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- Coming out as a survivor therapist
  Understanding therapists' motivation for trauma-related disclosure within professional and public domains
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Growth through trauma

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From the Editor:

Dear Colleagues,

A warm welcome to the Spring 2022 edition of the *Irish Journal of Counselling and Psychotherapy*. A new year is upon us with one of the most notable aspects so far being the lifting of many of the restrictions related to the Covid-19 pandemic. This may bring a mixture of excitement and trepidation (and everything in between) for ourselves and our clients. I wish you well as your resource yourselves navigating this newness.

Trauma is the Greek word for 'wound'. Although the Greeks used the term when referring to physical injuries, nowadays, as we are aware, *trauma* is just as likely to refer to emotional wounds. An ever-increasing body of research suggests that experiencing traumatic events is linked to long-term psychological, physical and behavioural health risks and many of us support our clients to find ways of engaging with the world, with trauma as part of their lived experience.

As practitioners, we are aware that trauma manifests itself in many varied ways in the therapeutic space and offering a safe and welcoming environment and establishing a positive therapeutic relationship may be experienced as particularly supportive by our clients. Holding an awareness of the importance of timing, pace and titration, in order to avoid overwhelm of traumatic memories, is necessary when encouraging clients to express their emotions. Offering validation that their experience is reasonable and acceptable is essential and psychoeducation focusing on trauma-related symptoms may help normalise how clients are feeling, and allow them to see their symptoms are not unique. One intervention that may prove particularly helpful is the teaching of grounding exercises that promote safety.

While the articles in this edition of the *IJCP* vary in content, they are linked through the theme of trauma.

Our first offering from Julie Brown and Leanne Macken outlines details of a study undertaken by them on behalf of 'One in Four', which is a registered charity that supports adult survivors of childhood sexual abuse and their families.

In this article, clients' and therapists' experience of the overnight transition to technology-assisted therapy for complex trauma due to Covid-19 restrictions is explored. While elements of safety, boundaries and the therapeutic relationship were impacted, the ability to continue with therapy during restrictions was presented as the main advantage of technology-assisted therapy.

Our second article by Valerie Ballarotti explores the therapist as a survivor and their motivation for trauma-related disclosure within both the professional sphere and the public domain. Adversity and abuse in earlier years may often be presented by clients in therapy, but what of the therapists who may have also experienced abuse? In her contribution, Valerie presents the insights of three therapists who have embraced their dual identity of survivor therapist and offers us a window into their reasons for disclosing.

We are invited to consider the psychological supports that may be required by our clients who have survived a cancer diagnosis in our third article by Dave Cosgrove. Dave examines how this client population may be burdened with ongoing personal, psychological and existential crises. Included in this article are the insights of five psychotherapists with experience of working with this client population, presenting the primary identifiable themes, the psychotherapeutic approaches employed by therapists and their view of this work.

Our final article invites us to consider the language we use in therapy with our clients. Alex Delogu highlights the habitual patterns evident that are often repetitive and lifeless. Alex suggests that keeping our language alive for ourselves and our clients could be beneficial in clinical practice and he explores how language can become stuck and presents ways of 'unsticking' it.

We continue with contributions from IACP members of poems in our poetry section entitled 'Florescence'.

I hope you enjoy this edition of the *IJCP* and would like to thank all of our contributors for taking the time to submit their work. I wish all of our readers a happy and healthy 2022.

Terry Naughton, Editor

Research Article

Technology-assisted psychotherapy for complex trauma

By Julie Brown and Leanne Macken

Technological advances aimed at increasing accessibility to therapy have resulted in the wide acceptance and normalisation of telehealth offerings. For clients who have experienced child sexual abuse, balancing convenience with factors including safety, the whole body in trauma work, and the potential impact of interruptions and intrusions is vital

Introduction

One in Four is a non-government organisation that provides psychotherapy and advocacy support services to adults and their families who have survived childhood sexual abuse. The organisation also delivers a prevention intervention programme to people who have committed a sexual offence against a child. This article outlines a small, mixed-methods study that explored clients' and therapists' experiences of the sudden and, for a time, total transition to technology-assisted therapy for complex trauma, necessitated by the Covid-19 pandemic. In particular, the study was interested in:

- Understanding the ways technology may influence the therapeutic relationship;
- Informing decisions in relation to programme delivery; and
- Providing a perspective on technology-assisted therapy with complex trauma.

The term technology-assisted therapy is used to refer to real-time client/therapist interaction using telephone or video-conferencing. Findings indicated that comments on convenience and the lifeline offered by technology-assisted therapy aside, the majority of participants preferred to return to the in-office setting. Despite the cyber security of online telemedicine platforms, the office setting's containment, safety, and privacy are not easily replicated for those accessing therapy via technology. The 'whole body' presence in the room is felt to be crucial for a majority of clients who have experienced sexual abuse.

Telehealth offerings

Notably, the literature on telehealth/telepsychology and eHealth comprises studies ranging from apps amd asynchronous e-mail communications to real-time therapist-engagement that most closely mirrors the traditional in-office setting (O'Connor et al., 2018; Sierra et al., 2018). The proliferation of telehealth offerings is propelled by imperatives aimed at improving access, cost-effectiveness and reducing other barriers, such as

stigma associated with attending therapy (Bennett et al., 2020; Morland et al., 2017).

Findings of studies on telehealth and eHealth often include self-guided treatments. Two meta-analyses studies that explored PTSD (post-traumatic stress disorder) based on CBT (cognitive behavioural therapy) and IBI (Internet-based intervention) models found some improvement in PTSD symptoms compared to wait-list control groups (Kuester et al., 2016; Sijbrandij et al., 2016).

Irrespective of the modality, most offerings utilise the principles of empirically-guided interventions. However, they do not address the therapeutic relationship itself (de Bitencourt Machado et al., 2016). This is curious given the general acceptance within the psychotherapy literature that the relationship itself is not only core to treatment outcomes, but arguably more important than any specific technique or modality (Carr, 2007; Horvath et al., 2011; Messer & Wampold, 2002; O'Connor et al., 2018; Wampold & Imel, 2015). While what constitutes therapy or treatment under the eHealth definition is broad and far-reaching, our study was interested in 'depth psychotherapy' – that is, moving beyond the focus on symptoms to the relationally-based exploration of all aspects, conscious and unconscious, of the client's experience – across therapeutic modalities.

Mixed-methods approach

For this article, a narrow and targeted literature review was undertaken to support analyses and provide context to findings. A mixed-methods approach was adopted, comprising a survey of 41 statements and seven qualitative questions, which was circulated to the organisation's clients and therapists. Using a five-point Likert scale, participants were asked their level of agreement ('Strongly agree' to 'Strongly disagree') for 18 statements for clients and 11 statements for psychotherapists. A thematic analysis (Clarke & Braun, 2014) on the qualitative replies was conducted in conjunction with statistical analysis using the Statistical Package for Social Sciences (SPSS). Data was analysed using descriptive and frequency analysis and comparison of means data and screened and coded for gender, age and participant type.

A small number of respondents linked being in their home environment to increased comfort and ease

A total of 64 responded and 57 completed the survey in full (psychotherapists 11%, survivors 71%, prevention/offenders 13% and family group 5%). Three themes emerged: therapeutic space and trauma; connections and disconnections; and therapeutic relationship and depth of work. While all clients who responded were grateful for the accessibility and lifeline offered by technology-assisted therapy, the vast majority wanted to return to the in-house setting.

The quantitative findings proved important, offering challenge, difference and context to responses to the qualitative questions, particularly in relation to safety, boundaries and the therapeutic relationship.

Therapeutic space and trauma

This theme refers to the concept of therapeutic space and its constituents, external and internal, influenced by trauma and shaped by the imposed restrictions of the Covid-19 pandemic. Comments on the convenience and practical advantages of not having to leave home for sessions, saving time and money and, in one case, reducing anxiety for the respondent as they did not have to request time off work were common and in keeping with the literature on accessibility (Maheu et al., 2012). One respondent commented: "The fact that I live so far away, it is helpful as I don't have to pay for public transport and I can get some work done."

A small number of respondents linked being in their home environment to increased comfort and ease, which may, for them, have created a sense of safety and relative ease. The physical therapeutic environment is accepted as important for trauma survivors (Smith & Watkins, 2008): "I was able [to] surround myself with my own objects – tea, comfortable seating, being able to stare out a window while speaking. It felt super familiar and peaceful at all times."

Results showed that over 60% of respondents felt comfortable using technology. This reflects the increased familiarity with, and reliance on, technology for day-to-day needs, such as shopping and online banking (Morland et al., 2017). Regarding the therapeutic experience itself, 46% agreed that they felt more tired after their online session than they would in person.

The quantitative findings posed questions and offered a challenge to the apparent advantages of this ease of accessibility. For example, figures showed that 34% did not feel connected to their therapist and 32% found it difficult to see their therapist in a different environment. In addition, nearly 40% of clients stated they found it difficult to talk about painful issues online.

There was a significant difference between men and women's level of comfort in talking about suicide and self-harm online, with men more likely to talk about it than women. This is at odds with a meta-analysis by Breslin and Schoenleber (2015), which found that women were more likely to report a history of self-harm

than men. It was also found that there was a more significant gender difference in the clinical settings than in the community settings. This difference might be accounted for by our small sample size, the fact that all female client participants were survivors of child sexual abuse, and that Breslin and Scoenleber's (2015) meta-analysis was not exploring reports in online therapy settings specifically. The Irish context might also be significant.

Figures varied across the sample in response to access to a private space for their therapy, with 17% of survivor clients saying they did not have access to a private space and 33% of prevention/offender clients reporting they did not have access to a private space. One respondent noted that "being in the home environment made it more difficult for me to speak openly and freely for fear of someone else overhearing". This respondent mirrored others in attempting what could be termed a compromise, engaging in the session but in a self-conscious and constrained manner.

Approximately 18% reported experiencing someone from their home entering the room during their session. These findings represent a challenge to the concept of a therapeutic space, not solely on the external or practical level but in relation to the internal – the importance of boundaries, the impact of intrusion, and the safety experience for abuse survivors.

Connections and disconnections

This theme explored connections and disconnections virtually as well as inter and intra-relationally. The continued facilitation of therapy during lockdown was a frequent, almost unanimous response:

> I think the most helpful thing about technology-assisted therapy was the ability to continue therapy from where we left off. It would have been much harder to just stop therapy or to keep putting off sessions until we could return to face-to-face.

"I found it strange trying to disconnect from my therapy – when I brought it into my home I didn't feel as safe"

Several commented on the screen itself. For some, the screen seemed to hinder connection and lead to a self-conscious engagement:

> I think in general with video calls … it's the same in a work setting … that you feel much more observed/constantly visible than you might in an in-person setting. It can make you feel a bit more self-conscious in moments when you're very upset.

Conversely, a couple of respondents felt the screen allowed a deeper engagement, increasing their confidence and ease: "Better sometimes in the separateness of online, giving confidence to say things that might not have been said if face-to-face."

Group clients, in particular, commented on the importance of initial in-house meetings as vital to fostering feelings of connection with the group:

> I personally would have found it extremely difficult to engage in the program online from the start. Having met face-to-face with the therapists and other members of the group before helped me feel comfortable enough to engage online.

Client respondents made important points about connecting or transitioning into and, just as importantly, transitioning out of, or disconnecting from, the therapy experience. Half of our respondents reported they had time to prepare and reflect before and after the session:

> I use the hour or so that it takes me to get into Holles St to mentally prepare for my session and the same to decompress on the way home. Now, I go from therapy right back into normal life, and it's a head wreck.

Another respondent revealed: "I found it strange trying to disconnect from my therapy – when I brought it into my home I didn't feel as safe."

Forty-three per cent of respondents referenced technical difficulties, and therapists particularly linked this with concerns for the therapeutic relationship. One therapist responded: "The Wi-Fi in my area is not great and I find that during sessions it is very distressing when the PC freezes and you have to ask the client to say it again." Another therapist noted that: "The pace of therapy is also skewed online, where the time gap due to the Internet often results in therapist and client speaking over each other."

Therapeutic relationship and depth of work

With few exceptions, therapists and clients missed the in-person therapy experience. Comments in Table 1 give examples of both the general view, but also note alternative experiences. Therapeutic modality seemed to influence the experience where those practising bodywork in particular felt the absence of the in-person contact most acutely. These quotes, taken from the qualitative responses, capture subtly and subjectivity in relation to the experience of the therapeutic relationship.

Discussion

At the time of writing this article in September 2021, the Rape

Crisis Network Ireland's (RCNI's) Clinical Innovation Project (Taylor & Walsh, 2021) had conducted a large survey with 645 survivors of sexual violence. The findings of our small survey largely cohere with the findings of that larger study, particularly concerning: the core importance of the body in work with trauma and implications on the impact of its distance in technology-assisted therapy; issues relating to safety, privacy and confidentiality, and importantly, the need to balance convenience with safety; ubiquitous technical challenges; and, with the exception of a minority, the preference to return to in-person therapy.

Literature on trauma highlights that the therapeutic relationship is paramount in recovery. According to (Herman, 2015) "the core experiences of psychological trauma are disempowerment and disconnection from others" (p. 133). Wallin (2007) describes the importance of a secure attachment within the therapeutic relationship, as it strengthens the capacity for affect-regulation. The importance of the body in trauma therapy is the capacity to assimilate the traumatic experience.

Odgen et al., (2006) argue that traumatic memories are encoded subcortically and that recurring activations of the traumatic memory continues to create a sense of threat: "Traumatised clients are haunted by the return of trauma-related sensorimotor reactions in such forms as intrusive images, sounds, smells, body sensations, physical pain, constriction, numbing, and the inability to modulate arousal" (p. xxix).

The fact that 15 out of 51 respondents engaged in therapy in the absence of any private space raises important safety questions. It also suggests that therapists should not assume that the physical frame provided through the private, uninterrupted, in-house setting has been internalised or can be replicated at home by clients. Reasons may relate to limitations in the environment and, perhaps, to normalisation of intrusion for abuse survivors:

> Traumatic events … shatter the construction of the self that is formed and sustained in relations to others … [it] destroys the victims' fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation. (Herman, 2015, p.51)

It appears that people connect very differently in an online environment and there is much that therapists may need to consider. Contracting for the arguably inevitable technical difficulties and interruptions is vital to support safety and containment. Exploring the client's associations to and experience of the screen(s) directly may provide insights and guidance to both parties that might assist in a deeper connection moving forward. It may also be important to attend to the healthy disconnection from the session that facilitates clients in getting on with their day. Finally, in-person contact for some is vital to establish the connection necessary to engage in therapeutic work.

Conclusion

The connection in relationship is core to creating safety, however, sadly this is an elusive experience for many trauma survivors. The respondents for this study unanimously named the ability to continue with therapy during lockdown – a time that increased strain on the already over-burdened nervous systems of trauma survivors – as the main advantage of technology-assisted therapy.

While a small number of respondents named feeling safer

Table 1: Therapist and client experiences of working online

Therapists	Clients
For me, personally, there is something that takes place within the therapeutic space that just cannot happen online. It is all the small nuances, the movement, pace and rhythm of therapy that is missed online.	Some sessions I would not be fully engaged or present, but when in a room I would be calmer face-to-face.
I feel that in-person, misinterpretations are easier to avoid – you don't have to concentrate so much and because of this, you are more presence both mentally and physically.	One-on-one therapy allows me to leave everything else outside the room – I find that difficult in technology-assisted therapy.
The in-depth connection you get when in the room with the clients, missing the feeling of the client, missing those non-verbal cues, missing helping the client regulate, missing doing bodywork.	The fact I haven't met my therapist face-to- face. It feels weird that I have disclosed so much of my life to her, yet have never met her face-to-face.
One advantage when working with deeply traumatised clients is the disinhibition effect, and I have found that clients have been able to say more as the PC/ phone has allowed a space to create a gap that they feel more comfortable in and able to speak more freely.	Sessions were no different in any way, full support at all times. I have felt able to talk, be validated and helpfully challenged in a therapeutic space.

in their home environment, for the majority, this coincided with increased interruptions and disconnections of differing types. Feeling less connected to their therapist and struggling to talk about difficult issues were named by respondents as challenges that could reasonably be assumed to be interconnected.

It is important to note that this survey related to home environments during a lockdown situation, which may differ significantly from a home environment at other times. Therapists and clients with a preference for body work seemed to struggle most, feeling the absence of the body in the shared therapeutic space most acutely.

While grateful for the offering, the vast majority of One in Four clients indicated the wish to return to in-person therapy when possible. A minority named a preference to continue working via technology for reasons surpassing convenience and accessibility, so it is important to continue this offering. In addition, offering therapy online has increased accessibility to our Dublin-based service for those in other parts of Ireland.

Following the literature, there may be scope to use technology to augment psychotherapy for those on the waiting list or as a step down in the transition to ending therapy. However, the depth of therapeutic work, at least in the experience of One in Four, is not easily achieved via technology.

Julie Brown

Julie Brown is a psychoanalytic psychotherapist and clinical supervisor working mainly from an object relations perspective. She has worked in the area of complex trauma and sexual abuse for 18 years and is Clinical Director of One in Four. Julie is a training analyst with the Irish Institute of Psychoanalytic Psychotherapy and a past Chairperson of the Irish Forum for Psychoanalytic Psychotherapy. Julie is in her final year of a Doctorate in Psychotherapy at Dublin City University where her area of research is a psychoanalytic exploration of online child sex offending.

Leanne Macken

Leanne Macken, BA Psych, Dip Counselling & Psychotherapy, MIAHIP, is a psychotherapist working in the area of trauma for over 10 years. Leanne is a senior psychotherapist on the Prevention Programme in One in Four. Leanne is currently doing a MLitt/PhD in the School of Psychology, UCD, where she is undertaking research on female offenders.

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Academic Article

Coming out as a survivor therapist

Understanding therapists' motivation for trauma-related disclosure within professional and public domains

By Valerie Ballarotti

Whilst the psychotherapy field is arguably prone to view childhood trauma as something affecting clients rather than those treating them, more therapists have started to refer to their own experiences of early adversity and abuse. Three colleagues who have embraced their dual identity of survivor therapists reflect on their motivation to disclose and what influenced their decision-making

Introduction

Despite the incidence of childhood trauma among mental health professionals, qualitative research on how individuals navigate their dual identity as 'survivor therapists' is scant. Derived from a larger Interpretative Phenomenological Analysis (IPA) study, conducted as part of the author's MA dissertation, this article explores trauma-related disclosure within the psychotherapy profession, focusing in particular on what motivated three therapists to 'go public' about their childhood sexual abuse (CSA) trauma.

The article reflects on how therapists may experience being CSA survivors as a 'concealed stigmatised identity' (Weisz et al., 2016), whilst also feeling empowered as 'wounded healers' to embrace 'public truth telling' as part of what Herman (2015) dubbed 'survivor mission'. Drawing on Chaudoir and Fisher's Disclosure Process Model (2010), the research considers the process of 'coming out' as a survivor therapist as a sequence of interrelated disclosure events occurring in different contexts and at various stages of therapists' professional lives. These include training, supervision and workplace, and sometimes extending to more public disclosures including press, social media, academic publications and radio. Four emerging themes are briefly outlined reflecting participants' reported motivation for salient disclosure events in their careers.

Both sides of the couch

Childhood trauma has been widely recognised as the common denominator for a plethora of enduring mental health difficulties in adulthood, including depression, low self-esteem, suicidal ideation, anxiety and panic, borderline personality disorder, dissociative identity disorders and eating disorders

(Knight, 2015). In Ireland, some 24,815 children were referred to Tusla – the state agency responsible for improving well-being outcomes for children – for various forms of suspected abuse in 2018. Of these, 6,137 referrals were for suspected physical abuse and 3,548 concerned sexual abuse (McMahon, 2019).

Since the Covid-19 pandemic, Women's Aid support workers received more than 30,000 disclosures of domestic violence, including 6,000 related to child abuse (Wilson, 2021). Hinting at the pervasiveness of childhood trauma, these recent statistics add to a sad legacy of historical and institutional child abuse in the Republic.

Unsurprisingly, within the mental health field "adult survivors of childhood trauma account for a majority of individuals seeking … clinical services" (Knight, 2015, p. 25). Childhood trauma among helping professionals, including psychotherapists, may be a more controversial issue, arguably warranting further consideration within counselling and psychotherapy literature and education (Bamber & McMahon, 2008; Elliot & Guy, 1993; Fussell & Bonney; 1990; Follette & Milbeck, 1994).

Concealed stigmatised identity

Unlike the substance abuse treatment field, whose endorsement of counsellors' lived experience gives them "the unique opportunity for personal and professional identities to align" (Curtis & Eby, 2010, p. 2), mental health professions appear to view therapists' trauma histories more as a professional risk than a potential asset (Curtis & Eby, 2010). With few notable exceptions (Benatar, 2000; Schauben & Frazier, 1995), research on survivor therapists has mostly highlighted their increased vulnerability to vicarious trauma and burn- out (Carr & Egan, 2017; Schnittiger, 2017; Sodeke-Gregson et al., 2013). Concerns have also been raised about survivor therapists' tendency toward over-involvement and excessive self-sacrifice (Adams & Riggs, 2008). Some findings point to a greater propensity to violate therapeutic boundaries with clients and to disregard supervisory guidance (Dickeson & Smout, 2018). Furthermore, since "childhood trauma doubles the risk of mental health conditions" (Torjesen, 2019, p. 364), survivor therapists' possible mental health sequelae might lead to fears of being pathologized by other clinicians (Torjesen, 2019).

Straddling the line between human vulnerability and professional competency, psychotherapy trainees are required to 'work on self' and to familiarise themselves with self-disclosure in both personal therapy and experiential work during training

Within the psychiatry survivor literature, survivor therapists (including psychiatrists, psychologists and other mental health workers) have highlighted "stigma, discrimination, and misunderstanding from clients and colleagues alike" (Adame et al., 2017, p. 57) as main deterrents to "being 'out' about one's … personal struggles in the professional mental health community" (Adame et al., 2017, p. 57). More specifically within the psychotherapy profession, Adams (2014) has also suggested that "psychotherapists don't always appear to trust other therapists [and have] little faith that [their] human frailties will be valued rather than judged as proof that [they] should not be working" (p. 8).

Given these concerns about professional stigmatisation, it is not unreasonable to assume that some therapists might experience their being CSA survivors as a "concealed stigmatised identity" – an "attribute that is stereotyped and devalued by society, but that can be kept hidden" (Weisz et al., 2016, p. 2935).

Wounded healers in their own words

Conversely, one might expect that as a field predicated on the healing potential of talking about one's difficulties, psychotherapy would endorse openness over concealment and validate painful experiences as opportunities for psychological growth. Encapsulating this dialectic, the Jungian construct of the 'wounded healer' – referring to an "individual who, after experiencing significant adversity becomes motivated to assist others through similar experiences" (Dickeson, 2017, p. 3) – offers an important counterargument to concealment as well as a rationale for therapists to reclaim their trauma histories.

Straddling the line between human vulnerability and professional competency, psychotherapy trainees are required to 'work on self'[1] and to familiarise themselves with self-disclosure in both personal therapy and experiential work during training. Since disclosure is so central to the psychotherapy endeavour, the "absence of

[1] https://iacp.ie/files/file601c2c9541773.202102041819

discussion or research on navigating decisions about disclosure to other professionals or 'going public' about woundedness" is striking (Zerubavel & Wright, 2012, p. 488).

Contributing to what Adams calls the 'myth of the untroubled therapist' (Adams, 2014) this lacuna may be particularly, but not exclusively, detrimental to survivor therapists. Fortunately, a spate of recent publications has challenged this dominant trend, featuring first-person narratives of survivor-therapists. Particularly in relation to CSA, these include autobiographical monographs (Armstrong, 2010; Murray, 2019) and chapters within edited collections (Farber, 2017; Rech, 2019), with a recent book focussing specifically on therapists' experiences of sexual abuse (Lee & Palmer, 2020).

In the review of the literature, the researcher gradually honed in on therapists' personal accounts of their trauma histories. Having located the contact details of some of these authors online and through word of mouth, they were emailed directly with an invitation to participate in the research. Three colleagues, all CSA survivors, kindly accepted the invitation to be interviewed. Each interview lasted approximately one hour, with two taking place in the author's office and one online.

The chosen methodology, Interpretative Qualitative analysis (IPA), is widely used in psychotherapy research (McLeod, 2011). Whilst recognising the researcher's involvement in the interpretative effort, IPA's focus remains firmly on participants' meaning-making and subjective experience with reference to relevant theorisations (Smith & Osborn, 2004).

A degree of homogeneity (Smith et al., 2009) was required in participants' inclusion criteria – all three participants are qualified and practising psychotherapists, identify as CSA survivors and their written disclosures are available in the public domain (in print, online and/or both). Participants diverge in gender, cultural location, and levels of professional experience. Names and identifying details have been changed to safeguard anonymity. Keith and Neil identify as male and are both Irish-based therapists with 11 and three years respectively of clinical experience. Ella identifies as female, and she is an American clinical psychologist, psychotherapist and supervisor practising for over 40 years.

Since in our digital era written or otherwise recorded disclosures often remain available on the Internet, their impact on therapists' online presence can be enduring and far-reaching

Disclosure Process Model and therapist self disclosure

Aligned with Chaudoir and Fisher's Disclosure Process Model (2010), therapists' trauma-related disclosure is viewed here as a complex and life-long process made of interrelated 'disclosure events'. While positive responses to single disclosure events influence subsequent disclosure choices in a 'feed-back loop' of increasing openness or concealment, 'ecosystem' or compassionate goals to promote connection and social support (Crocker et al., 2008) increase the likeliness that disclosers will experience the disclosure process as beneficial (Chaudoir & Fisher, 2010). This was corroborated by participants in this research, who foregrounded 'social contextual level goals' to challenge oppression and stigma, and reclaim their stigmatised identities, as main motivations for disclosing within professional and public spheres (Chaudoir & Fisher, 2010).

Counselling and psychotherapy literature on therapist self-disclosure (TSD) is generally confined to therapist-client interactions (Danzer, 2018). Even though few in the field would unambiguously endorse the traditional 'blank slate' approach, consensus around TSD is that therapists should err on the side of caution (Pinto-Coelho et al., 2018). Especially with clients sharing a similar interpersonal trauma history, TSD is thought to "strongly and inappropriately shift the focus of therapy to the therapist" (Danzer, 2018, p. 62), however, empirical research supporting this position is lacking.

Furthermore, since in our digital era written or otherwise recorded disclosures often remain available on the Internet, their impact on therapists' online presence can be enduring and far-reaching. Exploring the ramifications of 'digital transparency' for survivor therapists, however, lies beyond the remit of the current article (Zur, 2007).

Analysis of emerging themes

Following repeated and immersive readings of the audio-recorded interview transcripts, initial annotations were made and then distilled into emerging themes recurring across participants' responses. Emerging themes were then clustered into superordinate themes. Although the research from which this piece is derived

covered questions around perceived risks and obstacles, as well as participants' experiences of the reactions of colleagues to their revelations, the focus here will be on what motivated therapists' trauma-related disclosure in the professional and public spheres. What follows is a brief overview of some salient themes emerging from the interviews.

1. Social support

Chaudoir and Fisher (2010, p.17) note that for those with a concealed stigmatised identity "disclosure is a necessary prerequisite to obtain social support". All three participants highlighted that garnering social support informed their decision to disclose.

Finding group belonging was the dominant motivating factor for Neil, whose public disclosure pre-dated and was instrumental to his becoming a therapist. Neil's reason for speaking of his experiences on the local radio was to reach out to other CSA survivors and legitimise the creation of a peer support group in the area. Working with fellow survivors in this context eventually led him to train as a therapist "so that I could get into it in a deeper way". Mindful of the boundaries between his ongoing facilitation role within the group and his more recent therapeutic practice, he continues his advocacy work online, where he identifies as a CSA survivor and a psychotherapist.

Ella had completed her PhD and was a licensed psychotherapist working in a hospital when she recovered her memories of incest: "I had a horrible PTSD going on with lots of flashbacks and somehow because I think I dissociated so well, I was able to do my work."

Not only did she return to her previous interviewees to introduce herself as an incest survivor, but she eventually chose to include her own experience in her publication

Whilst fearing that disclosing at work may "diminish" her in the eyes of her peers or cast doubts over her ability to maintain boundaries with clients, she also felt concealment "creates this huge wedge between colleagues". Her choice to selectively disclose to a few trusted colleagues who knew her well and "wouldn't think less of me as a clinician" was driven by her need to feel supported in her therapeutic engagement with sexually abused children. Ella was also able to find support within an ongoing survivor therapists' group that helped her normalise her struggle. She recalled: "We met weekly for a while and a lot of us would talk about how strange it was to go through our own healing at the same time we were working with survivors and how clients felt we were so attuned to them, well, yeah, we got it."

Further research on support groups for survivor therapists and how they may foster therapists' positive self-transformation (Benatar, 2000) and vicarious post-traumatic growth (Bartoskova, 2017; Wheeler & McElvaney, 2017) would be a valuable addition to counselling education.

2. Shame of concealment

Being on the receiving end of other survivors' disclosures also had a strong influence on participants' disclosure choices. Despite having been in therapy for many years, Keith's first disclosure was in his third year of psychotherapy training and was linked to starting work with CSA survivors in his placement. Similarly, Neil and Ella identified turning points in their disclosure history, where hearing the stories of other survivors instigated more openness.

For Neil, who worked in youth outreach before becoming a therapist, a conversation with a young trauma survivor galvanised him to start therapy and his own disclosure journey. Impressed by how this brave teenager "was so able to talk about [her awful childhood], talk about going to counselling, talk about what worked for her, what didn't work for her" Neil remembered feeling "so ashamed of holding in all of this".

Research has shown how shame can be "a paradoxical double-edged sword: It may both elicit a strong desire to change … and simultaneously evoke avoidance-oriented responses" (Lickel et al., 2014, p. 58). Relating to disclosure, feelings of shame triggered by the openness of others may motivate but also inhibit disclosure for those with a similar but concealed stigmatised identity.

For her book project on CSA, Ella interviewed a number of people who were "completely identified as survivors". Yet, when asked about her interest in the topic, she had initially preferred to shelter behind her trauma specialist persona: "I began to feel more and more like a fraud; I'm asking them to be so brave and I'm … I wasn't willing to do that."

It was when an interviewee shared that she would not have taken "the courageous step" had she not been "nudged" by a

concerned family-member, that Ella overcame her hesitancy: "I felt safer somehow, like, oh I'm like you." This led to a long and deliberate coming-out process. Not only did she return to her previous interviewees to introduce herself as an incest survivor, but she eventually chose to include her own experience in her publication, using it as "the glue" binding the interviewees' stories together. "It makes me cry … that's what it was … I met all these brave people and then I became one of them. I never said that before."

As their professional roles gave them unique access to other survivors' disclosures, participants described an increasing discomfort about concealment, and a growing moral imperative to disclose, linked also to their values and professional responsibility as therapists.

3. Therapists' values

Across participants, professional values and theoretical concepts within the psychotherapy field were recurrent themes providing a rationale for disclosure. The Jungian construct of the 'wounded healer', mentioned earlier, validated for Keith "that someone who has walked the path is the best guide". For Neil, disclosing resonated with the core counselling value of congruence: "If I am hiding parts of me [in training], then I am not being congruent."

Keith was also adamant about needing to "flag" one's abuse history with supervisors, to enable them to watch for potential "blind spots". Concealment in supervision raised concerns about potentially a harmful parallel process: "If I am afraid to engage with or speak about something that's happened to me, that's communicated in some way to the client … how can they tell me then, or fully own what it is they fear."

Whilst the notion of 'survivor mission' may sound strident, it reflects an inner tension

Opposing us/them dichotomies and the reification of therapists' professional expertise, participants' self-perception as therapists revolved around values of 'shared humanity'[Ella], equality and authenticity. All of the participants felt cautious about using TSD around shared trauma in clinical work. "I won't ever tell [clients] about it. I don't know if that helps me in the work – it definitely doesn't help if I think I am past all that, and I am better and I am healed and you are broken … I don't stand any way above them, why would I pretend to?" Keith remarked.

Conversely, clients' knowledge or questions about their public disclosures were not seen as a threat to therapeutic boundaries but, rather, something to be unpacked and integrated in the therapeutic work.

Beyond the professional sphere, participants' motivation to go public was linked to needing to take a "moral standpoint" [Keith] and "tell the truth, even the ugly truth" [Ella]. 'Public truth-telling' is identified in the literature as a common denominator of "survivor mission" (Herman, 2015, p. 207). Related to the notion of 'political disclosure' (Cain, 1991), going public about one's stigmatised identity becomes a way "to contribute to the greater good of society by raising awareness … helping to reduce cultural stigma … and serve as a role model for others who are afraid to disclose" (Chaudoir & Fisher, 2010, p. 20).

4. Survivor Mission

In her seminal work on trauma, Herman (2015) highlighted that for some CSA survivors, becoming therapists may be an aspect of their 'survivor mission' (see also Eskreis-Winkler et al. 2014) – a way of redeeming their experiences by using it for the benefit of others.

According to Herman (2015): "Many survivors seek the resolution of their traumatic experience within the confines of their personal lives. But a significant minority, as a result of the trauma, feel called upon to engage a wider world" (p. 207).

Whilst the notion of 'survivor mission' may sound strident, it reflects an inner tension Keith was particularly sensitive to. He explained: "I do think that part of my public disclosure … there was a heroic element to it that maybe wasn't the best thing for me… that I would tell the world and I would do good and save the world, that's bigging it up there… it was not as grandiose as that … but that I would do some good and that it was the right thing to do."

Similarly, in his training, Neil referred to being on a "sort of a mission to say 'look, this is the reality, things like this do happen'". Whilst acknowledging the need to remain within one's level of competence, Neil wanted to encourage peers to see survivors' uniqueness and resourcefulness as individuals, rather than viewing them only as a challenging client-group. "Several people in the training would say I could never work with people … who had child abuse, and I'd say, but would you work with me? And they'd say yes, but you're different. *How* am I different?"

This echoes Ella's experience as a supervisor: "I talk about my

own personal experience with [my supervisees] when I want to make a point … I want to help them not identify survivors as damaged goods."

Through public disclosure participant Keith opposed prevalent notions that, as a CSA survivor: "You are broken or you are a mess and that anyone who's been abused is a non-functioning addict. That still stops a lot of people seeking proper help and I think of my own example. I was years and years in therapy and I never told anyone [because] you think this is a strange, peculiar thing that doesn't happen to many people."

Indeed, in particular with male CSA survivors, recent research has shown that believing their experience to be an anomaly stops men from seeking help or impairs therapy outcome by inhibiting disclosure (Sivagurunathan et al., 2019).

For Keith, the need to confront a cultural legacy of silence, stigma and shame was particularly relevant in an Irish context, where historical patterns of institutional abuse are increasingly being scrutinised partly on account of an active survivors' movement:

> The Irish view on abuse [is] don't tell anyone about it, we'll sort it out between ourselves, shush … that's exactly the same thing that the Church or the State does, or families do, so therapists are doing it now. I think that's so prevalent in our society, in our cultural psyche, and the profession buys into it, too. If it was a more accepting culture, I don't know if I would have written about it.

By going public, participants also sought to model openness in the hope this may help "lighten the burden of shame and secrecy" that some survivors might be carrying and encouraging them "to share the secret with somebody" [Ella].

Further research on how intersectional issues of race, ethnicity, class, disabilities, gender and sexual identity impact on survivor therapists' disclosure choices would be a welcome addition to the literature

Finally, providing alternative narratives of healing that others could "hold on to" [Neil] was important to all participants. Since becoming a therapist, Neil remarked how his blog focused more on "recovery and the therapeutic journey". Keith also mentioned not wanting the article he wrote about his CSA experience to be all "doom and gloom", ensuring that his narrative "didn't dismiss the horrible things that happened, but that the good stuff wasn't overshadowed either … because I got through it … so I wanted to kind of portray that."

Similarly, Ella expressed her desire to challenge the "clinging to the lifeboat" views of surviving, which were prevalent when she started her book project in the 90s: "I wanted to show other ways of being that is possible to heal. I wanted to show readers, I wanted to show the world and I wanted to show me."

Conclusion

Disclosure is an ongoing, multi-layered process, a shifting continuum between openness and concealment. Survivor therapists' motivations to speak and/or write about their survivor status are complex and subjective and need to be understood within the overarching disclosure process prior, during and after training as therapists.

Further research on how intersectional issues of race, ethnicity, class, disabilities, gender and sexual identity impact on survivor therapists' disclosure choices would be a welcome addition to the literature, as would be an investigation of therapists' choice not to disclose to other professionals. Focussing on the disclosure journeys of three colleagues who publicly embraced their CSA histories, this brief contribution hopes to spark interest and discussion about how we may strive together towards a professional culture that "values the expertise of lived experience, where it is safe to use this experience, and where people are supported to do so" (Perkins & Repper, 2014, para. 34).

Valerie Ballarotti

Valerie Ballarotti is a Galway-based counsellor and psychotherapist, accredited with IACP and BACP. Her therapeutic approach is rooted in psychosynthesis and informed by her further training in Jungian Psychology and Internal Family Systems Therapy. She specialises in trauma-informed psychotherapy with a focus on complex trauma. The current article is derived from a larger research project she conducted as part of a master's degree in counselling and psychotherapy at the University of East London. Valerie can be contacted by email via her website www.creacounselling.ie

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FLORESCENCE

My Black Coat

By Leonie Gallagher

Where has my coat of colours gone?
Gone to a space with my happiness and my love.
I search and search but can not find, any colours in my mind.
I'm feeling numb and cold and shocked...in limbo my emotions locked.

And in the corner of the room, a big black coat of doom...doom
doom.
It mocks and frightens me I think, that this black coat my only link...to where
I am inside and out.
I want to howl, I want to shout,
but keep it in...am terrified I feel a part of me has died.

A year has past I don't know how...in the house alone, just now,
my heart is aching, I rub my chest to ease this massive pain...I guess
and slowly tears being to fall, I am shouting out his name...I call
I reach out for the big black coat and wrap it round me...and I fall
Into the depths of my despair, I scream and howl it isn't right, it isn't fair.

I wear the black coat all the time and slowly I accept it's mine
some days it's heavy...some days light but with this coat, I no longer fight.
I wear my coat with pride you see because it is a part of me.

The years roll by and life moves on where has my coat of colours gone?...I close my eyes and then I see, the colours are in memories
My coloured coat was always there, I couldn't see it was unaware
So I look back and forward too, making memories anew for others when my time is done
Whatever coat I choose to wear.

Alone

By Sian Williams

Shelves are packed with stuff and still we feel alone,
Hearts filled with hurt and nowhere to call home.
Families torn apart through the ravages of addiction,
The disconnection from the land increasing the friction.

The media monster tells us to buy and spend more,
I beg you to see though the veil of lies I do implore.
Step into the pain, for shrouded in that pain you can learn to breathe again,
Gently think back, remember the joy when you were ten?

You needed nothing and knew of no other way to be,
For in that innocent of childhood you were free.
Not yet enslaved to the media indoctrination,
And your heart and soul were alive with conversation.

Days were long running, playing, laughing in the fresh air
Coming home for tea at six was your only care.
Looking back now I had nothing, but neither did you,
For this life, this freedom was all we knew.

I went back today to the places we played,
I closed my eyes and saw us there under the oak shade.
But now you are not here, and those days are gone.
I wish I could hear your voice sing one more song.

The pain engulfed you and you lost your way,
Day by day, you slipped away and no longer wanted to stay.
For then your heart and soul were alive to a new master.
The chaos of addiction devastated you and caused great disaster.

A Battered Woman

By Teresa Cleary O'Brien

So here I am, at this place, I hope nobody knows my face.

I'm standing here outside the door, but it's only ten to four!

Should I walk away or not? I don't want to miss my slot.

I ring the bell, me nerves are shattered.

I wasn't this bad when being battered!

But this is my time. Things have to change; though asking for help feels really strange.

The door opens and I'm f****d now but I'll have to go through with it,

I just don't know how.

I'm greeted with a friendly face.

I'm told I'm welcome, it's my space.

A cosy room, two comfy chairs.

A world outside that doesn't care.

I really don't know what to say; as I sit down (I hope he's gay).

I know that he'll stand up for men! They're all the same, no point in talking then!

It's cold out there today I say.

I sneak a look and look away.

It is he says; but how are you?

He looks at me and I turn to glue.

He sits back to let ME talk?

I'm still thinking I should walk!

I'm staring at my ugly feet, because his eyes I cannot meet.

The silence grows but it's not that bad, I've time to think of why I'm sad. I wish that he would make a start and help me fix my broken heart.

He's very patient for a 'man'!

He's getting well paid, I suppose he can.

It's time to get my answers now! At fifty quid I need 'know how'.

"How can I be happy again?" I ask out straight and sit back then.

"How can you be 'happy'...again ?" He asks me.

His voice is gentle and very kind; he seems sincere and doesn't mind that I have such a measly way and I don't think now that he's even gay!

I tell him that I need to know, "what should I do? Where should I go?"

He nods and sighs and says...NOTHING!

My stomach now is in a knot," I'm paying you, is this all that you have got?"

"I'm in a mess, I need some help."

"Tell me more, what is a mess?"

This is weird, it's just not me, to talk about my family, but talk I did and couldn't stop I had a voice...the tears did drop.

The tightness in my chest now makes it hard for me to breathe. I'm so upset and anxious but he calmly takes the lead, by breathing in so deeply, I feel that he is there, in that painful place beside me where alone I couldn't bear.

I've never known such deep respect.

No judgement here at all, just coaxing and acceptance no matter how I fall.

A new door has been opened. A new life plan inside.

I have to do the work though, it's just I have a guide.

I know now how you people work and you have the right, that when I leave your cosy room, with me I take my shite!

*THE PROCESS OF FLOWERING OR DEVELOPING RICHLY AND FULLY

Research Article

Survived but not recovered

An exploration of psychotherapy and counselling for people living beyond cancer

By Dave Cosgrove

With an increasing number of people surviving a cancer diagnosis, a greater understanding of the psychological supports that may be required in long-term cancer survivorship is necessary. An understanding of primary themes presenting in psychotherapy and counselling and the approaches employed by therapists with experience working in this area would benefit this population

Introduction

A cancer diagnosis often provokes overwhelming fear, instantly shattering feelings of invulnerability, destabilising one's sense of identity and undermining expectations for the future. Following treatment, and despite being medically cured of cancer, many are burdened with enduring personal, psychological and existential crises. With incidents of cancer increasing and survival rates improving, there is a greater need for enhanced understanding in the area of psychotherapy for people living beyond cancer. This article reviews information from five psychotherapists with experience of working with this population, and identifies the primary themes presented by clients and the psychotherapeutic approaches employed, while also informing on therapists views of the work.

Cancer in context

Cancer is the second leading cause of death globally and is characterised as a collection of diseases that can commence almost anywhere in the body when abnormal cells grow irrepressibly and spread to adjoining areas (WHO, 2017). The generic term 'survivor' applies from diagnosis, regardless of the disease trajectory (Mullan, 1985). The prevalent view is that a cancer diagnosis rapidly precipitates diverse psychological, spiritual and existential challenges of the most profound proportions (Caruso & Breitbart, 2020; Recklitis & Syrjala, 2017).

Various approaches to address the psychosocial needs of cancer survivors have been established, however, until recently most have focused on the treatment stage and in end-of-life care (Recklitis & Syrjala, 2017). In long-term or permanent survivorship, when the cancer is considered arrested, some people experience a renewed sense of life, although for many, the indelible toll on health, functioning and emotional well-being may persist long after treatment (Ganz & Hewitt, 2006).

The World Health Organization (WHO) predicts an exponential

increase in cancer incidents globally, from 14.1 million in 2012 to 21.6 million in 2030. However, better awareness, enhanced diagnosis practices and advances in treatments have improved survival rates (WHO, 2017). As illustrated in Figure 1, incidents of cancer in Ireland increased in the last two decades, while mortality rates decreased. Five-year net survival rates increased considerably in this time and continue to improve (Mullen & Hanan, 2019), although incidents of cancer are projected to double by 2045 (Department of Health, 2017).

A quarter of people with a history of cancer in Ireland have long-term physical and/or psychological issues (Department of Health, 2017). While it is acknowledged that this distinct group requires dedicated supports (Department of Health, 2017), their post-treatment care needs can remain undetected or unaddressed (Mullen & Hanan, 2019).

According to Mullen and Hanan (2019): "Cancer survivors around Ireland have told us that coming through cancer diagnosis and treatment is very challenging, but

> *A cancer diagnosis destroys one's perceptions of invulnerability*
>
> *(Cordova et al., 2017)*

that the transition that occurs after active treatment can be traumatic too" (p.10). Further research is required to investigate the psychosocial aspects of survivorship (Guglielmucci et al., 2018) as understanding these elements is essential for developing optimal post-treatment care (Meyerowitz et al., 2008).

The impact of cancer

Existing research shows that despite improved understanding, treatment and outcomes in general, cancer remains identified as synonymous with death (Else-Quest & Jackson, 2014), bringing overwhelming fear into people's minds (Lederberg & Holland, 2011). Cancer provokes thoughts of our own mortality – not that death comes to us all one day, but that it will come personally and possibly sooner than expected (Barnett, 2009a).

A cancer diagnosis destroys one's perceptions of invulnerability, (Cordova et al., 2017), interrupting somatopsychic stability and generating fear, anxiety and hopelessness (Guglielmucci et al., 2018). The capacity to manage this is somewhat dependent on existing coping skills, although this ability is enhanced by psychological support (Kissane & Watson, 2011; Lederberg & Holland, 2011).

Often outshone by mortality rates, the multifaceted challenges of life after cancer are often overlooked (Grassi et al., 2017; Sender et al., 2020). For many people, finishing cancer treatment comprises conflicting emotions; feelings of celebration and hope, but also uncertainty and fear (Haase & Rostad, 1994).

Permanent survivorship

Permanent survivors of cancer generally show positive psychosocial adjustment over time, however, many are at risk of subsequent compromised psychological well-being (Stanton et al., 2015), which may be delayed and/or potentially lifelong (Wen et al., 2019).

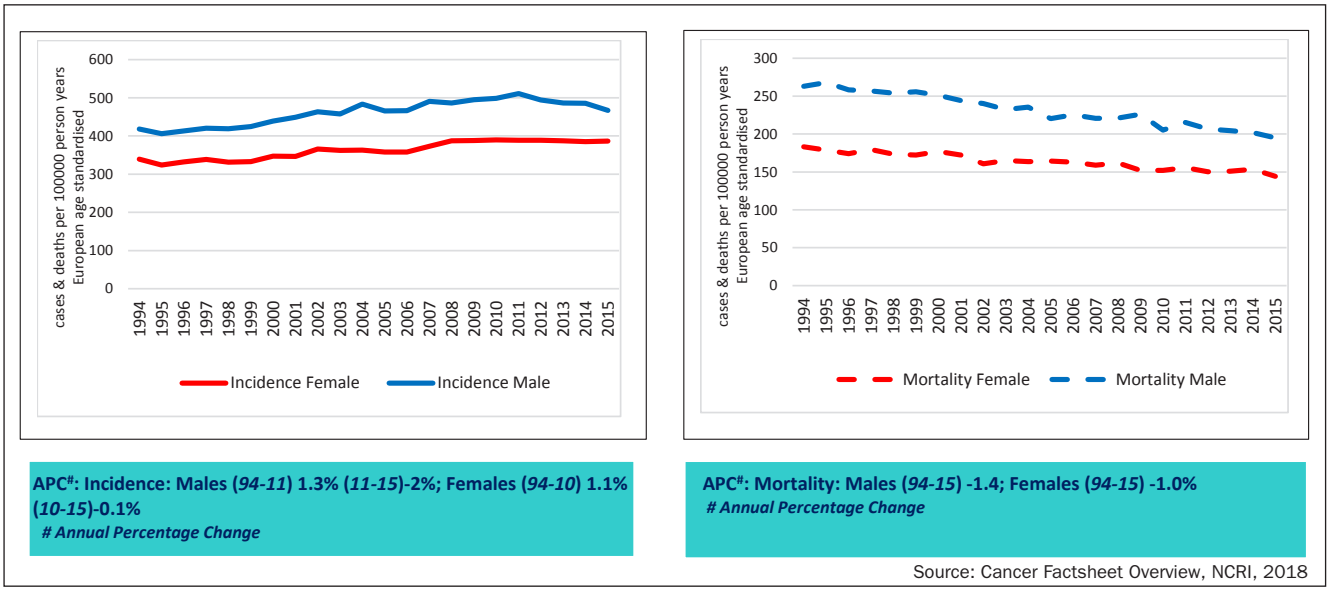

Figure 1: Trends in cancer incidence and mortality in Ireland, 1994-2015

Although some survivors report better interpersonal relationships and improved quality of life, most recognise both positive and negative changes, such as feeling stronger but also more vulnerable (Aspinwall & MacNamara, 2005). Prevalent post-treatment issues include depression, anxiety, fear of cancer recurrence (FCR) and reduced emotional well-being (Hinds & King, 1999).

Personal values and meaning in life within the boundaries of time and context are confronted throughout the cancer survival trajectory (Grassi et al., 2017). Personal identity is threatened (Little et al., 2002) and new dependencies, emotional trauma and loss of certainty can disrupt self-esteem and future outlook (Grassi et al., 2017).

Stigmatisation (Fife & Wright, 2000) and body self-esteem issues may occur (Grassi et al., 2017; Knapp-Oliver & Moyer, 2009), while survivor-guilt can manifest as survivors compare themselves to those who have died and subsequently struggle to justify their own existence (Glaser et al., 2019). Although supportive relationships are important for cancer survivors, fear of negative reactions or causing anxiety in others can cause reluctance to seek help (Knapp et al., 2014) or to divulge true emotional states (Waldrop et al., 2011).

Cancer adversely impacts families (Grassi et al., 2017) as roles and responsibilities are impacted (NCCP, 2020). Some survivors experience difficulties recommencing certain familial, social and occupational commitments suspended during treatment (Recklitis & Syrjala, 2017). Considered 'second-order patients' (Adler et al., 2008), caregivers and family members can experience anxiety, fear, social and physical burdens (Applebaum et al., 2014; Bultz & Walker, 2020; Grassi et al., 2017; Recklitis & Syrjala, 2017).

There have been growing implementation and dissemination of screening methods for the psychological consequences of cancer

Emerging themes

For this article, interview research was completed with five psychotherapists with experience of working with people entering permanent cancer survivorship. Thematic analysis was conducted on the collected data, with the results shown in Figure 2. The interviews validated the view that following successful medical treatment, while the cancer may be cured, the recovery is just beginning as emotional aspects, including fears related to initial diagnosis, can manifest.

Fear of recurrence

A consistent theme represented in the research was that people living beyond cancer present fears around future health, in particular FCR. FCR is considered one of the most distressing and enduring consequences of a cancer experience (Crist & Grunfeld, 2013), encompassing fears of cancer returning, subsequent medical check-ups, and future health in general (Mehnert et al., 2013). The interviews highlighted how cancer survivors' reduced confidence in trusting their bodily sensations heightened FCR, particularly when experiencing any ensuing physical ailments.

Fear and uncertainty around health were depicted as potentially lifelong – a new and distressing psychological burden on the individual.

Isolation

A sense of isolation was outlined as a prevalent issue presented in psychotherapy. This research found that finishing hospital treatment can be experienced as a loss of support

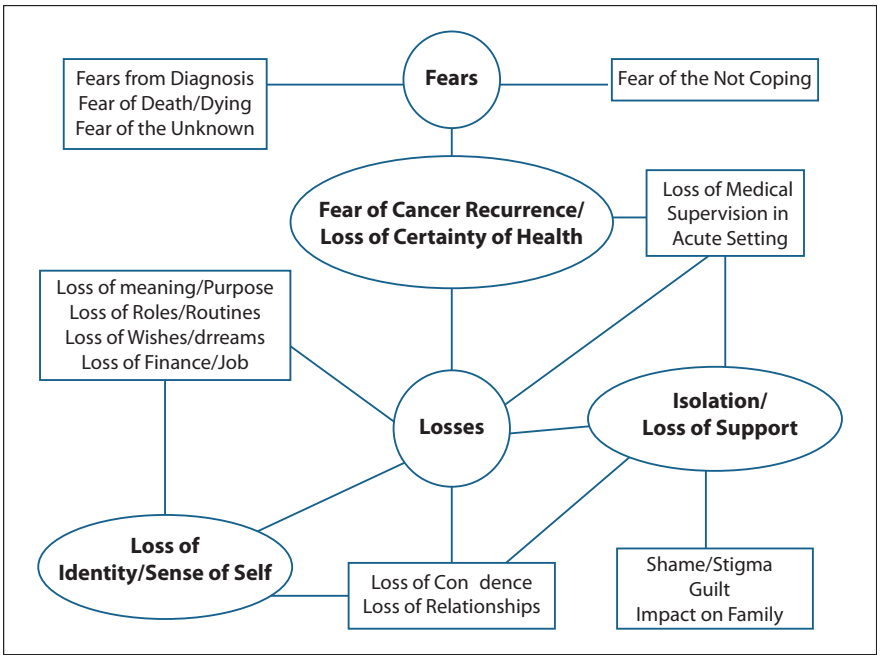

Figure 2: Thematic analysis of primary themes presented in psychotherapy

and safety pertaining to medical oversight, which for many provokes feelings of fear and abandonment, often compounded by reduced self-confidence. Aligned to this, fears of being a burden or the wish to shield others from potentially contentious truths, precipitates difficulties in relating honestly, heightening a sense of isolation.

Similarly, well-intentioned encouragement to relinquish their cancer experience to 'be positive' and move on following treatment can result in avoidance of candid disclosure. Existing literature outlines that uncertainty and fear can inhibit the reconstruction of a sense of belonging with others (Grassi et al., 2017) and that cancer survivors' inclination for communicating adverse emotional states can be impeded (Marroquín et al., 2016), with many assuming responsibility for causing anxiety in others (Knapp et al., 2014; Lederberg & Holland, 2011).

Loss of identity

This research revealed various 'living losses' a person may endure throughout their cancer journey, from loss of relationships and functional roles to ambiguous losses, such as wishes and ambitions, cumulatively constituting a loss of identity. Literature shows that cancer destabilises a person's emotional status, reduces self-esteem, and obscures future outlooks (Grassi et al., 2017), often devaluing the multifaceted and intricate concept of personal identity (Little et al., 2002).

Interviewees outlined that some survivors may not yet be ready to meet other's expectations in terms of recommencing responsibilities that were adjourned during treatment. A salient point identified was the indelible obstacle that an experience of cancer can be to maintaining stable psychological well-being in post-treatment survival. Interviewees explained that cancer permanently changes people's thoughts, beliefs and perceptions of self. Accordingly, they must find a way to incorporate the experience, to accept their 'new normal' situation in life.

Subsequent studies consider this constructivist therapeutic process as applicable for addressing ambiguous losses, such as the loss of intimacy in post-treatment survivorship

Therapeutic approaches

While it is known that psychotherapy is beneficial throughout a cancer journey, (Kissane & Watson, 2011; Lederberg & Holland, 2011), there is no ideal approach endorsed for people in post-treatment survivorship. Interviewees were asked what therapeutic approaches or techniques they found to be beneficial when working this population.

The provision of a safe space for post-treatment survivors of cancer to tell their story authentically, as it was for them, was identified as essential for effective psychotherapy. Existing research recognises that cancer survivors need to unburden themselves and should be encouraged to discuss their cancer experience – a process that often exposes emotional material (Lederberg & Holland, 2011). This research highlighted the critical importance of a safe and accepting therapeutic relationship, as characterised by Rogers' (1995) humanistic core conditions, including the receipt of unconditional positive regard and empathy by the client.

Acceptance of the client's positive and negative feelings engenders safety and the freedom to explore their inner experiences (Rogers, 2004). Fears of hurting or causing anxiety to others are mitigated by the safety of the relationship and the therapist's way of being, which is accentuated further given the potential for stigmatisation and feelings of guilt or shame.

As verified in the interviews, cancer support groups countenance negative feelings by inspiring survivors to challenge tendencies to avoid the emotions and implications of their cancer experience (Classen et al., 2001). Such groups benefit from group-cohesiveness, which promotes acceptance (Yalom, 1995) and universality, that individuals are not "unique in their wretchedness" (Yalom, 1995, p.5), thereby encouraging members to openly discuss their cancer experience and accept their 'new normal' situation. Narrative therapy and linguistic techniques were also referenced to encourage clients to derive new meaning by reshaping the language of their cancer experience, thereby reducing negative connotations and adapting perceptions (Snedker-Boman, 2011).

The 'here-and-now'

The use of the 'here-and-now' was proposed to assist clients to make sense of their current post-treatment situation and generate self-acceptance. Participants discussed how honouring the client's cancer experience, while also acknowledging what is required in the present to re-engage with obligations, relationships, and expectations as empowering. This supports the view of Classen and Spiegel (2011), who propose that realising and grieving losses while accepting changes, inspires the establishment of a fresh perspective.

The research identified similarities between some emotional reactions

in extended cancer survivorship and disenfranchised grief, with hurt, sadness and anger specified. Neimeyer (2011) promotes an alternation between a grief orientation for what is lost, and a restoration orientation focusing on the reality of the here-and-now, to address destructive perceptions and a diminished sense of self for those in palliative care or bereavement. Subsequent studies consider this constructivist therapeutic process as applicable for addressing ambiguous losses, such as the loss of intimacy in post-treatment survivorship, as it is predicated on meaning-making (Pillai-Friedman & Ashline, 2014).

Corroborating this, the interviews in this study presented a dual-process of oscillation between loss and repair as effective for people in post-treatment survivorship; acknowledgement of losses incurred, with concurrent recognition of existing abilities, to help the client make sense of their state of being in the here-and-now.

Humanistic and existentialist frameworks

Humanistic and existential-based approaches were prevalent in the interviews. Both therapeutic practices seek to provide clients with a compassionate, responsive and safe relationship to facilitate personal growth and healing (Corey, 2015). Humanistic therapy views human nature as tending towards actualisation in which meaning is found, while existentialist approaches highlight the anxiety of making sense of an existence that lacks intrinsic meaning (Corey, 2015). Existential therapy is often considered the therapy of the 'here-and-now', although it incorporates future possibilities and past experience (Barnett, 2009b).

An existential perspective considers survivorship as survival from death, but also survival for life; as such can address the cognitions and emotions around death within the context of life, while dealing with life in view of its limitations (Barnett, 2009a).

The provision of a safe space for post-treatment survivors of cancer to tell their story authentically, as it was for them, was identified as essential for effective psychotherapy

A need for meaning

Prevailing research highlights that cancer often provokes existential crises (Caruso & Breitbart, 2020; Recklitis & Syrjala, 2017). Consequently, meaning in life featured strongly in the data collated, substantiating Frankl's (2004) perspective, that difficult circumstances can activate a need for meaning. As suffering is an inevitable fate in life, Frankl (2004) argues, "then there must be a meaning in suffering" (p. 76). The discovery of unique and personal meaning, even in challenging circumstances, prompts psychological healing and emotional growth (Frankl, 2004; Yalom, 1980).

Until recently, literature on meaning in cancer survivorship concentrated on patients with acute or terminal prognoses (Van-Der-Spek & Verdonck-de Leeuw, 2016). This research, however, strongly endorses subsequent studies that promote meaning-centred psychotherapeutic approaches as effective for those living beyond cancer (Van-Der-Spek & Verdonck-de Leeuw, 2016; da Ponte et al., 2018).

The therapists' view

Existing literature asserts that effective therapy for cancer patients necessitates therapists to have an understanding of medical facets of cancer and treatments (Lederberg & Holland, 2011). This research indicates that this requirement is less critical when working with permanent survivors – that knowledge of medical aspects while deemed beneficial, is not necessarily essential given the cathartic emphasis on the client's experiences and emotions. Awareness of medications and their potential impact on mood and emotions was endorsed as practical.

Providing psychotherapy to permanent survivors of cancer, described as an often-neglected cohort, was outlined as rewarding, but affective for therapists at times. The therapist's self-awareness in the therapeutic space and cognisance of their knowledge and personal experience of cancer were presented as important. Therapists should remain sensitive to potential cancer-related stigma, which can impact client's emotional states and behaviours (Yilmaz & Cengiz, 2020). Active and robust supervision was strongly promoted as an invaluable resource.

Conclusion

Despite advances in medical care and improving survival rates, cancer diagnoses still elicit tremendous fear in people's minds (Lederberg & Holland, 2011), generating immense anxiety and despair (Guglielmucci et al., 2018). Even when medical treatment is successful, the transition into permanent survivorship can be traumatic (Mullen & Hanan, 2019). This research highlighted psychological difficulties relating to certain existential givens of human existence, characterised by fear, loss, and isolation which may manifest following medical treatment.

Emotional difficulties pertaining to the initial cancer diagnosis and subsequent medical procedures could be delayed, becoming affective or more pronounced post-treatment. For those burdened with emotional vulnerabilities, the cancer journey is 'not over when it is over', reflecting the irony that successful medical treatment does not necessarily mean subsequent good health (Recklitis & Syrjala, 2017).

This research confirmed that following successful treatment of cancer, people can experience diverse negative psychological effects, including FCR, a traumatic, persistent and functionally disruptive psychological issue. Survivor's self-esteem, emotional states and future expectations may be undermined, with various changes and ambiguous losses disturbing the subjective perception of identity. A sense of isolation was linked to the termination of medical treatment, often intensified by feelings of guilt or shame, or the non-disclosure of true emotional states for fear of causing anxiety in others. The interviews also presented the potential adverse impact of well-meaning encouragement to embrace a positive disposition and move on from the cancer experience, particularly for survivors whose emotional difficulties remain unexpressed.

Existing literature contends that the psychotherapeutic approach to people living with or beyond cancer should be flexible, encompassing various styles and techniques as required (Lederberg & Holland, 2011), however, there remains no consensus on an optimal approach (Iwashyna, 2010; Recklitis & Syrjala, 2017). Humanistic-existential frameworks, grief and bereavement and narrative-based techniques were identified in this research as beneficial. The provision of a safe space for post-treatment cancer survivors to tell their story, unencumbered and without influence or expectancy, was illuminated as of primary importance.

Improved awareness of the possible psychological impact of a cancer journey and the importance of emotional and social aspects in recovery are considered critical

The use of the 'here-and-now', to acknowledge cancer-related deficits but also existing strengths was described as empowering for clients while a grief and bereavement process of fluctuation between orientations of loss and restoration was presented as beneficial. While initially promoted for bereavement or palliative care (Neimeyer, 2011), this research endorses subsequent investigations which consider this process as helpful in psychotherapy following cancer treatment (Pillai-Friedman & Ashline, 2014).

The existentialist concept of meaning-making was endorsed as a means of cultivating better coping following traumatic experiences (Frankl, 2004; Yalom, 1980). Although a meaning-centred psychotherapy was developed specifically for cancer patients potentially facing a foreshortened life (Breitbart & Applebaum, 2011), this research advocates ensuing studies that view such approaches as effective in long-term survivorship (Van-Der-Spek & Verdonck-de Leeuw, 2016; da Ponte et al., 2018).

The research highlighted the importance of the therapist's self-awareness and personal supervision, while knowledge of medical aspects of cancer and its treatments was presented as beneficial, but not necessarily essential for the provision of effective psychotherapy with people living beyond cancer.

While people's experiences of and responses to cancer are distinct, this research, while neither authoritative nor exhaustive, indicates that there are particular issues and prevalent themes presented in psychotherapy by people following medical treatment.

Improved awareness of the possible psychological impact of a cancer journey and the importance of emotional and social aspects in recovery are considered critical. Accordingly, this research concludes that psychotherapy and counselling support, to address themes such as loss of identity and perceived isolation, with bespoke interventions for specific cancer survivorship issues such as FCR, should feature in post-treatment care plans. For an increasing number of people, such supports would improve the experience of living beyond cancer from survival towards full and holistic recovery.

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Research Article

Playing language games

By Alex Delogu

Language is pulled like gravity into habitual patterns. These patterns often become repetitive and lifeless. Keeping our thoughts moving and our language alive for ourselves and others could be hugely beneficial in clinical practice

Introduction

Psychoanalysis has been called the "talking cure" (Fink, 2007, p. 139). It operates largely through language exchanges between two people, with a slight asymmetry (Rose, 2004, p.9), where the client does more of the talking and is the primary focus of the talking (Delogu, 2020). To make a curious abstraction, psychotherapy is two people making sounds together. But what exactly is language, the currency with which we talk, and how does it operate? While there is no single answer to this question, several views will be suggested to open up thinking around language – the primary means of reciprocity in psychotherapy. This article will explore how language can become stuck and examine ways of 'unsticking' it.

Diving in

Languages flow and change; they can be born and they can die. "Language has no being beyond its drifting parts, and its sole consistency may lie in the layers of forgetting and remembrance that tie and untie it in ever-changing ways" (Heller-Roazen, 2005, p. 97). Attempts to stop its drift are always in vain (Heller-Roazen, 2005, p. 74). "Our languages may also be seen over time as momentary 'slowing downs' or 'thickenings' in a flow of norms that gives rise to a multitude of different structures" (De Landa, 1997, p. 259). That is, every language has its own characteristic sound patterns that have accrued over time. The flow of sound slows down enough to be stable and repeatable over time, without ever losing its slow slippage. It is just stable enough to provide us with some fixity in the world, like a raft in water. In essence, we join the chorus of language and belong to its song.

We are all born into a river of language, some into more than one. Born ourselves overflowing with pre-linguistic sounds, some of which must fall away to clear the way for language. In this sense, learning a language is the sculpting of babbling, where some bits are chipped away:

> Between the prattle of the infant and the first words of the child, there is not only no clear passage, but evidence of a decisive interruption, something like a turning point at which the hitherto-limitless phonetic abilities of the infant seem to falter. (Heller-Roazen, 2005, p. 10)

In moving from babbling towards speaking, we lose certain capacities, we forget. This is evident in other languages that have particular sounds we

ourselves have lost the ability to make, in order to speak our own language. There are many such differences between languages, for example, the distinction between the English 'r' and 'l' is absent in Japanese and, as such, is hard to perceive from their perspective. We have little choice in the words we are bound by and bound to, as we join the semi-stable language of our own environment.

Language games

Language encompasses the words we use, the specific sound patterns, and the way we use them – body language, gesture, tone, and rhythm, among other things, all play a part in communicating with others. But the words are still there, they are important. "In psychotherapy the healing process is in one mind to another, and the words are the vehicles that carry the mental attitude back and forth" (Symington, 1993, p. 94).

Language is a 'vehicle' carrying our patterning across the divide to each other – a sonic reaching across resonant touch. To use a different metaphor, "language is the money of thought" (McGilchrist, 2010, p. 115). Or another: "A concept is a brick. It can be used to build the courthouse of reason. Or it can be thrown through the window" (Massumi in Deleuze and Guattari, 2004, p. xiii). Vehicle/money/brick – they are all inert objects. The other important element is: to what use we put them and how we build or destroy with them.

The uses to which we put our words are almost infinite. According to Deleuze and Guattari, (2004), any statement:

> is not the same when said in the family, at school, in a love affair, in a secret society, or in a court: it is not the same thing, and neither is it the same statement; it is not the same bodily situation, and neither is it the same incorporeal transformation. (p. 91)

Speaking speech is speech that has something to say – it is alive and creative and responsive to its situation

We can add the therapy room to that list. Further still, if we consider that every family is different, then every family is putting their language to a specific use. We learn "not a certain stock of words, but a certain way of using them" (Merleau-Ponty, 2002, p.203), with each family having its own little accidents and politics of language use. To borrow an interesting term from Wittgenstein (2009) everyone is playing a different "language game" (p.8).

We have words that, on the surface, sound the same, but underneath are being put to use in specific ways. My happiness is not the same as yours, but the word is the same. Any word, like 'happy', 'sad', or 'reflective', will mean different things to different people and will elicit different responses from the various people they might be shared with. Sharing your happiness will return different reactions depending on whether it is your mother, political representative, or therapist. There is no doubt that these uses are shaped and moulded by the situation in which we grew up. What this means is that even though clients come to therapy speaking our shared language, the uses to which this language is put is immensely varied. There is just about enough overlap to make us intelligible to each other. "Language works well, but far from perfectly" (Rose, 2004, p. 37).

If we take into consideration these differing usages, it is no stretch to say that even if our words are the same, we are all speaking a different language. This seems especially clear in the work of psychotherapy. For example, when someone uses the word 'depressed', the meaning of that may change one week to the next and derives different meaning from person to person.

Groundwork

An infinity of languages is daunting. To get a flavour of this, let us start with a simple enough binary. Merleau-Ponty (2002) makes a useful distinction between "speaking speech" and "spoken speech" (p. 229). To make a rough definition: "speaking speech" is authentic and first-hand, whereas "spoken speech" is inauthentic and second-hand. Noting here that "inauthentic" is not a negative value – it is of neutral value for present purposes (Baldwin, 2007, p. 94). Neither is better, as "the new is not always powerful and the formulaic is not always sterile" (Peters, 2009, p. 103).

Speaking speech is speech that has something to say – it is alive and creative and responsive to its situation. Spoken speech, on the other hand, is something someone else has said, so it a repetition – something that does not have anything new to say. It can be assumed that all speaking speech will, over time, become second-hand; it will sediment, like the slowing down mentioned previously (Baldwin, 2007).

The reverse is also true; second-hand speech can be imbued with new life. The danger is that too much second-hand speech leads language into an impoverishment of meaning – it becomes lifeless (Abrams, 2017). The outcome, therefore, is that work has to be done in keeping language alive. It

is this impoverishment of meaning that therapists must avoid and, by extension, notice in others. This can be thought of more like forces acting on or through language rather than specific types of language. "The same object, the same phenomenon, changes depending on the force which appropriates it" (Deleuze, 2006, p. 3). Forces can deaden or stabilise language or free it up and destabilise it. The word itself is heavily shaped by the forces that seize it or we impart to it. "I can tap a surface – simple – and the field of potentiality opens up, whereas with writing, at which I am practiced, I can write a single sentence which may close down the field of potentiality for hours, days, even years" (Toop, 2016, p. 42).

The field of potential for words can similarly open or close. The author suggests there are two main ways of achieving this and more than likely a combination of both is useful. An over-reliance on one may actually lead to a loss of vitality.

New versus novel

The ways of accessing the potentiality of words lies in the distinction between newness and novelty, terms borrowed from Iain McGilchrist (2010). The new is often presented as incompatible with the novel, but both can be useful in their own way. Newness refers to what is new, what has not appeared before, something different. It is akin to the experience of sitting in a room and an unexpected sound occurs – our attention is drawn to newness. Babies are typically intrigued by newness as everything appears to them for the first time. Another typical example is the endless newness of scrolling through digital media or channel hopping on the television. A problem can arise when too much newness has a dulling effect on our senses. We habituate quickly to whatever is new. Too much newness becomes boring, as "when everything is unpredictable, unpredictability becomes the most predictable thing imaginable" (Peters, 2009, p. 105). Equally so, an over-abundance of newness can be alienating, lacking any familiar context.

Through paraphrasing, a sense of having been heard is created, which also brings a sense of thematic development to interaction

Novelty, on the other hand, describes a subtle but different experience. Novelty is the appreciation of the uniqueness of any thing or moment, regardless of whether it has been seen before. "It involves the reconnection with the world which familiarity has veiled" (McGilchrist, 2010, p. 173). It is like seeing something familiar with fresh eyes or appreciating the taste of your cup of tea. It is like saying something you have said many times before, like "I love you", and saying it as if for the first time.

With language, this is very much to do with the affective quality of speech mentioned earlier – not the words, but how they are said. It encompasses our tone, prosody (the rhythm, stress and intonation of speech), body language and the context. Again, it is difficult to maintain because we habituate to experiences so easily. "We delete differences, so as not to be tricked into thinking that everyone we meet is an individual, a unique instance of humanity worthy of attention" (Elsby, 2020, p. 10). How do we avoid this? It is this that is spoken of in Zen (Suzuki, 1970) with "beginner's mind." "For a while you will keep your beginner's mind, but if you continue to practice one, two, three years or more, although you may improve some, you are liable to lose the limitless meaning of original mind" (Suzuki, 1970, p. 21).

New words

Using new words has the capacity to bring about new potential in our speech. It is something this article has used frequently, borrowing from different contexts. It is also something that forms the basis of a therapist's reflecting practice through paraphrasing what the client says (Culley & Bond, 2004). Through paraphrasing, a sense of having been heard is created, which also brings a sense of thematic development to interaction.

Psychoanalyst Wilfred Bion introduced something similar with "saturated" and "unsaturated" elements (Sapen, 2012, p. 118). To apply this idea to language, language becomes saturated when constantly repeated and the meaning of words become familiar and evocative of similar things. When language becomes over-saturated it can spell the closure of different meanings. "An analyst with such a mind is incapable of learning because he is satisfied" (Bion, 1984, p. 29). Likewise, clients' language can become over-saturated with very unchangeable meanings. To find unsaturated language means finding language from other areas of life and applying them to therapy – learn and read far and wide.

Bion imported terminology from diverse fields, such as mathematics, to find a new language appropriate to analysis itself (Sapen, 2012). To become a beginner again with language means bringing about some

creative thought. An example from jazz saxophonist Ornette Coleman exemplifies this. The saxophone was Coleman's main instrument, but he started to play violin and trumpet, of which he had no training, so that he was not encumbered by his own technique on these new instruments (Frisk, 2014). To use Bion's language, the saxophone was saturated through practise, whereas the new instruments were not – they held greater unexplored potential. As is the intention of this article, we are trying to avoid letting our proficiency dictate our ways of speaking and to maintain the living creative feel of language.

The downside to chasing new language is that venturing too far into new terrain can feel alien. Open a textbook on law or mathematics and most of us are dropped into an unfamiliar language game. In practice, it is also important to communicate in a way that is relatable to clients. It would be helpful to avoid the use of overly technical language within therapy. In this sense it is prudent to try "to discern and speak in the person's natural language" (Rose, 2004, p. 4). Try first to play the client's language game and pay attention to what you yourself are playing with them.

There is a striking example of using new words in the book Maps of Narrative Practice (2007) by Michael White. White speaks of a boy called Jeffrey who has been diagnosed with ADHD. The focus is not particularly on language, but it is relevant, as White encourages Jeffrey to use his own language around the diagnosis. Jeffrey already had his own language around it, calling it AHD. They explore what this means through art and various other means. In this case it is important to see this not just as a quirky childhood misunderstanding of the 'correct' language game, but as a personal seizing of power over one's own language, translating the foreign element into something of one's own. The diagnosis is a term from a medical language game, a brick dropped into a families' language game. What do they do with that? What use is it, if any? White tries to discover some uses of the term for Jeffrey and his family.

The other approach to language is to use the same language, but to imbue it with a different affect to change the quality of its saying

While there are obvious issues around power imbalances in professional diagnosis (White, 2007), this article is more concerned with how that power has an effect at the level of the individual through language and how this can be counteracted. Words can induce or smuggle emotional states into someone and create psychic and emotional blocks. Depending on the diagnosis, it can also have real-world consequences that will in turn have psychic and emotional consequences. For example, according to Wang (2019) giving:

> someone a diagnosis of schizophrenia will impact how they see themselves. It will change how they interact with friends and family. The diagnosis will affect how they are seen by the medical community, the legal system … and so on. (p.13)

Novel words

The other approach to language is to use the same language, but to imbue it with a different affect to change the quality of its saying. As in the example highlighted earlier, it is about how the inert bricks of speech are used. This is obviously a more complicated process because language can be used in many different ways. It could be as simple as changing vocal intonation or it could be a more subtle change in our "stance" towards language (Peters, 2009, p. 139), simply thinking about something taken for granted. It could be a more profound surrender of will and simply listening to the original nature of every spoken word – mindful listening (McGilchrist, 2010).

I can recount an anecdotal example of this from another therapist that illustrates how to imbue the same language with new force. A client had the word 'stupid' placed on her by her family. Options were explored on how to unload these words and a plan was reached. It was to write the word on a piece of paper and hand it back to the person who had put that word on her. The client did this and returned the word on a piece of paper. This act alleviated the burden of this language. This is an excellent example of imbuing a word with new power, and in this case the word was literally 'handed back'. In therapy we are trying to achieve similar shifts through the relationship, reclaiming our own words.

We can watch for repetitive language in our own speech and that of the client. For example. saying similar phrases repeatedly or in the same way may begin to feel tired; phrases and words that repeat, that have some overly familiar quality to them; ways of speaking that have slowed and sedimented. This acts as a marker and could function in any number of ways. The main concern here is language that displays a lack of thought and vitality, either as a defence or simply from not knowing otherwise. This may be

the result, as the example of the client called 'stupid' above, of words smuggling feelings into us. The words might be obvious, but the feelings not so much.

The danger is allowing things to settle into mindless clichés – something that looms through repetition. Clichés can bring us to the sort of habituation that has a deadening effect. As explained by Machado (2019):

> We think of clichés as boring and predictable, but they are actually one of the most dangerous things in the world … This triteness, this predictability, has a flattening effect, making singularly boring what is in fact a defining and terrible experience. (p. 267)

This echoes Nietzsche's (1968) view that "words make the uncommon common" (p. 428). The challenge is to make what we think we know uncommon again, to see it with less assumptions, to "unsaturate" our words. As explained by Bion (1980): "Terribly. Frightened. These words are commonplace. But I now become alert when I hear that word 'terrible' because it is so worn. It's terrible weather; it's terrible this; it's terrible that; the word means nothing" (p. 8).

There is no escaping habits, it is more about how we are with them. Habits are not necessarily bad, habits free us from chaos; they are aspects of us that are not consciously thought about any more. Habits can be consciously cultivated like a musician who has a set of clichés or 'licks'; "collections of phrases that serve either as a repertoire of substitutes for spontaneity, or as a vocabulary of 'selected facts' that can undergo revision and recontextualization" (Sapen, 2012, p. 142).

Thoughtful habits

Therapists have plenty of such phrases, for example 'that sounds very challenging' or 'what was that like for you?' Bion (1960) observes that we get "into the habit of taking it for granted that one has decided to be an analyst, to be one for life as if it were a closed question; whereas I think it is important that it should remain an open question" (p. 30).

Conclusion

The purpose of this article is to encourage presence of mind around language. Language becoming habitual and unthinking is something everyone faces – nature pulls it there like gravity. The living element beneath is somewhat intangible and hard to explain, although it is the author's hope that a sense of it has come across the page through these words. Examples provided in this article are drawn from neuroscience, music and philosophy and are intended to extract some rough practical method. As such, this is about more than language. Language itself has its own unique peculiarities that are worth exploring as that is largely the medium through which therapy operates.

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