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- Childlessness as a springboard for post-traumatic growth
- A simulated interview with Fritz Perls: Part 2 – The process of therapy sessions
- Working therapeutically with clients taking psychotropic medication: Is it a help or hindrance?
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Pathways in practice

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From the Editor:

Dear Colleagues,

A very warm welcome to our first edition of the *IJCP* for 2023. As I write this editorial we have embraced a new year and are transitioning to a new season. Traditionally, spring is regarded as a time of hope, new beginnings and transformation. In the natural world, it signifies the end of winter-induced hibernation and a time of growth and reinvigoration as flowers spring to life and flourish. Likewise, for many of us, we have returned to our professional lives after an albeit short break, hopefully refreshed and revived.

For our clients, many approach therapy with hope at the forefront of their minds. Hope that pain will lessen, change is possible and new beginnings full of promise are not too far away. In the way that their stories are unique, so are the pathways in therapy they travel. Given this, it seems apt at this time of year to share articles that examine differential pathways in practice that promote well-being, flourishing, personal growth and hope for positive change.

In our first article, Dr Jolanta Burke and Dr Trudy Meehan explore post-traumatic growth (PTG) in women who want children but are unable to have them. While there is a growing cohort of women who choose not to have children, for others, being unable to have a child is marked by loss, grief and is regarded as a blocked goal. This insightful article incorporates a unique study that outlines the PTG domains that best predicted flourishing among childless women.

For our second article, James Overholser presents part two of his simulated interview with the founding father of Gestalt therapy, Fritz Perls. Perls talks candidly about the process of therapy sessions using the Gestalt approach, which encourages interacting with clients in a directive and confrontational way to encourage frank discussion about their emotional reactions. Perls highlights that the aim is to help clients accept personal responsibility and thereby promote growth and maturity.

Our next contribution by Grushenka Arnold looks at working therapeutically with clients taking psychotropic medication. Although counsellors and psychotherapists do not prescribe medication, it is a topic that frequently crops up in the therapy space. Grushenka conducted a small-scale study that provides some revealing insights into how clients feel about taking psychotropic medication, how therapists feel about working with medicated clients, and highlights that a lack of knowledge of medication on the part of the therapist can lead to self-doubt.

Our fourth article is provided by Dr Marion Mensing, who explores the role of neuroscience and neuroimaging in the psychodynamic approach. Working from the psychodynamic assumption that much of the human experience occurs unconsciously, the author questions if a stronger collaboration between neuroscience and psychodynamic psychotherapy could strengthen the relevance of psychodynamic models and methods in science of the mind, particularly in pharmacology and cognitive psychology. The article also explores links between psychotherapeutic moments of change and a hypothesised form of brain plasticity called memory reconsolidation.

Our final article comes from Sally O'Reilly, who writes about her experience attending a workshop led by psychotherapist and author Stella O'Malley on working with gender dysphoria in young people. Sally reflects on the contentiousness of the issue, which has become increasingly adversarial and divisive in recent years. Sally details core themes that were addressed, including the emergence of a new language of gender, gender identity theory, and the importance of therapists to not drive an agenda, but rather, assist exploration and facilitate young clients in safely forming their own opinions.

In this issue we have also included two emotive and thought-provoking poems in our Floresence section.

On behalf of the *IJCP* editorial committee, I would like to take this opportunity to sincerely thank our contributors and wish all our readers a happy, healthy and peaceful 2023. May it also be a time for you to grow, flourish and embrace new beginnings.

Kaylene Petersen, Editor

CORRECTION

On page 10 of the *IJCP* Winter 2022 issue the headline of the article 'Psychedelics, used responsibly and with proper caution, will be for psychiatry what the microscope is for biology or the telescope is for astronomy' should have been attributed to Dr Stan Grof. We apologise for this omission and error.

Academic/Research Article

Childlessness as a springboard for post-traumatic growth

By Dr Jolanta Burke and Dr Trudy Meehan

A study on post-traumatic growth (PTG) in women who have experienced distress because of not being able to have a child identifies the PTG domains that best predicted flourishing among childless women

Introduction

The prevalence of people not having children continues to grow in the Western world, with as many as 20% to 30% of women aged 40 and over reporting not giving birth to a child (Rybinska, 2021; Sprocha, 2022). Among them are a rising cohort of child-free women who have chosen not to have children and for whom motherhood is associated with a lack of personal freedom (Peterson, 2015). By contrast, another group of involuntarily childless women, some of whom see themselves as outsiders, feel resigned to a lifetime of loss (Malik & Coulson, 2013).

The reasons for childlessness vary, ranging from explained or unexplained infertility, non-marriage or late marriage, to spouses not wanting to have children (Boddington & Didham, 2009; Hansen, Salgsvold, & Moum, 2009). However, regardless of the circumstances, wanting to have a child and not being able to can be perceived as a blocked goal (Hansen et al., 2009), a disruption of the expected life course (Hagestad & Call, 2007), and is reported to evoke feelings of powerlessness (Koert & Daniluk, 2017). Moreover, women also cope with the stigma attached to childlessness, which is particularly harmful in pronatalist nations (Tanaka & Johnson, 2016). All of this can have a potentially negative impact on childless women's well-being.

Historically, individuals not having children are perceived as immature (Erikson, 1963; Letherby & Williams, 1999), materialistic (Callan, 1985), and unstable (Peterson, 1983). Furthermore, women are pejoratively described as barren, whereas their infertility is portrayed as a shame (Whiteford & Gonzalez, 1995), punishment (Freud, 1950) or a sin (Bartlett, 1994). Given this, childlessness can negatively impact a woman's self-perception (Nachtigall et al., 1992), subsequently affecting her well-being. Whilst these views are not as prominent today as they were in the past (Park, 2002), identities continue to be co-constructed in society.

The consequences of these social constructions are often normalising judgements and feelings of failing to measure up (Stoppard, 2010; White, 2007). However, there are attempts to distinguish between motherhood and female identity (Ireland, 1993), thus affirming that being childless does not make a woman less female. Additionally, there is a growing body of literature on a material-discursive-intrapsychic model of women and women's experiences (including

mental health and ill health), which allows us to socially situate women's individual experiences of distress (Erskine et al., 2003; Kruger et al., 2014; Ussher, 2010).

With the incidence of childlessness growing, we need more complex models to understand women's experiences outside of a deficit model (Singh, 2010).

Well-being and flourishing

Mental health can be assessed as the absence of mental illness or the presence of mental health symptoms. Mental health and mental illness are seen as independent from each other (Huppert & Whittington, 2003; Schotanus-Dijkstra et al., 2019), meaning that when a person is going through a difficult time and experiences symptoms of mental illness, such as depression or anxiety, they may simultaneously report the existence of mental health, such as close relationships with others or high levels of self-esteem. Of the four main models/measures of mental health (e.g. Diener et al., 2009; Huppert & So, 2013; Keyes et al., 2008; Seligman, 2011), the Mental Health Continuum (MHC: Keyes et al., 2008) is most prevalent, which is why it has been used in the current research.

To date, most literature about the well-being of women who do not have children has focused on the psychological deficits experienced as a result of not being able to have children. For example, they are reported to have higher levels of depression (Singh, 2010), especially following a miscarriage (de Montigny et al., 2017), which may last for up to three years (Blackmore et al., 2011). Likewise, it is reported that childless women experience lower levels of life satisfaction (Hansen et al., 2009) and higher levels of anxiety and depression (Singh, 2010). However, the findings are inconsistent (Cheng et al., 2014) and contingent on marital status (Engler et al., 2011; Graham, 2015).

> *A woman who is flourishing has the experience of living a life worth living and a feeling of being able to cope with life's adversities*
>
> *Dempsey & Burke, 2021*

Post-traumatic growth

Post-traumatic growth (PTG) is a "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). Of all models of PTG (e.g. Hobfoll et al., 2007; Joseph & Linley, 2005; Pals & McAdams, 2004), the most prevalent in research is the 'Five Domains Model' (Tedeschi & Calhoun, 2004), where positive changes result in outcomes of either one or several of the five domains: 1) Appreciation for life, meaning that individuals begin to see the world around them clearly and understand what matters in life; 2) New possibilities, meaning that they change their focus in life and create new life goals; 3) Spiritual change, meaning they may begin to attend a religious practice or start believing more in a higher power; 4) Personal strength, meaning that they report being stronger, more alive, open – in other words, they become a better version of themselves; and 5) Relating, meaning they become closer to others in their lives after adversity.

Trauma among childless women ranges from the experiences of miscarriage (Engelhard et al., 2001) to the trauma of finding out about one's own infertility, which is seen as "an injury to the individual's sense of coherence" (Kraft et al., 1980, p.623), and the loss of an ideal self, as well as the hope for immortality. Such trauma may also relate to women being unable to have children for reasons other than infertility. However, no prevalence rates exist for PTG among childless women. Understanding the process of PTG can assist both women and mental health professionals in guiding them effectively through the discrete traumas they experience on their journey of childlessness. Therefore, the current study aimed to identify the PTG domains that best predicted flourishing among childless women.

Flourishing describes a subjective state of positive emotional well-being and functioning. On the mental health continuum, flourishing is at the most positive side, exceeding even general well-being (Keyes, 2016). Keyes explains that this feeling should be in our lives at least once a day for most days over a period of a month. She suggests that one should feel either happy, interested, and/or satisfied (emotional well-being). In addition to feeling good, Keyes (2016) argues that when we are flourishing, we also have positive functioning in our personal and social worlds. Positive functioning includes things like: having a purpose and/or contributing to life; good relationships, belonging and a place in the world; personal growth and the ability to express yourself; a feeling that yourself and others are mostly good and okay; and an experience in which the world makes sense and you can manage your responsibilities in it. A woman who is flourishing has the experience of living a life worth living and a feeling of being able to cope with life's adversities (Dempsey & Burke, 2021).

Methods

This study involved a one-off,

online, cross-sectional survey. Participants were recruited via two UK and US online support organisations for women, who want to have children, but cannot. A total of 161 women completed the survey and their ages ranged between 25 and 75 years (M=43.90, SD=7.29). Table 1 provides detailed demographic information.

Measures

Two measures were used in the current analysis – The Mental Health Continuum Short Form (MHC-SF: Keyes et al., 2008) and Post-traumatic Growth Inventory Short Form (PTGI-SF: Cann et al., 2010). In addition to this, a series of demographic questions were applied, including a one-item measure of longing to have a child, which asked participants to decide on a five-point Likert scale (1 = does not apply at all; 5 = applies very much) how applicable the following statement is to them: My longing to become a parent is very strong.

Results

In the current sample, 11.8% of participants were languishing, 54% reported moderate well-being, and 34.2% were flourishing. A hierarchical regression analysis was carried out to assess the ability of all five PTG domains to predict flourishing after controlling for the longing to have a child. Preliminary analyses were conducted to ensure no violation of the assumptions of observed residual normality, linearity, multicollinearity and homoscedasticity. Longing to have a child was entered at step 1, explaining 11.2%of the variance in MHC. After the entry of the five PTG domains, the total variance explained by the model as a whole was 37%, F(6, 154)=15.27, p<.001. The five domains explained a further 26% of the variance in MHC, after controlling for longing to have a child, R squared change =.26, F change (5, 154)=12.88, p<.001. In the final model, only two measures were statistically significant. The highest beta value was reported in new possibilities (beta=.384), followed by relating (beta=.231). All other domains were not statistically significant. See Table 2 for details.

We can see that PTG and flourishing are correlated in these women, which points to the possibility of using therapies focused on trauma and PTG in childless women

Table 1. Demographic information

Variable	Results	Percentage
Location	UK & Ireland	33.5%
	US & Canada	22.9%
	Other (i.e. European, Australian, African, Asian, South American) countries	43.6%
Marital status	Married	54%
	Single	18.6%
	Divorced	7.5%
	In a non-committal relationship	19.9%
Reasons for childlessness	Unexplained infertility	18.8%
	Explained infertility	14.2%
	Not being able to find a partner to have a child with	20%
	Starting too late	30.5%
	Partner does not want a child	7.1%
Other	Miscarriage	13%
	Invested a lot of time and effort over the years to become a parent	37.9%
	Stopped trying	75.8%
	Have a strong longing to be mothers	41.6%

Table 2. Summary of Hierarchical Regression Analyses for Predicting the levels of Flourishing, after controlling for the strength of longing to have a child

Variable	Model 1			Model 2		
	B	SE B	□	B	SE B	□
Strong Longing	-.24	.05	-.33**	-.15	.49	-.21*
Life Appreciation				.01	.05	.02
New Possibilities				.24	.06	.38**
Spiritual Change				-.08	.05	-.12
Personal Strength				.01	.06	.02
Relations				.15	.06	.23*

*p<.05, **p<.001

Discussion

The current study revealed that 34.2% of women reported psychological flourishing, despite longing to have children and not being able to have them. Experiencing loss, such as that created by a lifelong goal that has been blocked, may result in an adjustment disorder (Carta et al., 2009), which may explain why childless women experience depression and other symptoms of mental illness, especially during the reproductive years (Graham, 2015). However, since flourishing reduces the risk of mood disorders (Schotanus-Dijkstra et al., 2017), the current study highlights the importance of assessing both mental illness and mental health to see a bigger picture of the well-being processes experienced by women.

This is also the first study showing that women who experienced the highest levels of well-being focused their attention on new possibilities in life and experienced growth in interpersonal relations. The new possibilities domain relates to adjusting life goals, learning and obtaining new skills, or refocusing attention on alternative activities (Tedeschi & Calhoun, 2004), which may occur when a significant life goal, such as childbearing, is unachievable (Hansen et al., 2009). Past research suggests that childless women tended to draw more from other activities in their lives, such as work, which for many becomes their passion (Engler et al., 2009), civic engagement (Kroll, 2011), or further education (Cwikel, Gramotnev & Lee, 2006; Koropeckyj-Cox & Call, 2007). Thus, these activities may serve as mediators for experiencing PTG.

The current study adds to past research by identifying the link between women's engagement with alternative activities and their experiences of PTG. However, further research is required to identify whether PTG is why women engage in extracurricular activities, or whether their ability to do so enhances their chances of experiencing PTG.

One value of such an approach is that it recognises the trauma experienced by some women going through childlessness without pathologising 'childlessness' as an experience that should always require intervention for mental illness

Furthermore, we need to acknowledge that the life goal of having a child is somewhat culturally shaped (Hawkey et al., 2018). Similarly, engaging with other activities, such as career and civic engagement, are valued in specific ways in a woman's life, depending on the culture she is living in. Future research into PTG could benefit from qualitative analysis of interviews with women about their experiences of changing their life goals and focus away from child rearing to other activities and exploring what socio-cultural discourses and practices enabled and or blocked this shift (Stoppard, 2007).

A similar cause-and-effect link applies to building relations. Recent studies show that childless women do not face large support deficits (Albertini & Mancarini, 2017). Furthermore, it is not necessarily the individual's parental status that affects their well-being, but their marital standing (Gibney et al., 2015; Graham, 2015). That said, the current study highlights the importance of developing closeness with other people when going through the potential traumas one can experience due to childlessness, as it positively impacts flourishing.

This study points to the value of taking a trauma-informed and socio-culturally situated approach to understanding difficult life events. We can see that PTG and flourishing are correlated in these women, which points to the possibility of using therapies focused on trauma and PTG in childless women. Such therapies would deal with the discrete and specific traumatic events experienced during the process of becoming childless and explore possibilities for PTG. The therapies would also support women constructing meaning and purpose in activities outside of childrearing and resisting cultural stigma or social norms. An example of this is the work of Ussher and how she combines CBT with a material-discursive approach (Ussher et al., 2002; Ussher & Perez, 2019). The work of Malik and Coulson (2013) similarly supports resistance to the norms by building an online community of support for alternative identity construction outside the norm of motherhood.

Secondly, by increasing opportunities for PTG, such therapies could likely mitigate the mental ill-health impacts that some of the literature reports are experienced by women who have become childless. One value of such an approach is that it recognises the trauma experienced by some women going through childlessness without pathologising 'childlessness' as an experience that should always require intervention for mental illness. In terms of furthering our knowledge, it is essential and helpful to distinguish between

trauma experiences and mental illness in women who have experienced childlessness. There is a tendency to conflate the two, but research into other issues shows that they can and should be treated as individual risk factors and experiences. For example, in the case of Complex Regional Pain Syndrome (CRPS) – a type of chronic pain that usually affects an arm or leg – there is no correlation between psychological ill-health and CRPS. However, there is a correlation between the number of life events and CRPS (Beerthuizen et al., 2009).

Lastly, this research explored identity and meaning and how it is co-constructed in women's lives. The research points to a more complex socially situated story of childlessness, which is not solely deficit-oriented and can be a story of flourishing.

Conclusions and policy considerations

Such a story of flourishing, which offers an alternative to the deficit-oriented narratives that are most available, challenge us to think about possible policy and practice implications going forward. The findings of the study point us toward a number of policy considerations.

The study highlights having a child as a significant life goal for many women, that is experienced as distress and poor mental health when this goal is blocked. Policy needs to recognise this and support women to enter motherhood more and to actively support and make fertility health care freely available. The study suggests that one can have experiences of trauma without developing a mental illness. Mental health and well-being policy need to differentiate between a trauma-informed approach and a mental health continuum approach to understanding distress. Meaning and purpose were predictive of post-traumatic growth in childless women in this study. At the same time, we know that there is a social stigma attached to childlessness that impacts on feelings of meaning and purpose. We need policies that support the social role of women outside of motherhood. One way to do this is by increasing the social role of men as fathers so that parenting is not overly weighted to women's identity at the cost of other meaningful identity options.

A practical implication of the study is to highlight the role of positive psychology and interventions that support post-traumatic growth in women who are distressed by their experience of not being able to have a child

A practical implication of the study is to highlight the role of positive psychology and interventions that support post-traumatic growth in women who are distressed by their experience of not being able to have a child. The study findings suggest that more interventions that support identity constructions outside of being a mother are very important for women. Such interventions can focus on developing meaning and purpose and creating social communities that reflect these values and identity options back to the women in these communities. Our findings demonstrate that the issue of childlessness is complex and may impact various women differently. Outcomes range from mental illness to discrete traumatic reactions, to post-traumatic growth and flourishing. In practice, one should never assume one outcome and leave space for both negative and positive outcomes from the experience of not being able to have a child.

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Dr Jolanta Burke is a chartered psychologist (BPS) specialising in positive psychology and a senior lecturer. She has authored eight books and been invited to speak at events worldwide. Her research delves into the application of positive psychology in daily life. Jolanta regularly contributes to the media and has written articles for the *Guardian* and *Irish Independent*. Jolanta writes an invited blog for Psychology Today and was acknowledged by *The Irish Times* as one of 30 people who make Ireland a better place.

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Academic/Research Article

A simulated interview with Fritz Perls: Part 2 - The process of therapy sessions

By James C. Overholser, Ph.D., ABPP

"In Gestalt therapy, maturity is achieved by developing the individual's own potential through decreasing environmental support, increasing his frustration tolerance and by debunking his phony playing of infantile adult roles" (Perls, 1978c, p. 76)

Gestalt therapy helps clients get in touch with their current sensory and emotional experience. The approach, founded by German psychiatrist Fritz Perls and his wife Laura Perls, tries to challenge habitual perceptions in an attempt to promote new learning (Peterson & Kolb, 2018). Clients are encouraged to increase their awareness of emotional reactions and express themselves in a candid manner. For many clients, it can be important to work through blocked emotions (O'Leary, 2013).

As an experiential therapy, Gestalt therapy focuses on the process more than the content of therapy (Praszkier & Nowak, 2021). Perls avoided lecturing to clients and instead promoted a process of self-discovery. Gestalt therapy includes strategies that are creative and some aspects may be different from more traditional forms of psychotherapy. He recommended a style of interacting with clients that is often direct and confrontational, helping clients to re-experience difficult situations and express their emotional reactions.

Gestalt intervention strategies aim to help clients accept personal responsibility for their decisions and actions, promoting growth and maturity. In Gestalt therapy, the therapist may rely on skilful frustration to force clients to identify, accept and utilize their own coping resources, instead of relying on deceptive practices designed to manipulate others into providing various forms of nurturance, support, guidance or sympathy.

The Gestalt approach can help clients to deal with their traumatic reactions by bringing their memories into the present moment, confronting their fears and releasing pent-up feelings of anger or resentment. Aspects of Gestalt therapy seem to serve as the forerunner to experiential therapy and exposure-based treatments. In addition, because of its focus on emotions, some aspects of Gestalt therapy serve as a useful complement to cognitive therapy (Tonnesvang et al., 2010). This article explores the process of therapy as recommended by Fritz S. Perls (FSP) during a simulated conversation with James C. Overholser (JCO).

JCO: Thank you for meeting with me again.

FSP: "Well, let's start right away" (Perls, 1969a, p. 114). "Are there some questions you'd like to ask?" (Perls in Clements, 1968, p. 71).

JCO: Certainly. In your view, how do psychological problems begin?

FSP: "Neurosis develops in an environment that does not facilitate this maturation process adequately" (Perls, 1967, p. 310). "People clog up their lives by dragging unpleasant parents around with them" (Perls, 1970a, pp. 34-35). "Possibly the most difficult feat for any patient is to forgive his parents" (Perls, 1970a, p. 27).

JCO: What do parents do wrong?

FSP: "Parents are never right. They are either too stern or too soft, too strong or too weak" (Perls, 1970a, p. 27). "Too much affection will spoil and suffocate the child … Instead of encouraging self-support, the parents will condition the child to rely too much on their help" (Perls, 1978b, p. 62).

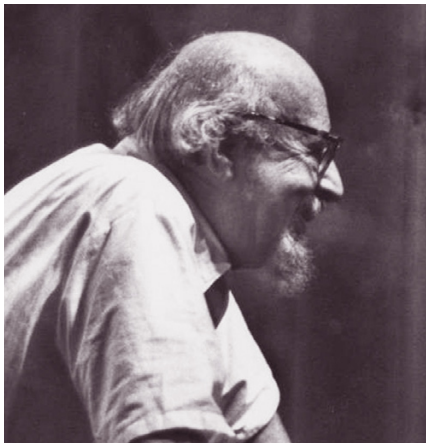
JCO: So, should a therapist become a supportive parental figure?

FSP: "Definitely not" (Perls, 1978a, p. 55). "Any helpful and too supportive therapist ... will only spoil that person more – by depriving him of the opportunity to discover his own strength, potential and resources. The therapist's real tool here is skilful frustration" (Perls, 1967, p. 310).

JCO: You believe that therapists shouldn't praise their clients?

FSP: "This is quite true" (Perls, in Dolliver, 1991, p. 302). "If you are in need of praise, then no amount of praise will ever get you enough" (Perls, 1953-54, p. 50). "If you need encouragement, praise, pats on the back from everybody, then you make everybody your judge" (Perls, 1969a, p. 36).

JCO: That is a powerful statement. So, in your view, frustration is a therapist's tool.



Fritz Perls - Photo source: exploringyourmind.com

FSP: "Yes, yes" (Perls in Clements, 1968, p. 71). "To bring about the transformation from external to self-support, the therapist must frustrate the patient's endeavours to get environmental support" (Perls, 1973, p. 105). "We frustrate the patient in such a way that he is forced to develop his own potential ... what he expects from the therapist, he can do just as well himself" (Perls, 1969a, p. 40).

JCO: You use frustration to provoke maturation?

FSP: "You might say that" (Perls, 1970a, p. 26). "If there is insufficient self support, we look for external support" (Perls, 1978b, p. 64). "In Gestalt therapy, maturity is achieved by developing the individual's own potential through decreasing environmental support, increasing his frustration tolerance and by debunking his phony playing of infantile adult roles" (Perls, 1978c, p. 76). "The malfunctions of the neurotic become manifest in his lack of genuine self-expression" (Perls, 1948, p. 574).

JCO: Therapy helps clients to become their true self?

FSP: "The answer is no" (Perls, 1978a, p. 70). "The usual advice 'be yourself' is misleading, for the self can be felt only as a potentiality" (Perls et al., 1951, p. 438). "It is simple to say 'just be yourself' but for the neurotic, a thousand obstacles bar the way" (Perls, 1973, p. 43). "The patient has taken great pains to build up a self-concept ... it is often a completely erroneous concept of himself" (Perls, 1973, p. 49).

JCO: Well, at least we can agree that therapy helps clients make positive changes.

FSP: "No, that's not true" (Perls, 1969b, p. 57). "We cannot deliberately bring about changes in ourselves or in others" (Perls, 1969a, p. 20). "Nobody can at any given moment be different from what he is at this moment, including all the wishes and prayers that he should be different. We are what we are" (Perls, 1969a, p. 47). "No eagle will want to be an elephant, no elephant to be an eagle. They accept themselves … they just are. They are what they are ... How absurd it would be if the elephant, tired of walking the earth, wanted to fly" (Perls, 1969b, p. 7). "Every individual, every plant, every animal has only one inborn goal – to actualize itself as it is" (Perls, 1969a, p. 33). "I am what I am, and at this moment I cannot possibly be different from what I am" (Perls, 1969a, p. 4).

JCO: So self-acceptance is key?

FSP: "Exactly. That's what I wanted to point out" (Perls, 1970b, p. 229). "You never overcome anything by resisting it. You only can overcome anything by going deeper into it" (Perls, 1969a, p. 230). "If you go deeper into what you are, if you accept what is there, then a change automatically occurs by itself. This is the paradox of change" (Perls in Clarkson & Mackewn, 1993, p. 91).

JCO: How does a therapist guide this process?

FSP: "What we want to do in Gestalt therapy is to integrate all the dispersed and disowned alienated parts of the self and make the person whole again" (Perls, 1973, p. 179). "Our aim as therapists is to increase human potential through the process of integration. We do this by supporting the individual's genuine interests, desires and needs" (Perls & Stevens, 1975, p. 1).

JCO: I'm still unclear as to *how* you work as a therapist.

FSP: "I almost never answer questions during therapy. Instead, I usually ask the patient to change the question into a statement" (Perls, 1970a, p. 26). "Every time you refuse to answer a question, you help the other person to develop his own resources" (Perls, 1969a, p. 38). "If you change your question into a statement, the background out of which the question arose opens up, and the possibilities are found by the questioner himself" (Perls, 1969a, p. 38). "You don't ask questions, you just respond" (Perls, 1969a, p. 22).

JCO: What about sharing helpful advice with clients?

FSP: "I don't think I can give you something through a lecture. I don't think words can convey anything, especially anything about Gestalt therapy" (Perls, 1978a, pp. 54-55). "Probably the most dangerous thing a therapist can do is to play the computer game ... you feed information into their computers" (Perls, 1970a, p. 29). "I avoid any interpretation. I leave this to the patient since I believe he knows more about himself than I can possibly know" (Perls, 1970a, p. 27). "Every interpretation, of course, is an interference. You tell another person what they think and what they feel. You don't let them discover themselves" (Perls, 1973, p. 142).

JCO: You believe that therapists should not use questions, advice or interpretations?

FSP: "I believe ... in learning by discovery rather than by drill and repetition" (Perls, 1969b, p. 33). "The therapist cannot make discoveries for the patient, he can only facilitate the process in the patient" (Perls, 1973, pp. 74-75). "Help the other person discover himself ... only what we discover ourselves is truly learned" (Perls, 1970a, p. 37).

JCO: How does a therapist promote discovery if it is supposed to be self-discovery?

FSP: "Self-discovery is an arduous process. Far from being a sudden flash of revelation, it is more or less continuous and cumulative" (Perls et al 1951, p. 3). "The successful experimenting of the trial and error kind comes with a glow of success and insight" (Perls, 2012, p. 76). "The patient is an active experimental partner in the session" (Perls et al., 1994, p. 36). "Learning is discovery" (Perls, 1969a, p. 27).

JCO: This sounds very Socratic.

FSP: "Yes, that's very interesting" (Perls in Clements, 1968, p. 68). "Psychotherapy is a humane discipline, a development of Socratic dialectic" (Perls et al., 1994, p. 36). "This internal dialogue is what Socrates called the 'essence of thinking'" (Perls et al., 1994, p. 229). "Am I becoming too philosophical?" (Perls, 1969b, p. 8).

JCO: Not at all. I have become quite interested in philosophy and the Socratic method.

FSP: "As for Socrates, he even surpassed my arrogance by saying 'you are all fools to think that you know something! But I, Socrates, am not a fool. I know that I don't know! This gives me the right to torture you with questions and to show you what a fool you are!'" (Perls, 1969b, p. 74).

JCO: I think the Socratic dialogue is a useful framework for therapy sessions.

FSP: "As Socrates pointed out, the comic and tragic are not far apart, and the same event from different points of view may be comic or tragic" (Perls et al., 1994, p. 191).

JCO: Therefore it depends on how you look at the events?

FSP: "You might say that" (Perls, 1970a, p. 26). "Neurotic suffering is suffering in imagination" (Perls, 1973, p. 126). "Many of our catastrophic expectations have no validity" (Perls, 1969b, p. 254).

JCO: You help clients shift to a more rational perspective?

FSP: "Rational thinking has its place; in the assessment of the degree to which catastrophic expectation is mere imagination or exaggeration of real danger" (Perls, 1967, p. 311). "Difficult situations create wishful or magic thinking" (Perls, 1948, p. 570).

JCO: So therapy can aim to change a client's beliefs?

FSP: "A basic error cannot be refuted ... it can be altered only by changing the conditions ... we allow for the emergence of a better judgement" (Perls in Brownell, 2010, p. 204). "Therapy ... consists in analyzing the internal structure of the actual experience ... not so much *what* is being remembered ... as *how* what is being remembered is remembered" (Perls et al 1951, p. 273). "To work through imaginary pains and unpleasant emotions we need a fine balance of frustration and support" (Perls & Stevens, 1975, p. 4).

JCO: How does therapy help to adjust a client's perspective?

FSP: "On your camera you have a view finder" (Perls, 1979, p. 10). "Something similar is done in radio, if the required station is tuned in, the hissing of the background is subdued; the contrast of the foreground music to a background of complete silence is what is desired" (Perls, 2012, p. 105). "The organizing principle that creates order from chaos; namely, the figure-ground formation. Whatever is the organism's need makes reality appear as it does … It evokes our interest, attention" (Perls, 1948, p. 571).

JCO: Do you typically explore why clients have certain struggles?

FSP: "Oh no, not at all" (Perls, 1969b, p. 191). "'Why' questions produce only pat answers, defensiveness, rationalizations, excuses and the delusion that an event can be explained by a single cause … All of the therapist's questions are interruptions of some ongoing process in the patient. They are intrusions" (Perls, 1973, p. 76). "'Why' cannot lead to understanding" (Perls, 1970a, p. 37). "'Why?' at best leads to clever explanations, but never to an understanding" (Perls, 1969a, p. 47).

JCO: I sometimes try to understand what motivates my clients.

FSP: "A major problem for all forms of psychotherapy is to motivate the patient to do what needs to be done" (Perls et al., 1951, p. 164). "The therapist is … a catalyst, an ingredient which precipitates a reaction which might not otherwise occur" (Perls, 1951, p. 17). "What I do as therapist is to work as a catalyst … I frustrate his avoidances … until he is willing to mobilize his own resources" (Perls, 1969a, p. 56). "When I work … I become nothing, no-thing, a catalyst, and I enjoy my work. I forget myself" (Perls, 1969b, p. 218).

JCO: Let me change topics. It sounds like Gestalt therapy stirs up emotions.

FSP: "Emotions are the very life of us … Emotions do not have to be explained, much less interpreted. They are the very language of the organism" (Perls, 1978b, p. 52). "One of the most serious problems of modern man is that he has desensitized himself to all but the most overwhelming kind of emotional response" (Perls, 1973, p. 84). "Modern man lives in a state of low-grade vitality. Though generally he does not suffer deeply, he also knows little of true creative living … he wanders around aimlessly, not really knowing what he wants … the expression on his face indicates his lack of any real interest in what he is doing … his present activities are merely bothersome chores he has to get out of the way" (Perls, 1973, p. xiii).

JCO: Many of my clients are troubled by their persistent negative emotions.

FSP: "We have become phobic toward pain and suffering. Anything that is not fun or pleasant is to be avoided … and the result is a lack of growth" (Perls, 1973, p. 118). "The enemy of development is this pain phobia – the unwillingness to do a tiny bit of suffering" (Perls, 1969a, p. 56).

JCO: Are some emotions emblematic of neurosis?

FSP: "That is right" (Perls in Dolliver et al., 1980, p. 137). "Guilt (and resentment) … both pervade all neurosis … Anxiety is the neurotic symptom par excellence" (Perls et al., 1951, p.150).

JCO: What about something like anger and aggression?

FSP: "The supermarket made us forget that we kill in order to survive" (Clements, 1968, p. 69). "Aggression is essential for survival … Nature is not so wasteful as to create such a powerful energy as aggression just to be 'got rid of' or 'abreacted'" (Perls, 1953-54 p. 48). "If we prevent ourselves from aggressing, we feel resentment or guilt instead … it is not aggression itself that is good or bad, but when we feel bad we feel aggressive" (Perls, 1953-54, p. 52).

JCO: But most mature adults have learned to suppress feelings of anger and despair.

FSP: "This is quite true" (Perls, in Dolliver, 1991, p. 302). "Consequently, in Gestalt therapy we draw the patient's attention to his avoidance of any unpleasantness" (Perls, 2012, p. 191).

JCO: Even painful emotions are natural?

FSP: "That's correct" (Perls, 1969b, p. 117). "Nature creates emotions as a means of relating" (Perls, 1970a, p. 31). "Emotions are the very means of our ability to make contact" (Perls, 1978a, p. 62). "Nothing blocks contact as much as uncommunicated emotion" (Perls, 2012, p. 177). "Emotions do not have to be explained, much less interpreted. They are the very language of the organism" (Perls, 1978b, p. 52). "Your emotional experience … is understood to not be a threat to rational control of your life but a guide" (Perls et al., 1951, p. 117). "Emotions … are the way we become aware of the appropriateness of our concerns: the way the world is for us" (Perls et al., 1951, pp. 477-478).

JCO: So, the therapist should ignore what the client is thinking to focus on emotions?

FSP: "No, no, no, no" (Perls in Bry,

1972, p. 62). "Emotion ... is not mediated by thoughts and verbal judgments, but is immediate" (Perls et al., 1951, p. 112). "Once we isolate thinking from feeling, judgement from intuition … verbal from non-verbal, we lose the self, the essence of existence, and we become either frigid human robots or confused neurotics" (Perls, 1953-54, p. 45).

JCO: What advice do you have for bringing emotions into therapy?

FSP: "Be real ... no more intellectualizing" (Perls in Bry, 1972, p. 59)."We avoid the bland, intellectualized 'about-isms' and strive vigorously to give all material the impact of immediacy" (Levitsky & Perls, 1970, p. 2). "Instead of telling a story, we tell a drama and we do it simply by changing the past tense into the present tense" (Perls, 1973, p. 179). "The therapist becomes almost cold-blooded and asks him to deliberately remain with whatever psychic pain [he] has at that moment ... to help the patient to distinguish between that which he imagines and that which he perceives" (Levitsky & Perls, 1970, p. 10).

JCO: How do you accomplish this goal?

FSP: "The Gestalt technique demands of the patient ... that he experience himself as fully as he can in the here and now" (Perls, 1973, p. 63). "We ask the patient during the session to turn all his attention to what he is doing at the present, during the course of the session – right here and now" (Perls, 1973, p. 63). "The analyst should not put pressure on the patient and persuade him to talk, but should attend to the resistances and avoidances" (Perls, 1969c, p. 74). "Often, however, the patient will escape from experiencing the present. He will go into the past or the future ... the past is of significance only as far as it embodies unfinished situations" (Perls, 1979, p. 14). "He must realize that if his past problems were really past, they would no longer be problems – and they certainly would not be present" (Perls, 1973, p. 63).

JCO: I feel that some clients find it useful to discuss their past.

FSP: "Psychoanalysis fosters the infantile state by considering that the past is responsible for the illness" (Perls, 1969a, p. 59). "The flight into the past is mostly characteristic of people who need scapegoats. These people fail to realize that, despite what has happened in the past, their present life is their own, and that it is now their own responsibility to remedy their shortcomings, whatever they may be" (Perls, 1969c, p. 208).

JCO: So therapy helps clients to become responsible adults?

FSP: "Exactly. I'm responsible only for myself" (Perls in Clements, 1968, p. 71). "The essence of a grown-up person is to be able to take responsibility for himself" (Perls, 1969a, p. 79). "We have a certain freedom … a freedom of choice" (Perls, 1978b, p. 53). "Without taking full responsibility ... no cure is possible" (Perls, 1969c, p. 217).

JCO: Some of my clients struggle because of events that happened during their childhood.

FSP: "No more unearthing of any childhood trauma will ever cure any neurosis. This has to be done in the here and now by reorganizing the structure and functions of our patients" (Perls, 2012, p. 172).

JCO: I have found that discussing childhood events can trigger strong emotions in therapy.

FSP: "Exactly" (Perls in Clements, 1968, p. 71). "We often gossip about people when we have not been able to handle directly the feelings they have aroused in us" (Levitsky & Perls, 1970, p. 5). "Never gossip about any person who is not present" (Perls, 1970a, p. 36). "The no gossiping rule is designed to promote feelings and prevent avoidance of feelings" (Levitsky & Perls, 1970, p. 5).

JCO: So how do you manage these emotions from past events?

FSP: "The present includes a childhood experience if it is vividly remembered" (Perls, 1948, p. 576). "By making the patient go back, as if travelling in a Wellsian time engine, to the place and time of the past" (Perls, 2012, p. 28). "Bring the absent one into an encounter by having the speaker play both roles" (Perls, 1970a, p. 36). "If a patient is finally able to close the book on his past problems, he must close it in the present" (Perls in O'Leary, 1992, p. 53).

JCO: Then clients need to describe their traumatic events in session?

FSP: "No, there is more to it" (Perls, 1970a, p. 25). "It is not enough to bring up undigested material; it also has to be re-chewed so that the digestive process can be completed" (Perls, 1948, p. 582). "The therapist keeps leading the patient back to that which he wishes to avoid" (Perls et al., 1951, p. 166). "The 'stay with it' technique encourages the patient to undertake a similar 'chewing up' and painstaking assimilation of emotional experiences which have hitherto been unpleasant to the taste, difficult to swallow and impossible to digest" (Levitsky & Perls, 1979, p. 11).

JCO: What about clients who have suffered from a major loss or a traumatic event?

FSP: "Traumatic neuroses are essentially patterns of defence that originate in an attempt by the individual to protect himself from a

thoroughly terrifying … clash with the environment" (Perls, 1973, p. 31). "In defending himself against this situation, the child is likely to develop rigid patterns of behaviour. And these may persist long after the danger is past. They were called into action by a trauma, but they continue to operate even when the trauma itself has disappeared" (Perls, 1973, p. 32).

JCO: So how do you help clients overcome a traumatic event?

FSP: "Gestalt therapy is an experiential therapy … We ask our patients not to talk about their traumas and their problems in the removed area of the past tense and memory, but to re-experience their problems and their traumas … in the here and now" (Perls, 1973, p. 63). "All therapy has to be done and can only be done in the now" (Perls, 1970b, p. 17).

JCO: So, a person gets over their fears by confronting their fears?

FSP: "Not only that. I go a step further" (Perls in Clements, 1968, p. 70). "It is not the conflict … that causes the misery, but the avoidance of bringing the fight into the open and clearing the air" (Perls, 1953-54, p. 51). "Avoidance as the main characteristic of neurosis … its correct opposite is concentration … Psychotherapy means assisting the patient in facing those facts which he hides from himself" (Perls, 1969c, p. 189). "He must return to 'unfinished business' which he left unfinished in the past because it was so painful that he had to flee. Now, if he is encouraged to go back and finish it, it is still painful; it reactivated his misery" (Perls et al., 1951, p. 164). "The therapist actually expects one to do hard work and undergo pain … Therapy involves concentrated doses of what one sought to be relieved of" (Perls et al., 1951, pp. 165-166).

JCO: This sounds like prolonged exposure therapy?

FSP: "I partly don't follow you … I don't know enough of it from the little I have understood" (Perls, 1969a, p, 21).

JCO: Some forms of therapy expect clients to confront their fears, tell their story, and relive their trauma.

FSP: "That is correct" (Perls, 1969b, p. 171). "All this is so obvious. I am rather embarrassed to mention it at all" (Perls, 1969b, p. 46). "What time is it?" (Perls et al., 1951, p. 510). "I usually have a cigarette break after 20 minutes" (Perls, 1969b, p. 183).

JCO: Maybe we should stop for the day and finish our discussion later?

FSP: "Okay. Thank you" (Perls, 1973, p. 153). "Come back once more" (Perls, 1973, p. 132).

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Academic/Research Article

Working therapeutically with clients taking psychotropic medication: Is it a help or hindrance?

By Grushenka Arnold

Although prescribing medication does not fall under the remit of counsellors and psychotherapists, it is essential that we have a basic understanding of how psychotropic medication may affect the therapeutic process

Introduction

The utilisation of psychotropic medication (PM) within the mental health care field has changed considerably over the past 25 years (Angermeyer, Auwera, Matschinger et al, 2016). PM is a broad term that refers to medications that affect behaviour, mood, thoughts or perception. Continual innovation and research have divided both professional and public opinions on the use of PM when offered as an effective treatment option (Purdy, Little, Mayes & Lipworth, 2016).

At the turn of this century, a new trend of prescribing medication for numerous conditions developed; if there was a condition, there was a medication for it, says Hart, (2000). Such conditions include social phobia, eating disorders, premenstrual syndrome, depression and anxiety. Discussions relating to prolific prescribing were encouraged in order to urge experts to be mindful and consider both the associated risks and benefits of prescribing such medications (Hart, 2000).

This article explores the question should counsellors and psychotherapists have an informed understanding of psychotropic medication and introduces a small-scale study of accredited therapists and their views and experiences of working with clients taking PM and its impact on the therapeutic process.

Types of PM

Types of PM can be grouped into various classes depending upon the ailment it is intended to treat, for example, antidepressants for depression, antipsychotic medications for psychosis, anxiolytics for anxiety and mood stabilizers "… including lithium, lamotrigine, carbamazepine, and valproate for diagnosis such as bipolar disorder (BD)" (Olfson & Marcus, 2010, p. 1457). Prescribing PM for people with BD can be a complex process because the same medication used to treat depressive symptoms can induce mania. On the contrary, medication used to reduce mania may cause 'rebound' depression (Geddes & Miklowitz, 2013).

According to Veseth et al. (2019) therapists describe the process

of working with individuals taking PM as challenging at times. This is because some individuals may be resistant to taking medication as they do not want to take it, or they may be non-compliant and not take it when it has been prescribed. Further, pharmacological interventions are central to clinical work when working with individuals with BD. One therapist described the use of medication as the "bedrock of therapy" when working with individuals with BD (Veseth et al, 2019, p. 69). This is because, the authors noted, therapists' accounts of working with individuals without PM included some individuals terminating therapy too soon, having to be hospitalized, engaging in self-harm or dying by suicide in the absence of medication. With these factors in mind, lithium was a major factor in a positive treatment outcome in one of the therapist's experiences, as it anchored the individual with BD (Veseth et al, 2019).

Winters (2000) argues that while not every individual that presents for treatment requires medication, it may be necessary in some instances. Chemical changes are needed to alleviate severe depression and cannot be achieved by some individuals on their own. Thus, medication can be helpful in facilitating a positive change (Winters, 2000).

A study by Niven, Goodey, Webb, & Shankar (2018) demonstrates the prolific prescription of PM in the absence of multi-disciplinary teams (MDTs) with individuals displaying challenging behaviours. They suggested that clinicians are quick to prescribe rather than explore other options that may be more beneficial in terms of treating mental health issues. Their research highlights the importance of MDTs when exploring an individual's treatment options – it underpins the importance of professionals coming together with different skill sets to optimize treatment options.

Results demonstrated that the therapists that had participated in the survey would welcome guidance in terms of how best to work with clients taking PM or psychiatric drugs that have been prescribed for a particular disorder

Psychotropic medication, psychotherapy or both?

Cuijpers, Reynolds, Donker, Li, et al. (2012) found that medication was more efficacious than psychotherapy for individuals presenting with dysthymia (persistent depressive disorder), postnatal depression and depressed women experiencing infertility. Interestingly, they found combined treatment demonstrated no significant difference. However, this study focused solely on short-term outcomes (Cuijpers et al, 2012).

Some studies have indicated that in cases of acute treatment of depression, research has demonstrated cognitive behavioural therapy (CBT) to be efficacious and have an 'enduring effect' as an alternative to individuals taking medication, whereas medication did not indicate efficacy over a period of time (Driessen & Hollon, 2010). CBT with medication combined demonstrated efficacious treatment for individuals with BD (Driessen & Hollon, 2010).

Thibodeau, Quilty, De Fruyt, et al. (2015) conducted a randomised double-blind study exploring the efficacy of two antidepressant medications and three approaches to therapy (CBT, psychodynamic and supportive therapy) over a six-month period. Findings demonstrated that both psychotherapy and PM together were an effective treatment when examined over a period of six months or more. (Thibodeau et al, 2015). However, this research was limited in both the number of antidepressants and the forms of therapy.

Pharmacotherapy as part of psychotherapy training

King and Anderson (2004) claim that the use of PM together with therapy is the "standard of care for many mental health disorders" (p. 329). Thus, psychotherapists must understand the impact that PM use may have on therapeutic outcomes. The authors comment that it is not sufficient to have an awareness of PM and its effects and suggest psychotherapists must be educated on pharmacotherapy at master's level (King & Anderson, 2004).

Interestingly, Aston et al. (2021) point out that the BPS (British Psychological Society) require that doctoral training courses in clinical psychology include training in psychopharmacology so trainees have an awareness of the "impact and relevance" (Aston et al, 2021, p. 360) of medication and other approaches from a multi-disciplinary perspective. The researchers continue that courses can vary in terms of the material they teach related to PM.

Survey findings by Aston et al. indicate that 98% of participants (clinical psychologists) had involvement in their client's use of PM, despite the fact that only 49.7% of respondents had attended specific training related to PM.

A survey by Blair et al. (2021) was carried out on 1,230 therapists in the UK. Results demonstrated that the therapists that had participated in the survey

would welcome guidance in terms of how best to work with clients taking PM or psychiatric drugs that have been prescribed for a particular disorder.

Benefits of training

Training in psychopharmacology allows the therapist to be aware of what to look out for when working with a client. These may include benefits, values, medication compliance, side effects, dosage adherence, medication change/alteration and other poly-drug use not disclosed i.e., drugs and/or alcohol (King & Anderson, 2004). Most recent research indicates that up to 2019, there was little guidance offered to psychotherapists in terms of how best to support clients who are prescribed PM and how best to navigate a range of issues that may arise (Blair et al, 2021). Guy, Davies, et al. (2019) published *Guidance for Psychological Therapists*, which may have been hugely beneficial to many therapists. Interestingly, in the survey by Blair et al. (2021), the researchers reported that one in five therapists felt inadequately trained when topics arose around PM from clients. Results from their study also demonstrated the importance and need for training in PM for therapists.

Becoming unstuck

According to Hart (2000), one benefit of taking PM is that it may facilitate an individual to become unstuck and allow them to advance through their therapeutic process and overcome obstacles that may have been compounded by anxiety or depression. PM can initiate and influence chemical changes within the brain required to lift the individual out of depression, although side effects from taking PM can be uncomfortable and unwelcome (Winters, 2000).

The first key theme identified was the lack of modules offered academically to inform therapists and equip them with knowledge regarding PM

However, side effects from PM can be a welcome alternative to the symptoms of the ailment being experienced (Winters, 2000). Further research is required in order to explore the potential impact taking certain medication may have over a long period of time (Cartwright et al., 2016).

The present study

For this article a study was undertaken to explore psychotherapists' experiences of working therapeutically with individuals taking psychotropic medication, and to explore if it is a help or hindrance to the psychotherapeutic process. Four fully-accredited therapists, all with a number of years' experience ranging from five to 25 years in practice were invited to participate in this study (Therapist 1, 2, 3, 4 = T1, T2, T3 and T4).

The research was a qualitative design using semi-structured interviews to gather psychotherapists' experiences of working with individuals in practice that are taking, or may have taken, PM in the past. Interpretive Phenomenological Analysis (IPA) was implemented in order to analyse and explore data for superordinate and subordinate themes (Smith, Flowers & Larkin, 2009). Emerging and recurring themes were analysed and coded (with descriptive title and numbers) (Leech & Onwuegbuzie, 2007).

The types of medication the therapists had experience working with included selective serotonin reuptake inhibitors (SSRIs), mood stabilisers, anti-anxiety medication, anti-depressants, anti-psychotics, sleeping tablets, illicit drugs bought on the street, 'over the counter' medication and caffeine tablets/energy drinks.

Superordinate/key themes and sub themes

Findings from the therapists' experiences were organised into five superordinate themes: 1) Modules on PM not part of training; 2) Presenting issues/symptoms and diagnosis; 3) Types of medication prescribed; 4) Therapists' beliefs and understanding of PM; and 5) Experiences working with clients taking PM.

Modules on PM not part of training

The first key theme identified was the lack of modules offered academically to inform therapists and equip them with knowledge regarding PM. All four therapists encountered individuals either taking PM or had worked with individuals taking PM in the past. Only one therapist had covered modules on PM during training. T4 explains that they "didn't really pay attention in training, because it didn't feel relevant at the time … because as psychotherapists, we do not prescribe". Not having more in-depth knowledge about medication was one of the biggest obstacles facing this particular therapist.

Autonomous learning

An interesting sub theme found within the data was how therapists navigate obtaining knowledge of PM and how it works. It emerged that if a client presents and they are taking PM for a particular issue, the therapists would then 'Google' the medication to get a better understanding of what the client might be taking and what it is specifically used for (T1, T2, T3).

T2 stated: "We are not educated on medication". Thus, there is a requirement for autonomous learning on the part of therapists. According to T3, there are an "awful lot of clients" presenting who are taking PM. Due to limited training, T2 felt that as therapists, we are "going through the dark" when it comes to knowledge on PM.

T1, T2 and T3 suggested that CPD courses, or modules on training courses, would be helpful to gain some understanding of the use of medication within psychotherapy. T3 said when a client came in to a session and had a "list of medications" they "had no idea what half of them were; I had no idea how they worked together, which is something I still find quite difficult to get my head around and fully understand". The consensus from the surveyed therapists revealed that when the issue of medication arose it created internal conflict.

T4 spoke about their "self-doubt" and disclosed they often wondered "Am I able to help them? Am I doing all I can? Am I a good enough therapist? Am I helping this person at all?" T4 continued: "It would be helpful to know how medications work and what the potential side effects are. If someone is thinking of taking medication, it would be helpful for us to know what to expect and how it might impact the therapeutic work". Similarly, T3 spoke about their own "inner critic" when in the room with a client and doubting themselves when it came to knowledge of PM. T3 described experiencing "imposter syndrome" in the early days of practice, because they felt they did not know enough about medication to support the individual at the time.

T4 explains their experience with an individual on medication for a long period of time: "If a client has been on medication for some time and it might not be working, I'm a bit drowning in a sense because I don't really know what to say and just refer them back to their GP."

Some clients did not want to take medication or be "seen to have a mental health disorder" when they had come to therapy for a different reason

Presenting issues, symptoms and diagnoses

T1 detailed working with an individual with "really bad anxiety" that was prescribed anti-anxiety medication by their GP. In this case the medication did not agree with the client and the prescription was changed by their GP. T1 felt that there was a noticeable change five weeks into the therapy as the individual presented as "more stabilised". The therapist noticed that a mild dose of anti-anxiety medication helped the client "slow down" and it had "taken the edge off". In this instance the therapist felt PM had "lifted" the client so they were able to function, calm down and take back control. This aligns with research by Hart (2000), demonstrating that medication supports the individual to become 'unstuck'.

Resistance to taking PM

Participants detailed their experiences of client resistance to taking PM if it was prescribed by their GP. T4 explains that some clients did not want to take medication or be "seen to have a mental health disorder" when they had come to therapy for a different reason, for example, relationship break-up, personal development, values exploration, intrapersonal conflicts, interpersonal relationships and family dynamics, which in some instances led to depression.

In T4's experience, clients also did not want to be "labelled". T2 noted from their own experience: "It's not so much the actual PM helping or hindering the process, but more so the labels placed upon individuals that might help or hinder."

Side effects

T2 noticed that individuals can be reluctant to take PM because of the side effects. The therapist added that some people do need medication and can take PM short-term or long-term depending on the symptoms or diagnosis they have been given. T2 explains that in their experience, talk therapy is always more effective in terms of outcomes.

T1 described working with an individual with debilitating anxiety that was also experiencing depressive symptoms and this was "getting in the way" of doing the work. When prescribed anti-anxiety medication from their GP, this helped to "lift" the client's mood. PM supported the individual in accessing that part of them that was required to work through their own process. In this instance, it was found that medication helped. It is worth keeping in mind though, that while PM can help in some instances, T2 observed that the side effects of medication exacerbated one individual's anxiety symptoms.

T2 spoke about their experiences with clients presenting with side effects from anxiolytic medication – medication that reduces anxiety – that were "keeping the anxiety alive" for one client. In this instance, anxiolytics appeared to increase anxiety and caused leg/limb tingling in one of their clients, adding further stress to their daily life. T2 continued that in their experience it was a case of "the worse the condition, the more the medication" and revealed one client

had overdosed on their medication because they were feeling suicidal. With this in mind, T2 explains: "I always refer back to the GP … because we are not equipped to understand these medications."

T2 also recalls a client experiencing disassociation because of the amount of medication they were on, noting that one client had contacted them out of hours and did not remember doing so.

Medication 'masking' problematic issues

T1 spoke of a crossover between therapy and medication; PM can be an extra support, but it was found that it can also "mask" something else. In one instance, T1 recalls a client who came to therapy for support for heightened anxiety. It transpired that the client was drinking 15 cans of energy drinks a day. T1 described this as something they may have missed because the client may not have disclosed this organically; in this case it was disclosed during exploration and conversation. The therapist explained how this impacted them, as they questioned themselves internally: "How am I supposed to work with that?" Again, this demonstrates the need for sufficient training and knowledge on what to look out for.

Therapists' beliefs and understanding of PM

T1 and T3 both describe PM as "another tool in the box". PM can be a "facilitator" and the use of PM and therapy used together can be viewed as a "dual relationship" (T3), which ultimately may support the individual through their own process.

PM has its place

A common sub theme among all four therapists was that medication "has its place" along with its "pros and cons" (T1).

Another challenge described was the risk of an individual taking street drugs or engaging in recreational drug use

T2 described their beliefs as "adaptable", but also felt that a client is better trying the process of therapy without the aid of medication first, so as to avoid the possibility of learning being compressed in some way. If a client is struggling, and depending upon their individual process, referral back to their GP is always recommended.

Therapist experiences of working with clients taking PM

T1 and T3 narrated their own personal experience of anxiety and panic attacks, which informed their own understanding and beliefs. When asked what informed their own beliefs about medication T1 explains: "Probably my own experience because there was a time where I went through really bad panic attacks; it was related to something that was happening in my life at the time. I was getting them at night time … and [they were] really scary'. I was finding it difficult to function during the day because I wasn't sleeping." Following a visit to their GP, T1 was prescribed sleeping tablets. Although they knew they had them, they never took them, but the idea that they were there in case they could not sleep was enough to settle their racing mind. Having this experience encouraged T1 to read more about medication in relation to its use for anxiety management.

It was found that autonomous research and attending personal therapy was also influential in terms of learning about PM (T1, T3). T4 found that a big challenge for them is "not knowing enough about medication". T3 spoke about the challenges they faced when working with individuals taking PM – the biggest being personal bias and judgement. T3 explained that their own judgement and bias can be a challenge "because of how fast some GPs prescribe medication after speaking with an individual for such a short space of time". This aligns with research by Niven et al. (2018) that GPs can be too quick to prescribe. T3 describes a time they were in university and a friend was going through a difficult time. Following a visit to the GP, the friend was prescribed antidepressants after only speaking with the GP for 10 minutes. T3 was surprised with how quickly the prescription was issued without further exploration of any mitigating factors that may have been affecting their friend. T2 also felt that GPs were "quick" to prescribe because they are working from a medical model.

Another challenge described by T1 was the risk of an individual taking street drugs or engaging in recreational drug use, for example, anxiolytics or cocaine, and then going 'cold turkey' after using it for a sustained period of time. Although the therapist did not work specifically with addiction, they were able to implement a different approach (harm reduction) in order to address underlying concerns that were leading the individual to opt for illicit 'street bought' drugs in the first place.

Therapeutic setting

T3 and T4 both work in private practice and clinical settings e.g., mental health facility/hospital setting. In private practice, individuals were generally on a low dose of antidepressants or anti-anxiety medication, says T4. This did not appear to have a direct effect on the sessions, or on the process itself (T3 and T4). However, working in a hospital

setting, where there were more complex diagnoses, the dose was sometimes higher depending on the individual, says T4. In these cases, both therapists felt that there was a lack of engagement from the client and a sense that the client was not fully present. T4 found that in community settings, individuals might present with anxiety or depression, but in a hospital setting they were inpatients because of a psychiatric diagnoses. For example, one individual they were working with was diagnosed with schizophrenia; the medication they were taking, the therapist felt, was affecting their ability to focus and be "present".

Conclusion

Although counsellors and psychotherapists do not prescribe medication, it is an issue that frequently arises in the therapy room. One would be remiss not to draw attention to the need to advocate for modules on PM being part of all psychotherapy training.

Overall findings of this research indicate that all four therapists felt that PM did not hinder the therapeutic process in general. It was also found that therapists felt it had no effect on overall outcomes for the majority of clients. Further, in most cases therapists stated that, in their experience, PM helped the therapeutic process.

Proficient knowledge around PM would enhance confidence in some therapists, eliminating self-doubt and encourage them to perform to the best of their ability in practice. Robust modules related to pharmacotherapy and psychopharmacology are of paramount importance and should be included in curricula during psychotherapy training. Possessing sufficient knowledge of PM is key to facilitating therapists to support clients who may be taking PM.

One must be mindful though that there are pros and cons to taking medication and, to reiterate the response of two therapists in this research "it has its place". Having knowledge and understanding of how medication can work is of paramount importance for both therapist and client in the therapeutic relationship.

Grushenka Arnold

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FLORESCENCE*

The magic

By Sian Williams

Today I sit and wonder, who I am meant to be

If I slowly drop the mask for all the world to see?

So deep within this medicine, I called for myself to come home

A little girl once forgotten, the world was hers to roam.

Filled with fear and sadness, dripping in anger and rage

These emotions were not welcomed so they were locked up in a cage.

Always pretending not to feel or to need a hand to hold

But knowing late at night the loneliness keeps you cold.

But the magic of this plant, she showed me where to go

How to heal, how to be, how to laugh and how to grow.

Embraced by her powerful teachings now I'm not afraid

As I take this new deep breath, I'm really glad I stayed.

One of nature's best

By Margaret Bassett

Don't think he has a notion

Nor understands the heart he brings

While he lives in our orbit

There's unexpected joy in ordinary things.

There's a purpose and a promise

Leaning in to our every day

Shy smile with dimples beaming

How can we lose our way?

And the years fly by too quickly

As he hovers expectantly around the nest.

Tomorrow's young manhood awaits

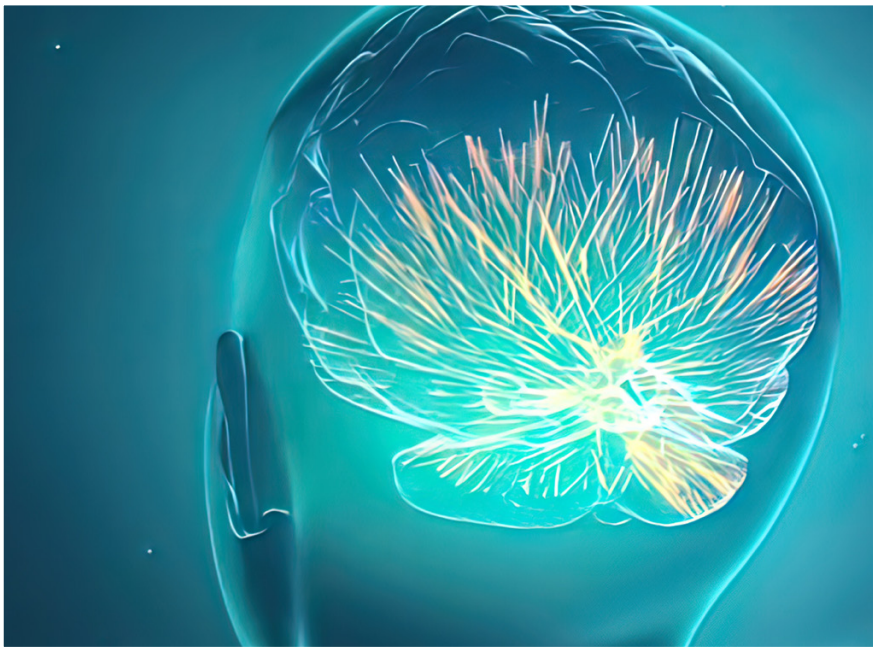
For not just a boy, but one of nature's best.

*THE PROCESS OF FLOWERING OR DEVELOPING RICHLY AND FULLY

Academic/Research Article

An exploration of the role of neuroscience and neuroimaging in the psychodynamic approach

By Dr Marion Mensing



Psychodynamic psychotherapy assumes that much of human experience occurs unconsciously. Could memory reconsolidation provide a key to alleviate unconscious emotional learnings?

Introduction

The important neuroscientific discovery of brain plasticity – the ability of the brain to change with experience not only in childhood and adolescence but all through life – appears highly relevant to psychotherapeutic modelling and methods. Psychodynamic psychotherapy works under the assumptions that much of human experience happens in the unconscious mind and that childhood experiences have a strong impact on how the mind functions.

Therapeutic change focuses on engaging with unconscious processes and enabling the client to move towards change by becoming aware of them (Reeves, 2013). A number of questions present themselves: How can these assumptions be tested in an objective, scientific way?; how do unconscious emotional learnings from childhood experiences reflect in the memory system of the brain?; how does engaging with unconscious processes and helping the client to become aware of them move the client towards change?; what does the experience of a psychotherapeutic encounter involve in order to facilitate lasting change?; and can neuroscience validate any answers in an unbiased way?

This article explores if psychodynamic studies should consider the neuroscience of mind and the technology of neuroimaging and, hence, enrich psychodynamic theory and therapy with biological understanding. Neuroimaging studies may have the potential to become an unbiased and objective research tool for psychotherapeutic models of the mind. A stronger collaboration between neuroscience and psychodynamic psychotherapy could strengthen the relevance of psychodynamic models and methods in the clinical setting towards pharmacology and cognitive psychology. Secondly, underlying brain mechanisms of memory and fear will be examined and, finally, the exploration will concentrate on possible links between psychotherapeutic approaches and a certain suspected form of brain plasticity around memory, called memory reconsolidation.

Potential for joining forces

Pulver (2001) emphasised that neuroscience could not contribute anything to the "various ways in which the analyst attempts to optimise the atmosphere of the relationship to gain as much understanding as possible" (p. 7), but could be beneficial in choosing between competing psychodynamic theories by testing different hypotheses. This could have an impact on the development of psychodynamic theory in the future. Blass & Carmeli (2007) drew attention to a hidden conflict between the neurobiological science of mind and psychodynamic therapy in its essence, arising from the assumption that only biology was real; they feared psychodynamic therapy was about to lose the phenomenological view on subjective meanings. Conceding that mental phenomena had underlying mechanisms in biology, Blass & Carmeli (2007) questioned any benefit of understanding the associated biological processes for psychodynamic theory and practice.

On the contrary, Blass & Carmeli (2007) worried how neuroscientific findings could influence psychodynamic practice negatively – for example, if neuroscience was to find that conscious and unconscious memories were stored in different neural systems, and therefore concluded that unconscious traumatic memories could never become conscious – would psychodynamic therapists consequently give up on searching for traumatic memories?

Beutel & Huber (2008) explored the potential contributions of functional neuroimaging studies to a better understanding of what makes therapy effective. The task design in such neuroimaging studies is of particular importance, as those tasks need to arouse particular emotions or to allow for the examination of specific thought processes (Beutel & Huber, 2008). All of the published neuroimaging studies Beutel & Huber (2008) compiled in their review – except for one case study – had applied brief behavioural therapy and had focussed on a comparison with pharmacological treatment, showing that effective therapy also changed the functioning of the brain. Preliminary data from that one case study and a hitherto unpublished trial indicated tentatively that the same could be a valid assumption for psychodynamic therapy (Beutel & Huber, 2008).

Boeker et al. (2013) connected the individual meaning of a certain picture and the associated subjective affect with a corresponding brain state

However, Boeker & Richter (2008) expressed strong doubt that modelling neuroimaging studies in the same way as before – just by replacing brief behaviour therapy with psychodynamic psychotherapy – would bring any valuable insight for the development of the psychodynamic model. A mere comparison with the symptom reduction of pharmaceutics would not account for the fact that psychodynamic psychotherapy aimed for more than symptom reduction, namely for lasting therapeutic change of the deep underlying issues (Boeker & Richter, 2008).

Unbiased evaluation

Boeker et al. (2013) suggested a new way of modelling neuroimaging studies that would provide an unbiased evaluation of the psychodynamic encounter in its main characteristics, but would also account for the rich psychodynamic examination of subjective experience. According to Boeker et al. (2013), this would require two steps: 1) Systematic evaluation of a patient's subjective experience, leading to unbiased and quantified subjective data; and 2) Studying the neural mechanisms underlying those subjective data through neuroimaging.

To break the first ground, Boeker et al. (2013) developed a new model to examine a specific aspect in psychodynamic therapy for depression, that is, any shifts in the behaviour and feelings towards others. Boeker et al. (2013) transferred a validated self-evaluation questionnaire with 32 rating items around interpersonal behaviour patterns into validated pictures with abstract stick figures that symbolised certain behaviour patterns. During neuroimaging, test persons saw those pictures and had to evaluate on Likert scales how typical they found these illustrations with respect to their own behaviour, and also their level of emotional arousal while watching them (Boeker et al., 2013).

In this neuroimaging experiment, Boeker et al. (2013) connected the individual meaning of a certain picture and the associated subjective affect with a corresponding brain state. It was included in a one-year, large-scale study investigating the efficacy of psychodynamic psychotherapy for depressed patients. For Boeker et al. (2013), it was essential to acknowledge that psychodynamic psychotherapy deals with the person and not with the brain, and hence they warned against attempts "to map the psychodynamic concepts in a one-to-one way with neural activity in particular brain regions or networks and thus strive for what is described by the concept of 'neural correlates'" (p. 9).

Likewise, Beutel & Huber (2008) warned against the isolated use

of so-called brain correlates of mental disorders for diagnostic purposes because there was no evidence that certain brain states were the cause for certain mental phenomena. On the contrary, neuroimaging studies had already shown that voluntary changes of mental attitudes changed the functioning of the brain. "Patients do not seek treatment for changes in blood flow or brain metabolism, but for subjective difficulties, suffering and so forth" (Beutel & Huber, 2008, p. 13). Studies of learning gave some indication of psychotherapy even having the potential to change the structure of the brain (Beutel & Huber, 2008).

Mental training study

In this context, the study of Valk et al. (2017) is worth noting. Valk et al. (2017) conducted a neuroimaging study with 332 healthy adults between 20 and 55 years of age. The participants engaged in nine months' mental training with three different learning modules related to presence, affect and perspective and measured the change in thickness of the outer layer of the brain (cortex) in different areas after each of the three learning modules.

Presence training focussed on mindfulness-based attention towards inner and outer present experience; affect training focussed on compassion, handling of difficult emotions and positive social attitude; and perspective training focussed on meta-cognitive skills and the capacity to observe one's own mental states and the mental states of others, partly based on the psychotherapeutic model of internal family systems therapy (IFST) (Valk et al., 2017).

Three months' presence training resulted in an increased thickness of the most frontal part of the brain in the forehead (anterior prefrontal cortex), correlated with improvement in attention (Valk et al., 2017). Three months' affect training increased the structure in different regions related to regulation of emotion and empathy, correlated with an increase in compassion (Valk et al, 2017). And three months' perspective training increased thickness in lower frontal and in lateral regions, correlated with an enhanced ability to understand others (Valk et al., 2017). In sum, it appears that effective psychotherapy changes both brain functioning and brain structure.

Short-term memory required a change in the strength of the synapse – the communication between two neurons through their communication terminals

(Kandel, 2006)

Brain mechanisms underlying memory and fear

Kandel (2006) discovered the two learning processes of fear-reducing habituation and fear-increasing sensitisation as being fundamental – habituation weakened effective communication between neurons and sensitisation strengthened it. Genetics determined the possible connections between nerve cells, but experience determined the effectiveness of the communication between them (Kandel, 2006).

Kandel (2006) found that short-term memory required a change in the strength of the synapse – the communication between two neurons through their communication terminals. However, long-term memory required structural change, that is the growth of new communication terminals and new synapses and possibly deactivation of some existing terminals. Structural change in long-term memory depended on the production of a certain new protein in the cell – long-term learning through practice or through intensely emotional events 'switched on' certain genes in the cell nucleus that are responsible for the production of proteins that build new synapses (Kandel, 2006). "The fact that a gene must be switched on to form certain long-term memory shows clearly that genes are not simply determinants of behaviour but also responsive to environmental stimulation, such as learning" (Kandel, 2006, p. 276).

The hypothalamus regulates the autonomic nervous system – the automatic control system of vital body functions and their adaption to emotion (Kandel, 2006). The hypothalamus and the autonomic nervous system play a role in unconscious aspects of emotions. The cortex evaluates the conscious aspects and the amygdala has a crucial function in both conscious and unconscious parts of emotions, particularly in fear (Kandel, 2006). The amygdala can store an unconscious long-term memory of a single threat, whereas conscious memory requires the involvement of the hippocampus (Kandel, 2006).

In case of threat, the amygdala may use a slow neural pathway to the cortex for evaluation and modulation, but may also bypass the cortex and directly activate a fast pathway to the autonomic nervous system (Kandel, 2006). Kandel (2006) found a way to diagnose baseline anxiety through functional neuroimaging. After measuring the background anxiety of a group of volunteers through a questionnaire, Kandel (2006) showed them pictures with fearful faces while scanning their brains, so that in one case they could perceive the faces consciously and reflect on them, and in the other

case he presented the faces too rapidly for conscious perception but still as unconsciously perceivable. Kandel (2006) found that unconscious fear lit up a different area of the amygdala than conscious fear; unconscious fear activated the basolateral nucleus and conscious fear the dorsal region.

Another finding was that the lighting up of the basolateral nucleus was directly correlated to the background anxiety of the volunteers, hence, this test could serve as a diagnostic tool and as an outcome measure after therapy (Kandel, 2006).

The questions arise how therapeutic interventions can modify unhelpful and unconscious emotional learnings of the past, and if neuroscience can provide a better understanding of the associated mechanisms.

Processes of change

Ecker et al. (2012) claimed that core processes of change in psychotherapy can be linked to the neurobiological process of memory reconsolidation. The discovery of memory reconsolidation, a hitherto unacknowledged form of brain plasticity, has challenged the traditional view of a century that memories of past experiences always stay original and permanent (Alberini & LeDoux, 2013). However, according to various post-millennial research studies, memory storage is dynamic and established memories can be modified (Alberini & LeDoux, 2013). An animal study with rats showed that the retrieval of fear memories destabilised the memories, and a pharmacologically induced disruption of the subsequent re-stabilisation, called reconsolidation, suspended the learned fear response (Nader et al., 2000).

Schiller et al. (2010) provided evidence in a trial with humans that certain psychological interventions interfered with the reconsolidation of a retrieved fear memory and lastingly updated this memory with fear-eliminating information, if the interventions took place while the retrieved memory was unstable, that is, within the reconsolidation window of about six hours.

Gorman & Roose (2011) drew an analogy between the reconsolidation window and the claim in psychoanalysis that timing is important for effective interpretation

Högberg et al. (2011) suggested a new reconsolidation-informed protocol for trauma psychotherapy – evoking positive emotions first to ensure that the updated memory includes safety, then reactivating the traumatic memory as a sensorimotor experience, and finally imagining a positive modification of the memory. Further, Ecker et al. (2012) promoted imaginary work as effective because for neural networks engaged in emotions, imagined or physical experiences would be largely the same, referring to the observations of Kreiman et al. (2000). Kreiman et al. (2000) had found that 88 per cent of the neurons in the human brain that responded to both vision and imagination did not differentiate between vision and imagination in their responses.

Gorman & Roose (2011) came to the conclusion that contemporary animal studies and neuroimaging studies with humans reflected two core hypotheses of psychodynamic psychotherapy: "1) That early life experiences can have a profound and lifelong influence on human emotion and behaviour; and 2) That unconscious mental processes strongly impact conscious mental processes and awareness" (p. 1201-1202). Hence, Gorman & Roose (2011) found interest in exploring possible links between the neuroscientific discoveries about manipulating the reconsolidation of fear memories on the one hand and some core processes in psychoanalysis on the other hand.

According to Gorman & Roose (2011), psychodynamic psychotherapy was about recovering and rewriting a client's narrative by bringing unconscious self-deceptions into awareness. They suggested to regard this psychoanalytic process as the 'reconsolidation' of an updated narrative. Gorman & Roose (2011) hypothesised similarities: 1) Between the conversion of childhood trauma into unconscious mental processes, and fear-conditioning in a laboratory animal; 2) Between the impact of repressed traumatic memories on behaviour and emotions, and the 'freezing' response of the animal towards the fear stimulus; 3) Between the processes of recovering a client's narrative, and reactivating a fear memory; and 4) Between the process of rewriting a client's narrative, and the updating of former fear memories through memory reconsolidation.

Regarding the seemingly crucial timing requirement for the updating of fear memories, Gorman & Roose (2011) drew an analogy between the reconsolidation window and the claim in psychoanalysis that timing is important for effective interpretation.

A certain unpredictability

Sevenster et al. (2012) discovered that memory retrieval on its own was not sufficient to destabilise fear memory and consequently initiate the reconsolidation process in humans. In fact, it

was necessary for the retrieval situation in their trial to connect a certain unpredictability regarding the outcome with the stimulus of the fear memory, to create a real possibility of the unexpected to happen – a new learning opportunity. Another important finding was that fear-reducing manipulations during memory reconsolidation alleviated the unconscious, automatic fear response of the memory without affecting the conscious, cognitive content of the memory (Sevenster et al., 2012).

In a functional neuroimaging study, Agren et al. (2012) localised a fear memory trace in the basolateral nucleus of the human amygdala and showed that disrupting the reconsolidation of the retrieved fear memory by updating the memory with new unfearful information 10 minutes after memory reactivation completely eliminated the fear component of the memory in the amygdala. Björkstrand et al. (2015) followed up on this study and confirmed that the erasure was still valid after 18 months.

Supposedly based on the neurobiological memory reconsolidation process, Ecker et al. (2012) defined a four-step protocol to create lasting change in psychotherapy for a client's problematic emotional learnings: 1) Trigger the targeted learning; 2) Create an experience that significantly differs from the client's expectations from the learning; 3) Create a new learning within five hours from evoking the old learning that contradicts or modifies the old; and 4) Verify the erasure of the old emotional learning. According to Ecker et al. (2012), erasure entails that former triggers do not reactivate the specific emotional reaction and the connected symptoms have permanently disappeared without requiring any further measures.

However, the existing body of neuroscientific research has not provided undisputed evidence for the existence of the memory reconsolidation update mechanism in humans

Ecker et al. (2012) mentioned some psychotherapy modalities to be inherently coherent with the therapeutic reconsolidation process: accelerated experiential dynamic psychotherapy, coherence therapy, eye movement desensitisation and reprocessing (EMDR), emotion-focused therapy, focussing-oriented psychotherapy, Gestalt therapy, Hakomi therapy, IFST, interpersonal neurobiology, neuro-linguistic programming and traumatic incident reduction.

However, in a more recent study, Klucken et al. (2016) were not able to replicate the previous results of Schiller et al. (2010) and Agren et al. (2012), and found no evidence for fear erasure through updated memory reconsolidation. Elsey et al. (2018) compiled a wide meta-analysis of the existing research around the memory reconsolidation update mechanism. This multitude of studies showed consistent results with the reconsolidation model, but not all of them. The limitations of various studies, the lack of clear criteria and the inconsistent findings that could lead to different explanations prompted Elsey et al. (2018) to suggest clear conditions for all future research around memory reconsolidation, given the importance this research has also for therapeutic approaches.

According to Elsey et al. (2018), the existing body of research has not yet provided clear and consistent evidence for the hypothesised memory reconsolidation update mechanism in humans. However, they also emphasised that this would not deny the clinical usefulness of therapeutic approaches that are based on the hypothesised reconsolidation, because here the only question is if the approaches are effective for patients.

As with any promising new therapeutic intervention, ethical considerations should play a role from the beginning when entering experimental research or clinical practice – especially in connection with the use of pharmacological agents that interrupt memory reconsolidation – to avoid unintended or undesirable collateral changes and to prevent misuse and abuse of memory modifying techniques (Elsey & Kindt, 2016; Hui & Fisher, 2015). Furthermore, therapists that work with memories should be aware of the risks in possibly creating false memories through suggestions or imagination, as explored by Loftus (1997).

Conclusion

The dynamic development in the neuroscience of mind around memory and learning provoked a stronger involvement of psychotherapy in general, fuelled by the discovery that neural circuits can unlearn what they learned before. However, psychodynamic therapists have mixed feelings. Openness for studying the brain mechanisms underlying psychodynamic psychotherapy also faces fears – that neuroscience could restrict psychodynamic practice in its richness; subjective experience could lose its relevance; 'brain correlates' replace the view on the person; and the focus could move from deeper underlying issues to a mere symptom reduction. Neuroimaging studies have already provided evidence that effective

psychotherapy changes the functioning and the structure of the brain.

In general, genetics limit the possible connections between nerve cells, but experience determines the intensity of communication between them. New long-term memory brings along structural change – the growth of new communication terminals in the nerve cells linked to gene activation. The hippocampus is essential for long-term memory; whereas the amygdala stores unconscious memories, in particular those connected to fear. The amygdala can bypass the conscious thinking parts of the brain and communicate directly with the body in a case of threat.

The discovery of the molecular process of memory reconsolidation – although not unequivocally confirmed – was particularly exciting for psychotherapy and some theorists of therapy pushed ahead the implementation of congruent protocols into practice. The idea of having found an evidenced way for eliminating fear in unconscious trauma memories by updating them with non-fearful information a short while after reactivation is captivating.

However, the existing body of neuroscientific research has not provided undisputed evidence for the existence of the memory reconsolidation update mechanism in humans. Nevertheless, psychotherapy does not need to wait and can – with all due caution relating to ethics and risks – focus on clinical evidence for now.

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Practitioner Perspective

Working with gender dysphoria in young people

By Sally O'Reilly

A workshop led by psychotherapist and author Stella O'Malley provided the 'most up-to-date thinking and understanding of how to best support gender-related distress in young people'. One attendee provides their review of the experience

Introduction

"The sharp rise in the number of young people questioning their gender has led to many professionals feeling unskilled in this area. This workshop will provide psychotherapists, counsellors, teachers, nurses and others with the most up-to-date thinking and understanding of how to best support gender-related distress in young people." This was the blurb circulated by Live Life Now, the event organisers who hosted a workshop led by Stella O'Malley, MA, psychotherapist, in Cork on the 26th November 2022.

The audience was comprised primarily, but not exclusively, of therapists with varying degrees of experience and from diverse schools of therapy – an interesting, eclectic mix. There was a certain sense of unease in the room, created by the fact that the original venue, UCC, had changed to an undisclosed new venue two weeks prior to the workshop. We all received an email the day before the event informing us that Hayfield Manor was the new location. It was a small gathering of professionals, with just 40 or so attendees, for three and a half hours. As a graduate of UCC I was disappointed, but also happy that at least the surroundings would be more comfy and the all-important coffee would surely be of better quality!

On a more serious note, and this is why I mention it, the curiosity around the venue change was a notable reflection of the contentiousness of the issues with which we are faced when working with clients who are gender questioning and/or self-identify as transgender. The issue has become increasingly adversarial, divisive, and with strong political and social ramifications. Some of us wondered if there was a political element to the venue change. Or was that paranoia? There is a lot of it about these days. It is easy to feel victimised, particularly when there is 'chat' online urging events – including this one – to be cancelled, and lists of attendees are sought. To what end we don't know, but it was not a warm, comfy, inclusive feeling, that's for sure.

The thing is, one needs to be on Twitter or Reddit to be fully cognisant of the division, anger and aggression out there when it comes to any discussion of 'The Trans Issue'. And while I applaud and indeed encourage frequent social media holidays or, indeed, abstinence, the result of not engaging in social media is that one is not privy to the social discourse that is influencing and, in some cases, overtaking the lives of many of our clients. As for professionals, it makes open discussion about working with gender-questioning minors difficult in a way that is unprecedented.

A new language

We live in a world with a growing and new lexicon. Words and phrases like cisgender (cis), cancel culture, ROGD, LGBTQI+ versus LGB, gender critical, non-binary, gender fluid, AFAB, AMAB, de-trans, desisting, pronouns, affirmation care, mis-gendering, dead-naming, exploratory therapy (isn't it all exploratory?), are part of the new common parlance. A new language has emerged and this language can be confusing for those not living in or familiar with the (virtual) reality of online life.

Those of us who work with children, teenagers and young adults know well that this is where *a lot* of time is spent. This world feels utterly real to many young people. For many, particularly those who have difficulty connecting socially IRL (in real life) it was their sole point of social contact during the darkest days of COVID-19. It was, and is, where they meet, discuss, find connection, acceptance and approval. Bread and butter stuff for all of us, but especially so for teenagers.

The threat of 'cancellation' is now so strong that people can and

Stella O'Malley

do feel misunderstood, silenced and bullied. Terms like conversion therapy are misused, sexuality and gender are incorrectly conflated and in the midst of all this confusion we – the therapists – are holding spaces with clients, while at times feeling utterly bamboozled ourselves. It is a difficult space for us to inhabit. Many of us simply avoid the conversation, perhaps even hoping it will all go away. It does not appear to be going anywhere for a while yet. It may never. What does this mean for the work we do as therapists? How can we continue to work ethically in such an evolving and changing social landscape?

How can we feel competent?

It is my curiosity about these questions and my passion for working with young people that prompted me to attend this workshop. I had my first trans-identifying client back in 2016. I had no idea at the time what trans identifying even meant, what binders were (an elasticated garment to flatten and compress breast tissue), or how big the market for them would become. Despite my 20 years' experience working with teenagers, I felt suddenly unskilled and lacking in knowledge. There were new words, new ideas and what seemed like the beginning of a new social contagion – although I did not have the language for that either at that time. Reviewing my old notes recently I can see how troubled I was: eager to affirm my client, to not pathologise, to support her but also to support her relationship with her parents, which was fast deteriorating. Was binding a form of self-harm? What did we know about the effects? (not much at the time). What did we know about the process of transition? (again not much). What lay ahead for this client if she proceeded? Why did she suddenly not want to be a woman?

I saw the traits that I would later recognise as neurodivergent. I heard a history of trauma. These were all elements of what was emerging as a pattern for therapists all over the world, but we were as yet to connect the dots and, as yet, to connect with each other. It was a pattern I was soon to observe in my own practice – I was seeing common trajectories, common histories and common 'scripts'. I had no idea what was ahead.

Two years later Stella O'Malley made the film *Trans Kids;* later books like *Trans*, and *Irreversible Damage* were written. The new transgender 'movement' was ushered forth and it feels like so much has changed. Diversity is king. And yet we seem to have narrowed rather than widened our collective focus and sense of inclusivity.

In the meantime, what was happening to our vulnerable young clients and their parents? If we are to not panic and feel unskilled, how can we best support them without changing how we work, while staying faithful to our core beliefs

about what therapy is, irrespective of our training and background?

I can summarise in a few simple sentences how this workshop provided the answers to those questions. Stella took care to reassure us that there is nothing different we need to do with gender-questioning teenagers and clients. We simply continue to do the work of therapy. What we *would* benefit from is doing some homework – learn the new language. And as she said, that can be done in about 30 minutes, otherwise, pretty much keep doing what you are doing, folks.

The psychoeducation part

Stella began by taking us through some definitions to form the backdrop and give context to the meat of the workshop. Words and phrases like those I mentioned above were listed and explained. We were encouraged to think about gender, stereotypes and the evolution of diagnostic criteria according to the *DSM* for gender dysphoria, which was also defined for us. And while, as therapists, we are not in the business of diagnosis, this evolution is fascinating, useful and worth knowing for many reasons. But for me, one of the most salient reasons is that in this era of labels and self-diagnosing, teenagers are coming to us fully attached to and engaged with their own diagnosis from Dr Google and his colleagues Drs Twitter, Reddit and TikTok.

Our clients, she said, feel fully informed, but they are not. I have seen this too. A little exploration in the therapy room and the confusion becomes apparent. I recall asking a 14-year-old: "how can one be both non-binary and trans? Is the latter not dependent on the existence of a binary? How can we both 'smash a binary' and affirm a male or female gender identity?"

I wondered how this was settling on person-centred therapists and those among us who were unaccustomed to offering feedback

This mess of contradictions and dissonance is not new to those of us who work with teenagers. It is useful and can be used creatively to encourage the young person to explore and expand their own thoughts. Teenagers like to think critically, despite the oft-voiced assertion that they are incapable of doing so. They are in a sea of information and misinformation and are, as a result, often misinformed, or at best under-informed.

Listening to Stella I was reminded of the responsibility we have to our clients to be as informed as possible, and to engage critically with any information we might receive and encourage them to do the same, *if and when* that comes into the room. That point was also repeated – we are not to drive any agenda, but rather assist the exploration and facilitate our young clients in safely forming their own opinions.

How reliable are our own sources? What biasses might we ourselves have? We were prompted by the use of images and photographs from Stella's own collection to ponder these thoughts. We know that today's teenagers more than any other generation are bombarded by imagery and memes. We did not have to contend with this. It is dizzying when you think about it – and I like that we are prompted to think about it.

Gender identity theory

Next we dug a little deeper into gender identity theory as a way of formulating thoughts on what leads to gender dysphoria. We took a brief look at the biological model for gender dysphoria – a developmental model that theorises gender dysphoria as a maladaptive life strategy that can develop during the process of identity formation. We also looked at the biopsychosocial model, which views gender dysphoria as a result of a combination of factors. Of note, everything was referenced and evidence-based. It was clear that Stella is not sharing her opinion with us – she is imparting information, illustrating some points with examples from her practice and inviting our own thoughts and questions throughout. One of the things I appreciated was that disagreeing or challenging comments was not merely invited, but encouraged. While there were none, there was a sense of permission, for me at least, to challenge or disagree on all points.

The practice part

Where this all brought us was our options in the therapy room. It was outlined that the person with gender dysphoria is left with three clear(ish) paths:

- The individual's sense of gender can be altered to align with their biological body;
- The individual's ability to cope with and manage their distress can be improved with a range of different psychological approaches; and
- The individual's body can be altered to align with their sense of gender (Stella O'Malley, 2022).

Each of these paths brings with it its own challenges and the latter, of course, brings a

heavy medical burden that will inevitably be lifelong. The issue of informed consent arose at this point and Stella facilitated our thoughts around what that means. The professional onus on us to engage in informed consent was floated – the consequent implication being that we need to be informed ourselves. What are the consequences of social transition, the side effects of hormone treatments, of surgery? How does testosterone affect the biologically female body? I think I can safely assume that none of the attendees had covered modules about transition and medical and psychosocial effects of same.

Next it was time to engage in some self-directed learning, and the responsibility to do so weighed heavily during this workshop, but not in an overwhelming way. I wondered how this was settling on person-centred therapists and those among us who were unaccustomed to offering feedback; there simply wasn't time to look at that – one of my few disappointments.

Before proceeding to have a look at what each option involves, Stella took care to address the issue of conversion 'therapy' as it applied to homosexuality and as it might apply to transgender clients. As an audience, we were left in no doubt as to her thoughts and feelings about the cruel and outdated practice. She is of the opinion that conversion therapy is in itself an oxymoron, preferring instead, as many of us do, to use the phrase 'conversion practices'.

Stella referenced the results of the most recent report on conversion "therapy", Minister O'Gorman's 2021 *LGBTI+ Youth in Ireland Europe: A two-phased Landscape and Research Gap Analysis*. The research reviewed all relevant research on LGBT+ youth defined as under the age of 26) in Ireland and Europe between 2000 and Sept 2019. Happily, the review found no examples of conversion therapies in sexual and gender minority (SGM) youth in the literature since 2000 in Ireland or in Europe.

> *We don't live and practise in the US where this is a far more urgent and contentious matter as minors in some states can legally access medicalisation, including surgery*

Throughout, Stella took care to clarify that we are not in the business of pushing our agenda on our clients. It's therapy 101, really – for example, would we assume that an unhappy spouse should leave their relationship? Or might we be more inclined to explore our client's relationship, the historical context, the family of origin? We would surely think of words like systems, constellations, patterns, dynamics, habits, adaptive and maladaptive, meaning, metaphor, repression and emotion. Our job is not to have a private agenda and to push it onto our clients and then deem them 'cured' or doing 'the right thing'. That is unethical practice. In the same way, there are issues to consider when working with trans-identified clients.

Stella introduced us to and summarised the most recent research around the new cohort of gender dysphoric youths, in particular. There has been a 4,000% increase in presentations to the now defunct Tavistock Gender Identity Disorder (GIDs) Clinic in the UK, which worked with clients from both the UK and Ireland. In Ireland we have a 4,000% increase in Irish female under-18 presentations and 65% to 90% of these have an autism diagnosis. There followed a well-referenced section on the historic development of gender dysphoria as contrasted with what we are witnessing today. We were then introduced to a brief but lively discussion of peoples' experiences with their own clients with autism and gender dysphoria.

An example that came to my mind was an experience I had with a client who is on the autistic spectrum and who said to me that she had decided that she would go ahead with "top surgery" once she turned 18 and started identifying as a man. Top surgery is common Internet parlance for double mastectomy – it sounds far less scary doesn't it? "As you know, Sally" she said with confidence, "my boobs will grow back if I change my mind later". This might sound shocking to you – to think that an intelligent teenager might believe this, but there are two things to consider: she had watched hours of TikTok videos telling her that breasts grow back and/or are easy to replace; and she is a literal thinker – meaning, if she identifies as a woman later in life, her breasts will grow back *because she will be a woman again*.

Stella gave other examples of how the cohort of clients can think with her own experiences, which is always helpful during a workshop like this. I could see in the room that some were reeling, but appreciating that education is essential here. In other words, when it comes to informed consent, we *might* be among the few evidence-based informers in the child's life. We don't live and practise in the US where this is a far more urgent and contentious matter as minors in some states

can legally access medicalisation, including surgery. In Ireland, gender dysphoric minors do not receive surgical intervention. Again, I wondered how this sat with others in the room? I wondered what exactly is the nature of the differences between gender dysphoric children, adolescents and adults with regard to medical treatment and access to same? I was saddened that we simply did not have time to discuss these questions, however, the references provided did lead me to answers to these complex questions later.

Rapid Onset Gender Dysphoria (ROGD), a phrase coined by Lisa Littman, was described and contrasted to the historical presentation in a way that illustrated clearly and in an evidence-based manner that what we are dealing with today is a new phenomenon. Other presenting issues such as body dysmorphia, transgender obsessive-compulsive disorder (OCD) and distorted body image were outlined, as well as their similarities with previous surges in presentations of anorexia, bulimia, and self-harming. Quite a few of us were 'long in the tooth' and remembered these clusters of behaviours appearing. We were gently walked through an array of presenting 'co-morbidities' (please forgive the phrase co-morbidities; I'm aware of the label, however, much of the language does originate in the world of psychiatry and the much lauded *DSM*) – autism being the most salient within this current cohort.

In the third and final section of the workshop, Stella spoke about the options for working therapeutically with this client population. Again, taking care to reference and emphasise 'back to basics' therapy that she spoke about earlier that morning. The three basic options for therapists pared down are:

- Gender identity affirmation: Encouraging the child to live in the gender that feels most comfortable right now, with or without medical intervention;
- The psychotherapeutic approach: Exploring the child's understanding of gender roles and self-acceptance; and
- Watchful waiting: Allowing time to pass before medical intervention or therapy is used.

There was a strong sense throughout of 'you've got this'; that, as experienced practitioners who already work with adolescents, much of the work of therapy is what it always was

Core principles

The workshop was for psychotherapists and so the psychotherapeutic approach was looked at as an alternative to the affirmation model – remembering that alternative is not conversion. Stella reiterated that regardless of our core training, we can assume that the following are core principles that we hold dear and are essential to ethical practice. They are and must remain:

- Compassion;
- Patience;
- Respect of the adolescent's defences;
- Awareness of the propensity to 'relapse'; awareness of the adolescents' vulnerability to social contagion;
- Awareness of developmental stages; and
- Awareness of up-to-date research. On this point, true suicide risk was outlined and again heavily referenced. There is much of panic and understandable fear around inflated and or misinterpreted statistical analyses out there. Again, I am reminded of how much we can miss if we do not keep ourselves informed. And difficult it can be to keep ourselves informed. If it is hard for us to trust sources, how daunting must it feel for our young clients and their parents?

There was a strong sense throughout of 'you've got this'; that, as experienced practitioners who already work with adolescents, much of the work of therapy is what it always was. However, there *is* an onus to educate ourselves in the language of gender – not just to illustrate to our client that we know what they are talking about, but that *we know*, as best we can, what we are talking about. To help allay that sense of flounder that so many of us feel in this new landscape of gender dysphoria and the rather vicious and, for some, genuinely frightening social backdrop against which it stands.

The final section of the workshop looked at de-transitioning and working with de-transitioners. This is a term used to describe those who socially and or medically transition, but then decide to reverse that decision. This growing cohort requires the same level of support, of course – and we were alerted with some case studies – to the fact that often the social rejection these people experience

as a result of changing their identities back can be excruciating. It was a profoundly moving and sad section of the workshop.

As a supervisor I am aware that many therapists are quite anxious around, or avoid completely, taking referrals of gender dysphoric, transgender or de-transitioning clients. A lot of that is driven by the toxic online environment where it has become quite contentious to align oneself with anything other than the affirmative model. Our collective sense of competence has been eroded, but perhaps this is an opportunity to look at what therapy is, and what it is not.

Collective responsibility

The discussion really brought home to me our collective responsibility and was an opportunity to look at our work as therapists: how we do it, and why we do it. We need to safeguard our profession, for example, from cries of 'conversion therapy'. The wording of the proposed bill to ban conversion therapy is an example of how we need to be clear on what we do. You may not be aware that in its current form the bill could criminalise any therapy that is not affirmative. This is deeply concerning. As therapists it is not our role to affirm or whatever the opposite of affirm is. There were many concerned conversations during the break about this very matter. I could certainly feel a sense of release as people spoke about these concerns openly with colleagues and, possibly, for the first time.

It is vital that we are protected by law and are allowed to work ethically with and support this vulnerable cohort in their decision to *either* transition or desist. We are told desistence figures for childhood onset gender dysphoria are quite high, with estimates running from 70% to 94%, depending on the study and severity of dysphoria. So for many, it seems, it resolves naturally during puberty or early adulthood. Again this was referenced for us. Therapy is exploration, not conversion, not coercion of any kind. This was oft and reassuringly repeated.

There are various trainings and seminars where information is being shared that is unhelpful and inaccurate. We were frequently encouraged to research ourselves after the workshop, and to source reputable academic studies with peer-reviewed and up-to-date research

We were also reminded in this workshop – or for some of us it new information – of the power of social contagion for adults. There are various trainings and seminars where information is being shared that is unhelpful and inaccurate. We were frequently encouraged to research ourselves after the workshop, and to source reputable academic studies with peer-reviewed and up-to-date research. The landscape is fast changing and more research is coming out all the time. In some ways, these are exciting times. In other ways, quite unnerving.

Stella finished up the morning by speaking about some of the various organisations that have come into being recently, including Genspect, GETA, and PITTs. Stats for Gender.org was a site she recommended for accessing studies on the subject. I am sure that if we had more time it would have been used enthusiastically. I wondered if there were other organisations to mention that might also be helpful or interesting to explore? There is so much more to learn, more case studies to share, more research to dig into, more questions to ask and answer or simply explore. We were a room full of curious listeners and I for one could have done with more, but this is not a complaint. I found the workshop valuable and enjoyable. Stella's presentation was clear, well-paced, moving and sometimes even entertaining. If there is a repeat workshop, I am happy to recommend.

The bottom line – psychotherapy is not conversion therapy and we know how to 'do' psychotherapy. We simply need to do some homework. Maybe a lot.

If your interest is piqued and you would like a full list of the workshop references, I can be contacted via the details below.

Sally O'Reilly

Sally O'Reilly is a counselling psychologist, psychotherapist and supervisor and holds a BA (Psych), a MA CounsPsych, and the European Certificate of Psychotherapy. She also holds a Diploma in Integrative Supervision, a Diploma in Cyber Therapy, as well as a Practitioner's Certificate in EMDR from MTU. Sally is an accredited IAHIP therapist and supervisor and is a member of the British Person-Centred Association. She lives in Cork and works full-time in private practice and has a special interest in adolescence.

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