The Irish

Journal of Counselling and Psychotherapy

formerly Éisteach • Volume 17 • Issue 4 • Winter 2017

- Unpacking Self-Care
- Green Care and Walk & Talk Therapy
- Decision Making Regarding Motherhood in Ireland
- Anxiety and stress in the transition from primary to secondary school
- We need to Talk about Anti-Depressants

Care in Mental Health

iacp

Irish Association for Counselling and Psychotherapy

Contents

From the Editor 3

Unpacking Self-Care 5
By Mia Christina Döring

Green Care and Walk & Talk Therapy: An Underused Resource that has Benefits for Everyone 8
By Ian Birthistle

Decision Making Regarding Motherhood in Ireland: Making a Space for Women's Voices in Counselling 16
By Margaret O'Connor

Anxiety and stress in the transition from primary to secondary school - How lasting psychological impact can be avoided 21
By Maretta Byrne

We need to Talk about Anti-Depressants 26
By Mari Gallagher.

Workshop Review 29

Noticeboard 30

Editorial Board:
Donna Bacon, Mike Hackett, Dr. Cóilín Ó Braonáin (Chair), Maureen Raymond-McKay, Antoinette Stanbridge, Hugh Morley and Alan Kavanagh.

Design and layout:
GKDesign.ie

Co-ordinator:
Deirdre Browne and Gary Culliton.

ISSN:
2565-540X

Advertising rates and deadlines:
Contact the IACP for details. (Early booking essential.)

© Irish Association for Counselling and Psychotherapy – IACP

All rights reserved. No part of this publication may be reproduced, stored in, or introduced into a retrieval system, or transmitted in any form or by any means (electronic, mechanical, photocopying, recording, or otherwise), except for brief referenced extracts for the purpose of review, without the prior written permission of the copyright owners.

Our Sub-title

The word Éisteach means 'attentive in listening' (Irish-English Dictionary, Irish Texts Society, 1927). Therefore, 'duine éisteach' would be 'a person who listens attentively.'

Disclaimer:

The views expressed in this publication, save where otherwise indicated, are the views of contributors and not necessarily the views of the Irish Association for Counselling and Psychotherapy. The appearance of an advertisement in this publication does not necessarily indicate approval by the Irish Association for Counselling and Psychotherapy for the product or service advertised.

Next Issue:

1st March 2018

Deadline for Next Issue:

15th January 2017

Scripts:

Each issue of Éisteach is planned well in advance of the publication date and some issues are themed. If you are interested in submitting an article for consideration, responding to the Therapist's Dilemma or wish to contribute a book or workshop review or Letter to the Editor, please see 'Author's Guidelines' on the IACP website, www.iacp.ie.

Wishing you a

Merry Christmas

and a

Happy New Year!

from everyone at

iacp

THERAPY ACADEMY

INVEST IN YOURSELF

PROFESSIONAL DEVELOPMENT FOR ALL THERAPISTS

Counsellors · Psycotherapists · Psychologists · Supervisors

ACHIEVE CPD HOURS

Visit www.therapyacademy.ie to check out our online CPD courses.

You can access the very first online therapy courses, developed by recognised experts.

Therapy Academy lists all of the regular courses and workshops going on around the country.

If you would like to create an online version of your workshop or list a regular workshop – please email michael@therapyacademy.ie or get in touch with us on our social media platforms below.

Advertise with IJCP

2018 Advertising Rates

(unchanged since 2005)

BLACK/WHITE	Price	Vat @ 23%	Total
Full Page	€600	€138	€738
Half Page	€360	€82.80	€442.80
Quarter Page	€240	€55.20	€295.20
Eighth Page	€120	€27.60	€147.60

COLOUR	Price	Vat @ 23%	Total
Full Page	€720	€165.60	€885.60
Half Page	€480	€110.40	€590.40
Quarter Page	€360	€82.80	€442.80
Eighth Page	€180	€41.40	€221.40

FLYERS	Price	Vat @ 23%	Total
(supplied by advertiser)	€720	€165.60	€885.60

ADVERT SPECIFICATIONS

When supplying or specifying advertisements to your graphic designer please use the following dimensions.

Full Page: 179mm x 249m
Half Page: 179mm x 123mm
Quarter Page: 88mm x 123mm
Eighth Page: 88mm x 60mm

To advertise with IJCP contact: Deirdre Browne - deirdre@iacp.ie

The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.

From the Editor:

Dear Colleagues,

Welcome to the Winter Edition of the Irish Journal of Counselling & Psychotherapy (IJCP). I am delighted to present this edition as one centred around the theme of 'Care'. As therapists, we are familiar with this word as it represents a core tenet of what we do. Through our training, continuous development, therapeutic practice and ongoing reflection we look at the concept of care through a variety of lenses. It is also worth acknowledging that care can be expressed in a multitude of ways and is experienced differently by different people at different times in their lives which leads to the realisation that there is no one-way to caring.

This premise forms the central position of this edition. In the five articles presented.

In our first article, Mia Christina Döring presents a reflective practitioner-led approach to the development of her four-facet model of self-care. In it, she proposes four areas; "curious self-awareness, self-compassion, boundaries and resourcing". Led by her own experience, her wisdom and passion for this area, Mia unpacks several dimensions of these four facets and offers us a way to self-assess where we are at concerning our self-care. Her central hypothesis can be summarised in a wonderful quote she offers at the outset which frames her reflection; "Caring for myself is not self-indulgence it is self-preservation".

Our next article is penned by Ian Birthisle and explores the exciting ideas of Green Care and Walk & Talk Therapy. In this piece, Ian makes two central arguments; the benefits and research on the impact of nature on mental health and that therapy outside is worthy of serious consideration as the benefits of therapeutic work are amplified by the effects of being in nature while 'in-session'. He draws on his own experience of offering Walk & Talk Therapy to his clients in his private practice and the practical, professional and conceptual considerations which therapists interested in offering this form of therapy need to pay to safety, planning, confidentiality and therapeutic benefit for therapist and client alike.

Switching gears somewhat to a more phenomenological aspect of care, Margaret O'Connor explores the importance of hearing the voice of women in counselling as they grapple with decisions around motherhood in Ireland. In a piece of research she conducted as part of a Masters Programme in Gender, Culture and Society, Margaret illuminates the experience of those interviewed who felt isolated and unsupported as they wrestled with the decision about whether or not to become a parent. Influences of social pressure, motherhood as a rite of passage, treatment of women who do not have children, the impact of pronatalist policies, the role of the media and workplace contexts all feature in her research and shed light on this often-challenging area for clients. In her final piece Margaret issues a call to action. She invites us to both contest "the dominant discourses … of motherhood and womanhood so that they match the lived experience of women" and as therapists; offer an antidote to the isolation and lack of support experienced by those struggling with whether to parent, nor not to parent.

Changes in season from summer to autumn herald not just a step change in weather and nature, but also a time of transition for children. In our fourth article, Maretta Byrne explores the impact of a range

of themes on the mental health and wellbeing of children moving from primary school to secondary school and signposts a range of interventions which can be used to care for children at this often-anxious time. A powerful advocacy piece, informed by research and implications for practice, as well as offering suggestions for actively supporting children during this stage of their lives are explored. It is a good reminder that children are the adults of tomorrow, and by educating them through a range of transition activities, we can help them stave off the later impact of stress, anxiety and depression as they enter their next life transition into adulthood.

Our final article in this Edition is a short piece by Mari Gallagher. If therapeutic interventions, therapeutic context, interventions at times of transition and therapist self-care frameworks all offer something to the canon of care in mental health, then so too does the role of medication and in particular, anti-depressants. In this piece, Mari explores the prevalence of anti-depressants in Ireland and their side effects, examining the role anti-depressants play in the life of the client. She deals with the difficulties clients can face when they decide to phase out this support and advocates for therapist support for client autonomy as they grapple with this decision.

And so, I hope you enjoy this Winter Edition and the diversity of insights on the theme of 'Care'. As always, we welcome discussion, letters, comments and input from members on any of the papers, articles or indeed any of the content of our journal. You can write to us care of the IACP Head Office, or email at eisteachchair@iacp.ie

Finally, on behalf of all of us here at the IJCP and indeed on behalf of the IACP, we wish you all a very Merry Christmas and Happy & prosperous New Year.

Mike Hackett IASD ARCHTI MIACP – Editor, Winter Edition, IJCP. November 2017.

Practitioner Perspective

Unpacking Self-Care

By Mia Christina Döring

'Caring for myself is not self-indulgence, it is self-preservation."

Audre Lorde (1988)

Introduction

This article discusses a model of self-care as designed by the author. The model consists of four facets of self-care, as hypothesised by the author. These areas are: curious self-awareness, self-compassion, boundaries and resourcing. The article explores and unpacks these facets as they relate to the individual, bringing to light or reminding us of forgotten perspectives,or maybe giving us ideas or reflections on client work.

At the time of writing I am sick with a common cold. It is the third time I have been sick in the preceding five weeks, and as more and more of my life gets postponed, cancelled, delayed, a question keeps tapping away at me. *In what ways am I not looking after myself as I should be?* Clearly, getting sick so often in such rapid succession is telling me something. I don't know what it is just yet. But I will listen to myself and hear what comes.

It is well known that those who operate in the caring, helping or therapeutic sectors can struggle with self-care, though we are likely adept at helping or advising others to become better self-carers. We know the value of self-care, deeply, yet can fail to make the time to allow ourselves reap the benefits.

The term 'self-care' is used a lot these days and this prevalence of use has also diluted the meaning of it to some extent. Anecdotally, in the wider community, 'self-care' can mean a shopping trip because you feel you deserve it, or a bar of chocolate, or some other superficiality lacking in responsibility; it can be seen as indulgence, rather than a considered act of self-nourishment designed to sustain and maintain our mental and physical wellbeing. This isn't to say that shopping and chocolate can never be meaningful acts of self-care, of course. For some they can be, for others they can be a source of anxiety. What constitutes self-care one day may not constitute it the next – it is about in the moment awareness of the specific needs and availability of choices for that particular individual.

Because of this over-prevalence of use, I've moved to calling self-care 'refueling' or 'self-resourcing', or, as Audre Lorde (1988) says, 'self-preservation', as a more succinct descriptor. In a recent self care workshop, the atmosphere in the room shifted and became more focused as I introduced words like 'survival', 'preservation', 'crucial' and 'vital'. Self-care is not an indulgence; it is not giving into self-pitying behaviour, it is not shirking responsibility and it is not being 'selfish'. Self-care is so much more and so much more meaningful than

'doing something nice for yourself'.

Over the last few years of various courses, learning, therapy and listening to myself and others, I've unpacked 'self-care' into four sections – curious self-awareness, self-compassion, healthy boundaries, and resourcing – and this is the model I use when I facilitate self-care workshops.

Curious self-awareness

The first step is *curious self-awareness & connection*. Mindful self-awareness raises our ability to recognise when some self-care is needed, and how it is needed. Many people don't realise they are in need of some self-care intervention until it is too late and burn-out has hit. But this is still valuable information – by listening to our bodies, thoughts, behaviour and feelings when experiencing burnout, we now have a collection of 'red flags' to resource around for the future. A question to ask is *what tells me I need a break* using the Choice Theory Total Behaviour paradigm (Davenport, 2017). How are our thoughts, feelings, behaviours and physiology when we are nearing or at burnout? The reason for curiosity being a vital component of this exploration is exactly because it is an exploration. Without curiosity about our own inner process, we are unlikely to explore it. In addition, as long as curiosity is present, judgement cannot be, and self-judgement has no place in self-care. As long as we have an attitude that is along the lines of *I just want to fix the problem*, it is unlikely any significant or beneficial change or growth will occur. However, with curiosity and mindfulness we can connect with ourselves, and therefore others.

Self-compassion

Self compassion is a vital component in any self-care behaviour. If we are doing something because we feel we have to, or because we will berate ourselves if we don't, or because we have added 'self-care' to a list of tasks we must complete, this may not be a self-compassionate attitude. Again looking at our Total Behaviour when we are nearing burn out (or anytime), we can ask ourselves: how can I introduce self-compassion to the four areas of my behaviour? Can I think self-compassionate thoughts, can I act self-compassionately, can I talk to myself compassionately, can I nurture my body self-compassionately? Without self-compassion there is no self-care.

> *A huge part of self-care is being aware of and respecting our boundaries, and looking upon them with compassion and no judgement.*

Boundaries

A huge part of self-care is being aware of and respecting our boundaries, and looking upon them with compassion and no judgement. As we know, some people have incredibly rigid boundaries and some have porous ones and some people have more flexible boundaries. Awareness and flexibility is key. For example when a client comes into the room for the first time I ask them about how the chairs are set up, giving her an opportunity to make adjustments. This allows the client to become aware of her own boundaries and own them in the therapeutic space.

Something to reflect on is what the word boundary brings up for you. If you were to imagine a boundary, what might it look like? What is it made out of? What is it's texture like? Is it moveable or stuck fast? Is it rigid or can it bend? Is it thin, thick, and so on? Is it strong, easily pushed through or somewhere in between? This visualisation can tell us a lot of information about the quality of our boundaries. There is no wrong or right way to be boundaried. There is just the boundary, and then the awareness of whether it is helpful or less helpful in any given situation. With this awareness we can make adjustments. What can we change about this particular boundary in this particular moment that might be more helpful for us?

Another reflection we can do is to take a look at what happens for us when a boundary gets tested. What happens in our *Total Behaviour* of thinking, feeling, doing and in our bodies? What helpful choices do we have when a boundary is tested? Can we press the pause button and create space for reflection? Can we resist blaming the other person or circumstance which is impinging on our boundary and take ownership of it and our subsequent choices in an attitude of self-compassion? Sometimes we feel we have no choice in the moment but to allow our boundary to be pressed. Sometimes people or situations can overwhelm our capacity to hold our boundaries. We may not have the tools we need in that moment. Creating a bit of space later to reflect self-compassionately on what happened for us can help us fill that toolbox. If you could go back to the moment what could you have done differently? This is not judging or blaming yourself. This is creating tools. Ask these questions with gentle self-love. If you feel too raw about the situation, wait until you feel ready to explore it.

The same is true for when we have overly rigid boundaries and are doing ourselves a disservice – maybe keeping people at arm's

length out of fear that if they get too close they will hurt us in some way. Again the key is compassionate awareness and asking ourselves if this particular boundary with this particular person/situation is helping or hindering? How can we do things differently? How could this boundary be more helpful and conducive to our happiness? In an ideal world, if we had a magic wand, what would this boundary look like?

Resourcing

When we feel burnt out, raw, sad, victimised, hurt, and all the other less pleasant emotional responses to life, resourcing ourselves is a key part in our self-care routine. We have internal, external and somatic resources at our disposal in any given moment. An example of an *internal resource* might be how we speak to ourselves around the issue at hand, what we tell ourselves about it, or what it says about us. We might remind ourselves of all we have to be grateful for in our lives, we might focus on the love of a close friend, or a happy memory, we might tap into or remind ourselves of our strength, compassion, patience, and so on, all of our traits which helped us survive previous challenges.

An *external resource* might be texting or calling a friend. When I have bad days I do this a lot – not necessarily to fill them in on what is happening for me, but often I send something silly or frivolous, knowing that they will likely connect back in kind. This gives me two things – connection with an other (which is anything but frivolous, no matter what frivolity is going on), and the opportunity to experience lightness – essential when we are burdened. If connecting with another person doesn't sit right, another external resource might be taking the dog out for a walk, taking yourself out for a coffee, reading a chapter of a novel, getting immersed in voluntary work, watching an entire series on Netflix, planning a weekend away - the list is endless and individual to each person.

If connecting with another person doesn't sit right with you, another external resource might be taking the dog out for a walk, taking yourself out for a coffee, reading a chapter of a novel, planning a weekend away - the list is endless and individual to you.

Somatic resourcing relates to the body. It could be doing yoga, going for a walk or run or swim. If that is too active there is restorative yoga, or curling up on the couch under a blanket. You could hold your arms around yourself in a hug for a few moments, close your eyes and allow yourself to feel the support of the chair underneath you. You could try listening to a mindfulness body scan. You could lift weights. You could go to the seaside and feel the sun on your face and ice-cream in your mouth and salt on your skin, you could hold your baby niece, you could stand at a windy spot and spread your arms and feel the cleansing wind rush your entire body, you could relax by the warmth of a fire, you could cuddle your dog. Again the list is endless and individual to each person.

Bringing awareness to our resources can also cultivate another aspect of self care – gratitude for everything we have to hand, probably a lot more than we thought we had. Without gratitude we may take the people and circumstances of our life for granted, not appreciate them, and therefore may not feel their value in our lives. Tapping into gratitude, especially when we feel we are wanting is vital in order to build our resilience and emotional strength. And showing others appreciation can often deepen ties and inspire them to show their appreciation of us – a beautiful side effect.

Self care/preservation/re-fueling is not just a behaviour – it is a way of being. It is a way of thinking, feeling and doing. It is a life philosophy, and it is vital self-preservation.

References

Davenport, B. 2017. An Introduction to Choice Theory. Retrieved from http://www.brucedavenport.com/total-behavior.html

Lorde, A. (1988). A Burst of Light. New York. Firebrand Books.

Mia Christina Döring

Mia has a degree in Counselling and Psychotherapy from the Institute of Counselling and Psychotherapy and a diploma in Psychology from DBS, along a degree in Fine Art and a Masters in Journalism. She is a pre-accredited member of IACP. She holds a practitioner certificate in Cognitive Behavioural Therapy from IICP and undertook the Dublin Rape Crisis Centre therapist training programme for working with issues of sexual violence and childhood sexual abuse. She has worked in addiction and domestic abuse settings. She has a special interest in mindfulness, psycho-education and post traumatic growth. In her spare time, she writes fiction and poetry and runs workshops on boundaries, self-care and resourcing. She works in private practice via Daring Greatly Counselling and Psychotherapy.

Practitioner Perspective

Green Care and Walk & Talk Therapy:

An Underused Resource that has Benefits for Everyone.

By Ian Birthistle

Introduction

This article is a literature review of green care followed by my own observations and feedback on Walk and Talk Therapy (W&T) that I offer to clients. Green care is defined as a nature based therapy or treatment intervention, designed, structured and facilitated for individuals with a defined need (Green Care Coalition, 2015). The benefits of Green Care include increases in memory performance and attention span (Berman et al., 2008), and improvements in mood and self-esteem (Barton & Pretty, 2010). Views of nature can positively affect job satisfaction (Kaplan, 2007), while images depicting natural scenes can aid physiological recovery from stress (Brown et al., 2013). Exposure to nature has resulted in shorter hospital stays (Ulrich, 1984), while Green Care has also been noted to significantly decrease anxiety, depression, anger, fatigue, confusion and to increase vigour (Park et al., 2010; Lee et al., 2011; Li,2012). Green Care can have positive effects on dementia (Erickson at al., 2012), while Li et al., (2007, 2008, 2010 & 2011), found significantly reduced blood pressure and stress hormones, and increased human Natural Killer (NK) cellular activity after a trip to a forest park

If this was a drug I wonder how much would we pay? Yet this resource is readily available, completely free of charge. The question then has to be asked; Could our natural environment combined with any level of exercise be used more extensively when the limited research is showing a great potential for positive mental, emotional, physical and spiritual outcomes?

Green Care

Green care offers many opportunities to be tailored to suit a vulnerable person's needs and abilities and there are many variations; Walk and Talk Therapy, Green Exercise, Care Farming, Animal Assisted Therapy, Social & Therapeutic Horticulture, Nature Therapy, Wilderness Therapy, Environmental Conversation as a treatment intervention, Ecotherapy and Ecopsychotherapy.

Related to Green exercise is 'Blue Exercise' which refers to physical activity undertaken in and around 'natural' aquatic environments such as lakes, rivers, canals and the coast, these activities can include being in the water, on the water or simply by the water (Depledge and Bird, 2009). People living near the English coast tend to report higher self-reported health than those inland (Wheeler et al., 2012), while longitudinal data suggests that self-reported physical and mental health tend to be higher among individuals in the years they live nearer the coast (White et al., 2013). A study in an aquarium also found that the longer children stayed at a fish exhibit the calmer they appeared as well as experiencing enhanced

mood (Cocker, 2012).

Walk and Talk therapy (W&T) is an opportunity to engage in therapy with the added mindfulness coping skill of becoming present in nature while clients experience the physical and mental health benefits of exercise, nature, and therapy simultaneously. An arrangement is initially made to meet in a park with weather appropriate dress, and then we walk through the more private areas of Dublin's parks, forests and beaches. The session is an hour in duration and encompasses walking at the client's pace and/or perhaps sitting depending on the client's energy levels.

Richard Louv (2005), coined the term 'Nature Deficit Disorder' referring to human beings (especially children) spending less time outdoors, resulting in a wide range of behavioural problems including attention difficulties, diminished use of their senses, and higher rates of physical and emotional illnesses. It has been hypothesised that the average Australian child spends less time outdoors than a maximum-security prisoner (Government of South Australia, 2014), with the typical American child being engaged with electronic media more than fifty hours each week while involved in outside free play less than one hour during a typical day (Louv, 2005). Although modern technology offers many benefits it may also be linked to reduced physical activity, less time spent outdoors and the potential for cyber-based overload resulting in increased stress (Misra and Stokols, 2012). A supervised programme of exercise can be equally as effective as antidepressants in treating mild to moderate depression (Halliwell, 2005; Richardson et al., 2005), yet 93 per cent of GPs have prescribed antidepressants because of a lack of alternative treatment options (Hairon, 2006).

The Psycho-Evolutionary Stress Reduction theory (Ulrich, 1981), suggests that exposure to nature provides distractions from daily stresses and produces feelings of ease, calm and interest which in turn reduces stress symptoms and promotes positive emotions. Exposure can be direct contact with the outside world, or indirect contact through potted plants, a garden or aquarium, or a representational contact through pictures, symbols or stories. The positive effects can be seen in reductions in blood pressure, heart rate and stress hormones after exposure to nature and also in a study where hospital patients with a window view of nature had shorter hospital stays than patients with a wall view. These latter patients also required far more potent pain killers than those with a nature view. (Ulrich, 1981, 1984, 1991; Herzog and Strevey, 2008; Ewert et al., 2011).

Another study found significant reductions in stress and aggressive behaviour in visitors and staff in a hospital emergency waiting room after it was re-fitted with natural materials, carpeting and fabrics, nature murals and potted plants (Ulrich, 2008). In a psychiatric facility in Gothenburg in Sweden, refurbished with more natural light and materials, plants and gardens, Kellert and Finnegan (2011) found a significant decline in hostility and aggression; a 40% reduction in the use of physical restraints and a 20% decline in compulsory injections to control aggressive behaviour. Anecdotal evidence from other hospitals also suggests the calming, the stress relieving, and the emotionally restorative impact of exposure to nature along with positive contributions to staff satisfaction and morale, although the lack of a systemic approach to design and little focus on the external environment does limit the lessons to be learnt (Kellert, 2016; Barton et al., 2016).

Before the onset of antipsychotic medication O'Reilly and Handforth (1955) also noted, outdoor activity and gardening led to greater cohesion and social interaction, with increases in verbal and nonverbal forms of communication in patients with schizophrenia. This has huge implications for the practice of medicine and the design of healthcare facilities and landscapes, but it can also be extended to the workplace.

One quarter of European workers report work related stress for all or most of their working time with an estimated 136 billion euro lost to sick leave and diminished productivity due to mental ill-health (European Agency for Safety and Health at Work, 2014). Stress increases the likelihood of making mistakes, it decreases performance and increases sick leave resulting in increases in staff turnover and losses in productivity. In the modern workplace, there has been an increase in repeated stressors in quick succession with an inadequate response and lack of time to recover from a stressor (Gladwell and Brown, in Green Exercise, Barton et al., 2016). Over time this causes chronic exposure to fluctuating or heightened neural or neuroendocrine responses which causes physiological damage to the body (allostatic load), and thus causes ill-health (McEwan & Seeman, 1999). There is also some evidence to suggest that nature can act as a buffer to stressful life events (Van den Berg et al., 2010).

A more active workforce in nature could therefore reduce absenteeism, health care costs and increase productivity, which will be of great benefit to

A recent study found that walking in nature decreased both self-reported rumination and neural activity associated with rumination, while a walk in an urban environment had no such effects

employers (Proper *et al*., 2002). However rigorous research in this area is limited and needs to focus on engaging with natural spaces during working time; the effect of regular short breaks; repeated exposure to green exercise and the cost-effectiveness of these interventions.

The Attention Restoration Theory (Kaplan and Kaplan, 1989) suggests that directed attention which requires mental effort and concentration can lead to fatigue, irritability, stress, accidents, impulsivity, distractibility and inattentiveness. However, when focus is redirected to involuntary attention which requires no work and which natural environments promote, this then provides an opportunity for recovery from mental fatigue.

Berman, Jonides and Kaplan (2008) found memory performance and attention spans improved by 20 percent after people spent an hour interacting with nature in any season. They also found that when participants walked in a botanical garden or arboretum they improved their short-term memory by 20 percent but they showed no improvements after walking down city streets. These results were also replicated when subjects sat inside and looked at pictures of either downtown scenes or nature scenes. This is supported by the Transient Hypofrontality Hypothesis (Dietrich, 2006) which suggests that directed attention is associated with prefrontal cortex activation which lessens with physical movement thereby resulting in prefrontal cortex restoration. Kaufmann (2015) suggests that interactions with nature may lead to that activation of neural networks that support subconscious processing and cognitive flexibility. Other researchers have found that people have an easier time resolving minor life problems while spending time in natural environments (Mayer et al., 2008). A recent study found that walking in nature decreased both self-reported rumination and neural activity associated with rumination, while a walk in an urban environment had no such effects (Bratmann et al., 2015).

Five minutes of interaction with nature has been shown to improve mood and self-esteem (Barton & Pretty, 2010), while views of nature, especially trees, appear to positively affect job satisfaction (Kaplan, 2007). Natural views out of a window can enhance directed attention during cognitively demanding tasks (Tennessen & Cimprich, 1995), while images depicting natural scenes can aid physiological recovery from stress (Brown et al., 2013). Green exercise incorporated into a working and/or a relaxing day could produce profound affects for our psychological, emotional and physical well-being. A limitation of this research is that it can lack rigorous control over the duration and intensity of the exercise undertaken which will obviously influence the outcome, as does an individual's initial mood or upset and their predisposition for any given place and exercise.

Forest bathing refers to a short leisurely visit to a forest where one can relax and breath in the phytoncides derived from trees, such as α-pinene and limonene (Li in Green Exercise, Barton et al., 2016).

A two-hour forest walk has been shown to significantly decrease anxiety, depression, anger, fatigue and confusion and increase vigour in both male and female subjects (Park, et al., 2010; lee et al., 2011; Li, 2012). It is also hypothesised that nature can provide a preventive effect on depression (Li and Kawada,2014), with Schiffman et al., (1995) suggesting that phytoncides from many species of trees may in part contribute to a calming effect. A reduction in sympathetic nervous activity has also been noted in forest bathing along with an increase in parasympathetic nervous activity and a regulation of the balance of autonomic nerves (Park et al, 2010; Tsunetsugu et al., 2010; Lee et al., 2014). Li et al., (2011) found that a trip to a forest park significantly reduced blood pressure, heart rates and urinary noradrenaline and dopamine levels whereas an urban trip did not. Mao et al., (2012) reported that forest bathing had therapeutic effects on hypertension in the elderly and it also induces inhibition of the renin-angiotensin system and inflammation, thus inspiring its preventive efficacy against cardiovascular disorders.

Forest bathing has been noted to reduce stress hormone levels such as urinary adrenalin, urinary noradrenaline, salivary cortisol and blood cortisol, inducing a more relaxed state (Li et al., 2007,2008, 2009, 2010, 2011; Park et al., 2010). Forest environments also significantly increase dehydroepiandrosterone sulfate levels (DHEA-S) and serum adiponectin, with lower than normal blood adiponectin concentrations associated with obesity, type 2 diabetes mellitus, cardiovascular

disease and metabolic syndrome (Simpson and Singh, 2008). Epidemiological evidence in humans suggests that DHEA-S has cardioprotective, anti-obesity, and anti-diabetic properties (Bjørnerem et al., 2004), however large scale longitudinal studies in different countries are needed to further assess the therapeutic properties.

Forest environments can also act directly on the immune system to promote increased human Natural Killer (NK) cellular activity by increasing the number of NK cells and intracellular levels of anti-cancer proteins such as perforin, granulysin (GRN), and granzymes (Gr) in both male and female subjects. This increased activity has been shown to last more than 30 days after the forest trip (Li et al., 2007, 2008, 2010). People with a higher NK activity report a lower incidence of cancers while those with a lower NK activity report a higher incidence of cancers (Imai et al., 2000). With forest environments also reducing levels of stress hormones which can inhibit immune functioning, therefore this and all the above suggest that forest bathing has a preventive effect on cancer. This is supported by the lower incidence of cancers among males and females living in areas of high forest coverage in all prefectures in Japan even after the effects of smoking and socioeconomic status is controlled (Li et al., 2008).

In the UK, dementia directly affects around 800,000 people and a further 670,000 carers with annual costs to the health service, local government and families estimated at £23 billion (Prince et al., 2014). Exercise promotes the growth of new brain cells that shrink with age, it improves cell and tissue repair mechanisms, it can be most effective in reducing the risk of getting dementia and it can help slow down the progression of dementia in those already suffering (Erickson et al., 2012). The benefits of engaging with the natural environment are seen in better eating and sleeping patterns and better mobility, in reduced stress, agitation, apathy and depression, and also in improved self-esteem and control leading to improved social interaction and a sense of belonging (Clark et al., 2013). Engagement with nature and exercise can be encouraged through the provision of well-designed green space which may increase their use and physical activity in those who live nearby (Giles-Corti et al., 2013). This has implications for designers and planners in making green spaces more dementia friendly through being easily accessible, safe, easy to use and interactive through the senses. More robust large scale research is needed into the benefits of different activities for different groups and both sexes with dementia.

By being employed, offenders can become optimistic and motivated to change, leading to a reduction in stress and increase in self-confidence allowing them to make the right choices towards a pro-social life.

Desistence is the process of stopping repeat criminal behaviour, and care farming can assist in achieving this. Being needed and believed in, having time away from negative environments, time to reflect and reassess one's life, creating a new non-criminal identity and feelings of belonging are mechanisms that clients report as positive benefits of being part of the care farming community (Hassink et al., 2010; Granerud and Eriksson, 2014). By being employed offenders can become optimistic and motivated to change, leading to a reduction in stress and increase in self-confidence allowing them to make the right choices towards a pro-social life (Evans and Evans, 2015). Therapeutic horticulture and care farming have also been shown to reduce depression scores in patients with clinical depression (Pederson et al., 2011). More robust long term trials are needed as the majority of research studies in this field are uncontrolled before and after studies with high levels of bias (Murray et al., 2016, in Green Exercise, Barton et al., 2016).

Strongly linked to the above is Wilderness Therapy which is a therapy program in a remote outdoor setting. Wilderness Therapy can foster personal, social and emotional growth (Russell, 2001, 2006a; Norton and Watt, 2014), while significant positive changes in self-esteem, self-efficacy, confidence, behaviour and decision making have been noted (Russell, 2006b; Asfeldt and Hvenegaard, 2014; Hoag et al., 2014). Self-esteem has an inverse relationship with depression and anxiety (Orth et al., 2009), it is a risk factor for mental ill-health (Griffiths et al., 2010) and it has also been linked to anti-social behaviour and behavioural difficulties (Moksnes et al., 2010) (Roberts et al., 2016, Barton et al., 2016).

Evaluations of The TurnAround Programme, a nature based project for vulnerable English adolescents aged 15-21, have consistently shown significant improvements in self-esteem, mood, behaviour, wellbeing and hopefulness (Peacock et al., 2008; Barton et al., 2010; Wood et al., 2012,

2013). Evidence also suggests that wilderness expeditions have long lasting health benefits which increase over time (Hattie et al, 1997; Asfeldt and Havengaard, 2014). The added benefits of group style care are a sense of meaningfulness, stimulated interest in associated activities, and increased social interaction which develops social inclusion and cohesion (Sempik and Bragg in Green Care, 2013). With long term positive shifts, surely this program should be considered as an alternative to the very expensive, punitive and often unsuccessful methods used today. It could benefit society as a whole and also be a useful tool for helping the growing number of young people at risk of mental ill-health, crime and anti-social behaviour.

Walk & Talk

The following is based on my own observations of a number of my clients who have come directly into W&T, and also my observations of a number of my clients who have converted from the office to W&T therapy. As regards the latter, they seem to be processing their issues faster and dealing with more issues than when office based. W&T clients are reporting fewer symptoms of depression and anxiety, lower levels of stress and anger, and they are experiencing more insight and 'eureka' moments. Many are delving deeper into their processes than they did in the office through their seemingly increased ability to face and process their fears. This may be linked to a number of other reasons.

The physical exercise is a benefit for my clients with ADD and for those who are nervous, embarrassed, anxious and resistant of therapy. Without the formality, confrontation and anxiety of the therapy room some find it easier to let their guard down and open up. W&T is easier for emotionally restrictive men and those who struggle with direct eye contact, and silence while walking is also easier thereby promoting deeper incubation of thoughts and processes.

More evidence is required for the differences in ethnicity and between the sexes, while individual characteristics such as personal preferences, previous experiences, memory and perceptions of nature and exercise need also to be addressed.

Clients seem more able to view a situation from different angles with more clarity, more depth, more insight, and they are making more emotional connections than in the office. The environment and exercise can at times provide more memory retrieval cues, and the mood-improving physical activity with its associated increase in blood flow is sparking creative and deeper ways of thinking in both the client and in myself. I have also noted some W&T clients to be more physically active on their own personal time which in turn has improved coping skills, and quality and quantity of sleep. Clients have more energy and interacting with nature and dealing with all weather is also strengthening the interpersonal connection between me and my clients.

For clients with anxiety disorders, exercise seems to be reducing their fears of fear and their related bodily sensations such as a racing heart and rapid breathing, while exposure to the outdoor social aspects is desensitising them to social anxieties. Clients report that being outdoors and accomplishing something positive for one's health is invigorating and it reduces their feelings of isolation.

Clients visibly loosen up as they experience the outdoor freedom and with this lessened sense of confrontation they have become more receptive to feedback than when in the office. Clients also have to engage more with their senses with the result of being much more present, talkative and relaxed. They are reporting increases in self-esteem, in positive risk taking activities, and some have noted the relationship between their own physical forward movement and progression in their own processes. Many are surprised by how much they enjoy the sessions, they would definitely recommend it to others and most of my W&T clients will not return to the office even when the Irish weather is at its worst.

The above is based on my own observations and feedback I have received from clients. Robust research is needed with larger samples and specific groups over an extended time in therapy, with clients who have experienced both types of therapy and with those who have not. The author's bias also needs to be noted as this is a therapy that I very much believe in.

Conclusion

There are numerous adjustments to be made in W&T therapy compared to office based work, and many areas that need attention by the therapist. These include route planning especially when there are concerns around being seen crying and being overheard by passers-by. Attention is needed to give good eye contact to emotionally reassure and also to pick up on indicators of mood. Walking time needs to be monitored well and distractions to be avoided interrupting deep

processes or alternatively used as part of therapy.

With all of the above being of obvious benefit, I have to return to my original question; Could our natural environment be used more extensively? W&T has huge potential in the treatment of many physical and emotional ailments, some have been mentioned while others are as yet unexplored. More rigorous research is needed in all the above areas and also in nature's potential in the treatment of various disorders. More evidence is required for the differences in ethnicity and between the sexes, while individual characteristics such as personal preferences, previous experiences, memory and perceptions of nature and exercise need also to be addressed. Bigger groups need to be used and attention paid to how people engage with nature and with exercise.

Nature has vast benefits for us all in our physical, emotional and economic lives, but I believe natures' full potential in our lives is as yet unexplored.

References

Asfeldt, M. and Hvenegaard, G. (2014). Perceived learning, critical elements and lasting impacts on university-based wilderness educational expeditions. *Journal of Adventure Education and Outdoor Learning*, 14: 132-152.

Barton, J., Hine, R. E. and Pretty, J. (2010). The TurnAround Project - Phase 2: Follow on from the TurnAround 2007 Project – Phase 1. *Report for the Wilderness Foundation. Colchester*: University of Essex.

Barton, J and Pretty, J. (2010). What is the best dose of nature and green exercise for improving mental health? A multi-study analysis. *Environmental Science and Technology,* 44: 3947-3955.

Barton, J., Bragg, R., Pretty, J., Roberts, J., & Wood, C. (2016). The Wilderness Expedition an Effective Life Course Intervention to Improve Young People's Well-Being and Connectedness to Nature. *Journal of Experiential Education,* 1053825915626933.

Berman, M. C., Jonides, J. & Kaplan, S. (2008). The cognitive benefits of interacting with nature. *Psychological Science,* 19: 1207-1212.

Bjørnerem, A., Straume, B., Midtby, M., Fønnebø, V., Sundsfjord, J., et al. (2004). Endogenous sex hormones in relation to age, sex, lifestyle factors, and chronic diseases in a general population: The Tromso Study. *Journal of Clinical Endocrinology and Metabolism*, 89: 6039-6047.

Bratman, G. N., Hamilton, J. P., Hahn, K. S., Daily, G. C. and Gross, J. J. (2015). Nature experience reduces rumination and subgenual prefrontal cortex activation. *Proceedings of the National Academy of Science,* 112(28): 8567-8572, doi: 10.1073/pnas.1510459112.

Brown, D. K., Barton, J. L. and Gladwell, V. F. (2013). Viewing nature scenes positively affects recovery of autonomic function following acute-mental stress. *Environmental Science and Technology,* 47: 5562-5569.

Clark, P., Mapes, N., Burt, J. and Preston, S. (2013*). Greening dementia – a literature review of the benefits and barriers facing individuals living with dementia in accessing the natural environment and local green-space*. Natural England Commissioned Reports, 137. Online at: http://publications.naturalengland.org.uk/file/5997922130853888

Cocker, H. (2012). The positive effects of aquarium visits on children's behaviour; A behavioural observation. *The Plymouth Student Scientist*, 5: 165-181.

Depledge, M. H. and Bird, W. J. (2009). The blue gym: Health and wellbeing from our coasts. *Marine Pollution Bulletin*, 58(7): 947-948.

Dietrich, A. (2006). Transient hypofrontality as a mechanism for the psychological effects of exercise. *Psychiatric Research*, 145: 79-83.

Erickson, K. I., Weinstein, A. M. and Lopez, O. L. (2012). Physical activity, brain plasticity and Alzheimer's disease. *Archives of Medical Research*, 43: 615-621.

European Agency for Safety and Health at Work (2014). *Psychosocial Risks in Europe Prevalence and Strategies for Prevention*. Online at: https://osha.europa.eu/en/tools-and-publications/publications/reports/psychosocial-risks-eu-prevalence-strategies-prevention

Evans, A. and Evans, S. (2015). *Social healing through integrated farm therapy*. Online at: www.clinks.org/sites/default/files/SHIFT%20Hereforshire%20ToC.pdf

Ewert, A., Overholt, J., Voight, A. and Wang, C. C. (2011). *Understanding the transformative aspects of the wilderness and protected lands experience upon human health.* USDA Forest Service Proceedings, 1: 140-146.

Giles-Corti, B., Bull, F., Knuiman, M., McCormack, G., Van Niel, K., Timperio, A., Christian, H., Foster, S., Divitini, M., Middleton, N. and Boruff, B. (2013). The influence of urban design on neighbourhood walking following residential relocation: Longitudinal results from the RESIDE study. *Social Science and Medicine*, 77; 20-30.

Gladwell and Brown (2016). Green Exercise in the Workplace. In Barton, J., Bragg, R., Wood, C. and Pretty, J. Green Exercise: Linking Nature, Health and Well-being. London, New York, Routledge.

Government of South Australia (2014*). Healthy and strong children. Building a Stronger South Australian Policy Initiatives Paper 8, Adelaide*. Online at: www.premier.sa.gov.au/strongersa

Granerud, A. and Eriksson, B. G. (2014). Mental health problems, recovery, and the impact of green care services: a qualitative, participant-focused approach. *Occupational Therapy in Mental Health,* 30: 317-336.

Green Care Coalition (2015). Discussions from the Green Care Coalition Working Group. Personal communication: October 2015.

Griffiths, L. J., Parsons, T. J. and Hill, A. J. (2010). Self-esteem and quality of life in obese children and adolescents: a systemic review.

International Journal of Pediatric Obesity, 5: 282-304.

Hairon N. (2006), *'PCTs poles apart over depression services',* Pulse 9 March.

Halliwell E. (2005*), Up and Running? Exercise therapy and the treatment of mild or moderate depression in primary care*, Mental Health Foundation.

Hassink, J., Elings, M., Zweekhorst, M., Van Den Nieuwenhuizen, N. and Smit, A. (2010). Care farms in the Netherlands: attractive empowerment-oriented and strengths-based practices in the community. *Health and Place*, 16: 423-430.

Hattie, J., Marsh, H. W., Neill, J. T. and Richards, G. E. (1997). Adventure education and outward bound out of class experiences that make a lasting difference. *Review of Educational Research*, 67: 43-87.

Herzog, T. R. and Strevey, S. J. (2008). Contact with nature, sense of humour, and psychological well-being. *Environment and Behaviour,* 40: 747-776.

Hoag, M. J., Massey, K. E. and Roberts, S. D. (2014). Dissecting the wilderness therapy client: Examining clinical trends, findings and patterns. *Journal of Experiential Education,* 1: 1-15.

Imai, K., Matsuyama, S., Miyake, S., Suga, K. and Nakachi, K. (2000). Natural cytotoxic activity of peripheral-blood lymphocytes and cancer incidence: an 11-year follow-up study of a general population. *The Lancet,* 356(9244): 1795-1799.

Kaplan, R. (2007). Employees' reactions to nearby nature at their workplace; the wild and the tame. *Landscape and Urban Planning*, 82: 17-24.

Kaplan, R. and Kaplan, S. (1989). *The Experience of Nature: A Psychological Perspective*. New York: Cambridge University Press.

Kaufman, J. A. (2015). A model of our contemplative nature. *Ecopsychology*, 7(3): 137-144.

Kellert, S. and Finnegan, B. (2011). *Biophilic Design: The Architecture of Life*. Online at: www.bullfrogfilms.com/catalog/biod.html

Kellert, S. R. (2016). Nature in Buildings and Health Design. In Barton, J., Bragg, R., Wood, C. and Pretty, J. *Green Exercise: Linking Nature, Health and Well-being.* London, New York, Routledge.

Lee, J., Park, B. J., Tsunetsugu, Y., Ohira, T., Kagawa, T. and Miyazaki, Y. (2011). Effect of forest bathing on physiological and psychological responses in young Japanese male subjects. *Public Health,* 125: 93-100.

Lee, J., Tsunetsugu, Y., Takayama, N., Park, B.-J., Li, Q., et al. (2014). Influence of forest therapy on cardiovascular relaxation in young adults. *Evidence Based Complementary and Alternative Medicine*, doi: 10.1155/2014/834360

Li, Q. (ed.) (2012). *Forest Medicine.* New York: Nova Science Publishers Inc.

Li, Q. (2016). Forest Bathing in Japan. In Barton, J., Bragg, R., Wood, C. and Pretty, J. *Green Exercise: Linking Nature, Health and Well-being.* London, New York, Routledge.

Li, Q. and Kawada, T. (2014). The possibility of clinical applications of forest medicine*. Nihon Eiseigaku Zasshi,* 69: 117-21. (in Japanese).

Li, Q., Morimoto, K., Nakadai, A., Inagaki, H. and Katsumata, M., et al. (2007). Forest bathing enhances human natural killer activity and expression of anti-cancer proteins. *International Journal of Immunopathology and Pharmacology*, 20(S2): 3-8.

Li, Q., Morimoto, K., Kobayashi, M., Inagaki, H. and Katsumata, M. et al., (2008). Visiting a forest, but not a city, increases human natural killer activity and expression of anti-cancer proteins. *International journal of Immunopathology and Pharmacology,* 21: 117-128.

Li, Q., Kobayashi, M., Wakayama, Y., Inagaki, H., Katsumata, M. et al. (2009). Effect of phytoncide from trees on human natural killer function. *International Journal of Immunopathology and Pharmacology*, 22: 951-959.

Li, Q., Kobayashi, M., Inagaki, H., Hirata, Y., Li, Y.-J. et al. (2010). A day trip to a forest park increases human natural killer activity and the expression of anti-cancer proteins in male subjects. *Journal of Biology and Regulatory Homeostatic Agents*, 24: 157-165.

Li, Q., Otsuka, T., Kobayashi, M., Wakayama, Y., Inagaki, H., et al. (2011). Acute effects of walking in forest environments on cardiovascular and metabolic parameters. *European Journal of Applied Physiology*, 111(11): 2845-2853.

Louv, R. (2005). *Last Child in the Woods: Saving Our Children from Nature-Deficit Disorder.* Chapel Hill, NC: Algonquin Books.

Mao, G. X., Cao, Y. B., Lan, X. G., He, Z. H., Chen, Z. M. et al. (2012). Therapeutic effect of forest bathing on human hypertension in the elderly. *Journal of Cardiology*, 60: 495-502.

Mayer, F. S., Frantz, C. M., Bruehlman-Senecal, E. and Dolliver, K. (2008). Why is nature beneficial? The role of connectedness to nature. *Environment and Behaviour*, 41(5): 607-643.

McEwen, B. S. and Seeman, T. (1999). Protective and damaging effects of mediators of stress. Elaborating and testing the concepts of allostasis and allostatic load. *Annals of the New York Academy of Sciences*, 896: 30-47.

Misra, S. and Stokols, D. (2012). Psychological and Health Outcomes of Perceived Information Overload. *Environment and Behaviour*, 44 (6): 737-759.

Moksnes, U. K., Moljord, I. E. O., Espnes, G. A. and Byrne, D. G. (2010). The association between stress and emotional states in adolescents; The role of gender and self-esteem. *Personality and Individual Differences*, 49: 430-435.

Murray, J., Elsey, H. and Gold, R. (2016). Care Farming and Probation in The UK. In Barton, J., Bragg, R., Wood, C. and Pretty, J. *Green Exercise: Linking Nature, Health and Well-being.* London, New York, Routledge.

Norton, C. L. and Watt, T. T. (2014). Exploring the impact of a wilderness-based positive youth development program for urban youth. *Journal of Experiential Education*, 37: 335-350.

O'Reilly, P. O. and Handforth, J. R. (1955). Occupational therapy with

'refractory' patients, *American Journal of Psychiatry*, 111: 763-766.

O'Shea, E and Kennelly, B. (2008), *The Economics of Mental Health Care in Ireland.* Dublin: Mental Health Commission.

Orth, U., Robins, R. and Meier, L. L. (2009). Disentangling the effects of low self-esteem and stressful life events on depression: Findings from three longitudinal studies. *Journal of Personality and Social Psychology*, 97: 307-321.

Park, B.-J., Tsunetsugu, Y., Kasetani, T., Kagawa, T. and Miyazaki, Y. (2010). The physiological effects of Shinrin-yoku (taking in the forest atmosphere or forest bathing): evidence from field experiments in 24 forests across Japan. *Environmental Health and Preventative Medicine,* 15(1): 18-26.

Peacock, J., Hine, R. and Pretty, J. (2008). *The TurnAround 2007 Project.* Report for the Wilderness Foundation, University of Essex.

Pedersen, I., Nordaunet, T., Martinsen, E. W., Berget, B. and Braastad, B. O. (2011). Farm animal-assisted intervention: relationship between work and contact with farm animals and change in depression, anxiety, and self-efficacy among persons with clinical depression. *Issues in Mental Health Nursing*, 32: 493-500.

Prince, M., Knapp, M., Guerchet, M., McCrone, P., Prina, M., et al. (2014*). Dementia UK: Update.* London: Alzheimer's Society.

Proper, K. I., Staal, B. J., Hildebrandt, V. H., van der Beek, A. J. and van Mechelen, W. (2002). Effectiveness of physical activity programs at worksites with respect to work-related outcomes. *Scandinavian Journal of Work, Environment and Health*, 28: 75-84.

Richardson C.R., Faulkner G., McDevitt J. et al. (2005), 'Integrating Physical Activity into Mental Health Services for Persons with Serious Mental Illness', *Psychiatric Services* 56 (3): 324–31.

Roberts, J., Barton, J. and Wood, C. (2016). In Barton, J., Bragg, R., Wood, C. and Pretty, J. *Green Exercise: Linking Nature, Health and Well-being.* London, New York, Routledge.

Russell, K. C. (2001). *Assessment of Treatment Outcomes in Outdoor Behavioural Healthcare.* ID: Wilderness Research Centre, University of Idaho.

Russell, K. C. (2006a). Brat camp, boot camp, or…? Exploring wilderness therapy program theory. *Journal of Adventure Education and Outdoor Learning*, 6: 51-67.

Russell, K. C. (2006b). Evaluating the effects of the Wendigo Lake Expeditions program on young offenders. *Journal of Juvenile Justice and Youth Violence*, 4: 185-203.

Schiffman, S. S., Suggs, M. S. and Sattely-Miller, E. A. (1995). Effect of pleasant odours on mood of males at midlife: comparison of African-American and European-American men. *Brain Research Bulletin*, 36: 31-37.

Sempik, J. and Bragg, R. (2013). Green Care: Origins and Approaches. In Gallis, C. (ed), *Green Care: for Human Therapy, Social Innovation, Rural Economy, and Education*. New York: Nova Science Publishers.

Simpson, K. A. and Singh, M. A. (2008). Effects of exercise on adiponectin: a systematic review. *Obesity,* 16: 241-256.

Tennessen, C. M. and Cimprich, B. (1995). Views to nature: Effects on Attention. *Journal of Environmental Psychology*, 15: 77-85.

Tsunetsugu, Y., Park, B.-J. and Miyazaki, Y. (2010). Trends in research related to "Shinrin-yoku" (taking in the forest atmosphere or forest bathing) in Japan. *Environmental Health and Preventative Medicine,* 15: 27-37.

Ulrich, R. S. (1981). Natural versus urban scenes: some psychophysiological effects. Journal of Environment and Behaviour, 13: 523-556

Ulrich, R. S. (1984). View through a window may influence recovery from surgery. *Science,* 224: 420-421.

Ulrich, R. (2008). Biophilic Theory and Research for Healthcare Design. In Kellert, S. R., Heerwagen, J. and Mador, M., *Biophilic Design: The Theory, Science, and Practice of Bringing Buildings to Life.* Hoboken, NJ: Wiley.

Ulrich, R. S., Simons, R. F., Fiorito, E., Miles, M. A. and Zelson, M. (1991). Stress recovery during exposure to natural and urban environments. *Journal of Environmental Psychology*, 11: 201-230.

Van den Berg, A. E., Maas, J., Verheij, R. A. and Groenewegen, P. P. (2010). Green space as a buffer between stressful life events and health. *Social Science and Medicine*, 70: 1203-1210.

Wheeler, B. W., White, M., Stahl-Timmins, W. and Depledge, M. H. (2012). Does living by the coast improve health and well-being? *Health and Place*, 18: 1198-1201.

White, M. P., Alcock, I., Wheeler, B. W. and Depledge, M. H. (2013). Coastal proximity, health and well-being: Results from a longitudinal panel survey. *Health and Place*, 23: 97-103.

Wood, C., Bragg, R., Pretty, J. and Barton, J. (2012). *The TurnAround Project – Phase 3.* Colchester: The Wilderness Foundation, University of Essex.

Wood, C., Bragg, R. and Barton, J. (2013). *The TurnAround Project – Phase 4.* Colchester: The Wilderness Foundation, University of Essex.

Ian Birthistle

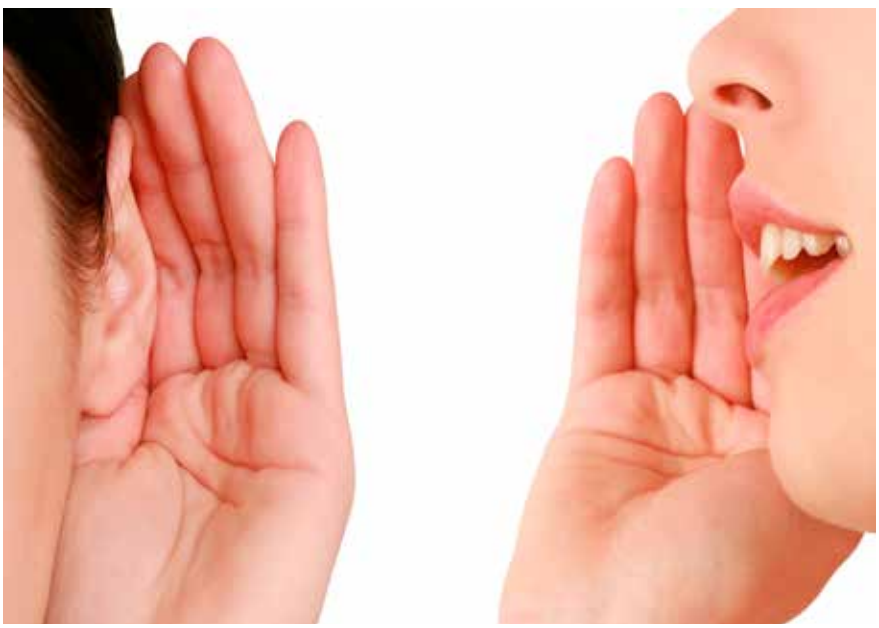
Ian Birthistle is a counselling psychologist with a private practice in Dublin. He has worked with heroin addicts and in the Rutland Centre, and for the last seventeen years he has co-run a fathers of addicts support group in North Clondalkin. Ian deals with a wide range of mental health issues, he has published a number of articles on addiction, suicide, and male gender role conflict, and his book, 'Tackling Depression' was published in 2010. His practice is office based in Dublin city centre for one day a week and then it moves to a Dublin park and a South-East Coast beach where Walk & Talk sessions are offered.

Practitioner Perspective

Decision Making Regarding Motherhood in Ireland:

Making a Space for Women's Voices in Counselling.

By Margaret O'Connor



Introduction

Motherhood is a powerful concept which affects women throughout their lives, both by its presence and absence. Motherhood can now be a conscious choice, theoretically at least, to be actively pursued or avoided with medical technology. There is increasing accessibility to reproductive technologies for people with fertility issues. Meanwhile, there is a growing proportion of women, and couples, who actively choose not to become mothers. This choice is a relatively new experience.

While it is deeply personal, motherhood is influenced by external factors including political, social and cultural contexts. Academic literature mainly focuses on decisions from the point of motherhood onwards, with little attention to the decision itself, unless there are other factors such as medical conditions present which may complicate a pregnancy. I could not find any research in an Irish context and I wanted to address this.

Methodology

I conducted a qualitative research study where I interviewed fifteen women living in Ireland, aged between 25 and 40 years old who were not mothers. I used semi-structured interviews in person and via Skype. This is an issue that affects men and couples also but I focused on the experience of women due to the limited time and resources available for my research. The nature of the study is deeply personal and potentially sensitive. Therefore I felt the best sampling strategy was volunteer convenience sampling. This is a "non-random sampling where members of the target population that meet certain practical criteria such as… availability at a given time or the willingness to participate are included" (Etikan et al., 2016, p. 2). Convenience sampling is frequently used with sensitive topics where it is more ethically appropriate for participants to self-select. Convenience sampling does have limitations; it is difficult to generalise findings from the sample group to the wider population. It is also difficult to know if the group actually represents the population under study due to the nature of self-selection (Etikan et al., 2016). However, I am not attempting to create generalisable results due to the postmodern approach of the research. Postmodernism does not tolerate grand narratives; "privileged discourse(s) capable of situating, characterising and evaluating all other discourses" while being beyond examination themselves (Fraser & Nicholson, 2008, p. 354). I regard motherhood as being one of these grand narratives and I want to expose it to examination. The category of mother is not fixed and does change over time. I am curious to know how women regard the current categories of motherhood and how they choose to locate themselves in relation to them – do

they embrace them, reject them or find some way of negotiating them. I want to acknowledge that every woman inhabits "multiple locations within structures that are not rigid but always shifting" (Jaggar, 2008, p. 345). I am not planning to uncover the entire story but "only a story acknowledged to be partial and perspectival" (Ibid.).

Decision Making Processes

My research shows that there are several types of decision making processes present for women. Participants described it as a very personal and internal process. See Table 1. This reflects the finding of Maher and Saugeres (2007) for women who chose not to have children. I found this also applies to those choosing to become mothers. Uncertainty is often present regarding several areas including whether motherhood is something you really want. There is a fear of regretting whichever decision you make and also of losing your identity as a person to the role of mother, where this overrides your other roles and interests. This strongly reflects O'Reilly's idea of sacrificial motherhood which "requires and results in the repression or denial of the mothers own selfhood" (2004, p. 15). There is uncertainty about ability to cope with the physical and emotional changes of motherhood, for your relationship to cope and anxiety around possible health complications for mother/child. There is also practical uncertainty about when is the right/best time to have a child; work/career and finances are very influential here.

While some women are simply sure that they do or do not want to be mothers from an early age, for others it is a much more complicated experience with frequent changes of position. Some women can be forced to make a decision sooner than they expect due to health conditions which affect fertility. Women who had not yet made a decision reported it as being present in the background e.g. a woman may have no intention of becoming a mother in the near future but still includes maternity cover in her health insurance policy.

Factors Affecting the Motherhood Decision

As we can see in Table 2, there are a wide range of factors which influence the decision to become a mother or not and factors appear to be either practical of philosophical issues e.g. finances and relationship status versus view of self as a mother and family context.

The theory of planned behaviour is regarded as a very useful way to examine fertility decisions and allows us to "explain how macro level conditions influence the evaluation system, intention and behaviour" of individuals (Philipov et al., 2009, p. 35). It was developed by Icek Azjen and comprehensively captures the wide range of factors involved and the interaction between them to trace how individual decisions are made (influenced by personality traits and values, age, gender, cultural background, education, income, religion, past experience, knowledge and media exposure) and how societal factors can influence these (e.g. the persons' perception of external social pressures to have children and that they are able to perform this behaviour) (Azjen, 1991).

Friends/family providing opportunities for interactions with the children and observation of family life is strongly influential. This can be for or against motherhood as people may either feel this is not what they want when they see the reality or it can provide positive experiences which may override other concerns. This shows the importance of maternal desire; for those who feel it strongly enough, other factors can be worked through whereas if this is not present or strong enough, there is not enough motivation to pursue it.

This shows the importance of maternal desire; for those who feel it strongly enough, other factors can be worked through whereas if this is not present or strong enough, there is not enough motivation to pursue it.

Table 1

Decision making processes regarding motherhood

Lack of process	Is imply sure either for or against motherhood, no need for conscious decision process
Over and back process	Change of mind between positions
Forced process	Need to make a decision due to health or age factors
If becomes when	If you decide to become a mother, a series of other decisions follow
Conscious and unconscious elements	They can be a background factor but they can change to become a very definite issue
Questioning of decision due to social pressure	This can add an extra step if you make a decision but feel under pressure that it is not a socially acceptable decision.

Table 2 ***Influential factors on the motherhood decision***	
Health	Physical and mental health
Relationship Status	The need to be in a relationship, for it to be the right time in that relationship, to be in agreement and have a supportive partner
Finances	Need for financial stability and secure accommodation
Maternal/ Biological Desire	The desire to be a mother needs to be present and strong enough
Family Context	Family background can provide positive or negative experiences of family life. It can also provide a broad or narrow view of what constitutes a family e.g. fostering, adoption
Support Networks	Availability and proximity of family and friends who can provide emotional and practical support
Personal Development	View of self as a mother Life experience, developing values and goals
Work	Conflicting ambitions between work and motherhood Precarious employment conditions and inability to plan ahead Ability to achieve work/life balance Opportunities to work with children
Irish Health System	Concerns over safety of the health system
Lifestyle	Concerns re: change of lifestyle required
Social Expectation	Assumptions and questioning by others regarding life choices

Social Pressure
Social pressure is a strong influencing factor and impacts the decision making process itself. It also affects the experience of decision making which the majority of participants described as negative, no matter what decision they made. It adds an extra layer of questioning and uncertainty – women ask themselves if they 'should' want children on top of whether they actually want them. This pressure is on going, pervasive and has a very negative impact.

Liminality – Motherhood as a Rite of Passage
Liminality "refers to the transitional space in between well defined structures" and is a process people pass through to achieve a new status (Boland & Griffin, 2015, p. 39). Victor Turner describes how "liminal entities are neither here nor there; they are betwixt and between" (1969, p. 359). This is in contrast to someone who has completed their transition, who "is in a relatively stable state once more, and… has rights and obligations…of a clearly defined and 'structural' type" (ibid). This caused me to think about women as, traditionally, childbirth has been regarded as the full achievement of womanhood (Russo, 1979), and is still acknowledged as a key life event. While this growth is available to women who become mothers, what happens to women who, by choice or circumstances, do not do so? Is it possible to have other liminal experiences or are they stuck due to the lack of legitimized alternatives?

There is a sense that women who do not have children are missing something from their lives and whatever else they achieve is only acting as compensation for this.

"You Wouldn't Understand"
Participants may not have recognised the term but they could all relate to the real and practical effects of liminality regarding motherhood. Women who are not mothers report being treated differently and negatively by parents. The often used phrases 'you wouldn't understand' and 'wait until you have your own' are deeply hurtful and disregard any professional expertise or personal experience a woman may have regarding children or family issues. There is a sense that women who do not have children are missing something from their lives and whatever else they achieve is only acting as compensation for this. This is even worse if you have consciously chosen not to have children without a socially acceptable reason, of which there are very few.

Two possible explanations emerged for this negative reaction. Firstly, some people really love being parents and the idea of not wanting this is too alien for them. Secondly, for people who may be regretting or

questioning their decision to be a parent, your choice could make them reflect on this and this is too close to the bone so they lash out at you instead. There is a sense that it is not acceptable to express these thoughts within society so it is easier to assume that parenthood did not work out for you and therefore you can be pitied. I was really fascinated by these dynamics and feel they reflect Anna Gotlib's findings that non-mothers are portrayed as "either a menacing presence… (or) as the pitiable 'spinster'" (2016, p.330).

Impact of Pronatalist Policies

Gotlib explores the impact of Western pronatalist policies on women, particularly voluntarily childless women. Pronatalism is "a view, shaped by political, social, economic and medical narratives that motherhood is naturally synonymous with womanhood, and that female identity cannot be (and ought not to be) extricated from its motherhood role" (Gotlib, 2016, p. 330). This has very serious consequences as motherhood is offered as "an image of female self-actualisation and the fulfilment of an essential, natural role" (ibid.).

Gotlib is clear about the destructive effect of pronatalist views on women who do not become mothers; she believes that it marks them "as incomplete women who are selfish, empty or emotionally and psychologically immature" (2016, p. 328). They are therefore "burdened with damaged identities that can leave them personally othered and socially liminal" (ibid.). Women find that it is possible to remain childless due to the availability of contraception but it is deemed as the wrong option. This is reinforced by the lack of recognition of any other life choice or achievement as an alternative liminal experience: "this single choice invariably defines them as transgressive in the eyes of others, and because this transgression cannot be undone by any other act, it marks them as permanently and irrevocably liminal" (Gotlib, 2016, p. 342). This is an isolating and lonely place to be – "to be seen and invisible, … to exist within a community but not necessarily be part of it" (ibid). It is clear that there is a large "gap of perception" (Maher & Saugeres, 2007, p. 19) between societal views and how some women want to live their lives.

Women and men, mothers and non-mothers need to be involved in these discussions so that everyone can understand that motherhood requires support and should be valued, and not just seen as something women should and will do.

Liminality in the Workplace

There is a strong and practical interaction between liminality and work as a factor in the decision making process. Participants reported that, on the one hand, women who are not mothers feel they are not taken as seriously in the workplace; there is a sense of parental authority on child related matters and parents get preference for annual leave etc. However, being a parent is seen as a hindrance to progressing in the workplace as there is an assumption that a mother's priority is her children at all times and that she cannot be as flexible or dedicated as other workers. So motherhood is valued symbolically but not practically within the workplace. Women feel like they cannot win no matter what they do and all of this is very unspoken but heavily implied.

Liminality in the Media

Liminality also influences the media through targeted advertising and social media which I had not previously encountered in the literature. Participants reported that advertisements for pregnancy tests, baby food and fertility treatments appear on their social media accounts even though they have never researched the product. The advertisements appear to be illustrating a projected life course and participants found this to be very negative if their life choices were different. The lack of representation of other life decisions apart from biological motherhood compounds the sense of isolation some participants feel.

Conclusion

Women, men and couples find that they can now make a choice about whether to become parents or not. However, the participants in my study felt isolated and unsupported in this process. There is a sense of secrecy surrounding motherhood which adds to uncertainty for those who are not mothers. It feels unsafe to name these uncertainties or concerns regarding motherhood. There are many practical issues to be considered but social expectation and pressure exerts a very real influence on top of these; women question if they 'should' have children as well as if they actually want to have them.

Change requires contesting the dominant discourses and

I believe that counselling can play a vital role in these changes. It can provide a safe space for women and couples to discuss concerns and to feel supported in reaching the best decision for their situation. It can raise awareness of these choices, as we do with many others, to reduce stigma and educate people on changing social contexts.

broadening our understanding of both motherhood and womanhood so that it matches the lived experience of women. The media needs to represent different family forms, including those which do not include children. We also need real discussions around motherhood so women can make a fully informed decision. Women and men, mothers and non-mothers need to be involved in these discussions so that everyone can understand that motherhood requires support and should be valued, and not just seen as something women should and will do. Equally, we need to remove the stigma of choosing not to have children, to see that it is a choice and there are many other ways to contribute to society apart from having children.

Role of Counselling

I believe that counselling can play a vital role in these changes. It can provide a safe space for women and couples to discuss concerns and to feel supported in reaching the best decision for their situation. It can raise awareness of these choices, as we do with many others, to reduce stigma and educate people on changing social contexts. I would like counsellors to be aware that this can be issue and to be able to support those who face it through this process without adding to the shame that society tries to attach to them. The formation of support groups and further research will also help illuminate this topic and help people know that they are not the only ones grappling with these issues.

References

Azjen, I. (1991) "The Theory of Planned Behaviour" Organizational Behaviour and Human Decision Processes Vol. 50 pp. 179 - 211

Boland, T. & Griffin, R. (2015) 'The Death of Unemployment and the Birth of Job-seeking in Welfare Policy: Governing a Liminal Experience' *Irish Journal of Sociology* Vol.23 No. 2 pp.29-48.

Etikan, I., Mussa, S.A., Alkassim, R.S. (2016) 'Comparison of Convenience Sampling and Purposive Sampling' American Journal of Theoretical and Applied Statistics 5 (1); 1-4

Fraser, N. & Nicholson, L.J. (2008) 'Social Criticism without Philosophy: An Encounter between Feminism and Postmodernism' in Jagger, A.M. *Just Methods: An Interdisciplinary Feminist Reader* USA: Paradigm Publishers pp. 352-361

Gotlib, A. (2016) 'But you would be the best mother: Unwomen, Counterstories and the Motherhood Mandate' *Journal of Bioethical Inquiry* Vol. 13 issue 2 pp.327 -347

Jagger, A.M. (2008) *Just Methods: An Interdisciplinary Feminist Reader* USA: Paradigm Publishers JNRS (2014/2105) www.newsbrandireland.ie/data-centre/readership [accessed 18th May 2017)

Maher, J.M. & Saugeres, L. (2007) 'To be or not to be a Mother? Women Negotiating Cultural Representations of Mothering' *Journal of Sociology* Vol. 43 issue 1 pp. 5-21

O'Reilly, A. ed. (2004) *Mother Matters: Motherhood as Discourse and Practice* Canada: Association for Research on Mothering

Philipov, D., Theveenon, O., Klubas, J., Berardi, L & Liefbroer, A.C. (2009) 'Reproductive Decision Making in a Macro-Micro Perspective (REPRO): State of the Art Review' available: www.researchdepository.murdoch.edu.au/id/eprint/23537/i/edrp_1_09.pdf [accessed: February 20th 2017]

Russo, N. (1979) 'Overview: Sex Roles, Fertility and the Motherhood Mandate' *Psychology of Women Quarterly* Vol. 4 issue 1 pp.7-15

Turner, V. (1969) 'Liminality and Communitas' in *The Ritual Process: Structure and Anti-Structure* Chicago: Aldine Publishing pp.94 -113, 125-30. Abridged.

Margaret O'Connor

Margaret O'Connor is a fully accredited member of the IACP and works in Limerick Social Services Centre in Limerick City and in private practice, specialising with women who experience uncertainty regarding motherhood. She has worked in the area of community development for over ten years and is an experienced group facilitator. Please contact her at oconnormgrt@gmail.com

Acknowledgement

This research is based on her thesis which was completed as part of a Masters in Gender, Culture and Society in UL this year. She would like to thank her participants who so openly shared their experiences and her supervisor Dr. Izabela Handzlik for all her guidance.

Practitioner Perspective

Anxiety and stress in the transition from primary to secondary school

How lasting psychological impact can be avoided.

By Maretta Byrne

Introduction

...this transition period involves stresses and anxiety for all students, even those who adjust well to secondary school. A poor transition is associated with concurrent psychological problems and a poor transition can set in motion chains of events that impact on future attainment and adjustment. (Rice, Frederickson & Seymour, 2010, p.3)

Adult clients suffering from stress and anxiety continuously present themselves in the counselling space. Counsellors spend a great deal of time with these clients trying to get to the cause(s) of their anxiety. The origins of anxieties vary greatly but in some cases it relates back to events in a person's early life. Disord (2014, cited in Pine et al., 1998) stated that "the presence of anxiety disorder during adolescence also predicted a two-to-threefold increased risk for anxiety in adulthood". Transitioning from primary to secondary school is one of the first major transitions for adolescents. Clearly, this transition can present physiological, academic, social and emotional challenges for adolescents which may result in long term negative consequences for their mental wellbeing.

In this article I first look at the anxieties for students around the transition to secondary school. I then identify the students most susceptible to these anxieties. Finally, and most importantly, I look at what can be done to alleviate the potential long-term psychological impact on students.

Areas of anxiety around school transition

Coping theorists recognise that loss is central to any concept of stress, and while there can be loss or gain from a stressful situation, loss is more severe. Transition from primary to secondary school is seen as stressful and this could be because of the perceived academic and social losses associated with this period (Mackenzie, McMaugh & O'Sullivan (2012) cited in Frydenberg (2008), p.300)

Anxiety is a term generally associated with adults but in a survey conducted by UCD School of Psychology and Headstrong (2012), it found that "1 in 3 of our young people had mild to severe feelings of anxiety" (p. 55). In relation to the transition to secondary school I group the areas of concern for students under three headings, social and emotional, curriculum and learning and bureaucratic.

Social and Emotional

Social and emotional relates to perceptions and feelings and can be summed up by the term 'mental wellbeing'. While social and emotional relates to an individual's own perception of themselves, it is significantly influenced by their outside social world and how they relate to it. Symonds (2015) notes that "when people experience a significant life event such as changing schools, it can have a profound effect on how they feel

about themselves and who they think they are" (p. 98).

The most important outside influences include peers and friends. Yalom and Leszcz (2005) note that "nothing seems to be of greater importance for the self-esteem and well-being of the adolescent.... than to be included and accepted in some social group and nothing is more devastating than exclusion." (p. 57). Most students have been in the same school and in the same class since the age of four or five. Then at around twelve years of age they separate from their friends since childhood.

Bullying can often be considered the flipside of having friends and being accepted by peers. Bullying occurs in all aspects of life but is particularly prevalent in schools. Lester, Cross, Shaw & Dooley (2012, in Cross et al.,2009) state that "...an increase in bullying behaviour appears to occur at age 11 and in the immediate transition period from primary school to secondary school." (p. 215). A recent development is the role that social media is playing in bullying. What was once the security and safe space of home is no longer the case, as the bully cannot be left behind in the classroom. I have seen first-hand the impact of social media on one of the students in the school where I work. A picture was taken of the student sitting alone at lunch and posted on social media with the phrase 'loser'. She had no idea until another friend drew her attention to it. She spent the next few hours in her room on Facebook/ Snapchat, checking the comments posted about it. It's easy for adults to say "ignore it or switch it off" but for young people, switching off, is breaking off communication with their outside world.

Another less obvious social and emotional issue is having to contend with teachers, personality differences. In the eight years of primary school students have had no more than eight different teachers; in secondary school they can have up to eight teachers in the one day! Claire Redmond in her article in the Irish Independent acknowledged "Sometimes teachers may not be aware that their actions are causing genuine distress to the student. In their efforts to maintain order and effectively manage the classroom, teachers may terrify students" (Redmond, 2010).

Curriculum and Learning

"Curriculum and Learning" relates to the academic side of secondary school and includes; homework; exams; subjects and a student's academic ability. Research has shown that where students are weak academically they have significantly greater concerns about the transition to secondary school. Maguire and Yu (2014) found that "Specific academic abilities (e.g. spelling ability), among other variables, predicted the success of adolescents' transition to secondary school" (p. 84). They also reported that "... children's numeracy performance continued to show a significant association with child-reported difficulties with the transition to secondary school" (p. 95). Anxiety in this area is often related to the prospect of having thirteen subjects and facing state exams.

The area of class streaming (separating students by academic ability) is particularly relevant and contentious. Schools that stream students entering secondary school, end up segregating pupils based on a subjective assessment. This can have the effect of differentiating students from one another in first year. Smyth, McCoy and Darmody (2004) found that "where streaming does occur, it tends to result in the labelling of students as 'smart' or 'stupid .....students in streamed schools, especially those in the lower streams, make less progress in reading and mathematics during first year." (p. 6).

Bureaucracy

There are small differences in secondary school when compared to primary school (which adults either do not consider or are not aware of). However these differences can often create significant issues for students as they attempt to settle into secondary school. These differences include: - (i) timetable stressors (ii) forgetting books (iii) locker issues (iv) getting lost (v) new teachers (vi) discipline (vii) new subjects and (viii) getting to school.

Identifying the students most at risk to anxiety during a school transition

There are many factors that predispose children to stress at transition. These include being pubertal, being female, experiencing childhood adversity, lacking social support, having had a bad prior transition and viewing change as a threat rather than a challenge. Also, children with existing anxiety disorders may be more vulnerable to the differences in school environment. Teachers can use these characteristics when they think about which children in their care might be more anxious than others. (Symonds, 2015 p. 44).

Having established the areas that cause greatest anxiety for students, how do we identify the 'at risk' students; that is those most vulnerable and as a consequence most likely to be affected psychologically in the transition to secondary school. If we want to help them then we need to know who 'they' are. The source for information on students must come from the partners in education, namely family and schools.

Parents/Guardians

Parents know their child's

personality best. Parents can look back on their school days with 'rose tinted glasses' often remarking to their children about the 'best days of your life'. They forget some of the realities of youth - the fears of rejection, trying to fit in, exam pressure, cliques. Janis Ian's song 'Seventeen' comes to mind "To those of us who knew the pain, of valentines that never came, and those whose names were never called, when choosing sides for basketball" (Ian, 1975, A2).

Schools - Primary and Secondary

Primary schools have been involved in student's growth and development for eight years and know their learning strengths and needs, as well as their peer relationships. Primary schools are also best placed to assess if the needs of a child are being met in the classroom or if extra resources are required such as the help of a resource teacher or a Special Needs Assistant (SNA).

Secondary Schools along with students themselves will benefit most from the transition being a positive experience. As such these schools must ensure that they are pro-active in identifying the students that need support.

Two key categories help identify possible vulnerable students. The first category is the **student groupings** to which the greatest number of 'at risk' candidates belong and the second category is those students with **personality traits** that have a tendency to experience anxiety and stress.

Category One: 'At Risk' Groups

Emer Smyth in her report "Junior Cycle Education: Insights from a Longitudinal Study of Students" (2009) mentions some of the groups that experience issues settling into secondary school. She notes "girls report taking longer to settle in than boys, newcomers (immigrants) and traveller students take longer to adapt, and students who were already disaffected by their primary experiences have greater adjustment difficulties" (p. 2).

Ethnic minority groupings are becoming increasingly significant in secondary schools. Children from the Traveller Community, who in the past would have exited education in primary school, are now attending secondary school in greater numbers. Forkan (2006) reports that "the number of traveller children enrolled in mainstream post/primary education has risen dramatically over the last decade or so"(p. 79). Also with the influx of immigrants and refugees in the last 20 years, ethnic diversity in the classroom has expanded significantly.

In her paper Dr. Teresa Whitaker made reference to the Department of Education's statistical findings, "According to the Department of Education's Statistics Office (2011) newcomer children constitute 12% of the primary school population and 9% of pupils in post-primary schools (Department of Education and Skills, 2010, p. 217)".

Another 'at risk' group which warrants particular attention is those students with Special Educational Needs (SEN). Each year there are a significant number of these students that make the transition from primary to secondary school. O'Brien (2017) in his article in the Irish Times commented that "It is now estimated that about 25 per cent of school-going children in Ireland have some form of physical, learning and emotional or behavioural difficulty".

Category Two: Personality traits of Students

It is important to consider each student as an individual. Personality traits and the ability to embrace change are key to the psychological impact that the transfer to secondary school presents. According to J. Symonds there are two types of anxiety that are particularly associated with school transitions; "The first is children's transition anxiety which can be described as their worries about changing schools. The second is children's tendency to have the symptoms of an anxiety disorder, such as separation anxiety." (Symonds, 2015, p.41)

Also, the ability to make friends is a skill that some people have innately, but others lack. Lyons & Woods (2012, in Rubin et al. 2002) when they

...found that socially shy or withdrawn children do not lack the social skills ....rather the confidence to act upon their knowledge and skills in social situations appears to hinder their interactions. Therefore, the social/ peer dimension of self-esteem may be crucial in supporting children's successful transition to the new social situations of secondary school (p. 21).

Actions to alleviate anxieties around school transition

Awareness is the critical first step for all educational stakeholders. They need to be aware of the anxieties for students in the transition to secondary school, and of the potential impact these anxieties can have on a student's mental wellbeing. They also need to be aware of which students are most susceptible to these anxieties. However awareness is not enough if positive outcomes are to be achieved.

What can Schools do?

There are many activities, processes and procedures schools can put in place that would help to alleviate the anxieties surrounding a transition from primary to secondary school.

Gathering Information

The simplest and most effective use of resources will be the gathering of appropriate information relevant

to each child ahead of transitioning into the school. Sources for such information include: (i) primary schools, (ii) parents, (iii) educational psychologist reports (iv) the children themselves (v) the recently introduced 'Education Passport' reports. A member of the secondary school staff, usually the Year-Head designated to incoming first year students, should visit the primary schools some months before the students transfer. These face to face meetings allow for discussions around specific students and their needs.

Changing Student Perceptions

Student anxieties are often centred round what they think might happen whereas the reality is generally totally different. Mackenzie, McMaugh & O'Sullivan refer to Lazarus' cognitive-transactional stress theory (Lazarus & Folkman, 1984) when they say "that the perception of the event changes the outcome of the situation ……if the same situation was appraised as an opportunity for growth, then a positive and well balanced emotional response would follow" (Mackenzie, McMaugh & O'Sullivan, 2012, p.301). Schools can alleviate anxieties by introducing activities and programmes to change the view of transition from that of a threat to a challenge.

Induction Programmes

Induction Programmes ahead of transition are some of the best ways to help students directly. They give students the opportunity to visit the school and to meet the teachers ahead of transitioning. This helps ease students' anxieties ahead of the move by familiarising themselves with their new school environment.

Another intention of induction days is to reduce student concerns by introducing them to 'new friends' ahead of the transition. As the saying goes 'strangers are just friends you haven't met yet'.

Class Formation

Having visited the primary schools of the students, the Year-Head should have a 'database' on each student. In forming classes, secondary schools should consider some of the following:

(i) Placing students with a friend from their primary school in their main class.
(ii) Explore class dynamics vis-a-vis male : female ratio (if it is a mixed school).
(iii) Separate students who had issues in primary school.
(iv) I would also recommend mixed ability classes, thereby eliminating class distinction. A simple dynamic like this can go a long way to help develop self-esteem amongst these young adults.

Buddy System

Evangelou, Taggart, Sylva, Melhuish, Sammons, Siraj-Blatchford (2008), found that "Older children in the school could assume the role of an 'older sister/brother' since children with other siblings adjusted better in this regard" (p. v). The 'Buddy System' allows for peer support from senior students to junior students and involves an all-inclusive approach in schools. I have seen first-hand the success of this small practical approach.

What can Parents do?

In order for our young adolescents to become independent and accepted by their peers it is important for parents to acknowledge the need to 'step back' from their teenager. However this does not mean that parents have no involvement. Withdrawal can be as detrimental as being intrusive. Rice et al. in their report conclude "Parental expressions of warmth and affection have a long-term influence on how self-controlled children are which in turn affects how well they do at secondary school both in academic and behavioural spheres." (p. 21). Parents need to be positive and supportive in their attitude to their child's move to secondary school.

Parents are also vital in the process of information gathering. Information such as a one-parent family, siblings, recent bereavements, etc. all give a more complete picture of a student and possible personal issues they are facing at the same time as their transition to secondary school.

Conclusion and Call to Action

Life is challenging, especially for adolescents on their way to adulthood. While we can't remove every difficulty from their lives, we can provide them with the knowledge, skills and tools they need to respond to these challenges in a healthy and constructive manner (Pieta House, 2014).

For most students, the move to secondary school is a positive experience, in that they feel more grown up, have a variety of subjects and have more independence. As they move into secondary school they find themselves challenged emotionally; as their peer situation changes; challenged intellectually; as they face new subjects and state exams and finally; challenged by the bureaucracy of a new school system. For some these challenges can become overwhelming.

As a society we need to ensure that teachers are trained adequately both in awareness around transition and its implications for students and also in terms of best practice in dealing with the process of transition itself. It's a concern that there is neither a standardised approach amongst schools nor proven programmes such as 'induction days' and 'buddy systems'. In recent years, the Department of Education cut guidance hours in schools, which in my opinion, was a backward step. This indicated that academic attainment was the only

focus of education, without room for the equally (if not more important) social and emotional development of students. Thankfully common sense is prevailing and these cut backs are being reversed. A fresh look needs to be taken at the aims of education in our second level institutions and what we as a society consider to be the priorities for our children.

Primary to Secondary school transitions are events which test our coping abilities. Many of us have had first-hand experience of the tragedy that is the suicide of a young person and the question always asked is why? The complete answer we will truly never know. Maybe in part issues of self-esteem, anxiety and coping come together with others in what can be a mental 'perfect storm'. As a Profession of Counsellors and Psychotherapists, we must be a voice for the mental wellbeing of young people. A voice I believe that needs to be heard, particularly at this moment in time. This article is about that 'voice' – what it should say and to whom it should speak. We pride ourselves on our listening abilities but as a profession we must also to be heard. The IACP's purpose statement is to create "….wider awareness of the value of Professional Counselling and Psychotherapy" (IACP, 2017) – maybe this is one area in which we can contribute to the wider debate?

Helping adolescents realise that change is not to be feared, but should be viewed as a positive challenge, is a lesson worth teaching.

References

Disord, J. Affect (2014). *Anxiety disorders in adolescents and psychosocial outcomes at age 30.* HHS Public Access. Retrieved from: http://www.pubmedcentralcanada.ca/pmcc/articles/PMC4028371/

Dooley, B. & Fitzgerald, A. (2012). *My world survey, national study of youth mental health.* UCD School of Psychology, Headstrong.

Evangelou, M. Taggart, B. Sylva, K. Melhuish, E. Sammons, P. Siraj-Blatchford, I. (2008).*What makes a successful transition from primary to secondary school?* Institute Education, University of London. Retrieved from: http://www.ioe.ac.uk/projects/eppe

Forkan, C. (2004). *Traveller children and education.* Youth Studies Ireland.

Ian, J. (1975). *At seventeen.* On: Between the Lines. Vinyl. US. Columbia.

Irish Association for Counselling & Psychotherapy, (2017). *Purpose Statement.*

Lester, L., Cross D., Shaw T., Dooley, J., (2012). *Adolescent bully-victims: social health and the transition to secondary school.* Routledge: University of Cambridge, Faculty of Education. Retrieved from: http://www.tandfonline.com

Lyons, R. & Woods, K. (2010). *Effective transition to secondary school for shy, less confident children: a case study using 'pyramid' group work.* The British Psychological Society.

MacKenzie, E., McMaugh, A., O'Sullivan, K.A. (2012) *Perceptions of primary to secondary school transitions: challenge or threat.* Macquarie University: Issues in Educational Research

Maguire, B., Yu, M. (2014). *The longitudinal study of australian children annual statistical report.* The Australian Institute of Family Studies. Retrieved from: http://www.growingupinaustralia.gov.au/pubs/asr /2014/asr2014e.html

O'Brien, C. (2017). *Why is the cost of special education soaring?* Irish Times. https://www.irishtimes.com/news/education/why-is-the-cost-of-special-eduction-soaring

Pieta House. (2014) *Statement.* Pieta House.

Redmond, C. (2010). *High school heebie-jeebies: the transition from primary to secondary school.* Irish Independent. Retrieved from: http://www.independent.ie/life/family/mothers-babies/high-school

Rice, F., Frederickson, N., Shelton, K., McManus, C., Riglin, L., Ng-Knight, T., (2015). *Identifying factors that predict successful and difficult transitions to secondary school.* Retrieved from: www.ucl.ac.uk/stars

Rice, F., Frederickson, N.& Seymour, J. (2010). *Accessing pupil concerns about transition to secondary school.* The British Psychological Society.

Smyth, E. (2009). *Junior cycle education: insights from a longitudinal study of students.* Economic and Social Research Institute, Dublin

Smyth, E. McCoy, S. and Darmody, M. (2004). *Moving up: the experiences of first year students in post-primary education.* Dublin: Liffey Press

Symonds, J. (2015). *Understanding school transition.* Routledge.

Whitaker, T. Dr. (2013). *Reflecting on teaching interculturalism and diversity to teachers in first and second level education in Ireland.* Limerick Education Centre & Clare Education Centre – 2013 Research Conference Journal – Volume III Retrieved from: www.otb.ie/images/Dr._Teresa_Whitaker_paper.pdf

Yalom, I.D., Leszcz M. (2005). *The theory and practice of group psychotherapy.* 5th Edition. New York: Basic Books

Maretta Byrne

Maretta holds a First Class BSc (Hons) Degree in Counselling and Psychotherapy from Middlesex University and is a graduate of PCI College. She is an associate member of IACP, working towards accreditation. Maretta, late to the profession, having worked in a secondary school, has a particular interest in adolescents and their issues. She also holds qualifications in CBT and Mindfulness. Maretta is a Counsellor/Psychotherapist practising in South Dublin.

If you would like more information please see www.therapistmarettabyrne.com.

Maretta can be contacted directly at therapistmarettabyrne@gmail.com

Practitioner Perspective

We need to Talk about Anti-Depressants

By Mari Gallagher.

Therefore it is essential that therapists are aware of the potential impact of anti-depression medication on the mood and disposition of the client.

Introduction

A strong movement questioning the efficacy and aptness of long-term[1] prescription of anti-depressant medication has been present in the psychiatric and medical profession for some time now. In this article I will reflect on the role of the therapist when a client expresses a wish to discontinue anti-depressant medication. In order to place my reflections in context of the current debate, I will cite statistics outlining the extent of anti-depressant prescription in Ireland, a summary of the side effects of anti-depressants and also reference literature from both psychiatric and medical circles questioning the efficacy of the long term taking of anti-depressant medication. I will include observations on this topic from my client work and conclude by reflecting on the role of the psychotherapist in the face of an increasing movement towards questioning the value of long term anti-depressant medication.

I realise that to write about client work in the context of medication veers towards stepping outside the boundary of my training – I am not medically qualified, therefore am not equipped to make diagnosis or prescribe. However, significant numbers of clients are, in my experience, on long-term anti-depressant medication and frequently include living life "anti-depressant-free", as one of the goals of therapy. To try to separate client anti-depressant medication from the process of therapy is to ignore a salient aspect of the healing process: therapeutic work is as much a constituent of the recovery process as is the taking of medication - in fact, the citations in this article would suggest that talk therapy contributes to recovery in a far greater way. Therefore it is essential that therapists are aware of the potential impact of anti-depression medication on the mood and disposition of the client. This is not stepping outside the boundary of training but rather a responsible noting of all aspects of the client's world while endeavouring to assist that client towards recovery. Also, it is important to note that questioning the potential negative impact of long term use of anti-depressants is not in any way a dismissal or minimizing of the potency and debilitation of the suffering

[1] Long-term prescription of anti-depressants has been defined as > 1 year – Oxford Handbook of General Practice (2014).

Brogan (2016) also notes that the long-term use of anti-depressants has also been associated with an increased acute risk of suicide in younger patients.

experienced during depression or an ignoring of the apparent benefits of short term doses of such medication.

This article, therefore, seeks to explore the psychotherapist's role in a situation where the client speaks during therapy of side effects of his/her long term medication and expresses a desire to become anti-depressant-free.

Statistics

Much has been made in media reporting in recent years of Ireland as the "Medication Nation." Shanahan (2015) reports that an analysis of figures based on publicly-prescribed drugs under the GMS Scheme (which covers medical card holders), shows two million plus prescriptions were written for the top five anti-depressants in 2012 for the benefit of 331,368 patients. When prescriptions for the same medication written under the Drug Payment Scheme (DPS) and the Long Term Illness Scheme as well as private patients whose bills do not reach the monthly threshold to qualify for the DPS are included, the numbers on anti-depressant medication in Ireland is estimated as being close to half a million, a significant 10% of the population (Shanahan, 2015).

Side effects of anti depressants

Information on the side effects of anti-depressants is widely available. Side effects are also outlined on the information leaflet accompanying medications. Brogan (2016) cites a 2014 review in the Journal of Affective Disorders: "Side effects include headache, nausea, insomnia, sexual dysfunction, agitation, sedation, stroke, cardiac conduction defects and increased risk of mortality." Brogan (2016) also notes that the long-term use of anti-depressants has also been associated with an increased acute risk of suicide in younger patients and that there is growing body of research suggesting that when anti-depressants are used in the long term as a maintenance treatment, they can lose efficacy, and may even result in chronic and treatment resistant depression.

It is important that therapeutic work is done within the context of awareness that aspects of a client's presenting issues may be potentially related to the side effects of the long-term taking of anti-depression medication.

Depression: A Chemical Imbalance or not?

Doubts have been raised by neuroscientists, general medical practitioners and psychiatrists alike on the claim that depression is caused by chemical imbalance. Lynch (2015) refers to the lack of evidence on chemical imbalance as a contributory factor in depression. Lynch states there was never good scientific reason to believe that anti-depressants healed a chemical imbalance in the brain and supports his statement with exhaustive coverage of expression of doubts from a wide variety of psychiatrists, general practitioners and neuroscientists. Lynch concludes that "existence, experience and life itself is at the heart of the human distress that doctors reframe as psychiatric diagnoses such as depression" (2015, p.340).

The client often does not wish to question the opinion of their general practitioner or be seen, as one client put it, "to be telling the doctor how to do his job".

Renowned psychiatrist Professor Ivor Browne has consistently been a critic of the long term use of anti-depressants and writes:

> It was experiences like this which taught me how bogus is the concept of "clinical depression". The idea that there is a chemically mediated form of depression which is an "illness", quite separate from the sadness and depression which are part of the slings and arrows of ordinary life, is manifest nonsense (2008, p.125).

Davies (2013) writes of the tendency to turn to anaesthetics as a first response when there is often value in working through our suffering productively. Davies asks: "What if psychiatry, by progressively lowering the bar for what counts as mental disorder, has recast many natural responses to the problems of living as mental disorders requiring psychiatric treatment?" (2013, p. 40).

Davies (2013) also cites Dr Joanna Moncrieff, a psychiatrist and senior researcher specialising in anti-depressant research:

> The idea that there is a brain disease, or a chemical imbalance or a faulty neural network that anti-depressants correct is completely false

and unsupported. You cannot therefore say that these drugs are having curative or remedial effect if the evidence doesn't support that point of view (p.111).

Brogan (2016) writes: "antidepressants have repeatedly been shown in long-term scientific studies to *worsen* the course of mental illness". Brogan posits that the true cause of depression is not simply a chemical imbalance, but a lifestyle crisis that demands change which can be achieved not through medication but through talk therapy and dietary interventions (2016).

In the therapy room

The therapy room provides clients with a safe and confidential space for expression of innermost thoughts. Frequently, these thoughts include reservations with being on long term anti-depressant medication. The client often does not wish to question the opinion of their general practitioner or be seen, as one client put it, "to be telling the doctor how to do his job". If a system for coming off anti-depressants has not been put in place for the client, and significantly in my experience this seems to be the case, medicating can continue for several years. In one instance, a client reported being on anti-depressants for fifteen years.

Clients have spoken about the side effects of anti-depressants: dry mouth, dizziness, slurring of speech, insomnia, drowsiness and in the case of long term medication, no ongoing improvement in their feelings of low mood. Brogan (2016) writes that it is not easy to get off psychiatric medications once started and not easy to get information on how to wean oneself safely from them. For the client who expresses a wish to live life without anti-depressants and who is in therapy in the first place to address issues of low self esteem, the prospect of approaching a medical professional and requesting to come off medication, can be daunting. Where the client does not have the confidence or self-belief to address the situation, medicating continues. The purpose of therapy is the empowering of the client to make the changes necessary to improve his life. Therapy work will encompass the development of strategies for accomplishing goals, including the building of the self-esteem necessary to adopt a firm approach with regard to the prescription of anti-depressant medication when dealing with medical professionals.

The therapist who encounters a client who expresses a desire to come off anti-depressants may arbitrate that the inclusion of such a goal in the therapeutic work is to step outside the boundary of their training.

Conclusion

Carl Rogers (1961) has reiterated that the client is the person best equipped to know how to heal himself. The therapist who encounters a client who expresses a desire to come off anti-depressants may arbitrate that the inclusion of such a goal in the therapeutic work is to step outside the boundary of their training. However, reservations are held by medical experts on the efficacy of long term prescription of anti-depressants. By helping the client develop the tools to take the necessary steps to make changes in his life, one of which is maybe anti-depressant free, the therapist is fulfilling his role in a congruent, responsible way.

References

Brogan, K. (2016). *A Mind of Your Own* UK: Harper Collins Publishers

Browne, I. (2008). *Music and Madness.* IR: Atrium Books.

Chantal,S., Everitt, H., van Dorp,F., & Burkes,M. (2014). Oxford Handbook of General Practice. 4th Edition. UK: Oxford University Press.

Davies, J. (2013). *Cracked: Why Psychiatry is Doing More Harm Than Good.* UK: Icon Books Ltd.

Lynch, T. (2015). *Depression Delusion: The Myth of the Brain Chemical Imbalance.* IR: Mental Health Publishing.

Rogers, C.,R., (1961) *On Becoming a Person: A Therapist's View of Psychotherapy.* US: Mariner Books.

Shanahan,C. (2015). The Anti-depressant Generation. www.irishexaminer.com accessed 6/9/17

Mari Gallagher

Mari Gallagher is an integrative psychotherapist and CBT practitioner in private practice in Kildare and she is a pre-accredited member of IACP, also volunteering in Village Counselling Service in Tallaght and Newbridge Family Resource Centre. Mari specialises in adoption issues and her adoptive parenting memoir Becoming a Mother - Reflections on Adoptive Parenthood is being considered for publication in September 2018 by Orpen Press. Previous articles have been published in Irish Medical News, Irish Medical Times and The Irish Times.