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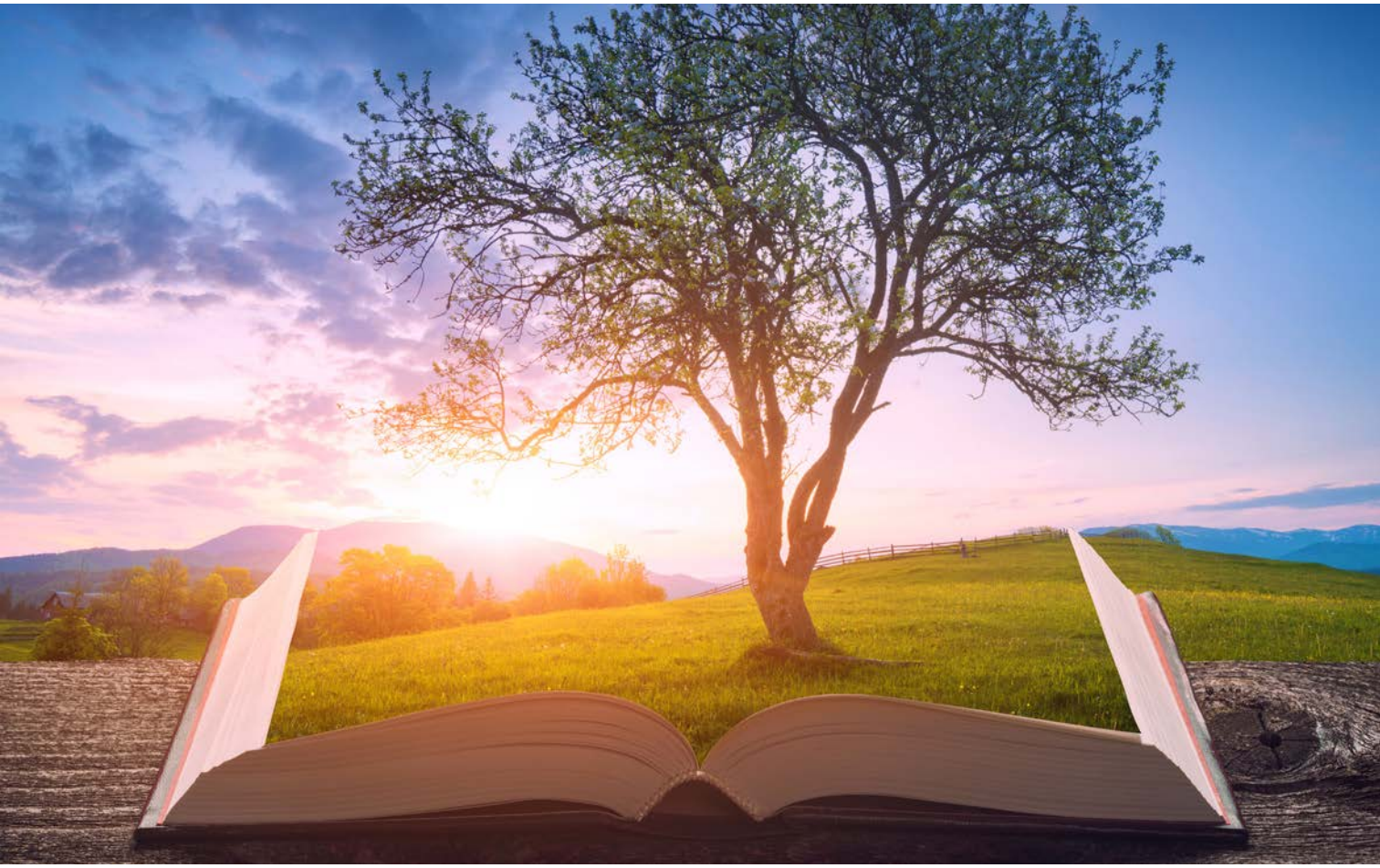

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Embracing Knowledge

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Irish Association for Counselling and Psychotherapy

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From the Editor:

Dear Colleagues,

Welcome to the 2020 Spring edition of the *Irish Journal of Counselling and Psychotherapy*. As we dive headlong into a new year, indeed a new decade, it is pertinent to look back at where we as a profession have been and forward to where we are heading. Anyone who has worked in the field of mental health for a significant length of time will remember when personal disclosures around mental health were largely confined to GP rooms - if they even happened at all. Today, with our mental health services literally bursting at the seams, we are all too aware of the need for transparency around mental health concerns.

More often than not, our clients come to us struggling, in turmoil, perhaps battling feelings of inadequacy and hopelessness. In most cases they have already tried to navigate their difficulties themselves. As mental health professionals on the frontline, it is our responsibility to not only provide the most researched and proven interventions, but also the most informed.

Society is constantly evolving. In order to effectively provide what our clients need, *we* need to be informed and embrace our changing world. For this reason, I am delighted to present the articles in this issue that look at new ways of thinking and therapeutic approaches that may be useful additions to current ways of practice.

Our first article by Suzanne Mitchell examines the need for training programmes for counsellors on the potentially harmful effects of counselling and psychotherapy. Research has shown that some 10 per cent of clients may deteriorate as a result of psychotherapy, yet this statistic is largely unrecognised. Suzanne's well-researched and insightful article calls for a heightened focus on the negative effects of therapy in student training programmes. In particular, she states that students must not only be made aware of such outcomes, but be equipped with the necessary tools to help identify and measure them.

Our second offering by Robert Barry looks at the changing face of Irish society and questions the importance of informed knowledge when working with clients from different cultures. As Ireland becomes increasingly multicultural, more so than ever questions arise around the necessity of prior cultural knowledge for person-centred counsellors working with multicultural clients. Robert's timely article examines multicultural counselling skills, including his own work with a client from India, and his personal experience as both client and therapist as a member of a minority group himself.

Our third article by Mari Gallagher looks at bibliotherapy as an intervention for bereavement, loss and grief. With bibliotherapy, or 'book therapy', the client is able to identify with characters who are similar to themselves by reading a specific text to experience the release of particular emotions, leading to a catharsis. This catharsis can manifest by offering the client an alternative approach to change in their lives and/or by vicariously allowing them to try out new ways of interacting with others. Mari's thought-provoking article looks at the benefits of bibliotherapy for adults and children, the importance of selecting suitable reading material and personal case histories detailing the effectiveness of bibliotherapy.

Our fourth article concludes our three-part simulated discussion of Reality Therapy as developed by William Glasser and interviewed by James C. Overholser. In this exchange, the cultivation of positive habits, such as involvement in positively addicting activities, is discussed as an aid to providing a sense of confidence and satisfaction.

Finally, in this edition, if you are still not convinced on the benefits of embracing knowledge, Dr Cóilín Ó Braonáin offers 10 reasons why we should care about research, with some interesting findings that may help us reflect on our own awareness.

On behalf of the editorial board of the *IJCP* I would like to take this opportunity to sincerely thank all our contributors to this issue and wish our readers a happy, healthy and prosperous 2020.

Enjoy!

Kaylene Petersen, MIACP

Academic Article

When Therapy Goes Wrong – A Case for Increasing Focus on the Negative Effects of Counselling and Psychotherapy in Training Programmes

By Suzanne Mitchell

Training programmes are often geared around bolstering the belief, albeit true in most instances, that therapy has positive outcomes for clients. However, research has shown that up to 10 per cent of clients are worse off as a result of therapy and that some therapists underestimate the frequency of negative outcomes. It is crucial that trainees are aware of the risks involved with this caring profession

Introduction

Counselling and psychotherapy have repeatedly been shown to be effective in helping people who are experiencing emotional and psychological distress (Rozantal, Kottorp, Boettcher, Andersson & Carlbring, 2016). More than ever, therapists' work practices must be based on current research and, as a result, counsellor training programmes are evolving to meet this demand (Cooper, 2008). There appears to be a belief that talking therapies carry little risk to clients (Berk & Parker, 2009), yet evidence to the contrary exists.

The body of evidence demonstrating the efficacy of counselling and psychotherapy is expanding. We know now that up to 10 per cent of people may deteriorate because of psychotherapy (Boisvert & Faust, 2003). Despite practitioners having an ethical responsibility to do no harm, research into the potentially harmful effects of this potent intervention is lacking.

The aim of this article is to make the case for a heightened focus on the negative effects of therapy in undergraduate training programmes. Students must be made aware of the risks associated with talking therapies and be offered the tools to help identify and measure negative outcomes, while at all times respecting client autonomy.

Existing research

In his 2008 research, Cooper found that eight out of 10 people benefited from therapy as opposed to not having therapy at all. There was no statistically significant difference in outcomes between the main therapeutic orientations. Justifiably,

researchers are trying to identify the elements that make therapy effective, with a view to enhancing outcomes. However, "little is known about the occurrence and characteristics of possible negative effects, reflecting a major shortcoming in clinical research" (Bystedt, Rozental, Andersson, Boettcher & Carlbring, 2014, p. 319). Bystedt et al (2014) argue that most of the emphasis on negative effects has been on fringe therapies such as rebirthing and recovered memory techniques, with less attention given to "negative effects that might be associated with evidence-based care" (p. 314). Some evidence suggests that clinicians have a propensity to underestimate negative effects (Castonguay, Boswell, Constantino, Goldfried & Hill, 2010; Leitner, Martens, Koschier, Gerlich, Liegl, Hinterwallner & Schnyder, 2012; Slade, Lambert, Harmon, Smart & Bailey, 2008). Furthermore, some practitioners are unable to predict when clients will get worse. In one study involving 48 therapists, some 20 per cent noticed that their clients were deteriorating (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa and Sutton, 2005). Lambert (2010, as cited in Leitner et al 2012) found that just half of the therapists surveyed reported deterioration in their own clients. Whilst these studies have relatively small samples sizes, a worrying trend in practitioners' inability to notice adverse effects appears to be emerging.

Obstacles

Why this reticence to exploring the shadow side of psychotherapy? Linden and Schermuly-Haupt (2014) offer several reasons. Firstly, they argue that because the therapist provides the treatment, they are responsible for all negative outcomes "which results in a perceptional bias towards positive rather than negative effects"

Therapists already work in a profession described by Freud as "impossible"

(p. 306). Secondly, the range of negative effects is very broad as there is a focus on social behaviour of clients as well as symptoms. Thirdly, there is no consensus on what to call negative. For example, crying in therapy can be unpleasant, but is often positive therapeutically. Fourthly, there is no delineation between side effects, failure of therapy and deterioration of illness. Finally, they note that as yet there has been no agreement on how to measure and assess negative effects or rules on how to plan scientific studies to monitor these.

Nutt and Sharpe (2008) also argue that many trials have not entertained the idea that therapy could cause harm. They suggest that researchers, and indeed the public, assume that because it is only talking, it is innocuous. There is stiff competition for limited funding to further the field of mental health. The Improving Access to Psychological Therapies programme in the UK will only allocate funding to "those therapies for which there is clear evidence of effectiveness" (Cooper, 2008, p. 9). The author believes this competition could incentivise researchers to produce evidence that therapy works, rather than highlighting when it does not.

Defining harm

Classifying harmful treatments has generated controversy (Dimidjian & Hollon, 2010). Methodologically, it can be difficult to differentiate between negative effects from therapy itself, normal life events and the progression of a mental illness (Bystedt et al, 2014). Traditionally, deterioration effects and negative effect sizes from meta-analyses of therapeutic outcomes have been used to assert that psychotherapy can be harmful (Lilienfeld, 2007). Deterioration can be described as "not only worsening symptoms, but lack of significant improvement when it is expected" (Lambert, Bergin & Collins, 1977, as cited in Berk & Parker, 2009). Barlow (2010) discusses the example of critical incident stress debriefing (CISD). This is offered to people immediately after experiencing a traumatic event, such as a natural disaster or car crash. People who scored high on a measure of the impact of a traumatic event actually experienced more severe symptoms after four months and a three-year follow-up than those who scored lower.

Dimidjian and Hollon (2010) argue that harmful outcomes of therapy are those that are more than simply unhelpful, but are those interventions that cause injury or damage. May and Franks (1980, as cited in Bystedt et al, 2014) coined the term 'negative outcome'. This is when a person's functioning declines after beginning therapy, and continues to decline for a significant length of time (which is not specified) after termination. Linden and Schermuly-Haupt (2014) believe that similarly to pharmacotherapy, "a distinction must be made between side effects, unwanted events, adverse treatment reactions, treatment failure, malpractice effects, side effect profile, and contraindications" (p. 306).

Why pay attention to harmful effects?

Given that therapists already work in a profession described by Freud as "impossible" (1937, as cited in Barnett, 2007, p. 258), the existence of a multitude of obstacles is insufficient reason

to neglect a critical aspect of this caring profession. It is the author's view that ignoring the evidence surrounding potential client deterioration could potentially and unnecessarily put clients at risk - a sentiment echoed by Dimidjian and Hollon (2010) who believe that "failure to detect harm can have serious consequences" (p. 21). Furthermore, "a duty to avoid harm to any client" is one of the underpinning principles of the IACP Code of Ethics ('IACP Code of Ethics', 2019).

What do we already know?

Lilienfeld (2007) believes that the emphasis on the gathering of evidence for the efficacy of empirically supported therapies is misplaced. Empirically supported therapies are those interventions that have been found in controlled trials to be effective for specific disorders, for example, major depressive disorder, obsessive-compulsive disorder and bulimia. He argues that because a practitioner's prime responsibility is to do no harm, identifying therapies that are potentially harmful should be afforded a higher priority. To that end, by examining current research findings, he created a list of potentially harmful therapies that includes items such as CISD, rebirthing therapies, grief counselling for normal bereavement and relaxation treatments for panic-prone clients (Lilienfeld, 2007). He expects the list to be updated and revised continuously. Importantly, he refers to these as 'potentially' harmful.

The evidence suggesting they have adverse effects is not definitive and they are not harmful for all individuals exposed to them. Lilienfeld (2007) believes that there is an attitude of complacency in the field towards the harmful effects of counselling and psychotherapy. He argues that exposure to research in this area should be an integral ingredient in the training of mental health professionals, stating that "students in training also need to understand that even well-intentioned interventions can sometimes produces harm" (Lilienfeld, 2007, p. 66).

> *"Having a credible framework to learn from and proficiency in specific skills can help trainees feel more confident in their abilities"*
>
> *(Hill, Roffman, Stahl, Friedman, Hummel and Wallace, 2008)*

Tools to assess negative outcomes

We cannot learn from our mistakes if we do not know we are making them. Sapyta, Riemer and Bickman (2005) posit that practitioners need to be aware of client outcomes if they are to learn from clinical experience. According to Mearns, Thorne and McLeod (2013), an increasing number of counselling services require their staff to use brief surveys to collect client feedback. A popular tool used for this is the CORE outcome measure (CORE Information Management Systems, 2019). Providing clinicians with regular feedback on client progress has been shown to improve outcomes for those predicted to leave therapy worse off (Harmon, Lambert, Smart, Hawkins, Nielsen, Slade & Lutz, 2007). Slade et al (2008) point out that if clinicians can identify clients who are at risk of deterioration earlier in the therapeutic process, then they would be in a better position to prevent this.

Despite the lack of consensus in relation to defining and measuring negative effects of therapy, there are instruments available to practitioners and researchers alike to monitor negative therapeutic outcomes. The Inventory for the Assessment of Negative Effects of Psychotherapy, devised by Ladwig, Rief and Nestoriuc in 2014, is a self-assessment tool clients complete at the conclusion of therapy to determine whether it had a positive or negative effect. With Linden's (2012) Unwanted Events to Adverse Treatment Reactions checklist, therapists can assess side effects of therapy at fixed intervals.

In 2016, Rozental et al designed the Negative Effect Questionnaire. This 32-item instrument is used throughout therapy to assist in the identification of clients who are at risk of a negative outcome so that alternative interventions can be offered.

Having a credible framework to learn from and proficiency in specific skills can help trainees feel more confident in their abilities (Hill, Roffman, Stahl, Friedman, Hummel and Wallace, 2008). It is the author's view that exposure to instruments such as those listed above, in a supportive learning environment, would not only give invaluable feedback on their progression, but also help overcome reluctance to use such tools in professional practice.

Why focus on training programmes?

It is apparent to the author that in order to address the aforementioned shortcomings, training programmes must increase their focus on identifying potential harmful and negative effects. Mearns, Thorne and McLeod (2013) expect graduates to be able to use instruments that evaluate the effectiveness of their work.

Castonguay et al (2010) assert that "one of the mandates of graduate training in clinical and counselling psychology should be to raise awareness of and to prevent, to the extent possible, predictable sources of harm in psychotherapy" (p. 35). Sapyta et al (2005) state that "therapists are trained, are supervised, and practice in the absence of information about client treatment response from objective sources" (p. 147). In most training programmes, emphasis is on teaching results of studies where the evidence supports the efficacy of therapy. Less attention is given to the fact that not all outcomes are positive (Castonguay et al, 2010).

Recommendations

In light of this knowledge gap, Castonguay et al (2010) make a number of recommendations for training programmes. Many of these already exist in most programmes as they are theorised to contribute to positive therapeutic outcomes. However, Castonguay and colleagues underscore the importance of emphasising the avoidance of doing harm when training therapists. They clustered their recommendations into a set of overarching principles, plus five general guidelines.

Overarching principles

Castonguay et al (2010) argue that students should be exposed to Lilienfeld's list of potentially harmful therapies and kept up to date with any expansions as it provides "clear warning signals of harm for certain populations or contexts" (p. 35). Furthermore, trainees should be encouraged to critically assess the evidence that supports the claim that a particular intervention is potentially detrimental. For example, just because relaxation techniques have been shown to induce panic attacks in some clients, they should not be applied to everyone. Some deleterious effects only occur in certain contexts. For that reason, training clinicians in how to monitor changes and a lack of improvement is of the utmost importance. It is also prudent to invite trainees to identify commonalities amongst potentially harmful therapies. For example, grief counselling for normal bereavement, boot camp interventions and CISD may all induce intense emotions.

> *"A vast body of research demonstrates that a healthy therapeutic alliance is a good predictor of positive therapeutic outcomes"*
>
> *(Yalom, 1980; Mearns Thorne & McLeod, 2013; Duff & Bedi, 2010)*

General guidelines

1. Enhance therapeutic relationship

A vast body of research demonstrates that a healthy therapeutic alliance is a good predictor of positive therapeutic outcomes (Yalom, 1980; Mearns Thorne & McLeod, 2013; Duff & Bedi, 2010). This is not a new concept in counsellor training. Castonguay et al (2010) propose that these findings can also inform training guidelines to avoiding harm. They advocate explicitly focusing on teaching skills that enhance the therapeutic relationship such as communicating empathy and setting collaborative goals.

2. Skilful and appropriate use of technique

Students must be made aware of the potential negative impact of techniques employed, even if they are used in an empirically supported therapy (Castonguay et al, 2010). It is not necessarily the techniques themselves that may be detrimental, but the strict adherence to their use. To illustrate, when faced with resistance from a client, cognitive behaviour therapists often increase their adherence to an intervention. This in turn may lead to more opposition to the technique from the client. Additionally, frequent interpretations by psychodynamic therapists were associated with poor therapeutic outcomes (Castonguay et al, 2010). Boisvert and Faust (2003) also caution again insisting on using a particular intervention, despite resistance from the client as this may threaten the relationship.

3. Prevent and repair toxic relational and technical processes

There is an abundance of empirical evidence on the importance of relational factors, such as the therapeutic alliance to advocate for a clear focus on interpersonal skills in therapist training. (Castonguay et al, 2010). Fostering self-awareness amongst trainees and increasing countertransference managements skills are important considerations for training programmes. So too are teaching technical processes, such as identifying when a client is not responding to an intervention, and responding in a flexible way. Ackerman and Hilsenroth (2001) also argue that positive therapeutic outcomes rely heavily on the therapist's "capacity to recognize and effectively control negative process" (p. 171).

4. Adjusting treatment to client characteristics

Castonguay and his colleagues highlight the importance of ensuring that trainees are aware that

different clients react differently to various interventions. For example, clients with depression have a tendency to externalise their issues. These clients are often more responsive to cognitive-behavioural approaches rather than insight-oriented approaches. Practitioners must adapt to client needs and Castonguay et al (2010) suggest that therapists be trained to integrate a variety of evidence based interventions in their work. Trainees must be reminded that not all interventions work with all clients and if a client does not respond to therapy, it is not necessarily an indication of their incompetence.

5. Recognising practitioner traits that may be less effective

Wampold (2006, as cited in Castonguay et al, 2010) suggests that 'therapist effect' may be more predictive of outcomes than the therapeutic relationship. In other words, some practitioners are more likely to cause harm than others. For example, therapists with anxious attachment styles may have less empathic exchanges with clients. Though existing research into harmful therapist characteristics is inconclusive, Castonguay et al (2010) offer examples such as a tendency to be authoritarian, passive, detached, an excessive need to be liked, an inability to receive criticism and perfectionism. To counteract the potentially damaging effects of therapist traits, trainees must be encouraged to become aware of their vulnerabilities, as well as their strengths.

Client responsibility

Despite numerous challenges defining and researching negative therapeutic effects, there are tools and guidelines available to begin to overcome these hurdles. We must remember, however, that therapy is not a solitary endeavour undertaken by therapists. Our clients are equally part of the process.

> *Our clients "are not inert objects upon which techniques are administered"*
>
> *(Bergin & Garfield, 1994)*

It is tempting to conclude that therapists bear all responsibility for any negative outcomes that occur. This was even suggested by Linden and Schermuly-Haupt (2014). By that rationale, are therapists also responsible for all positive outcomes? The author argues that by taking full responsibility for all results, we risk undermining client autonomy and subverting clients' capacity for personal responsibility. These are the very qualities we are supposed to help our clients cultivate (Kinsella, 2018; Mearns, Thorne & McLeod, 2013, Yalom, 2011).

Our clients "are not inert objects upon which techniques are administered" (Bergin & Garfield, 1994, as cited in Bohart & Tallman, 2010, p. 84). As practitioners, we must be responsible *to* our clients, but we cannot be responsible *for* them (Mearns, Thorne and McLeod, 2013). The significance of a client taking personal responsibility for their own therapy cannot be understated. According to Overholser (2005), "clients are more likely to benefit from treatment when they are willing to assume their share of responsibility for good and bad events" (p. 370).

Therapists, of course, have an ethical responsibility to do no harm, however we cannot accept all responsibility for how clients react to interventions, even those that are empirically supported. Yalom (2011) urges therapists to explain to clients the importance of being responsible for themselves, calling it an "essential first step in the therapeutic process" (p. 144).

Kinsella (2018) states that "autonomy sits at the epicentre of counselling and psychotherapy" (p. 5). From the author's perspective, therapists must be aware of therapies that have potential for harm. They must be willing to reflect on, and manage, personal traits that may produce unwanted effects. Practitioners must be vigilant, on the look-out for any deleterious effect. However, it is critical that we collaborate with clients when these occur and ultimately allow them to decide what is the best course of action for them.

Conclusion

With an increasing focus on evidence-based practice, the field of counselling and psychotherapy is undergoing a paradigm shift. However, as has been shown, not enough attention has been paid to negative outcomes. Lilienfeld's pioneering research illustrates that there are a significant number of interventions that have the potential for harm.

We have seen that practitioners are not always aware when their clients are deteriorating. Obstacles to defining and researching harmful effects abound, yet this does not relieve us of our duty to make advances in this overlooked area. There are tools available to help practitioners monitor and identify deleterious outcomes that can be taught in training programmes, so as to encourage their use in professional practice.

Castonguay and colleagues have offered guidelines for the incorporation of research on negative effects into counsellor and psychotherapy training programmes. Therapists cannot be responsible

for all negative effects as client responsibility plays a central role in outcomes. Like medical practitioners, counsellors and psychotherapists have an obligation to abide by the credo *primum non nocere* (first, do no harm). We can continue to fulfil this obligation by instilling the significance of paying attention to the shadow side of counselling and psychotherapy in trainees.

Suzanne Mitchell

Suzanne works as a people manager in the private sector and is a pre-accredited member of IACP. She holds a BSc (Hons) in Counselling and Psychotherapy from Middlesex University and is a volunteer counsellor and psychotherapist with The Oasis centre in Dublin 1.

In 2018, Suzanne was awarded the Martin Kitterick award. This is presented annually by PCI College to a final year student who produces a relevant and engaging thesis of outstanding academic quality in memory of Martin Kitterick, a former director who passed away in 2012. This article is an abridged version of her winning submission. Suzanne can be contacted at: mitchellsuzanne1@gmail.com

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Student Voice

Investigating the Necessity of Prior Cultural Knowledge for Person-Centered Counsellors working with Multicultural Clients

By Robert Barry

With the changing face of Irish society and the recent debate around a new language of racism in Ireland, counsellors need to be mindful of how they approach their work with multicultural clients

Introduction

I was asked in class recently how might I work with culturally-diverse clients? In my head, I immediately questioned the relevance of knowing the client's background before meeting them. This comes at a time when in my own practice I have been working at trying to fully enter the world of my clients and to experience their personal meanings and experiences as they do (Rogers, 1961). I believed that prior knowledge of their culture was not necessary and that being person-centred would be enough; striving to create a facilitative relationship that fostered Rogers' (1961) core conditions of empathy, unconditional positive regard and congruence.

Culture can be defined as the "ideas, customs, social behaviour, products, or way of life of a particular nation, society, people or period" (*Oxford English Dictionary*, 2018, Culture). Sue, Arredondo and McDavis (1992) describe culture as relating also to racial and ethnic minorities, women, gays and lesbians and other special populations. Quinn (2012) says that in the United States, you would be in the dominant culture if you are of white, European American descent, middle-class, male, heterosexual, Christian, young, able-bodied and English speaking. From the above descriptions of culture, it is therefore inevitable that in our work as therapists we will encounter clients from culturally diverse backgrounds.

This article will examine multicultural (MC) counselling skills, including my work with a female client from India. As a gay male and part of a cultural minority, I will also look at my own experiences of being a therapist as well as a client. Furthermore, I aim to explore some of the approaches to MC counselling, concluding with the possibility of a best practice approach.

Although I have the consent of my client, all names and identifying features have been changed for ethical reasons and to protect privacy.

Language barriers

The first of Rogers' Necessary and Sufficient Conditions states that two people should be in psychological contact (Rogers, 1957). I believe that verbal communication is the keystone to such psychological contact, although Rogers' (1951) work with clients limited in verbal communication may demonstrate otherwise. Cornelius-White (2014) questioned the need for a translation when listening to a woman with whom he had no common language. He knew what she had said and grasped the content and the details. He prefaces the story by explaining how the woman began to share her experience of being imprisoned in her country for political reasons. I question the limits of how real emotion can transcend language in this way and how I could ever maintain a therapeutic relationship long-term with a client whose verbal language was foreign to me.

Clarke (2004, cited in Moodley, R., Lago, C. and Talahite, 2004) outlines her difficulty in working with a Muslim woman of Pakistani heritage. Words and phrases are often spoken in a way that have hidden meaning, which might be alien to someone who is from a different culture. Clarke (2004) wondered if she was hearing the right music behind the words to realise true empathy. In trying to understand the client's frame of reference (Rogers, 1957) it meant asking more questions and that felt intrusive and interrogatory. This can also take up valuable time for the client, which will affect the overall client flow of the sessions (Freire, Elliott and Westwell, 2014).

My personal therapist is from China and I have often felt the limitations of language in our sessions. We are from two very different cultures and her first language is not English. At times I can feel her frustration when struggling to find the words with which to respond; often resorting to a different phrase in the hope that it will suffice. I have also noted how in some of her responses she has misinterpreted what I have said. The quality of therapists' communication is of crucial significance. The only way that the accuracy of an empathic understanding of the client can be verified is by its coherent communication to the client (Temaner-Brodley, 1993 cited in Merry, 2000). If the communication between myself and my client is restricted by language, I feel empathic understanding and potentially all of Rogers' core conditions (Rogers, 1961) will be restricted also.

We are mindful of our differences and I don't presume that my therapist could understand certain colloquial expressions and figures of speech

As a therapist working with a client, Sarah, from India, I struggled initially with understanding her accent and the speed at which she spoke. Her first language is not English, but I got used to her accent and listened more intently when she spoke. At times I wondered if I understood her correctly; I learned that instead of asking questions, often the answers would naturally flow through the course of our conversation. In our early sessions, she described how, in her culture, she saw men as being very dominant and this was a struggle for her now that she was living in the UK. My knowledge of India has been acquired almost entirely from television programmes and newspapers. I had heard some horrific stories of rape and so Sarah's description of the dominance of men seemed to fit with my vision of India.

It was only in later sessions that I learned how Sarah's experience was individual to her. She had developed conditions of worth (Rogers, 1961) because of the effect that a male teacher had on her during her schooling. I had made an assumption and related this to the culture as a whole. In a later session, when I summarised her experiences of men, Sarah made clear that these were *her* experiences and almost jokingly explained that this was not her view of *all* men. Sarah reminded me of the importance of being guided by her - of understanding the world through her eyes. Drawing conclusions or carrying out an assessment of Sarah's earlier sessions would not have given an accurate picture of her personal experiences. In this situation, the person-centred approach gave Sarah the time and space to explore the meaning her feelings had for her. An alternative approach could easily have missed this and made generalised assumptions early in therapy.

I feel Sarah and I are similar in that we sometimes adjust our verbal language to help the therapist. We are mindful of our differences and I don't presume that my therapist could understand certain colloquial expressions and figures of speech. However, I am not confident that this would be the case when working with the general public.

Clients are facing their own challenges in therapy - this includes trying to help the therapist and explain such things as their faith concepts or beliefs to yet another uninformed helper (Mearns, Thorne and McLeod, 2013). Cooper, O'Hara, Schmid, and Wyatt (2007) describe what happens in the client as a real reciprocal of what is occurring in the therapist - as the therapist is listening to the client, the client finds it easier to listen to themselves. If a client is focused more on the need to explain or partially translate for the therapist, is the session then in

danger of becoming therapist-centred to the detriment of the client's better understanding of themselves? (Somerbeck, 2015) Besides fluency in the person-centred approach, the more a therapist can learn about, and be comfortable with, different culturally determined linguistic and behavioural patterns, the more one is likely to be successful in multicultural communication (Cornelius-White, Motschnig-Pitrik, and Lux, 2013).

Lago (2011) outlines the considerable disadvantage of not having knowledge and awareness of the different terms associated with cultures and how these terms change over time. An example of this would be the use of the word 'Queer'. Originally a derogatory term towards members of the LGBTQ+ community, in recent years it has been reclaimed and is now seen as a term of defiant pride. This process has occurred mainly due to younger members of the community and so older generations may still not be comfortable with the use of the word (UC Berkeley, 2018).

As a therapist, I need to remain guided by my client at all times. This involves being acutely aware of the language that they use and how I might react/respond to a client when they use words or phrases that I might deem to violate social norms (Moodley, Shipton and Falken, 2000 cited in Moodley, Lago and Talahite, 2004).

In the video *Carl Rogers counsels an individual on anger* (2017 [1974]), Rogers takes what I feel is a real risk when he restates a contemptuous term for a black or dark-skinned person. The word may shock and offend some therapists and I believe such a reaction could be detrimental to the therapeutic relationship. Although it is the client that first uses the word, I feel Rogers is very brave in restating it in an attempt to acknowledge the meaning the word has for the client. He is being guided by the client, not shying away from the issue of race, even though it goes against the social norms he may be used to.

> *If the client is not yet ready to discuss issues that are at the edge of their awareness, forcing them to do so could be detrimental to them and the therapeutic relationship*
>
> *(Mearns et al., 2013)*

Thus, the question is, is it possible to ever penetrate such a vast field of MC knowledge? In working with Sarah, she often referred to her Jainism religion. I had no knowledge whatsoever of this term. I tried to learn more about Jainism from my Indian housemate. He, to my surprise, had not heard of the term either. This led me to question how we could ever successfully culturally match therapists with clients. Clarke (2004, cited in Moodley et al., 2004) discusses similar struggles in understanding a client going through a divorce. Her client was married under Islamic law but not English civil law. Although she struggled to see things through her client's frame of reference (Rogers, 1957), she explains how she felt more in touch with her client when she was trying to understand her client's feelings, rather than the complications surrounding her divorce.

Cultural segregation

Sue (1998) cites that one of the major problems in delivering therapy is the kind of cultural and linguistic mismatches discussed in the previous paragraphs. However, in striving to culturally match clients with therapists I feel there is a real danger of cultural segregation, e.g. where the staff in a service are from the cultural minority group, speak the relevant language, and offer the service within the cultural minorities' community. When I moved to the UK, I looked into volunteering with a local LGBT+ network. On their website, it states that "To become a volunteer, you yourself must be lesbian, gay, bisexual or trans". For me, this statement makes a sweeping generalisation of each individual's life experiences. I believe it also creates a divide from the rest of society. This statement questions if I could be understood or supported by a person outside of the above list of people. Would I need to be vegan to work with a client who is vegan? I would not want to attend a therapist who knew a lot about the LGBTQ+ community but not a lot about me (Mearns, 2002).

The work should be centred on the experience of the client and not in terms of the general client issue. "Far too common, new and experienced therapists trust too much in their theory, experience, or intuition more than the client's perceptions - to their clients' and their own detriment" (Cornelius-White, 2014).

There is a general consensus that culturally-competent counsellors should (a) be aware of their own bias, assumptions and values, and (b) understand the world view of the client and be constantly trying to broaden their knowledge by learning new ways in which people interact with one another. Quantitative and qualitative research in support of this can be found in Rogers, 1951; Sue, 1978, 1998; Sue, et al., 1992; Holcomb-McCoy, 2000; Mearns, 2002; Williams, 2003; Lago, 2011; Mearns et al., 2013; Cornelius White, 2014; Ratts, Singh, Nassar-McMillan, Butler and McCullough, 2016; IACP, 2018.

Divisions occur, however, when some of the above approaches go further and include a third competency, which includes the use of techniques or intervention strategies in working with MC clients

(Sue, 1978, 1998; Sue et al., 1992; Holcomb-McCoy, 2000; Williams, 2003; Ratts et al., 2016). Therapists will carry out assessments of clients and these assessments will determine the culturally appropriate techniques that are best suited to the client. MC counsellors will be experts in working with these client groups and provide suitable intervention strategies.

Sue (1998) and Sue et al. (1992) believe that person-centred therapy is at a disadvantage because it is not recognising the cause of people's problems and does not have appropriate intervention strategies to deal with such problems. This is reminiscent of the medical profession of categorisation and treating 'conditions' rather than people (Mearns, 2002). Therapists are seen as cultural experts in working with the client group, something that Sue (1998) recommends.

Cultural differences

One way to counteract the issue of cultural avoidance in the person-centred approach might be to replicate the training of many students of clinical psychology in the UK and America. Mier and Witty (2004, cited in Moodley, R., Lago, C. and Talahite, 2004) explain how these students are often taught how to respond directly to cultural differences within their practice. For example, the therapist might point out the racial differences between them and their clients. This will directly address the cultural differences within the room, as a way of showing acceptance towards the client. They go on to point out, however, that such a statement in therapy is often not true and just a 'tick box' exercise. The therapist may not be congruent and might just be stating something because they have been told to do so. In doing this, the therapist may be exerting their power from the start.

What if a client has encountered much aggression and racism in their daily life? They have come to therapy in such pain that they are unable to immediately talk about their experiences for fear of their safety and of being judged (Owen, Tao, Drinane, Hook, Davis and Kune, 2016). They have buried their feelings under layers of defences and have become an expert at putting up an elaborate façade (Rogers, 1961). The person-centred approach would create the right climate to allow the client, in their own time, to delve into their deep-rooted feelings and fears. If the client is not yet ready to discuss issues that are at the edge of their awareness, forcing them to do so could be detrimental to them and the therapeutic relationship (Mearns et al., 2013).

The worldview of the client dominates much focus in all MC counselling approaches. I feel if a gay client can only be seen by a gay therapist, the therapist is in danger of assuming the worldview of the client instead of seeking to understand and honour the client's worldview (Kirschenbaum, 2007). I can try to make well-informed guesses as to what the client is experiencing, but I am well aware that common experiences can often prove a major hindrance in the relationship by making empathy more difficult, as well as preventing me from seeing things through the client's frame of reference (Mearns et al., 2013; Rogers, 1957). I am reminded that I can learn something new from each client that walks through the door and they may cause me to question all of my previous hypotheses (Rogers and Shaffer, 1949).

Conclusion

Raskin (2007 cited in Moodley and Mier, 2007, p.149) describes the person-centred approach as being culture-free; the therapist is focused on culture only to the extent to which the client raises these issues. To this point, prior cultural knowledge may not be necessary. However, to be able to understand what the client then brings up, I feel it is necessary to achieve as much MC knowledge as possible. Without this knowledge, the likelihood of failure in the therapeutic relationship is much higher. In this article, I have shown how failures can occur due to restrictions in relation to communication, making assumptions and jumping to conclusions, lack of understanding of the culture and associated terminology and treating conditions rather than clients.

I believe that MC knowledge will help me understand people and how they communicate with one another - not as a way of predicting the behaviour of an individual client, but to help me widen my experience so that I can better understand behaviour once it is presented (Mearns, 2002). If as a therapist I worked in a prison where a client was a doctor who carried out female genital mutilation, I may find such a practice abhorrent. However, if I have some understanding as to why people carry out these practices, then my ability to offer empathy and unconditional positive regard will be much greater than if I had a complete lack of knowledge in the area (Rogers, 1957).

When I started with my therapist, I got to a place where I told my story of growing up gay and getting to where I am in life today. I found this a highly cathartic experience and one of my most memorable therapy sessions. I would never try to presume that my experience would be the same as one of my clients and I would be very hurt if my therapist assumed the same about me. Each client will react to their reality as they experience it and we can all perceive things differently (Rogers, 1951). It is important that we honour the client's personal description and perception of their own world and their lived experiences (Bozarth, 1998).

To say that prior-cultural knowledge is necessary seems too absolute - a static, unobtainable goal. I believe that if I want to be a competent MC counsellor, I should strive to constantly revise my knowledge through up-to-date research and experience.

To do this, Rogers (1951) recommends that students have a broad experiential knowledge of human beings within their cultural setting. This can be achieved through literature as well as through lived experiences with people from other cultures and ideally in clinical work.

I am very aware of gaining experience in the way that Rogers recommends and of avoiding the likelihood of pigeon-holing myself by working with a narrow client field. "Although I am and will always be highly interested in working with clients who are LGBTQ+, I also wish to broaden my knowledge and work with clients from any and all cultural backgrounds.

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Practitioner Perspective

Bibliotherapy as a Counselling Intervention for Bereavement, Loss and Grief

By Mari Gallagher

For those who demonstrate an interest in reading, bibliotherapy is a proven means of helping clients understand the issues they are experiencing, normalizes those experiences, and offers hope for positive change. As a therapeutic modality, bibliotherapy is accessible and provides one potential format for therapeutic work outside of sessions

Introduction

Bibliotherapy involves the use of literature to help people cope with emotional problems, mental illnesses, or change in their lives (Pardeck, 1994 cited in Neville, 2010) so as to produce affective change and promote personality growth and development (Lenowsky, 1987, Adderholt-Elliot & Eder, 1989 cited in Neville, 2010). This article will explore the history of bibliotherapy, intervention for bereavement, loss and grief (BLG), with a particular reference to counselling children, suggestions for selection of appropriate titles, as well as personal and professional examples of the effectiveness of bibliotherapy.

The terms grief and loss are often interchangeable with bereavement: the suffering of loss due to the death of a loved one. However, for the purposes of exploring the effectiveness of bibliotherapy as a counselling aid, grief and loss can be interpreted as an umbrella term encompassing other matters that may present in the counselling room, such as loss of a close relationship or marital breakdown. A personal experience of bibliotherapy as an intervention in the case of loss of biological connection in adoption will also be outlined.

Loss happens in many forms. The American novelist, Mark Twain, summed up the comprehensive breadth of grief and loss by suggesting that nothing that grieves us can be called little - by the eternal laws of proportion, a child's loss of a doll and king's loss of a crown are events of the same size (1990).

Bibliotherapy offers the client who has an interest in reading a problem-solving approach to recovery and emphasises the potential of self-management (Irish College of General Practitioners, [ICGP] 2013). The book that stands in for a counsellor may provide the client with a more enduring, even lifelong therapeutic relationship, unlike the therapist as a live individual (Frank & Frank, 1991

cited in Lampropoulos & Spengler, 2005).

Bibliotherapy works on the principle that the reader identifies with the characters who are similar to them and reads a specific text to experience the release of particular emotions, leading to a catharsis (Neville, 2010). This catharsis can manifest itself in two ways: firstly by offering them an alternative way of how they might make a change in their lives and; secondly, by vicariously allowing them to try out new ways of interacting with others (Gladding & Gladding, 1991, cited in Neville, 2010).

History of bibliotherapy

The term bibliotherapy originates from Greek language – *biblion* meaning 'book' and *therapeio* meaning 'therapy' (Moses & Zaccaria, 1978, cited in O'Rourke, 2012). Recognition of the therapeutic power of reading was evident 4,000 years ago, as demonstrated by the inscription over the library door at Thebes, Eygpt: 'The medicine chest of the soul' (Davis, 2009).

Bibliotherapy has been extensively used in psychiatric hospitals in the 1930s and 1940s (Gumaer, 1984 cited in O'Rourke, 2012) and also in more recent years by school counsellors, psychologists, psychiatrists and medical doctors (Pardeck & Pardeck 1993, cited in O'Rourke, 2012). American author and professor of psychiatry, Irvin D. Yalom, is a dedicated advocate of bibliotherapy as a counselling intervention. As a child he avidly read fiction, finding refuge in an alternate, more satisfying world, a source of inspiration and wisdom (Yalom, 2002).

A counselling intervention for Bereavement, Loss and Grief

BLG is a complex and dynamic process influencing individuals of all ages (Briggs and Pehrsson, 2008). BLG is described by Tatelbaum: "The death of a loved one is the most profound of all sorrows. The grief that comes with such a loss is intense and multifaceted, affecting our emotions, our bodies, and our lives" (1980, p.7).

Provocative literary material can help or hinder that process. Excitement about literary tools can cause any counsellor to overlook the potential harm to clients. Hence, for most counsellors who address BLG by utilizing literary resources in their work, the potential for misuse or unintended consequences is great

(Bowman, 2004)

Elizabeth Kübler-Ross (1969) identifies the five stages passed through by the dying as they approach the end of their lives – denial and isolation, anger, bargaining, depression, and acceptance. These stages have been universally accepted as also describing accurately the process experienced by those affected by BLG (Pass, 2006).

Denial and isolation are natural reactions to initially manage shock, as it is easier to try and tell oneself the loved one has not died, quickly followed by a deep sense of loneliness and isolation at the loss. Anger may be directed towards medical staff, family or one's spirituality – 'how could this happen to me?' Bargaining with one's inner spirit, trying to rationalise the loss and negotiate a cure, could be followed by depression when reality hits that the loved one is definitely gone. Finally, acceptance, when the client faces the truth - a life without the loved one (Kübler-Ross, 1969).

Not everyone will progress through all five stages or experience them in the same order; the bereaved will oscillate and vacillate between stages, often arriving back at the anger stage and some even staying stuck at the denial stage (Kübler-Ross, 1969). In the context of bibliotherapy as an intervention for BLG, the counsellor must always be aware of timing – a client's readiness for a piece of reading may not be as the counsellor assumes (Bowman, 2004).

Selection of appropriate reading material

Clients who are suffering from the trauma of BLG can struggle to talk about what they have seen, heard or felt. Finding words for those sensory experiences can also affect their ability to reflect on what happened to them (Bowman, 2004). Provocative literary material can help or hinder that process. Excitement about literary tools can cause any counsellor to overlook the potential harm to clients. Hence, for most counsellors who address BLG by utilizing literary resources in their work, the potential for misuse or unintended consequences is great (Bowman, 2004).

For example, I attempted to read C.S. Lewis' *A Grief Observed* (1961) during the early months of bereavement. The accuracy of Lewis' description of grief fitted so well with my own experience that instead of offering hope and comfort, I found myself dissolving further into a maelstrom of melancholy. I share this insight

as a way of illustrating the importance of matching reading material with the stage of grief - books with a task-oriented focus rather than a memoir/chronicle of grief are likely to provide more therapeutic assistance, while BLG is still new and raw.

In the case of the early stages of grief, Judy Tatelbaum's *The Courage to Grieve* (1980), would be my recommendation as a text offering practical insights and a task-oriented approach to BLG. Tatelbaum's words helped me face the inevitable – a life without a beloved, younger sister and soulmate. I learned that it was possible to recover and move on: "Although it may be hard to believe, we can recover from our sorrow. Recovery from grief is the restoration of our capacity for living a full life and enjoying life without feelings of guilt, shame, sorrow, or regret" (p.94). Tatelbaum also offered practical suggestions such as facing death "squarely" by making a will, getting our own belongings organised as a way of assisting loved ones in the event of our own death and buying life assurance.

Also, during the early days of grief, Mary E. Frye's (1932) poem, *Do Not Stand at My Grave and Weep,* offered an inspirational and comforting view on death, as well as a sense of relief in the continued spiritual presence of the loved one.

Awareness of this aspect of bibliotherapy as a therapeutic intervention is particularly important for newly-qualified psychotherapists. The basis of successful intervention is the establishing of a warm and trusting relationship with the facilitating conditions of unconditional acceptance, genuineness, empathy and trust (Rogers, 1961). Knowing and understanding the client and where they are 'at' in the grieving process is, in my view, crucial for the making of a suitable recommendation for reading material.

Not every client is receptive to bibliotherapy as an intervention and making the decision to suggest reading material as part of counselling will be based on the therapist's understanding of how the client is disposed towards reading as a pursuit

Effectiveness of bibliotherapy

Little research exists about the use of literature with grieving adults, so the extent to which this method is used (or its success) is difficult to know (Briggs, C & Pehrsson, D. 2008). The effectiveness of bibliotherapy depends on the motivation and application (as well as the literacy) of the person using a self-help text (Frude, 2005). Those who actively read the self-help material and engage with it enthusiastically and conscientiously are more likely to benefit than those who are reluctant in their attempts (Frude, 2005).

In selecting a book for the client to read, the counsellor must be familiar with each work, that is, the counsellor must have read the book before making a prescription (Briggs, C & Pehrsson, 2008). The aforementioned is essential, in my view, as it ensures that the counsellor will be able to knowledgeably discuss the book's contents with the client. One possible counselling intervention is that the client retells the story or discusses characters or case studies from the selected reading material, allowing the client a safe way to talk about their own painful experiences of loss (Briggs & Pehrsson, 2008).

Irish author, Éilís Ní Dhuibhne writes of the combined support of counselling and bibliotherapy in the wake of the loss in 2013 of her beloved husband, Bo Almqvist. In her memoir, *Twelve Thousand Days: A memoir of love and loss*, she cites a number of titles that she found helpful. In particular, Colin Murray Parkes's study of grief in widows proved comforting (1972). Ní Dhuibhne writes: "*Bereavement: Studies of Grief in Adult Life* (1972) is a scientific study of the process of grief, but it's written in accessible prose (p.196, 2018)."

As the therapeutic relationship deepens, the client can begin talking about personal loss in comparison to the losses described in the literature (Jackson, 2001, cited in Briggs & Pehrsson, 2008). Book-based therapy will not be suitable for everyone, but it is certainly appropriate for a proportion of those who consult their GP or other healthcare professionals with an emotional problem (ICGP, 2013). Not every client is receptive to bibliotherapy as an intervention and making the decision to suggest reading material as part of counselling will be based on the therapist's understanding of how the client is disposed towards reading as a pursuit.

Public library services as a resource for the therapist and client

'Shelf Help' is now available in libraries nationwide, and is a collection of titles covering the topics of low mood and depression, worry, stress and anxiety, general mental health and

wellbeing, addiction, parenting, relationships and social issues (Kildare County Library and Art Services, 2019). As a matter of note, I have borrowed books from my local library and passed them to clients who have consistently returned them after reading. (It is important to note that if lending a library book to a client who decides to finish therapy before returning a book, it is possible for the client to drop the book to his/her nearest library rather than be obliged to return the book directly to the therapist).

Forgan (2002, p.75, cited in Strub, 2007), writes: "Have you ever read a book for self-help or to find answers to your difficulties, such as how others dealt with a loss, learned to become self-assured, or overcame a hardship? If you responded 'yes', then you have used bibliotherapy."

Many books with a great variety of themes, which are more or less psychological in content, are available on the market.

Benefits of bibliotherapy for children

Orton (1997, cited in O'Rourke, 2012) outlines five values which underpin the benefits of bibliotherapy for children:

- Free expression of issues that are sometimes hidden, especially if the book is a good match to the child's problem.
- Helps the child analyse why they are feeling the way they are feeling, particularly in the safety of their own thoughts.
- Provides information to solve problems and foster positive thinking; Books such as the Harry Potter series, which show the hero overcoming a number of life-changing obstacles, provide the reader with valuable insights that serve to foster self-reliance and resilience.
- Promotes relaxation while reducing anxiety and fostering emotional release as well as an escape from loneliness.
- A fun way to experiment with new coping skills and try out new ways of doing things by taking the example of heroes in the literature.

Adoption grief is a grief often compounded and deepened by the fact that it is frequently not acknowledged by society in general and, by extension, adoptive parents

(Keefer and Schooler, 2000)

Bibliotherapy and adoption loss

The only 'bad' grief is that which is unexpressed (Oates, Martha, 1988, cited in Michael O'Rourke, 2012). Adoption grief is a grief often compounded and deepened by the fact that it is frequently not acknowledged by society in general and, by extension, adoptive parents. (Keefer and Schooler, 2000). If the child's adoption loss is not acknowledged by those closest to him, grief may be acted out in other ways, such as explosive anger, nightmares and social withdrawal (Eldridge, 1999).

As an adoptive parent, I acknowledge the benefits of bibliotherapy for the adopted child and can confirm that reading certain literature assisted in illustrating to the child that grief and loss is universal and can be overcome. The reading of the Harry Potter series (1997-2007) provided not just the usual enjoyment experienced from an imaginative and wonderfully constructed tale, but also an excellent opportunity to discuss loss.

For example, in *Harry Potter and the Philosopher's Stone* (1997), Harry finds the mirror of Erised ('desire' spelled backwards), in which he can see the faces of his deceased parents, who are waving and smiling at him. Harry is repeatedly drawn back to the mirror until the headmaster, Dumbledore, takes the mirror away and tells him "it does not do to dwell on dreams and forget to live" (p.157).

While reading this passage, it was clear from the reaction of my children that they had absorbed a very important message about moving on from loss and a discussion on same ensued. Markell (2008) cites the Harry Potter series as a particularly helpful addition to a therapeutic reading list for children dealing with BLG.

Adoptive mother, Jamie Lee Curtis' (1996) book, *Tell Me Again About the Night I Was Born,* was also instrumental in helping with the essential job of clarifying the events around adoption.

Case histories of bibliotherapy as a counselling intervention

A client who presented with suicidal ideation spoke of his perception of a lack of meaning in his life following a relationship break-up and restricted access to his children. The client's reading of Viktor E. Frankl's (1946) *Man's Search For Meaning*, instigated a dialogue in the counselling room about the key thrust of Frankl's classic book: no matter how bad things are, there is always a reason to live (Frankl, 1946). The client declared a renewed determination to forge ongoing connection with his children.

Another client reflected on the links between childhood trauma/parental abuse and his ongoing battle with low self-esteem and depression. Reading Haemin Sumin's *Love for Imperfect Things* instigated a dialogue on self-acceptance and the client spoke of keeping quotes from the book for ongoing reference.

A client who presented with depression and anxiety in the wake of a difficult marital break-up spoke of her struggles to deal with her life as a single mother, described finding solace in books I lent in the counselling room: Don Miguel Ruiz's *The Four Agreements,* from which the quote: "Don't take anything personally. Nothing other people do is about you. It is because of themselves" (Ruiz, 1997, p. 48) was selected by the client to keep close to hand for ongoing reference and inspiration. A second book by Dr David D Burns, *The Feeling Good Handbook* (1990), was described by the client as helpful and informative, assisting her in the development of necessary skills for the forging of new relationships.

Conclusion

This article has defined bibliotherapy, shared personal and professional insights on its effectiveness, examined the importance of the selection of suitable reading material, outlined the application of bibliotherapy in the BLG counselling process and looked at counselling children, with a focus on adoption loss.

While bibliotherapy is a worthy counselling intervention and is particularly suitable for clients who are readers by nature, it must be noted that there is no substitute for the establishment and nurturing of a warm, congruent, empathic relationship, irrespective of the suitability of reading materials provided.

To conclude, an observation from *Shadowlands* (1993), the movie adaptation of C.S. Lewis' *A Grief Observed* might be appropriate, an observation that underpins the answer to the 'Why' of bibliotherapy: "We read to know we are not alone."

Mari Gallagher

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Academic Article

A simulated interview with William Glasser: Part 3 – Useful Goals for Psychotherapy

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

Introduction

Reality Therapy provides useful guidance for helping clients to shift their thoughts and actions. The therapist avoids discussing past events from the client's personal history or developmental problems because these historical events cannot be changed. Instead, the focus remains on helping clients to develop concrete plans for improving their future. Therapy helps clients to develop a clear vision for their quality world - a life where their basic desires are being satisfied (Wubbolding, 2015).

At times, therapy aims to cultivate positive habits that can be incorporated into daily routines. Clients can begin to spend their time involved with a positively addicting activity that provides a sense of confidence and satisfaction. The principles underlying Reality Therapy can be used to guide psychotherapy sessions and can be adapted into school-based prevention programmes. The present article concludes the simulated discussion of Reality Therapy as developed by William Glasser (WG) and interviewed by James C. Overholser (JCO).

JCO: Thank you for meeting with me again. I have just a few more questions.

WG: "Sit down and make yourself comfortable" (Glasser, 1976d, p. 654). "What was on your mind when you came in here?" (Glasser, 1976d, p. 655).

JCO: As a therapist, how do we know what are the best goals for therapy?

WG: "Our job is to help the patient help himself fulfil his needs right now" (Glasser, 1965, p. 56). "Always, the emphasis is on the present - 'what are you doing now and what do you plan to do in the future?'" (Glasser, 1980a, p. 49).

JCO: I am still confused about establishing treatment goals and priorities.

WG: "I'd be happy to explain it to you" (Glasser in Onedera & Greenwalt, 2007). "Until we have a good idea of what it is we want, we are not able to understand how badly the behaviours we are choosing are working for us" (Glasser, 1989, p. 6). "The quality world… is made up of pictures of the people we most enjoy, the images of the things we get great pleasure from, and the systems of beliefs that govern our lives" (Glasser & Glasser, 2007, p. 44). "Your picture album… is the world you would like to live in, where somehow or other all of your desires, even conflicting ones, are satisfied… It is the picture in *your* head, nobody else's, that causes you to do what you do" (Glasser, 1984, p. 30). "My quality world is the core of *my* life; it is not the core of anyone else's life" (Glasser, 1998, p. 53).

JCO: How do these pictures guide behaviour?

WG: "Our behaviour, then, is actually generated by the difference between what we want, the pictures in our heads, and what we have… When there is a difference, we must behave to try to reduce this difference (Glasser, 1989, p. 7).

JCO: In your style of therapy, do you focus more on emotions, attitudes, or behaviours?

WG: "Our behavior is always made up of four individual components: acting, thinking, feeling, and the concurrent physiology, all of which always blend together to make a whole or total behaviour" (Glasser, 1989, p. 8).

JCO: How does a client's choice enter in?

WG: "We choose all our actions and thoughts and, indirectly, almost all our feelings and much of our physiology" (Glasser, 1998, p. 4). "If you picture your total behaviour as a four-wheel drive car, each component would be one wheel of the car" (Glasser, 1989, p. 9). "The motor is the basic needs. The steering wheel controls the front wheels, which are acting and thinking. The rear wheels, which also move the car, are feeling and physiology, but they have to follow the front wheels" (Glasser & Glasser, 2007, p. 57). "Of these four components, two are under my direct control (my thinking and my acting), two are not under my direct control (my feelings and my physiology). I can indirectly control how I feel and, to a lesser extent, my physiology by how I choose to think and act" (Glasser, 2002, p. 120).

> *"Regardless of how we feel, we always have some control over what we do"*
>
> *(Glasser, 1984, p. 45)*

JCO: So clients 'steer the car' to direct their own lives?

WG: "You choose essentially everything you do" (Glasser, 2000, p. 178). "As in a car, you have total and voluntary control over where you steer the front wheels of your car" (Glasser, 1989, p. 10). "We have almost total control over the doing component, some over the thinking component, and even less over the physiological component of our total behaviour" (Glassser, 1984, p. 51). "If you want to feel better and have a healthier physiology, you can steer the front wheels, thinking and feeling… Since the rear wheels have to follow the front wheels, you will feel better and your physiology will be healthier" (Glasser & Glasser, 2007, p. 58). "Our behaviours are a combination of what we do, what we think, and what we feel, but to the people who are upset, it may seem that how they feel is most important" (Glasser, 1980a, p. 49-50).

JCO: So you help clients learn to control their feelings?

WG: "I don't claim that people can control their feelings. I claim they can control their total behaviour of which acting and thinking are most important. Feelings and physiology are not the parts they can control" (Glasser, 2016, p. 37). "Every thought that comes into your head and every physical action … is a choice (Glasser & Glasser, 2007, p. 24). "No matter what the client is complaining of, if he wants to make the effort, he can choose to steer his life in a better direction than he is steering it now" (Glasser, 1989, p. 10).

JCO: I often tell people - if you change your attitude, you can change your life. Do you agree with that view?

WG: "It might. But mostly it won't" (Glasser, 2000, p. 191). "It is almost impossible for a person to change his feelings without first changing his behaviour" (Glasser, 1975, p. 80-81). "Changing behaviour leads quickly to a change in attitude" (Glasser, 1965, p. 34). "Individuals can more easily control their behaviour than their thinking and feeling" (Glasser & Zunin, 1979, p. 318).

JCO: Why does your approach emphasize behaviour change?

WG: "Regardless of how we feel, we always have some control over what we do" (Glasser, 1984, p. 45). "To change a total behaviour, the way we can do it is to choose to change its doing and thinking components… Unless I choose to change what I do, think, or both… I will not change what I feel, because the total behaviour of depressing makes good sense to me right now" (Glasser, 1984, p. 49). "As important as the feeling component is, we are fortunate that it is only one of the four components that make up the total behaviour, depressing" (Glasser, 1984, pp. 49-50).

JCO: So patients can treat their depression by changing what they do during their typical day?

WG: "Yes, I think that they would" (Glasser in Gough, 1987, p. 661). "We have a lot of control over our suffering" (Glasser, 1998, p. 4).

"The doing component of our behaviour has come almost completely under our voluntary control" (Glasser, 1984, p. 51). "We have nowhere near the quick or arbitrary control over our feelings and/or our physiology as we have over our actions and thoughts" (Glasser, 1989, p. 10).

JCO: Why is behaviour change more important than cognitive change?

WG: "To a great extent, we are what we do, and if we want to change what we are, we must begin by changing what we do" (Glasser & Zunin, 1979, p. 315). "Because we always have control over the doing component of our behaviour, if we markedly change that component, we cannot avoid changing the thinking, feeling, and physiological components as well" (Glasser, 1984, p. 51).

JCO: How can we help clients to take control of their lives?

WG: "To gain control over our lives, we need to get along well with those close to us" (Glasser, 2013, p. 131). "If you use external control psychology, which is 'I know what is right for you and I'm going to change you', it will harm your relationships" (Glasser, in Nelson, 2002, p. 98). "To me, everything boils down to relationships" (Glasser, Haight, & Shaughenessey, 2003, p. 410).

JCO: Sometimes I think I need to push my clients harder to make changes every day.

WG: "I think there's where you're making the mistake" (Glasser, 2000, p. 188). "Therapists should not try to force or pressure any client … to change" (Glasser, 2000, p. 166). "You can only control your own behaviour" (Glasser, 2000, p. 54). "As much as we try to control other people, the only person we can control is ourselves" (Glasser in Brandt, 1988, p. 44). "The only behaviour we can control is our own. This means that the only way that we can control events around us is through what we can do" (Glasser, 1989, p. 2).

> *"A positive addiction increases your mental strength and is the opposite of a negative addiction, which seems to sap the strength from every part of your life except in the area of the addiction"*
>
> *(Glasser, 1976a, p. 39)*

JCO: How can clients begin to change their lifestyles?

WG: "I began to hear stories from many people claiming that they were positively addicted to a variety of activities such as swimming, hiking, bike riding, yoga, Zen, knitting, crocheting, hunting, fishing, skiing, rowing, playing a musical instrument, singing, dancing, and many more" (Glasser, 1977, p. 174). "If you get involved in it on a regular basis, if you are non-self-critical in the process and if your mind begins to spin out or transcend, you will eventually become addicted to the activity" (Glasser, 1977, p. 175).

JCO: This is quite a shift from our usual view of addictions.

WG: "A negative addiction is something that harms you, like drug addiction, gambling, etc. Positive addiction builds you up. It increases your creativity and helps you to gain more confidence in yourself" (Glasser, 2016, p. 122). "All of the addictions… provide pleasure, but they don't provide happiness" (Glasser, Haight, & Shaughnessey, 2003, pp. 412-413). "All the reasons in the world for why he drinks will not lead an alcoholic to stop. Change will occur only when he fulfils his needs more satisfactorily" (Glasser, 1965, p. 40).

JCO: How can I use positive addiction to help my clients?

WG: "Since all positive addictions are simple activities that can be easily accomplished, there is no possibility of failure in what you attempt to do. What is hard is to do them long enough to become addictive" (Glasser, 1976a, p. 141). "Getting involved in a positively addicting activity is analogous to getting an opportunity to play a slot machine without putting in money: We may win and we cannot lose" (Glasser, 2013, p. 212).

JCO: Can I just call them hobbies?

WG: "I wish it was that simple" (Glasser, 2000, p. 207). "I call them positive addictions because they strengthen us and make our lives more satisfying" (Glasser, 1976a, p. 2). "It is leaving one's mind alone to do its own thing" (Glasser, 1977, pp. 174). "A positive addiction increases your mental strength and is the opposite of a negative addiction, which seems to sap the strength from every part of your life except in the area of the addiction" (Glasser, 1976a, p. 39).

JCO: How do you choose an activity that might be good to develop into a positive addiction?

WG: "It is something non-competitive that you choose to do and you can devote an hour (approximately) a day to it… It doesn't take a great deal of mental effort to do it well…. You can do it alone… it has some value (physical, mental, or spiritual) for you… If you persist at it you will improve… you can do it without criticizing yourself" (Glasser, 1976a, p. 93). "For example, a physical exercise or meditating or yoga of a kind of mental exercise where the mind is literally being trained not to do anything" (Glasser, 1977, p. 55).

JCO: Why did you shift your focus from psychotherapy to school-based programmes?

WG: "Choice theory is much more effective when it is used to prevent problems than to solve them" (Glasser, 1998, p. 207). "We teach patients better ways to fulfil their needs" (Glasser, 1976b, p. 94). "Have you got any other questions?" (Glasser, 1976d, p. 660).

JCO: How often do you explore why a client developed their problems in the first place?

WG: "I don't really think the past is very important. What happened is done and people have to satisfy their needs now. To give you a simple example: if you missed a meal last week, you can talk about it forever, but there is no way you can eat it" (Glasser in Nystul & Shaughnessy, 1995, p. 441-442). "The past is fixed and cannot be changed. All that can be changed is the immediate present and the future" (Glasser & Zunin, 1979, p. 319). "No matter how much the past may have contributed to his problems, the past will never solve them" (Glasser, 1976c. p. 349).

> *"We are not trying to do the impossible, which is to change their history. We also try to teach our clients that the only person's life they can control is their own, so we do not spend much time focusing on what others are doing"*
>
> *(Glasser, 1989, p. 13)*

"The more you stay in the past, the more you avoid facing the present" (Glasser, 1998, p. 130).

JCO: But many clients ask why their problems developed; why they have low self-esteem or compulsive urges.

WG: "In Reality Therapy we rarely ask, 'why?'" (Glasser, 1975, p. 93). "Our usual question is 'what?' What are you doing - not why are you doing it?" (Glasser, 1973, p. 580-581). "Focusing on the past is counter-productive" (Glasser in Nystul & Shaughnessy, 1995, p. 447). "Rather than reconstruct the past - because nothing can be done to modify it - the present and the future are emphasised" (Glasser, 1990, p. 584). "The therapist adheres to the present and points to a hopeful future" (Glasser, 1965, p. 100).

JCO: Are you saying the past does not matter?

WG: "That's right, I am" (Glasser, 2000, p. 52). "We cannot change the past, only the present" (Glasser, 1965, p. 39). "Since we can only correct for today and plan for a better tomorrow, we talk little about the past - we can't undo anything that has already occurred" (Glasser, 1980a, p. 49). "Since the problem is always in the present, there is no need to make a long intensive investigation into the client's past" (Glasser, 1998, p. 116).

JCO: But you can learn a lot from a client's life story. Are you saying we should ignore the person's past?

WG: "Obviously, I don't cut history off with a knife… If asking historical questions really pertains to the person's present behavior, then of course, ask the question and tie it in" (Glasser in Evans, 1982, p. 461). "Good counseling does not poke excessively into the past, and when the past is discussed, it is always related to the present" (Glasser, 2013, p. 155). "If I do go into the past, I look for a time when she was in effective control of her life. We can learn from past successes, not from past misery" (Glasser, 1998, p. 130). "We need not be victims of our past or our present unless we choose to be so" (Glasser, 1989, p. 3). "Clients use the past to avoid facing what is really happening in their lives now" (Glasser, 1998, p. 231). "We are not trying to do the impossible, which is to change their history. We also try to teach our clients that the only person's life they can control is their own, so we do not spend much time focusing on what others are doing" (Glasser, 1989, p. 13).

JCO: But so many of my clients were raised in harsh or abusive families. It seems important to help them work it out in session.

WG: "I don't agree" (Glasser, 2003, p. 99). "The past is never the problem" (Glasser, 1998, p. 63). "While we are all products of our past, unless we choose to be so, we need not be victims of this past" (Glasser, 2016, p. 21). "Focusing on the past is

counterproductive. It gives people an excuse to stay where they are and is very harmful" (Glasser, 2016, p. 48). "No matter what happened in the past, it is over. … the only way you can deal with a traumatic past is to move into a satisfying present" (Glasser, 2016, p. 21). "Past events are not to be used as an excuse for behaving in an irresponsible manner. No matter what 'happened' to him in the past, he must take full responsibility for what he does now" (Glasser & Zunin, 1979, p. 302). "We spend too much time acting as victims and blaming others" (Glasser in Nystul & Shaughnessy, 1995, p. 444). "Now we're ready to go on to the last question" (Glasser, 2000, p. 45).

JCO: I am curious - what are your thoughts about graduate training in psychotherapy?

WG: "Much of the present academic curriculum is not worth the effort it takes to learn it" (Glasser, 1992, p. 691). "Even students in colleges and graduate schools, are asked to learn well enough to remember for important tests innumerable facts that both they and their teachers know are of no use except to pass tests" (Glasser, 1992, p. 691). "You can't get quality out of assigning people useless or busy work. I'd say about 90 percent of the questions asked of students are answered by the student having memorized some useful bit of information" (Glasser in Harmon, 1993, p. 45).

JCO: I have heard faculty being encouraged to view their students as customers of the university, and it is important to keep our customers happy.

WG: "I don't think the student should be looked at as a customer. The customer of the school is the community and the parents" (Glasser in Harmon, 1993, p. 45).

> *"I feel that Reality Therapy helps me encourage my clients to take control of their lives, beginning today, by making visible changes in how they steer their thoughts and actions toward their major life goals"*

JCO: Well, what kind of training is best for helping a young professional become a good psychotherapist?

WG: "It's a program with some theory but mainly practice and then comparing what you have found in practice with the theories that you have studied" (Glasser, 2016, p. 45). "It would be one where they have a mentor, someone whom they can really work with and talk with about their problems in learning to become a good psychotherapist" (Glasser in Nystul & Shaughnessy, 1995, p. 444).

JCO: So we should reduce the reliance on lectures and expand the value of supervised experience?

WG: "Yes, that's a fair statement" (Glasser in Evans, 1982, p. 461). "Lawyers have the same problem. They spend much time in the classroom and not enough time practicing law" (Glasser in Drummond, 1977, p. 52). "I evolved my ideas as I practiced and evaluated what I did with my clients; what seemed to work and what seemed not to work" (Glasser, 2016, p. 47). "Teachers who teach therapy and counselling can… point out to students that here is a theory that is backed up in practice (Glasser, 1980b, p. xiv).

JCO: So a young psychotherapist learns best by doing the actual work of therapy, not sitting in a classroom?

WG: "I don't think anyone is really trained until they actually are doing the job they are supposed to do… internship usually is only a start… Medical schools do not train a doctor extensively in the classroom. A doctor has to be under direct supervision while he/she cares for patients (Glasser in Drummond, 1977, p. 52).

JCO: If you learn it by doing it, how can we prepare students for working with their first clients?

WG: "If you intend to practice Reality Therapy, the technique cannot be learned from books. It must be learned from someone who is experienced and trained" (Glasser, 1976e, p. xi). "All psychiatric theory is meaningless unless there is a therapist who knows how to use it" (Glasser, 1964, p. 139). "Although the practice of Reality Therapy is readily understandable, it is not easy to do. It takes skill and experience to apply these ideas successfully" (Glasser, 1975, p. 71). "It seems simple, but try it, it's much more difficult than it looks" (Glasser, 1976f, p. 653). "Students can role-play the clients and… in so doing discover how difficult the simple and clear-cut steps are to apply in practice" (Glasser, 1980b, p. xiv).

JCO: I have a few more questions, would that be okay?

WG: "Wait a second. Let's stop here" (Glasser, 1976g, p. 467).

JCO: Sure. Thank you for your time

and your contributions to the field of psychotherapy. I have learned quite a lot from your ideas.

WG: "Tell me, what have you learned" (Glasser, 2000, p. 192).

JCO: Well, I feel that Reality Therapy helps me encourage my clients to take control of their lives, beginning today, by making visible changes in how they steer their thoughts and actions toward their major life goals. This is very helpful.

WG: "Thank you" (Glasser, 2000, p. 45). "I hope you will try out these ideas" (Glasser, 1971, p. 22). "The best way is to begin applying it in your own life" (Glasser in Brandt, 1988, p. 43).

JCO: Yes, of course. Thank you.

WG: "You're welcome" (Glasser, 1976d, p. 661). "I think we've had a real good get-together" (Glasser, 2000, p. 208). "I always enjoy working with you" (Glasser, 2016, p. 125).

Jim Overholser

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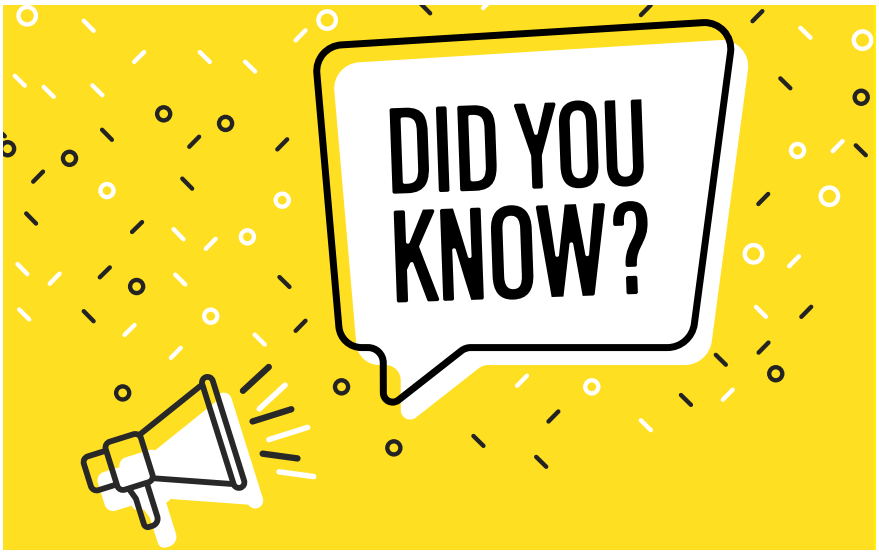
Practitioner Perspective

10 Reasons Why You Should Care about Research

By Dr Cóilín Ó Braonáin



Dr Cóilín Ó Braonáin delves into Mick Cooper's 'Essential Research Findings in Counselling and Psychotherapy: The facts are friendly' and discovers some results that you may find surprising

How do we know what we know? Typically, we all go through life with a sense of knowing what's what. We know where we are, what we are doing, and we have a sense of general competency. For everyday purposes, that assumption of understanding, knowing and confidence in ourselves is mostly effective.

When it comes to effectiveness as a counsellor, following training, a similar approach to knowledge is often taken. But is experience, intuition and self-belief actually enough to justify how we do therapy, in the absence of hard facts? Well, let's take a quick look at 10 aspects of psychotherapy upon which we may have firm views and see if there are any surprises.[1]

1. Does therapy work?

As it happens, different studies produce varying answers to this and other questions. Consequently, we need to look at many studies and compile an average result. In this case, when counselling clients are compared to people with similar problems who don't receive treatment (control groups), there is 79 per cent more improvement in people who have received therapy. So, about eight out of 10 clients get better. Not bad, eh? But what happens to the other two clients?

2. Do some people get worse in therapy?

Well, yes. About five to 10 per cent of clients deteriorate in therapy (some others experience no change either way). Clearly, this raises the question of whether or not all potential clients should be screened in private practice. Such screening could identify contraindications to therapy, and those people could be referred elsewhere saving them unnecessary distress.

3. How good is your client retention?

Probably not great, according to the research. About 50 per cent of clients drop out for a variety of reasons. Some obvious reasons are the cost of therapy, and modality factors (not every client is amenable to every type of therapy). However, less obviously, have you ever considered the possibility that counselling may be simply better suited to some cohorts than others? In fact, those from lower socio-economic groups, those with lower levels of education, and ethnic minorities are more likely to drop out. Food for thought?

4. Does psychotherapeutic orientation matter?

This hot potato is more difficult to answer. Research tends to look at differential effectiveness, that is, which modality is best for which ailment. A problem with this approach

[1] The information in this article is sourced from Cooper. M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly.* Los Angeles: Sage.

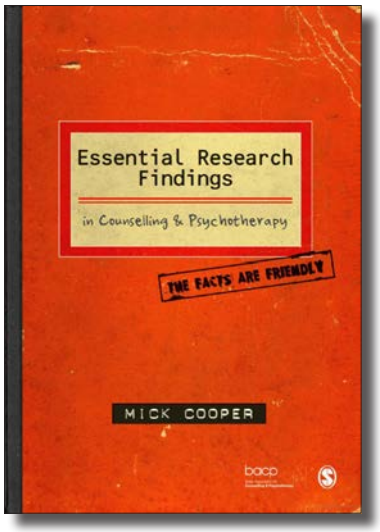
is that some modalities, especially cognitive behavioural therapy (CBT), have done more research than others, which skews the results somewhat. Also, *DSM-5* diagnoses are often quite broad, containing menus of symptoms, so that, for example, several people suffering from depression may have different combinations of symptoms. So, it is difficult to compare like with like. Nonetheless, a lot of research has been done and many studies show that there is little difference in effectiveness across modalities (known as the dodo bird verdict). A few studies even show control groups doing as well, or even better than therapy clients! Other studies favour CBT for a variety of problems, including depression and anxieties.

5. What else makes a difference in outcomes?

Lambert's Pie suggest that the orientation question may not really matter a whole lot, because it may be the case that modality has limited relevance to outcomes. According to Lambert's research, only 15 per cent of the benefit of therapy to clients is due to technique and model factors. Another 15 per cent is down to expectancy and placebo, while the therapeutic relationship contributes 30 per cent of the positive effect. However, the largest slice of the pie (40 per cent of effect) is attributed to client variables and extra-therapeutic events. Therefore, more than half of the therapeutic effect may have nothing to do with you, or your modality. Surprised?

6. Therapist factors: Does it matter who you are?

Mostly, no. Your age and personal experiences do not correlate with client outcomes. There is no strong evidence to say that therapist personality matters. Gender does not matter much, although female therapists may be slightly more effective with female



clients, on average. Also, clients from marginalised groups may do better with therapists from similar backgrounds. CPD for therapists has some beneficial effect on outcomes, but not a whole lot. Overall, therapist characteristics don't matter much - it's the therapeutic relationship that is most important.

7. Does what you do work?

There are many therapeutic techniques or intentionally implied procedures used in order to bring about therapeutic results. However, how effective are they in reality? Non-directivity as a 'technique' is often of interest, in particular when comparing person-centred therapy (PCT) with CBT. PCT would argue strongly that direction undermines the client's autonomy and that direction is counterproductive, whereas CBT is typically quite directive. Research shows that many clients do not like a complete absence of direction, however, others dislike a high level of direction. It seems that moderate direction is best supported by the research, whereby the therapist makes tentative suggestions, thus influencing the client is certain directions, without being too pushy.

Another more specific example of a techniques is that of Paradoxical Intervention (PI). PI is a technique where the client is encouraged to do the opposite of what she desires, for example, suggesting to an insomniac client she try hard to stay awake instead of trying to sleep. PI has strong support in the literature when measured against control groups. Counterintuitively, PI can bring about the desired result.

8. Is online therapy effective?

Some would argue that the therapeutic relationship cannot be established effectively by phone or the Internet, but what are the facts? Cooper finds that both phone and Internet therapy seem to be as effective as face-to-face counselling. Clients may even be more comfortable disclosing personal information at a distance, and clients report equal satisfaction with distance therapies compared with meeting in person.

9. Can clients engage with therapy while on medications?

Another old chestnut is the view that medications such as anti-depressants dull the emotions and impede the therapeutic process. True or false? In general, false is the answer; antidepressants do not hamper therapy. But are medications beneficial to outcomes, if taken in conjunction with counselling? Apparently not, says the research, except in cases of severe or endogenous depression. If choosing between medications or therapy, for most clients, therapy alone is equally effective to medicine.

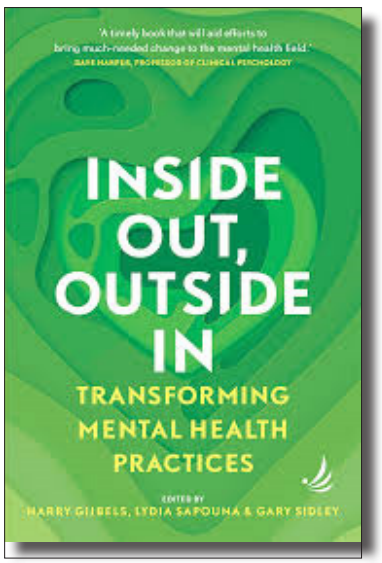
10. What else might we assume without evidence?

How long should a therapy session last? One hour, 50 minutes? Why not 30 minutes? Is once a week the best frequency for sessions? Yes? How do you know? Is personal therapy for counsellors important? You might be surprised at the answer. Is it wrong to accept gifts from clients? Not necessarily. To close on a cliché, if I may, could it be that more research is needed?

Book Review

Title:	*Inside Out, Outside In: Transforming Mental Health Practices*
Editors:	*Harry Gijbels, Lydia Sapouna and Gary Sidley*
Published:	*2019*
ISBN:	*9781910919491*
Reviewed by:	*Pat McElroy, Counsellor, Cork Counselling Services*

Launched at their very successful 11th Annual Critical Voices Conference held in University College Cork recently, the editors have collected persuasive arguments for mental health transformation between the unassuming covers of this highly readable publication.



The bio-medical ethos of psychiatry-led mental health systems is criticised for understanding human distress in terms of biological disorder and psychological deficit. This, it is argued, can lead to mental health systems that are ineffective and even harmful at times. The book showcases current constructive projects that offer user-centred, context-informed, non-medical ways of helping people who experience distress and overwhelming experiences. Some of these projects look to influence change from within mainstream services, others have established themselves as radical independent entities.

The chapter on the Open Dialogue approach being implemented in West Cork is very well written, and gives the reader an excellent overview of what it is all about - for both service users and professionals who adopt the approach. The author, Iseult Twamley, paints a picture of the challenges and opportunities that surface. From a psychotherapeutic perspective, there is lots to learn in relation to tolerating uncertainty and to being present with clients without the use of psychological concepts or agendas. The final quotation from a service user is an apt description of how open dialogue radically differs from conventional psychiatric practice: "I just felt like I'd go to the doctors, I felt like, I dunno, I used to just close up, I had something really bottled up, but I couldn't get it out… whereas the [Open Dialogue] team were in my living room and it was like talking to someone I knew all my life."

In chapter 6, 'A pause before prescribing - rethinking antidepressant use in general practice', Irish GP Bryan McElroy describes his efforts to bring about meaningful change in his profession. The chapter gives a detailed insight into why antidepressant prescribing is so prevalent in Ireland today. It also contains information regarding withdrawal effects and side effects and examines the influence pharmaceutical companies have in educational settings, reinforcing the illness narrative to explain human distress, which is solved by medication. Who better than a GP to raise general practice issues?

In chapter 8, we learn of the remarkable story of Slí Eile - a unique therapeutic community offering mental health patients 'another way' to heal and recover a sense of self by integrating into a healthy community setting. The story is an inspiring one. Against odds and challenges of every kind, Joan Hamilton of the Cork Advocacy Network and a number of volunteers set out to create a working community farm and end up with an organic bakery and cafe in the process. It reminds me of a wonderful quote by Margaret Mead: "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

The final chapter of this book is co-written by two professors in mental health from the University of Central Lancaster. It is a thoughtful reflection on the potential of 'truth and reconciliation' approaches to challenging the mental health system. This chapter took me a while to get into and understand - perhaps because the topic was slightly foreign to me. However, the more I read, the more I appreciated the work and insights of the authors. I particularly liked the following sentence in relation to creating meaningful dialogue between service users and service providers: "It (truth and reconciliation) doesn't assume that any particular expert (by profession or by experience) contains the 'correct position' or the final word about mental suffering, or indeed mental health services."

Finally, the editors write about the divisive effect of 'quick-fire responses' to human distress that predominate social media debates and argue that such communication does little to promote meaningful dialogue. This is something I have noticed too recently on forums such as Twitter and Facebook. Overall, and in contrast, I appreciated the thoughtful, considered responses to human distress that prevail throughout this book, which I recommend as an interesting, imaginative and stimulating read.

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