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Embracing the unknown

- The complexities of therapists communicating 'no'
- The 'Energy Therapy Technique' and Irish Celtic Shamanism
- The unfolding narrative from Covid-19
- Managing mental health in second level education

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Contents

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From the Editor:

Dear Colleagues,

Welcome to your Summer 2022 issue of the *Irish Journal of Counselling and Psychotherapy*. The theme for this issue is Embracing the Unknown.

Globally, we've had a bit of a crash course in what the poet Keats called 'negative capability' these past few years. However personal or distant the impact, we've all had to deal with the consequences of the unfolding pandemic.

As therapists and supervisors (and humans), we know that the more we can not only learn to live with but embrace the unknown, the easier it is to flow with life.

With that in mind, our first offering to help us work with the unkNOwn is **A supervisor reflects on the complexities of therapists communicating 'no'**. Emma Redfern encourages us to strengthen our 'no' muscles by exploring the benefits she has experienced from therapists and supervisors saying 'no' to her as well as her own learning edges around 'yes' and 'no'. Even though we probably all have plenty of experience of working with clients and supervisees, helping them set healthier boundaries, I found it to be a reassuring read as I still (after decades of progress not perfection) find it much easier to support others' boundaries than to affirm my own. Even so, it definitely gets easier.

Then we have **The 'Energy Therapy Technique' arising from Irish Celtic Shamanism, enabling spiritual expression in the counselling/psychotherapeutic relationship.** Karen Ward remembers dealing with the unknown as she integrated and developed her unique blend of psychotherapy and supervision with energy work. Awed by the power of Ireland's landscape, her Energy Therapy Technique helps clients and supervisees as well as others she works with to connect with their own power and capacities for healing and transformation.

The third article is from Breda Friel and Jonathan Beavis, **The unfolding narrative from Covid-19: emerging themes and skills in practice**. They explore the traumatic impact of Covid-19 as so many have dealt with the unknowns.

The fourth piece is **Guidance/ Counselling: Managing mental health in second level education**. Róisín Traynor examines some of the ways in which guidance counsellors have to deal with so much of the unknown as they attempt to hold space while also accessing whatever additional support is available for the teenagers in their care.

One of the saddest things we can ever experience, and never fully understand, is the death of a loved one by suicide. In this issue, Alan Kavanagh reviews Francis McGivern's *Life After a Partner's Suicide Attempt*.

And we continue the poetry section, Florescence with more IACP members' offerings.

I'd like to thank the whole IJCP Editorial Committee for their support as I stepped into the unknown to edit my first issue. Sending special thanks to Annette, Terry, Mike, Kaylene and Hugh – I couldn't have done it without you.

We are listening to member feedback and the desire to see more reflective pieces published so I would like to encourage you to think about what YOU would like to see in future issues. Please check out the Submission Guidelines from the website and consider submitting a piece on an aspect of our profession you are passionate about.

Wishing you a delightful summer as you potentially expand your comfort zones and work with your edges as you (if you choose to) embrace the unknown in different areas of your own life and practice.

Eve Menezes Cunningham, Editor

Reflective Article

A supervisor reflects on the complexities of therapists communicating 'no'

By Emma Redfern

In a world perpetually at war, with the human population and mindset ravaging the planet's resources, new viruses endangering the vulnerable, and inequity and injustice flourishing, boundaries of every kind seem more important than ever. As therapists and supervisors, it is important we do our inner work and use our reflective abilities to access, and choose appropriately, both 'no' and 'yes'. To do so involves welcoming discomfort and challenge. Vulnerability and courage are needed to exercise choice while living (and dying) in this complex, endangered outer world while leading the multitudes within, or 'parts' as Internal Family Systems therapy calls them.

Introduction

As a supervisor, working throughout the global pandemic, I have noticed more than ever the struggles therapists have in flexing their 'no muscles'. Using case examples, I advocate for mental healthcare professionals reflecting upon and embracing their ability to communicate no to their clients, supervisees, themselves, colleagues, and organizations. I also include reference to my own evolution as I have related to the concept and practice of finding my own 'no muscles' and receiving my therapists' 'no's. I refer to some of the unconscious and systemic processes that can influence a therapist's ability to not say 'yes'. Some words in the article are italicized to signpost for the reader that they feature in the BACP Ethical Framework; 'no' and 'yes' are highly emotive and power-laden tools and need to be handled with sensitivity and ethical awareness. I begin with reference to the myriad ways 'no' might be communicated in therapy.

Ways to communicate 'no'

The ability to say no is often very contextualized and can be expressed in some relationships with more ease than in others. Certainly, it can be a complex endeavour, not least because humans contain multitudes and can experience inner conflict. We can communicate more than one message at once. Saying 'no' to someone else is often saying 'yes' to ourselves. In therapy, 'no' can be signaled or perceived in:

- Purposefully holding a silence
- Offering a different perspective
- Changing the subject and ignoring what the other has said
- Saying 'no' without thinking and later reflecting 'I should have expanded on that'
- Stating 'yes' while simultaneously thinking and communicating 'I don't agree with you but …'
- Shaking the or moving the head (which in some South Asian cultures, suggests agreement or understanding')
- Lowering the gaze
- Sharp intake of breath, or holding the breath
- Missing payments, sessions, or frequent rescheduling; and more.

Factors that affect a therapist's ability to say 'no'

How many of us experienced secure attachment, learnt how to set clear boundaries, and say 'no' and 'yes' appropriately? Certainly not me. In my childhood in the '60s and '70s, only adults seemed allowed to communicate 'no'. They used it as a blunt instrument of social control. I kept well below the radar to avoid 'no' being shot my way and I wanted nothing to do with that sort of control and power over another. In addition, the only 'no' I was able to use internally to regulate myself was dissociation, I had developed no other way.

Also relevant in my case, the direct and intergenerational experience of trauma influences an individual's ability to communicate 'no'. By its very nature, the victim of trauma is powerless to say 'no' to the abuser, torturer, neglectful or punitive parent/ authority figure, or event. Reynolds (2022) highlights that offspring of prisoners of war suffer intergenerational trauma, as do Holocaust families; I believe trauma from any source can be transmitted intergenerationally. So powerful and implicit are the previous generation's experiences that the next generation is powerless to say no to them and their effects without therapeutic and focused assistance. Many of us are wounded healer therapists, and working through the trauma in our systems is crucial to ethical and effective practice as unresolved trauma can block healthy access to one's inner world and often leaks out in damaging way (Reynolds, 2022). Yet, it can be tempting, perhaps, to say no to deep inner work as sufferers of trauma are often able to avoid their emotional pain and continue functioning (in IFS terms, protectors keep wounded parts exiled at great cost, Schwartz and Sweezy, 2020).

I see this in therapy training in England and online where there is an 'all welcome' approach with little assessment of which applicants to accept onto the course and which to turn down

Racial inequity and injustice also significantly affect the power to communicate 'yes' and 'no', both of which are often more easily wielded by white males against those less privileged. Rajeshwar, self-described (2022, p.45) as a "second-generation, South Indian, person-centred supervisor" writes of supervision with a white, trainee therapist who seemed not to *value diversity* but rather to reduce her own fears by dismissing her potential client's differences: "She's from Pakistan or Nigeria maybe. … It's fine. She's just a person." At the time, Rajeshwar responds "[Pause] OK, I see. [Silence]" (2022, p.43). Rajeshwar shares her process of reflecting on cross-cultural congruence, recognising her acculturated conditions of worth and the shaping of her *values* and beliefs by the first-generation South Indian immigrant diaspora. She comes to a more meaningful, detailed response to the supervisee through realizing she had colluded with their "'treating everyone as equal' approach" (2022, p.44) How many of us have not at some point colluded with a client, therapist, supervisee or supervisor, later working out what we would like to have said or done differently, that we might be more prepared next time to choose our no rather than respond automatically from conditioning and fear?

I believe there is also a therapy culture in which 'no' is under-used. I see this in therapy training in England and online where there is an 'all welcome' approach with little assessment of which applicants to accept onto the course and which to turn down. The training ends with little assessment (self, peer, or otherwise) of competency and everyone becomes qualified. Saying 'yes' to a drive to get 'bums on seats' overrides possibilities of 'no'. Similarly, emails flood my inbox cajoling me to say 'yes' to yet another 'must-have' so-called training (which these days often equates to listening to experts being interviewed on a topic); enticing me to say 'no' to my own inner resources and sufficiency.

On the other hand, due in part to problems of supply and demand, organizations such as the NHS in England, who are tasked with providing mental health services, often have to say 'no' in ways that seem anti-therapeutic, like

communicating that a potential client's symptoms aren't severe enough to get on a waiting list. Staff are told not to extend pieces of work to shorten waiting lists. Meanwhile, it seems staff feel their sole means of saying 'no' is to leave through sickness, absence or by seeking employment elsewhere.

Positive experiences as client of receiving my therapists' 'no'

What can be done to counter some of the above influences? For me, therapy has been a place to learn about and develop healthy boundaries and embrace the nuanced concept and practice of saying 'no'. Over 22 years (on and off) of therapy, my therapists have actively modelled saying this to me and helped facilitate me saying it in multiple ways, both intrapersonally and interpersonally, inside and outside the therapy room.

My first therapy experience was in-patient group therapy for PTSD and the initial exercise involved me being led blindfold around an (imaginary) obstacle course by another member of the group. As requested, beforehand I chose who I wanted to assist me and went outside the room while things were set up. I then came in to find another member of the group facilitating me. Later one of the two therapists asked how it was for me not to get the helper I had requested. Wow! An authority figure had allowed me to choose, then chosen to say 'no' to my choice and asked for the impact of that on me – I could trust these people, I could say 'yes' to learning and receiving from them! This therapist's 'no' was not attacking, it came alongside help, and we could be curious, together, about its impact on me.

Years later, in individual therapy, doing a creative exercise and voicing feeling unlovable, another 'no' was gifted to me (as in 'I don't agree with you'). My therapist responded, "How would it be, Emma, if it was that your mother struggled to love you, not that you are unlovable?" Later again, having therapy with a male psychotherapist, I shared with him my first dream of the therapy adding, "It's all about sex" then stumbled awkwardly to a halt. He declared with humour and generosity, "I like you, Emma, and you can like me if you want to, and no we are never going to have sex." Another, wow of a 'No' Like him and trust him I did, and I learned a lot about the concept of 'No' by saying a wholehearted 'Yes' to that long-term therapeutic relationship.

This therapist's 'no' was not attacking, it came alongside help, and we could be curious, together, about its impact on me

I view the first example, from group therapy, as an invitation to self-reflection, especially on power dynamics. The second communicates a significant reframe from a place of difference. The third lays down a clear ethical *boundary* for my well-being. Each 'no' was potentially risky for the individual therapist daring to offer it, especially if their attunement had been slightly off. All three individuals referred to above were senior clinicians and highly experienced. Each 'no' increased my trust in the person offering it.

Post pandemic - an IFS supervisee and I explore her potential 'no' to clients

My experience with no continued with my supervision training – where we were taught how to give feedback – and supervision practice. Now, two years on from the start of the global pandemic, I notice that as therapists have been negotiating in-person, hybrid, or wholly online working, they have been availing themselves of the opportunity to explore their relationship to 'no' in supervision.

Using anonymized real-life case study material drawn from multiple supervisory relationships, two case examples follow. In the first example a therapist brings her inner conflict around saying 'no' in the form of changing existing therapy relationships. Tonya tells me, "I'm bringing my work with a few female clients I've been working with long-term. We stopped seeing each other during the pandemic and I've now completed Level 1 Internal Family Systems therapy training and want to start offering IFS. I know some of them won't be up for that. They will want to resume from where we left off. That feels to me like wearing old clothes that don't fit anymore".

It was important we make space in supervision to hear from Tonya's inner voices or parts (each sentence represents one voice):

"I want to be there for my clients in the way they want me to be"

"Afterwards, I feel like I've betrayed who I am as a therapist"

"I'm all she's got, she's alone in the world I can't stop working with her"

"I want to end it without her feeling rejected"

"I'm afraid she might harm herself if we stop working together"

"It's too difficult, I'll just keep working with them until they decide to stop"

We will return to Tonya later.

Possible processes involved in the inner conflict

- Drama Triangle dynamics may be in play in which therapists take on the Victim role and feel trapped. Parts of us may fear becoming the Persecutor ("You're abandoning me") and want to Rescue ("I'm all she has").

- There may be a process of 'demonization' occurring which is commonly used to get out of a relationship 'righteously'. If we can convince ourselves that the other is 'the worst client (or therapist or supervisor, etc.) ever' who is 'never going to get it/me/the problem', then we can justify bailing on the relationship.

- Also, subconsciously in play may be 'The Myth of the Ideal Therapist (or Ideal Therapy)' who is everything to everyone, only ever says 'yes' to the client and has no needs of their own. When a therapist unconsciously operates out of such a drive, when things don't work out or the therapist reaches burnout, an opposing drive can come forward to call the shots. Unfortunately, if social media is to be believed, this has been happening lately with clients posting being dropped suddenly by therapists. Supervisees report clients who feel traumatized by having been dropped by a previous therapist.

A supervisor communicates and teaches 'no'

Various life events, including personal health challenges, the pressures and opportunities of the pandemic have led to me choosing to flex my 'No muscle' more and more. These experiences have felt empowering and valid, *and* at times involved discomfort and upset for me and for others. I believe in modelling. If I can't risk saying 'No' then how can I expect supervisees to say it for themselves and to help clients to embrace this *human right*. (Also, if I cannot choose 'no' can my 'yes' be wholehearted?)

Another aspect of assessment in which therapists (novice and more experienced) struggle to consider saying 'no' is in therapeutic contracting

Some therapists offer free or reduced rate 'meet and greet' sessions to showcase who they are, what they offer and explore if the client wants to work with them. Later, encountering difficulties, therapists may bring the relationship to supervision. The beginning to a longer conversation might be:

"And you decided you wanted to work with them?"

"How do you mean?"

"Well, I'm aware you offer a free initial session and I wondered if you use that session to consider whether you want to work with a client and whether you are likely to be or become a 'good fit' or not?"

"Oh. No, I hadn't thought of that. It's just for them to meet me and feel comfortable with me before we begin."

To me, this doesn't *appreciate the variety of human experience and culture.* It doesn't take professional responsibility for really seeing who is coming for therapy and assessing whether the therapist can forge a sound therapeutic relationship with this unique individual in their context and circumstances. I wonder how therapists espouse the principle of *autonomy: respect for the client's right to be self-governing* when as therapists we seem to fail to respect our own right to self-governance. This includes accessing aware choice in relation to who we will or won't work with, rather than following an internalized bias to say 'yes' to whoever asks us.

Another aspect of assessment in which therapists (novice and more experienced) struggle to consider saying 'no' is in therapeutic contracting. Here is a fictionalized excerpt from an Internal Family Systems supervision session:

"What's your contract with this client?"

"Good question. I'll just have to look back through my notes … To stop their intrusive thoughts."

(Pausing for more that doesn't come.) "And you agreed to this?"

"Yes, we've been working for months with that part."

"Does this seem like a sound IFS contract to you from here, now?"

"Hmm, I'm guessing not. I'm used to agreeing to what the client brings to work on."

"Sure, and I wonder how the part or parts with the 'identified problem behaviour' feel at you and the client forging an alliance to get them to stop what they're doing."

"So, should I have said 'No,' to what they wanted to work on?"

"Possibly, although I'm not trying to tell you what to do. I am sharing my experience that

thinking systemically is important in therapeutic contracting. As is distinguishing between more transformative types of therapy such as constraint-releasing IFS, and other forms of therapy (such as cognitive behavioural) which are perhaps more counteractive (Ecker, 2012).

"I do feel under pressure when I take on a client to agree something and just crack on."

"Yes, I can understand that. It's easy for parts to bring a 'Yes, of course' mindset when we first meet a client. Yet, if we are being trustworthy, we bring all our skills and Self-leadership to bear at this important stage of the relationship. We bring our discernment and skills of differentiation so we can dialogue sufficiently inside and out and negotiate a sound contract to which both systems can give informed consent."

What is needed?

In negotiating 'yes' and 'no', I believe we all need to reflect on our practice, the ability to tolerate distress in oneself and others, and the willingness to have difficult conversations. Let's return to Tonya from earlier. A therapist terminating a relationship abruptly to end their own inner conflict out of fear is not showing necessary *care* and *diligence*. This needs to be weighted alongside lack of *care* through continuing to work with someone when constantly feeling out of one's depth, resentful or irritated towards a client.

Tonya showed *courage, humility* and *integrity* and brought her concerns to supervision. Together we worked with some of her wounding. She gained space to listen to the different inner voices, enabling her to act from a place of *wisdom* and perspective, carefully approaching each client to say she wanted to continue her *contract of care* but in a different way. She has shown *empathy*, *resilience*, and *respect* for her clients as they have responded in different ways to her communications. Some have voiced anger, loss, grief and a preference for the old relationship. Some have felt abandoned and some chose to end the relationship.

It seems timely to me now to reflect on my ability to say 'no' to myself and to others and to encourage others to do likewise

Together each dyad is learning to tolerate interpersonal discomfort, shared vulnerability, and *candor*, take risks, and collaborate on a journey of (mutual) healing which preferences the s/Self-healing of the client. As Tonya and I have shown, *breaks and endings*, and changes to the *contract*, need careful communication and planning, especially if initiated by the person with more *power*, the therapist (or by the supervisor in a supervisory relationship). Ideally the end is raised in the beginning during contracting. This might include referring to a professional will in case the therapist becomes incapacitated for a time or dies in service. As a supervisor, I recall saying to someone in our first session together, "This isn't a forever relationship. It will end at some point." Somehow, this brought feelings of freedom for both of us.

Matters of life and death

In view of a recent revelation of the British Government's double standards in saying 'no' to ordinary people congregating during lockdowns while themselves not abiding by those rules, it seems timely to me now to reflect on my ability to say 'no' to myself and to others and to encourage others to do likewise. In recent years, matters of 'no' have more noticeably taken on life and death proportions, as they are elsewhere in the world, Ukraine for example, where its people are publicly and in myriad ways declaring 'no' to war and occupation.

Emma Redfern

Emma Redfern (BACP Senior Accredited psychotherapist and supervisor) is a certified Internal Family Systems therapist and approved IFS clinical consultant in private practice working online from Devon, UK. Having described herself as a talking therapist (Humanistic Integrative), and trauma therapist (EMDR), she now positions herself as an IFS professional. The lenses through which she looks include: white, straight, cisgender female, first generation university educated, English speaking, spiritual, with a significant trauma history and less able-bodied than she looks. She has edited the multi-author title Internal Family Systems Therapy: Supervision and Consultation (July 2022, Routledge). Emma can be contacted by email via her website www.emmaredfern.co.uk

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Academic Paper

The 'Energy Therapy Technique' arising from Irish Celtic Shamanism,

Enabling spiritual expression in the counselling/psychotherapeutic relationship

By Dr Karen Ward MIACP

Shamanic energetic/spiritual techniques increasingly are married with humanistic approaches to counselling and psychotherapy that empower the client further in the therapeutic alliance. This research provides new theoretical and practical insights in an Irish context using an original technique as a safe, practical and robust transformational agent.

Introduction

Within the field of counselling and psychotherapy there has frequently been some issue with addressing personal spirituality. Some approaches, for example Psychosynthesis, do focus on spirituality, though in the mainstream there have been limitations on how it can be approached (Cooper & McLeod 2011; Steere 2019). Counsellors and psychotherapists who are aware of this trend, are conscious of addressing this issue seeking ways of working with their clients that are safe and effective. This article charts the development of a new energetic/spiritual tool, the Energy Therapy Technique, utilised in my academic doctorate research, that enables therapists to offer their clients an inclusive way to tap colloquial into their spiritual beliefs.

The first section of this article will focus on the evolution of counselling, psychotherapy and spirituality and energy therapies, specifically shamanism. The second will explore the evidence-based component parts of the Energy Therapy Technique. The final section offers salient quotes from my doctoral research study from both clients and therapists who have found this holistic addition to their clinical sessions helpful. The conclusion will summarise the findings of this unique and original work within the biopsychospiritual field in an Irish context.

Counselling, psychotherapy and spirituality

Modern counselling and psychotherapy have reaped the rewards of Carl Rogers' (1942) huge emphasis on empiricism and many new approaches have emerged that marry the theoretical with the experiential. The development of a new therapy takes key stages: the study and practice of a seminal training method, different theories emerging with experience, research and further study (Cooper and Dryden, 2015). The advent of continuous professional development and regular course attendance assimilates contemporary ways of working. It is with the introduction of new techniques and research, that the evolution of counselling and psychotherapy continues today.

Since the 1960s there has been an increase of interest in what could be termed the secular sacred – spiritual

practices that are not linked to specific religions but which focus on personal empowerment (Cosgrove et al, 2011). According to Mackinnon (2012, p.13-14), "This 'psycho-spiritual' movement is developing parallel to and is enforced by scientific discoveries, mainly in quantum physics."

However, discussing religion/spirituality is a field in which even experienced counsellors/psychotherapists frequently find themselves unprepared or confused. Verbeck et al. (2015, p.104) contend that "four factors may underlie the failure to discuss religion/spirituality in counsellors' client sessions:

- 'religion/spirituality is not a factor in their [counsellors] own lives and therefore not relevant to the sessions (Plante, 2007);
- they feel that they are poorly trained (Miller and Bright, 2010);
- they may struggle with ethical issues believing that religious/spiritual inclusion is beyond their remit (Rosenfield, 2010).
- they may wish to avoid personal disclosure re their own belief system (Gregory et al. 2008)."

The British Association of Counselling and Psychotherapy (BACP) currently offers its membership 7 additional subsets including 'BACP Spirituality' while the American Counseling Association (ACA) has 18 divisions including the 'Association for Spiritual, Ethical and Religious Values', both with their own peer reviewed journals. IACP do not have specific subsets/divisions yet, however, currently 1277 members cite 'spirituality' as part of the therapeutic services offered on their website listing.

Counsellors' perspectives of spirituality

A key theme to emerge in my research was the paucity of language to describe spirituality and the inherent dilemma of initiating this topic with clients. An inhibiting factor in the verbalisation of spirituality related to the perceived lack of communication skills required when attempting to converse about the indefinable. This perception of the tentativeness around the spiritual topic was observed by counsellors, psychotherapists and their clients (Rosmarin et al. 2013). It may be concluded that ascertaining if the client holds any beliefs at the entrance interview stage would facilitate knowing if their counsellor was open to its inclusion in their work together (Hathaway, Scott and Garver, 2004). Death, dying and the 'afterlife' were popular themes which naturally instigated the subject. Many come to counselling and psychotherapy to ponder the great meanings of life and inevitably this broaches these concepts with reference to belief systems and spirituality.

Spirituality in a contemporary Irish context

In Irish culture today there seems to be a distinctive loss of basic values and traditions that previously sustained a sense of thorough grounding in who and what we are as a people. The resultant loss of security and sense of anchoring in turbulent times may have led to the manifestation of a plethora of physical, mental and energetic illnesses (Ingerman, 2010; Ward, 2013). This is particularly evident today, with the rise in holistic centres and mindfulness practices signalling that many Irish people have left their former religious practice for a variety of reasons and are yearning for connection and an aspect of religiosity and spirituality in their lives (Cosgrove et al., 2011). Irish people are increasingly choosing, of their own volition, a variety of spiritual tools either privately or with practitioners. Counsellors and psychotherapists, similar to other health professionals, have been seeking to incorporate these into clinical sessions, so that clients may combine both if seeking this approach. This endeavour requires careful and considered handling to ensure maximum success (Stewart, Moodley and Hyatt, 2017).

Counselling, psychotherapy and shamanism

One of the emerging paradigms in the integration of the spiritual is that of shamanism and related energy therapies (Kuhling, 2011). Shamanism, an ancient tradition, is the name given to holistic healing with particular emphasis on the spiritual. It is a nature-based wisdom tradition, not a religion and has no dogma (Meier et al., 2005). Core principles of shamanic energy therapy are founded upon the view that the human body has a life force or energy that permeates the physical, mental and emotional aspects of the body from birth to death. This energy (referred to as Prana, Chi or Ki in Eastern countries) is anchored in the nervous system of the physical body in seven key areas often referred to as 'chakras' - the Indian Sanskrit word meaning 'wheel of light' (Maret, 2009). As with Eastern philosophies and corresponding with worldwide indigenous practises, Irish Celtic Shamanism concurs with the premise that energy is a 'currency' of spirituality (Cantwell, 2007).

A key tenet of energy therapy from a shamanic perspective is the principle that all illness and disease begin first at the energetic (spiritual) level and percolates from there to bring imbalance to the psycho-emotional and physical levels (Villoldo, 2001). If blockages or toxicity are removed and disassociated elements restored at the foundation level of the energetic, then the client's psycho-emotional symptoms are improved from the deepest layer of causality.

This addresses, not only energies underpinning negative patterns that are consciously held by the client, but crucially those held unconsciously too. As a result, the client may be released of the deepest unresolved patterns of ancestral, cultural, familial and relational ill-health, accelerating personal, spiritual and inter-personal growth (Fotiou, 2012).

Psychosynthesis, Gestalt Therapy and Process Orientated Psychotherapy, as well as Jungian therapy and Energy Psychology all offer their clients tools/techniques whose origins borrowed heavily from ancient shamanic and esoteric philosophies and principally shamanism (Feinstein and Eden, 2008). These include Applied Kinesiology, Tapas Acupressure Technique (TAT), Emotional Freedom Techniques (EFT), Thought Field Therapy (TFT) and Dynamic Energetic Healing.

US anthropologist Michael Harner (1990) brought distilled ancient shamanic techniques into contemporary usage as 'core shamanism' and combined this with standard counselling methodologies to coin what he referred to as 'shamanic counselling'. Cuban/American psychologist and medical anthropologist Alberto Villoldo (2001) also spearheaded the use of shamanic energy therapies in a modern context comprising extraction (removing toxicity and energetic blockages), soul retrieval (restoring dissociated elements) psychopomp (death and complicated grief) and auric cleansing work.

Shamanism in a contemporary Irish context

Shamanism, when practiced from a Celtic spiritual perspective, has key elements that correspond with worldwide shamanic practices, yet has a distinctive aspect denoting the cultural and traditional context that both attracts and seems to suit the Irish psyche.

Shamanism, when practiced from a Celtic spiritual perspective, has key elements that correspond with worldwide shamanic practices

This combined approach, charted below, illustrates that a person, often with no previous holistic or shamanic training, can with intent, be safely and fluently assisted to find healing resources from a non-ordinary reality (altered state of consciousness) by tapping into their innate sense of spirituality.

The Energy Therapy Technique - a new secular spiritual tool based in Celtic Shamanism

As a psychotherapist, I experienced the requirement for spiritual tools to safely practice with clients who sought a holistic approach and I felt a frustration at the lack of variety of such techniques especially in an Irish context. Contemporaneously, as a Celtic shamanic therapist I experienced the freedom to discover, test and evolve ancient principles with spiritual help, into a form acceptable to the modern client.

In my psychotherapy core course, which had a holistic approach, spirituality was discussed and tools in the form of breathing and meditation were offered. However, through my shamanic training, I became aware of specific areas of empowering energetic work that would facilitate clients to heal their presenting issues and I began to harness these for their benefit. I recognised that initiating a conversation with clients around spirituality was important but harnessing their personal beliefs to facilitate self-healing was a further possibility if the two genres could be combined within the biopsychospiritual approach.

For the past 17 years I have been practicing as a shamanic energy therapist, having studied extensively with Alberto Villoldo's Four Winds Society (2003-2008) and Martin Duffy's Irish Centre for Shamanic Studies (2006-2019). When combined with 25 years of psychotherapy and 13 years of supervisory practice, I recognised a unique opportunity to devise a contemporary Celtic shamanic spiritual tool for use within a counselling/psychotherapeutic clinical setting. During this period, I completed a research masters in All Hallows College, DCU, on the subject of Celtic shamanism in the greater Dublin area while concurrently developing a new energetic/spiritual technique. Working with two different supervisors, volunteer colleagues and eventually willing clients, I devised what I called the Energy Therapy Technique (ETT) over a period of 2 years from 2005 - 2007 and honed and refined it over the following 5 years in tandem with supervision and peer review.

Having developed and utilised the technique, I decided to conduct research to discover if it had the espoused potential, thus providing the evidence base from an academic standard. My thesis investigated the meanings of spirituality among accredited counsellors and psychotherapists practicing a new energy therapy technique that brings a spiritual aspect, based on shamanic principles into a clinical session. This encompassed documenting the Energy Therapy Technique in terms of academic literature, training and mentoring 14 accredited counsellors and psychotherapists. Subsequently, I interviewed them to explore their meanings of spirituality, having implemented the technique with selected clients. The findings were disseminated through Interpretative Phenomenological Analysis (IPA) methodology indicating that counsellors' meanings of spirituality developed with major and minor

changes. A new paradigm of trust ushered a palpable divine presence of Spirit into the clinic room, bringing empowered awakening to the counsellors of their own volition. The ability to easily facilitate their clients tapping into their sense of spirituality and self-heal were key components of their developments.

For example; clients, who are holistically aware, often sense that they are holding an energetic blockage. Classic statements relating to these include 'I feel sick to my stomach', 'he broke my heart' and 'I've the weight of the world on my shoulders' that are psychosomatic with no basis in medical terms. This work is facilitated from the counsellor/psychotherapist's perspective through asking their client specific questions and inviting them to sense what needs to be released and/or realigned energetically when in a dreamlike altered state of consciousness. The advantage of the technique is that it may be incorporated smoothly into a counselling/psychotherapeutic session in the same way as breathing or stress management techniques. In working with clients, a majority who are open to holistic ways or have experienced Reiki or Bio-Energy are usually highly receptive while, as with all techniques, it does not suit every client, counsellor or psychotherapist.

This technique has been attractive to clients yearning for healing and connection, whilst respecting their autonomy, all (and no) faiths, genders and ethnicity. It has key elements that correspond with worldwide core shamanic practices, yet has a distinctive Celtic aspect, denoting the cultural and traditional context within which it has been developed (Ward, 2013). The method is straightforward and empowering, founded on the principle that the human being is by nature a self-healing organism.

An ETT session begins with an introduction to energy therapies (nature, the chakra system etc.), the client's permission, a detailed entrance interview and the setting of a clear intention. Next short yoga-like breathwork is followed by semi-guided visualization where the client, of their own volition, identifies any blockages, understands their origins and the energetic dynamics of same. Facilitated by the counsellor/psychotherapist, the client then has the opportunity to release any blockages - 'remove' the weight off their shoulders, or return any 'missing' aspects of themselves - 'bring back' the sense of self trust they perceived lost, to gain insight for their issue and/or cut any 'unhealthy energetic ties' with anyone living or deceased. The technique protocol finishes with a solid grounding and exit interview while choosing simple ways to integrate the work at home following the session. An anchor stone (Lia Naofa, in Irish Gaelic meaning sacred stone) is chosen to 'ground' the client during the session. The technique takes place with counsellor/psychotherapist seated opposite the client who has their eyes closed thus facilitating a smooth transition from talk therapy to this energy work with no requirement for any equipment or change of positioning.

Therapist and client comments feedback

This final section offers salient quotes from both clients and therapists in my doctoral research study who have found this holistic addition to their clinical sessions helpful. Counsellors/psychotherapists used the ETT after four days' training and mentorship in identifying clients who are open to this type of work of their own volition.

Salient comments from counsellors/psychotherapists in my research:

"The main benefit is restoring the locus of control and power back to the individual."

"It is my belief that shamanism is a key part of the emerging psychotherapy of the future."

"I feel fulfilled, I feel I have really showed up to help these people to move on."

"I probably was hiding the spiritual part because people might think that's a bit whacky."

"I've become a lot more aware. I started to trust my own intuition."

Salient comments from the counsellor/psychotherapists' clients in my research:

"I'm transformed, I'm a different person."

"I couldn't believe it, I have never seen such brightness before… a beautiful session."

"I tapped into a deep part of me that I never knew held me back so much. I am free now."

"This technique we did today opened up something and released old hurt and pain."

Conclusion

Since the 1960s there has been an increase of interest in what could be termed the 'secular sacred' – spiritual practices that are not linked to specific religions but focus on personal empowerment (Cosgrove et al., 2011). Both counselling and psychotherapy have been evolving to integrate the spiritual and to embrace the restoration of the spiritual-healing paradigm as a central honouring of holistic health (Lines, 2006). Following on from the spiritual integrative movements including Psychosynthesis (1930s) and Transpersonal Psychology (1960s), Villolodo, Harner and Ingerman (1990s) have brought major credence to including shamanic based energetic/spiritual techniques within professional healthcare settings. Brockman (2006) and MacKinnon (2012) in particular, in the last two decades, have brought these

techniques to the forefront of the modern counselling establishment.

Every counsellor and psychotherapist in the research articulated that using the shamanic based energetic/spiritual technique developed for the research had a profound effect on their trust, confidence and way of working, leading to a felt experience of rapid, deep shifts by actuating a holistic approach into their client work. These dramatic changes were mirrored by other qualitative studies also using similar metaphysical tools (Rosmarin et al., 2013; Verbeck et al., 2015; White, 2016).

For counselling and psychotherapy to work, the client needs to believe implicitly in the abilities of their therapist so there is a given that in appropriate circumstances new tools in the form of techniques may be introduced *i.e.* stress management mindfulness or anti-panic attack breathing. This new energy technique facilitates clients to energetically release, realign and restore issues decades old but do so from a positionality of empowerment. This compassionate way of working permitted clients to reach a wide range of issues by accessing their spirituality.

As we have seen, Ireland is changing and when attending counselling or psychotherapy, gradually more and more clients are seeking to explore their issues from a holistic standpoint, importantly including spirituality. The ETT acts as a safe, practical and robust transformational agent. Shamanic energetic/spiritual techniques fit with current humanistic, pluralistic and integrative approaches to counselling and psychotherapy thus honouring the client as the 'adept' in the therapeutic alliance. This research has been deemed a unique and original work within the biopsychospiritual field cultivating new ground within this sphere, thus providing new theoretical and practical insights in an Irish context.

Dr Karen Ward

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FLORESCENCE

Ego, Free go, I Go

By Ed Meaney

Ego
Please, you hit yourself enough with that stick,
put it down you've left a scar,
it's OK to be wrong from time to time,
Please, take a breath, lower that bar.

You're just a kid remember that,
put down the fork and make mistakes,
don't be old before your time,
forget your rules, your restraints.

I know it's easier to be on your own,
there is comfort in empty rooms,
but at what cost will you isolate,
take off the 'big boy' costumes.

Free Go
Well, there you are - we've hardly met,
I've heard you sing once or twice before,
can you run carefree with any friends?
play curbs or pretend you're a dinosaur.

Like a frightened bird with a twitching head,
You're missing the joy, the laughter,
but together we can deal with anything,
It's not possible to be happy ever after.

I'm trying to think of another way to say act your age,
You'll bear the burden of adults soon enough,
Go walk on walls and scrape your knees,
Fly a kite, laugh out loud and trust

I Go
I still feel the weight of what I could have been,
Those kids remain an element of me,
they ensured my survival when I was small,
their energy, resilience and bravery.

I will always listen for those quiet voices,
allow their rightful place within my roots,
they can raise their heads and mutter 'do this',
but they do not define me – they are not my
absolutes.

All my parts

By Alan Kavanagh

Throughout my life
I've ignored certain parts,
Causing me a myriad of strife.
Never permitted them space
To be seen, To be heard,
Simply never havin' the courage to face,
Feared to befriend.

Forever yearned to be minded, to be held
By another,
In turn giving away all my power,
Heart ached at never feeling enuff.
I know, my body needs to shake,
Instead, I eat far too much cake,
Why do I feel so fake?
Struggling in what it will take,
Action, more self-compassion.

I feel so raw,
As if, I pulled the short straw.
It seems an impossible feat
To overcome what I've lost,
Time has come at last.
Perhaps, I will eventually become,
By standing on my own two feet.

Beginning to believe in myself,
My whole self,
To piece me together,
There's no more neglect
No need to protect.
Ready to make contact
With all my parts.

Finally dipped further in
How I dreaded diving in.
What if I drown in the salty water?
No, I dare to become,
My parts are aware how
far I've come,
All my parts are now-
Friends.

Academic Paper

The unfolding narrative from Covid-19:

Emerging themes and skills in practice

By Dr Breda Friel and Jonathan Beavis

Covid-19 became a long-term crisis event, the physiological and psychological impact of which is unfolding across the community. Psychological First Aid and crisis management theories offer an opportunity for the management of community recovery from the Covid-19 crisis. This article articulates theories, and skills in developing and applying such responses across a range of settings.

Introduction

Crises, sudden incidents, or severe emergency events go beyond our capabilities and capacity for response. Such traumatic incidents have an unexpected impact – arising from either an acute episode, such as a sudden death, or other one-off incident, or an accumulation of events, such as bullying, domestic violence, threat of terrorism or long-term health issues. Without doubt, the impact of Covid-19 has progressed into a chronic crisis that has impacted all aspects of functioning. For global and local regions such as Northern Ireland that are post-conflict, or embroiled in persistent terrorist threat, the pandemic has awakened and heightened fear, vigilance, if not terror, resulting in a stress reaction and symptoms that impact well-being and mental health.

As the governmental and societal response to the pandemic changes with the easing of restrictions, the effect of long-term crisis symptoms is emerging. It is therefore essential to understand the psychological and emotional impact on individuals and communities and argue for improved resourcing of therapeutic services to respond to the unfolding need. A noteworthy and peculiar aspect of the Covid-19 pandemic is that while it impacted with a sudden, unforeseen seriousness, many assumed it would be acute and short-term in duration. The impact created shock and surprise as the virus developed into a chronic stressor, overwhelming the coping mechanisms and capacity of so many of those affected.

Given the unprecedented nature of Covid-19, the virus confounded national and international medical experts such as the World Health Organisation (WHO). It evolved, mutated, and changed, with the emerging Delta and Omicron variants escalating uncertainty and necessitating responses at all levels. It is understandable therefore that so many citizens are feeling beleaguered, overcome, and devastated. The uncertainty and fear are exacerbated as

we all witness and experience the devastating effect, varied responses of governments, lack of preparedness, unfolding knowledge and subsequent actions across the institutions of state.

There can be no doubting the necessity for research to advance the knowledge of the unfolding qualitative and quantitative data emerging because of the current pandemic. Indeed, it was evident in 2020 that the formal and informal reflection, discussion, and narrative arising from the pandemic was ahead of the randomised control trials and quantitative research, constructing the knowledge base about symptoms and short- and long-term experience of the virus. Research outputs have generated knowledge and emerging reports of experiences as professionals across services meet clients in practice. Articulating and capturing these emerging themes is an essential consideration in the present circumstances, with the specific focus of offering an understanding of Covid-19 using crisis and trauma recovery and management theory.

The traumatic impact of Covid-19 has been examined against theoretical knowledge on disaster and catastrophe management. The emerging themes for clinical practice have been investigated and the importance of supporting narrative accounts of the unfolding impact of the pandemic is argued as a significant qualitative account of the trauma and crisis due to Covid-19. Finally, the emerging themes for practitioners are considered in responding to the unfolding and presenting mental health and well-being issues. Specifically, we will consider how to frame the pandemic into a theoretical construct, understand the application in context, thereby improving and enhancing understanding and practice for frontline professionals across caring disciplines who are engaging with individuals and groups affected by Covid-19.

A critical incident is an event, or series of events, that cause emotional stress to a sufficient level to overcome the usual coping methods of people who experienced it

Defining and understanding crisis and trauma

We define a crisis as any event that overwhelms, the impact of which goes beyond our usual capacity to respond, beyond our capabilities, and defined for this purpose as any event, or series of events that overwhelms our usual coping mechanisms. There is a distinction between the impact of an unexpected onset critical incident that happens suddenly, and chronic events that persist, causing increased stress that lasts for some time. The word 'crisis' evokes images of watershed, emergency, a defining moment or turning point, a sense of danger, disaster, a predicament and experience or trouble. Thus, crises consist of a period following event/s that are potential danger. A critical incident is an event, or series of events, that cause emotional stress to a sufficient level to overcome the usual coping methods of people who experienced it.

Covid-19 developed as an acute, sudden, and unexpected crisis that was expected to be short-term in duration. It quickly evolved into a chronic, unpredictable, and unprecedented global life-threatening episode. It impacted all aspects of functioning, individually, socially, and culturally at all levels of societal and global life. The unexpected frightens humans who are bound by rationality, limited in the capacity and tolerance of uncertainty and unpredictability.

General populations crave structure and place their confidence in the institutions of state. The consequential feeling of being overwhelmed is understandable as so many citizens witnessed the tentative, slow, and sometimes confusing responses across different countries through mainstream and social media.

Covid-19 and the impact on community

The Covid-19 pandemic has instigated deep reflection on the nature of society and community. Communities, whilst sharing many values and beliefs, are not wholly homogenous. People belonging to a 'community' undeniably build a sense of togetherness around features such as ethnicity or socio-economic status or a geographical place, but they may have very differing views and opinions on other aspects of their lives.

In the past two years, community cohesiveness has come to be challenged because community members have articulated many opposing views. Differences on mask wearing, shielding, social distancing, and 'freedoms' have been points of major contestation and tension. These have often manifested as arguments between neighbours or the breakdown of friendships that had been the bedrock of a local community's sense of togetherness. Added to this has been the deep sense of grief and trauma for those who lost loved ones or who were seriously ill with the disease and are still suffering its consequences.

Critical Incident Stress Debriefing (CISD) and Crisis Management (CISM)

Theory and practices from crisis management and Psychological First Aid (PFA) can be applied to the management of the uncertainty, such as during the current pandemic. The concept of psychological debriefing and management covers a range of typically short-term interventions aimed at alleviating long-term distress. The focus is to intervene at an early-stage post-crisis, thereby preventing and mitigating against the potential development of PTSD (Gist & Devilly, 2002). The application of the model can inform interventions and methods in dealing with the impact of Covid-19. Critical incident stress debriefing (CISD) as one aspect of crisis management (CISM), is structured in a format of phases – the elements of which can assist the facilitation of client narrative and experiences arising from the pandemic. The application of debriefing phases in context offers the structure to set down personal, subjective experience, thereby validating the story of those affected (Lewis & Roberts, 2002, as cited in Dulmus, C. & Hilarski, C., 2003). Whilst the outcome and efficacy of debriefing as a concept has been the subject of debate, the use of it as a structured methodology for capturing the experiences of clients will be considered.

A concise definition of the concept of CISM has eluded writers, with confusion in terminology across the literature about CISD (Mitchell & Everly, 2001). The field of emergency mental health and crisis intervention *per se* has been made unnecessarily complicated because of an imprecise and unreliable utilization of even the most fundamental of terms" (Mitchell & Everly, 2001).

A significant feature of crisis is when there is a perceived threat to life, and the perception of such a threat can create intense fear and horror responses, with subsequent psychological and physiological reactions

As a method of dealing with crisis events, CISD offers a focused opportunity of time-limited duration for individuals and groups to 'set down,' clarify and organize facts, thoughts, emotions, and symptoms arising from a critical incident, thereby creating structure to the timeline. This process will begin normalizing the abnormal and so commence recovery.

Disaster and catastrophe management theory

Debates are varied about the efficacy of crisis management theory, usefulness of psychological debriefing and the theoretical and practice management of critical events. Discussions range from questions about the effectiveness of CISD interventions or the management and delivery of approaches. Research debates can be generally categorized into those that are advocates of CISD, critics of the methodologies, and personal narrative accounts of crisis events (Lewis & Roberts, 2002, as cited in Dulmus, C. & Hilarski, C., 2003).

There is no doubt that knowledge, skills, and methodologies from Psychological First Aid (PSA), CISM and CISD protocols can offer guidelines in responding to Covid-19. The models offer a valuable part of the repertoire of knowledge, skills and practices that can be applied to the understanding and managing of experiences of Covid-19 in multi-disciplinary settings. The models offer a theoretical and skills-base to counselling and allied health professions when engaging with the impact of Covid-19.

Impact of crisis and trauma

Traumatic events can feel surreal and shocking, with survivors and first responders describing experiences of, among other symptoms, psychic numbing, which is a mental and emotional reaction to trauma. Such numbing is characterized by decreased responsiveness, feeling detached from the external environment. It can also result in reduced capacity for expression and acknowledgement of emotion. As the number of deaths from Covid-19 increased nationally and globally, anecdotal reports emerged of detached coping and psychic numbing – a tuning out coping mechanism by frontline workers and citizens alike.

Trauma is considered as the impact of an overwhelming information flow due to a critical event or series of events. A significant feature of crisis is when there is a perceived threat to life, and the perception of such a threat can create intense fear and horror responses, with subsequent psychological and physiological reactions. The response to possible danger activates a reaction formation, the Stress Response is activated, thereby mobilizing the human into action. The biological reaction is like a vicious circle impacting the balance of neurotransmitters. The pituitary, or master gland and adrenal systems responds to crisis by altering levels of adrenaline and cortisone hormones in response to signals from the hypothalamus. This impacts functions including temperature regulation, thirst, hunger, memory, sleep, and emotional behaviour. This Stress

Response phenomena can create high levels of vigilance and stress in some people because of critical events. Covid-19 presented such a threat – the danger arising from the sudden, unexpected, emerging pandemic. It generated levels of fear and shock unprecedented in our lifetime and with ramifications that are far reaching.

Reactions and symptoms

When a crisis occurs, the impact has a ripple effect varying from acute impact on those directly affected, to variable effects on wider family, and community indirectly in proximity to the crisis trigger. As an unfolding critical occurrence, Covid-19 has defied efforts to categorize or even estimate the potential impact and subsequent management of recovery. The virus produces a wide range and disparate array of symptoms, causing varying levels of ill-health depending on age, culture, social class, ethnicity, and individual underlying health conditions.

Presentations range from the asymptomatic, to those requiring hospitalization, critical care, ventilation, and those who unfortunately succumbed to the virus. Reports have emerged of cognitive symptoms, such as loss of concentration and memory function. Physiological symptoms range from fatigue, muscle pain, palpitations and cardiac problems to chest and lung problems including pneumonia, coughing, asthma and pleurisy.

Emotional symptoms including anxiousness, fear, resignation, mood changes, loss, sadness, anger, hurt, low-level motivation and feeling 'down and/or flat' are reported by those post-viral, those bereaved due to Covid-19 and the wider community. Two years on from its emergence there is the additional economic and lockdown fatigue, as people hope for brighter days and easing of restrictions. Those with symptoms, particularly of 'long Covid,' report experiences of being discredited due to factors including lack of medical precedent, poor knowledge, and public assumptions that recovery time ranged from five to 14 days.

Inequalities in educational, employment and economic opportunities have been highlighted, exacerbated for those already marginalized, and with emigration and mobility options less available in times of any recession that might arise

Disaster and crisis strike with a sudden violence, impacting individual lives. The sense of ordinariness is gone, the trauma is unexpected, and this can create distress, short-, medium-, and long-term symptoms. The trauma of Covid-19 created multiple experiences of shock and profound feelings of disbelief. Short-term responses require an identification and provision of support following exposure and suffering due to disasters and crises. Symptoms experienced by those affected can include fear of being overwhelmed, of losing control, sadness if injury or death occurred, guilt, anger as particularly helplessness, as witnessed during the pandemic and subsequent lockdowns. Covid-19 generated a particularly troubling range of emotions in families, neighbourhoods and communities as people reacted to the demands of lockdown, social distancing, mask wearing and hygiene rules in social settings. They developed patterns of coping that include maladaptive defensive mechanisms in dealing with the demands of lockdown and persistent stress, including behavioural avoidance and isolation, anger, rage, fear, and relief.

Responding to the crisis of Covid-19

Community recovery across the lifespan must ensure that emerging adversity narratives, personal commentaries and subjective experiences are afforded the opportunity for validation and consideration. The authors argue that the importance of strength-based, finely tuned management of community recovery phases that are culturally, and context sensitive is essential and a significant feature of planning services through the opening of society in the aftermath of Covid-19. We have witnessed evidence of immense strength and resilience, resourcefulness, and positive coping skills across communities (Morris & Malone, 2020), yet those experiencing marginalization and exclusion prior to the pandemic have witnessed, if not an escalation of isolation, no improvement in social support and connection.

Themes for practice: Reframing approaches

There are profound immediate and longer-term implications for practice arising from Covid-19. Inequalities in educational, employment and economic opportunities have been highlighted, exacerbated for those already marginalized, and with emigration and mobility options less available in times of any recession that might arise. Access to services for emotional, mental health and well-being issues arising from the pandemic are already experiencing widespread demand as highlighted by *The Irish Times* in June 2020, the article

acknowledging that young people, whilst not as physically susceptible to coronavirus, may suffer most economically and psychologically due to the pandemic (Freyne, 2020).

We argue the necessity to do things differently in practice approaches, emphasizing a trauma-informed, strengths based and hope centred approach. This should be aimed at the provision of resilience-based, narrative-centred programmes that are informal or non-formal. Long-term recovery from the pandemic can be supported through preventive, universal and targeted provision for young people and adults using statutory, voluntary and community providers. Transforming policy and provision in such a way will help mitigate against the developing of long waiting lists in the under-resourced statutory mental health services.

Psychological holding

The rapidity and unexpected impact of Covid-19 mean that the time for reflection and assessment on this period may come in the years ahead, such archives may be important for commemorative reflection of the things lost as communities, families and as individuals. We define the concept of therapeutic holding as creating a safe structured listening space involving mental and emotional containment, that respects, supports and validates experiences (Friel, McDermott & Doherty: 2021). This involves non-intrusive assessment of need and concerns with listening ear, therapeutic engagement, and psychoeducation on recovery from crises. At a basic level, people need comfort, calming and connection to information, services, and social supports. Most fundamentally, individuals require confidence in setting down their experience in a held space – a development of self-support and emotional self-soothing capacity with steps toward recovery.

Creating a sense of structure is psychologically important, as recovery following exposure to adverse events necessitates process that encourages a normalizing of the abnormal event with eventual integration

The development of structures that offer psychological and emotional holding (Friel, McDermott & Doherty, 2021) is a priority need to facilitate the ventilation of experiences and validation of narrative, particularly those difficult feelings. Recovering from crisis involves the creation of space for physical, emotional, and psychological rest, restoration, and reflection. This is particularly important given the unique signature of Covid-19 with its distinctive symptoms, exclusive and rare impact, resulting in everyone's account being personal, unique, and particular to the individual.

Creating a sense of structure is psychologically important, as recovery following exposure to adverse events necessitates process that encourages a normalizing of the abnormal event with eventual integration.

Loss

The losses associated with critical events can be complex and at multiple levels, as demonstrated during the pandemic. Individuals can experience loss of structure, loss of routine and loss of attachment due to death and enforced separations. For some, the loss is associated with their sense of a perceived future when circumstances have changed profoundly in social contact, employment, education and future hopes and plans. There is the potential for lost faith in the fact that life has a certain consistency and meaning, such loss of structure impacts relationships resulting in a feeling of disorder. For many, there is an associated loss of meaning and sense of safety. The Covid-19 pandemic, like other traumatic events, created uncertainty for many around travel, living circumstances and loss of turf, defined for the purposes of this discussion as upheaval or grieving for context, absence of neighbourhood, territory, or home setting (Friel, McDermott & Doherty, 2021).

Trauma informed

The trauma perspective is compelling in recognising the physical, emotional, behavioural, and psychological impact of external traumatic experiences (Bloom & Farragher, 2010). Trauma-informed and post-traumatic growth models recognise how highly stressful events challenge beliefs and assumptions regarding control, predictability, and benevolence in the world. Adversity challenges the validity of hypotheses about safety in our lives, causing distress and reaction, the manifestation of exposure to previous or present adverse experiences and traumatic events. Such is the impact of the Covid-19 pandemic, with emerging medium- and long-term physical and mental health symptoms across the lifespan. Crucially, practitioners can apply a trauma-informed approach to reframe the narrative about the impact of the pandemic. Changing a deficit question, such as 'what is wrong with you?' to a trauma-informed question of *'what happened to*

you?', (Winfrey & Perry, 2021) changes the meaning for those affected by adversity, transforming the assumptions, the stigmatizing and eliciting a conversation that recognizes how trauma impacts individual behaviour and development.

Shifting practice with those impacted by Covid-19 to a focus on positive change following challenging life events will create capacity for transformative change. Utilising post-traumatic theory, which we consider as psychologically positive changes that are experienced due to struggles with highly challenging life circumstances, (Tedeschi, 2020) allows for a paradigm shift across professions. Those who have lived through stressful events can be supported to recognise (1) new possibilities, (2) personal strength, (3) spiritual or religious change, (4) relating to others, and (5) a greater appreciation of life (Tedeschi & Calhoun, 2004) – the five key areas where Tedeschi and Calhoun argue positive change occurs through post-traumatic growth.

Conclusion

There is no doubting the societal, community and individual impact of the Covid-19 pandemic, and it is useful to remember the unique signature of Covid-19, the distinctive effect of the physical and psychological factors emanating from the disease and associated lockdown measures. The authors argue that disaster management perspectives and strength-based approaches can offer a framework for symptom mitigation and can support crisis and trauma recovery in practice with clients. Resourcing is essential for individual and community recovery from the crisis of Covid-19. The setting down of individual and community narratives through a listening ear and therapy is helping to construct the meaning making, grief and acknowledgement of the journey. What role then might therapeutic services have in connecting with the emerging themes arising from the recent crisis? Long-standing debates from academic literature have noted the role of counselling services in creating safe spaces for emotional and social renewal, and the time for this to be put wholeheartedly into action has clearly arrived.

The setting down of individual and community narratives through a listening ear and therapy is helping to construct the meaning making, grief and acknowledgement of the journey

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Academic Paper

Guidance/Counselling - Managing mental health at second level:

An exploration of Second Level Guidance Counsellors' perceptions and lived experiences of seeking to meet student mental health needs

By Róisín Traynor

The Department of Education in Ireland states that counselling within schools includes personal, educational and career counselling (Hayes et al., 2011). The Guidance Counsellor has more than one role serving multiple needs. This research offers insight into the Guidance Counsellors' perception of their ability to meet these multiple needs.

Introduction

The role of the Second Level Guidance Counsellor is a broad one. Arguably, counselling for mental health is just a part of their role and we want to explore how Guidance Counsellors' assess their ability to perform this part within a school setting. In terms of counselling for mental health within the role of a Guidance Counsellor, the Department of Education has defined this as part of the role as, being offered for development and personal crisis as well as to empower students to "make decisions, solve problems, address behavioural issues, develop coping strategies and resolve difficulties they may be experiencing." (Hayes et al. 2011). What are the perceptions and lived experiences of the Guidance Counsellor in looking to meet these needs?

Literature review

According to the Institute of Guidance Counsellors (IGC) the most suitable member of staff in Second Level schools, that can assist students with mental health difficulties, is the Guidance Counsellor. This is due to the distinctive role Guidance Counsellors have in terms of personal, educational, and vocational guidance, as well as professional supervision (*Irish Examiner*, 2018). This means that the role of the Guidance Counsellor has become multifaceted.

It is possible that this is due to many reasons including the 2011 Budget Cut which lead to 91% of Guidance Counsellors admitting to spending less time with students on a one-to-one basis due to hours being decreased. These cutbacks caused students struggling with their mental health to have difficulty receiving help when needed (*Irish Times*, 2014). In turn, this caused students to

be at a disadvantage in terms of general support and mental health (Teachers Union Ireland, 2017). The cutbacks also caused Guidance Counsellors to spend more time teaching, leading to lack of time dealing with crisis situations as they are required to go and teach a class (*The Journal*, 2017).

The Department of Education states that Guidance Counsellors are fully equipped to offer counselling to students (National Centre Guidance Education (NCGE, 2018). Yet, according to the IGC, Guidance Counsellors know within one-to-ones with students that they should not attempt "well-meaning counselling - territory for which they have no training or professional supervision". It seems for one that a clear definition of well-meaning counselling is needed. (*Irish Examiner*, 2018).

The findings of the research conducted by the NCGE show that Guidance Counsellors are under great deals of stress attempting to do both guidance and classroom teaching. Other alarming results from the survey conducted was the lack of understanding of what the job involves. There was no shared understanding of therapeutic counselling in terms of how many times they see a student or how much time is given to counselling sessions. Variations of how Guidance Counsellors try to meet demands for counselling in Second Level were seen (Egan, 2014). In 2004, the NCGE stated that counselling is only one of seven guidance activities completed in the role. These included giving information, advice, educational development, personal and social development and well as referrals (NGCE, 2014).

All Guidance Counsellors interviewed felt high levels of stress due to the increase in mental health counselling needs of students

(Egan, 2014)

Although the students' need for counselling may vary from school to school, it is suggested that Guidance Counsellors make outside referrals for those students who need recurrent counselling. According to the IGC, Guidance Counsellors are frequently dealing with a range of issues such as anxiety, depression, self-harm, suicidal ideations as well as sexual abuse, bullying, substance abuse etc. (NGCE, 2014). The research also showed Guidance Counsellors are unsure as to when to refer students (Egan, 2014). The current referral system is not effective enough for theses changing times, says the IGC. Ms. Dooley expresses concern for Guidance Counsellors and their students: "Guidance Counsellors are left holding them, sometimes for months before they are successfully referred on to the appropriate mental health services" (*The Journal*, 2017).

A mixed method study of adolescents in Irish schools by Doyle et al. (2017) found that students feel the dual role of Guidance Counsellors and teacher should be separate. The "It Just Doesn't Feel Right" study surveyed students in Dublin schools and found 84% of students would not talk about mental health problems due to the Guidance Counsellor's dual role of teacher and worries around limitations to confidentiality (Doyle et al., 2017).

Egan (2014) conducted a qualitative research project into the role of the Guidance Counsellor from a psychotherapeutic perspective. All Guidance Counsellors interviewed felt high levels of stress due to the increase in mental health counselling needs of students (Egan, 2014). The changing times and social media are possibly causing higher levels of anxiety in adolescents, according to *The Journal*. Issues that Guidance Counsellors are facing are becoming more severe and more frequent (*The Journal*, 2017).

Research methodology

As this research is based around lived experiences and perceptions, a qualitative approach was chosen. The research took a phenomenological stance to gain deep insight into participants' experiences. The phenomenon of interest here is Guidance Counsellors' lived experience of dealing with students with mental health difficulties. An unstructured interview technique has been chosen for this research as unstructured interviews do not disturb or regulate the research yet gain significant insight of participants' experience (Yan Zhang et al., 2019).

Thematic analysis (TA) was employed to identify, analyse, and report themes emergent from the data. This method, according to Rice and Ezzy (1999) allows for "emerging themes" to be categorised for analysis (Fereday et al., 2006). Potential ethical issues were carefully considered throughout this study including confidentiality and anonymity. Ethical issues are deemed vital when conducing any type of research (Roshaidain Arifin, 2018).

Research findings

Guidance Counsellors' experience with outside referrals

All participants discussed issues with outside services, including waiting lists, students' experiences with the service and examples of the reality of dealing with such services. There were questions as to whether this service that provides assessment and treatment for young people experiencing mental health difficulties was working as affectively as needed for school students. Long waiting lists can lead to students waiting months for appointments. Not only do students have to wait for an appointment, once they have received their initial assessment appointment, they are still left waiting months after that to see a specialist.

A general kind of referral would take a long time and those kids would stay with us until they go in and that can be over a year.

It is evident that students have also had negative experiences with outside organizations including students refusing to go back to these organizations after initial appointment. Participant 3 felt very strongly about discussing an example of a student who felt unheard and uncared for. This student decided then that "the system would not work for them".

She had an awful experience and decided that it was the only experience they will have with them and will NEVER go back.

Participant 1 discussed a student with additional needs in his school who was "turned away" from such organizations. He also stated a "big portion of autistic kids" would have been referred and turned away. Guidance Counsellors seemed negative in terms of the service being "not up to par at all". When students are turned away, the Guidance Counsellors are "left to pick up the pieces or trying to support them as much as you can".

It is important to note that some Guidance Counsellors prefer careers and vocational type of work instead of one-to-ones, where others may not have much time due to teaching roles

Continuous Professional Development and difference within initial training

Guidance Counsellors felt they needed to regularly upskill with their local branch. An example of appropriate training was the updating of counselling skills and knowledge to assist with the personal development side of counselling. Participants 3 and 4 discussed their value for CPD that is available, particularly with the Institute of Guidance Counselling (IGC). According to Participant 3, the IGC surveyed Guidance Counsellors to explore what CPD is needed. She stated there was "always something interesting and worthwhile" as well that, sometimes branches can fund half of the training which is a "really supportive professional system." Participant 4 spoke about a very useful behavioural therapy course she had done after feeling like she needed more skills and techniques for helping students with mental health difficulties.

I'll have a student who has issues around eating disorders and I will have to pass them on....without the specialist training, it is very hard to know what to do in those situations .... you feel a bit helpless.

This leads to questions as to whether Guidance Counsellors should upskill to Counselling and Psychotherapy. Participant 2 stated, "they should look into the model of having a psychotherapist to back up the Guidance Counsellors or to upskill the Guidance Counsellors a notch." It is suggested that Guidance Counsellors be supported to upskill into more and more psychotherapy or be supported more by a psychotherapist as it "would be far more beneficial to the kids than this like half mash, holding, then we are passing you on, falling through the cracks." This participant wishes for a postgraduate course for Guidance Counsellors in Counselling and Psychotherapy. Another participant commented on the complexities of dealing with students with mental health difficulties. This participant mentioned lack of knowledge and skill in terms of eating disorders, self-harm and suicidal ideation. Seen frequently within the role, this causes Guidance Counsellor to feel they "can't support them" as much as they would like to or as effectively as a Counsellor or Psychotherapist could.

You can never know if you're saying or doing the right thing.

Guidance Counsellors have done initial qualifications with different institutes, all at different times. Due to this, it is possible that there are a wide variety of qualifications, "although it is the same level, it is such a wide role

that you're covering the social and vocational and you know then the personal comes into it," states Participant 3. It is important to note that some Guidance Counsellors prefer careers and vocational type of work instead of one-to-ones, where others may not have much time due to teaching roles. Participant 1 discussed challenges with preparation for the role. This participant stated that on the job there is continuous learning and development however within initial training courses, there were strong feelings about being "thrown into scenarios". This includes the experience of practicing on your peers "that can be challenging enough" as you are restricted to "very low scale kind of stuff". Participant 1 later went on to state that he feels "lucky" to have three other Guidance Counsellors in his school to "bounce off".

Dual role of Guidance Counsellor and teacher

Participants described the dual role as feeling like "two different people because you have to be quite strict with some of the classes." As a Guidance Counsellor, this can be a difficult transition as it causes complexities in terms of building relationship with students as a Guidance Counsellor. In turn, professional ability to teach and be a Guidance Counsellor is questioned. This participant states she has allowed her maths teaching to "slide" to be an effective Guidance Counsellor.

> *Ideally you are just a Guidance Counsellor but I didn't have that luxury. The Guidance Counsellor is better placed with their full head in the guidance game. You can't be both and be excellent. You can only be both and mediocre.*

Participants described the dual role as feeling like "two different people because you have to be quite strict with some of the classes"

Participant 5 mentioned issues around dealing with students on personal matters and then later having to teach them a subject. The participant mentioned having to go to a class after a one-to-one goes over the allocated time. This can cause the Guidance Counsellor to have to leave subject classes to deal with students' personal matters such as anxiety attacks. Although it is necessary for Guidance Counsellors to be available to such students, the class is then falling behind. Guidance Counsellors would also have difficulty dealing with students with behaviour problems. There are times when Guidance Counsellors may need to do a report for a student misbehaving in class. This can be difficult when you are the only Guidance Counsellor within the school. Participant 2 discussed her consistent debate of trying to figure out who she is professionally. She states it is "not ideal" and it is not where she wants to be with her role in the school.

The "holding space"

All participants discussed the "holding space" that Guidance Counsellors see daily. This might be a physical environment such as a private office, where students are supported as best as possible by the Guidance Counsellor. Generally, this happens when the student is also on a waiting list for outside services. Students are then left being supported by the Guidance Counsellor within the school. Participant 1 describes this as "challenging".

Aware of her limitations, that she is not a Counsellor or Psychotherapist, Participant 3 describes her role as Guidance Counsellor as the "first point of call" for students with mental health difficulties within schools. Also stated by Participant 1, the guidance sessions are not counselling. "It's more, 'So how are you doing? How's the week going?' and things like that." Participant 1 also acknowledged that Guidance Counsellors "can only do things to a certain level." Yet, the "holding space" has its benefits as it becomes a familiar space for students. It gains some ease around it compared to travelling outside of school for the service.

On the other hand, there is evidence that the holding space can be problematic. Guidance Counsellors have described issues such as feeling like they are "picking up the pieces" when outside services are telling the students that "there is nothing we can do." This can lead to the over-reliance on schools due to long waiting lists with outside referrals. Participant 4 takes the researcher through her reality of the holding space. She states, the first few sessions are looking at the spectrum of risk, informing the student that their issue will not be sorted right away, which can bring about its own difficulties. It also allows the student to feel safe within the guidance environment while they are waiting for outside help. This can become difficult if a student has already had experience, perhaps counselling outside "hasn't gone well for them." Participant 2 states that the holding space, along with limitation

in skills can be a problem. At this point, "We are aware that we can only hold them for so long and then they need to be referred out and we don't have an internal referral. So we are very aware that there are limits to our skills."

> *We aren't skilled enough to hold them.*

Challenges faced in relation to cuts

Within this theme, the number of Guidance Counsellors' positions and hours cut in 2011 within Second Level by the Minsters for Education discussed. Participant 4 experiences feelings of "working on the front line". This caused the workload of Guidance Counsellors to be "back tracked" as they were still expected to carry out personal, social, and educational supports, while the majority were also teaching a core subject. She later went on to explain that the "environment isn't set up for major in-depth mental health work with kids."

Participants state that some means of using Guidance Counsellors more effectively within a school setting to better help students should be put in place. In turn, more hours and positions would need to become available which would allow for a more supportive and engaged "whole school community." Participant 5 states that there is limited time for counselling within the guidance profession. Yet "so many kids who need so much help" and there just are not enough hours in the day. In relation to this, Participant 4 discusses the feeling of "holding back a flood ever since the 2011 cuts." Since then, she went on to mention how "difficult and stressful" working as a Guidance Counsellor has become due to the cuts. Guidance hours have not returned to time allocations prior to 2011. Within this research it was evident that Participant 4 felt it was extremely critical to manage her own professional and personal boundaries within her work, for the sake of her own mental wellness.

> *There were questions as to whether this service that provides assessment and treatment for young people experiencing mental health difficulties was working as effectively as needed for school students*

> *I really felt it around the time of the guidance cuts. I felt this massive responsibility that I still have to be able to be there for the students despite the fact the government didn't think it was important to be there.*

Study limitations

The participants in this study all taught extra subjects along with their Guidance Counsellor position in Second Level. The study did not include Guidance Counsellors who had no extra teaching subjects. Further research into this area could give a wider variety of perceptions Guidance Counsellors may have in relation to their ability to help students in terms of mental health difficulties. Although the majority of Guidance Counsellors completed CPD and initial training qualifications, none of the participants came from a counselling or psychotherapy background. They did not have any formal counselling or psychotherapy qualifications which may also be taken into consideration for future research.

Conclusion

From the research, we now know Guidance Counsellors feel the "holding space" can be of use to the students. It can benefit students by being a familiar space where outside travel is not required and that it is an effective way to help students when they are on long waiting lists. However, most participants discussed the negatives associated with this. Guidance Counsellors have described issues such as feeling like they are picking up the pieces when outside services are telling the students, "There is nothing we can do to help."

The skills and knowledge of the Guidance Counsellors comes up here, and while there is no literature to back it up, participants felt strongly about only having the ability to help students to a certain level. Often, students who are in this holding space, require more professional skills. Clinical supervision may be of benefit here.

The role of Guidance Counsellors is hindered by the long waiting lists for outside referrals. This leads to frequently using an already-busy schedule to 'hold' students when they have already been referred on due to complex issues. In particular, the evidence from literature supports findings that outside referrals may need to operate more effectively to help Guidance Counsellors, but more importantly, to help the students. Another point within this theme that was highlighted within the literature is students experience with outside referrals. Guidance Counsellors who participated in this study also expressed concerns for students' experiences with the service

and examples of the reality of dealing with such services. There were questions as to whether this service that provides assessment and treatment for young people experiencing mental health difficulties was working as effectively as needed for school students. This is a significant finding as it was discussed by participants the most.

The literature and findings also bring the question as to whether Guidance Counsellors should be teaching. Despite the fact Guidance Counsellors are required to have teaching qualifications in Second Level, the dual role of Guidance Counsellor and teacher is evident to be disliked by Guidance Counsellors and students. As we know from this study, all Guidance Counsellors interviewed are also qualified in another subject. Four out of five participants mentioned how being in the dual role caused a loss of love for their original subject. They also discussed how teaching affects their ability to be a Guidance Counsellor and the difficulty in the classroom being the teacher and Guidance Counsellor.

Despite the fact Guidance Counsellors are required to have teaching qualifications in Second Level, the dual role of Guidance Counsellor and teacher is evident to be disliked by Guidance Counsellors and students

The research acknowledges a more effective working system is needed within the Irish Health Care system for those at school in Second Level. The researcher agrees with Lisa Molloy from the Irish Association for Counselling and Psychotherapy (IACP), that the Government needs to start prioritizing mental health in schools. The IACP suggest launching school based therapeutic counselling to prioritize mental health in schools. Senator Colette Kelleher recently presented this idea along with IACP in Leinster House and propositioned a new project called Pathfinder. This proposal of Pathfinder asks the government for funding to enable school-based counselling interventions (IACP, 2019). Due to findings of this research, it seems that Guidance Counsellors and most of all, students, would benefit from a prioritisation of mental health within Second Level schooling. The researcher would like to recommend such initiatives in mental health and counselling services.

Róisín Traynor

Róisín Traynor holds a BSc in Education and Training, a Postgraduate in Career Guidance and a Master's in Counselling and Psychotherapy. She has always had a keen interest in mental health and education. Róisín has worked as a Guidance Counsellor in a variety of different schools in Ireland and abroad. Currently, she works as a Mental Health Officer at Meath Partnership and is passionate about evoking change within education, for example making the role of Counsellor prominent in a school setting and separate from the role of Guidance Counsellor. You can contact Róisín at Róisínnealatraynor@gmail.com

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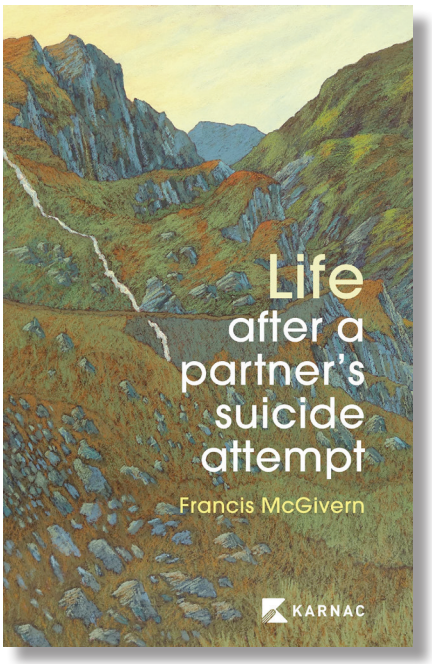
Book Review

Title: *Life after a partner's suicide attempt*
Author: *Dr Francis McGivern*
Published: *2021*
ISBN: *ISBN: 978-1-913494-34-6 (Paperback)*
ISBN: 978-1-913494-35-3 (Ebook)
Price: *€20.08 (Paperback)*
Reviewed by: *Alan Kavanagh MIACP*

As Kant once proclaimed, 'Experience without theory is blind, but theory without experience is mere intellectual play.'

In this landmark book, Dr Francis McGivern explores in-depth the aftermath of a partner's suicide attempt and reveals the origin for his obvious passion for this area.



Partners are often overlooked in suicidological research, in the treatment process and the recovery journey of the person that attempted suicide. The author succinctly marries the lived experiences of significant others while offering a comprehensive theoretical foundation and in his focus on ambiguous loss, draws on the pioneering work of Pauline Boss. As therapists, we work with clients who have suffered loss in all its forms. Personally, in an Irish context, through my work with the Traveller Counselling Service, I am confronted daily with ambiguous loss often beyond my comprehension as a person from the majority general population. The harsh reality is that the suicide rates in the Traveller community are seven times the national average. As such, attempts are far greater.

This book pinpoints the gaps in services that were gathered from the harrowing accounts of significant others in addition to the author's extensive review of the literature and polices pertaining to suicide. McGivern proposes therapeutic frameworks to support partners; particularly, but not limited to Attachment injuries that generally emerge in the aftermath of a suicide attempt. Additionally, his work captures the transformation that can occur within individuals and their relationships when those impacted by a suicide attempt are supported. Furthermore, the author suggests a road map in treatment care and strongly advocates for inclusive policy change and enhanced understanding of the impact of suicide attempts on significant others.

The lack of support in care was evident when one research participant disclosed '*I felt on my own…I cannot believe what they were asking me to do,*' one of many raw reflections on the impact and the burden of care placed on the partner after a suicide attempt. Francis invites the reader into the worlds of those left '*searching for answers*' of why their partners attempted suicide as notable participants felt they were the focal point in '*the blame game*' as one partner describes the multi-layered experiences she went through and how the accusations from in-laws of not showing their partner enough '*TLC*.'

Sadly, it is not that suicides are rare occurrences; rather, it is a rarity if a person has not been affected by suicide. However, consideration needs to be given to the rates of suicide attempts and their subsequent impact on partners. Certainly, a topic for Continuous Personal Development as we meet clients that struggle with a grieving process that is often not socially accepted as loss. This book would be well placed on therapist's bookshelves and to a wider non-professional readership. Perhaps even for clients via bibliotherapy?

This book endeavours to normalise the emotions and thoughts following a suicide attempt and the denial of the inevitable myriad of feelings associated with grief. The overarching message is the necessity to rethink the response to include all of those impacted by a suicide attempt. Through personal communication with the author, he hopes that '*partners feel truly 'seen,' the personal impact of their lived experience acknowledged, and that they can benefit from the recovery pathway*' and that services work systemically with partners reflected in proposed policy change.

I can attest the book strives to achieve the former; however, it will take collective action and advocacy for the latter to become best practice.

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