Éisteach

A Quarterly Journal of Counselling and Psychotherapy

Volume 12 No. 4 • Winter 2012 •

iacp
Irish Association for Counselling and Psychotherapy

Mandatory reporting of child abuse concerns will not be introduced this year and, in my view, is unlikely to be introduced before 2014. We do not yet know what form it will take or what obligations it will place on us. This is important say because there is huge confusion on the issue among therapists as well as a good deal of fear, some of it due to misinformation put about by people who should know better.

As matters now stand, the Children First guidelines, which have been in place for many years, recommend that we report concerns of possible current abuse happening to children; they also recommend that disclosures of abuse that took place in the past should be reported *if the person receiving the disclosure has a concern that children are currently in danger from the abuser.*

These recommendations may become obligations if and when the Children First Bill (based on the guidelines) becomes law but this is likely to be a lengthy process. Currently there is no Children First Bill. The Minister for Children and Youth Affairs produced a Heads of Bill (a document which precedes the drafting of a Bill and sets out what the Minister proposes to do) and this has been considered by an Oireachtas committee. The Minister must now produce a new Heads of Bill and send this to the Attorney General. The Attorney General will produce a draft Bill to go before the Houses of the Oireachas where it must pass through the committee system, be amended and so forth. Eventually the Bill will, if passed by the Oireachtas, become an Act. However, it will not become law until the Minister signs a regulation bringing it into effect and she has indicated that she will not do this straight away: a great deal of preparation needs to be done first.

As readers can see, this is not a piece of work that can be done quickly.

In the meantime, therapists concerned with how to proceed in this area might make themselves familiar with the briefing document on Children First which can be accessed from the menu on the right hand side of the front page of the IACP website.

In 2010, IACP adopted the Children First guidelines as its policy which means that members should follow these guidelines. The two key obligations which these place on us are similar to what most therapists practice anyway and are as follows:

Abuse of a child: A member who has concerns that children with whom they are in contact may have been abused, may be suffering abuse or may be at risk of abuse should report these concerns to the HSE child protection services. If the child is in immediate danger and the HSE cannot be contacted, a report should be made to the Gardaí.

Past abuse: This issue arises when an adult discloses abuse that occurred during his / her childhood. The section places an onus on the member to consider whether a child is at risk currently from the alleged abuser and if so to make a report to the HSE.

Padraig O'Morain

Contents

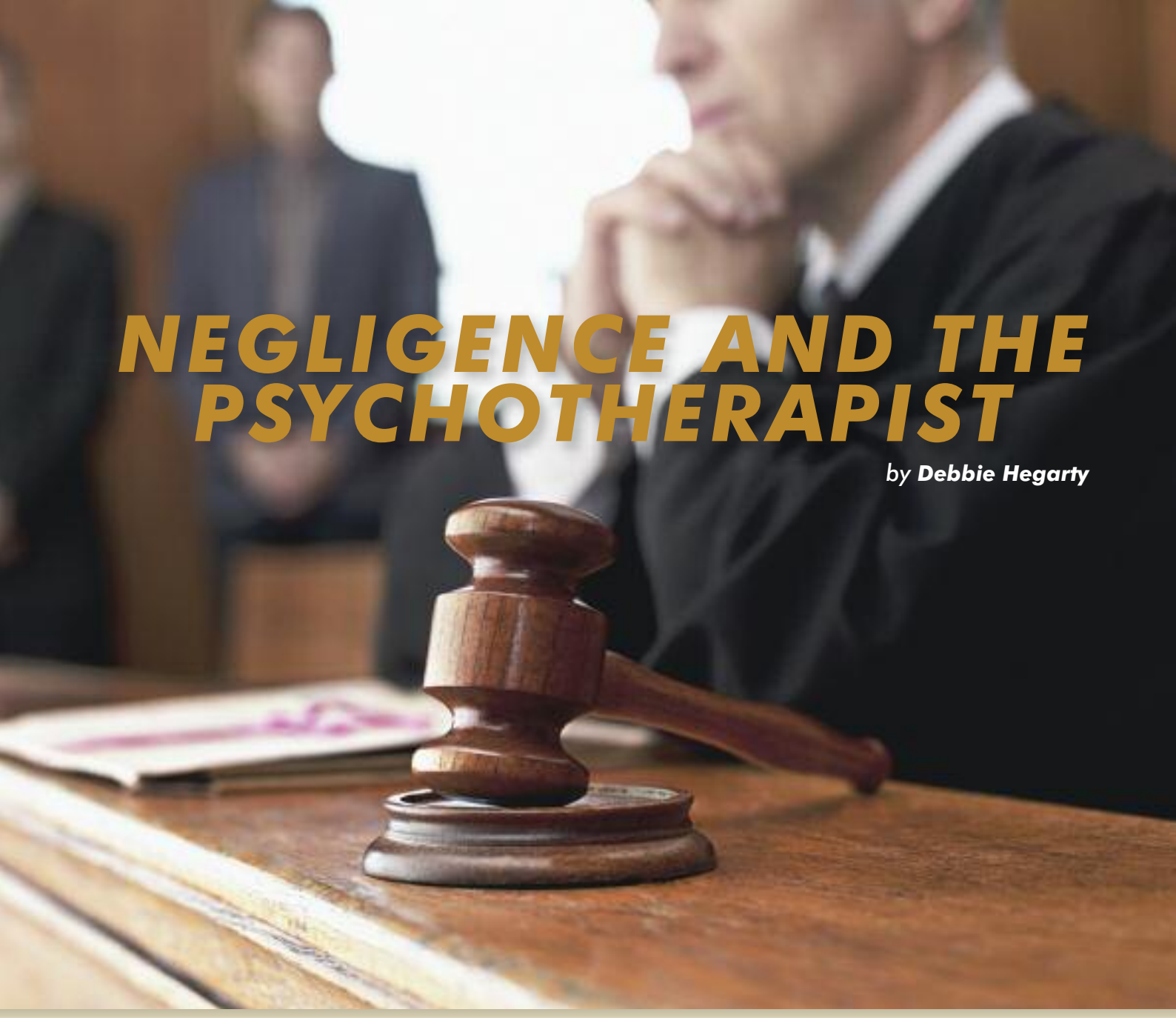
Editorial Board:Geraldine Byrne, Luke Devlin, Barbara Dowds, Donna Hayes, Mike Kelly, Alison Larkin, Padraig O'Morain.

Design and layout: Niamh Power, Print Design Services.

Co-ordinator: Deirdre Browne.

ISSN: 1393-3582. Advertising rates and deadlines: Contact IACP for details. (Early booking essential.)

Scripts: Each issue of *Éisteach* is planned well in advance of publication date and some issues are themed. If you are interested in submitting an article for consideration 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.



NEGLIGENCE AND THE PSYCHOTHERAPIST

by **Debbie Hegarty**

This article is intended as an introductory guide on the issue of negligence and the psychotherapist. It outlines fundamental strategies that apply to psychotherapy and the law. It includes the topics of negligence, ethics, data protection, note keeping, contracting, the role of the expert witness, the legal system, attendance in court, the court procedure and potential risk concerns. It is by no means an authoritative or definitive interpretation of this topic. Rather it is intended to engage psychotherapists in a dialogue.

There are four fundamentals in negligence: duty of care, failure to conform to the required standard, actual loss or damage to the plaintiff and close causal connection between the conduct and the resulting injury. A simple way of looking at negligence is to think of it as the failure to do something which a reasonable person in ordinary circumstances would do, or something a reasonable person in ordinary circumstances would not do. Four additional fundamentals to take into consideration include: recording sessions, data protection, the expert witness and the court experience.

Duty of care by the psychotherapist also refers to the ability for self-care while seeing clients. The ability to make good, sound judgements in terms of conceptualising an appropriate treatment plan for the client can be significantly impaired if mind altering substances such as alcohol, prescribed drugs or non-prescription drugs are being

abused. Even excessive use of coffee to combat exhaustion can impair judgement. It has been well documented that burn out can occur without the awareness of the person affected by it (Lee at al., 2011; Skovholt, 2001; Somerville, 2009) and thus can result in apathy towards clients in our care. The most effective method of ensuring safe practice is to attend regular supervision with an experienced and accredited supervisor. Objective professional supervisors can spot the symptoms of burnout and potential addiction in us that we may be unable or unwilling to take responsibility for.

In addition duty of care applies to being transparent in terms of the treatment plan being provided. A key question for every psychotherapist is "how suitable am I to work with this client?" If there is any doubt the client should be referred on to a more appropriate psychotherapist.

In principle if the psychotherapist does not utilise the appropriate standard of care and the client suffers additional stress, injury or loss then the psychotherapist could find himself on the receiving end of a claim in damages for negligence as well as in breach of contract. It is the obligation of the psychotherapist, in so far as is possible, to ensure that that client is in a fit state prior to leaving the consulting room. In the event that the psychotherapist finds himself as a witness in court proceedings brought by a third party and not the client, the psychotherapist will have to be able to present evidence of procedures adopted and utilised which meet the required standard of the profession. Hence psychotherapists should ensure that comprehensible, legible and contemporaneous notes are kept safe and secure. While the psychotherapist has no legal requirement to keep notes after each session she has an ethical requirement to do so. Therefore it is incumbent on the psychotherapist to record all attended sessions in a legible, concise, accurate and factual manner. Records should show the presenting issue, past history, medication history, planned interventions and care plans, tasks given and goals agreed upon and results obtained and any referrals or discharge letters. I find it helpful to include a comment in my initial intake session that states that psychotherapy is not a diagnostic model, that I keep very brief sessional notes and am no expert witness. I also include the following three conditions in my initial intake sheet which pertain to the three areas where confidentiality might be breached. Firstly, I may need to discuss my work with my supervisor. This is standard practice for all psychotherapists and my supervisor is bound by his association's Code of Ethics. Secondly, if I suspect a client is at risk of self harm or harm to another I would seek suitable professional help and would make every effort to discuss the situation with the client in advance. Finally I would break confidentiality if required to do so by the law.

When writing up sessional notes keep in mind that a judge and a client's legal representative might end up reading them. I would suggest all psychotherapists write their notes with their client on one shoulder and a judge on the other. Most psychotherapists are not in a position to make a diagnosis unless they have clinical training so be mindful of descriptions of the client's presenting problem or any subsequent observations. It may be preferable to write, "my client presented with the **symptoms** of depression", or "my client was referred by her GP who diagnosed depression" rather than "my client is depressed". Legal action can be taken by a client for up to two years after any case of negligence and we are obliged to hold the notes and intake sheet of our clients for six years minimum and seven years maximum. Finally I suggest that there should be no identifiable information in the sessional notes apart from first names. The sessional notes can be stored separately from the initial intake sheet with a coded system linking the two.

This raises the question of when notes can be used in court and what privilege is attached to these notes. Currently, the only privilege that exists in Irish courts is that between the confessor and priest. So if a client is involved in court proceedings and the other party serves a witness summons on the psychotherapist, the psychotherapist is obliged to attend court, does not talk to the other side and is not obliged to talk to them. Generally in a court lawyers do not call a witness without knowing what answers would be given to any particular question. However there are occasions when this does happen. If called to give evidence in such circumstances, firstly ask your client for permission to give evidence and if the client permits then answer the questions. But if client does not give permission then explain this to the judge hearing the case and he will direct on the matter.

The **Data Protection Guidelines** regarding the storage of sensitive personal data ensures that the privacy rights of individuals are safeguarded in relation to the processing of all personal data. The Data Protection Acts 1988 and 2003 confer rights on individuals as well as placing responsibilities on those persons processing personal data.

Disclosure of confidential material can occur in certain circumstances, where the client consents by order of a court or tribunal, where the interest and safety of the public requires appropriate disclosure, or under statutory powers of investigation.

Data Controllers are those who, either alone (in private practice) or with others (as part of an agency), control the contents and use of personal data. Data Controllers can be either legal entities such as companies, government departments or voluntary organisations, or they can be General Practitioners or sole traders such as psychotherapists. If you, as an individual or an organisation, collect, store or process any data about living people on any type of computer or in a structured filing system, then you are a data controller. In order to establish whether a psychotherapist is a Data Controller, ask yourself do you decide what information is to be collected (Client Intake Sheets, sessional notes etc.), stored, when it should be deleted or altered? If the answer is yes then you are a Data Controller.

As a **Data Controller** you have certain key responsibilities in relation to the information you process. You must

- obtain and process information fairly,
- keep such information only for one or more specified, explicit and lawful purpose or purposes,
- use it and disclose it only in ways compatible with these purposes,
- keep it safe and secure.
- appropriate security measures must be taken against unauthorised access to, or alteration, disclosure or destruction of, the data and against their accidental loss or destruction
- keep it accurate, factual, complete and up-to-date
- ensure that it is adequate, relevant and not excessive
- retain it for no longer than is necessary for the purpose or purposes. As mentioned we are obliged to retain notes for six years minimum and seven years maximum.
- give a copy of his/her personal data to an individual, upon request. On making an access request, any individual about whom you keep personal data is entitled to a copy of the data you are keeping about him/her. To make an access request the data subject must apply to you in writing (which can include email). In response to an access request you must supply the information to the individual promptly and within 40 days of receiving the request. You must also explain any coding system applied.

A restriction to the right of access of the data subject is possible should the information you provide about him/herself cause serious harm to his or her physical or mental health or emotional well-being. Should you ascertain that an access request can be restricted then you must notify the data subject in writing within 40 days of their request and you must include a statement of the reasons for the refusal. A Data Controller found guilty of an offence under the Acts can be fined amounts up to €100,000 on conviction on indictment and/or may be ordered to delete all or part of the database.

Expert Witness

According to Caroline Conroy (2004), a witness in any court procedure is limited to giving evidence of fact, i.e. what he/she saw, experienced or learned. The evidence of an expert witness is in two parts, written and oral. This principle is subject to certain exemptions, one of which allows experts who have the required expertise to give their opinion on issues within their field (Conroy: 2004:8). The onus of proof on the question of the expert's expertise lies with the party who calls that expert. An expert witness is a person qualified and experienced in a certain field who is asked to give an independent opinion to the court on facts arising within their field. The expert witness' view needs to be independent, impartial and objective even if involved by one side in the case. Integrity is essential and it is important not to jeopardise objectivity or independence. In short the duty is to tell the truth and assist the court by doing so. The court is relying on the expert witness to educate and assist the decision maker with the benefit of expert knowledge.

Every witness, whether an expert or otherwise, must tell the truth, the whole truth and nothing but the truth. Lawyers are not allowed to influence witnesses in respect of their evidence. To do so puts them in breach of their professional conduct rules and may result in them being struck off. The expert witness might be prosecuted for perverting the course of justice if any coaching or manipulation is evident. In proceedings, a potential witness must not discuss her evidence with other potential witnesses in the case.

If a client is involved in a litigious process then it is ethical practice for the psychotherapist to inform them of the following:

- A subpoena is a court order to attend and testify in court.
- The client has the right to release the obligation of confidentiality when involved in litigation.

Should the psychotherapist's sessional notes be subpoenaed, disclosure of all relevant

It is the responsibility of the psychotherapist to inform the client that they cannot choose what is disclosed and what is withheld and therefore it is ethical and good practice to inform the client of the possible implications of giving his consent to release the material

confidential material pertaining to the case is a legal requirement, provided the psychotherapist is satisfied the client has consented to the release of the material.

It is the responsibility of the psychotherapist to inform the client that they cannot choose what is disclosed and what is withheld and therefore it is ethical and good practice to inform the client of the possible implications of giving his consent to release the material. If the client has **not** given consent then the psychotherapist is **not** obliged to release any material requested by a solicitor or a member of the Garda Síochana. However the psychotherapist may be compelled to release sessional notes by virtue of a Court Order for Discovery.

If, as a psychotherapist, you have concerns about disclosure in an open court you can request the judge hear you in his private chambers.

Being subpoenaed as an expert witness appears to engender fear among psychotherapists. Appearing in court can be, and often is, a daunting experience for all those involved. In my opinion the most effective way to allay fear is to become informed which is why I outline that process in the next section.

The Legal System

The following information was given me during training as a Mediator with Friarylaw MCM and I have sought and been given permission to use it. I also referred to a document entitled 'Irish Judicial System' which I ordered from the Department of Justice, Equality and Law Reform. Irish law is based on Common Laws modified by subsequent legislation and by the Constitution of 1937. Statutes passed by the British Parliament before the formation of the Irish Free State in 1922 have the force of law unless repealed by the Irish Parliament. Common law is enacted by judges whereas civil law is enacted by legislators. Justice is administered in public in courts established by law. Judges are appointed by the President on advice of the Government. Judges are guaranteed independence in carrying out their functions but can be removed from office for misbehaviour or incapacity only by resolution of both Houses of the Oireachtas. There are two legal systems, **Inquisitorial** consisting of Coroners Court, Tribunals, Inquiries and **Adversarial** consisting of Criminal and Civil Courts. In order to succeed or win your case you must first prove it by providing evidence which is open to be challenged.

The legal profession is divided into solicitors and barristers. Solicitors deal mostly with legal issues outside the Courts. They can attend Court for the right of audience before the Courts in either the District Court or in making appeals to the Circuit Court. In higher courts cases are normally conducted by barristers. Barristers are advised by and retained by solicitors. Free legal aid is available in criminal and civil cases.

Attendance in Court

The following guidelines will prepare you for the witness box:

- Meet with your lawyers as early as possible
- Tell your lawyers the questions to ask you, do not presume what they know about psychotherapy/counselling/psychology practices
- Review your files, particularly your own records that were discovered
- Have all your notes and records in order
- Clarify what the issues are and what aspects of the case you are dealing with
- Establish the strengths and weaknesses in your case
- Anticipate likely questions and your answers in cross-examination
- Update yourself on recent developments in your area
- Practice your introduction
- Dress appropriately
- Arrange transport
- Identify venue
- If possible pay a visit the court before to watch another hearing
- Ask about anything you do not understand

Lawyers use many techniques during cross-examination to test and undermine their opponent's witness. **During this process remember at all times that you are not on trial.** Your role as an expert witness is to assist the Judge in making a decision. You are not there to win the case but merely to present your information. It is the lawyer's job to test you.

The following guidelines will help you when you are in the witness box:

- Listen carefully to the question being asked
- Use all questions as opportunities to clarify explain and present information that will help
- Refer back to the original point if you have been deviating
- Stay as composed and grounded as is possible. It helps to place your feet firmly on the ground aligned toward the Judge. Using your breath also helps (even reminding yourself you have breath!) when attempting to quieten inevitable disquiet.
- Do not take it personally. After all you are not your evidence
- Don't argue with the lawyer
- Remember you are there to **assist** the court
- Don't read from notes as you are talking but do refer to them briefly to make sure you are disclosing facts
- Address all answers, whether asked by the lawyer, barrister or Judge, to the Judge. This is a mark of respect but it is also because ultimately the decision maker in all courtrooms is the Judge. With that in mind position yourself so that you are facing the Judge, turn to the lawyer for the question, and then turn back to the Judge. If there is a Jury present then they will also become decision makers therefore direct your answers to them as well as the Judge but never the lawyer of barrister.
- The Judge is always referred to as Judge no matter which court you are subpoenaed to. Barristers are referred to as Counsel or by their last name
- Finally Court Procedure will include an Oath, an Introduction, an Examination, Cross-examination, Re-examination and Conclusion.

I hope this can be helpful to the reader. As already stated it is by no means a complete research piece. Upon reflection, experience has allowed me to conclude that that which frightens and threatens us most is that which we do not know. I spent time as a volunteer member of the Garda Síochana Reserve ranking and part of my training and duty was to attend criminal cases in the District Court. I learned how easily a witness can be rumbled when they present to the court ill-prepared and uninformed.

Note: An earlier edition of this article appeared in the IAHIP journal, *Inside Out*.

Debbie Hegarty, MIAHIP, MIACP, works with individuals, couples, families and groups in Cork city. She also presents workshops on Couples Therapy. She became interested in the legal implications of practising privately as a therapist while serving on the Ethics Committee of IAHIP. Currently she is a member of IAHIP Governing Body. She is also an accredited mediator. Email:debyhegarty@gmail.com

REFERENCES

BAILII - the British and Irish Legal Information Institute, providing case law, legislation, reports of the Irish Law Reform Commission and decisions of the Irish Competition Authority and Irish Information Commissioner. Retrieved from http://www.bailii.org/

Citizens' Information - Irish government website for the general public, including information about tribunals of inquiry. Retrieved from http://www.citizensinformation.ie/en/

Courts Service Ireland - background information on the history and organisation of the Irish courts, plus judgments of the Supreme Court (2001 onwards), the Court of Criminal Appeal (2004 onwards) and the High Court (2004 onwards). Retrieved from http://www.courts.ie/

Department of the Taoiseach - full text of the Constitution and other official information. Retrieved from http://www.taoiseach.gov.ie/eng/

Whelan, D. (2005) *Guide to Irish Law*. Retrieved from http://www.nyulawglobal.org/globalex/Ireland.htm

Houses of the Oireachtas - recent Acts and Bills. Retrieved from http://www.oireachtas.ie/viewdoc.asp?fn=/documents/nav/legislation.htm&m=b

Index of unreported judgments provided by the Boole Library at University College, Cork. Retrieved from http://booleweb.ucc.ie/

Irish Law Site - hosted by the Faculty of Law at University College, Cork, provides a useful set of Irish legal links, an email discussion list, Irish legal news, legislation and case law. Retrieved from http://www.irishlaw.org/

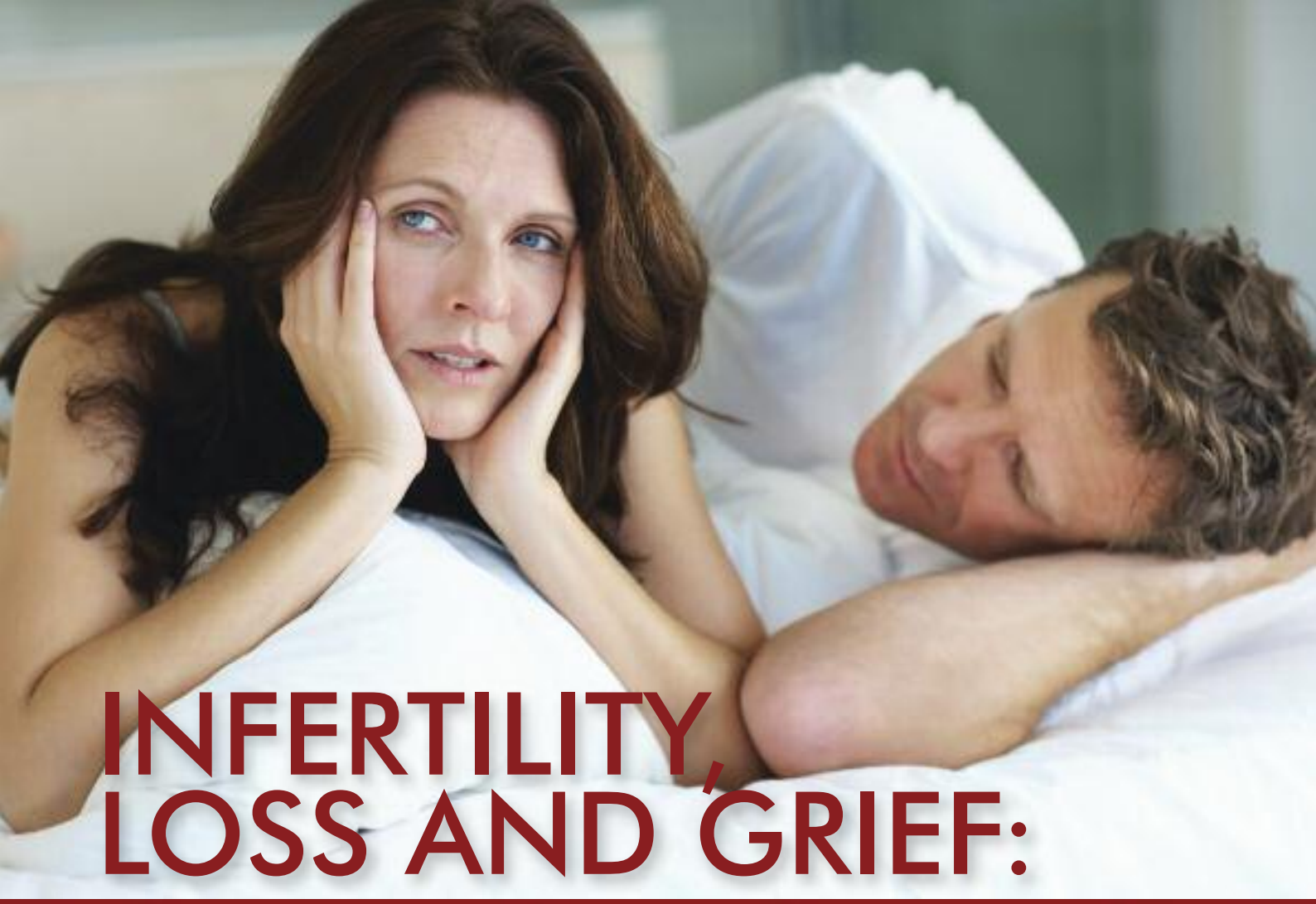
Irish Statute Book - legislation from 1922 onwards, provided by the Office of the Attorney-General. http://www.irishstatutebook.ie/

IRLII, the Irish Legal Information Initiative, providing a complete index to judgments of the Irish High Court, Supreme Court and Court of Criminal Appeal from 1997 onwards, the full text of leading cases (arranged by subject) and legislation. Retrieved from http://www.ucc.ie/law/irlii/index.php

Lee, J. Lim, N. Yang, E. Lee, S.M. (2011) *Antecedents & Consequences of Three Dimensions of Burnout in Psychotherapists: A Meta Analysis*, APA Research and Parctice, Vol 42 (3) June 2011, pp 252-258.

Skovholt, T.M.(2001) *The Resilient Practitioner: Burnout Prevention & Self Care Strategies*, Boston: Allyn & Bacon.

Somerville, U. (2009) *Inside Out: IAHIP Quarterly Journal*, Vol 57 Spring Edition, pp 2-12.



INFERTILITY, LOSS AND GRIEF: do we truly understand?

by **Caroline Rock**

Infertility is a problem of global proportions. The World Health Organisation estimates that 10-18% of couples around the world experience difficulty conceiving a child, or 1 in 6 couples worldwide. The prevalence of fertility-related problems is not likely to decrease in the near future. This implies that professional counsellors are more likely to have clients who have feelings of grief and loss, often intense, if their treatment efforts fail (Daniluk, 1997). A couple's need for counselling and support has long been emphasised in the literature. As Judith Daniluk (1991) states; "It is important counsellors familiarise themselves with the experiences and difficulties of infertile clients and with intervention strategies that may serve to reinforce experiences as an opportunity for psychological and marital growth".

Despite its prevalence infertility still remains a taboo subject. Couples encountering fertility problems can be reluctant to share their experiences. Very often those who have no experience of infertility may be ignorant to the facts and feelings associated with it and may unintentionally come across as insensitive. In order to have empathy towards clients, counsellors must try and touch on the pain felt by couples and individuals going through this life crisis. Looking at infertility through the lens of grief and loss can help us to do so.

Background:

Johansson and Berg said of Infertility:

> "It is not only a medical phenomenon, but also a life crisis as the possibility to have biological children may give a feeling of eternal life. Everything that has to do with involuntary childlessness, where the original and in a wide sense, biological function is threatened, is culturally, socially, psychologically and existentially charged"
>
> (Johansson and Berg, 2005, p.58).

One of the predominate aspects and one which is least understood among society is the feeling of loss and/or the disenfranchised grief experienced by couples going through infertility.

If current predictions are correct the rates of infertility are set to increase. Many couples struggle to come to terms with a diagnosis on their own. Reconstructing new meanings and identities can be difficult to do without guidance and can result in relationship breakdown, depression, anxiety and overall decrease in life satisfaction. However, with the help of a therapist, couples and individuals can negotiate the grieving process associated with infertility, heal their relationships and reassess their motivations and life plan.

It helps to look at both the female's and male's perspective, because as counsellors it is likely that we may be working with both in the therapy room.

The Female Perspective:

> "That's the one experience that women who have children easily miss out on in life.....The intensely female grief which accompanies the fear that those children might never exist"
> (Elton, B., 2000, p.316,).

In a study carried out by Abbey, Andrews & Halman (1992), it was reported that, on the whole, women experience higher levels of fertility-reported stress than men. This is supported by other literature. Miall (1985, p.391) describes how childlessness disqualifies infertile women from being part of the "in-group of mothers". In brief, compared to men, women are more likely to have lower self esteem, blame themselves, avoid children and pregnant women and initiate treatment (Abbey, Andrews & Halman, 1991). Matsubayashi et al (2001) reported that depression is more common among infertile women as compared to fertile or pregnant women.

In a study carried out by Sandelowski, Holditch-Davis & Harris (1990), women intimated that their inability to have a child may have constituted a punishment for past transgressions, including failed marriages, elective abortions and feeling relief after the loss of an unwanted pregnancy. This underlines the feeling of guilt which the woman may also have to bear.

"When I discovered I was infertile, I felt damaged. Why couldn't I accomplish something as 'natural' as conceiving a baby? Suddenly, my sense of self-worth was shaken" (Mahlstedt 1985, p.339).

Women more often than men will internalise images of the self as abnormal, defective or failing. They will not see infertility as just an element of the body but the entire self as damaged. Women tend to incorporate infertility into the self, interpreting it as a state of being. It is seen as an 'I am illness' as opposed to men who see it as an 'I have' or 'I had' condition which they share with their wives (Estroff, 1989, p. 189).

Women who are trying to conceive, and in particular women undergoing fertility treatment, have a heightened awareness of their bodies. They experience an increased sense of their physical body, sensitising them in particular to their menstrual cycles. According to a study by Allan, (2005), menstrual cycles were "subjectively experienced as painful or disappointing and objectively as recorded fact".

When a woman realises she cannot beget a biological child her womanliness can be questioned. "Infertility appears to most profoundly affect an individual's sense of femininity or masculinity and confidence in themselves as sexual beings" (Abbey, Andrews, & Halman, 1992, p.410).

With the perception of the sense of self distorted, the associated feelings of lower self esteem, anxiety, guilt and frustration will follow. Studies show that compared to their fertile counterparts, women with fertility problems are far more likely to feel depressed. Hormonal changes in relation to drug therapy regimes for women undergoing IVF can also contribute to these reactions (Robinson & Stewart, 1995).

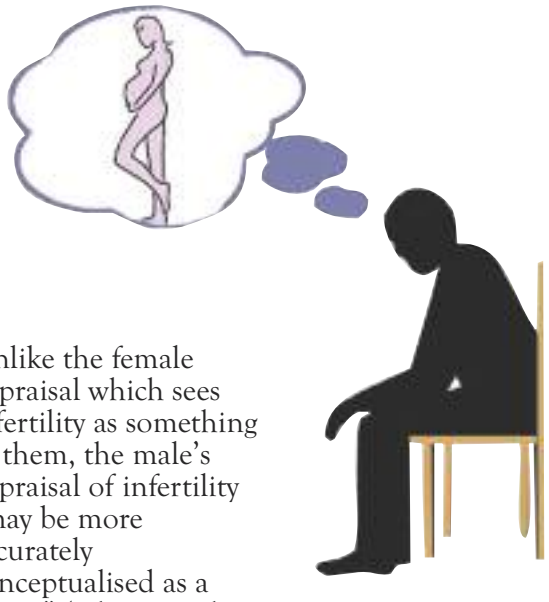
This emotional turmoil is usually not afforded an outlet, leaving the woman to silently carry her pain as she participates in a life which continues on oblivious to this sorrow. On a daily basis she will often have to carry the burden of infertility alone, hide it from friends and family and maintain a certain facade in particular around family gatherings involving children and the announcements of pregnancies amongst friends.

The Male Perspective:

> "The thread connecting sexual potency, fertility, strength and manhood is deeply woven into every culture, marking a corresponding fault-line of insecurity"
> (Winston, 2006, p.xvi)

The male perspective can be overshadowed by the female experience of infertility. Although results of the studies performed by Newton (1990) and Wischman (2005) showed that depression is higher among infertile women than infertile men, infertile men still experience levels of depression higher than fertile men. It seems men are presumed to be less sensitive to the subject of infertility and people may be less compassionate towards the male. Compared to females the issue can be a source of humour with such everyday phrases as 'shooting blanks' in our colloquial. This could be because the fertility problem may be presumed to say more about his female partner and therefore it may not affect him as much. But either way, whether the male is solely responsible for the issue or it is a female factor or it is combined, there is still a level of emotional anguish to be dealt with. Statistically males are not as willing to speak about their fertility issues with any other person other than their wives or partners.

Although male partners may cope differently they still experience painful emotions. In a study by Smith et al (2009), of 256 couples treated unsuccessfully with IVF, male partners were found to have increased marital and social stress, decreased overall mental health, increased physical stress, more feelings of sexual failure and increased coping effort. According to Shindel et al's study (2008) the male partners reported depression, erectile dysfunction and sexual relationship problems; in addition they reported significantly lower standardised scores on mental health.



Unlike the female appraisal which sees infertility as something in them, the male's appraisal of infertility "may be more accurately conceptualised as a threat" (Glover et al, 1996). According to Sandelowski et al (1990, p.204) "men tended to encapsulate infertility, to halt its spread, to keep it from becoming a master status or from spoiling their identities as intact males". This may be the reason why they are less likely to talk about it than their female counterparts.

According to Feuer (1983 cited in Daniluk, 1991, p.317) the female often presents with the most overt emotional distress, whereas reactions of the male partner are often less overt and may be more difficult to assess. It is therefore important from the outset for couples to acknowledge infertility as a couple's problem and not an individual one. This will eliminate blame and guilt.

Grief and loss:

> "Viewing a diagnosis of infertility through the lens of grief and loss allows for a more in-depth exploration into the personal and relational meanings of an often devastating disruption in life course"
> (Bridges, 2005, p.12).

One of the predominant aspects of infertility common to both the male and the female is the feeling of loss and the silent mourning that accompanies it. It is not a typical loss and often cannot even be identified cognitively.

Researchers and therapists alike agree that a diagnosis of infertility is a disruption in a person's life course which is similar to the disruption caused by death, with grief and mourning a natural outcome. The loss associated with infertility is different, though, as the grieving is for a hope or desire, for an assumed life course event rather than an actuality (Bridges, 2005). According to Doka

(2002 cited in Bridges 2005, p.10) "because loss of an aspiration does not involve death, a profound traumatic event or a removal of a tangible beloved object, this kind of loss is often socially disenfranchised as loss". There are no social rituals, for instance funerals or graves, when mourning the loss of fertility. When there are no clear social and relational pathways to begin to understand this process of loss, couples and individuals turn to traditional models of loss and coping that present a stage model as a way of 'moving on' (Bridges, 2005).

There are a number of losses experienced throughout the ordeal of infertility. There is the loss of control over one's body: this can be at the outset when a couple first realise they are having difficulties conceiving and it can also refer to the lack of control during the fertility treatment processes. There is the loss of the ability to conceive a baby naturally. For those who do not choose IVF or those with unsuccessful treatments there is the loss of the potential to have a child. There is also the loss of identity within society where the couple no longer fits into the 'parent group' but the minority 'childless' group. There is loss of immortality as children may be seen as the way to live on. There is also loss of the experience of pregnancy, loss of sexual identity or loss of confidence. The Kubler-Ross (1970) model of grief delineates five stages; shock, denial, anger, bargaining and acceptance. The losses are multiple and may mean moving in and out of this grief model a number of times and visiting and revisiting the different stages. This is why the process of trying to conceive is described as a rollercoaster. The couple has very little time to grieve the previous failed attempt at pregnancy before their hopes are raised at the next chance. This oscillation between hope and despair eventually takes its toll and there arrives a point where the couple has to move into the next phase which might be accepting the idea that they may never conceive naturally or at all.

Gibson, (2007, p.281) compares the experience of infertility with death attitudes and notes that the most striking similarity is how individuals seek to make meaning. She says that "for infertile individuals existential meaning-making is closely linked to the social constructions of parenthood in our society. This is also true about individuals' beliefs and assumptions about death". Part of helping the couple with fertility problems is to deconstruct these beliefs and assumptions in the quest to form new identities. Like death and dying it is a process of meaning making.

Providing Support:

Counselling and psychotherapy can help a couple through their grief and help them to take their finger off the pause button and try and live life. It can help couples achieve a level of acceptance. Sometimes it may even be enough for couples to know there are others out there going through the same experience.
In Ireland the state agency The Women's Health Council has published two reports in relation to infertility. The reports deal with the effectiveness of current infertility treatments and the psychological and social difficulties which couples affected by fertility problems will encounter. They have recently called out for increased information on treatments, success rates and risks. The council has predicted that the demand for advice and treatment for fertility problems will increase in Ireland over the coming years because of the trend here to delay parenthood to pursue career and financial security. This emphasizes the need for available information on all issues of infertility including possible preventative measures and management measures (www.rte.ie/news/2009/0923/fertility.html.). Importantly it also highlights the need for awareness around the subject among counsellors and society as a whole.

Conclusion:

For a lot of people the desire to have children comes from deep within, it is instinctual, emotional, cognitive and it is also conditioned. When this longing is not satisfied it can wreak havoc with a person's sense of self. Cognitive distortions can take over, adverse emotions and feelings can erupt and the overall psychological well being of the person is compromised. Infertility can be a long and arduous journey. Because no two persons' experience is exactly the same it can be very lonely at times. Family, friends and society are usually not equipped to respond to the pain felt by a couple faced with infertility. Professional help, in particular fertility counselling, is therefore highly important.

The vehicles for acceptance, hope and recovery are therapeutic counselling and a proactive role taken by society. Counsellors can guide couples to reconstruct and reevaluate their lives while they are going through these challenging times. In doing so couples may eventually find personal growth and learning through the experience. Society can be proactive in encouraging awareness of infertility among

couples, providing facts and choices, providing financial assistance, letting people know there is counselling help out there and sharing the experiences of real people. Most importantly society could take responsibility for creating a feeling of empathy towards those struggling with this issue.

Society evolves through learning. People grow through learning, whether from other people's experiences or their own. Infertility is deeply personal and painful. Being aware of this can open people's minds to questioning their own position on the subject and to relate it to their own lives. As with any taboo subject the way to remove the stigma is to include it in everyday language and discussion. This can promote empathy as well as choice. It can spread learning as well as healing. The sharing can encourage caring, beginning in the therapy room, then amongst family and friends and then society too.

The following is a quote from a woman undergoing infertility therapy. It eloquently expresses the anguish of an infertility patient. From it we can learn about the grief and the level of pain associated with infertility, and harness a sense of empathy and understanding toward the struggle that is infertility.

> "My infertility is a blow to my self-esteem, a violation of my privacy, an assault on my sexuality, a final exam on my ability to cope, an affront to my sense of justice, a painful reminder that nothing can be taken for granted. My infertility is a break in the continuity of life. It is above all a wound... to my body, my psyche, to my soul."
>
> Jorgensen
> (1981 in Scharnowski 2011).

Caroline Rock graduated from PCI with a BSc in Counselling and Psychotherapy. She currently works from her private practice in Ashbourne, Co. Meath and is specialising in the area of Fertility Counselling. Caroline also works as part of the counselling team in SIMS IVF Clinic in Clonskeagh, Dublin. The article is an excerpt from her thesis titled "Awareness, Appropriate counselling intervention, and a more evolved societal response can greatly ease the burden of those affected by the global phenomenon of Infertility."

REFERENCES

Abbey, A., Andrews, F.M., & Halman, L.J. (1991). Gender's role in responses to infertility.
Psychology of Women Quarterly, 15, 295–316.

Abbey, A. Andrews, F.M & Halman, J.L. (1992). Infertility and subjective well-being: The mediating roles of self-esteem, internal control and interpersonal conflict. *Journal of Marriage and Family, 54,408-417.*

Allan, H.T. (2005) Gender and embodiment in nursing: the role of the female chaperone in
the infertility clinic. *Nursing Inquiry*, 12(3): 175–183.

Bridges, S.K. (2005). A Constructivist Approach to infertility: Loss and Meaning Reconstruction. *Contemporary Sexuality* Vol. 39, No. 12.

Daniluk, J.C. (1991). Strategies for Counselling Infertile Couples. *Journal of Counseling and Development*. Vol.69: 317-320.

Daniluk, J. C. (1997). Gender and infertility. In S. R. Leiblum (Ed.), *Infertility: Psychological issues and counseling strategies* (pp. 103-125). New York: Wiley

Elton, B. (2000). *Inconceivable*. London: Black Swan Press

Estroff, S. E. (1989) Self, identity, and subjective experiences of schizophrenia: In
search of the subject. *Schizophrenia Bulletin*. 15. 189-96

Gibson, D.M. (2007). The Relationship of Infertility and Death: Using the Relational/Cultural Model of Counseling in Making Meaning. *The Humanist Psychologist*, 35(3), 275–289.

Glover, L., Gannon, K., Sherr, L., & Abel, P. (1996). Distress in sub-fertile men: A longitudinal study. *Journal of Reproductive and Infant Psychology*, 14, 23–36.

Mahlstedt, P.P. (1985).The psychological component of infertility. *Fertility and Sterility*, 43 (3), 335-346.

Miall, C.E. (1985). Perceptions of informal sanctioning and stigma of involuntary childlessness. *Deviant behaviour, 6, 383-403.*

Matsubayashi H, Hosaka T, Izumi T, Makino T. (2001) Emotional distress of infertile women in Japan. *Human Reproduction* 16: 966-969.

Newton CR, Hearn MT, & Yuzpe AA. Psychological assessment and follow-up after in vitro fertilization: assessing the impact of failure. *Fertility and Sterility* 1990; 54: 879-886.

Robinson, G. E., &Stewart, D. E. (1995). Infertility and new reproductive technologies. *American Psychiatric Press Review of Psychiatry, 14*, 283–306.

Sandelowski, M., Holditch-Davis, D. & Harris, B.D. (1990).Living the life: Explanations of infertility. *Sociology of Health & Illness Vol. 12 No. 2.*

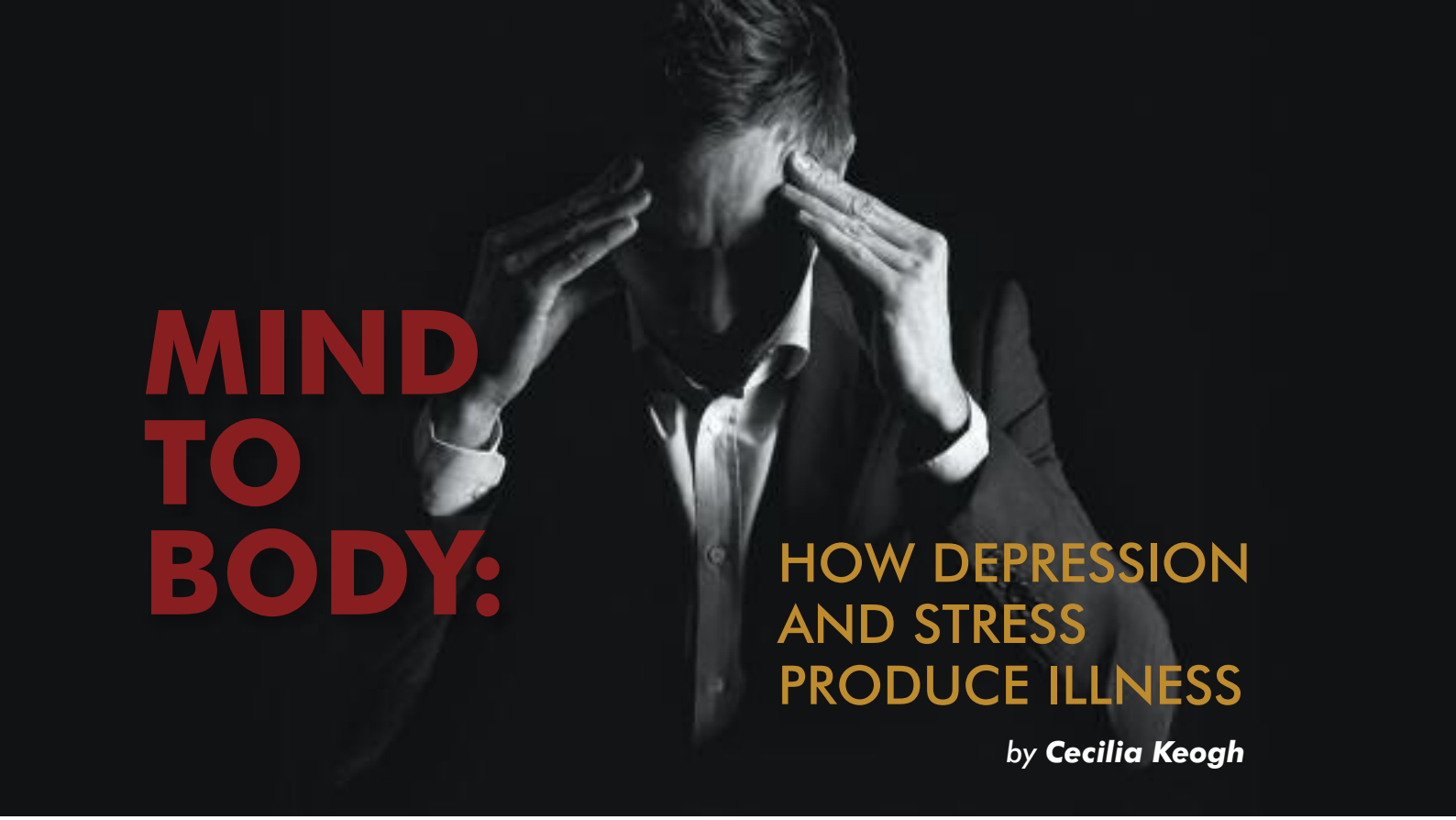
Shindel AW, Nelson CJ, Naughton CK, Ohebshalom M, Mulhall JP. (2008). Sexual function and quality of life in the male partner of infertile couples: prevalence and correlates of dysfunction. J Urol 179:1056-1059.

Smith, J.L. et al (2009). Sexual, Marital, and Social Impact of a Man's Perceived Infertility Diagnosis. *J Sex Med*; 6:2505–2515

Winston, R. (2006). *A Child Against all odds*. London: Bantam Press.

Wischmann T. Psychological aspects of fertility disorders. *Urology* 2005; 44:185-1894.

www.rte.ie/news/2009/0923/fertility.html



MIND TO BODY:

HOW DEPRESSION AND STRESS PRODUCE ILLNESS

by **Cecilia Keogh**

Knowledge of the ways in which depression and stress interact with the physical self to produce illness can add a valuable dimension to the work of counsellors and psychotherapists. Outside our profession, such knowledge could lead to a much needed change in which a holistic view is taken of the patient so that he or she is treated as a person whose emotional life needs to be nurtured as physical conditions are addressed.

In this article I will look at the interaction between depression, stress and physical illness; I will describe the role of the central nervous system; I will briefly mention the nervous system and Borderline Personality Disorder; and I will refer to my own research into nurses' views on the role of counselling in the treatment of patients.

Role of Depression in illness

That there is a link between depression and physical illness is increasingly accepted.

For instance, research (by Khalil *et al*, 2010) suggests that depressive symptoms are a risk factor for increased morbidity and mortality in patients with renal (kidney) failure. Their work points out that depressive symptoms have been hypothesized to stimulate cytokine production within the body. Cytokines are proteins secreted by cells of the immune system. The production of cytokines causes inflammation in people with chronic illness.

In the process just described, depression is thought to lead to inflammation. It is particularly interesting to note that this may be a two-way process: not only may depression stimulate inflammation but inflammation may produce depression.

In this regard, Khalil *et al* state that evidence from animal studies demonstrates that when pro-inflammatory mediators (such as cytokines) are present in the central nervous system they can produce behaviour consistent with depressive symptoms. Haemodialysis can, they state, stimulate the inflammatory process so that this link is especially significant for persons who receive haemodialysis.

They cite a 2003 study which demonstrated an association between depression and inflammation in humans. In the study, a serum protein was measured as a marker of inflammation in over six thousand men and it was found that the men with depressive symptoms had over two and a half times higher level of the protein.

A further study by Duarte *et al* (2009), shows that depression has been proven to be an important predictor of morbidity and mortality in renal patients. This is because it is associated with immunological and inflammatory changes which themselves are associated with increased cytokine levels. These inflammatory changes were shown to increase the incidence of infection in patients receiving a particular form of dialysis.

What of the link between depression and heart disease? Doyle *et al* (2007), state that depression following myocardial infarction (heart attack) is reported at twice that of comparable general population samples.

However, there is now an increasing realisation that depression may have been present prior to the cardiac event and that depression may actually be important as a cause and predictor of coronary heart disease. Depression has been associated with reduced pumping ability in the heart muscle. Doyle *et al* cite several studies that show a link between depression and heart disease. They note, however, that relatively little has been done to examine the link between psychological well being and reduced risk of heart disease.

These findings, and especially the finding that depression may contribute to heart disease, add an urgency to the need to treat depression as effectively as possible.

Role of Stress in Illness

The link between stress and illness involves hormones that affect, or are produced by, the central nervous system, specifically the hypothalamic-pituitary-adrenal (HPA) axis; these hormones have potentially both protective and maladaptive consequences. Stressors stimulate the release of a hormone adrenocorticotrophic hormone (ACTH) by the hypothalamus and pituitary glands (situated in the brain). ACTH in turn triggers the release of glucocorticoids from the adrenal cortex, which is situated over the kidneys. These glucocorticoids produce many of the effects of the stress response.

The level of circulating glucocorticoids in the blood is the most commonly employed physiological measure of stress. In the short term this stress response helps us adapt to and respond to stressors. However, if maintained over the long term it produces maladaptive changes such as enlarged adrenal glands, gastric ulcers and increased susceptibility to infection.

The effects of stress are widespread. Research by Ross (1999) found that stress levels influence the autonomic nervous system (a part of our nervous system which operates outside our voluntary control, regulates heart rate and performs other vital functions). This can lead to coronary vessel constriction, tachyarrhythmias (irregular, fast heartbeat), and other adverse cardiac events.

Ross also states that depression has been associated with increased mortality in the general medical population. One reason is that depression has been associated with enhanced platelet aggregation (blood clotting).

The Central Nervous System

The amygdala is an almond shaped set of neurons located in the medial temporal lobe of the brain and forms part of the limbic system. Emotional expression is controlled by the limbic system. The traditional approach in neuroscience to the study of cognition in humans has excluded examining emotion. However recent studies in cognitive neuroscience have highlighted the interaction with human emotions.

According to Phelps (2006), even abstract representations of fear can influence the amygdala which in turn stimulates the physiological response to fear.

Certain stimuli, as is well known, are prone to evoke an emotional reaction, but the way in which these stimuli are processed and interpreted is crucial to the effect on emotion, behaviours and actions. Phelps argues that through conscious strategies and practice the interpretation of events can be altered and this can in turn alter emotional reactions. Reappraisal is described as seeing the glass half full as opposed to half empty. In other words reappraisal has a great deal in common with the therapeutic practice of reframing.

The change brought about by the cognitive act of reappraisal has been shown to alter the perception of emotion by reducing amygdala activation. This must lead us to the conclusion that conscious reappraisal can influence the emotional response. Thus reframing, if adopted by the client, can have the physical effect of dampening down the emotional response in the brain.

As mentioned the amygdala is critical for the expression of symbolically acquired fears. These are fears that are imagined and anticipated even though the object or event is never actually experienced. Traditionally it was assumed that fears were acquired through a conditioned response as described by behavioural theorists. Phelps argues that humans have developed a more efficient symbolic means of communication which is language. This means that fears can be acquired through indirect means.

She gives the example of someone learning to fear a neighbourhood dog by listening to a discussion about how dangerous the dog is. This type of instructed learning will result in a fear response to the dog even though there is only symbolic knowledge. She goes on to say that the amygdala may be involved in learning to associate stimuli with positive outcomes but concedes that future research will need to explore this theory.

She emphasises that the amygdala is not the only brain structure identified as important for processing emotion and that limits in neuroscience techniques necessitate looking at structures individually rather than how they interact. Overall she concludes that it is increasingly difficult to separate emotion and cognition when processing stimuli. This is very significant in understanding psychological theories particularly cognitive behavioural approaches. It suggests that cognitive retraining can influence our emotional response and this has been verified by these studies of the amygdala.

Empathy and Borderline Personality Disorder

Pinel in the book *Biopsychology* states that the amygdala is believed to be the structure in which the emotional significance of sensory signals is learned and retained (1997, p.448). I would suggest that this adds a physiological aspect to counselling as the changes in perception resulting from talk therapy lead to neurological changes.

In his book *Zero Degrees of Empathy* (2011), Simon Baron-Cohen also emphasizes the role of the amygdala in relation to its role at the "centre of the emotional brain". In a study on empathy, subjects underwent brain scans while looking at pictures of other people's eyes and were asked to make judgements about their emotional and mental state. One brain region clearly activated was the amygdala.

Individuals with BPD were unable to detect accurately the emotions portrayed. An article by Vincent Di Norcia (2011) entitled *Ethics on the Brain* also emphasises the importance of the amygdala and states that it "helps a person to consciously respond to another's expressions of anger, fear and disgust by linking attention with emotion". This could have enormous implications for working with clients with BPD and could provide increased insight into their condition. It suggests that their neurological make-up is at the source of their condition.

Ulcers: an emotional/physical link

Pinel (1997) describes how the study of stress induced gastric ulcers has focussed on the amygdala because of the key role it plays in response to threat. Electrical stimulation of certain areas of the amygdala increases the flow of hydrochloric acid and decreases blood flow in the gastric mucus (stomach lining). As a result, stimulation of these areas of the amygdala can even after a few hours produce gastric ulcers. Hydrochloric acid is a major constituent of stomach secretions and it has the function of digesting food: it is normally present in concentrations capable of dissolving some metals. This indicates that feelings of stress can have direct physiological implications.

Counselling and illness

That counselling is beneficial for persons suffering from a chronic illness is supported by research, including my own research with nurses. In their research, Kelly and Tibbles (2004) report that eighty four percent of patients found counselling helped them cope better with their situation. Responses in my research indicate that the expressing of feelings and fears may lead to increased acceptance of illness. This in turn appears to lead to empowerment and increased feelings of control.

Sixty six percent of patients in the Kelly and Tibbles survey believed that counselling helped towards being positive about their treatment. Again this was echoed by nurses in my research who reported that support and coping tools led to a more positive attitude and acceptance which can lead to increased compliance with treatment. As one nurse put it, "to have the patient psychologically prepared for what is ahead can be half the battle". Another said, "a chronic illness is for life so acceptance is vital to maintain day to day living."

Another raised the issue of loneliness and suggested that some patients may enjoy hospital admission for company and a break from daily problems. This was echoed by another who proposed that group therapy in the community would cut costs as patients could be cared for at home.

Sadly, though most respondents considered that counselling would be cost effective, most doubted if funding would be provided.

Yet the benefits for some some patients could be profound. Research (for instance by Duarte, Miyazaki, Blay et al, 2009) proposes that depression leads to immunological changes, development of infections, increased hospitalizations and decision to withdraw from dialysis. Other researchers have found that depression increases medical costs for renal patients (Katon and Ciechanowski 2002) arising from primary care visits, specialised consultant visits, laboratory test and inpatient costs. These findings point to counselling providing both a preventative and health promotion role in illness.

One respondent considered that counselling intervention would be most beneficial when a patient is first diagnosed. She proposes that many complications could be prevented if acceptance of the condition was facilitated soon after diagnosis. Indeed, research by Guthrie (1996) found that well-timed psychological interventions during the initial state of an illness may have a protective effect against the subsequent development of psychological disorder.

The issue of lack of counselling

I found it worrying that people with quite traumatic symptoms were not always in a position to avail of psychological help. For instance, patients who have chronic obstructive pulmonary disease need support as this can cause extreme breathlessness which is both anxiety provoking and frightening. Fifty percent of nurses in my research cited this condition as being particularly suitable for counselling intervention. It seems unacceptable that patients who have conditions that lead to physical changes such as amputation and colostomy formation on general hospital wards are not routinely offered support. One respondent who worked in a burns unit reported that patients were offered a psychiatric referral only if the burns were self inflicted. These are, as noted by respondents, life changing events but no routine opportunity to process them is offered.

Conclusion

Counselling and psychotherapy will need to be accepted by the medical community as an adjunct to medical treatment before it will be routinely offered to patients. Further research which provides a more complete picture of the benefits is necessary. It may not be until research includes brain scans before and after psychological support that doctors will consider it routinely.

Empirically validated research that links physiology, emotions and cognition is the way forward. However, this would be prohibitively expensive at the present time. Also neuroscience is still in its infancy and much more knowledge needs to be gained in this field in order that results obtained can be accurately assessed.

Ultimately, what is needed is a change of perspective in which the person could be viewed holistically within a health care setting rather than the emphasis being on the symptoms and medication involved in their care.

Such a change will allow the individual to feel validated and understood thus leading to greater self care and perhaps less medical intervention. As counsellors and psychotherapists we have a key role to play in this development.

Cecilia Keogh is a qualified nurse and has graduated with a Professional Diploma in Integrative Counselling and Psychotherapy from the Institute of Integrative Counselling and Psychotherapy. At the time of writing she has completed the requirements for the award of BA (Hons) in Integrative Counselling & Psychotherapy from IICP.
She has a special interest in the interaction between psychological and physical health. She works as a Placement Therapist for Pieta House.

REFERENCES

Baron-Cohen, S. (2011) Zero Degrees of Empathy. London: Allen Lane

Di Norcia, Vincent .(2011) *Ethics On The Brain*. Philosophy Now. November/December2011. P. 17-20.

Doyle, F., Conroy, R. and McGee, H. (2007) Challenges in reducing depression–related mortality in cardiac populations: cognition, emotion, fatigue or personality. *Health Psychology Review*. Vol. 1 No. 2, Pages 137-172.

Duarte, S.D., Miyazaki, M.C., Blay, S.L. and Sesso, R. (2009) Cognitive-behavioural therapy is an effective treatment for major depression in haemodialysis patients. *Kidney International* . Vol.76, Pages 414-421

Guthrie, E. (1996) Emotional disorder in chronic illness: psychotherapeutic interventions. *The British Journal of Psychiatry*. Vol. 168, Pages 265-273.

Katon, W. And Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*. Vol. 53, Pages 859-863.

Kelly, M. And Tibbles, R. (2004) Counselling should be offered to people with end-stage renal failure. *EDTNA/ERCA Journal* XXX, No. 1. January/March. Pages 31-33.

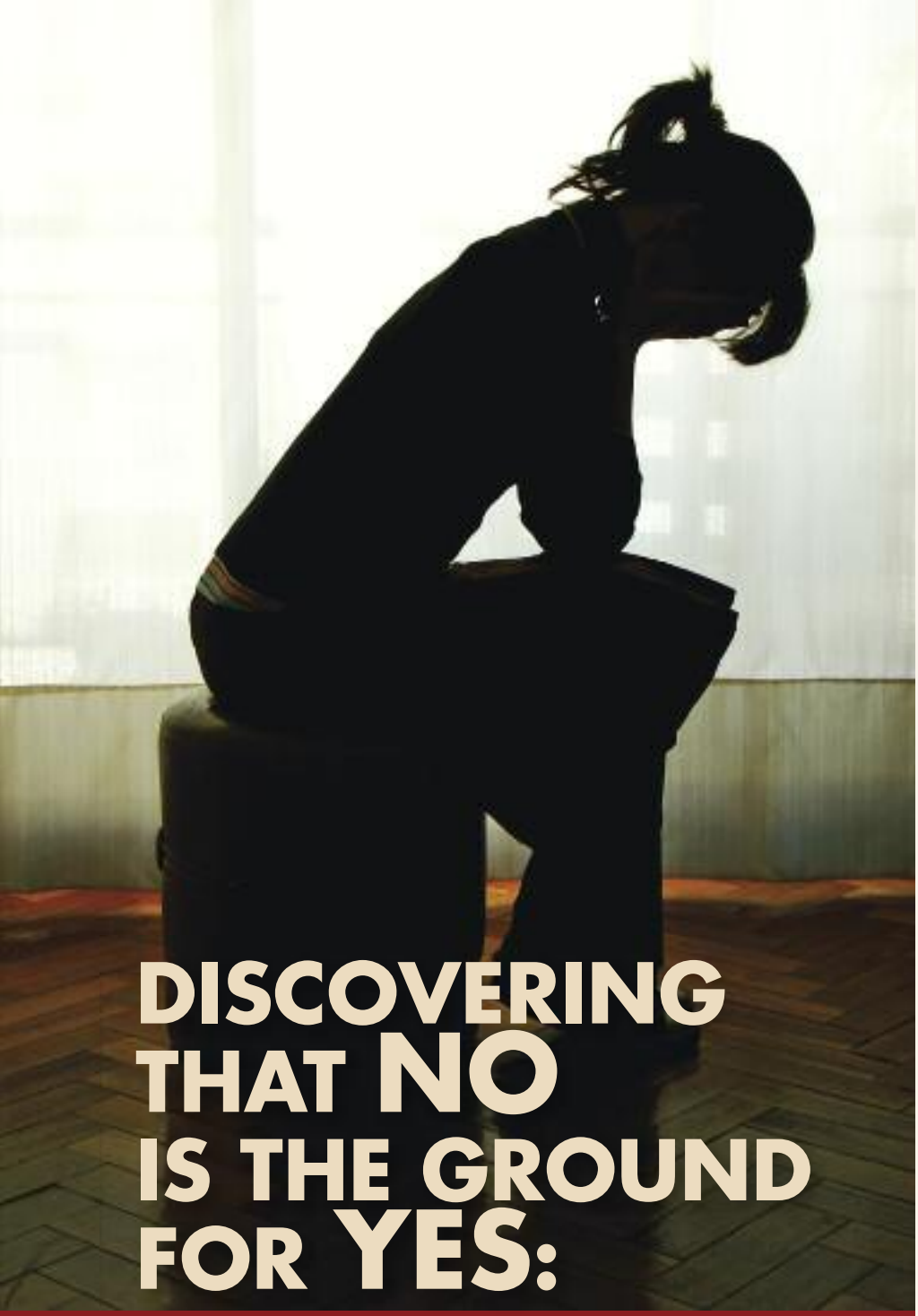
Keogh, C. (2012) Dissertation: a paper submitted to the Institute of Integrative Counselling and Psychotherapy,
Dublin, in partial fulfilment of the requirements for the award of BA (Hons) Degree in Counselling and Psychotherapy.

Khalil, A., Lennie, T. and Frazier, S. (2010). Understanding the negative effects of depressive symptoms in patients with ESRD receiving haemodialysis. *Nephrology Nursing Journal*. Vol. 37, No. 3, Pages 289-308.

Phelps, Elizabeth, A. (2006). *EMOTION AND COGNITION*: Insights from studies of the Amygdala . *The Annual Review of Psychology*. 2006 P.57-23.

Pinel, John P.J. (1997) *Biopsychology Third Edition*. U.S.A: Viacom

Ross, R. (1999) Atherosclerosis: An inflammatory disease. *New England Journal Medicine*. Vol. 340 pp.115-126



DISCOVERING THAT NO IS THE GROUND FOR YES:

childhood sexual abuse trauma and working with the motoric fields of Biosynthesis

by **Attracta Gill**

'So many childhood sexual abuse survivors are basically held captive and their last resort is to just become immobilized'

Pat Ogden

ABSTRACT:

David Boadella (1931) is the originator and pioneer of Biosynthesis Somatic Therapy. He is the author of 'Lifestreams: An Introduction to Biosynthesis (1987) and 'Wilhelm Reich: the evolution of his work' (1985). One of his major contributions has been the dedication that he put into founding and editing *Energy & Character*, the first journal about Body-Psychotherapy (rather than any particular method) which has been published continuously now for over 30 years.

Biosynthesis, which means integration of life, is a body-oriented and psychodynamic psychotherapy which has roots in depth psychology, influenced by the humanistic tradition of psychotherapy and with a strong transpersonal dimension. Biosynthesis has been researched and developed over the last 30 years by David and Silvia Boadella and has been integrated with the emerging flow of discovery produced by neuro-science.

Biosynthesis therapists believe that each person from the moment of conception has a unique potential and this potential is greater than the trauma or pathology experienced. We work within the containing membrane of the therapeutic alliance to help the client realize this unrealized potential or inner essence.

In this article I would like to explore the work of motoric fields in Biosynthesis and show through an example of a short case study how a client who experienced childhood sexual trauma can use somatic movement to move from a place of being victimized and frozen to a place of awakened expression of assertion and potential.

The 9 Motoric Fields of Biosynthesis:

'Motoric Fields join movement to breathing, and movement to feeling and can be used to construct a new body image reflecting the potentiality for adaptive response to environmental stress and for experiencing the joy of living'.

David Boadella

The German embryologist Erich Blechschmidt (2004), who developed the concept of embryo-dynamic fields to describe the different force fields that act on embryonic tissue when the body is forming, heavily influenced David Boadella. David has used this concept as a descriptive schema to explain the 'motoric fields that are involved in every developmental step, from free floating in the womb, through birth and suckling, to crawling, standing, grasping and all later skills' (1999:55). These fields are centred on movement and each of them has a healthy and unhealthy aspect depending on the type of character conditioning and trauma experienced.

Boadella (1999) explains that two nervous impulses pattern our movements; the first of these originates in the brain cortex and travels down to the alpha nerve to give direct signals to the voluntary muscles to act. The second originates in the brain stem and travels down to the gamma nerve and through the muscle spindle it gives signal to the muscle to get into appropriate tonus. This is called the readiness system.

As the conditioned movement overlays the unconditioned movement (just as the conscious mind overlays the unconscious mind) in Biosynthesis we are interested in looking for the movement tendency which can be seen as the seed of change to step out of our character pattern or pathology. This happens anatomically when the spindle receives fibers from the vegetative nervous system, which regulates the flow of emotional energies in the body. Therefore by listening and looking for movement impulses from the readiness system the Biosynthesis therapist is in a good position to help the client elicit spontaneous changes on a somatic level which contacts the unconscious without using words as the primary tool. Boadella organized the motoric fields into four pairs of polarities, which relate to the eight movements available to the embryo in the womb with the ninth field positioned at the centre of the motoric field system. This he calls the pulsation field.

The Pulsation Field:

'Pulsation links with play and play links to life. We can help the client to play and recover the joy and playfulness of life'

David Boadella

This represents the main pulsation in the body, which starts with the heartbeat of the fetus at 21 days after conception. Following on from this the body has many pulsations such as the rhythm of breathing, which begins after birth. Boadella (1999) points out that some people emphasise their in-breath more than their out-breath. He differentiates between the containment stroke and the release stroke. With the containment stroke we might encourage the client to move out and breathe in – this will help to build boundaries and contain charge. By using the release stroke we breathe out and move out – this is helpful in states of tension or blockage and helps to open boundaries, emotion and charge.

The Flexion and Extension Fields:

According to Boadella (1999) this is related to the flexion field of the fetus in the womb and is connected to contraction and expansion. He believes that as an adult it can have a self-protective and self-preservative function such as in times of fear or cold. This motoric field also occurs frequently when a person is characterologically identified with depression or hopelessness. On the other hand when a person denies fear or defends against collapse this field will be avoided. In the extension field the body moves into the opposite of flexion. Boadella (1999) sees birth itself as the first great extension. The baby will kick and move her arms into space. This field is related to the client expressing strong feelings of rage or distress and being able to 'stand up for himself or herself'. An unhealthy extension field occurs when a person believes that being small is dangerous and they find themselves trying to extend all of the time.

The Traction and Opposition Fields:

The Traction field is found primarily in the arms and a healthy traction field is recognized by being able to sustain healthy contact in relationship whilst getting your needs met. In the unhealthy expression of this field we meet co-dependency, fear of independence and symbiosis. The Opposition field is the opposite of the Traction field and is developed in pushing. Boadella (1999) points out that the fetus experiences the earliest opposition field as he pushes against the pelvic floor with the head. Having good clear boundaries and being able to express 'no' characterize a healthy opposition field. It is essential to develop this field for people who have experienced invasion of their boundaries during their childhood. An unhealthy expression of this field can be met in the angry psychopathic character that pushes all contact away. Boadella (1999) suggests that for such a character expression of other fields will be more helpful in the therapeutic work.

The Canalisation and Rotation Fields:

Boadella (1999) describes the canalization field as highly linear and focused. This field is related to purpose, focus and is goal oriented. An unhealthy expression of the canalization field is obsession, tunnel vision and rigidity. These characters might be better served by rotation or pulsation. The Rotation field is related to our birthing process as the child rotates during birth and we can express it in a healthy manner by being flexible and open to new ideas. Boadella (1999) explains that we can meet unhealthy expression of this field particularly in the hysterical character that gets ungrounded easily.

The Activation and Absorption Fields:

A healthy Activation field means that a person is ready to move and prepare for action. Some people have great difficulty expressing this field and this shows in more depressive tendencies. Boadella (1999) suggests running, dancing or jumping as ways to express this field. An unhealthy expression of the Activation field is seen in over-activity and being unable to rest. The Absorption field allows a person to lie quietly and take in nourishment from the environment, being rather than doing. This may be a helpful field for the client who has just worked with strong emotion and needs to move into the absorption field of nourishment and integration. An unhealthy expression of this field can be seen in the person who procrastinates and gets stuck.

The Dance of Interaction between the helper and the helped:

> *'The trauma can only be worked through after a secure bond is established with another person. The presence of an attachment figure provides people with the security necessary to explore their life experiences and to interrupt the inner or social isolation that keeps people stuck in repetitive patterns'.*
>
> Van Der Kolk

Jane had a history of early childhood sexual abuse continuing until the age of 10. Her mother colluded with the abuse and would leave her in situations where the perpetrator had access to her. In other words she would encourage the victimisation of her child. Jane reported that her mother was clingy, mean, cruel, cold and selfish. In order to survive, Jane was very dependent on her mother and never argued or stood up to her. She had an unhealthy symbiotic relationship with her.

As an adult Jane often has a strong negative transference reaction to older women, particularly those in authority and has repeated experiences of being victimised and bullied. She has a conflict between her 'inner feeling' of protesting and her 'outer feeling' of freezing and being submissive. She feels unable to use an assertive 'no'. Her therapist happens to be an older woman and Jane starts to feel afraid and intimidated of her. She brings this to the attention of her therapist at the start of her session. The therapist asks her client to sculpt her body into the scared position. The client sits on the floor and takes the position of the fetus **(Flexion field)**. The therapist then asks her to take the position of how she experiences the therapist. She stands waves her arms and makes a hissing noise **(Activation field).** The therapist switches positions and becomes the small client in a fetal position and asks the client to become the hissing therapist. The client positions herself about 10 feet away and becomes the hissing angry therapist. She slowly approaches the figure on the floor whilst hissing and flailing her arms. In this position the client gets to visually see what happens to her in the flexion field when she feels bullied and overwhelmed.

The therapist now comes back to the here and now of the issue at hand and asks the client to once more take the fetal position and the therapist resumes the transferential relationship of being the perpetrator. The therapist approaches the cowering client, hissing and attacking and stands with her arms stretched over her. The therapist keeps in good contact by voice and asks her client about any inner impulse she may be experiencing. The client reports that she now has an impulse to do something very different from her history. She experiences an impulse to stand **(Activation field)** and with the encouragement of her therapist she starts to move into the standing position **(Extension field).** Jane then uses her arms and hands to touch the therapist's hands and starts to push **(Opposition field)**. As she pushes forward the therapist encourages her to use sound and voice the word 'no'. The client continues to push the therapist firmly using the word 'no' and all the while being supported by the therapist to use her breath and to stay focused and grounded with the earth **(Canalisation field)**. She finally backs the therapist to a wall and her body spontaneously breaks into a joyful dance **(Rotation field).** The session ends with therapist and client sitting on the floor processing the client's experience **(Absorption field).**

> *'On the deepest level, change always involves the body. A new attitude means new perceptions, new feelings, and new muscular patterns. Psychological and physiological change go hand in hand. Since our deepest traumas are imbedded in our guts and muscles, to free ourselves we must free our bodies. Yet we are more than just bodies. We are minds and spirits, feelings and imaginings. And though the body speaks, it must always be the whole person to whom we listen.'*
>
> Ron Kurtz

In this session we see that with the support and emotional resonance of the therapist, the client moves through the motoric fields of the body in order to access the healthy movement impulses that had been blocked due to sexual and emotional trauma. The therapist facilitates this by firstly asking the client to experience the polarity of victim and perpetrator and then victim again. Thus we are starting to look for signs from the client and her readiness system in relation to mood and intention.

'In Biosynthesis the therapist is interested both to follow and support spontaneous movements: and to induce and elicit them by leading a part of the body in a certain direction, where it is invited, not required to follow' (Boadella, 1999:54). Therefore the Biosynthesis therapist seeks to listen to the gamma tone of the muscle and its readiness. This is what David Boadella calls the 'Soul of the Muscle'. The therapist supports the client to move through the motoric fields of flexion, extension, opposition, canalization, activation, rotation and absorption. The use of these movement tendencies is central to Biosynthesis, particularly in the work of Trauma.

The one motoric field that we did not work with is Traction. The therapist consciously makes this clinical decision because the client has reported that she had been overly dependent on her mother and experienced unhealthy symbiosis to survive. She gets stuck in the pathology of the Traction field, which does not serve her well as an adult. We can clearly see in this vignette how the appropriate form of action of saying 'no' to perpetrators was inhibited and not possible. The flexion and traction field may feel very safe to this client as she can withdraw from the world or cling to help herself feel safe. These were probably the positions that gave her the most comfort as a child. The client feels fearful to activate the extension field, which would require her to stand up for herself and open her up further to the stresses of the world and relationships.

The client being over-powered as a child experiences the Opposition field as being violated; she could not resist the sexual abuse through fear of further punishment. 'For people who learned to give up their boundaries and surrender to invasion without protest, the opposition field is essential to practice and develop' (Boadella, 1999:60) These motoric fields that have remained frozen in the body as dormant tendencies are waiting to be re-evoked in the relevant therapeutic context. As Boadella (2011) explains 'We are not trying to relive the trauma but reshaping history, finding a different way to respond, a different way of being in the world'.

An important question to ask is what could we do that is the opposite of the disturbance? What could the client do that is the opposite of the flexion field? As Biosynthesis therapists we offer a safe place to creatively explore progression out of the frozen history of the trauma. As Van Der Kolk (1989:406) suggests 'Once the traumatic experiences have been located in time and place, a person can start making distinctions between current life stresses and past trauma and decrease the impact of the trauma on present experience'.

We trust that the inner ground and inner impulses will appear if we create a safe place for the client. We attempt to get the inner feeling, the action and the emotion connected so that our movements and relationships in life are rewarding. Before the session, the client's inner feeling is protest, the action is submission and the emotion is freezing and victimisation. After the session the client's inner feeling is one of protest, the action is healthy opposition and the emotion is healthy aggressiveness and empowerment. Peter Levine (2001:5) suggests that 'when you are able to help people resolve trauma in this way, in this titrated, gentle, progressive way you get again as a side affect a real thing between instinct, feeling sensation *and* perception and cognition'.

Alexander Lowen (1995) suggests that any individual who was crippled psychologically by the forced suppression of his natural impulses becomes free and joyous as his body regains its freedom and grace. Joy is waiting to be let out of the prison of childhood trauma, which cuts off the sun from reaching the heart. In this case study we can see that childhood sexual abuse has had a very negative impact on the healthy aspects of the various motoric fields. From this perspective Biosynthesis Somatic Psychotherapy is very well placed to work with the trauma of childhood sexual abuse in a way that avoids re-traumatisation of the client and encourages the discovery of latent possibilities within the body.

Training in Biosynthesis:

'Working with the Body can change the mind'
David Boadella

Biosynthesis establishes a link between the 7 chakras and possible disturbances as evident in different character structures. In the first week of training the emphasis is on the root chakra, autonomy and the will to survive. Major teaching themes are grounding and holding patterns in the body, polarity tendencies in the body, and impulse qualities in movement.

In the centering week the emphasis is on the hara chakra and on pre- and perinatal aspects of experience, womb life, birthing, and ways to help clients with birth or pre-natal trauma.

The bounding week concentrates on the energies of the solar plexus chakra, and the sympathetic emotions of anger and anxiety, in relation to the movement patterns of constructive aggression, and constructive self defence, or safety-seeking. The emphasis is also on self-esteem and image.

The fourth week of bonding focuses on the heart chakra as the centre of a love relationship, and looks at patterns of cooperation in partnership, (as opposed to symbiotic collusion, or destructive collusion).

The sounding week concentrates on the throat chakra, clear communication and self-expression. The 3rd eye chakra is connected to facing and letting go. Therapeutic work on the eye block includes ways of transforming restrictive imagery to creative imagery, and ways of grounding imagery in the body and in movement.

Finally the crowning week connects the crown chakra as a gate between personal existence and the transpersonal. We work with themes of healthy spirituality as opposed to pseudo spiritual escape from the body. We look at attitudes to death. There is intensive teaching on working with resources and qualities of essence.

Conclusion:

In this article I have attempted to show how movement patterns in the body can be negatively impacted on by childhood trauma. I have explored specific Motoric Field Patterns (healthy and unhealthy aspects) found in different character structures and through the example of a clinical piece of work illustrate how we can work somatically by increasing the range of body responses available to the client. David Boadella who celebrated his 80th birthday last year has dedicated his life to researching Body Psychotherapy and its connections to neuro-science, imagery, spirituality, meditation, movement, language and philosophy. He is an original man who is passionate about helping people find resources somatically to transform the misery of human suffering and trauma. His training is well structured and is grounded in sound psychological and scientific theory whilst allowing for the creativity of both therapist and client to emerge intuitively and collaboratively. I feel very fortunate to have discovered David and his pioneering work of Biosynthesis. I look very much to the future and feel inspired to 'break new ground' and introduce his life's work to Ireland.

Attracta Gill, MA MIACP MIAHIP ICP ECP, has studied Psychodynamic Psychotherapy, Biosynthesis Somatic Psychotherapy, Gestalt Psychotherapy, Existential Philosophy/Psychotherapy, Art Therapy and Dance and Movement therapy. She has a love of working with dance, movement and poetry to help people reconnect with their inner essence. Having spent 5 years training at the International Institute for Biosynthesis in Switzerland, David and Silvia Boadella have asked Attracta and Austin Breslin to take responsibility for the new Irish Institute of Biosynthesis. This will provide Post Graduate training at Introductory, Certificate and Diploma level. In Brussels in October 1998 Biosynthesis was the first body-psychotherapy method to receive scientific recognition from the European Association for Psychotherapy (EAP) and graduates can apply for the European Certificate for Psychotherapy. For further information please contact agill3@hotmail.com or 087 2382978.

REFERENCES

Blechschmidt, E., Freeman, B. (2004). *The ontogenetic basis of human anatomy: The biodynamic approach to development from conception to birth.* North Atlantic Books: Berkeley, CA.

Boadella, D. (1987). *Lifestreams: An Introduction to Biosynthesis.* New York: Routeledge & Kegan Paul.

Boadella, D. Shape Postures and Postures of the soul: The Biosynthesis concept of motoric fields. *Energy & Character, International Journal of Biosynthesis*, 1999;30 (1).

Boadella, D. (2011). *Biosynthesis Training Solar Plexus Week.* Lecture/Class Heiden: Switzerland, unpublished.

Kurtz, R., & Prestera, H. (2004). *The Body Reveals: An Illustrated guide to the Psychology of the Body.* Harper & Row: New York.

Levine, P.A., & Frederick, A. (1997). *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences.* North Atlantic Books.

Levine, P. (2011). *How to learn from the unspoken voice of Trauma.* Paper presented at A Teleseminar Session with Ruth Buczynski New Treatment for Trauma Series 2011: NICABM:Connecticut USA, viewed December 2011.

Lowen, A. (1995). *Joy: The Surrender to the Body and to Life.* Penguin: USA

Ogden, P., Pain, C., Minton, K. (2006). *Trauma & the Body: A Sensorimotor Approach to Psychotherapy.* Norton & Company

Van der Kolk BA. The compulsion to repeat the trauma: re-enactment, revictimization, and masochism. *Psychiatr Clin North Am* 1989;12(2):389-411

EMOTIONALLY FOCUSED THERAPY: *AN ATTACHMENT THEORY PERSPECTIVE TO COUPLE THERAPY*

by **Gail Palmer**

Relationship counsellors respond to and strengthen one of our world's most precious resources: that of our intimate adult relationships. In order to effectively treat relationships in jeopardy, therapists need a model that gives meaning to the couple's distress and provides effective interventions that not only modify and shift the couple's destructive dynamics but also help create a sustainable and resourceful love connection. Secure, loving and lasting marriages that provide a safe haven and secure base for all family members is a realistic and achievable goal when relationship counsellors have a therapy map. Emotionally Focused Therapy integrates attachment theory and its conceptualization of adult love into a structured therapeutic framework that combines experiential and systemic interventions that specifically target the emotional bond between adult lovers.

Adult attachment is defined as the bond that exists between individuals who are emotionally connected to one another and who have primary significance in each other's lives. John Bowlby developed a theory that postulated that human beings, both as children and as adults, are biologically wired to seek and maintain a few intimate relationships and reach out to these significant others when upset, and miss them when they are gone. A secure attachment is created through emotional responsiveness and accessibility from the attachment figure. This security provides the individual with both a safe haven to come home to and a secure base from which to explore and provides a source of comfort, support, nurturance and love.

Bowbly postulated that when an attachment bond is threatened there is a predictable response to the separation distress including angry protest, clinging, depression and despair and if the attachment figure remains inaccessible, eventually detachment. How each individual responds to unresponsiveness of an attachment figure over time can be defined along two basic dimensions – anxiety and avoidance. One strategy is to either over activate proximity-seeking behaviours when the bond is threatened by anxious clinging, and pursue or react in anger in an attempt to have the important other respond. This insecure attachment style is referred to as either preoccupied or anxious in the literature.

An alternative strategy, especially if the hope for responsiveness is diminished, is to deactivate attachment behaviours and either avoid or limit emotional contact and suppress one's attachment needs. This insecure attachment style is labelled as dismissive or avoidant.

A third way of responding is a combination of both anxiety and avoidance and involves seeking contact but then rejecting the contact when it is offered. This style is referred to in the literature as disorganised or fearful-avoidant.

These strategies for coping with unresponsiveness can develop into habitual styles of relating to others and becomes a way to approach relationships, influencing how one experiences oneself and the other in relationships. Bowlby labelled these styles as being comprised of internal working models of self and other. Securely attached people believe that others are trustworthy and dependable and that they can expect that they will be loved and valued. Insecurely attached individuals have had repeated experiences that have taught them others cannot be trusted, that they will be hurt and that either others do not want to be as close as they would like (anxious attachment style) or they are uncomfortable being close (avoidant attachment style).

One can imagine that insecure internal working models of self and other could be seen as a major factor in troubled relationships and that a distressed adult relationship would continue to reinforce and maintain these learnt strategies. What is important for relationship counsellors to be aware of is that these models can be modified through effective attachment based intervention.

Treatment Options

Couples who rely on insecure attachment strategies may generally experience decreased marital satisfaction and therefore will likely be the couples that look for therapy to help alleviate the distress. In session, partners will enact and evoke their attachment dance as conflict activates internal working models and individuals will respond to relationship challenges differently depending upon their preferred attachment strategy. Bowlby believed however that people are capable of changing their models of self and other. Relationship counsellors possess the unique opportunity to provide a therapeutic experience that impacts attachment security.

Attachment theory is the ideal guide for treatment as it is systemic, linking the self with the system and the system with the self. Therapy involves the connecting of the interactional patterns between partners and their internal models of self and other. The therapist must be able to focus on the interaction between the spouses, which generally is an enactment of the internal script and on the emotional underpinnings of the couple's interaction. In session, the therapist creates a safe haven and intervenes with the couple to help them create emotionally supportive and accessible responses to one another. Change for couples comes from the creation of new dialogues that arise as a result of a reprocessing of the inner emotional experience, which is imbedded in each partner's internal working models.

Emotionally focused therapy links all the critical elements integral to adult attachment and provides a powerful experientially based therapy designed to strengthen the attachment bond. Outcome research has found that EFT produces positive results for the majority of couples (see icceft.com for further details). Interventions are made on both the interpersonal and intrapsychic levels with the goals of:
1) de-escalation of negative cycles, such as attack/withdraw that tend to reinforce and maintain attachment insecurity
2) creation of responsive and accessible interactions through specific change events - withdrawer re-engagement and blamer softening- that promote attachment security
3) consolidation of attachment rituals that continue to redefine the relationship as a safe haven.

EFT utilises attachment emotions as they arise in the interactional dance to begin to shape and prime soft and responsive interactions. Insecure

strategies are ways for partners to protect themselves emotionally and to help regulate their emotions in an intimate relationship. Therefore, an individual with an avoidant attachment style might take a rational, cool stance with their partner, dismissing, ignoring or deflecting their lover's bids for connection. For the partner who demonstrates a preoccupied attachment style, there are usually difficulties around differentiating and regulating their emotions. An anxious partner may take a critical, blaming stance towards their partner as a protective measure and as a means to ignite a response, using anger as a shield to more vulnerable attachment needs.

EFT Case Example

Rod and Alice are a middle-aged couple who sought therapy when their youngest child left home for university. This couple had focused their emotional energy on raising their children, and although Alice had suffered periodic episodes of depression, they had never sought help for their relationship. The couple had fallen into a pattern of Rod as caretaker and provider and Alice as the complaining, fragile partner. It was, however, Alice's personal growth and insistence for a different kind of relationship that brought this couple to therapy. Rod had learnt very early in life to take care of others as his father deserted the family when he was ten, and being the only child he looked after his mother, who became alcoholic, until he met Alice when he was 19 years old. Alice also had a very lonely childhood and parents who fought violently and were physically abusive and harsh with the children.

The couple began therapy describing a fairly typical negative cycle of pursue/withdraw; however the primary difference with this couple is that Alice was a very soft pursuer and although she would complain and criticise, she would do this in a very soft way and would retreat if met with a lack of response from her husband. A typical session would begin with Alice, with a strained voice and a tight face, saying "You are just not around – you go to your computer and you just stay there. I really can't count on you for anything more than paying the bills. As long as I leave you alone, you are happy. But I am not – this marriage is a emotional desert".

As the EFT therapist helps validate and normalise Alice's frustration as a protest to disconnection, utilising slow and reflective interventions, there begins an uncovering of softer, more vulnerable emotions. Alice is able to state, "I am just so tired and lonely. I feel all alone." Rod, in response to his wife's emerging sadness around her need for affection and attention, states that he really doesn't need "any of that stuff" and that really all he is looking for from his wife is space to "do his own thing". As his wife dissolves in tears, the therapist explores with Rod the look of frustration on his face. Rod is able to acknowledge his frustration and is helped by the therapist to stay in touch with his own emotion rather then rely on his defence of telling Alice how to take care of herself or attempting to cheer her up through humour. Through validating Rod's secondary emotion, and evoking the stimulus of Alice's tears, the therapist intervenes further, "Of course, this is really frustrating when you see her tears, and you know she's hurt, and she is looking to you...what happens then, what happens inside when you see her tears?" The EFT therapist is working to help Rod engage and stay in contact with his attachment emotions, and to deepen and expand his emotional experience in session.

This is a difficult and slow process for Rod and while he can describe in detail all the different facets of his frustration: annoyance, irritation, grumpiness, he struggles with accessing and labelling any softer emotions. Through the therapist helping Rod listen more to his internal cues and specifically his bodily reactions, he comes to name first disappointment and then finally feeling lost and alone. Once Rod has opened the door to his own vulnerability, he can talk more readily about his own anxiety around failing his wife and his secret fear that in the end, if he really appeared weak or "sissy", Alice would reject him.

Eventually Rod is helped to express his attachment needs to his partner and become a more fully emotionally engaged, responsive and accessible partner. Looking at his wife, Rod slowly states; "I have such a hard time with this. I know you need me to show you more how I feel and I want to try. I just might get it wrong and I need you to understand and be patient". These softer, more accessible responses allowed Alice to see a different side of her husband and de-escalate her negative emotional reactions.

This more open stance is a segue into the shaping of a change event in EFT where a previously blaming, critical spouse is able to ask for their attachment needs to

be met from an emotionally vulnerable position. It is at this juncture in therapy that the fears relating to models of self and other are more directly experienced. As the therapist notes Alice's reluctance to hear her partner's reach for her, she gently explores what is blocking the engagement, and Alice moves further and further into her emotional experience, the therapist helping her articulate what she "knows how" but does not "know what". (Wallin, 2007)

The therapist helps reframe Alice's shut-down and numbness as a shield for her fear that no one will be there for her, a fear she learnt a long time ago, when she needed to grow up quickly and look after herself. Alice then accesses her sadness and grief around no one being there for her in her life and her fear around trusting her partner's present response. "I don't know how - how could he be there - no one has ever been there". As the therapist gently encourages Alice to depend on her husband, she also touches her fear that if she really lets him in he will find her unlovable and unworthy. The EFT therapist then helps Alice communicate her attachment needs in a direct yet soft manner, " I need you to take care of me", which allows for an affiliative response from her husband. "Sure I can do that – it's been so long since you let me really be close – I want to be there for you."

This case example shows a shift in attachment strategies, particularly for Rod who had developed an avoidant or dismissive attachment style. The EFT therapist worked with Rod to help expand his internal world and access his attachment fears and longings. In EFT, reengaging the spouse who has been emotionally withdrawn and softening the more critical partner, constitute change events that are critical to the treatment success. These events begin to redefine the relationship as secure, where partners can turn towards each other and be comforted, nurtured, supported and loved.

Partners can then be intimate and interdependent with each other and the creation of attachment rituals helps to reinforce and maintain attachment security. Having a secure base and safe haven in life makes possible positive, loving interactions which in turn help build and broaden individual growth and potentially provide the foundation to a cohesive and secure family from which children can grow and flourish.

Gail Palmer, MSW, RMFT is co-directory of the International Centre of Excellence in Emotionally Focused Therapy in Ottawa, Canada. For over twenty years, Gail has trained and supervised therapists and students in Emotionally Focused Therapy across Canada, the US and Europe. Gail will lead a four-day externship training in Dublin, Ireland January 17–20, 2013. For further details please contact EFT coordinator James Parrin, jparrin@eircom.net. 087 202 9755

REFERENCES

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

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock.

Bowlby, J.(1980) *Attachment and loss: Vol. 111. Loss: sadness and depression*. New york: Basic Books.

Johnson, S.M., Bradley, B., Furrow, J., Lee, A., Palmer, G. Tilley, D., & Woolley, S. (2005). *Becoming and emotionally focused couple therapist: The workbook*. pp 134–137. New York: Routledge.

Johnson, S. M. (2004) *Attachment theory: A guide for healing couple relationships*. In Rholes & Simpson (Eds.) *Adult attachment: Theory, research and clinical implications*. (pp 367–383) New York: Guildford Press.

Johnson, S. M. (2004). *The practice of emotionally focused marital therapy: Creating connection*. (2nd Ed) New York: Brunner /Mazel

Johnson, S.M. (2003) *Introduction to attachment: A therapists guide to primary relationships and their renewal*. In Johnson & Whiffen (Eds.) *Attachment processes in couple and family therapy* (pp.3–17) New York: Guildford Press.

Johnson, S.M. (2003) *Attachment theory: A guide for couple therapy*. In Johnson & Whiffen (Eds.) *Attachment processes in couple and family therapy* (pp.103–123) New York: Guildford Press.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schlinder, D. (1999). *Emotionally focused couples therapy: Status and challenges. Clinical Psychology: Science and Practice*. 6, 67–79.

Johnson, S. M., & Taliman, E. (1997). *Predictors of success in emotionally focused marital therapy*. Journal of Marital and Family Therapy. 23, 135–152.

Johnson, S. M. (1998). *Emotionally focused interventions: Using the power of emotion*. In F. Dattilio (Ed.) *Case studies in couple and family therapy: Systemic and cognitive perspectives* (pp. 450–472). New York: Guildford Press.

Wallin, (2007). *Attachment in psychotherapy*.

Workshop Review

Working with Complicated Grief

Presenter: Dr Helen Greally

Reviewed by: Liz Sugar

Date: 20 October 2012

Venue: Tuar Ard, Moate, Co. Westmeath

Dr. Helen Greally works as Director of Psychology and Support Services at Cancer Care West. In 1998 she completed the first major study of coping with grief and loss in Ireland and lectures widely on the subject. She continues to work with many individuals who have experienced loss in their lives and sees grief as a journey of adaptation over time, which involves different tasks for each individual.

Twenty people attended this very well presented workshop which identified some of the current thinking around complicated grief.

In her introduction, Dr. Greally brought in the controversy that exists as to whether complicated grief exists and whether it will be in the DSM V and the ongoing discussion as to whether the present criteria that the death must have occurred at least six months before diagnosis will be extended to 12 months. Dr. Greally went on to say research has shown that usually drugs are not beneficial in treating complicated grief unless there are previous psychiatric/psychological issues.

Before looking at complicated grief, Dr. Greally spent a little time looking at how we work with normal grief and for her the main focus is to support the bereaved person in not avoiding the painful issues – this may involve retelling the story time and time again as each time it is told makes it more real. Grief is a universal response throughout the animal kingdom and rather than seeing it as 'something to be got over,' the process may be seen as using our resilience to adapt to changing circumstances. We grieve because we are attached and in working with bereaved clients it can be helpful to assess the level of attachment.

Dr. Greally feels that for many people, their grief does not fit some of the earlier 'stage' models and she sees grieving more as a roller-coaster with each person making their own unique journey of adaptation. She also stressed that the acute grief experienced in the first six months of a bereavement is not complicated grief and she feels it very important to pay attention to the dual process of grief – both the loss and the restoration – as the person struggles to adapt.

Research shows that 10-15% of people bereaved experience complicated grief and the highest risk of this is in parents who have lost a child, particularly parents of adult children.

Dr. Greally outlined the work of Patricia Shear who post-9/11 developed a process for working with complicated grief. This comprises three elements:

1. Cognitive behaviour therapy – this is directive and quite focussed
2. Interpersonal psychotherapy – this creates the safe place for the client
3. Motivational interviewing – the client sets their own goals

This process comprises three phases:

Introductory phase–3 sessions–the focus here is to establish a safe place for the client, get an overview of the client's story and their relationship with the deceased. There is also some psycho-education around grief and introduction to goals. In Shear's model, the third session is given to meeting with a significant other so as to understand how someone else experiences the client's grief. However, Dr. Greally rarely uses this part of the process.

Intermediate phase–here the role of the therapist is to work with avoidance as the client experiences the 'seesaw' of the dual process. The client keeps retelling the story with the purpose of moving on and also works with the personal goals that have been set.

Termination phase–3 sessions–review the process with the client and help make plans for going forward and for any difficult times the client may encounter.

This was a fascinating workshop which definitely enhanced my knowledge and understanding of grief and complicated grief. We were given very good handouts and we broke into small groups to look at a case study. A huge amount of ground was covered in a very short time and I would like to extend our appreciation to Dr. Greally for an excellent day.

STUDENT'S VOICE

Éisteach hopes to begin publishing an article in each issue of specific interest to counselling students. If students wish to tell us what they would like to see covered, they can do so by emailing deirdre@iacp.ie

Chiron's Corner

MAN AND HORSE

I notice an increasing tendency for people in our area of work to describe themselves as "counsellor and psychotherapist". That's one way to address the great, unanswered question: "What is the difference between a counsellor and a psychotherapist?"

I've never heard a satisfactory answer and the question often produces a bemused silence.

I have been here before when it comes to unanswered and unanswerable questions. When I went into journalism I asked how long we had for lunch. This question, too, produced a bemused silence. Telepathically it was communicated to me that it was in nobody's interest to ask such a question let alone answer it. I often wondered what the answer might be but never troubled anyone with the question again – not in a business known for long lunches.

The matter of the difference between a counsellor and a psychotherapist is, of course, a grander affair than the lunch arrangements of hacks. Yet they both go unanswered and people get tired asking.

And just as the question of the length of the lunch hour was irrelevant in journalism at that time, the question of the counsellor/psychotherapist difference is irrelevant to the public who provide us with such custom as we get and who couldn't care less about it.

Nor should we. Counsellors delve into the past, just as psychotherapists do and psychotherapists work with the present just as counsellors do.

If the public doesn't care at all, why do we?

And why do we bother to attach both tags to ourselves: the "counsellor" tag which describes us perfectly adequately to our clients and the "psychotherapist" tag which doesn't describe us at all so far as many members of the public are concerned?

Of course, I don't know the answer to that either.

When we adopted the Chiron logo for this column one of our number observed that it represented the counsellor/psychotherapist dilemma, Chiron being half man, half horse.

The question is, which half is the counsellor and which half is the psychotherapist?

Padraig O'Morain

NICE BUSINESS

Has niceness become an affliction in the counselling profession? It's everywhere: the Rogerian approach is very nice; we try to look nice and sound nice; and counselling courses are conducted in a welter of niceness, most of the time.

An amusing aspect of niceness is the extreme difficulty some counsellors have in asking a client to pay when he or she is forgetting to do so. It is always fun to ask counselling students to do role plays about this, having first shown them the clip from the Sopranos in which Tony's therapist asks him to pay for a missed session - a request which is met with the sort of robust attitude you might expect.

Somehow, in asking for the money, you are not nice anymore. You are a nasty, horrid business person and the relationship may never recover. I think that's the fear. Well, the relationship recovers instantly and your client is spared the embarrassment of realising that he or she left without paying.

What is more important, though, is what niceness does to our therapeutic practice. I get a sense sometimes that many of us feel we help our clients because we are nice and not because we know what we are doing. How could you not be be made whole by spending an hour a week with such a nice, warm, cuddly person as myself?

But look up Albert Ellis on YouTube - niceness doesn't come into it. The same goes for William Glasser who developed Reality Therapy - it isn't that he's rude, not in my book anyway, but that he doesn't really do niceness.

And this is not a plea for therapists to start being unpleasant to their clients. I simply want to make the point that niceness isn't enough and that we need to learn our trade as well.

Padraig O'Morain

As readers may have noticed, items in Chiron are now attributed to whoever writes them. Readers are welcome to send items for Chiron, about 200 to 300 words in length, to deirdre@iacp.ie.

Why Chiron? He is the wounded healer of Greek mythology: it was in seeking relief from his own suffering that he learned how to heal others. As shown in the logo, Chiron was a centaur – half man, half horse.

Note: *The opinions in Chiron's Corner are not necessarily endorsed by the IACP or the editorial board.*

POETRY

I leave my thoughts, my laughter, my dreams
to you whom I have treasured beyond gold
and precious gems.

I give you what no thief can steal,
the memories of our times together:
the tender, love-filled moments,
the successes we have shared,
the hard times that brought us closer together
and the roads we have walked side by side.

I also leave you a solemn promise
that after I am home in the bosom of God,
I will still be present,
whenever and wherever you call on me.
My energy will be drawn to you
by the magnet of our love.
Whenever you are in need, call me;
I will come to you,
with my arms full of wisdom and light
to open up your blocked paths,
to untangle your knots
and be your avenue to God.

All I take with me as I leave
is your love and the millions of memories
of what we have shared.
So I truly enter my new life
as a millionaire.

Fear not nor grieve at my departure,
you whom I have loved so much,
for my roots and yours
are forever intertwined.

Claire O'Reilly

Claire O'Reilly was a qualified nurse, a creative writer and facilitator who was also involved in voluntary work. In 2009 she graduated from Northside Counselling Service and was studying for her degree when she was diagnosed with cancer. She died in 2011. Her biographical article *A butterfly on my shoulder* was published in the Summer 2009 edition of *Éisteach*.

LETTER TO THE EDITOR

Éisteach welcomes members' letters or emails. If you wish to have your say on either the contents of *Éisteach* or on an issue that concerns you or you feel strongly about, please send your views to;
e-mail: eisteach@iacp.ie or
***Éisteach*, IACP, 21 Dublin Road, Bray, Co Wicklow**.
We hope the 'Letters to the Editor' section will become a regular feature in each edition of *Éisteach*. For that to happen we need your comments and views. We look forward to hearing from you.

INTEGRATIVE CBT

Dear Editor,—My thanks to Ursula O'Farrell for her remarks in relation to my article "What is Integrative CBT?" (Letters page, *Éisteach*, Autumn 2012). It's great to get feedback on one's ideas, especially since Integrative CBT is very much work in progress. As Ursula rightly points out, this is especially the case in relation to the core theory of therapeutic change underlying the model, and I certainly agree with her on the "…need to remain grounded within some theoretical framework…"

I would see some form of psychological Learning theory as being the most promising unifying thread. In my clinical experience the common factor which varies across the different levels of therapeutic approach is some form of Structured and Facilitated Experiential Relearning ("SAFER"). I take CBT to be the approach most grounded in modern Learning theory (see e.g. Persons 2008), hence my focus on Integrative CBT rather than more broadly on Integrative Psychotherapy. However, the model may yet be renamed something more like Structured Experiential Learning Framework ("SELF").

Crucially, I don't see the need for a new approach to Counselling/Psychotherapy as such, but I do see the need for a way to coherently put together the best of what we have from all the main schools. All ideas welcome!— Yours etc.,

EOIN STEPHENS

References

Persons J. (2008) *The Case Formulation Approach to Cognitive-Behavior Therapy*, New York: Guilford Press.