourages the reader to pick up and choose the activities most relevant to them. This book does not offer a manualised programme which makes it very adaptable. Yet it could be argued that without a solid prerequisite understanding of the process of grief, the reader needs a clearer layout in order to structure and support the use of the book's intervention tools.

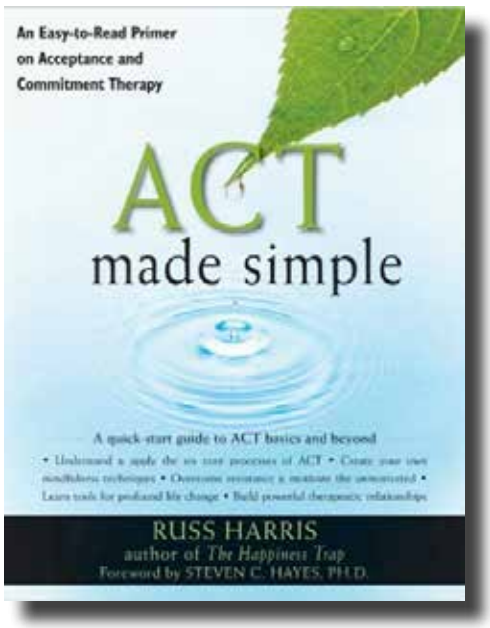
Overall, this book provides valuable resources. The extensive experience of Caroline Jay, combined with the insightful talent of Unity-Joy Dale makes this activity book inspiring to say the least. It has a place on the book shelves of counsellors, play therapists, art therapists, creative therapists, teachers, support workers and parents.

Book Review

Title:	*Act Made Simple*
Author:	Dr. Russ Harris
Published:	November 2009
ISBN:	978-1572247055
Reviewed by:	Clair Be-Maguire, MIACP

If you have any interest in Acceptance and Commitment Therapy, this book ***'ACT Made Simple'*** by Russ Harris is the book for you. Harris may be known to you from his other books *'The Happiness Trap'* and *'The Confidence Gap'* and *'The Reality Slap'*.

The use of ACT - pronounced 'act', (ACT; Hayes, Strosahl, & Wilson, 1999) is a proven therapy for a myriad of disorders aiming to increase psychological flexibility. It comes out of the third wave of CBT interventions focussing on present day functioning and is also connected to Mindfulness by staying in the present moment. It has 'values guided action' at its core and uses 'defusion' or 'un-hooking' processes and asks "what is deep in your heart?"



Harris de-mystifies ACT explaining that what we are aiming for is to let go of the struggle with our thoughts and feelings. This is done through accepting them while understanding that acceptance does not mean liking, wanting or approving of them. Instead we can put energy into moving in the direction of our values and making our lives more meaningful.

He takes you through 'The Six Core Processes of ACT' over fifteen chapters supported by references, expandable worksheets, websites, links to MP3downloadable files and podcasts along with YouTube videos and Newsletters you can link into. It is peppered with good common sense practical tips and usable scripts which you can adapt. Furthermore, he provides explanations and remedies for pitfalls or roadblocks that can arise whereby clients may believe that they can *control* their feelings with defusion or that it is a magic wand.

As an example, to lessen the impact of negative self judging, e.g.- *'I am useless'* try fusing with the thought for ten seconds and then defusing it by singing it to the tune of 'Happy Birthday' or hearing it in the voice of a cartoon character, without trivializing the thoughts or feelings associated with it. There's also a helpful summary of Defusion Techniques (p. 124).

One metaphor I particularly liked was 'Demons on a boat' (p.147). This 'defusion' technique assists with what is called 'creative hopelessness' and provides you with a script that you can modify for each client. Additionally, Harris has devised many other defusion exercises alongside Mindfulness skills.

ACT emphasizes that thoughts are not seen as being correct or incorrect but as being useful in obtaining a more valued life. The normality and evolution of negative thinking is explained and how it judges, compares and predicts the worst. The idea of this normality also sends a powerful message to clients that their mind is not dysfunctional and is only doing what all minds do.

He also explains how to help a client unpack and accept emotions and talks about 'the nine basic emotions' (p.142) and concludes that most of us consider at least six of these emotions to be negative. He asks this question – how realistic is the idea of a 'feel good society' or the notion that we should feel good all the time, when at least two thirds of all human emotions we repeatedly experience are negative?

ACT looks at the 'Three Senses of Self'- The Conceptualized Self, the Self –as Awareness and Self-as-Context (p. 174) which allows clients to stand back from themselves and observe self.

He explains the concept of a 'Living Person's Goals' (p.65) as opposed to as 'Dead Person's Goals' by which he means a dead person's goal is anything that a corpse can do better than a live human being. So a corpse will never yell at their kids, use drugs or be depressed. So the therapist helps the client to move by asking what can you do differently with your living life?'

The book is aimed at newcomers who want a quick and simple introduction to the ACT model. However, it is also detailed enough to be a resource and a refresher for the more experienced counsellor.

IACP South East is presenting an ACT workshop on Saturday 21st November - please see Workshop Notices.

Workshop Review

RECONNECTING SEXUAL INTIMACY

Presenter:	Fiona Daly	Reviewed by:	James McDonagh
Date:	Saturday 25th April 2015	Venue:	The Spencer Hotel, IFSC, Dublin 2
Organised by:	Dublin Regional Committee		

A workshop designed to give couples therapists some techniques drawn from contemporary Tantric practices that help re-ignite sexual intimacy.

The aim of the workshop was to introduce and experience four or five Tantra techniques that would be helpful for the therapist working with couples where sexual intimacy was in difficulty or non-existent. Fiona brought an element of fun and play to the day. It was interesting to observe five men and thirty five women engage with the experiential techniques and to be open about sex.

Secure attachment plays a very important role in using any technique to help couples reconnect sexually. Stress or fear requires recognition so as to help couples develop techniques to counter them. Attachment theory well recognises that the play and exploration cease the moment fear enters the room or the relationship.

Fiona's opening exercise introduced the "Dance of connecting, merging and separating" which brought a sense of play, relaxation, and fun to the start of the day. Then Fiona addressed the meaning of Tantra and the Tantric view of life, which resonates with Maslow's Self-actualising tendency. Tantra is most famous in the west because of its association with sex as a spiritual practice. However, it is about an even more expansive experience of one's self and one's relationship with everything in life. This includes sexual energy that created us and allows us to procreate.

Fiona's model of working with the experiential exercises is based on promoting secure attachment, which include the role of care giving and receiving; attunement and mirroring; and touch and consistent benevolent emotional responding. This is as essential in the adult attachment as it is in childhood attachment. Triggering the fear system causes a turning away from each other with rigidity and an inability to play. The goal of this is to be "an individual in a secure dependent relationship while being independent and individual, inviting the other into your life". The experiential exercises demonstrated were:

Boundary awareness: this facilitated experiencing both active and passive participation, where the active person was 'in control' tuning into their own bodies and directing the passive participant to move towards or away from them, while also being tuned into and experiencing the response in their own bodies.

Listening to the breath: with both active and passive partners, the active partner attuned their own breath and breathing to their partners while mirroring every noise, sigh or throat clearing made by the passive partner.

Soul gazing: both partners sitting close enough to see their partner's eyes. The aim is to be mindfully present, allowing oneself to be seen by their partner, while also noticing and attending to what is surfacing in emotions as well as what is happening in their body.

Touching for your own pleasure: with both an active and passive partner, the active partner touches and explores their partners hand, forearm, or face for their own pleasure. The passive partner is allowed to respond to what is pleasing or displeasing for them.

Using the attachment model Fiona brought very practical exercises to us as a group of therapists that helped us to find new and creative ways of working with clients who find it difficult to connect.

For more information on similar workshops and events please go to Fiona's website www.fionadaly.com

Workshop Review

COMPLEX FAMILY CONFIGURATION: MEANING MAKING & IDENTITY FORMATION FOR THE ADOLESCENT.

Presenter:	Bronagh Starrs	Reviewed by:	Jimmy O'Connell
Date:	Saturday 6th June 2015	Venue:	St Michael's Family Life Centre, Sligo
Organised by:	West.North West Regional Committee		

Bronagh Starrs is a widely respected psychotherapist, teacher and workshop presenter. Her particular expertise is dealing with children and adolescents in the family context. In this particular workshop she focused on the adolescent's experience of parental separation and divorce.

In a family that has experienced separation and divorce the fall out can be very traumatic for all concerned. The adolescent can find herself or himself in the throes of a power struggle between their parents and newly 'adopted' parents, step brothers and sisters, the wider system of social services, social workers, counsellors, psychologists, psychiatrists, and the legal system, and then between themselves and the school system where very often their behaviour triggers a referral for interventions. This can be hugely confusing and dis-empowering for the adolescent.

In the workshop, Bronagh very successfully explored the complexities of the situation from the adolescent's point of view. She also pointed out how important it is that we as counsellors and psychotherapists working with adolescents do not succumb to "urgency and despair". As we naturally want to help our young client's and also want what is best for them, we feel the "urgency" to resolve and solve their problems. We also feel the "despair" at our failure to do so as well as at the daunting task it is to work with families going through such a complex set of emotions and decisions. "Nothing good is done in urgency and despair".

In all the confusion and pain that families, and especially adolescents go through, the essential task of the counsellor/psychotherapist is to focus relentlessly on setting boundaries and to avoid getting sucked into the game of rescuing the parent and allowing an alliance with one parent over another, or against the adolescent. Secondly, the aim is to be relational with the adolescent rather than trying to quickly fix the "problem"; our relational contact with the adolescent client will lead to a strategy and then to a particular effective technique that will be useful for this client and this time.

I would highly recommend Bronagh Starrs to anyone working with adolescents. She has a deep and practical understanding of the life and experiences of the adolescent. Spending a day in her workshop helps you see how important this kind of work is and how rewarding it can be. More importantly it helps understand how to avoid the pitfalls that are ever present when working with this particular client group.