Éisteach

The Irish Journal of Counselling and Psychotherapy

Volume 15 • Issue 4 • Winter 2015

Existential & interpersonal isolation are intricately interwoven

- **Depression – Understanding and Therapeutic Intervention**
- **Reunion in Adoption – A Tumultuous Life Event**
- **The Affects Social Media has on People with Eating Disorders**

iacp

Irish Association for Counselling and Psychotherapy

Contents

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

Design and layout:
GKDesign.ie

Co-ordinator:
Deirdre Browne.

ISSN:
1393-3582.

Advertising rates and deadlines:
Contact the IACP for details. (Early booking essential.)

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.'

Disclaimer:

The views expressed in this publication, save where otherwise indicated, are the views of contributors and not necessarily the views of the Irish Association for Counselling and Psychotherapy. The appearance of an advertisement in this publication does not necessarily indicate approval by the Irish Association for Counselling and Psychotherapy for the product or service advertised.

Next Issue:

1st March 2016

Deadline for Next Issue:

24th January 2015

Scripts:

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,

When I volunteered to edit the winter edition of Eisteach some months ago I could not have known that my professional and personal life would be the busiest it has been all year. So as I was chasing my tail I began to mutter to myself about why I am doing this when I am so busy? But my reasons for volunteering both as an editorial committee member and occasional scribe came quickly to mind. First of all I get to learn a valuable skill; I get to influence even if only indirectly, the pursuance of the aims of my governing organisation, and last but not least my inherent need to belong to groups is met. My thought processes then led me to think about all the other volunteers in IACP who carry out the essential work of achieving the organisation's objectives, such as The Accreditation Committees, the Regional Committees, the Committee that organise workshops etc. So here's to the volunteers. Free association led me to recall an aphorism I heard many years ago "if you want something done ask a person who is busy".

Around the time I was reading articles/essays for this edition I was dipping in and out of the Essays of the renowned 16th century essayist, Michel De Montaigne. Montaigne invented the word *essai* - meaning trial - as a literary term, in order to test his response to different subjects and situations. He wrote about almost everything e.g On the education of children, On liars, On idleness, On presumption, On books. He even wrote about his toilet habits. But all the time he is making a trial of himself and his opinions to see which of them are permanent and which of them are temporary. Have you dear reader some idea you want to trial? Or do you already have a favourite essay/article stuck in the back of a drawer, perhaps from your college days, that might just need some up-dating? If so why not let my colleagues and I on the Editorial committee have a look at it. We will give you gentle feedback if it needs some tweaking, and whilst you may not make it to print first time around, don't give up, as the Noble Laureate Samuel Beckett said 'fail, fail again fail better".

So with regard to the Winter edition I want first all to thank the subscribers Krzysztof Kielkiewicz and Ivan Kennedy (co-authors), Mari Gallagher and Mairead Carey for taking the time to write and submit articles on issues which are grist to the mill for therapeutic intervention.

Mari Gallagher's article on Reunion in Adoption aptly uses the word tumultuous to describe the event of adoptees seeking reunion with birth parents. Mari an adoptive mother herself, explores reunion from the viewpoint of the adult adoptee with particular reference to the Irish context and suggests how we might work with the adoptee adult in the counselling relationship. The search for one's biological parent needless to say has to precipate the searcher, into a roller coaster of emotions. So by means of projective identification it is possible that the therapist will also feel at least some of the client(s) emotional upheaval particularly if there is unacknowledged grief residing in the therapist. Mari outlines how we might work with the adopted adult who has reunited with a birth parent.

Krzysztof and Ivan have presented us with an extremely well researched article on the etymology of the construct depression and particularly its meaning in the discipline of psychology today. Krzysztof's and Ivan's review paper 'aims to examine existing knowledge [regarding depression] in order to develop a comprehensive model of therapeutic intervening. I was particularly moved by the information that 66% of people who are clinically depressed do not undertake any treatment, nor consult their GP [HSE report] particularly as statistics suggest that the vast majority of people who undertake treatment against depression successfully recover. Could we as an organisation do something about this?

Mairead's qualitative research article on the effects of social media on people with eating disorders although undertaken with a small sample of the population -17- produced disquieting enough information to warrant further research with a larger number of participants. What was most disquieting was the report by some of the research subjects of the negative outcomes of seeking information or support via social media. Some 93% of the respondents found that 'graphic images would trigger their disordered eating behaviours". Some participants received mails "requesting a fasting buddy". This is where you would invite a person online to restrict food intake alongside you so that it would keep the person motivated to starve themselves.

So colleagues I hope you find this edition's articles as informative and as moving as I did. Maybe even some of you will be moved to take political action. Who knows. I will leave you with a reminder that the Committee's inbox is somewhat on the skimpy side. Are you busy enough to change that? We will be delighted to hear from you.

Maureen Raymond-McKay

Depression - Understanding and Therapeutic Intervention

by Krzysztof Kielkiewicz & Ivan Kennedy

Abstract

Depression is considered a mental disorder of increasing incidence throughout current civilised societies. Studies suggest that 25% of people are or will be touched by this problem. Recent literature extensively investigates various aspects of depression to ascertain models to understand, cope, and heal this dysfunction. Depression, as an ailment, is handled by various medical and therapeutic approaches (including psychiatry and psychotherapy) which appear as specialised and diverse. This review paper aims to examine existing knowledge in order to develop a comprehensive model of therapeutic intervening. For this purpose, it utilises recent studies and presents pros and cons of different therapeutic understandings and models of intervening with depression.

Introduction

Even though the term "depression" was not generated within the discipline of psychology, in recent decades it has become highly associated with it as a mental state and syndrome of psychological imbalance. The reason for this lays, perhaps, in the fact that depression appears increasingly as a problem within civilised societies. Statistics suggest that 10% of people living in economically developed and developing societies suffer from depression. According to the HSE, around 300,000 (7.7%) of the population of Ireland have depression (HSE, 2014). The highest cause of admissions to psychiatric hospitals in Ireland in 2009 was depressive disorders (CSO, 2012, Table 5.10). According to the HSE (2014), every fourth woman and every tenth man living in the Republic of Ireland has experienced or will experience depression at certain stage of life. Despite the fact that men are less likely to experience depression, they are more likely to die by suicide than women. Although 10,000 people are hospitalised in Ireland yearly, costing the Irish economy around 170 million euro, 66% of people who are clinically depressed do not undertake any treatment nor consult with their GP[1]. If all clinically depressed people did undertake treatment, the cost would rise to over half a billion euro yearly. Nevertheless, statistics suggest that the vast majority of people who undertake treatment against depression successfully recover (Keller & Boland, 1998; Kessler et al., 2003) and that the promotion of treatments would be a valuable pursuit.

Various disciplines have developed many understandings of this social problem and accordingly employ courses of treatment. The theme of depression is broadly investigated in current medical and psychological literature (Bose, 1995; Berger et al., 2008); whereas many aspects are well explored, knowledge about depression still expands. The aim

[1] HSE report published in *Independent.ie,* 2004.

of this research paper is to present a comprehensive understanding of the problem of depression based on the existing evidence within different disciplines.

Understanding of Depression

Ancient Greeks identified four personality types (or *humours*): choleric; melancholic; sanguine; and phlegmatic. These humours were understood as somatic fluids that ran through the human body and affected personality and attitudes. i.e., any deficiency or excess of any of them caused an imbalance and an unhealthy condition.

Hippocrates (460-370 BC) identified personality with dominant levels of melancholia as a disease. In his work *Aphorisms* (section 6.23), he stated, "fears and despondencies, if they last a long time" are symptoms of illness. Clearly, the depressive human condition was recognised many years ago. However, the term "depression" has seen many definitions contingent upon area of study, e.g., geography, a ground lying below the sea level (Barnhardt, 1995), economics, a severe recession sustained for two or more years with symptoms of unemployment, decline in gross domestic product, the bankruptcy of companies and other economic failures (MacFarquhar, 1997), and medicine/psychiatry a long-term state of low mood with aversion to any initiative or activity, affecting thoughts, feelings, behaviour and sense of wellbeing (Salmans, 1997).

From the psychological viewpoint, Newman (2007) identifies (i) depressive symptoms as disadvantageous and long-term states characterised by sad mood, tearfulness and feeling down, (ii) depression as more severe and extensive feelings of low mood, despair, self-depreciation, guilt, self-blame, hopelessness and helplessness, and (iii) clinical depression as associated with somatic disorders of eating, sleeping (extensive or reduced), with long-term lasting chronic pains; the aftermath of which could be a self-harming mentality and severe cases may be characterised by withdrawing from reality and experiencing delusions, hallucinations or becoming psychotic.

It is generally accepted that mammals evolved developing attachment as an environmentally advantageous adaptive feature helping to survive in harsh environmental conditions by ability of building social bonds. In order to prevent breaking relations and social bonds, mammals' brains developed a negative reaction to loss and breaking union by experiencing so called "separation distress". This sensation could be captured by such words as protest, panic or despair (see Solms, 2012). Many premises referring to this constant and pathological experience of separation distress are linked to depression. Somatically, separation distress is activated by releasing hormones and peptides to the body system. However, what causes this pathological experience of despair remains unclear. Perhaps, the answer does not necessarily lie in the hands of anthropologists and biologists.

Psychiatry

In psychiatry, depression is perceived as a neurological reaction to an imbalanced level of hormones or other neurochemicals. Neuropsychologists and psychiatrists believe that depression is largely caused by a low level of the neurotransmitter serotonin, which is responsible for feelings of wellbeing such as happiness (Young, 2007). According to Solms (2012), recent decades of neuropsychological research on depression vastly focused on the processes of serotonin depletion as a reason for depression (Schildkraut, 1965; Harro & Oreland, 2001; De Kloet et al., 2005; Zupancic & Guilleminault, 2006; Levinson, 2006; McEwen, 2007; Koziek et al., 2008). However, other findings demonstrate that serotonin depletion is not a direct cause of depression (Delgado et al., 1990), because this neurotransmitter plays the role of modulator while experiencing emotions and feelings either positive or negative (Berger et al., 2009). This suggests that while serotonin is important in experiencing or non-experiencing of depression, it does not cause nor prevent depression itself.

Leaving aside the complexities of neuropsychological reactions in the human nervous system and discussion of whether one neurotransmitter or another triggers depression, it can be said that beyond the biochemical processes, the grounds of the ailment lies somewhere else; perhaps somewhere deeper than within the sphere of somatic and neuropsychological reactions. Somatic and neuro-somatic actions in the body do not appear unreasonable, but are triggered by beyond-body stimulation, which are environmental, psychological, and/or spiritual.

Behavioural Approach

Within the growing psychological and psychotherapeutic family of sub-disciplines, behaviourism plays an important role. With CBT, and its pragmatic tools of intervention, behaviourism is commonly recognisable as a fast and effective manner of therapeutic help for

many issues, including depression (for more on the effectiveness of CBT in therapy see Elkin et al., 1989; Clarke et al., 1999).

Skinner, the father of behaviourism, defines humans as organised systems of responses (Skinner, 1953). According to behaviourists, human personality consists of acquired experiences, genetic conditions and learned behaviours. Personality is just a complex of contingencies which expresses itself through the repertoire of behaviours (Pérez-Álvarez & García-Montes, 2006). Different personalities have different contingencies according to their different repertoires. Depression, in this context, functions as a learned attitude, out of which the maladaptive thoughts and behaviours create a state of depression. Treatment of depression is based on the unlearning of these maladaptive thoughts and behaviours and the learning of adaptive repertoires of behaviour.

However, behavioural understanding of depression as well as the whole concept of behaviourism faces challenges, especially in recent decades. Psychoanalysis can perceive behaviourism as a superficial concept that neglects large spheres of the human condition (Moran, 2008), psychoanalysts can perceive behaviourism as limited as it neglects the unconscious sphere of a personality, which plays a crucial role in understanding and handling depression from a more comprehensive perspective (Milton, 2001).

Psychoanalysis

Simplifying the psychoanalysts' perspective, mental dysfunction is a reaction to unconscious and repressed feelings. Although feelings can be reactions to direct environmental stimuli, reactions to subconscious and/or repressed feelings may appear in a form of negative experiences, popularly called depression. Feelings associated with depression are very similar to those accompanying loss and grief. The difference, however, lies in the processing of both conditions. Whilst grief is typically a dynamic process from the experience of loss to recovery, depression is a constant and long-term experience of the aforementioned negative feelings. Therefore, the statement can be made that depression is a pathological form of grieving or a pathological reaction to loss (Freud, 1917, see pp. 239-258). This opinion is also shared by Bowlby (1969; 1980) who believes that first depressive symptoms are triggered by the experience of social loss. Further psychoanalytical explanations of depression link biology and evolution (Freud, 1917).

When the basic social bond between mother and offspring is lost, the offspring automatically and subconsciously feels "bad" rather than consciously acknowledging that the loss of the mother decreases chance of survival. Similar happens to the mother (Solms, 2012): the "feel bad" is just an emotional shortcut to and/or a simplification of a long conscious thought process (Bowlby, 1980).

Carey (2005) calculates that since our bipedal ancestors left the trees, they spent 99.6% of their evolution time living in the pre-agricultural stages; modern humans' lifestyle changed drastically within only 0.4% of the entire evolution time. Additionally, our ancestors lived for millions of years in hunter/gatherer groups of 20-150 individuals. Usually, they were preoccupied with survival challenges including the need to eliminate a useless individual from the original herd, e.g., an old male who is unable to hunt and an old female who cannot breed nor feed. As such, depressive symptoms like shame, rejection, uselessness, and guilt developed within a time when one's survival was more precarious (Carey, 2005).

Intervening with Depression

Psychiatry

Since psychiatry categorised clinical depression as a mental illness, comprehended as an excess or shortage of certain neurochemicals in the body, the goal of treatment is to bring the body system back to balance by use of drugs or other medical means. Treatment, therefore, intends to stimulate some neurological processes which influence a sensation or perception of self towards increasing the client's wellbeing. Contrarily, the process may break some neurological process causing negative feelings in order to achieve the same purpose.

Antidepressants are the most popular ways for treating depression; however, placebo pills are also effective. Another method is electroconvulsive therapy which stimulates the brain to facilitate relief in the illness (Rudorfer et al., 2003). Similar to electroshock is a developing method of deep brain stimulation (Marangell et al., 2007). This technique implants an electronic device into the brain which constantly stimulates a specific part of the brain in order to release the tension. Similarly, magnetic stimulation utilises magnetic streams instead of the electric one.

Among less popular ways of treating depression in the psychiatric field are giving up

smoking, music therapy, light therapy, exercises, meditations, which would belong to niche and experimental methods.

Numerous scholars see the weakness of the psychiatric approach to the problem of depression in overrating effectiveness of antipsychotics and other medications. DePaulo (2010) says that "some psychiatrists refer to themselves as psychopharmacologists, a term meant to indicate their expertise in the use of psychotropic medicine" (DePaulo, in Hartelius, 2010, (p. 170). A similar sentiment is shared by many psychiatrists, e.g., William Glasser.

Glasser (2003) states that the psychiatric approach could worsen the patient's condition as some depressed people are not sick in psychiatry terms but are simply extremely unhappy. As said by Hartelius (2011, p. 124), "science and medicine do not tell the whole story" [of depression], it can also be said that psychiatry is unable to give extremely sufficient tools to handle depression to its core; then, in the search for solutions the same task needs to be directed to other bodies.

CBT Approach

The cognitive-behavioural approach to depression focuses on coaching and elimination of maladaptive thoughts, behaviours and emotions that stimulate and/or exacerbate depression. The first step in therapy would be to identify the irrational beliefs feeding depression such as, "I am useless", "I must do...", etc. A further aim would be a transformation of these thoughts into more rational ones such as "sometimes I fail, but I am not bad", "I do not have to do...", etc. The aim of CBT is to challenge the client's way of thinking from 3 perspectives – logical (if what the client thinks makes sense), empirical (if what the client thinks appears in reality) and pragmatic (is the client's way of thinking helpful in everyday life?) (Dryden, 1999; James, 2012).

The behavioural therapeutic approach is largely based on simple mind training. From session to session, interspersed with homework, the client practices new ways of thinking and behaving – adaptive ways. The tasks would be formed depending on the character of depression and the specific issues faced by the client (Dryden, 1999; James, 2012). CBT is a goal oriented therapy with strategies to teach the client to control the thoughts and behaviours in order to eliminate depression as a dysfunctional condition and to learn how to maintain balance in life. The role of the therapist is to coach and educate on the path to therapeutic solutions. However, as mentioned above, a limitation of this approach is that CBT intervention works on the conscious level only (Solms, 2012) whilst excluding and not even referring to the deep layers of human personality. In some cases, such exclusion of (crucial) subconscious processes may detract from the therapy and hinder healing depression.

Reality Therapy/Choice Theory (RT/CT) Approach

RT/CT is a therapeutic approach developed by William Glasser (1925-2013), an American psychiatrist who moved into psychotherapy[2]. According to Osatuke et al., (2005) RT/CT was a transitional approach between CBT and Person Centred Therapy (PCT).

The RT/CT approach to the problem of depression perhaps starts with the understanding of the client's dysfunctional "Quality World" that refers to things, people and meanings present and driving the individual's life. The client's general outlook on one's own self, personal values, other people, material things, relationships etc., does not operate as it "should" or as the client wants it. This causes a complexity of negative dynamics in forms of thoughts, emotionality, physiology, and/or actions (Total Behaviour) causing depression. In other words, the person acts and thinks in a destructive or inaccurate way so she/he feels bad emotionally and/or physically. The goal of RT/CT would be an identification of the dysfunctional thoughts and behaviours and changing them, what consequently would positively influence the client's interaction with reality through feelings, emotions and somatic responses (Glasser, 2010).

The role of a therapist is to assist and to help to identify the dysfunctional thoughts and behaviours and then to help the client to undertake constructive decisions to change life. Limitation of RT/CT is that this approach generally is focused on solution than causes. Additionally, it does not pay much attention to the client's individual sensitivity and needs that could be satisfied in the way of therapist's being.

Rogerian (PCT) Approach

Carl Rogers (1951) was an American psychologist who introduced a new and innovative approach to therapy. The PCT approach changed the focus from the psychological dilemma of the client into a genuine relationship with the client and counsellor. The problem of depression in PCT could be generally understood

2 William Glasser graduated (MA) in 1947 in clinical psychology and in 1949 (MD) in psychiatry.

as a consequence of sacrificing one's own self for the benefit of positive regard from others. This theoretical frame could be applied to any specific condition where depression develops and damages the well-being of a person who loses touch with one's deep self. Consequentially, the developed ailment would manifest itself by incongruence, a discrepancy between one's being and acting. PCT emphasises a client's role in the process of recovery and the role of the therapist is to assist with the client's journey. The counsellor offers a genuine relationship to the client and the goal of the therapist is also to look at the problem from the client's frame of reference by employing an emphatic understanding.

With depression, PCT, as a humanistic approach, utilises various theoretical backgrounds without restrictions, as long as they may be helpful. The healing notably occurs through the accepting relationship with the therapist which leads to self-acceptance within the client. On the path of healing, PCT works from the reference of client's self-actualising tendency. This means that it is a natural desire for every human being to be healthy, strong, mature, wise, free, etc., and every person has a capacity to follow this path. Limitation of the PCT is a perspective of lengthiness in the therapeutic process and perhaps only psychoanalysis proceeds slower. Perhaps, this is the reason why PCT has poor prospects to be incorporated as a part of health care. Insurance companies are unlikely to invest in long-term treatment which does not diagnose a problem.

Conclusion

The discipline of counselling and psychotherapy develops as a humanistic approach to the problem of human mental health. It expands within its own theoretical and practical framework; however, it is also a largely interdisciplinary utilisation of achievements from the fields of humanities, social science and medicine. References to the above enrich perspectives on various current psychotherapeutic concerns. Development of psychotherapy as an occupational paradigm, but also as an academic discipline, requires interdisciplinary confrontation with different practical and theoretical forums. Current disciplines of social sciences or humanity also do not grow within isolated frames, but utilise achievements of other disciplines for their own purposes.

Due to the fact that theories included in this study represent very developed concepts, this paper had to refer to the core of their comprehensions. Therapeutic disciplines and traditions which were presented herein aimed at capturing the deepest core of depression and to embrace the most meaningful knowledge reflecting the ailment. The above presented content cannot be considered as a complete approach; this goal would be very difficult to achieve in the context of such developed evidence. Whilst there is an increase of the depressive disorders emerging in civilised communities nowadays, raising knowledge about the problem within society is important.

References

Ardila, R. (1988). Sı´ntesis experimental del comportamiento [Experimental synthesis of behaviour]. *Madrid, Spain: Alambra*.

Barnhardt, W. A., Gehrels, W. R., & Kelley, J. T. (1995). Late Quaternary relative sea-level change in the western Gulf of Maine: Evidence for a migrating glacial forebulge. *Geology*, *23*(4), 317-320.

Berger, M., Gray, J. A., & Roth, B. L. (2009). The expanded biology of serotonin. *Annual review of medicine*, *60*, 355-366.

Bowlby, J. (1969). Attachment: Attachment and loss (vol. 1). *London: Hogarth*.

Bowlby, J. (1980). Attachment and loss: Loss, sadness and depression (Vol. 3). *New York: Basic*.

Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-behavioral treatment of adolescent depression: efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*(3), 272-279.

CSO (Central Statistical Office), 2012. Women and Men in Ireland 2011, *Government of Ireland 2012.*

De Kloet, E. R., Joëls, M., & Holsboer, F. (2005). Stress and the brain: from adaptation to disease. *Nature Reviews Neuroscience*, *6*(6), 463-475.

DePaulo, B.M., in Hartelius, E. J. (2010), The rhetoric of expertise.

Delgado, P. L., Charney, D. S., Price, L. H., Aghajanian, G. K., Landis, H., & Heninger, G. R. (1990). Serotonin function and the mechanism of antidepressant action: reversal of antidepressant-induced remission by rapid depletion of plasma tryptophan. *Archives of general psychiatry*, *47*(5), 411-418.

Dryden, W. (1999). Structured disputing of irrational beliefs. *Glodsmiths University of London*.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F. & Parloff, M. B. (1989). National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments. *Archives of general psychiatry*, *46*(11), 971-982.

Freud, S. (1917). Mourning and melancholia. *Standard edition*, *14*(239), 1957-61.

Glasser, W. (2003). *Warning: Psychiatry can be hazardous to your mental health*.

HarperCollins Publishers.

Glasser, W. (2010). *Choice theory: A new psychology of personal freedom*. Harper Collins.

Harro, J., & Oreland, L. (2001). Depression as a spreading adjustment disorder of monoaminergic neurons: a case for primary implication of the locus coeruleus. *Brain Research Reviews*, *38*(1), 79-128.

Hippocrates, *Aphorisms*.

HSE, (2014). Depression. Available at: http://www.hse.ie/eng/health/az/D/Depression/ [Accessed on 28.03.2014].

Hyde, M. J. (2011). The expertise of human beings and depression. *Social Epistemology*, *25*(3), 263-274.

Independent. ie, (2004). Depression: The Symptoms, The Statistics, The Help. Available at: http://www.independent.ie/unsorted/features/depression-the-symptoms-the-statistics-the-help-25907766.html [Accessed on 28.03.2014].

James, P. (2012). *Disputing Irrational Beliefs*. IICP College Dublin, Unpublished article.

Keller, M. B., & Boland, R. J. (1998). Implications of failing to achieve successful long-term maintenance treatment of recurrent unipolar major depression. *Biological psychiatry*, *44*(5), 348-360.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., ... & Wang, P. S. (2003). The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *Jama*, *289*(23), 3095-3105.

Kozisek, M. E., Middlemas, D., & Bylund, D. B. (2008). Brain-derived neurotrophic factor and its receptor tropomyosin-related kinase B in the mechanism of action of antidepressant therapies. *Pharmacology & therapeutics*, *117*(1), 30-51.

Levinson, D. F. (2006). The genetics of depression: a review. *Biological psychiatry*, *60*(2), 84-92.

MacFarquhar, R. (1997). *The origins of the cultural revolution* (Vol. 3). Oxford University Press.

Marangell, L. B., Martinez, M., Jurdi, R. A., & Zboyan, H. (2007). Neurostimulation therapies in depression: a review of new modalities. *Acta Psychiatrica Scandinavica*, *116*(3), 174-181.

McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: central role of the brain. *Physiological reviews*, *87*(3), 873-904.

Milton, J. (2001). Psychoanalysis and Cognitive Behaviour Therapy-Rival Paradigms or Common Ground? 3. *The International Journal of Psychoanalysis*, *82*(3), 431-447.

Moran, S. (2008). After behaviourism, navigationism?. *Irish Educational Studies*, *27*(3), 209-221.

Newman, M. (2007). Broader Horizons: Depression. *Bereavement Care*, *26*(2).

Osatuke, K., Glick, M. J., Stiles, W. B., Greenberg, L. S., Shapiro, D. A., & Barkham, M. (2005). Temporal patterns of improvement in client-centred therapy and cognitive-behaviour therapy. *Counselling Psychology Quarterly*, *18*(2), 95-108.

Pérez-Álvarez, M., & García-Montes, J. M. (2006). Person, behaviour, and contingencies (an aesthetic view of behaviourism). *International Journal of Psychology*, *41*(6), 449-461.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory* (p. 491). Boston: Houghton Mifflin.

Rudorfer, M.V., Henry, M.E., Sackeim, H.A. (2003). Electroconvulsive therapy. In A Tasman, J Kay, JA Lieberman (eds) *Psychiatry, Second Edition*. Chichester: John Wiley & Sons Ltd, 1865–1901.

Salmans, S. (1997). *Depression: Questions You Have–Answers You Need. People's Medical Society*. ISBN 978-1-882606-14-6.

Schildkraut, J. J. (1965). The catecholamine hypothesis of affective disorders: a review of supporting evidence. *American Journal of Psychiatry*, *122*(5), 509-522.

Skinner, B. F. (1953). *Science and human behavior*. Simon and Schuster.

Solms, M. (2012, September). Depression: A neuropsychoanalytic perspective. In *International Forum of Psychoanalysis* (Vol. 21, No. 3-4, pp. 207-213). Taylor & Francis Group.

Young, S. N. (2007). How to increase serotonin in the human brain without drugs. *Journal of psychiatry & neuroscience: JPN*, *32*(6), 394.

Zupancic, M., & Guilleminault, C. (2006). Agomelatine: A preliminary review of a new antidepressant. *CNS Drugs*, 20, 981-92.

Krzysztof Kielkiewicz

Krzysztof Kielkiewicz is a pre-accredited IACP psychotherapist who works in Mullingar and Dublin. Krzysztof was previously active as a youth and social worker engaging with young people at risk of social exclusion. He has completed his MA at the University of Poznan and then graduated from IICP College, Dublin. Currently he is doing a Ph.D. in Human and Health Sciences at the University of Huddersfield, UK. More recently, he worked as a research assistant and administration assistant for the *Journal of Criminal Psychology* and is also reviewer for the *Mental Health Review Journal* and *Journal of Forensic Psychiatry and Psychology*.

Contact: kkielkiewicz@gmail.com, mob. 0851506506

Ivan Kennedy

Ivan Kennedy is a pre-accredited counsellor and psychotherapist who works in Carlow and Kilkenny. Ivan is the Director of the Samaritans, Kilkenny & Carlow branch. He holds a BSc in Psychology and PhD in Education and Psycholinguistics from Bangor University, Wales. Ivan has previously worked as a lecturer in Child Development, Masculinity and Psychology of Men and in Research Methods, as an ABA Tutor for children with autism, and as a Care Worker in residential care with adolescents with emotional and behavioural difficulties

Contact: kennedy.ivan@gmal.com, mob. 0851473040,

Reunion in Adoption – A Tumultuous Life Event

by Mari Gallagher

Introduction

This article will explore reunion in adoption from the viewpoint of an adopted adult, outlining relevant statistics in order to estimate the likely incidence of such an issue in the counselling room, together with the possible presenting issues of the adopted person as they relate to both relinquishment in early childhood by birth parent and reunion in adulthood with that parent. Adoption and adoption reunion, as each applies in a general and specifically Irish context, will be covered, to include an exploration of secrecy, silence, shame and disenfranchised grief in adoption. Furthermore, the author will outline how a therapist might work with the adopted adult who has reunited with a birth parent. Finally, the author will evaluate the role of the therapist in helping the adoptee through such a tumultuous life event.

Adoption – an Overview

Adoption, as per Adoption Authority of Ireland (AAI): "provides for the permanent transfer of parental rights and duties from the birth parents to the adoptive parents. An adopted child is considered to be the child of the adopters as if born to them in lawful wedlock." Adoption is a global phenomenon that touches the lives of numerous families. Interest in the role of legal adoption as both a child welfare solution and as a means of alternative family formation for adults wanting to become parents has never been higher (Wrobel & Neil, 2009).

While the positive impact that adoption can make on childrens' life chances has been well documented, the author notes that an extensive body of literature has been published by adopted adults worldwide, outlining deep and passionate dissatisfaction with aspects of the adoption process. International research stresses that adoptees have a higher risk of psychiatric contact than their non-adopted peers (Laubjerg & Petersson, 2011). Adopted adults also carry with them a strong tendency to deny that adoption can be the basis for their problems (Small, as cited in Robinson, 2003, p. 136). The latter suggests, in the author's view, while reunion in adoption may pose challenges that require therapeutic help, and reunion is the specific focus of this article, adoptees may present as clients at any time with an issue unrelated to adoption, and it is important for the therapist to be aware that unacknowledged feelings around adoption may be the root cause.

Adoption – The Irish Perspective

Societal progress has changed attitudes to birth outside of marriage and has led ultimately to fewer children being placed for adoption. Domestic adoption in recent decades has been a rare occurrence in Ireland and the enactment of the Adoption Act 1991 gave intercountry adoption a statutory basis (AAI). Between 1991 and 2007, 3,596 children born outside of Ireland were placed for adoption (in Ireland) as per the Registrar of Foreign Adoptions (O'Brien, 2009). Many of the adult adoptees (+18 years old) now potentially presenting in the counselling room were born in countries such as Romania, Russia, Vietnam and China.

Search and Reunion - Overview

Though it is not the norm, some adoptees start an active search for birth parents during adolescence. Demographic studies indicate that the typical searcher is a young adult – the average age is 29 – and that up to 80% of searchers are female. Psychological searching, that is, clarifying his or her feelings about being adopted, is an inherent part of clinical work with adoptees (Brodzinsky, Schechter & Marantz, 1992). In the author's own experience as an adoptive parent, birth family contact provides relief and fulfilment for the adopted child - in the words of the writer's sixteen year old son upon receiving e-mail contact from his Russian birth sister: "a weight has been lifted from my shoulders."

Erikson's (1950) model of the life cycle indicates the psychosocial task - Ego Identity versus Identity Confusion - as the defining aspect of adoptee adolescence and the period when adolescent adoptees are coping with peer reactions to adoption, connecting adoption to one's sense of identity, coping with racial identity in cases of intercountry adoption and considering the possibility of searching for biological family (Brodzinsky et al, 1992).

Adoptee young adulthood stage – Intimacy versus Isolation – involves further exploration of the implications of adoption as it relates to the growth of self and the development of intimacy, the adjusting to parenthood in the light of the adoptee's own relinquishment and facing one's unknown genetic history in the context of the birth of children (Brodzinsky et al, 1992).

Only in recent years has come the realisation that adopted people, regardless of how apparently problem-free their adoptions have been, experience a deep and painful sense of loss because they have been separated from their birth family.

The central conclusion of a British study (2000) of search and reunion experience of 126 adults adopted at under 18 months and reuniting in their late 30's with birth mothers now in their 50's and 60's was that the reunions had largely been beneficial albeit accompanied by intense emotions (Triseliotis, Feast & Kyle, 2000). The personal accounts are full of apprehension, excitement, relief and often the quelling of longstanding guilt and discomfort.

For adopted people, contact appeared to lead to better integration of the experience of having two families (Triseliotis et al, 2000). Verrier (1993) writes: "reunions often seem to have a calming effect....it's as if the adoptee had been holding his breath for all those years and could begin breathing again. There is a release of tension and a renewal of life" (p.151).

Winterson, a British adoptee who described her reunion with birth family as unsuccessful, writes: "Many people who find their birth families are disappointed. Many regret it. Many others do not search because they feel afraid of what they might find. They are afraid of what they might feel – or worse, what they might not feel" (2011, p. 226). Dodds (1997) an American-German adoptee writes of the loss of cultural and national identity inherent in intercountry adoption and his devastation with reunion with his German birth mother with whom he stated he was unable to form a bond.

An adoptee's reason for searching may ostensibly be to access medical history. To an adoptee, no matter what her age, the cold hard fact that she doesn't know her birth or medical history can be a painful aspect of her existence (Eldridge, 1999).

Positive communication about adoption, in general and in response to a child's specific curiosity, can support active information seeking. The search for birth information is not fuelled by poor psychological adjustment or negative family relationships, but occurs in the context of positive family functioning (Wrobel & Neil, 2009).

Search and Reunion – The Irish perspective.

Given that it is now widely accepted that most, if not all, adopted people need to learn something of their birth history (Eldridge, 1999) the recent passing of The Adoption (Information and Tracing) Bill 2015, is a welcome, positive development for the estimated 50,000 adoptees in Ireland who heretofore have been without the right to their birth certificates or to be given the names of their birth parents (O'Brien, 2015).

The facilitation of reunions is a relatively new phenomenon in Ireland. In 2005, the National Adoption Contact Preference Register (NACPR) was set up to facilitate contact between adopted people and their birth families. AAI (2015) confirmed that 7,516 adopted people and 3,525 birth relatives have signed up to the NACPR since 2005 with a total of matches standing at 706.

This figure, while a relatively low percentage of client population, indicates that reunion in adoption is a growing phenomenon that places demands on the helping professions for increased expertise on the specific complexities of adoption.

Reunions often seem to have a calming effect.... it's as if the adoptee had been holding his breath for all those years and could begin breathing again.

Silence, Secrecy and Shame in Adoption

For generations, people discussed adoption only in guarded, hushed tones, and most laws, policies, practices and attitudes related to adoption were shaped more by good intentions than by good knowledge (Pertman, 2009). The adoptive parent may believe that non-acknowledgement or 'playing down' of the child's adoption is in the best interest of the child. Letting the child know from an early age that he was rejected by his birth parent is likely to make a brutal assault on self-esteem (Kirk, 1984).

Adopted persons who are now adults have taught us important things: secret keeping is damaging and divisive, deception creates family mistrust and shame, and hiding the truth destroys family intimacy and security. Above all, open, honest, sensitive communication about adoption and the past builds the gateway to healthy individual adjustment and family life (Keefer & Schooler, 2000). If adoption has always been treated as an unspeakable secret, the adoptee gets the feeling that being adopted is something horrible and shameful (Brodzinsky et al, 1992).

The existence of a role handicap, that is, situational discrepancies that interfere with competent role performance, impacts on the adoptive parent's ability to deal with the challenges of rearing the adopted child (Kirk, 1984). The adoptive parent's feelings towards adoption can also be a barrier to the adopted person instigating a search for birth family. Adopted people often wait until after the death of adoptive parents to start searching, thereby reducing the chance of reunion with birth parents while they are still living (Robinson, 2003).

Disenfranchised Grief

Doka (as cited in Lenhardt, 1997) defined disenfranchised grief as the grief that people experience from a loss that is not, or cannot be, openly acknowledged, publicly mourned or socially supported. Only in recent years has come the realisation that adopted people, regardless of how apparently problem-free their adoptions have been, experience a deep and painful sense of loss because they have been separated from their birth family. Adopted people often raise issues of their sense of identity and sense of belonging. Because they are told that, by virtue of being adopted, they are "special", "chosen" and "lucky", their grief at the separation from their birth family is denied, by society and often by their adoptive parents (Robinson, 2003). The therapist, consequently, will need to be aware of the possible impact of unacknowledged grief when dealing with the adopted adult.

Implications of Reunion for Adoptee

Notwithstanding that increasing numbers of adopted people are undertaking a search for their birth families, little has been written about the effects of such a reunion on the individual. It is important that therapists are aware of the particular emotional state of adoptees post-reunion (Moran, 1994). The post-reunion emotional state (Moran, 1994) can be divided into four stages:

Stage 1: Paralysis: Initial reaction of utter amazement and shock as the adoptee has looked into the face of the person who gave her life. Paralysis may arise from the simultaneous experience of so many emotions – the mind and soul are on overload. Physically, an overwhelming lethargy may set in, making routine tasks impossible.

Stage 2: Eruption: Emotions will wash over the adoptee like the

aftershock of an earthquake. During this stage the adoptee will have time to absorb the realities of her origins. It is the time when the fantasies about the biological mother and the circumstances surrounding the adoption must be laid aside. Although the truth may set one free, it is not always easy to face.

Stage 3: Loss and Grief: The realisation of loss of bonding in having been relinquished by birth parents can be devastating for the adoptee. In this stage, the adoptee realises that the primary bonding cannot be recaptured. It will take time to move beyond this stage of loss and grief.

Stage 4: Empowerment: With acceptance comes a sense of self-empowerment. During empowerment, the adoptee moves beyond acceptance to the growth of a new self-knowledge and self-awareness.

Lifton (2010) states that in order for a therapist to help adoptees and their adoptive parents, he/she must be able to see the ghosts that accompany them. These ghosts spring from the depths of unresolved grief and trauma that both parties have experienced: loss of biological child by the adoptive parents and loss of birth parents by the adoptee. Professionals cannot really see the adoptees and adoptive parents that enter the counselling room, unless they can see the ghosts that accompany them (Lifton, 2010).

The adoptee in the counselling room

Frankie Pearse, a British adoptee, writes:

> *If you do decide to go for counselling, make sure you go to someone who specialises in adoption. Someone who may not be trained within that field may not understand why you think, feel and act the way you do. I once had a series of sessions with a counsellor who could not understand why I kept wanting to talk about my mother and how she treated me. This experience put me off going to see another counsellor for a while. As I was still suffering from depression, which was getting heavier and heavier in my head, I was advised to go to the Post Adoption Centre (2012, p.53).*

As already outlined, Lifton (2010) emphasises the importance of therapist understanding of adoption issues and how these issues are likely to present in the counselling room.

Self-concept, as described by Rogers (1961), begins in early childhood, when the child starts to experience self as separate and different from other selves. As a way of understanding, the therapist will explore with the adoptee the experiences of childhood. If the adoptive parents transmitted the message, knowingly or unknowingly, that adoption must be kept secret or is something to be ashamed of, the adoptee is more likely to experience problems in adjusting to being adopted and all that being adopted entails (Kirk, 1984). The adoptee has an opportunity, in therapy, to explore occasions of his childhood when he felt different from his adoptive family, both in looks and personality. Feeling different from significant people in one's life often has a profound impact on the adoptee's self-concept (Brodzinsky, 1992). The adoptee may fear that he could lose his adoptive parents, who he senses might feel betrayed by the adoptee's decision to reunite with birth family (Lifton, 2010).

Multicultural counselling

The author believes there are two main strands to multicultural counselling of adopted persons. The first strand refers to a therapist meeting with a client who is of another race but adopted into an Irish family. Racial diversity adds further complexity to the adoption mix. Physical characteristics help children define themselves and make connections with others. Feelings of belonging and security are nurtured by looking like the people around you (Brodzinsky, 1992).

The therapist may be meeting a client who is not only dealing with post reunion emotions but also with the impact of a lifetime of feeling racially different, both within the adoptive family and outside. Gehringer (2014), a Korean adoptee raised in America, writes: "the repetitiveness of questions such as 'speak any Chinese?' filled me with annoyance….the constant reminder that I didn't belong caused me to become full of unnecessary anger and resentment" (p.17). The term "genealogical bewilderment" is used to describe a sense of disconnectedness, a feeling of being cut off from your heritage,

your culture and your race (Sants cited in Brodzinsky, 1992).

The second strand of multicultural counselling of an adopted client relates to the perceived differences inherent in having been reared by non-biological parents and being reared by one's biological family. This perception by the adoptee may exist even if she is of Irish heritage. Adoptees have written of their secret envy of friends who have been reared by their biological families and their perception of such friends as privileged (Curran, 2013).

Conclusion

This article has sought to demonstrate how a therapist might work with the adopted client who has reunited with birth family, by outlining a background to adoption, the current status of adoption reunion in Ireland and the stages of emotion the client might experience. Suggested therapeutic approaches have been outlined.

In conclusion, the author notes the words of Alex Haley (1976/2007):

> "In all of us there is a hunger, marrow-deep, to know our heritage, to know who we are and where we have come from. Without this enriching knowledge, there is a hollow yearning and the most disquieting loneliness" (p. 8).

References

Brodzinsky, D.M., Schechter, M.D., & Marantz H. (1993). *Being Adopted: The Lifelong Search for Self* USA: Anchor Books.

Curran, A. (2013). *Searching for Me – My Adoption Story*. IR: Emu Ink Limited.

Dodds, P.F. (1997). *Outer Search Inner Journey – An Orphan and Adoptee's Quest.* US: Aphrodite Publishing Company.

Eldridge, S. (1999). Twenty Things Adopted Kids Wish Their Adoptive Parents Knew. US: Bantam Dell.

Erikson, E. H. (1950/1963/1964/1986/1993). *Childhood and Society.* New York. WW Norton & Co.

Gerhinger, E. (2014). The Beginning of The End. In Myung-Ja, J, Potter, M.A., Allen, L.V. (ed). *Adoptionland: From Orphans to Activists.* US: Against Child Trafficking Publishers

Haley, A. (1976/2007). *Roots: The Saga of an American Family.* US: Vanguard Press.

Keefer, B. & Schooler, J.E.. (2000). *Telling the Truth to Your Adopted or Foster Child.* US: Greenwood Publishing Group

Kirk, H.D. (1984). *Shared Fate: A Theory and Method of Adoptive Relationships.* US: Ben Simon Publications.

Laubjerg, M., Petersson, B. (2011). Juvenile Delinquency and Psychiatric Contact among Adoptees compared to Non-Adoptees in Denmark: A nationwide register-based comparative study. *Nordic Journal of Psychiatry.* Vol. 65. Issue 6. p365 -372.

Lenhardt, A.M.C. (1997). Grieving Disenfranchised Losses: Background and Strategies for Counsellors. *Journal of Humanistic Education & Development.* Vol. 35. Issue 4. P208. 9p.

Lifton, B.J. (2010). Ghosts in the Adopted Family . *Routledge: Psychoanalytic Inquiry.* 30.71-79. Doi. 10.1080/07351690903200176

Moran, R.A. (1994). Stages of Emotion: An Adult Adoptee's Postreunion Perspective. *Child Welfare League of America.* Vol. LXXIII, Number 3/May-June.

O'Brien, C. (2015) *Right to access birth cert for up to 50,000 adopted.* Retrieved 28 July 2015 from www.irishtimes.com

O'Brien, V. (2009). The Potential of Ireland's Hague Convention Legislation to

resolve ethical dilemmas in inter-country adoptions. *Irish Social Worker. 13-19 Irish Association of Social Workers.* http://hdl.handle.net/10197/3221

Pearse, F. (2012). She is my Past and I am her Future. In P. Harris (Ed.). *Chosen: Living with Adoption* (pp. 50-54). UK: British Association for Adoption and Fostering (BAAF).

Pertman, A. (2009). Foreword. In G.M. Wrobel & E. Neil. (Eds.). *International Advances in Adoption Research for Practice* (p.11). UK: Wiley-Blackwell.

Robinson, E.B. (2003). *Adoption and Loss – The Hidden Grief.* South Australia: Clova Publications.

Rogers, C.R. (1967/1986). *On becoming a person: A therapist's view of psychotherapy.* London, UK: Constable.

Triseliotis, J., Feast, J., & Kyle, F. (2000). *The Adoption Triangle Revisited: A Study of Adoption, Search and Reunion Experience.* UK: British Association for Adoption & Fostering (BAAF).

Verrier, N.N. (1993). *The Primal Wound: Understanding the Adopted Child.* US: Gateway Press

Winterson, J. (2011). *Why Be Happy When You Could Be Normal?* UK: Vintage Books.

Wrobel, G.M. & Neil, E. (2009) *International Advances in Adoption Research for Practice.* UK: Wiley-Blackwell.

www.aai.ie *Definition of adoption*. Retrieved 17 February 2015

Mari Gallagher

Mari Gallagher is a trainee psychotherapist, in her third year, with IICP Killinarden. An adoptive parent to two teenagers, Mari has undergone extensive adoption training with Barnardos Post Adoption Service and aims to specialise, when qualified, in adoption counselling. Her articles have been published In Irish Medical News, Irish Medical Times and The Irish Times.

The Affects Social Media has on People with Eating Disorders

by Mairead Carey

Abstract

Objective: Usage of Social Media (SM) by sufferers of Eating Disorders (ED) has not been widely researched. However as most people use SM e.g. Facebook/Tumblr/Twitter, does this widespread usage cause ED to worsen? Are sufferers of EDs using SM to continue with their disorders?

Method: Interviews were conducted via email, using a list of prepared questions. This ensured that the results provided a qualitative methodology.

Results: The results showed that the majority of participants found SM negatively affected their EDs. These effects were shown to be quite complex.

Conclusion: SM use has a detrimental effect on some people with ED. Problems arose, as it can cause triggers which may lead to relapse. However, a small portion of participants, found that SM use can be inspirational and beneficial to recovery.

Table of Abbreviations

SM	Social Media
ED	Eating Disorder
SMED	Social Media Eating Disorder (used when talking about online profiles)
AN	Anorexia Nervosa
BN	Bulimia Nervosa
EDNOS	Eating Disorder Not Otherwise Specified
PA	Positively Affected
NA	Negatively Affected

Introduction

How does Social Media (SM) affect people with eating disorders? Does SM feed the distorted thoughts of those who suffer from EDs? Does it affect a person's recovery from an ED? If so, is the effect positive or negative? There is little research on the effects of social media on those with eating disorders. There is also very little content published on the use of SM among the psychiatric population (Veretilo & Billick, 2012).

The way in which people communicate has significantly changed since the introduction of the World Wide Web but communication has changed more significantly with the emergence of social media websites (Ozguven & Murcan, 2013). SM has allowed space for virtual communities to be set up (Luxton, June & Fairall, 2012). Communities on the main SM websites such as Facebook, Tumblr and Twitter contain groups that appeal to the similar or common interests of other people but reaching them on a global scale. Through these online communities, a high number of online friendships can be established but a high number of Facebook friends may not reflect actual social support (Junghyn & Jong-Eun, 2011).

There are SM communities set up online specifically for people with EDs. These online communities are sometimes

recovery based sites but there are also communities that are there to inspire people with ED to continue with their disturbed eating behaviours (also known as "thinspiration"). There are communities for Pro Ana (pro-anorexia), Pro Mia (pro-bulimia) and EDNOS (pro eating disorder not otherwise specified). These sites all contain highly emotional material such as: instructions and tips on how to starve oneself, methods for purging, photographs of emaciated bodies or photographs of purging. Those who are currently ill with anorexia show high levels of dysfunction in their emotional processing (Oldershaw et al,. 2012). This may manifest in various ways depending upon how the individual's emotions are affected. For example, they display an inability to communicate their emotions (Davis et al., 2011). For those suffering with anorexia, emotional situations can lead them to restrict their food intake whereas for people suffering with bulimia, it can lead to excessive eating (Danner et al., 2012).

This study examined the consequences of SM use on people who were suffering with an ED. It was hypothesised that those with EDs would be seriously negatively affected and it was hypothesised that the majority of the sample would have SMED(social media eating disorder) profiles, and therefore their recovery would be hindered and relapse would be imminent. The normalisation of ED and competitiveness between online members about their illness was also expected.

Method

Ethics were considered in this research. Effects on myself were considered before undertaking this research as a lot of time was going to be spent on SM profiles dedicated solely to eating disorders, self harm and suicide. The material on these sites could be a potential trigger for myself so I had to make sure supports were in place before undertaking this project. Ethical consideration was given to those who wanted to participate. Anyone who participated in my study had to have an SMED profile. Anyone who did not seem to have any link to the SMED profiles I did not allow participate for ethical and safety reasons.

This is a qualitative research study. A small number of participants were sourced through a Facebook friend. The majority of the participants were sourced through an anorexia recovery Facebook group. I posted a message on the group wall to explain that I was researching the affect of social media on eating disorders. I then asked if anyone was willing to participate.

Originally the plan was to hold Skype interviews but the participants were too embarrassed to talk face-to-face. It was then decided that I send the questions by email. In the email I sent a little description about who I was, what I was studying, my contact/college/confidentiality details and explained I would like the questions to be answered in an interview style, to expand as much as possible. The first few questions were to obtain the information on age, gender, location, what type of eating disorder, was it professionally diagnosed and did they have a separate SMED account. The rest were open ended questions enquiring about the effect of SM, the effects of having a separate profile for their ED, the effects of seeing graphic images. Some of the questions asked if SM helped or hindered their recovery and if they experienced any other positive or negative effects.

Participants: 17 people participated. The mean age was 29, all participants were female. They were from a range of different countries, 7 from the USA, 5 from the U.K, 2 from Ireland, 1 from Malta, 1 from South Africa and 1 from New Zealand. 10 of the participants had Anorexia Nervosa (AN), 5 had an Eating Disorder Not Otherwise Specified (EDNOS) and 2 had Bulimia Nervosa (BN). 15 of the participants were professionally diagnosed and 2 were self diagnosed. 1 of the self diagnosed had diagnosed herself as anorexic and the other diagnosed herself as EDNOS. The names of people who participated in this study will not be shared for confidentiality purposes.

Results

Almost 60% of participants had a separate SM profile for their ED, 42% had ED profiles on Facebook and 18% had an ED profile on Tumblr. The other 40% had "real" SM profiles, 86% of which had a "real" Facebook profile but had ED content on it and 14% of which used a normal Twitter account but used it for inspiration towards recovery. 100% of participants stated that SM affected their ED. 53% of the participants claimed that SM had positively affected them, although 88% went on to say social media negatively affected them. 53% of participants said SM has helped their recovery but 88% said it

hindered their recovery. There are some overlaps in the sections of people who claimed social media was both positive and negative. Below I describe where these overlaps occurred. I divided the results into two sections; positively affected and negatively affected.

Positively Affected(PA):
53% of participants claimed that SM had positively affected them. 41% of whom said that it also helped their recovery, although 41% also went on to say it hindered their recovery. 35% claimed that it both helps and hinders their recovery. One person said it neither helped nor hindered her recovery, they were not choosing recovery. Another 6% found that it only hinders their recovery and 6% again found that it only helps their recovery. 42% claimed that they were negatively affected and 47% stated that material on SM sites trigger their disordered eating behaviours.

Friendships: There were many positive affects of SM reported by the participants. 66% of those PA stated that they developed new friendships through SM. 55% of those PA stated that the social media groups enabled them to be honest and open about their struggles; free to disclose what they wanted online and within an online SM group; as well as relief as a result of sharing such struggles.

Openness of Struggles: 55% of those PA stated that the social media groups enabled them to be honest and open about their struggles; free to disclose what they wanted online and within an online SM group; as well as relief as a result of sharing such struggles.

Feeling Understood in their ED: 66% PA felt they were understood in their SMED. These participants felt connected to other people who understood them online. They found that when they posted their struggles on their SM pages they would receive positive encouragement to keep fighting. People would commonly pass on phone numbers, skype or mail each other when struggling with their ED.

Inspired: 56% PA found inspiration through SM. These participants connected with people who would actively be online to inspire others. They would post messages of strength, courage and hope. These participants found being connected with this type of people online would help motivate their recovery from ED.

Feeling Connected: 56% PA said that SM has led them to feel connected. They all experienced isolation due to their ED but SM helped break through the isolation. It gave them a place to talk, to vent and to be honest. Through this they found connections which broke down the isolation they were feeling due to their ED.

Recovery based sites helpful: 33% PA had actively sought out recovery sites. The participants stated that sites would have information on how to stay safe and healthy. They would have information on how to cope and would post motivational and inspirational messages. Some groups even had a private message option so that the person could talk about their ED in confidence.

Negatively Affected (NA):
88% of participants were negatively affected by SM use. 47% said they were also positively affected. 93% of the NA went on to say that SM hinders their recovery, 53% of the NA claimed that SM helped their recovery. 7% out of the NA who were also PA claimed that SM did not help nor hinder recovery because they were not in recovery. 93% of the NA also claimed that items and material on SM would trigger their negative eating behaviours.

Received negative/offensive/ hurtful mail/comments online: 38% NA received negative private mails or comments. Some participants received mails requesting a fasting buddy (this is where you would invite a person online to restrict food intake alongside you so that it would keep the person motivated to starve his/her self). Other participants received negative comments under their photographs, some in particular received comments telling them to give up recovery. Other messages received were to lose weight. Others received "hate mail" from other people through their private mail.

Triggered by online material: 93% NA found that graphic images would trigger their disordered eating behaviours. Triggering material would contain photographs of emaciated women. Pictures that were most triggering were the "thigh gap", collar bone, "xylophone" ribs, "bikini bridge" and spine. These images would lead to restriction of food intake. Some participants found that they would struggle with diet pills due to the images. Some participants felt SM fed their ED and made them become competitive towards others who struggled with ED.

Normalises their ED: 53% NA said that SM normalises their ED. Some

participants stated that because ED was discussed constantly it gave their ED more power to take over their lives. 27% of participants were part of Pro Ana and said that they felt it normalised their ED. These participants actively promoted Pro Ana and felt that it normalised the idea that if a person is skinny she will also get sex. 7% said low weight and exercise becomes normal as they see it every day on SM.

Affected by Pro Ana/Mia sites: 94% NA participants went on to say the Pro Ana/Mia SM websites effected them in a negative way. 73% felt pressure to be thinner due to the photographs posted and negative messages they would spread. These messages would contain material on tips on how to restrict food intake, how to purge, and how to hide their ED. Participants found it made them competitive.

Relapsed due to SM use: 73% NA also claimed to have relapsed due to SM use. The relapse would begin due to the content posted by ED profiles or forums. This would trigger negative thoughts. The more they were triggered the more negative content they would actively search for.

Discussion

More Research needs to be carried out on the positive and negative influences that are caused by social media (Luxton, June & Fairall, 2012). I believe a large scale research project could be carried out on this topic. One of the participants mentioned that she also had a separate Tumblr account for self harm (SH). Similar to the SMED profiles, SMSH (social media self harm) profiles are full of images of fresh wounds and collected blood. SH profiles are seriously dangerous because they can trigger others to cut themselves, unlike anorexia which happens over a period of time, self harm is instant.

SMED profiles give people a sense of connection through their disorder and friendships are established. To create and maintain these friendships it requires a significant amount of time and effort (Junghyun &Jong-Eun, 2011). This time and effort required online may take people away from actual society and could easily normalise mental illness. As seen in this research, people with ED surround themselves with other ED people. Although it breaks down isolation in one sense, I wonder what impact it is having on them by surrounding themselves with only ED people.

Within the AN population it was discovered that these people use fewer words to describe emotional experiences (Davis et al., 2011). If people with AN struggle with words for emotional experiences maybe SM is a way for AN people to communicate by posting photographs of their emaciated bodies. The same also applies to people who suffer with BN. Binge-Purge individuals seem to have severe emotional problems and unfortunately do not seem to be able to deal with emotional issues (Danner et al. 2012). Maybe the only way BN people can communicate their struggle is by talking about purging tips. More research definitely needs to be conducted.

Discovery: As you can see from this research there are positive and negative effects of social media use for people with ED. The concerning part is the negative side to social media use in that its content triggered a high number of participants to indulge in their disordered eating habits and also triggered a high number of people to relapse

Through my correspondence with one participant she told me she had attended 3 funerals of people she met through ED accounts. 2 participants told me they got tricked by fake ED profiles. Someone had set up a fake ED profile and used photographs of another person's profile (this is called "Catfishing"). I was informed that these Catfish profile people go on to fake their own death. I was informed this had huge negative triggering affects on friends through that online profile. 24% said they were active in promoting Pro Ana but these women were also the most vulnerable as their thoughts around their ED were quite distorted. 6% did not want to choose recovery and their goal online was to trigger other peoples' eating disorders. Another person who was triggered felt she had to share the triggering content so that other people would suffer with her.

SM use created a space to actively mentally hurt people through illness and created a space for unhealthy competitiveness in their ED. Over 50% stated that the frame of mind they are in will direct them to what they find online. If they are feeling low they will purposely look for negative ED content. If they are feeling hopeful they will search for inspirational posts online.

Strengths and Limitations

This may be the first ever study completed on the impact of SM use on people with ED. 89% were professionally diagnosed. The

ages of participants ranged from 18 - 47. The mean age was 29. All participants were female but were from 6 different countries worldwide. The participants represented a variety of cultural and ethnic backgrounds. This piece of research contains people with "real" SM profiles but also those who had SMED profiles. The qualitative methodology gathered huge amounts of information. Similarities in affects of SM use were found in all ED participants.

The limitations of my research was the amount of wording I could use. Also the participants were too embarrassed to participate in Skype interviews. Areas I found interesting in their replies I hope to expand on in future studies. Other limitations would be participants who are quite ill might not be able to fully expand on the negative effect of social media use or they may not be able to see any negative effect at all.

Conclusion

Globally, humans have entered the beginning of an era in relation to SM. SM is becoming something that is quite complex. It can reach people on a global scale and unfortunately gives room to a lot of dangerous accessible material. SM mixed in with the complexities of the human condition may have serious, negative, even life threatening affects on people. SM can give a platform for the dark side to the human psyche which can be very unsafe on forums that are unmanaged and not policed. The complexity of SM with the complexity of EDs and the issue of legality such as freedom of speech leaves all of this information in a type of limbo.

This research shows the dangerous effects of SM use such as triggering disordered eating behaviours, negative emotional responses, and relapse. People with ED suffer isolation due to their disorder but online creates a new type of isolation. It gives space to create forums and communities that are ED based which in turn may isolate these people from actual society. SM can create a place where mental disorders become normal and even trivialised. There are no boundaries online. A person with ED searching for ED content may cross many boundaries without realising and this in turn will feed their disorder. The further a person has searched the depths of the dark side of SM, the harder it is to come back from it.

The dangers of social media are very real. Although some positive effects were discussed, the negative effects were far more complex and far more reaching. The positive effects that were felt through SM use for the participants were effects that can be felt by actual social interaction and social support. Whereas the negative effects that were discussed are things that would not be experienced through actual social interaction. Logging onto SM daily exposes these vulnerable people to graphic material that breaks through boundaries and crosses a line in one's psyche. Something needs to be done, more research needs to be carried out and education needs to be given to those with mental disorders around use of SM.

References

Danner, U. N., Evers, C., Stock, M., VanElbung, A. & DeRidder, D. (2012). A double burden: emotional eating and lack cognitive reappraisal in eating disordered women. *European Eating Disorder Review, 20, 490-495.*

Davis, H., Swan, N., Schmidt, U. & Tchanturia, K. (2011). An experimental investigation of verbal expression of emotion in anorexia & bulmia nervosa. *European Eating Disorder Review, 20, 476-483.*

Junghyun, K. & Jong-Eun, R. (2011). The facebook paths to happiness: effects of the number of facebook friends and self presentation on subjective well-being. *Cyber Psychology, Behaviour and Social Networking, 14. 359-364.*

Luxton, D. D., June, J. D. & Fairall, J. M. (2012). Social media and suicide: a public health perspective. *American Journal of Public Health, 102, 195-199.*

Oldershaw, A. DeJon, H., Hambrook, D., Broadbent, H., Tchanturia, K. & Treasure, J. (2012). Emotional processing following recovery from anorexia nervosa. *European Eating Disorder Review, 20, 502-509.*

Ozguven, N. & Murcan, B. (2013). The relationship between personality traits and social media use. *Social Behaviour and Personality an International Journal, 41(3), 517-528.*

Veretilo, P. & Billick, S.B. (2012). Psychiatric illness and facebook: a case report. *Psychiatry Q, 83, 385–389*

Mairead Carey

Mairead Carey has a Dip Counselling & Psychotherapy, Cert in Psychology, Cert in Applied Suicide Intervention Skills Training (ASIST) and Cert in Creative Therapies. she opened her own counselling and psychotherapy practice (Round Tower Psychotherapy) in Clondalkin Village in 2014.

Contact Details

Contact No: 085 2021266

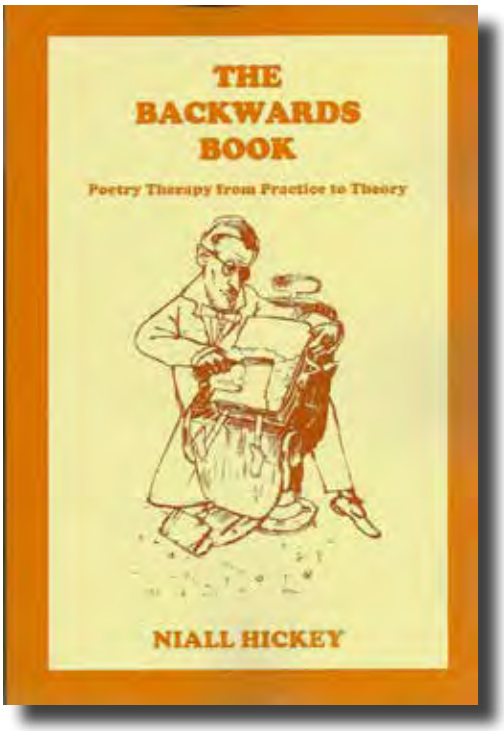
Email: roundtowerpsychotherapy@gmail.com

Website: www.roundtowerpsychotherapy.ie

Book Reviews

Title:	*The Backwards Book. Poetry Therapy from Practice to Theory*
Author:	Niall Hickey
Published:	2014
ISBN:	978-1-907855-07-8
Reviewed by:	David Keane

*A "*backwards book*",* as the name implies, means what is usually at the end of a book comes first and vice-versa. In this instance, the reader is immersed in Poetry Therapy from the get-go, albeit in a gentle manner. The first section of the Backwards Book, *Strategies*, explores themes and concepts within literature and therapy. These are approached in a personable way, with Hickey sharing anecdotes from his life. Childhood imagery mixes with adult literature as fairytales and literary giants, such as Yeats and Wordsworth, stand side by side. The brief chapters of this section each take an image or theme, such as fairies, puppets, and flowers (to name a few) and delve momentarily into their latent and overt meanings, as related to literature and therapy. What is garnered is a sense that the expression of creativity within a therapeutic context can have a profound effect on the individual. Hickey posits that "failure to activate innate creativity may indeed cause us to be disempowered" (p26). Each chapter is ended with a theoretical standpoint, which serves to bring a sense of completeness to the chapter; otherwise it would simply be a section of nice but indifferent stories from Hickey's life, laced with literary references.



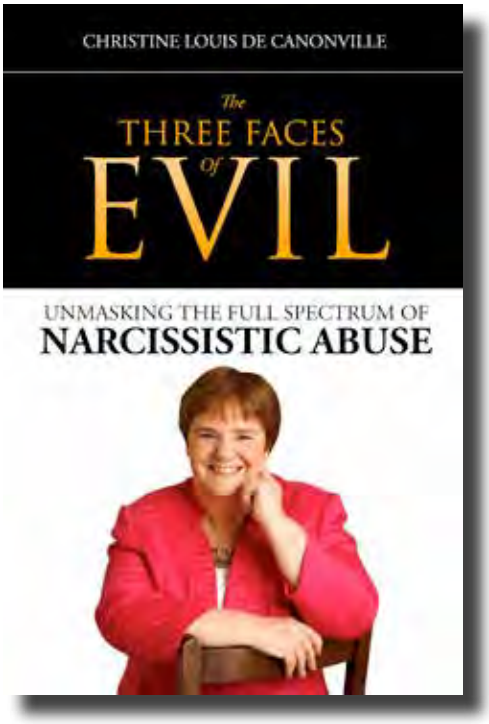
Section two of the book is titled *Complexities* and each chapter therein is based tentatively on the four elements, as well as less tangible areas such as *Darkness & Light and Pandora's Box*. These chapters mostly end with a theoretical underpinning, however some summate with a commentary instead. In *Complexities* the reader is also introduced to several characters through segments entitled *Imagine*. His is Poetry Therapy in practice however it can be jarring at times and continues throughout the book. Overall, section two provides further insight into the role that Poetry Therapy can play in the therapeutic relationship and how society (through literature/arts) impacts the psyche, either consciously or unconsciously. Awareness of this enriches the work of therapy, as does the use of imagination.

The subjectiveness of Poetry Therapy allows much scope for movement, creativity, and manipulation of existing work. Hickey points out, and rightly so, that narratives have been written and re-written many times through the ages. The penultimate section, *Towards a Theory of Practice*, introduces the reader to the concept of the Altered Book, which is used to represent a narrative from the person's own life. Broadly, it combines something that already exists with a person's individual experience in the hope of making sense of it. In a nutshell, this is the process of Poetry Therapy. Use of cinquains (five line poems) as an introduction to Poetry Therapy is given a chapter of its own, as is the Altered Poem. Hickey elegantly states that poetry can become a portal which when passed through can bring about positive change.

The final section of *The Backwards Book* is quite brief and explores *Alternative Modes* used in Poetry Therapy, namely opera and film. These highlight that different expressive forms can be used in Poetry Therapy.

This book explores a wide variety of symbols, metaphors, and text that can be used in Poetry Therapy, running in tandem with sample narratives and anecdotes. Samples of experimental and experiential work are also provided, although it should be mentioned that this is not a book heavy on theory. Rather it serves as a primer, whetting the appetite. For anyone interested in Poetry Therapy and therapeutic arts it will make a good read but its light-hearted approach makes it an easy read for anyone. The book itself, not merely its content, serves as a lesson in Poetry Therapy.

Title:	*The Three Faces of Evil: Unmasking the Full Spectrum of Narcissistic Abuse*
Author:	Christine Louis De Canonville
Published:	Black Card Books Division of Gerry Robert Enterprises Inc. Ontario Canada 2015
ISBN:	9781772041450
Reviewed by:	Ursula Somerville MIAHIP



This is an easily accessible book written by a woman of wisdom, wisdom that was learnt through pain. The author writes about The Dark Triad which are the three faces of evil in narcissism: 1. Profile of a Narcissistic Personality Disorder; 2. Profile of the Malignant Narcissistic Personality; 3. Profile of a Psychopath and she reminds us of the necessity for all of us to have some of these traits and explains this using the Good Wolf (healthy narcissism) "… who walks the path of growth and enlightenment.." (Louis De Canonville 2015: 1) and Bad Wolf "…narcissist chooses to feed the Bad Wolf which has dire consequences for themselves and others". (Louis De Canonville 2015: 1) But the book explores the destructive elements of this condition using the symbol of the Russian doll system which includes the healthy narcissist as the smallest part.

The book opens with the personal tale of the author at the hands of her narcissistic brother, setting the tone from where her knowledge originated. I must say on first reading I found it hard not to have persons, whom I have worked with, jumping off the pages and I read it a second time to integrate the important message within.

It has just 119 pages to it and each page is nicely broken up with images so the text is not too dense. I really like the way they had numbered each page – the light and dark side of personalities. I like also that the author is of Irish descent and a psychotherapist who has worked closely with victims of narcissistic abuse. The author is clear from the outset that her ambition now is to educate those working in the mental health sector to help support victims of narcissistic abuse.

She alarmingly tells us that "unhealthy narcissism" has reached epidemic proportions (Louis De Canonville 2015: 3). Citing the last epidemic she witnessed was AIDS and how this needed Herculean efforts to educate people both young and old. Though help is stated in the book when she says "the best way of protecting oneself against these predators is to know what you are dealing with and to be able to spot these predators before they spot you" (Louis De Canonville 2015: 4) the author explains the deep wound that the person suffers from in order to present in this manner and this is helpful and important to know. She mentions this as she explains each of the three faces.

In the book the reader will find the qualities of a healthy narcissist as well as the "qualities" of a destructive narcissist moving on to the pathological narcissist.

I feel this is an important publication and essential reading for trainees in psychotherapy. Not least because it does not try to use the tale of Narcissus to explain the disorder but instead uses plain English and offers a balanced view of the condition.

I wish I had read this book before I worked on voluntary committees!

We are looking for reviewers

We have received the following books:

Becoming a Wiser Practitioner
Tools, Techniques and Reflections for Building Practice Wisdom.
By Tony Evans

Counselling skills for Working with Shame
By Christiane Sanderson

The CBT Art Activity Book (Colouring Book)
By Jennifer Guest

If you are interested in reading and submitting a review of any of the above books please contact Deirdre Browne at head office and she will post them out to you.

Workshop Reviews

THERAPISTS IN COURT

Presenter: Roger Murray*
Date: Saturday 27th June 2015
Organised by: Northern Ireland Regional Committee

Reviewed by: Marina Sweeney
Venue: City Hotel, Derry City

On Saturday 27th June 2015the Northern Ireland Regional Committee hosted an important, informative and very useful workshop under the title "Therapists in Court". The presenter Roger Murray is to be congratulated for a well structured, relevant and expertly presented training day. I would emphasise 'training day ' because I left the venue feeling that I now possessed a great deal more knowledge and confidence in my ability with regard to litigation issues and court appearances than I had on arrival that morning. The title of the workshop had attracted me not alone as an interesting topic but because I will very likely be a therapist in court on at least two occasions in the not too distant future and I know from past episodes that this occurrence can be potentially overwhelming and anxiety provoking to say the least.

Many counsellors and psychotherapists fear the court system and are sometimes unaware of what happens when we find ourselves caught in the legal arena through our work with clients and this was the main focus of the day together with note taking from our counselling sessions and how these notes can become so important when subpoenaed to be used as evidence by the courts or in writing a report for presentation within the court system.

Time was given to how to prepare for and present in court and there was a useful discussion on legal requirements in relation to child protection issues on both sides of the border.

The style of delivery was creative, supportive, humorous and professional and included experiential role play of a court setting where participants were given the opportunity to role play different relevant scenarios.

Overall the entire entire workshop was relevant, current and informative. It was expertly presented with a useful balance between information given and small group experiential exercises as well as the opportunity for a bit of ('Judge Judy' style) amateur drama.

The level of involvement was excellent and an indication of the presenter's skill and encouraging approach as well as the usefulness of the material presented. The workshop ended with an interesting and energetic plenary discussion and many questions were presented. All these were answered with generosity and in plain 'lay persons' language.

At the end of the day I spoke to several attendees and they were all enthusiastic about the relevance of the workshop and also appreciative of the many injections of humour which proved to be energising and uplifting in the midst of a very serious and often emotive topic.

In the current climate where there appears to be an increase in the demand for therapists to release client notes to be used as evidence or to appear as witnesses in court I believe that this is a piece of training that will prove be invaluable to many of us in future.

**Roger Murray is a partner and the head of the medical negligence unit of Callan Tansey Solicitors in Sligo, the largest legal firm in Connaught*

ACT

Presenter:	Aisling Curtin	Reviewed by:	Pauline Macey
Date:	Saturday 4th July 2015	Venue:	Newpark Hotel, Kilkenny
Organised by:	South East Regional Committee		

This excellent workshop was presented by Aisling Curtain, Counselling Psychologist, Founding Director of ACT Now Ireland and President of the International Getting ACT out to the Public Special Interest Group. She works in a variety of settings and has published both nationally and internationally on the topics of Mindfulness and ACT.

The aim of the workshop was to introduce Counsellors and Psychotherapists to ACT (Acceptance and Commitment Therapy). ACT (founded by Steven C. Hayes) is the first of the 'third wave' of Behavioural therapies along with Dialectical Behavioural Therapy, Mindfulness-Based Cognitive therapy and several others. While it is both scientific, evidence-based and supported by extensive research – Hayes had concerns that some psychotherapies were becoming too narrowly focussed on DSM disorders and ACT broadens the focus to include a broad range of issues that influence human behaviour. It is a Mindfulness-Based, values-oriented behavioural therapy based on six core processes.

Aisling modelled the approach from the outset by encouraging us to remain mindful throughout the day of how the therapist's own process influences our client's process, and the subtle ways in which we are impacted and effected by each other. After a brief introduction to the core concepts of ACT, she asked us to choose a 'buddy' participant who we felt safe to team up with and process a series of experiential exercises that were an essential part of this workshop.

We discussed and revisited the six core processes at various points during the day and were encouraged to reflect on the different ways in which they weave a web between the therapist and the client (and how we can get entangled in the web).

1. **Cognitive defusion** – avoiding getting entangled and bound up in limited thoughts
2. **Acceptance** – embracing our full experience and not avoiding discomfort
3. **Being Present** – connecting more fully with the here and now
4. **Self-as-Context** – developing an observer self to examine thoughts and feelings independent from our private experience.
5. **Values** – clarifying what gives our life meaning and what we would like our lives to be about.
6. **Committed action** – doing what matters and taking steps towards our chosen values in the face of difficulty or discomfort.

We were invited to think of a client we experienced difficulties with and work with our 'buddy' to examine how our own process regarding the above became part of the impasse. This also helped us to appreciate the central role of psychological flexibility that is at the heart of ACT.

We were asked to reflect on our motives we had for signing up for the workshop as a relevant example and demonstration of the roles of context and function in ACT. If we only wanted to do it for the sake of fulfilling CPD requirements (value) then we were unlikely to engage in a meaningful way (committed action).

By creating safety and trust and inspiring confidence and competence through her own personal and professional sharing, and a profoundly moving 'real play' in the afternoon, Aisling helped us all to be more specifically aware of the entangled thoughts, memories and experiences that contribute to our own individual psychological rigidity.

She introduced each experiential piece with a brief mindfulness exercise which was highly effective in demonstrating its role in promoting psychological flexibility through helping us to stretch our comfort zone and pay more compassionate attention to our full experience in the present moment. We were reminded of the research that shows how repressing discomfort, anxiety or unwanted thoughts or experiences only serve to increase their power over us and add to our difficulties in the long run.

Aisling gave us a choice as to what elements we wanted to focus on for the afternoon, explaining that the workshop is usually run over two days. By the end of this highly informative and enriching day, most of us were asking about the possibility of a follow-up day. She provided excellent handouts, directed reading, website and other resources.