The Irish
Journal of Counselling and Psychotherapy

formerly Éisteach • Volume 23 • Issue 2 • Summer 2023

Does nutrition have a place in the therapy room?

Also in this issue:

Irish Association for Counselling and Psychotherapy

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Contents

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ISSN:
2565-540X

Advertising rates and deadlines:
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In Autumn 2017, our title changed from "Éisteach" to "The Irish Journal of Counselling and Psychotherapy" or "IJCP" for short.

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1st September 2023

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From the Editor:

Dear Colleagues,

It is with great pleasure that I welcome our members to the summer edition of the *Irish Journal of Counselling and Psychotherapy*. Hopefully this season will bring much needed sunshine to promote our well-being and improve our levels of vitamin D, which is vital for our overall-health.

This edition introduces some changes to the *IJCP*, as you will see from the cover page. Previously, we have focused on themed issues, for this edition we shall use a lead-article format.

Our first article is by Jayne Leonard on a topic quite a number of us are conscious of, but may not have had any formal training. Jayne explores the subject of nutrition and mental health, enquiring as to why there is little or no training in this area. She also looks at the benefits of discussing with clients their nutrition and the importance of having balanced eating habits. The author points out that formal training is necessary to impart this information effectively and that clients need to be fully aware of the importance of their own nutritional self-care.

In our second article, James Overholser presents the third and final part of his simulated interview with Fritz Perls. In this article the author illustrates how Perls firmly believed in working in the moment with his clients, rather than discussing past events. Perls also preferred the lived experience of group therapy, as he felt there was more opportunity for spontaneous interaction to develop, whilst emphasising the necessity of an authentic relationship in his work with his clients. Interestingly, we note that Perls disavowed the use of psychotropic medication, despite his medical background.

The next article by Dr Marion Mensing examines the effect of materialist science on our world. The author poses questions on our future safety if we blindly follow the rationalist's view and how this path could even endanger the survival of humankind. Her article is very timely, because as I write this piece, a leading computer scientist in AI has resigned, due to his concerns about the profound risks to society and humanity.

Our fourth article acknowledges that online therapy is part of how we work with clients now, but emphasises the need to ensure that appropriate boundaries are set, so that both the client and the therapist are fully engaging in sessions. The author, Helen Browne looks at research, but is also is very open about her own experiences, some that we have probably encountered in our own practices. Her piece highlights the pitfalls and her suggestions for improvement are practical and helpful.

Next, we have an article about a therapist's own experience of gender transitioning. The author, Rhea Askins, has been very open and courageous in taking pen to paper, illustrating the challenges she has faced and those with which she continues to encounter. Rhea details her struggles with finding support in areas where she expected to find it, only to have been disappointed. However, her resilience has enabled her to find herself and move on with her life, thus bringing her the happiness she sought for so long.

Finally, we introduce our first entry in our essay style section under the title 'Issues and Controversies in Counselling and Psychotherapy'. This essay by Mike Hackett delves into the topic of 'free therapy' and argues for the abandonment of this practice. The author highlights the issues around this subject, and points out that due to the costs involved in therapy provision, there cannot be such a thing as 'free therapy'. Mike looks at the effect this practice has on newly qualified and experienced therapists and their well-being. In the author's opinion it is essential that therapists make a living out of their profession and do not shy away from protecting the value of their profession.

Included under the poetry section is a reflective poem and there is a book review on practical approaches to psychotherapy and I hope you will enjoy both.

Lastly, dear colleagues, on behalf of the editorial committee and the *IACP*, I sincerely thank all of our contributors. A call out to you, our readers, to consider submitting articles for consideration. For now, I wish all of you a summer that allows you time to relax and take breaks from all stresses in life, allowing for that much needed rejuvenation.

Annette Murphy M.I.A.C.P.
Editor

Academic/Research Article

Does nutrition have a place in the therapy room?

By Jayne Leonard

Diet and nutrition are rarely included in psychotherapy training, yet research suggests that nutritional status is strongly correlated with mental wellbeing. Acknowledging this connection may enhance the therapeutic experience, and provide clients with a complementary means of supporting their mental health

Introduction

It has long been known that our food choices have a significant impact on our physical health. In the last few decades, however, the burgeoning field of nutritional psychiatry has been highlighting the relationship between food intake and mental health. The findings are consistent and persuasive – better diets typically equate to a better mental health status, while poorer diets equate to poorer mental health.

Despite the impressive body of evidence put forward by the field of nutritional psychiatry, the research has been largely excluded from the counselling and psychotherapy profession. Nutritional education and methods of intervention remain largely absent from psychotherapy training and practice; while psychotherapists and other mental health professionals worldwide report poor nutritional literacy. Perhaps the time has come to consider the potential benefits for clients, if therapists were to have greater awareness, as well as training, in the area of nutrition for mental health.

The field of nutritional psychiatry

Psychotherapy, or talk therapy, typically involves treating clients based on the assumption that they have underlying interpersonal issues, unhelpful patterns of thinking or behaving, emotional regulation issues, or adverse childhood experiences. It does not usually explore the possibility that there may be nutritional reasons for client mental health issues. Yet the emerging field of nutritional psychiatry presents compelling evidence to suggest that nutritional deficiencies and dietary choices may contribute, at least in part, to some mental health issues.

Nutritional psychiatry is a discipline that examines the influence of diet and supplements on mental health. Its origins can be traced back to the 1970s, when researchers explored the relationship between specific food components and neurotransmitters, such as

serotonin (Gessa, Biggio, Fadda, Corsini, & Tagliamonte, 1974; Tagliamonte, Biggio, Vargiu, & Gessa, 1973). Since these early explorations, multitudinous studies have been carried out to uncover connections between nutrition and mental health. While the majority of these studies focus on diet and depression, much of the discussion accompanying them is relevant to many aspects of mental health, ranging from attitude changes to violent behaviour (Logan & Jacka, 2014). Furthermore, several nutritional psychiatry studies focus on other aspects of mental health, such as anxiety, behavioural problems, bipolar disorder, cognitive impairment, psychological distress and schizophrenia (e.g. Cha, Yang, and Kim, 2021; Jacka et al., 2009; Mantzorou et al., 2021; Mishra, McNaughton, O'Connell, Prynne, & Kuh, 2009; Noaghiul & Hibbeln, 2003; Peet, 2004; Scarmeas, Anastasiou, & Yannakoulia, 2018; Zaalberg, Nijman, Bulten, Stroosma, & Van Der Staak, 2010). Additionally, nutritional status may impact on behaviours that have a knock-on effect on mental health, such as fatigue and sleep difficulties (e.g. Azzolino, Arosio, Marzetti, Calvani, & Cesari, 2020; Hajianfar et al., 2021).

Diet and depression – the evidence

A myriad of evidence from several sources implies that dietary factors influence depression risk (Opie et al., 2017). For example, meta-analyses indicate that addressing low levels of omega-3 fats can help treat depression, perinatal depression and bipolar disorder (Appleton, Rogers, & Ness, 2010; Lin & Su, 2007; Logan & Jacka, 2014). Similarly, review papers report a substantial link between vitamin D deficiency and depression, with vitamin D supplements found to be comparable to antidepressant use in alleviating symptoms (Cuomo, Giordano, Goracci, & Fagiolini, 2017; Spedding, 2014). Other vitamins and minerals, including vitamin B6, folate, selenium, and zinc, as well as certain dietary patterns, may also influence depression risk (Chen et al., 2021; Ferreira de Almeida et al., 2021; Opie et al., 2017; Rienks, Dobson, & Mishra, 2013).

Despite the significant and persuasive efforts by nutritional psychiatry researchers, individuals and healthcare providers do not seem to have translated research findings into practical changes

Studies further indicate that adhering to traditional dietary practices, such as Mediterranean or Japanese diets, can lead to a reduced risk of depression (e.g. Gianfredi et al., 2021; Konishi, 2021; Lasserre et al., 2021; Mantzorou et al., 2021), with some sources citing a 25%-30% lower risk of depression when people adhere to such traditional diets (Selhub, Logan, & Bested, 2014). Factors influencing depressive symptoms, where diet is a key mediator, include gut microbiota, chronic low-grade inflammation, and oxidative stress (Dash, Clarke, Berk, & Jacka, 2015; Kaplan, Rucklidge, Romijn, & McLeod, 2015; Marx, Moseley, Berk, & Jacka, 2017; Mörkl et al., 2020).

Consistent and persuasive findings

Overall, the research findings are persuasive and largely consistent – there appears to be a positive association between healthy diets and good mental health and between unhealthy diets and poor mental health. In many studies (e.g. Ferreira de Almeida et al., 2021; Mantzorou et al., 2021; Yin et al., 2021), this relationship exists in a dose-response pattern – the healthier the diet, the better the mental health. Researchers propose several mechanisms for these effects, such as nutritional impact on the the immune system, the gut microbiota, neurotransmitters, and brain development and function (Mörkl et al., 2021).

While many nutritional psychiatry studies are cross-sectional in nature, meaning they cannot show the direction of causation, several researchers (e.g., Vassou et al., 2021; Yin et al., 2021) believe that the relationship between the quality of a person's diet and their mental health is likely bidirectional. Furthermore, the evidence consistently demonstrates a relationship between diet and mental health across numerous populations and age groups which is not explained by other factors (Marx et al., 2017).

Findings from the field of nutritional psychiatry are exciting, due to their potential to benefit people with mental health issues. They offer an alternative to traditional treatments, which typically only address symptoms, rather than root causes, and are largely ineffective. When it comes to depression, for example, antidepressants and psychotherapy may avert less than half of the disease burden (Marx et al., 2017). Recent evidence (Jorm, Patten, Brugha, & Mojtabai, 2017) suggests that depression may be on the increase, despite the rise in use of psychotropic medication, which may indicate the presence of environmental risk factors for depression (Marx et al., 2017) – one of which could be diet quality. Given these

findings, it is unsurprising, then, that some suggest that "diet is as important to psychiatry as it is to cardiology, endocrinology, and gastroenterology" (Sarris et al., 2015, p.271).

Real-world application of findings

Despite the significant and persuasive efforts by nutritional psychiatry researchers, individuals and healthcare providers do not seem to have translated research findings into practical changes. One possible reason for this is that traditional policies (as well as older nutritional psychiatry studies) focus on individual nutrients and foods. Recently, however, the research focus has moved toward a 'whole of diet' approach, which takes into account the complex combination of various foods and nutrients that people typically consume in real life settings (Konishi, 2021; Vassou et al., 2021). This shift will potentially trickle down and have a knock-on effect on food education and policies in years to come, translating research findings into guidelines and practices that are easier for individuals to follow.

Another challenge is that mental health professionals remain largely uneducated about the effects of diet on mental health. A recent study by Mörkl et al. (2021) assessed the nutritional literacy of 1,056 mental health professionals – including psychiatrists, psychologists, and psychotherapists – in 52 countries. The findings indicate that most participants had no training in nutrition, and 92.9% would like to expand their knowledge of nutritional psychiatry, even though most of them already used nutritional approaches in their work. In the counselling and psychotherapy field, specifically, there appears to be a significant gap between current research findings and training, policy, and practice.

The consumption of unhealthy foods, meal skipping, and overeating can create a vicious cycle that intensifies stress and emotional distress which, in turn, increases the risk of poor nutrition

Nutritional awareness within psychotherapy

Research on the use of dietary and nutritional interventions within counselling and psychotherapy is scarce. Earlier studies have explored therapist engagement with clients in relation to diet and other health behaviours (Burks & Keeley, 1989; Edwards, 2002; Royak-Schaler and Feldman, 1984), and one small study (Terry & Reeves, 2015) looked at therapists' understanding of diet and nutrition in relation to therapy. The few studies that do exist largely suggest that many therapists lack confidence in bringing nutrition into the therapy room (Burks & Keeley, 1989; Edwards, 2002) and they often do not feel supported in being able to do so (Terry & Reeves, 2015). This is perhaps unsurprising, considering that counselling training institutes typically do not provide comprehensive training and education on the topic, and accrediting bodies do not typically publish guidelines on nutrition for mental health.

Despite therapist concerns, the research suggests that conversations around nutrition *are* happening within therapy rooms. According to Burks and Keeley (1989), 68% of participants suggested that a client follow a specific diet or had referred a client on to someone to suggest a specific diet. Royak-Schaler & Feldman (1984) report that almost half of participants attended to diet or other lifestyle factors in client work. Mörkl et al. (2021) found that 65.9% of psychotherapists reported using nutritional approaches in client work; while Terry and Reeves (2015) state that all six participants used nutritional interventions to some degree with clients.

The literature also suggests that therapists want more training on nutrition. Burks and Keeley (1989) report that over half of the participants in their study believed that diet and exercise should be a required component of training and, as cited earlier, almost 93% of participants in the 2021 survey by Mörkl et al. wanted further training in nutritional psychiatry.

Bringing nutrition into the therapy room

Given the potential benefits of nutrition for mental health and the likely bidirectional nature of the relationship, it could be prudent for therapists to explore client food choices with them. As Terry and Reeves (2015) note, if therapists are aware of the contribution of nutrition to positive mental health, then it becomes an important therapeutic issue. Perhaps even an ethical one.

Along with helping clients to manage their mental health issues, there are other potential benefits to therapists being aware of nutrition and health. For example, clients present with an array of issues, including those relating to self-esteem and weight, stress, disordered eating, substance misuse, and physical illnesses (such as cancer and autoimmune conditions) that impact their mental health. While it may be unreasonable and even unethical to expect psychotherapists to use dietary interventions for physical issues, a simple awareness of the effects of nutrition on the body and

brain, could enhance the therapist-client discussion in these areas. For example, vitamin and mineral intake may provide some protection against substance misuse (Schroeder & Higgins, 2017). Additionally, diet and nutrition may impact a person's stress levels and this stress can then have knock-on mental and physical effects (Edwards, 2002).

The consumption of unhealthy foods, meal skipping, and overeating can create a vicious cycle that intensifies stress and emotional distress which, in turn, increases the risk of poor nutrition. Furthermore, therapists who work with women of child-bearing age may wish to consider diet and nutrition in their work, due to the emerging evidence that "maternal and early-life nutrition is a determinant of later mental health outcomes" (Sarris et al., 2015, p272). Essentially, not only does early diet impact mental health outcomes later in life, but the effects of diet can pass from one generation to another.

Therapists also need to be aware that some clients prefer to take a natural approach to health (Caldwell & Jorm, 2000; Jorm et al., 2000), with many psychotherapy clients also utilising complementary and alternative therapies (including dietary interventions) alongside psychotherapy to manage mental health issues (Elkins, Marcus, Rajab, & Durgam, 2005). Yet just 34% (Elkins et al., 2005) discuss their use of these therapies with their psychotherapist. Perhaps therapist openness and familiarity with dietary interventions could support better integration of client goals, treatment, and outcomes.

Finally, effective dietary-related therapeutic interventions could help empower clients to support their own mental health, long after therapy has ended.

Of course, even acknowledging this separate-but-related discipline poses some interesting questions for our profession

Conclusion

Nutritional psychiatry research from the last few decades has established that there is a strong relationship between diet and mental health. Studies have indicated links between nutritional status and depression, anxiety, violent behaviour, bipolar disorder, schizophrenia, cognitive impairment, and more. Findings tend to be consistent across multiple populations and age groups. In some cases, altering a person's nutrient status can be as effective as taking antidepressant medication. There are several potential explanations for these effects, which may include diet's impact on the gut microbiota, neurotransmitters, and the body's inflammation levels.

The field of counselling and psychotherapy seems to be lagging behind in terms of integrating these findings into training and practice. There are several potential explanations for this. Firstly, nutritional literacy among psychotherapists (and other mental health professionals) is poor. Secondly, research on nutrition specifically within the psychotherapy field is lacking. Thirdly, the research that does exist suggests that therapists want more training and support when it comes to the topic of nutrition.

Of course, even acknowledging this separate-but-related discipline poses some interesting questions for our profession. Are there ethical implications of continuing to exclude the subject of nutrition from psychotherapy, given the persuasive research findings? Should we use this newfound knowledge with our clients? If so, how? What might the interventions look like? How do we integrate this into training and supervision? What about issues of competency and insurance? Right now, perhaps, we do not have the answers to these questions. However, they certainly give us food for thought.

Clearly, much more research is necessary – specifically within the field of counselling and psychotherapy – in order to determine how and when therapists could possibly apply this knowledge to their work with clients, as well as the barriers that currently prevent them from doing so. Furthermore, understanding the opinions, preferences, and the lived experiences of both clients and mental health professionals with regard to this complex topic could provide invaluable information to move this area of research forward, and make meaningful contributions to policy and practice.

Jayne Leonard

Jayne Leonard is an accredited psychotherapist working in private practice in Ennis, Co. Clare. She holds an MSc in Pluralistic Counselling and Psychotherapy, where her research focus was on nutrition for mental health. She also holds a Diploma in Nutritional Therapy and is a registered Nutritional Therapist with the Federation of Nutritional Therapy Practitioners (FNTP).

Jayne is passionate about increasing awareness of the role of nutrition in mental health and can be contacted at info@ViveCounselling.com. Further information is available on her website www.ViveCounselling.com.

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Academic/Research Article

A simulated interview with Fritz Perls: Part 3 - Final pearls from Perls

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

Throughout his career, Perls shunned discussions of past events in favour of experiencing the here-and-now moments that occurred during therapy sessions. He preferred the lived experience of group therapy, due to the spontaneous interactions that developed during them and his lively workshop demonstrations

Fritz Perls was the charismatic leader of Gestalt therapy. He embraced the gestalt approach, retaining a focus on the here-and-now momentary exchange between people. Throughout his career, he shunned discussions of past events in favour of experiencing the here-and-now moments that occurred during therapy sessions. Fritz Perls' ideas have clinical utility that have persisted beyond his own teaching.

Over the course of his career, Perls published several books and articles, but he preferred the lived experience of group therapy and his lively workshop demonstrations. He endorsed a fluid and creative approach to therapy. Perls believed that group work is more useful than individual sessions, because the spontaneous interactions that develop during group sessions bring the issues into the here-and-now moment. His emphasis on authentic relationships was aligned with the genuineness endorsed by Carl Rogers and the social games identified by Eric Berne. Perls' discussion of the social roles played by most adults foreshadowed the valuable ideas highlighted in transactional analysis.

Despite holding a medical degree, Perls disavowed the value of psychotropic medications. Furthermore, he avoided diagnostic labels in favor of viewing client struggles as problems with adjustment (Lobb, 2016). Staying true to the Gestalt movement, Perls was not invested in research to examine or support his ideas, which makes sense, because of the reductionist approach that is required for most research investigations. Perls was never active in research and he believed that research studies have become overly structured and quite artificial. Thus, empirical research has not been a good fit for an experiential approach like Gestalt therapy (Reck, 2017). Over the years, there has been little research conducted to support Gestalt therapy (Brownell, 2016; Raffagnino, 2019). However, Gestalt therapy could be strengthened by the current emphasis on evidence-based practice (Reck, 2017) or the Gestalt approach may risk obsolescence (Beja et al., 2018).

This article presents the third and final simulated interview with Frederick (Fritz) Salomon Perls (FSP) led by James C. Overholser (JCO).

FSP: "Okay. Sit down" (Perls, 1973, p. 121). "Before you ask questions, I want to say something" (Clements, 1968, p. 66). "It took us a long time to debunk the whole Freudian crap" (Perls, 1969a, p. 1). "I think individual therapy is obsolete, that it should be the exception rather than the rule" (Perls, 1970a, p. 36). "I have eliminated individual sessions altogether, except for emergency cases ... all individual therapy is obsolete and should be replaced by workshops in gestalt therapy" (Perls, 1967, p. 306).

JCO: Well, that gets the conversation rolling. I prefer individual sessions using the traditional 50-minutes hour.

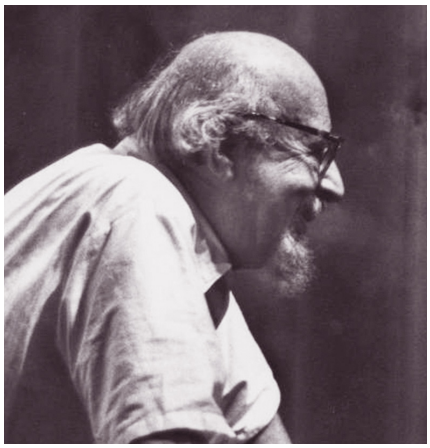
FSP: "That's crap and being compulsive, the 50 minutes ... Sometimes we work 20 minutes with a person, sometimes an hour and a half. This whole individual therapy crap is completely obsolete. It's a fossilized survivor of the Freudian period" (Clements, 1968, p. 70).

JCO: Well, that does not align with my expectations for therapy.

FSP: "I am not here to live up to your expectations" (Perls, 1969a, p. 4).

JCO: Fair enough. Why do you feel group therapy is better than individual sessions?

FSP: "In the group situation something happens that is not possible in the private interview ... Somehow, trust in the group seems to be greater than trust in the therapist" (Perls, 1967, p. 311). "The group's observation of the manipulative games which the neurotic plays, the roles he acts out in order to keep himself in the infantile state, facilitates their own recognition" (Perls, 1967, p. 312).



Fritz Perls - Photo source: exploringyourmind.com

JCO: And group therapy is more efficient than individual sessions?

FSP: "Exactly" (Perls, 1970b, p. 229). "I have tried to find a method to shorten the time required for psychoanalysis" (Perls, 1979, p. 11).

JCO: Like what?

FSP: "Home exercises are an important factor in the shortening of the treatment" (Perls, 1979, p. 17). "We ask all our patients to try doing some homework, and many are capable of speeding up their therapy considerably" (Perls, 1973, p. 82). "I give integration exercises to my patients according to the nature and severity of their dissociation. I know quite well that they cannot do these exercises in an efficient manner, so, as we go along, we analyze the difficulties or resistances step by step" (Perls, 1979, p. 12).

JCO: I agree. Assignments are helpful, but it can be a struggle with some patients.

FSP: "I am fully aware that the patient cannot be immediately successful in the tasks which I put before him. If he could, he would not need my assistance" (Perls, 1948, p. 575). "The problem of psychotherapy is to enlist the patient's power of creative adjustment without forcing it into the stereotype of the therapist's scientific conception" (Perls, Hefferline & Goodman, 1951, p. 328).

JCO: Let me change topics. How would you describe yourself as a psychotherapist?

FSP: "I believe that I am the best therapist for any type of neurosis in the States, maybe in the world" (Perls, 1969b, p. 217). "I like my reputation as being both a dirty old man and a guru" (Perls in Thomason 2016, p. 8). "There, I did it again. Boasting" (Perls, 1969b, p. 2). "I am sure that in spite of all my boasting I don't think much of myself ... most of my showing off is overcompensation" (Perls, 1969b, p. 2). "I often ask for approval, recognition, and admiration during conversations" (Perls, 1969b, p. 6).

JCO: You have a degree in medicine, but you do not rely on medications to treat your patients.

FSP: "That's right" (Perls, 1969b, p. 117). "Neurosis is an unbiological attempt of solving man's social problems" (Perls, 1979, p. 20). "Medical means are insufficient" (Perls et al., 1951, p. 360). "Today we spend years and millions on testing the safety and efficiency of every drug that comes on the market" (Perls, 1969b, p. 136). "We believe further that the 'mental-physical' or 'mind-body' split is a totally artificial one" (Perls, 1973, p. 53) "The either/or emphasis on 'mental' and 'physical' ... limits the therapist's ability to handle it" (Perls, 1973, p. 53). "This psychological process cannot be divorced from the physiological one; that each contains elements of the other" (Perls, 1973, p. 6).

JCO: What about something simple like headaches?

FSP: "We do not try to get rid of the headaches" (Perls, 1953-1954, p. 49). "We ask them to take more responsibility and less aspirin. We do this by asking them to discover … how they produce their headaches" (Perls, 1973, p. 67).

JCO: Do you ever prescribe pain killers or mood stabilizers?

FSP: "Definitely not" (Perls, 1978a, p. 55). "Pharmacological 'pain-killers' are a means of partially blocking out one's actuality" (Perls et al., 1951, p. 36). "The physician who prescribes barbiturates for insomnia … prevents the problem in question from coming to the foreground by prescribing sleeping drugs, which are a very potent means of diminishing awareness, and he thus perpetuates a situation which the organism in its infinite wisdom is trying to resolve" (Perls, 1979, p. 9).

JCO: Why are you so strongly opposed to psychotropic medications?

FSP: "You might also take refuge in the panacea of modern psychiatry, tranquilizers, the damper of the excitement of our life force, and push your unsolved problems under the rug" (Perls, 1969b, p. 90). "The drug temporarily dulls the pain, but it does not solve the problem" (Perls et al., 1951, p. 195). "With the tranquilizer we cut out his vitality" (Perls, 1969b, p. 167).

JCO: The medications may disrupt psychotherapy. I worry that clients may stop working to make changes and instead they passively wait for the medications to bring about some positive effect.

FSP: "Yes, that's very interesting" (Perls in Clements, 1968, p. 68). "For surgical and pharmacological forms of medical treatment, the patient can be perfectly passive, and it is better if he is" (Perls et al., 1951, p. 165).

JCO: How are things different in psychotherapy?

FSP: "From the beginning the patient is an active partner in the work … and the emphasis is shifted from the rather comfortable sentiment that he is sick to the sentiment that he is learning something" (Perls et al., 1994, p. 36).

JCO: What is your view of psychiatric diagnosis?

FSP: "I think it is stupid" (Perls, 1970b, p. 226). "The method of defining and pigeon-holing seems to get us nowhere" (Perls, 2012, p. 91). "The distinction between normal and neurotic has become less than irrelevant; it is positively misleading" (Perls et al, 1951, p. 362). "Every person in our society has his 'neurotic trends', 'unresolved conflicts', or ''areas of maladjustment'" (Perls et al., 1951).

JCO: So, neurosis means immaturity?

FSP: "The word "neurosis" is very bad. I use it, too, but actually it should be called growth disorder" (Perls, 1969a, p. 30). "I consider the neurosis to be a symptom of incomplete maturation" (Perls, 1969b, p. 23). "A neurotic may be defined as a person who is unable to assume the full identity and responsibility of mature behavior. He will do anything to keep himself in the state of immaturity" (Perls, 1967, p. 308). "To mature means to take responsibility for your life" (Perls, 1969a, p. 46). "Maturation is a continuous growth process in which environmental support is transformed into self-support" (Perls, 1967, p. 309).

JCO: Do you feel that most clients avoid taking responsibility for their life?

FSP: "Neurosis … arises when the individual somehow interrupts the ongoing process of life and saddles himself with so many unfinished situations that he cannot satisfactorily get on with the process of living" (Perls, 1973, p. 23). "When the individual is frozen to an outmoded way of acting, he is less capable of meeting any of his survival needs, including his social needs" (Perls, 1973, pp. 25-26). "The neurotic, instead of mobilizing his own resources, puts all his energy into manipulating the environment for support" (Perls, 1980, p. 305).

JCO: But many people, myself included, feel they should do more, should be better.

FSP: "You find that you are always, always full of should. 'You should do this,' 'Don't do this,' 'This shouldn't be,' 'This isn't fair'" (Perls, 1978a, p. 59). "In order to comply with the 'should' demands of society, the individual learns to disregard his own feelings, desires and emotions … When the individual attempts to live according to preconceived ideas of what the world 'should' be like, he brackets off his own feelings and needs" (Perls, 1975a, p. 2).

JCO: How *should* someone respond to *should* statements? Hah!

FSP: "In responding to "should" demands, the individual plays a role … He shies away from seeing his limitations and plays roles unsupported by his potential … He constructs an imaginary ideal of

how he "should" be and not how he actually is ... the individual develops a phony facade to impress others" (Perls, 1975a, p. 3).

JCO: It sounds like therapy helps clients to behave like adults?

FSP: "The answer is no" (Perls, 1978a, p. 70). "Very few people can really see themselves as adults" (Perls, 1970b, p. 222). "An adult is in my opinion a person who plays a role of an adult, and the more he plays the role, the more immature he often is" (Perls, 1969a, p. 29). "It is difficult for him to realize the difference between mature behavior and *playing an adult* " (Perls, 1978c, p. 76). "Be aware of the games we play" (Levitsky & Perls, 1970, p. 6).

JCO: What do you mean by games?

FSP: "As social beings we play roles and games" (Perls, 1969b, p. 4). "In the social system the loss of nature is replaced by rules of games" (Perls, 1978a, p. 64). "A great deal of our thinking consists of internal rehearsal and preparation for playing our accustomed social roles" (Levitsky & Perls, 1970, p. 9). "Playing sick is one of the many ways the insecure manipulate the world" (Perls, 1969b, p. 23).

JCO: Do you feel that clients often manipulate others?

FSP: "That's right" (Perls, 1969a, p. 25). "I call neurotic any man who uses his potential to manipulate others instead of growing up himself" (Perls, 1969b, p. 19). "The neurotic, instead of developing his own self support puts all his energies into manipulating the environment for support" (Perls, 1978a, p. 66). "He looks for environmental support through direction, help, explanation, and answers. He mobilizes not his own resources, but his means of manipulating the environment - helplessness, flattery, stupidity .... in order to get support" (Perls, 1967, p. 309).

JCO: Where did these problems come from?

FSP: "The child learns, often by copying some adult, to secure environmental support by playing helpless or stupid, by bullying, by flattering, by trying to be seductive, and so on and on" (Perls, 1967, p. 310). "The patient has been conditioned to manipulate his environment for support. He does this by acting helpless and stupid" (Perls, 1978c, p. 76). "Manipulating others is an art ... most frequent are the dependence games: 'I cannot live without you' ... You are so great, so wise, so good'" (Perls, 1969b, p. 20). "One of the main games we play is the 'one-upmanship game': 'I'm better than you are'" (Perls 1970a, p. 15).

JCO: So, clients struggle when their manipulations doesn't work?

FSP: "No, not exactly" (Perls, 1969b, p. 185). "The neurotic's problem is not that he cannot manipulate, but that his manipulations are directed toward preserving and cherishing his handicap, rather than getting rid of it" (Perls, 1973, p. 47). "His means of manipulating are manifold. He can talk, often drowning us with words. He can sulk and go on strike. He can promise and make resolutions; he can break promises and resolutions. He can be subservient, he can sabotage" (Perls, 1973, p. 47).

JCO: How do you address these issues in therapy?

FSP: "In Gestalt therapy, maturity is achieved by developing the individual's own potential through decreasing environmental support, increasing his frustration tolerance, and by debunking his phony playing of infantile and adult roles" (Perls, 1978c, p. 76). "What we frustrate is his endeavor to control us by his neurotic manipulations. This forces him to fall back on his own resources and develop self-support. Then he can develop all his manipulatory skill towards the satisfaction of his real needs" (Perls, 1973, pp. 108-109).

JCO: But frustrating the client could damage rapport.

FSP: "Yes, possibly" (Perls, 1973, p. 151). "We may be all-accepting saints like Carl Rogers, or anger-bristling, gouty, crochety misanthropes" (Perls, 1969b, p. 247). "We shift the responsibility onto you (Perls, 1969b, p. 247).

JCO: Still, clients could become angry with their therapist?

FSP: "The malfunctions of the neurotic become manifest in his lack of genuine self-expression (Perls, 1948, p. 574). "With this lack of adequate self-expression, an emotion will not be expressed and disposed of by emotional discharge" (Perls, 1948, p. 583).

JCO: Do you feel that clients stop being genuine and become phonies?

FSP: "You might say that" (Perls, 1970a, p. 26). "I call anybody phony who puts on an act" (Dolliver et al., 1980, p. 138). "You notice a beautiful polarity - phoniness, and the reverse, being real and authentic" (Perls, 1973, p. 173). "The gap between one's potential and its actualization on the one side of the ledger, and

the distortion of this authenticity on the other, becomes apparent" (Perls, 1969b, p. 7).

JCO: I don't like phonies.

FSP: "I don't believe it" (Perls, 1973, p. 141). "Can you hear your voice?" (Perls, 1973, p. 90). "If you say it so blandly, you make me unsure of how to begin" (Perls, 1969b, p. 163). "Now stand up and say the same sentence as a giant" (Perls, 1973, p. 171). "Talk to phoniness" (Perls, 1973, p. 172). "Again, in a louder voice" (Perls, 1973, p. 165). "Can you stay with this feeling? (Levitsky & Perls, 1970, p. 10).

JCO: I don't like PHONIES!

FSP: "Okay, how do you feel now?" (Perls, 1973, p. 124). "Can you feel it?" (Perls, 1973, p. 167).

JCO: Yes, I guess I feel better, maybe more open about it.

FSP: "Now we are getting somewhere." (Dolliver et al., 1980, p. 138). "There you get a little piece of gestalt therapy" (Perls in Bry, 1972, p. 62). "If you wear a mask ... anyone trying to touch you ... will merely make contact with the mask" (Perls, 1969b, p. 36). "Only the mask is in contact with the world" (Perls, 1978b, p. 65). "The patient will not part with the mask as long as his feeling of safety behind it outweighs the discomfort of wearing it" (Perls, 1973, p. 94).

JCO: Let me change topics. What do you think of the current push for objective science to support psychological treatments?

FSP: "There is no such thing as objective science" (Perls, 1969c, p. 14). "The objectivity of science is also just a matter of mutual agreement" (Perls, 1969a, p. 13).

JCO: What is your view of the relationship between scientists and practitioners?

FSP: "Admittedly, there is difficulty here" (Perls, 2012, p. 11). "Psychologists ... may be roughly divided into two groups ... the 'experimental approach,' while the others ... the 'clinical approach" (Perls et al. 1951, p. 6). "Experimentalists and clinicians have viewed each other with mutual distrust. To the experimentalist the clinician has seemed ... an untamed wild man, careening drunkenly through areas of theory and practice; while to the clinician the experimentalist has appeared an untreated obsessional, miserably bound to his counting mania and, in the name of pure science, learning more and more about less and less" (Perls et al., 1951, p. 8).

JCO: Although some research studies are vital to good clinical practice.

FSP: "Yes. Very rarely though" (Perls, 1969b, p. 205). "Present-day experimentalists still tend to be ultra-conservative in the selection of problems upon which to do research ... the experimentalist ... will clamor for 'objective evidence" (Perls et al., 1951, p. 7). "They have clung to the scientific method of the formal laboratory ... one must turn away from the fetishism of the accepted 'scientific method'. The experiment must be real ... in the sense of making a personal difference" (Perls et al., 1951, p. 465). "Great research does not shun the painful contradictory evidence to his theory but seeks it out to enlarge and deepen the theory" (Perls et al., 1994, p. 37).

JCO: Clinicians have a different way of looking at things than researchers.

FSP: "That is right ... there is a big difference" (Dolliver et al., 1980, p. 137). "Clinical approach has been regarded as the antithesis of 'experimental approach'. It has lacked rigor and quantitative evaluation of results" (Perls et al., 1951, p. 13).

JCO: What do you see as the problem with academic researchers?

FSP: "They carefully sterilized (controlled) the experimental situations, making them less and less possibly interesting" (Perls et al, 1951, p. 464). "To over-emphasize the abstract is characteristic of so-called intellectuals. With some of them one feels that what they say derives solely from other words - the books they have read, the lectures they have attended" (Perls et al, 1951, p. 47).

JCO: Do you align more with clinicians than researchers?

FSP: "Yes, possibly" (Perls, 1973, p. 151). "I believe one case, fully understood, will do more than the research and examination of hundreds of cases and control cases" (Perls, 1969b, p. 272). "The clinician ... was forced from the beginning to deal in some fashion with the full complexity of human behavior ... and protected the vital level of his work from sinking ever to the depths of what may be performed in the name of experimental science - namely, to grub away at safe tasks for the sake of adding items to one's list of publications" (Perls et al., 1951, pp. 7-8).

JCO: If research is rarely useful, do you find more value in psychological theories?

FSP: "Yes and no" (Perls, 1969b, p. 116). "Planning of any treatment is

dictated by the weltanschauung of the therapist" (Perls, 1979, p. 8). "The psychotherapist's philosophy determines his specific approach" (Perls, 1948, p. 571).

JCO: So, theories provide the guide for therapy sessions.

FSP: "The therapist ... should plan his course of action, but remain alert and elastic during the whole treatment" (Perls, 1979, p. 21). "A technique used without understanding is a gimmick" (Perls in Clarkson & Mackewn, 1993, p. 96). "The more the therapist relies on his convictions and prejudices ... they prevent the therapist from seeing anything else" (Perls, 1973, p. 103). "The healthy person trusts his senses rather than his concepts, his prejudices" (Perls, 1969b, p. 24).

JCO: I think a mix of different theoretical orientations works best.

FSP: "The division of psychotherapists into mutually hostile 'schools' has been more destructive to the young science of psychotherapy than the earlier hostility of the laymen; each school in its battle against the other has acted as if it had all the answers and, for the most part, has ignored insights of a rival school" (Perls, 2012, p. 75). "The various theories are not logically incompatible and often neatly supplement and indirectly prove one another" (Perls et al, 1951, p. 327).

JCO: How do you know when therapy can be finished?

FSP: "Treatment is finished when the patient has achieved the basic requirements: change in outlook, a technique of adequate self expression and assimilation, and the ability to extend awareness of the averbal level. He has then reached that state of integration which facilitates its own development" (Perls, 1948, p. 585). "A small hole cut into an accumulation of snow sometimes suffices to drain off the water. Once the draining has begun, the trickle broadens its bed by itself; it facilitates its own development" (Perls, 1948, p. 572).

JCO: That's an interesting metaphor.

FSP: "Somehow I feel mellower than usual today. This is a fitting place to end a series of talks" (Perls, 1975b, p. 73). "I wish to express my gratitude to you for having given me the opportunity to voice my point of view" (Perls, 1979, p. 22). "I think you did a very good job here" (Perls, 1969a, p. 202). "I must finish" (Perls, 1979, p. 20).

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Academic/Research Article

Facing the world that materialist science leads us towards

By Dr Marion Mensing

Is subjective experience a brain product, generated by chemical and electrical processes that can be replicated in machines? This article explores the implications of what we believe to be true

Introduction

To explore the role of consciousness in the world in relation to everything physical, I need to clarify first the terminology. In the following, I use the term *consciousness* in a broad sense, i.e. denoting subjective experiential activity in general, as McGilchrist (2021) employed it. Psychologically – following Jung's (1973) view on the psyche as a "conscious-unconscious whole" (p. 110) – it includes ego-consciousness, pre-consciousness and the unconscious, because even the unconscious psyche manifests as subjective experience albeit without ego-reflection. I also embrace McGilchrist's (2021) notion that something has the quality of being *fundamental*, if it is not reducible to components of something else, something even more fundamental. Accordingly, consciousness would be fundamental if it is not reducible to mindless, non-experiential components.

Can I really assume that a mountain has experience? But then, as McGilchrist (2021) put it, "how would you expect a mountain to behave if it did have awareness" (p. 1044)? Is matter totally mindless and unaware, but nevertheless generates subjective experience? Then, consciousness would not be fundamental. It seems obvious that the functioning of the physical brain strongly correlates with consciousness, how we experience the inner and outer world. However, does mindless brain matter *produce* subjective experience? Firstly, I evaluate this question further, and secondly, I explore possible new understandings of matter that entail consciousness as a fundamental property. Finally, I look at alternatives to the primacy of matter, and the Conclusion will draw everything to a close.

Materialist worldview

Searle (2000) expressed confidently that "variable rates of neuron firings in different neuronal architectures cause all the enormous variety of our conscious life" (p. 9). Dennett (2003) even paraphrased consciousness in IT-language as "user-illusions" (p. 19). These views stem from a materialist worldview, that Blackmore and Troscianko (2018) described as follows: Everything that happens in the universe involves matter and energy only,

and nothing else exists; mental states are brain states and as such functional.

Brain plasticity

Valk et al. (2017) conducted a neuroimaging study with 332 healthy adults and engaged them in nine months' mental training around (1) attention to present subjective experience, (2) compassion, and (3) meta-cognitive skills. Valk et al. (2017) found both improvement in all three mental areas and an increased thickness of the cortex in certain areas.

The participants' subjective learning experiences seemed to have created new brain matter. Or did some electrical and chemical processes in the participants' brains create the awareness of present moment experience, the experience of compassion, and the awareness of thought patterns? If this were to be the case, nothing would stop science to fully understand those brain processes in the future and as a result be able to fully replicate them in artificial intelligence.

Artificial intelligence

Subsequently, machines could replace everything that humans do, without exception, including therapy *and* science. This is the consequence, if the materialist worldview is true.

Koch (2020) framed it poignantly: "The birth of true artificial intelligence will profoundly affect humankind's future, including whether it has any" (p. 141).

However, Koch (2020) stated that it would be impossible for any software to compute consciousness or experience without massively changing the infrastructure and processor layout of the hardware. He argued that even the most powerful computer with the capacity to run a code simulating all the brain's connections between all the 86 billion neurons would still not create experience, because consciousness would not depend on the software, but on the level of *intrinsic existence* of the computer itself.

Higher states of consciousness, those rich mystical experiences that go beyond ego-consciousness, deserve some attention here as well

According to Koch's (2020) integrated information theory (IIT), a physical system exists intrinsically, if it makes a difference to itself. In Koch's (2020) view, it is this intrinsic causal power of brains that creates consciousness. Consequently, Koch (2020) assumed that only *neuromorphic electronic hardware* – special hardware imitating the brain's massive re-entry processing – – could match the intrinsic existence of the brain and therefore have human experience.

Critique of IIT

Although IIT appears consistent with several known facts in the neuroscience of consciousness (Koch, 2020; Seth & Bayne, 2022), it also attracted some criticism. Seth & Bayne (2022) found IIT lacking in relating experience to attention and learning. Kelly (2022) criticised that IIT would not consider the possible aspect of human consciousness of being *about* something. He also questioned how an irreducible structure of cause-effect information could fully represent the content of experience in all its meaning.

Perceiving here an attempt to explain consciousness through information, that would require consciousness in the first place, Kelly (2022) regarded IIT as fundamentally flawed. Similarly, Searle (2013) criticised that IIT would just claim that certain information and consciousness would be identical.

Brain acting as a filter?

Higher states of consciousness, those rich mystical experiences that go beyond ego-consciousness, deserve some attention here as well. Psychedelic states, for example, can be deep, complex, and insightful experiences, as described by Bache (2019) and Koch (Cooke, 2020). So far, neuroscientists have not been able to discover robust evidence for a brain activity that increases accordingly when a person enters these transcendent experiences through psychedelics (Carhart-Harris, 2018).

On the contrary, the findings of Carhart-Harris et al. (2012) pointed towards the opposite, because brain activity deteriorated and cerebral blood flow decreased, when the liveliness and richness of psychedelic experience increased. Certain other types of brain-impairment seem to relate also to transpersonal, richer, and more complex experience, discernible, for example, in near-death-experiences (van Lommel, 2011; Woollacott & Peyton, 2021) and in extreme acceleration (Forster & Whinnery, 1988). These phenomena led Kelly et al. (2010), Kastrup (2014), and McGilchrist (2021) to suspect that the brain might act as a *filter* for experience rather than as its generator, thus deeper experience would be the result of the filter's reduced activity.

Ego-transcendent experiences and intelligence

Koch's moving away from materialism towards *panpsychism* – a view that holds that certain aspects of mind are fundamental and omnipresent in nature (Goff et al. 2020) – seems closely related with his own psychedelic experience (Cooke, 2020). Barušs (2008) provided some evidence that extraordinary transcendent experiences, not only led away from materialism, but also appeared to have a positive effect on emotional and social intelligence.

More specifically, McGilchrist (2021) linked materialist thinking to an overactive left hemisphere of the brain, that he also found in schizophrenia and autism. According to McGilchrist (2019), the brain's hemispheres are related to completely different worldviews, making it possible to attend to the world in completely different ways: the left would narrowly focus on detail and the right would allow in the bigger picture.

Hemispheres out of balance

However, McGilchrist (2019) warned that the relationship between the hemispheres in the western world had become severely out of balance, with harmful consequences for healthy thinking and the survival of humankind, because the former *servant* – the left – had become the *master* in the interaction of the hemispheres. He linked the dominance of left-hemisphere activity to a strong focus on power and being in the right, driving towards a mechanical form of intelligence that would finally destroy humanity (Channel McGilchrist, 2022).

What else would break the dominance of the left hemisphere – apart from having ego-transcendent experiences? Based on McGilchrist's findings, the therapist Afford (2020) observed that the practice of sitting with uncomfortable feelings appeared to stop the left hemisphere and activate the right, so that meaning could emerge.

The conventional way of perceiving matter appears to conflict with quantum physics

Can there be a line between matter and consciousness?

McGilchrist's (2021) question, if embryos would be mindless matter in the materialist view, seems justified. Where is the line between non-experiential and experiential in human development? A way out of this dilemma – for Strawson (2009) the only way – would be to assume that everything is experiential.

The mystery of matter

A thorough scientific exploration of the properties of matter also requires looking at the subatomic level, at the implications of quantum physics. The early *Copenhagen interpretation* of quantum physics inferred that quantum mechanics would depend on a conscious observer (Frank, 2017; Hobson, 2017).

This faced the rejection of materialist scientists who developed alternative interpretations (Frank, 2017; Hobson, 2017), and – according to Frank (2017) – physicists have not yet discovered a way of testing the different interpretations experimentally. However, Frank (2017) emphasised that none of the possible interpretation – including the quantum fields interpretation as suggested by Hobson (2017) – would support the view that matter generates consciousness in any clear and straightforward way; on the contrary, from the view of physics, matter would still be a mystery.

Implications

Since the conventional way of perceiving matter appears to conflict with quantum physics, McGilchrist (2021) concluded that a new way of understanding matter "as part of a wholly experiential cosmos" (p. 1045), would open possibilities of understanding the connection with consciousness. This would require an openness to accept that matter may be not what most people thought. Chalmers (2021) described how the realisation of both the matter-consciousness-gap and the mystery of matter could move philosophers to panpsychism, the view that the nature of matter entails consciousness.

Panpsychism

Leidenhag (2020) carved out panpsychism's basic assumptions: (1) Some or all physical organisms are experiential, (2) subjective experience is fundamental, (3) matter and mind have only one and the same fundamental level of reality – fundamental monism, and (4) fundamental consciousness explains organic consciousness. Without the third thesis, as Leidenhag (2020) explained, there would be no clear distinction from *dualism.* Kelly et al. (2010) considered dualism, the assumption of a fundamental distinction between mind and matter, not to be viable anymore because of quantum physics.

Koch (2014) regards IIT as a modern form of panpsychism, distinct from materialism. Yet, conceding subtle abstract differences between IIT and

materialism, Kastrup (2014) could not see any practically relevant distinction, because both would assume that the brain generates consciousness and consciousness ends with death.

Strawson (2009) grounded his approach of panpsychism or *real physicalism* on the view that every mental process is physical – not in the classical meaning of physical, but more in the sense that everything physical is energy and all energy involves experience. In his interpretation, human consciousness emerges indeed from matter, but from a different kind of matter than normally thought of, that has experience from micro psyches of particles (Strawson, 2009). The question is how?

Dilemma of panpsychism

Silberstein (2009) described the dilemma: If particles would have a psyche just like humans, he argued, the question how the human psyche arises from all those micro psyches would be just as difficult to answer, as the question how mindless matter could give rise to consciousness. He saw the only way to avoid this problem in assuming that particles have a form of fundamental proto-psyche that forms human consciousness (Silberstein, 2009). However, this would mean, according to Silberstein (2009), that panpsychism would just replace the gap between the non-experiential and the experiential, with the gap between proto-psyches of particles and human subjective experience, which – in his opinion – would not solve anything.

Gap between science and theology

Kastrup (2014) defended – in his view – a much more parsimonious solution through a top-down approach, rather than a bottom-up approach for consciousness, leading to *top-down monism,* the view that one over-psyche infuses everything. Obviously, such a theory would move dangerously close to a theistic worldview and, hence, face a certain phobia against possibly entertaining the idea of God's presence in the context of science.

Jung regarded nature, as the unconscious psyche, and the divine/spirit as undistinguishable, and it also implicitly addressed his opinion that rationalist science disturbed both, the divine and humanity

Nagel (2013), another proponent of panpsychism, stated it clearly: "Even though the theistic outlook, in some versions, is consistent with the available scientific evidence, I don't believe it, and I'm drawn instead to a naturalistic, though non-materialist, alternative" (para. 9). Peters (2016) criticised Nagel's positioning of panpsychism as being "about just who gets to fill the gaps" (p. 7), a priori excluding theistic views because purpose and meaning would – in Nagel's view – have no place in science. Hence, the gap between science and theology seems also unbridgeable. As Main (2017) concluded, rationalisation has advanced so far, that

"there has been overall an increasing separation of God from the world, an ever-purer sense of God's transcendence, to the point where God has been so far removed from the world of experience as to have become for many […] an irrelevant hypothesis" (p. 1103).

Consciousness as the ground of everything?

Looking at the explanatory problems that panpsychism is facing, it seems only reasonable to take top-down monism or *idealism* into account. Idealism comprises worldviews that regard consciousness as all that exists and as the ground of all matter (Chalmers, 2021). Chalmers (2021) moved from panpsychism a little closer to idealism, by stating it would not be "greatly less plausible" (p. 29).

An alternative to panpsychism and idealism is *neutral monism*, a worldview that claims that consciousness and matter can be reduced to one neutral fundamental nature of the world (Stubenberg, 2018). And a variation would be *dual-aspect monism*, suggesting that consciousness and matter would be two fundamental aspects of this one fundamental neutral nature of the world (Atmanspacher, 2012). Kastrup (2018) argued here that idealism would be less complicated, but still accounting for all relevant aspects.

Jung and panentheism

Jung's (1991) view on the psyche also pointed more towards idealism because he regarded the unconscious – the experiential activity that is inaccessible to introspection or ego-reflection – as the "silent and undisturbed sway of nature" (p. 24) and declared:

"Our unconscious […] hides living water, spirit that has become nature, and that is why it is disturbed. Heaven has become for us the cosmic space of the physicists, and the divine

empyrean a fair memory of things that once were. But "the heart glows," and a secret unrest gnaws at the roots of our being. (p.24).

This statement showed that Jung regarded nature, as the unconscious psyche, and the divine/spirit as undistinguishable, and it also implicitly addressed his opinion that rationalist science disturbed both, the divine and humanity. Yet, Jung (2002a) did not see the unconscious psyche as identical with God, but as "the medium from which the religious experience seems to flow" (p. 63). This leads to a particular form of idealism, namely *panentheism.*

Panentheism is a worldview based on the assumption that the cosmos is *in* God (Main, 2017). It differs from the classical notion of a distance between God and the world that does not permit the world to essentially affect God; on the contrary, panentheists believe that the world can cause suffering to God (Brierly, 2008). That is not to say that panentheism infers that the cosmos *is* God (Brierly, 2008). Main (2017) explained in more detail how Jung's psychology implicitly fulfils the characteristics of panentheism. Referring to the possibility of knowing, Jung (2002b) emphasised a human's limitation to ego-consciousness before "the One, who dwells in him, whose form has no knowable boundaries, who encompasses him on all sides, fathomless as the abysms of the earth and vast as the sky" (p. 142).

My own view

My experience with internal family systems therapy (IFS) supports Jung's view of the One that dwells in all human beings. IFS provides ego-transcending, transformative, and meaning-making experiences. IFS assumes that the human mind comprises multiple parts, very similar to subpersonalities in psychosynthesis and what Jung regarded as complexes (Schwartz & Falconer, 2017). When a person disidentifies with these ego-forming parts, a new form of consciousness appears, the awareness of *Self* – universal in its qualities (Schwartz & Sweezy, 2020; Schwartz, 2021). Through IFS I can see consciousness moving from *the feeling of life itself* (Koch, 2020) towards *the meaning of life itself*. To put it another way, I experience IFS as a way to consciously relate to the divine. Like Kingsley (2018) pointed out, such a way makes the divine occupy a place between the ego and the vast unconscious as a new consciousness of Self; and for me, that *is* the meaning of life.

Humanity is currently facing a catastrophe and cannot have supporters of certain opinions stew in their own juice and assure themselves that they are right

Parts also seem to have parts and the capacity to let Self-qualities settle within themselves. If humans have parts that have parts, and a Self that appears to have identical qualities in every person and every part, it stands to reason that humans may be parts of a higher order mind that infuses and connects everything. To be completely honest, what I call Self means God to me. As Rohr (2019) puts it: "The Divine has never seemed very worried about us getting his or her exact name right" (p. 17).

In a nutshell, I cannot know the final truth about the nature of consciousness. All I have is my experience as a therapist, showing me on a daily basis how the rationalist's view undermines well-being, and I infer that the view of rationalism, of materialism endangers the survival of humankind.

Conclusion

If mindless brain matter produces consciousness, artificial intelligence could take over fully and replace humankind. Yet, research on ego-transcendent experiences points so far more towards a filter-function of the brain, that restricts consciousness. Ego-transcendent experiences seem to have a positive impact on thinking and intelligence, possibly connected to a stronger activation of the right hemisphere of the brain. The rationalist/materialist worldview may have a link to an overactive left hemisphere of the brain. Through the lens of materialism, the divide between non-experiential and experiential in nature leads to the problem of explaining exactly when a human foetus starts experiencing. Panpsychism avoids this problem by assuming that all matter has at least a proto-experience. Here the explanatory problem refers to the question how these proto-experiences of particles combine to finally shape human experience. The worldview of panentheism, that everything is in God, seems to have stronger explanatory power for some philosophers, theologists and also for Jung. However, the gap between main stream science and theism in general appears unbridgeable. From my experience as a therapist, it is this gap that is toxic.

Humanity is currently facing a catastrophe and cannot have supporters of certain opinions stew in their own juice and assure themselves that they are

right. Does it all boil down to the question: What is healthier thinking? If the right hemisphere of scientists' brains were to become more in charge, it might well lead to an *a priori* openness to all different views, more collaboration, more creativity, and also a rapprochement between science and spirituality which is badly needed.

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FLORESCENCE*

Dear Trauma

By Damian Morgan 2021

When you came you were not welcome, but you became a part of me.
Hiding in the shadows where no one else could see.
My memory of you has faded, I have pushed away the pain,
So far down the depths of me, that I forget your name.

Yet, you appear so unexpectedly, wearing a different disguise,
When I least expect you, you are there before my eyes.
Your face is anger or addiction, or another different guise,
I viewed you as a negative influence upon my life.

But now, now I see you differently, I want to name you, friend.
Because we may be together till the very end.
I wish to integrate you as part of my inner core,
And release you from the chains of my unconscious of yore.

I will ask of your protectors, will you please abide,
While this integral part of me walks here by my side.
Because, we can live together once we accept each other's place,
In this complicated world that we call our inner space

As we integrate, dear trauma, let us not lose sight,
That we are part of one another and together seeking light.
Once we learn to trust each other and accept that life will be,
We can look forward to our journey where we will both be free.

*THE PROCESS OF FLOWERING OR DEVELOPING RICHLY AND FULLY

Practitioner Perspective

Online therapy and the challenges of maintaining the therapeutic frame

By Helen Browne

Delivering Psychotherapy services using video has become part of daily life for practitioners. Many therapists offer a blend of online sessions in combination with their in-person client sessions. How can the boundary of the therapeutic frame be maintained when practicing in this way?

Introduction

This article explores the issue of rupture of the therapeutic frame in online therapy, a way of working for Psychotherapists which became widespread during the pandemic. Delivering Psychotherapy services online has become part of daily life for practitioners. Many therapists offer a blend of online sessions in combination with their in-person client sessions. How can the boundary of the therapeutic frame be maintained when practicing in this way? An overview of the literature and research relating to this issue and wider considerations of the therapeutic boundary will be presented, followed by discussion of a clinical case which represents the issue.

Solutions will be presented and discussed, and their strengths and limitations will be evaluated. The solutions presented are to be considered in the context of the time (Spring of 2020, during the first Covid-19 lockdown), when research and literature on online therapy was negligible. Validation of the solutions and their implementation is considered in light of new research on therapy practice during Covid-19. Professional practice implications and management of the issue will be considered from the perspective of the pluralistic approach.

The therapeutic frame on screen

The therapeutic frame refers to the static environmental and interpersonal conditions under which therapeutic work takes place. (Cooper & Knox, 2015) It can refer in a basic way to the practical arrangements under which the work is conducted, and can also refer to wider issues, such as how the work will proceed and for how long (Nolan, 2012). This therapist found that in the early days of the transition to working online during March 2020, as a result of the pandemic, the therapeutic frame was at times difficult to maintain, and for specific cases, ruptured in quite spectacular ways. The focus here will be on one specific case, the challenges of which represent the wider issue.

As for many other practitioners, the transition to working online was sudden, and took place without any prior training (Békés, Aaafjes-van Doorn, Luo, Prout, & Hoffman, 2021). McBeath, du Plock & Bager-Charleson (2020) state that prior to Spring 2020, literature was scant to non-existent. As the pandemic continued, the experience of therapists' difficulties

in working online and maintaining the therapeutic frame came to be more widely researched. Rizq (2021) relates the experience of perceiving that ironically, despite the client being on a computer screen, their perception of boundaries can be lessened, and the therapist can be involved in witnessing activities and habits that do not belong to the therapeutic space.

Exposure and distraction

Mearns and Thorne (2000) note that therapy exists between two individuals in the room and this boundary. This does not take into account changes in the client's lived reality outside the therapy room (2000, p. 31), a reality that can be more visible with online therapy. Mearns and Cooper (2005) further suggest that the therapist must be aware of the 'boundaries of acceptability' when it comes to behaviour during a therapy session (2005). Markowitz, Milrod, Heckman, Bergman, Amsalem, Zalman, H.,….and Neria (2021) note that for clients in online therapy, 'distractions abound' that can interfere with the therapeutic frame, and online therapy can give the therapist sight of things that expose their client's life.

It is this exposure, along with those distractions, that represents a breach of the therapeutic frame. As Eppel, Charlebois and McKim (2020) note, the therapeutic frame is designed to create an environment that is clearly separate from the client's daily life. Research has shown difficulties in maintaining the therapeutic frame were common during the pandemic online transition (James, Schröder, & De Boos, 2021). For some clients, there was at times a blending between their home life and their therapy session.

A representative case

The case which presented these challenges most clearly in this therapist's practice, was 'Anne', a client seen via video in early lockdown, 2020. She was a new mother, but as the lockdown unfolded, any support she had previously had, evaporated. She began to suffer from severe anxiety, questioning everything, and becoming highly distressed about making mistakes.

In this practice new Mums and babies have always been welcome, and indeed more than a few infants have been danced on this therapist's lap, while their Mum has poured out her woes

In this practice new Mums and babies have always been welcome, and indeed more than a few infants have been danced on this therapist's lap, while their Mum has poured out her woes. From the very beginning of 'Anne's' therapy the presence of her baby with her on screen was not a difficulty. She held her baby, talked to her, and generally attended to her while we were in session. However, as the sessions progressed, due her other distractions, the therapeutic frame began to break down. She cooked, cleaned, prepared baby food, changed her clothes, ate her lunch, lay in her bed, and on one occasion changed her baby's nappy in view of her phone screen. The struggle to stay connected to 'Anne' while she moved around, carrying her screen with her, became a dominant feature of the work. Rizq's paper (2021) provided comforting reading later, as she describes feelings during a similar experience: "I felt angry, baffled and helpless, a counter transferential response that made it difficult to understand exactly what was happening". Feelings of personal discomfort were also present for this therapist, as an intimate and sometimes disconcerting view of this client's most private spaces and habits was shared on screen.

Apart from the few moments in which 'Anne' was able to explore her anxieties and receive support in the sessions, it felt, unsurprisingly, like unsuccessful therapy work. It was difficult to know how to find solutions to the frame and boundary challenges, and for a time it seemed that this frustration represented a failure, that somehow these solutions 'should' have been known, and implemented.

However, the learning derived from the case was invaluable, benefitting future clients and the work in general. 'Anne' returned to therapy after lockdown, in-person, and some valuable work was undertaken with her. However, it should be noted that although seeing her in-person could be considered a solution to the challenges of working with her via video, it was not an available solution in cases with similar challenges at the time, and thus, other options had to be considered as lockdowns continued.

Guidelines and contracting

The research on boundary challenges for therapists working online during Covid-19 lockdowns overwhelmingly points to the efficacy of explicit and detailed contracting with clients, as a method of *prevention of frame ruptures* (James, Schröder, & De Boos, 2021). It should be noted that support in collaborative Supervision was essential at this time. There was great affirmation in the knowledge that other supervisees were experiencing the same issue, as indeed, was the Supervisor herself.

A detailed contract, or set of guidelines, on how online therapy should proceed was thus drafted and continuously modified to encompass any new challenges

which presented. Contracting is a such a formative part of therapist training, that it is difficult to remember exactly where the specific worded elements come from – and how they change over time in private practice. O'Farrell notes that the experienced therapist can often forget that the familiarity of their way of working can lead to assumptions about things that may not be obvious to a client (1999)

The current IACP Ethics and Guidelines document refers to 'review of the contract', yet no explicit contract content is given. (IACP, 2018) Sanders, Frankland and Wilkin (2009) suggest that contracts should address both the practical and the developmental framework of the therapeutic relationship. Feltham and Dryden (1993) make a distinction between the two, referring to the practical framework as the 'business' contract and to the developmental aspects as the 'therapeutic' contract.

The contract for working online was thus created to incorporate guidelines designed to create as contained a therapeutic frame as possible, in order for the work to proceed. Sources for modification of the existing contract/guidelines for application to these boundary issues when working online were scarce during 2020, as noted by McBeath et. al. (2020). However, Shariah, Islam & Arafat (2019) note that the therapist can act according to their experience, and adopt procedures that address any issues that could possibly arise during sessions.

When a new experience in rupture of the frame occurred, consideration was given as to its inclusion in the modified guidelines. For example, when a client introduced their partner during a session, an item was added thus: 'in order to protect confidentiality, please ensure that no one else is present in the room during your session'. Similarly, guidelines on where the client should consider having the session were given, i.e., in a chair, not a bed. This information was given to clients in advance of the first session throughout 2020 and beyond.

> *Identifying what physical space the client will use for therapy has proven to be an important factor in online work*
>
> *(Burgoyne 2020)*

Bond (2000) places the therapeutic contract and guidelines firmly in the area of ethical practice, suggesting that providing pre-counselling information to clients and to check that these guidelines are practical and acceptable to clients, along with regular review of same, can solidify the relationship from the beginning. With regard to defining the frame and physical space, Burgoyne (2020) notes that identifying what physical space the client will use for therapy has proven to be an important factor in online work, and that in helping to create an appropriate boundary, a definition of space must be considered.

During 2020, guidelines available from the IACP and other professional bodies focused almost entirely on issues of technology, GDPR and legalities, and the current guidelines emphasise the need for specialised training in the area (2021). Byrne and Ní Shiothcháin (2008) advocate that essential elements of any effective therapeutic contract must include (among others) establishment of the place where the therapy is held, potential limitations, and required behaviour - of both client and therapist. With a little modification of the word 'required' and some rather more therapeutic language, guidelines continued to be modified and given to each client in advance of therapy beginning. The structure of the therapeutic frame was thus more solidified, and benefitted the work hugely.

Implementation using the pluralistic framework

While the creation and modification of a set of pre-therapy guidelines, as a measure to prevent any boundary and frame issues in practice was helpful, the pathway towards implementation of the measure had at its core the principles of the pluralistic framework. The use of feedback creates a dialogue that is the basis for effective collaboration between therapist and client, as noted by Cooper & McLeod (2011).

Pluralistic techniques, such as metacommunication (McGrath and Donovan, 2013), provide the skills needed to collaboratively implement guidelines around working online, and instead of greeting each rupture as a negative thing, allow for a conversation about what should happen when such ruptures occur, either by accident or necessity. When it was perceived that a rupture was occurring, or about to occur, discussion with the client took place about what was happening, and how a return to the boundary of the session might be found through metatherapeutic communication. (Cooper and Dryden 2016).

For example, if a client moved around or engaged in a task, this was noted, "I see that you are attending to something in the room there", and the session was paused until they were finished: "I'll wait for a moment until you are ready to resume the session, is that alright?". In this way, metacommunication provided a way of commenting on what was being seen, as well as what was being said, and signalled that despite the rupture of the frame, the therapist was in tune with the client's non-verbal communication (McGrath and Donovan, 2013) Similarly, if the confidentiality boundary was

breached by the presence of another, the session was similarly paused until the other person was no longer present in the room.

Strengths and limitations

As Schmidt Neven reports (2020), the transition for therapists to working online in 2020 occurred suddenly and with an awareness that without making it, their practices could be irreparably damaged both financially and reputationally. Going forward, therapists may offer the option of a combination of in-person and online therapy session. Whatever the method, the therapeutic frame must be established and maintained in order to work ethically and safely with clients (Byrne and Ní Shiothcháin 2008). Contracting, guidelines and pre-therapy information establish and solidify the frame and boundary of the work, and can address issues that may arise (Shariah, Islam & Arafat 2019).

However, the risk of a therapist rigidly adhering to their guidelines in order to maintain the therapeutic frame of the session may appear hectoring, and therefore may further damage the client's view of self. The pluralistic therapist can affirm the effectiveness of what the client is already doing to improve their life, and by collaborative exploration, uncover pre-existing abilities and activities that can foster a more positive view of the self. (Flückiger, Caspar, Grosse Holtforth and Willutzki, 2009). However, when a client is in distress and potentially unable to hold the boundary of the frame when working online, interventions that seek to impose this boundary, may be damaging to the client and to the therapeutic relationship.

It can be contended further, as Mackrill notes (2009), that the strategies that clients bring with them to therapy are significant to the outcome of the work itself. For some clients in a state of serious distress it could be considered a strategy to behave in a way that assists them, or helps to process anxiety, even if it ruptures the formality of the therapeutic frame. The pluralistic therapist must work to create equality, but by any definition, the early moments of therapy are, as noted by Mearns and Thorne (1988) a "strikingly unequal encounter", perhaps even more so when boundaries are in question during online therapy. The need for therapeutic support can appear at times to stand in conflict with the pluralistic approach, and can even push a client outside of comfort (Cooper and Dryden, 2016).

> *The need for therapeutic support can appear at times to stand in conflict with the pluralistic approach*
>
> *(Cooper and Dryden, 2016)*

Professional practice - management of the issue

As noted in the most recent research regarding working online, not all clients are suitable for online therapy (Markowitz et.al., 2021) and so it seems imperative to allow for assessment of suitability for working online to be included in pre-therapy work, despite its geographical or practical convenience. The pluralistic approach begins with assessment, a process of information gathering, before work can begin in order to make decisions about how the therapy will proceed (Cooper and Dryden, 2016). This takes place through the facilitation of conversations between client and therapist, with the goal of exploring options for how the work will proceed (McLeod, 2013), including how boundaries will be created and maintained. Thus, ongoing management and prevention of ruptures in the therapeutic frame requires continuous engagement with the tools and resources of the pluralistic therapist, and the sureness of the experienced therapist (Råbu & McLeod, 2017).

As Mezirow states, we do not often pause and scrutinise the assumptions on which habits of expectation are predicted (1991) and this was especially true of the online migration of 2020. The collaborative nature of the supervisory relationship became even more essential during 2020. Research shows that during this time, many therapists relied on supervision and reflection with others (James et. al., 2021) to manage issues with therapeutic boundaries, and this therapist's experience was no different.

James, Shröder and De Boos (2022) propose that concerns about difficulties in therapeutic practice can be coped with constructively in supervision. As Safran, Muran and Eubanks-Carter (2022) illustrate, therapeutic outcomes are more positive when therapists receive specific supervision or training around the issue of ruptures.

Conclusion

Neither the issue of rupture of the therapeutic frame nor the practice of online therapy are new concepts in therapy. From the moment a therapist is in training, managing the way they and their client inhabit the space between them, is a part of the learning process. The experienced therapist later attempts to create a space that is safe and welcoming, and with a boundary structure that is consistent and clear. External forces can usually be kept at bay, with the most challenging distractions or ruptures confined to brief and manageable intrusions. However, when the space migrated to the online space between two screens, it seemed

that no assumptions could be made.

This article has examined the challenges in managing the therapeutic frame when working online and explored a specific representative case. Research on the experience of therapists working online during 2020-2022 confirms and affirms the challenges present in the issue under discussion. Exploration of the research points to the need for appropriate contracting in advance of making this transition. Solutions implemented focus on assessment and contracting with clients in advance of online therapy, maintaining the principles of the pluralistic approach.

As the recent research has shown, experienced therapists all over the world found themselves helpless, confused and even incompetent when dealing with issues of frame rupture in the early stages of the transition to working online during 2020 (Rizq, 2021, James et. al. 2021). The old dependable skills of addressing an issue in the room escaped many, as the room became two rooms and two screens. Contracting, metacommunication and assessment will be essential to ongoing management of rupture, and the application of pluralistic therapy principles offers the resources needed to address it when it arises in real time. Continued reflexive practice and committed engagement in supervision will be essential to the development of blended practice, which serves our clients as well as is possible in the continued use of this form of therapy.

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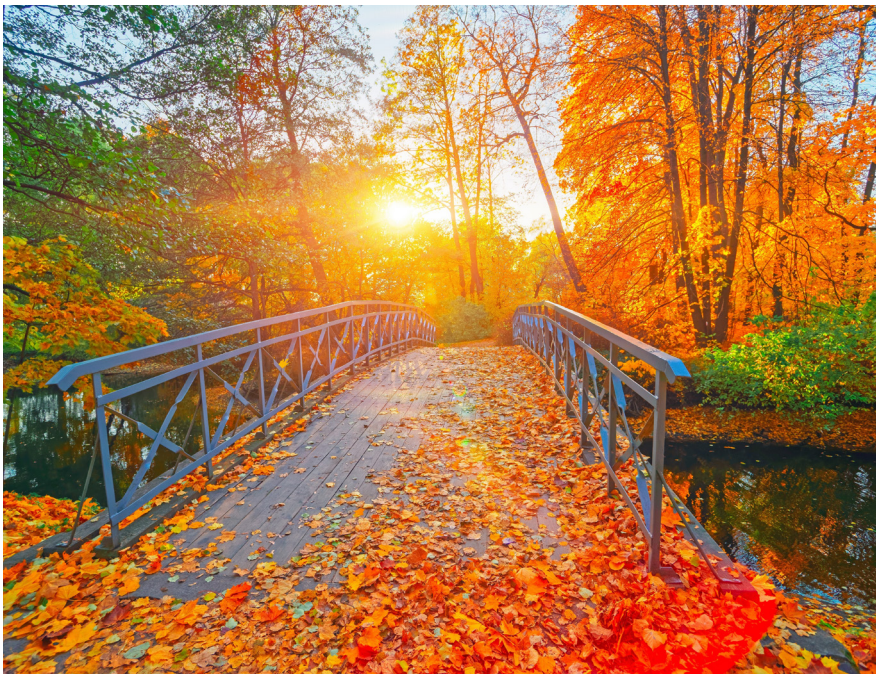
Reflective Article

The making of me:

My first year of transition as a practicing psychotherapist in Ireland

By Rhea Askins



Introduction

Some 82% of transgender (trans) individuals have considered ending their lives. And suicidality is highest among transgender youth with the rate of attempted suicide at, roughly, 40% (Austin et al., 2020).

I was 30 when I realised that I was transgender. For me gender exploration had begun years prior to that, through clothing. At any opportunity, home alone, I sifted through my mother's clothes and makeup, anxiously listening out for my family's return. Then I would have to put *myself* away again until the next opportunity. My dysphoria – a sense of ill-fit between one's appearance and inner sense of identity – solidified into secretive, ashamed elation. Contrary to anything I had ever known before. My epiphanic path is one of many among the transgender community.

In 2020, California's Cedars-Sinai Medical Center found that many transgender people first experienced gender dysphoria at the age of 4. Transgender women lived an average of 27.1 years and transgender men lived an average of 22.9 years before starting to transition. For many, dysphoria was almost unbearable due to a lack of early mental health supports, that could have eased their gender transition and improved their quality of life.

It is worth highlighting some phrases before proceeding further:

At birth, doctors assign us to one of two common gender groups (boy/girl) based upon the genitalia visible to them at that point; this is described among the transgender community as being either assigned female at birth (AFAB) or -male at birth (AMAB). Should a person assigned to a gender group later begin transition they are commonly referred to as being a transgender male (AFAB but transitioning to the male gender) or transgender female (AMAB but transitioning to the female gender).

In 2020, a study was published on the Cedars-Sinai hospital website under the title "Most gender dysphoria established by age 7." The study found that 78% of transgender men, and 73% of transgender women surveyed first experienced gender dysphoria by age 7. In this online journal article, study leader Maurice Garcia, MD, wrote a statement that applies simultaneously to the current situation of gender care services in Ireland:

'While policies regarding transgender people's rights are evolving, what is still clear and unchanged is the unequivocal need for accessible health care for transgender and gender nonconforming people of all ages.'

The National Gender Service (NGS) should be a support for transgender people who apply for interview via their waiting list. However, the situation in reality is quite different, based upon accounts from other transgender women I have met. The main consensual complaints about the NGS are as follows:

1) You may wait a decade to interview for an assessment to

decide whether or not they deem hormone replacement therapy or blockers (medication blocking undesired hormonal effects) necessary. 2) Many transgender people that I have met report feeling infantilised by a gatekeeper culture in the NGS. They highlight that medically-trained interviewers assume to know what is best for another autonomous individual, expecting applicants to comply to expected gender norms if they are deemed to have gender dysphoria by the NGS. This culture could be easily improved by adopting an informed consent approach, which would make service users feel believed and supported, rather than having to prove who they are. 3) Politicians and other people who are not, and have never experienced what it is like to be transgender themselves, are making decisions on transgender healthcare in Ireland.

In my experience, there are not enough adequate supports for transgender people in Ireland, and those seeking surgical transition have no choice but to travel abroad. In all, when attempts are not made, or are half-made to assist or embrace a group of people, ostracization and unwantedness can often be the message received by minority groups.

In recent years there has been progress, but there is still much to be done. An increase in the visibility, and normalisation of transgender people in mass media will reduce the perception of transgender people as something alien to those who do not know much about us. This and education are key if change is what we seek.

Finding trans

I first discovered the term *transgender* online, aged 12. Before that, I had seen the exploitation of gender variance as infamous plot twists and punchlines in movies like "*Ace Ventura: Pet Detective*" and "*The Crying Game*". In all, I never found gender variance to be shocking or worthy of laughter. Instead, I wondered why this perfectly valid form of personhood was considered to be climactic at all – because I identified with the representations I was seeing on screen; it just took me a long time to realise what that identification really meant for me deep down. I had assimilated the innately anti-transgender rhetoric espoused by mass media through their exploitation of it – which caused me to wrestle heavily, over years, with the possibility that I could in fact be that "punchline", or "shocking reveal"; that I could in fact be transgender too.

Because I identified with the representations I was seeing on screen; it just took me a long time to realise what that identification really meant for me deep down

During school I always preferred the company of other girls, wanting to express and dress like them, instead of suppressing my personality as a quiet, sensitive, apathetic boy to survive without sticking out of the crowd. Then, I came alive at home, surrounded by my art supplies, videogames, books, and close family. However, one vivid memory comes to mind above many others, when I think about my historical gender variance and the path and the time that I took to realise that I was transgender:

I was six, wearing a pair of yellow, wooden, floral clogs, and a cousin's *Snow-White* dress from the old *Disney* cartoon. I felt so free that day; it just felt right. Then my uncle arrived home and I suddenly froze up inside, sick, as though I'd been caught doing something terrible. But that ecstatic, aligning early dressing memory was just one of many events that made no sense to me for thirty years of my life – and it would, one day, lead to every neat and tidy box I ever thought existed exploding into a billion pieces, taking much of my old mindset and *Self* along with it.

Discovering my truth came as quite a shock. I began developing my new skin, my new identity; embracing a chance to live as my true self. An anxious leap into a brighter future, and one I would have regretted rejecting. That was the start of the making of me.

My aim, now, is to therapeutically support the LGBTQ+ community because meeting others with shared experiences to mine truly alleviated much of my social anxieties, feelings of isolation, difference.

Transition in practice

I was excited to be transitioning and moving towards a greater sense of alignment between who I was inside and how I looked outside. Naturally, I was concerned that changes in my appearance could impact my clients and my career. Doubts arose over my future in the field, but I chose to take it all in my stride.

I learned of Lucie Fielding and other trans mental health professionals practicing in America, and this made me feel less alone, but in Ireland, this had either never happened, nor was never publicised in the country's history before. In the event that there had been transgender psychotherapists practicing in the past or at the same time, I toyed with the tentative title of Ireland's first "out" transgender psychotherapist. However, shortly thereafter I decided that such a title did not define me or the work I did in my therapy practice. I include my gender identity in my professional biography as I am proud of the woman I am, and truly believe that representation is essential if gender variance and the LGBTQ+ community is ever going to be accepted and normalised.

Finding peers and supports

proved to be the greatest gift I could have given myself early-on, and this is usually one of the first things I explore with clients who are presenting with issues related to gender, grief and sexuality.

The sense of isolation and loneliness can leave many transgender people feeling; 1) societally unacceptable due to archaic, systemic social constructs that oppress many and are viewed as *right* simply because of how long they have been accepted as the benchmark, 2) lost and 3) alone. The social pressures to supress your true identity and to conform are deeply damaging psychologically and can be mortally debilitating, which is also why representation and support networks are essential for transgender people.

Although not every transgender person can, or chooses to pursue the same avenues in terms of transition, there are some who have become synonymous with the transgender community. The common types of transition some people choose to undergo in order to achieve a greater sense of alignment between who they are inside and how they appear and are perceived outside include:

Social transition, during which a person can alter their dress, gait, voice, and daily practices to that of their true gender. The option to medically transition exists, which involves undergoing HRT in order to feminise/masculinise one's physical appearance, hormones, and mindset as a result. There is also the option to surgically transition which can include, but is not limited to, *facial-feminisation surgery* (FFS), "*bottom surgery*" – or *gender-confirmation surgery* (GCS), and "Top surgery" – or *breast augmentation* (BA)/ *mastectomy*.

In February of 2022, when I had started to disclose my newly-realised truth to my nearest and dearest, I began my social transition by undergoing a year's worth of laser hair removal. At that time, over coffee, one of my transgender peers shared a story with me about the day that she decided to open up a conversation about her gender identity with her former therapist.

> *They stated very confidently: "I don't think you're gay"*

Outside of the family home for fear of being overheard, sitting in her car due to her sensitivities around the subject she was preparing to disclose that night, her mouth was dry, her heart was racing when she got to the point of phrasing her feelings, that she might be transgender. Her therapist's comment to follow this hugely trying piece of self-disclosure shocked me, due to its ill-informed and potentially damaging consequences and lack of ownership.

They stated very confidently: "*I don't think you're gay*."

It is mandatory for mental health professionals to engage in on-going training. However, in this instance – which is not the only event of this type that I have encountered – said therapist displayed ignorance; gender and sexuality are two separate things – just because a person is transgender does not mean that you can connote their sexual orientation or preferences from that fact. Also, clients who may belong to a part of the LGBTQ+ community may come to a therapist without a need to discuss their sexual orientation or gender identity; human beings are multifaceted and one part of us happens to be our gender identity, and sexuality.

I have integrated learning from my friend's experience into my work with LGBTQ+ clients who come to speak with me.

Simultaneously, I started seeking a source for HRT. At that time, I knew little of the years-long waiting lists and the reports of systemic bias towards people who looked as though they would blend in after transition, and conform to a heterosexual orientation.

When I met and enquired with a local GP about starting HRT, I discussed my fears about certain aspects of transition that I had read about in my research. I expressed concern over testosterone blockers, and the idea of what I had heard described as "chemical castration" online. They stated that they didn't think I really sounded sure of what I wanted, simply because I expressed concerns. Ultimately, they did submit my details to the glacial NGS's waiting list. Again, this is another example, in my experience, of a damaging, ill-informed professional whose utterances could have severely impacted the mental health of a person who was seeking compassion and assistance. We need to do better!

Despite the transphobic encounters I was exposed to, I ventured forward and eventually discovered a telemedicine company with whom I began the process within four months, avoiding entry into a lengthy waiting period of, at least, three-and-a-half years before being interviewed to find out if I would be approved to begin HRT.

At this time, I am saving for, researching and planning the next parts of transition that I feel I want to pursue, but my sense of wholeness has already improved since I started HRT through the dignified informed-consent model that assumes an adult individual can make decisions for themselves; unfortunately for many, Ireland does not yet use the informed consent model.

Surgical transition is often sensationalised in media as a punchline, or big reveal, which – due to its reach and popularity – implies that being transgender is akin to a secret, thus invalidating the existence of transgender people as people in disguise amongst us. When, really,

being transgender is as valid a form of personhood as any other. How we present, express ourselves and live our lives is not up for discussion as many presume it is. A person who is assigned female or male at birth, and is comfortable with their assigned gender identity is not challenged or tasked with proving their validity as a person who dresses, sounds or behaves a certain way.

I encourage allies and transgender people who read this piece to question the implicit superiority of the expectations that are being placed upon transgender people by society. You do not need to prove yourself to others, sound a certain way or try to fit a mould to suit another person.

I began my transition in order to live and feel more whole and authentic, but exposure to attitudes encouraging beauty standards, body types and behavioural alterations in order to blend in, just added more and more of somebody else, and less and less of me.

How much was I going to alter before I lost myself in my transition?

Instead, I decided that I would transition towards empowerment, the person that I wanted to be, and bring with me all facets of my old identity – passions, interests, etc. – that still felt like a relevant part of me. It is with this autonomy that I proceed with my transition, holding firmly to this solid ground when facing negative client reactions or any of the other challenges that the professional side of my transition may present.

Conclusion

A diary I had cracked in order to chart the year 2022 bears scratchy black felt and browned, pressed leaves on the cover; it was given to me by my godmother for my 30th birthday. I had started to journal one night in February of that year – exactly one year ago, at the time of writing – and the very first page begins:

30. Feels so young and so old at the same time… but this time feels different. I'm not sure what series of events led me to this, but years of ignored gender diversity notions suddenly landed on me [tonight]. My body and diet and mind have been turned upside-down, I've lost weight and I can't stop facing the fact that I've been unconsciously suppressing and that is that I want to be a woman…

As it appears here, so it flowed from my black pen then. Needless to say, I was dumbfounded. It explained so much that had never made sense before; inexplicably fluctuating confidence levels and comfortability in myself, challenges involving intimacy, self-shaming behaviour for myriad innocent acts, and the suppression of any inklings of gender diversity and/or sexuality into the realm of fetishisation and dismissal (Serano, 2007). Soon after my epiphany, I entered sessions with a therapist specialising in issues related to the LGBTQ+ community and I am an advocate for such manoeuvres of selfcare in sessions with my own clients today.

Since then, I have learned that my gender identity has always been female and that my journey was not as much one of "becoming" female, but of changing things in my life, for myself, in order to align my inner sense of identity and my external appearance which then creates an alignment of the self as a whole. My experience in realising that I am transgender has brought me to face anxieties, truths and challenges with a proactive mindset and I have met many other amazing women, on similar journeys to mine, who have adopted a similar perspective.

"Passing" matters to transgender people for a host of reasons – two of which can be either personal satisfaction, or personal safety in the world. If you do not stand out, the belief suggests, you stand less of a chance of being discriminated against or having hate speech or violence befall you. However, the more I experience, the more I realise that there is no definition of "womanhood" – only my own, that is the definition I am pursuing. This realisation is one that alleviates much of my earlier concerns regarding voice pitch, walking gaits, body size and shape, and mannerisms; for every recommendation I hear in order to "pass" more successfully as a woman in the world, I encounter a cisgender woman who contradicts such overgeneralisations.

It is through my own personal and professional journey that I have come to realise that transition is part of life for everyone. And it is my hope that those in need of my assistance might find me through this piece. Further, it is through compassion, understanding and education that you can help the push towards embracing the LGBTQ+ community going forward. Your kind word or action of love may just be what saves the life of a person who is simply attempting to be and become who they know themselves, inside, to truly be.

Rhea Askins

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Issues and Controversies in Counselling and Psychotherapy

We need to abandon the practice of 'free therapy'

By Mike Hackett

Credit: Ventura/Shutterstock.com

Nothing is free. Everything has to be paid for. For every profit in one thing, payment in some other thing. For every life, a death. – Ted Hughes, The Tiger's Bones

In this short essay, I will make the controversial case for our profession to abandon the practice of providing 'free therapy'.

What I mean by 'free therapy' is the provision of therapy to a client free of charge or in other words, on a no-fee basis.

From the title you will have noticed my use of enclosing quotes when referring to this practice. This is because there is clearly and demonstrably no such thing as 'free therapy' in an actual sense. Like everything that is labelled free, ultimately, someone pays and trying to determine who actually pays is actually very complex due to the proliferation of stakeholders involved in therapy provision. Today, we operate in a very fragmented therapy landscape in Ireland.

As far back as 1976, the American Journal of Psychiatry published an article exploring a number of therapeutic, relational and practical issues which may arise where therapists provide 'free therapy'. The paper 'Free psychotherapy: An inquiry into resistance' (Nash & Cavenar, 1976) presents five case studies of clients receiving 'free therapy' and found that this practice "may lead to patients depreciating the value of therapy, feeling obliged to therapists, or expect him to make inappropriate nonfinancial demands". In such cases, they further warn that such a service, "may become the focus of insoluble resistances to therapy".

Forty-seven years later, as a profession, we seem to have essentially institutionalised the provision of 'free therapy', explicitly, when we train therapists and implicitly, by normalising the practice as an altruistic virtue. The evidential basis for this claim is provided by pointing out that our very own accrediting body promoted the practice during the Covid-19 pandemic by advertising 'free therapy' for frontline workers and indicating in our "Find a therapist" database those members willing to offer the service. Surely then, this must be a good thing if our representative body promotes it right? I don't believe so, and I will explain why.

First, if the purpose of providing 'free therapy' is essentially *pro bono publico* (for the public good), do we spend enough time thinking about balancing public need with our own wellbeing (financial, social, professional etc.) and, more broadly how our profession is valued. For instance, surely the idea of counselling and psychotherapy as a profession carries with it a prerequisite monetary consideration for the work done in order for it

to be valued? Do people value products which are 'free', possibly, but free services – time, each week, week-on-week for potentially years – I'm not convinced of that position (more on this later when we look at the therapeutic issues 'free therapy' creates). I also wonder about our credibility as a profession in the eyes of the medical establishment when nearly one-in-ten of us charge nothing for our weekly work (B&A, 2021, p. 22). In all of my 50 odd years on this planet, I have never had a free GP consultation (as a once off), never mind a free ongoing GP service though clearly, both would be for my overall good.

Second, let's pick up again the theme of what the academic literature says about the practice of 'free therapy'. Looking as far back as Freud, the subject of fees has been explored somewhat intermittently. According to Freud, payment of a fee motivates the client to bring the work of therapy to a successful end (1913/1958). Fees can represent a means to define a client problem to both the client and therapist, Brody (1949). Koren & Joyce (1953) posit that clients who balk at fees, may in fact not be ready for therapy and the fee becomes a reason to drop out. Hofstein (1954) suggests that fees represent a limiting factor for the duration of therapy – ensuring it doesn't continue past what is necessary, and, that a client's ability to pay for therapy may be representative of their struggle with self-sufficiency in life. Menninger (1958) suggests that fees represent a sacrifice for the client sufficient to promote motivation for change, but cautions about the potential for indebtedness that can rupture the therapy relationship. Schonbar (1967) identifies the fee as an issue of both transference and countertransference in the

All of this essentially makes it incredibly difficult for graduates and early career therapists to make a living, despite investing years of their lives and tens of thousands of euros in training to enter the profession

therapeutic frame- both of which are a vital focus of effective therapy. Mintz (1971) suggests that the fee amount does not appear to influence therapy outcomes by any great degree – but I note that zero is not an amount, it is the absence of it! Chodoff (1972) asserts that fees may not motivate the client necessarily, but in fact may motivate the therapist in the work. This begs the question of the impact on motivation when no fee is involved. Eissler (1974) suggests that not charging a fee omits an important psychological factor in therapy, replete with symbolism and relevance for how clients live their lives e.g. as representing attachment schema. Geistwhite (2000) evaluates no-fee scenarios in US psychoanalytic therapy through the lens of inadequacy and indebtedness as a complex set of important elements in framing the therapy endeavour (e.g. boundary implications).

Working for nothing or an extremely low fee can lead to feelings of resentment in the therapist, especially when the work is challenging and long-term (Newman, 2012). Finally, most recently, the idea of *psycho-economics* has been explored in some depth as it relates to case formulation, treatment planning and ongoing psychotherapy in the work of Yager and Kay (2022). Their work posits that, to not consider the fee is to potentially overlook significant aspects of therapeutic practice.

My third and final argument is anchored in my concern for our profession overall. There seems to be no limit to the market potential for counselling and psychotherapy training, but no data exists as to how many graduates actually go on to become career therapists. This is likely due to a substantial range of factors including; the variety of motivations to become a therapist (altruism, to give something back, as a response to a family or community need or tragedy, as a career etc.); changing life circumstances; initial expectations changing over time; some entrants enrol for personal development and not professional practice; many wish to make use of retirement or plan for a second, part-time career outside the home, or; to rebalance quality of life. It may also be, for students at least, their early experience of being a therapist involves working for nothing often exacerbated by post qualification limited access to clients (perhaps due to their struggle to market themselves well) leads to working for therapy providers, who either don't charge clients (or on a donation/contribution basis) who expect therapists to work for nothing.

All of this essentially makes it incredibly difficult for graduates and early career therapists to make a living, despite investing years of their lives and tens of thousands of euros in training to enter the profession. Though most of us work in private practice (64%), 52% of our number work part time (B&A, 2021, p.6 and p.16).

So, with such strong evidence for the symbolic, process and practical role of the fee, having explored the idea of pro bono work and outlined briefly my concerns for our profession, should we maintain the

status-quo? I have compiled the following suggestions …

- That as a profession we abandon zero fee practices by introducing at least a minimal (contribution or donation) client-funded fee with an upward sliding scale of fees based on individual circumstances, having assessed client's circumstances to place them on the scale appropriately.

- Ensure that, where fees/ contributions/donations are contracted, that they are actually collected (per-session, outstanding fees, missed sessions, do-not-attends and in the case of early therapy termination) with appropriate policies in place to address non-payment or overdue fee collection.

- Explicitly train students and the wider therapeutic community, including non-therapists who provide therapy services in the psycho-economics of therapy.

- Bodies representing the interests of counsellors and psychotherapists should offer transparency and guidance for potential clients on the costs and benefits of psychotherapy, to set expectations, with advantages and disadvantages of the various service options available in the market to help clients make informed treatment access decisions (private therapy, public services, agencies, charities etc).

- Clinical Supervisors should be more assertive and vocal about the interests of student therapists and those who are required/expected to work for nothing, to challenge the status quo and dispel the notion that free labour is a virtue.

There seems to be no limit to the market potential for counselling and psychotherapy training, but no data exists as to how many graduates actually go on to become career therapists

- Government and other funding agencies should ensure that services providing therapy on their behalf (or in lieu of), collect data on the use of public monies in terms of cost, efficiency and other key measures to support future service funding decisions.

- College and training institutes should work with agencies using students, pre-accredited or accredited therapists with zero renumeration to cover practice related expenses including supervision and potentially CPD as minimal consideration to therapists expected to work for nothing.

- Student therapists should lobby training institutes to reasonably protect the value of their current and future work by addressing insurance and legal issues put forward as reasons for their requirement to provide free labour e.g. consider an apprenticeship model of training where living wage or stipends are considered a viable alternative to current practice.

I hope that this short essay has stirred some thought for you the reader on the topic of 'free therapy' by highlighting some of the many complexities inherent in the practice. I have for the most part, purposefully stayed away from the controversy of zero renumeration in this article as I hope this will be the subject of a future stand-alone piece.

My hope in writing this article is to argue for us as a profession to protect the value of our work, proactively consider client and therapist dynamics inherent in *the fee* and its practical and symbolic role in therapy and to offer some suggestions as places to start with the ultimate aim of finally abandoning the notion of 'fee therapy' both in theory and in practice.

[References available on request].

Mike Hackett

Mike Hackett is an accredited member and supervisor with the IACP and the Regional Representative for the International Association for the Study of Dreams (RoI). Mike is currently in full-time private practice having spent 11 years in training and education of counsellors and psychotherapists. Mike is passionate about our profession and the issues and controversies surrounding our past, present and future and our place in society as a community dedicated to the alleviation of human suffering. You are welcome to get in touch with Mike by email at any time at info@introspectcounselling.com.

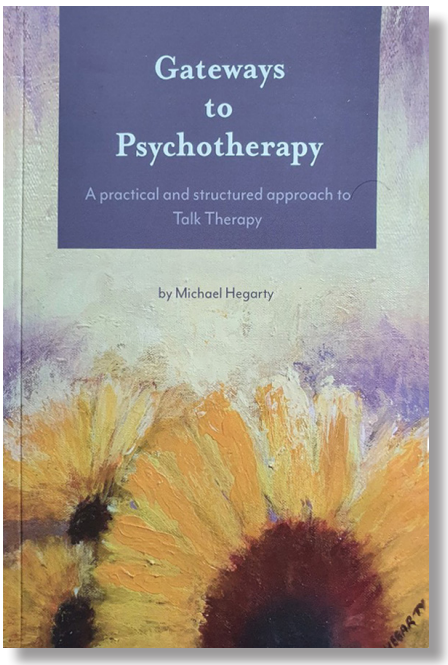
Editor's Note

This piece from Mike Hackett has been selected not on the basis of his status as Editor-In-Chief of this journal, but as an ordinary member in good standing of the IACP. The decision to publish this piece has been fully at the discretion of this quarter's editor. The standard content disclaimer (see the table of contents page of this journal) applies to this and all articles appearing in this edition and every edition.

Book Review

Title:	*Gateways to Psychotherapy – A practical and structured approach to talk therapy*
Author:	*Michael Hegarty*
Published:	*June 2022*
ISBN:	*978-1-80068-950-3*
Price:	*€20*
Reviewed by:	*Mary Lynn (MIACP)*

"Throughout these pages I advise students against sectarianism and suggest a therapeutic pluralism in which effective interventions are drawn from several different therapy approaches"
(Yalom, The Gift of Therapy)



Like many therapists I can easily recall the acute feelings of excitement and trepidation having completed my psychotherapy training with ICPPD. I couldn't wait to start working with clients and to help them on their journey of self-discovery. College training arms us with a variety of comprehensive and honed skills, but there is a transition where a therapist is finding their feet. There is a feeling of uncertainty as at the beginning of any journey. It takes time, dedication, exploration of what works and what doesn't to find your own style. We emulate and borrow from theorists, colleagues, supervisors, tutors, people we admire, our own life and from our clients, in becoming the therapist we are meant and want to be.

I was delighted to recently discover Michael Hegarty's book "Gateways to Psychotherapy". The book provides a practical guide from starting a practice to working with clients, to using integrative techniques that can be used to help clients with their own process in understanding themselves more.

At the start of the book the author explains that he wanted to write about his personal style of therapy which he has developed over the years, but also drawing on his previous career in the financial world. This gave him a structured way of working with clients. The author provides many practical insights which will help to enrich the therapeutic process. He highlights the importance of having structure and organisation, in particular at the beginning of the therapy process to make it a safe space for clients.

The book will be a great asset for practitioners providing a resource they can dip into, especially in those awkward sessions where both client and therapist become stuck in the process. There is a flow to the book and the content in each chapter follows logically from beginning to end. The reader can also dip in and out of chapters and choose to come back to chapters when working with clients and integrate relevant therapy techniques into practice as and when required.

I believe the most important element in therapy is the relationship between the client and the therapist where trust is the catalyst for change. The author offers integrative techniques to therapists to help clients become more curious about themselves and enable growth and change.

I have found some of the exercises in the book easy to implement in therapy. I would have loved if this book had been available to me when I first qualified, as it would have greatly helped, guided and reminded me of many interventions that I had studied but also acquainting me with new ones.

This a great book for trainees, new therapists and for established therapists who want to add to their personal and professional tool kit.

However, Michael Hegarty's book is more than a tool book to use within therapy. He has also shared his own personal story and his vulnerabilities to show that really all human connection is about being loved and to be loved. The book is dedicated to his beloved partner Brenda who sadly, passed away last August, aged 54. May she rest in peace.

I can see this book being used in various training colleges as a guide to good clinical practice. I have no problem in recommending it.

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