Practitioner health and self-compassion

- Is a therapist's attachment style predictive of stress and burnout in a sample of Irish therapists?
- Is there a role for counselling in the treatment of addiction?
- Mindfulness for Supervisors
- My personal experience of Grief and Loss and learning to live in the NOW.
Contents

From the Editor 3

Is a therapist’s attachment style predictive of stress and burnout in a sample of Irish therapists? 5
Ciaran Carr and Jonathan Egan

Is there a role for counselling in the treatment of addiction? 10
Mick Devine

Mindfulness for Supervisors 15
Padraig O’Moráin

My personal experience of Grief and Loss and learning to live in the NOW. 19
Marian Staunton

Book Reviews 22

Noticeboard 24

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

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

Next Issue:
1st June 2017

Deadline for Next Issue:
15th March 2017

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

Editorial Board:
Donna Bacon, Aíne Egan, Mike Hackett, Cóilín Ó Braonáin (Chair), Maureen Raymond-McKay, Antoinette Stanbridge

Design and layout:
GKDesign.ie

Co-ordinator:
Deirdre Browne.

ISSN:
1393-3582.

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

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

Myself and my colleagues enjoyed reading the contributions submitted for inclusion in the Spring Edition. If your article is not published in this edition don’t despair, we will be in touch. The articles we have chosen are diverse and for the first time we have classified them into the categories set out overleaf. There is one academic piece, two which fall into the category of practitioner perspective, and one is a reflective piece. The academic article relates to a study undertaken by Ciaran Carr and Jonathon Egan of NUI Galway which aimed to investigate whether attachment style as measured by current levels of attachment anxiety and avoidance predicted stress and burnout in therapists. Some of the independent variables tested reached statistical significance. For example, attachment anxiety predicted emotional exhaustion in therapists, with an avoidant attachment style predicting higher levels of depersonalisation in therapists. Even if statistics are not your forte it is well worth a fair reading.

Mick Devine in his (practitioner perspective) article asks if there is a role for counselling in the treatment of addiction? Mick who has a vast experience in the area takes as his starting point the disease model of addiction. He advocates counselling as an additional support in the treatment of addiction but it is his opinion “that counselling really comes into its own when the service user responds to the challenge of establishing a drug-free lifestyle as central to managing addiction”.

Padraig O’Morain in his article (practitioner perspective) on the use of mindfulness in supervision, explains what mindfulness is and goes on to describe how some mindfulness techniques can be used by the supervisor in the supervision encounter. For example giving “bare” attention can help us meet the supervisee “anew” thus ensuring that the current session is not coloured in a negative manner by some unhelpful hangover from the previous session. Also being in the present-moment will better allow us to recognise those inklings of countertransference and may help to restrain us from acting out of them in a destructive way.

Marian Staunton’s (reflective) and poignant piece on her experience of grief and loss during the illness, and following the death, of her beloved brother, speaks for itself.

As I complete this editorial it occurs to me that there is a theme that binds the articles together and that is practitioner health and self-compassion. Please keep your contributions coming, your voice needs to be heard. Also, keep the categories of article to hand. They will help you write to your strengths.

Maureen Raymond-McKay MIACP

Correction
In the Winter ’16 edition of Éisteach, we inadvertently omitted to indicate prior publication of the piece by Maeve Dooley and the full reference to same. We would like to apologise to the IAHIP and Inside Out (in which the original article appeared) and include the reference here to the original work. Dooley, M. (2015). Does Psychotherapy = Counselling? A View on Some Defining Differences. Inside Out (Issue 75). Retrieved from: http://iahip.org/inside-out/issue-75-spring-2015/does-psychotherapy-counselling-a-view-on-some-defining-differences
Publishing Policy
In addition to the authors’ guidelines printed in our recent Winter 2016 edition of Éisteach (and on www.iacp.ie), the Editorial Board wishes to further simplify the publishing process. We wish to broaden access and accommodate the diversity of membership within the IACP consequently we invite articles of four types, each with different criteria in terms of presentation and academic requirements. The aim is to enhance inclusiveness and diversity in the material published, while simultaneously maintaining high standards of publication. The four categories of article are; a) academic work, b) practitioner perspectives, c) reflective articles, and d) a student corner. Descriptions of each type of article follows.

Academic Work
An article designated as academic work will either be based on original research, or comprise a comprehensive literature review of the chosen topic. In both cases, the writing must be evidence-based and substantive claims must be supported by the literature, or the research conducted. Qualitative, quantitative or mixed methods are welcome, however quantitative findings should be described in language that will allow readers unfamiliar with statistics to appreciate the significance of the findings. Work in this category must apply the American Psychological Association (APA) style.

Practitioner Perspectives
Articles, which address clinical issues in counselling & psychotherapy primarily from the counsellors’ experience in delivering treatment to clients, may also refer (where relevant) to significant authors, but can be principally based on clinical experience and observation. Such articles are often based on a psychotherapist’s work with many clients who presented with the same or similar issues. Any passing reference to actual clients must be brief and anonymised. Full case histories are not accepted (even with consent), in order to avoid any possible inadvertent breach of client confidentiality. This category provides a voice for you the practitioner to educate, inform, contribute or encourage discussion in our field, expressing your professional basis and your passion for your subject.

Reflective Articles
Reflective articles centre on a member’s personal experience of a theme such as depression, or bereavement. These articles do not necessarily refer to specific client work, but focus on the personal development of the therapist, or supervisor and perhaps the application of that experience to client work. Reflective articles may also address specific topics in the field of counselling and psychotherapy, or reflections on the past, present or future of our profession. Reflective pieces do not require APA referencing but must be adequately well written to be considered for publication.

Student Corner
As tomorrows professionals, we want to encourage the voice of students of counselling and psychotherapy as they encounter the many facets of modern professional practice and personal development. Student articles, therefore, may conform to any of the above descriptions. While high standards of writing are expected, student articles need not meet the same rigour that is expected of accredited members. Articles which are pertinent to the student experience of aspects of training or self-development are welcome, in addition to work relating to psychological topics.
Is a therapist’s attachment style predictive of stress and burnout in a sample of Irish therapists?

Ciaran Carr and Jonathan Egan. NUI Galway

Abstract
The current study investigated whether attachment style, as measured by levels of attachment anxiety and avoidance, in a sample of (N = 137) therapists predicted stress and burnout. A series of hierarchical multiple regressions accounted for 20% of variance in stress, with insecure-anxious attachment and years working as a therapist being significant predictors, 12% in Emotional Exhaustion, with insecure-anxious attachment being significant, 17% in Depersonalization, with insecure-avoidant attachment and age being significant.

Introduction
Siegler, DeLoache and Eisenberg (2003) define attachment as ‘an emotional bond developed with a specific person that is enduring across both time and space’ (p. 213), with Ainsworth, Caldwell and Ricciuti (1973) proposing that attachment style is a relatively stable construct across time. She would go on to propose the existence of four separate styles of attachment, them being (A) secure, (B) insecure-avoidant, (C) insecure-anxious and (D) insecure-ambivalent (Ainsworth et al., 1973; Crittenden & Ainsworth, 1989). West (2015) determined that those working in the health services are at risk of developing negative health outcomes as a result of their attachment style. She determined that a carer’s attachment style can act as a moderator of well-being, which is often measured in terms of levels of stress, burnout and compassion fatigue. In spite of West’s (2015) assertion, there have been few previous applications of Attachment Theory specifically to therapists. In her review, she observed that an insecure attachment style predicted negative psychological outcomes in healthcare professionals, with a secure attachment predicting overall vitality. There is a developing literature suggesting that secure attachment is a predictor of general well-being. Pereira et al., (2011) observed that an insecure attachment style predicted increased levels of stress in those working in palliative care. In a study conducted over a period of six months, Kim, Kashy and Evans (2007) observed that palliative care workers with an anxious attachment style, characterized by ‘a strong desire for closeness’ (p. 35), as well as a ‘hypervigilance for cues of abandonment, and emotional upset both at separation and reunion’ (p. 35) with clients, presented with significantly higher levels of stress.

Burnout was defined by Maslach (1976) as ‘a syndrome of emotional exhaustion, depersonalization of others, and a feeling of reduced...
personal accomplishment’ (p. 16). Subsequently, the characteristics of increased emotional exhaustion, depersonalization and diminished personal accomplishment would form the foundation of her measurement criteria for burnout; Maslach’s Burnout Inventory. In a review of the literature, Bria, Baban and Dumitrescu (2012) determined that burnout is a process which is often experienced by individuals who are exposed to ‘overwhelming emotional and interpersonal interactions’ (p. 21), with elevated instances of burnout being observed in nurses (Allan, Farquharson, Choudhary, Johnston, Jones, & Johnston, 2009) and hospital consultants (Taylor et al., 2005) among others. In a further review of the literature however, Danhof-Pont, van Even & Zitman (2011) observed no consistent biological predictors of burnout. Indeed, Heard, Lake and McCluskey (2011) suggested that previous exposure to trauma predisposed healthcare workers to elevated emotional exhaustion, supporting Egan, Meehan, Carr and Hevey’s (2015) assertion that burnout may be the result of unconscious immature defense mechanisms such as dissociation, distortion of self by devaluing self in presence of others, or omnipotence, maintaining self-esteem by blaming the patient or other staff for their stress. The assertion that both immature emotional responding and the attachment security of the therapist-client relationships might be a fruitful area to develop research. Skovholt and Trotter-Mathison (2014) observed that secure attachment predicted lower levels of burnout in mental healthcare professionals, as well as higher levels of overall vitality and superior coping styles. Egan et al. (2015) reported that psychologists who used less mature defense styles (devaluing clients or self, or moving to omnipotence, or dominant/submissive positions in therapy) were more likely to present with both higher emotional exhaustion and depersonalization. Zerubavel and Wright (2012) expand on this by arguing that a therapist’s own psychological trauma can carry curative power for clients, but that the therapists need to be cognisant of their wound. Tosone, Bettmann, Minami and Jasperson (2010) observed that compassion fatigue was more prevalent in insecurely attached New York based social workers who worked with clients following September the 11th, 2001. In a subsequent study, Bawens and Tosone (2014), noted that secure attachment predicted greater resilience in Social Workers from New Orleans following Hurricane Katrina, while insecure-avoidant and insecure-ambivalent attachment styles predicted greater compassion fatigue.

In addition to attachment style, factors such as age (Rosenberg and Pace, 2006), gender (Craig & Sprang, 2010) level of qualification (Sodeke-Gregson, Holttum, & Billings 2013), years working as a therapist (Lim, Kim, Kim, Yang, & Lee, 2010), hours of client contact per week (Cherniss, 2016), as well as perceived levels of social support (Pines, 2004) have been observed to predict psychological well-being in healthcare-professionals (as measured by way of the levels of stress, burnout and compassion fatigue).

The current study aims to investigate the relationships between therapists’ attachment styles and their current levels of stress and burnout. There is a dearth of literature in relation to how attachment style and a therapist’s well-being interact. Insecure attachment in therapists by definition describes their tendency to seek or not seek others in the modulation of personal upset. A tendency to withdraw from or not engage in instrumental and emotional supports may result in a therapist slowly and imperceptibly becoming more and more physically and emotionally drained (Figley, 2002). The current lack of extant research is ironic given that stress (Cohen, 2004) and burnout (Bria et al., 2012) present more frequently in professionals who work directly with patients or service users in some capacity (Figley, 2002).

Method

Participants

A sample of 137 therapists aged between 26 and 74 years of age, average age 52 years, Standard Deviation (SD) = 9.9, were recruited for analysis. Demographics are displayed in Table 1 below. Both men and women who participated had similar ages.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Age</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25</td>
<td>54</td>
<td>9</td>
</tr>
<tr>
<td>Female</td>
<td>112</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>137</td>
<td>52.3</td>
<td>9.9</td>
</tr>
</tbody>
</table>

Measures

A series of questionnaires were used as part of analysis.

1. Attachment Style was measured using the Adult Attachment Questionnaire (AAQ; Simpson, Rholes & Phillips, 1996). The AAQ is a 17 item questionnaire that measures participant’s levels of avoidance and anxiety.

2. Perceived Social Support was measured using the 12 item Perceived Social Support (PSS) Scale (Zimet, Dahlem, Zimet & Farley 1988; Cronbach’s Alpha of .9).

3. The General Health Questionnaire-12 (GHQ-12) was used to measure general well-being (Goldberg & Williams, 1988; Cronbach’s alpha of .63).
4. Burnout was measured using Maslach and Jackson’s (1986) 22 item Burnout Inventory (MBI) for Human Services, with the items pertaining to Emotional Exhaustion holding a Cronbach’s alpha of .9. The Depersonalization subscale had a Cronbach’s alpha of .8, while the Personal Achievement subscale has a Cronbach’s alpha of .9.

Survey Monkey was used as a means of collecting the data from therapists. The use of online questionnaires ensured that participants could be easily contacted, provide consent, complete the questionnaires and be provided with an extensive debriefing in an efficient manner. Additional apparatus utilised was a personal computer, which facilitated the use of SPSS and Microsoft Word. SPSS was used to perform analysis on the data collected.

Procedure
Participants were contacted via e-mail. Participants were sampled randomly. A total of 1,046 e-mails were sent, with 177 responses indicating a response rate of 17%. Of these, 40 responses were incomplete and therefore excluded, thus leaving a total of 137 complete responses. The e-mail included an introduction to the author, a description of the research being conducted and a link to the online questionnaire.

Ethics
Ethical approval was sought and received from the School of Psychology at the National University of Ireland, Galway. Given the sensitive nature of what was being measured, participants were provided with a list of contacts for in the event that they became distressed during data collection. These contacts were provided on the consent form presented to participants prior to the study. The participants, however, were not considered to be vulnerable.

Results
A series of three hierarchical multiple regressions were employed to evaluate how age, gender, years working as a therapist, qualification, perceived social support, levels of anxious avoidant attachment predicted levels of general stress, emotional exhaustion, and depersonalization in therapists. In each regression, age, gender, years working as a therapist and qualification level were controlled for in Step 1, Perceived Social Support was entered in Step 2 and levels of avoidant and anxious attachment were entered in Step 3.

The first Hierarchical Multiple Regression was conducted to observe the predictors of Stress in Therapists, the results of which are displayed in Table 2.

With regard to therapists’ stress levels, the overall model was significant (F (8, 136) = 8.56, p = .00, R2 = .14, Adj R2 = .10), however, Perceived Social Support (β = -.10, p = .27) was not observed to be a significant predictor of stress in therapists. Step 3 was also observed to be a significant predictor of stress in Therapists (F (8, 128) = 8.56, p = .00, R2 = .24, Adj R2 = .20, all VIF (<1) and tolerance (> 1) scores ensured against multicollinearity). An anxious attachment style (β = .35, p < .00) significantly predicted stress in therapists, whereas the avoidant attachment style did not (β = .08, p = .41).

A second Hierarchical multiple regression was conducted in order to observe the predictors of Emotional Exhaustion in therapists. The results of the analysis is displayed in Table 3.

The overall model was significant (F (8, 136) = 3.29, p < .00, R2 = .17, Adj R2 = .12), accounting for 12% of the overall variance. Step 1 did not significantly predict any of the variance (F (5, 131) = 1.56, p = .18, R2 = .06, Adj R2 = .02), although age (β = .22, p < .02) and the number of years working as a therapist (β = -.19, p < .05) were observed to be significant predictors of stress in therapists. Step 2 was observed to be significant (F (6, 130) = 12.55, p < .01, R2 = .14, Adj R2 = .10), however, Perceived Social Support (β = -.10, p = .27) was not observed to be a significant predictor of stress in therapists. Step 3 was also observed to be a significant predictor of stress in Therapists (F (8, 128) = 8.56, p = .00, R2 = .24, Adj R2 = .20, all VIF (<1) and tolerance (> 1) scores ensured against multicollinearity). An anxious attachment style (β = .35, p < .00) significantly predicted stress in therapists, whereas the avoidant attachment style did not (β = .08, p = .41).

<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
<th>R²</th>
<th>Adj R²</th>
<th>F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.22*</td>
<td>.06</td>
<td>.02</td>
<td>1.56</td>
</tr>
<tr>
<td>Gender</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualification</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years Working as a Therapist</td>
<td>-.19*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of Client Contact per week</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td>-.10</td>
<td>.14</td>
<td>.10</td>
<td>12.55**</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>.07</td>
<td>.24</td>
<td>.20</td>
<td>8.56***</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.35***</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total R² = .24, Total Adj R² = .20. Significance Level: * = p < .05, ** = p < .01, *** = p < .00.

Table 2. Hierarchical Multiple Regression for Predictors of Stress in Therapists (N = 137)
of Emotional Exhaustion in Therapists. Step 3 was also observed to be a significant \( F(5, 131) = 2.53, p < .05, R^2 = .09, Adj R^2 = .05 \), however, age \((\beta = -.25, p < .01)\) was the only variable observed to significantly predict Depersonalization in therapists. Step 2 was also observed to be significant \((F(1, 130) = 3.9, p < .01, R^2 = .15, Adj R^2 = .11)\), but Perceived Social Support \((\beta = -.08, p = .43)\) did not predict elevated Depersonalization in Therapists.

A third Hierarchical multiple regression was conducted in order to observe the predictors of depersonalization in therapists. The results of the analysis is displayed in Table 4, with the overall model being significant and accounting for 17 percent of the variance \((F(8, 136) = 4.58, p < .00, R^2 = .22, Adj R^2 = .17)\).

### Table 3. Hierarchical Multiple Regression for Predictors of Emotional Exhaustion in Therapists \((N = 137)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>(\beta)</th>
<th>(R^2)</th>
<th>Adj (R^2)</th>
<th>(F) Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.13</td>
<td>.06</td>
<td>.02</td>
<td>1.61</td>
</tr>
<tr>
<td>Gender</td>
<td>-.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualification</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years Working as a Therapist</td>
<td>.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of Client Contact per week</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td>-.15</td>
<td>.13</td>
<td>.09</td>
<td>10.51**</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>.17</td>
<td>.17</td>
<td>.12</td>
<td>3.27*</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.22</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total \(R^2 = .17\), Total Adj \(R^2 = .12\). Significance Level: \(* = p < .05, ** = p < .01\)

### Table 4. Hierarchical Multiple Regression for Predictors of Depersonalization in Therapists \((N = 137)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>(\beta)</th>
<th>(R^2)</th>
<th>Adj (R^2)</th>
<th>(F) Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.25**</td>
<td>.09</td>
<td>.05</td>
<td>2.53*</td>
</tr>
<tr>
<td>Gender</td>
<td>.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualification</td>
<td>-.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years Working as a Therapist</td>
<td>.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of Client Contact per week</td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td>-.08</td>
<td>.15</td>
<td>.11</td>
<td>9.91**</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>.23*</td>
<td>.22</td>
<td>.17</td>
<td>5.77**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total \(R^2 = .22\), Total Adj \(R^2 = .17\). Significance Level: \(* = p < .05, ** = p < .01\)

### Discussion

One distinct limitation of the current research is that a cross-sectional design was employed. While cross-sectional designs enable the efficient collection of data, they do not allow for statements of causation, which is particularly important given Shanafelt et al’s (2012) observation that burnout in Healthcare Professionals develops gradually, over years of therapeutic encounters.

This is the first published study investigating the effect of attachment styles on a large sample of therapists working in Ireland. Having an anxious or preoccupied attachment style resulted in having higher general levels of stress which replicates West’s (2015) findings in health care professionals. Interestingly, attachment anxiety also predicted emotional exhaustion in therapists, with the avoidant attachment style predicting higher levels of detachment from clients via a depersonalization syndrome. As per Egan et al’s (2015) call for supervisors to be trained in identifying immature defence styles in therapists, the call might also need to be expanded to helping therapists reach out for support rather than becoming pre-occupied and anxious in relation to their clients, and for therapists who use an avoidant way of coping interpersonally, to stay present and to learn to tolerate attachment anxiety and distress.

Further research needs to take place to explore whether primitive defence styles related to the attachment system, such as dissociation could be key defences related to the avoidant attachment style being activated in therapists. Finally, it would also be interesting to investigate whether some therapists somatise their distress rather than seek a carer and put the distress into words. An analysis of commonly reported somatic symptoms such as musculoskeletal pain (neck and...
back), headaches (migaine and tension), gastro-intestinal upset and fatigue might be fruitful and add to the supervisor's understanding of the care-seeker.

References


Ciaran Carr

From the rural Fanad peninsula in North Donegal, Ciaran Carr is a recent graduate of the Health Psychology Masters program at the National University of Ireland, Galway. His undergraduate research dealt with the predictors of risky driving behaviour in male drivers as well as the predictors sexual hygiene and health in students. More recently, he has observed attachment style as a predictor of well-being in therapists, in term of the levels of stress, burnout and compassion fatigue they present with. He is currently employed as a Health and Social Care Support Worker where he hopes to garner vital experience that will aid his progression as a clinician in future, while also satiating his interest in research.

Contact details

e-mail: ciarancarr16@yahoo.com

Jonathan Egan

Dr Jonathan Egan is the Deputy Director of the Doctorate in Clinical Psychology at NUI Galway. He has previously worked as the principal specialist psychologist in the Mater Hospital and prior to this was one of the founding Directors of Counselling in the HSE. He presents and has written extensively on the effects of the work of therapy on therapists. This summer he was a keynote speaker at the National Counselling Services Annual Conference in Galway talking about his recent research on the importance of attachment style and the role of defences in well-being. He is currently undertaking further training with Dr Una McCluskey (York) who trains therapists about the goal corrected nature of care-seeking.
Is there a role for counselling in the treatment of addiction?

Mick Devine

Introduction

This article seeks to articulate the place for counselling in the treatment of addiction. With harmful and hazardous alcohol and drug misuse, education and prevention measures are preferred with some brief solution focused interventions (Department of Health; 2012). For opiate addiction, medical interventions to stabilize and reduce harm are rightly to the fore (Health Service Executive Social Inclusion Unit, 2010). I am Clinical Director of Tabor Group, a Cork-based treatment agency guided in treating addiction by the Minnesota Model of care. This approach is based on a ‘disease concept’ of addiction and favours the long term goal a ‘drug free lifestyle’ for clients. I am often asked “what is your success rate?” and in my experience, many who opt for ‘drug free lifestyle’ treatment options, relapse is common and is therefore seen as failure. To assist service users in achieving a drug-free lifestyle counselling is essential. In this article I present the case for counselling in the management of addiction at Tabor Group and this article uses the American Society of Addiction Medicine’s (2011) definition of addiction to answer the question posed in the title. This definition will structure the article as I present addiction as (i) a ‘chronic disease’, (ii) a ‘chronic brain disease’ that (iii) diminishes the person’s recognition of the problem. I will quote directly from this definition and also use it to reflect on my professional experience of the value of counselling in the treatment of addiction. This will prepare the way for presenting the role of counselling in treating addiction.

Multi-agency Treatment of Addiction

On one hand there is growing acceptance of harmful and hazardous misuse of alcohol and drugs which requires education and prevention services and where treatment services are necessary they may be brief and solution focused (HSE 2012). On the other hand there is a growing awareness of the complexity of needs that often accompanies addiction (MacGabhann et al., 2004; Najavits, 2002).

From this awareness results an emphasis on the need for multiple agencies to be involved in the rehabilitation of people affected by addiction (Department of Community Rural and Gaeltacht Affairs, 2009).

General Practitioners, Pharmacists, Detoxification Services, Community Drugs Workers, Homeless Services, Social Workers, Key Workers, Case Managers, Community Enterprise Schemes, Adult Learning and Training agencies, Probation Services, Treatment Agencies of various types, 12 Step Fellowships, Family Support Services, and Parenting Programmes all have valuable roles to play in rehabilitation. From my experience of engagement in delivering treatment for 20 years in the Health Service Executive Southern Region, all of these agencies have a caring dimension and staff is equipped with...
When science began to study addictive behaviour in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower.

Addiction is a chronic disease

To establish the nature of a chronic health condition it is useful to contrast it with an acute health condition. White (2003) outlines that acute health conditions are of sudden onset and short duration; symptoms appear suddenly and the pain is insistent. Additionally he argues that immediate care is required and is usually clearly defined, administered by an expert using surgery or medication and brings about a cure. Examples are infection, appendicitis and a broken bone. Acute health conditions, he says, are seen to be something that happens to a person.

White (2003) contrasts this with a chronic health condition which he says is persistent and long lasting, usually more than three months. He says that the onset is gradual and the condition may be characterised by periods of remission and relapse. Furthermore, the condition may not insist on attention until well progressed. He contends that the condition is managed rather than cured and the participation of the ‘patient’ is central to the successful management. Insight, for White, is a crucial component of the recruitment of the patient in the management of the condition. Examples of chronic health conditions are diabetes, hypertension and heart condition.

The following will hopefully portray the nature of the difficulty and also demonstrate how success is possible when counselling is fully utilised.

Disease Concept of Addiction

In her preface to National Institute of Drug Abuse 2010 publication, Drugs Brains and Behaviour, Nora Volkov MD, Director of National Institute of Drug Abuse recalls that when science began to study addictive behaviour in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. We now know addiction is a disease that affects the brain (National Institute of Drug Abuse, 2010). While the ‘disease concept’ of addiction seems to confirm that the lead agents in its treatment should be medical, it is this disease concept which appears to most securely establish the role of counselling in its treatment.

To elaborate the point it is useful to present a definition of addiction issued by The American Society of Addiction Medicine (short version) (ASAM,Web 2011):

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours (Home Page).

Addiction is characterised by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one’s behaviours and interpersonal relationships and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (Home Page).

There are many elements of this rich definition which provide food for thought when considering the question of the role of counselling in the treatment of addiction. However I will highlight three elements; (i) that addiction is a ‘chronic disease’, (ii) that addiction is a ‘chronic brain disease’ and (iii) that addiction is characterised by a diminished recognition of significant problems of one’s behaviour and interpersonal relationships and dysfunctional emotional response.
he concludes, are seen to be physiological defects in the person. Considering addiction as a chronic condition and that the individual must be actively involved in the management of their addiction creates an opening for the inclusion of counselling in this process. The management of a chronic health condition such as diabetes also requires the active involvement of the person but counselling is not usually required to secure the person’s engagement as the organ affected is the pancreas. Once the person has the insight that their pancreas is dysfunctional in the production of insulin and the patient needs to assist its functioning, they are generally recruited to the enterprise of managing the diabetes.

In the case of addiction however it is the brain that is affected. The person’s identity is centrally bound up with the brain because, while the pancreas produces insulin, the brain produces our thoughts, feelings, instinctual motivations, decision making apparatus and other functions central to all that establishes us as an individual. (Hanson & Mendius, 2009).

**Addiction is a brain disease.**

ASAM (2011) states that in addiction vital brain functions are impaired; (a) reward circuits, (b) motivation and memory circuits and (c) the executive function of decision making. The reader is referred to the full text of this rich definition for the following observations.

Firstly, if drugs enhance reward function then drug using is preferred to other healthy behaviours (Koob & Moai, 2001). The person is therefore more motivated for drug use than for other activities which the brain also rewards. Such activities include those which ensure safety and security, maintenance of interpersonal relationships, stable accommodation, successful occupation or student career. As far as the brain knows the drug use satisfies these needs. Over time such altered priorities for drug use lead to a lifestyle that is unsuccessful, frustrating and characterised by agitation and negativity (Keane, 2014).

Secondly, the repeated engagement in drug use leads to neuroadaptation in the motivational circuitry which leads to further addictive drug use hence the individual is motivated towards further drug use. In other words, the positive reinforcement of the euphoria obtained from drug using and the negative reinforcement of the relief from negative emotional states conspire to reinforce the motivation for continued drug use. Additionally, memory circuits play a role in addiction as memories of previous drug use trigger cravings to resume use in their current situation (Koob & Moai, 2001).

Finally, the frontal cortex of the brain is charged with executive functioning. Therefore, it is the centre with the power to think, solve problems and make decisions and when it becomes affected by addiction the person’s decision making capacity is impaired. Examples of such impairment include powers of perception, learning and judgement being compromised as well as the ability to defer gratification as impulsivity is strong. Furthermore, the person can make many mistakes when it comes to deciding if it is a good decision to use drugs. The ability to choose to avoid using is compromised by the strength of the craving to continue using, the strength of the reward obtained from using, and the positive memory of previous use. Therefore the situation is out of the person’s control and it is not realistic to expect choices to be made according to conventional value hierarchies. Despite the negative consequences that inevitably come with impairment of executive functioning the person shows a low readiness to change (Koob & Moai, 2001).

**Addiction is characterised by a diminished recognition of significant problems with one’s behaviour and interpersonal relationships and a dysfunctional emotional response.**

As part of the treatment programme at Tabor Lodge clients are encouraged to learn about addiction and apply the learning to their own real-life situations. The ASAM definition in its long and short versions is used. The Diagnostic and Statistical Manual of the American Psychiatric Association Edition V is also used. From many clients undergoing the treatment programme the following reflections are possible.

The addicted person cannot see the reality of their situation. The shame, guilt, failure and suicidal tendencies associated with addiction are defended against by the person. They do not recognise significant problems as such. The dysfunctional emotional response causes them to minimise the extent of their difficulties and disadvantage. They may become detached from their difficulties by being overly intellectualising. It causes them also to disregard, diminish or explain away the problems in inter-personal relationships. Alternatively, the dysfunctional emotional response may cause them to exaggerate their difficulties resulting in their anger.
and aggression, blaming, resenting, or self-pitying and hopelessness.

They adapt to accommodate themselves to their diminished circumstances and to avoid being confronted by the difficulties addiction is causing. Accommodation may take the form of developing a false self which has an insistence that ‘all is well’. Addicted people may become avoidant and distant and lose real contact with meaningful others.

Clients often acknowledge that changes occur both in cognitive and affective functioning. For example, the person is preoccupied with drug use, has a distorted view of the benefits of using and can attribute unwanted consequences to other causes than the drug using. Emotionally there is increase in anxiety and sensitivity to stressors. Furthermore, the client comes to see that there can also be emotional overreaction and under reaction. This may include emotional responses which are inappropriate for the situation such as an aggressive reaction to a child making a mistake and spilling milk or at another time showing no reaction to an inability to pay an important household bill.

The client can become crisis prone. Failures and set backs are inevitable. Over time the addicted person burns their bridges and their social and personal support network is weakened. It is harder for them to bounce back. If the person is the parent in a family unit the impact on all the family is devastating, particularly on children. As the situation spirals out of control the person’s ability to cope with stressors is overwhelmed. The resulting sense of panic increases cravings to continue using. Drug using is the main coping strategy and so the person has nowhere to turn. Stressful situations mount and escalate. In response the person becomes more defensive. The person is unable or unwilling to take corrective action. The person’s self-deception is significant.

**The Role of Counselling**

My experience in the field has led me to believe that it is very difficult to separate the impact caused by the addiction from that caused by the contribution of the person themselves; it is as if there is no difference between the two. The person is an addicted person. I mentioned above how the person’s reward center is affected by substance use, the person’s motivation and incentive system is affected by the substance use, as is their executive functioning. It is my opinion that these functions of our brain are instinctive and unconscious; they are part and parcel of who we take ourselves to be. Hence our identity is intricately wrapped around these brain functions. Therefore, to reflect on the thinking, feeling, attitudes, beliefs, perceptual apparatus, judgement and choices that have all become affected by substance abuse is very challenging as it is almost impossible for the person to separate all that out from who they are in the first place. The education is difficult for the person because the syllabus is themselves and what their life and the lives of their loved ones has become as a result of not addressing their addiction. Additionally, the insight is illusive because the instrument of obtaining insight is the most affected. It’s like the eye seeing itself.

I would argue therefore that counselling is crucial to the person in order to succeed in managing the condition. It is within a trusting therapeutic relationship that the person can undertake the necessary reflection so they can see the reality of their situation as opposed to the distorted perspective noted above.

Counselling is needed because it is uncommon for the person to be capable of such insight without assistance. The person must firmly but gently confront him/herself about situations that are beyond their ability to see for themselves. Hence, the counsellor is particularly well positioned to assist the person with this task and to provide the necessary emotional support for such confrontations. My experience has highlighted how the honesty required to allow the full picture to emerge is often not easy to come by yet the detached but trusted counsellor can provide the ‘holding’ to allow this to happen. I have witnessed how the greater the accuracy in developing an awareness of the extent of the impact of addiction, the more motivated the person becomes to manage the condition successfully. The counsellor skilled in the art of listening and empathic response, who has understanding of the defense mechanisms of a person feeling trapped and overwhelmed, and who has the ability to maintain the person in positive regard is crucial to the success of this enterprise. (Mate, 2012)

The insight needed for the management of a chronic condition can be gradual. The contribution of the counsellor can be an indispensable part of the treatment process. Through the expertise in the caring support of an interpersonal relationship the addicted person can achieve enough distance from the catastrophe to see it clearly and to see that that is not all there is to them. The counsellor models in their interactions that there is no stigma, no judgement, no loss of essential value and goodness. The addicted person can begin to believe that recovery is possible.

**Conclusion**

In this article I have tried to
In my experience, concealed within this medical definition of addiction is the securing of the place for counselling in the management of this chronic health condition.

articulate the centrality of the role for counselling in the treatment of addiction. I have used the short and long version of the definition of addiction of the American Society of Addiction Medicine. In my experience, concealed within this medical definition of addiction is the securing of the place for counselling in the management of this chronic health condition. I have demonstrated that if we don’t see the chronicity of the disease we overlook the role of the addicted person in the management of the condition. The organ chiefly affected is the brain. Our brain is the organ where our drives, attitudes and beliefs are seated as well as our executive capacities such as thinking, motivations, deferring immediate gratification and decision making. As such its functioning is central to our identity.

I hope it is now clear that, in my experience, the addicted person is challenged with an intractable dilemma. Those seeking to successfully manage the condition need help. For the addicted person to succeed they need to get some distance from this identity to see its operations. When they can do so with care and empathy can play a significant role. From this support the addicted person sees the disease in action and the part they play in its dynamics. They can also see their part in neutralizing these dynamics so as to achieve full rehabilitation (TZU, 2014; Dupuy, 2013).

References


Mick Devine

Mick Devine MA, Advanced Dip in Coun., Diploma in Family Systems, MACI is Clinical Director of Tabor Group, an addiction treatment agency in Cork, Ireland. He qualified as a Counsellor from Manchester University in 1991 and established a counselling service in a secondary school setting where he was a teacher of English and Religion. He gained experience of addiction treatment at Preston Alcohol Information Centre. He began work as an addiction counsellor with Tabor Lodge in 1997 on his return to Ireland.

He was Administrator of the unit from 2000 to 2011 and, upon its amalgamation with Renewal and Fellowship House; he became clinical director of Tabor Group. He was a member of National Drug Rehabilitation Implementation Committee (NDRIC) from 2008 to 2012. He is a member of the Treatment and Rehabilitation Committee of the Southern Regional Drug and Alcohol Task Force since its inception in 2003 and was chair of this committee from 2003 to 2012. He represents Tabor Group on Addiction Treatment Centres of Ireland (ATCI) and is currently playing an active role in the consultation process of Ireland’s new Substance Misuse Strategy 2016 - 2020.

He is committed to psycho-spiritual development, his own and others, and is currently engaged in a teacher training programme with Ridhwan School. He also runs a small private counselling and training practice in Cork.
Practitioner Perspective

Mindfulness for Supervisors

Padraig O’Moráin

This article is a reflection on the contribution that mindfulness and the attitudes surrounding it can make to the supervisory relationship and to the well-being of the supervisor himself or herself.

Little or no research has been done on mindfulness in the supervisory relationship and this article, as it is not research-based, does not aim to fill that gap.

I will begin by discussing what mindfulness is; then I will outline ways to create and maintain a mindfulness practice; and then I will reflect on the question of the contribution of mindfulness to supervision.

What mindfulness is

This is worth dwelling on because the effort to define mindfulness can be of practical help in our mindfulness practice.

My definition of mindfulness is that it is the practice of returning deliberately to awareness of what is happening here and now and of cultivating an attitude of acceptance in our lives.

Jon Kabat-Zinn (1990) who probably did more than anybody else to bring about the current Western interest in mindfulness, writes that “Simply put, mindfulness is moment-to-moment awareness. It is cultivated by purposefully paying attention to things we ordinarily never give a moment’s thought to.” (p.2)

He adds later that “Mindfulness is cultivated by assuming the stance of an impartial witness to your own experience. To do this requires that you become aware of the constant stream of judging and reacting to the inner and outer experiences that we are all normally, caught up in, and learn to step back from.” (p. 33)

This is what is meant by his more frequently cited statement that mindfulness involves paying attention with a non-judgmental attitude. It isn’t a question of abandoning all efforts to assess and evaluate what’s going on; it’s more a question of not rushing to judgement and of not getting swept away by habitual reactions. Mindful awareness, for instance of our breathing, can give us the space in which to take that non-judgemental attitude.

This attitude leads into the practice of acceptance: “Acceptance as we are speaking of it simply means that you have come around to the willingness to see things as they are. This attitude sets the stage for acting appropriately in your life, no matter what is happening.” (p.39) (citation)

For instance, accepting that you have a drink problem doesn’t mean that you will abandon all restraint. Accepting that you have the problem leads on, sometimes sooner, sometimes later, to a

Quite often, more attention is given to present-moment awareness than to acceptance in the public discourse on mindfulness.
consideration of what you can do about it.

Christopher Germer (2005) writes that acceptance is an important aspect of therapeutic relationships. In his chapter in Mindfulness and Psychotherapy he says that empathy and positive regard “overlap with acceptance” (p.7). This, of course, will not come as news to the readers of Eisteach.

Quite often, more attention is given to present-moment awareness than to acceptance in the public discourse on mindfulness. That’s a pity. In my experience, acceptance is the other half of mindfulness and may be the better half.

In his important book “The heart of Buddhist meditation - a handbook of mental training based on the Buddhist way of mindfulness,” Nyanaponika Thera (1962) sees “bare attention” as providing the “key” (p.30) to mindfulness.

“Bare attention consists in a bare and exact registry of the object.” He notes that “this is not as easy a task as it may appear, since it is not what we normally do, except when engaged in disinterested investigation. Normally man is not concerned with disinterested knowledge of things as they truly are, but with handling and judging them from the viewpoint of his self-interest, which may be wider or narrower, noble or low.” (p.32)

“Bare attention first allows things to speak for themselves, without interruption by final verdicts pronounced too hastily.” (p. 35)

Nyanaponika Thera wrote in the Burmese Buddhist tradition which had a major influence on mindfulness as practised today in the West.

This approach could be seen as an intertwining of awareness and acceptance. Both, of course, are central to the work done in the counselling space and in supervision.

Mindfulness as an approach has been most highly developed in Buddhism which traces its origins back approximately 2,500 years. Most of the people who use mindfulness in the West today are not Buddhists. Jon Kabat-Zinn’s implementation of mindfulness almost 40 years ago to help people to change their relationship to pain and to stress - through his Mindfulness Based Stress Reduction courses - was entirely secular, though the practices were Buddhist practices or derived from them. Similarly, Professor Mark Williams’ work on mindfulness and depression and Dr Marsha Linehan’s use of mindfulness as a resource for people with Borderline Personality Disorder are secularised without spiritual or religious connotations.

Ways to cultivate mindfulness
At its simplest, mindfulness means being aware of what you are doing while you are doing it. This means being aware that you are breathing, walking, driving, running making a phone call, cooking a meal and so on. When you notice you have drifted off into thoughts, you bring yourself back to awareness of what is happening in the world outside your thoughts - to what you are physically doing, for instance.

This return to awareness is done with acceptance that people drift off again and again, so it is done gently.

Quick mindfulness practices
Here are three:

1. Get in touch with your senses. Notice the temperature of your skin. Notice that you are breathing in and out. Notice background sounds around you. Notice your breathing again. Every time your mind drifts as you are doing this - and it will - bring it back gently to the present moment.

2. Just notice your breathing. Just notice that you are breathing in and out. Notice the in-breathe and the out-breath. When thoughts come into your mind, return to your breathing. Do not get involved with them. Simply go back to noticing your breathing in and out.

3. Create mindfulness triggers. Pick some everyday things that you do routinely. Decide that whenever you do them you will be mindful and will be aware that you are doing them. Examples are: brushing your teeth, going up or down stairs or steps, arranging your desk or other workspace, tidying, washing up, taking a shower.

Some slightly longer mindfulness practices are:

Awareness of breathing. Sit still. Notice that you are breathing in and out. Notice the in-breath and the out-breath. If you are breathing through your nose, notice that the air is colder when entering your nose than when leaving. When thoughts come into your mind just let them float on by. Do not get involved with them. If you like you can just label your thoughts: when you get a thought, just say to yourself “thinking”. Then go back
to noticing your breathing in and out. If you like, you can count your breaths, counting from 1 to 7 and then back to 1 again. Do this for 3 to 20 minutes, once or twice a day.

**Awareness of walking.** Notice the feeling of the ground against your feet as you walk. Notice your breathing. When you drift into your imagination, bring your mind back to your walking. Be aware that you are walking, of the feel of walking and of your breathing. Do this for 3 to 20 minutes once or twice a day.

**All these practices are simple.** What you are doing with them is training yourself to return easily and often from mind wandering to the present moment and to do so with acceptance (in this case of the fact that your mind wanders a lot).

From the practices above choose what suits you best. Do mindfulness practice at set times during the day or as the opportunity arises. Prof Mark Williams suggests at least eight minutes a day which can be made up of shorter periods. One option is to do a brief practice between clients.

If you want to explore further mindfulness practices, you will find audios which you can download and use at no cost on my website www.padraigomorain.com under the “Audios” heading.

**Mindfulness and supervision**

Here are the effects, as I see them, of mindfulness practice on supervision where the supervisor has made mindfulness part of his or her life.

a) **The supervisor is fully present in the room.** In other words, the supervisor is better able to step out of preoccupations with whatever may have happened before the supervisee arrives. If you had a fight with somebody in a call centre before the session, a short mindfulness practice can orientate you towards the supervisee and not towards your newly acquired enemy in the call centre, at least for the length of the session.

b) **Mindfulness allows you to “park” the effects of previous sessions at least temporarily.** In other words it can enable you to meet the supervisee “anew” and without having the encounter coloured from the beginning by the emotional hangover, so speak, of previous sessions with this person. Of course, patterns are significant, have a tendency to re-occur and need to be attended to. But mindfulness, by enabling you to step out of the patterns for a little while, can make more room for the arrival of new issues and material in the session.

c) **You can bring a perspective of “beginner’s mind” to the session.** This Zen concept describes the capacity to look at things afresh without having your very perception clouded by what has gone before. What has gone before doesn’t just include what has happened between you and the supervisee; it also includes your own experience of similar cases to that which the supervisee is bringing to you. How you handled a similar case may be useful and informative but it is probably less important than how the supervisee has handled, is handling and will handle the case which he or she is bringing to supervision.

Because in mindfulness we tend to step out of patterns of thinking and rumination, we have a far better chance of approaching these cases with “beginner’s mind” when we are mindful. This doesn’t mean that we only apply “beginner’s mind” and leave our previous experience outside the door. It means we try on a “beginner’s mind” as part of our approach to the issue and mindfulness practice makes this much easier to do.

d) **It improves the chances of spotting countertransference at work in the supervisor/supervisee relationship.** If countertransference is a human trait than supervisors being, presumably, human share that trait. Who else is sitting in front of you invisibly beside this person? An earnest/rebellious student? A respected/dodgy colleague? Uncle? Aunt? Son? Daughter? The possibilities are, of course, endless but it is well to have some inkling of them, how they might be pushing the supervisory relationship in a particular direction, whether that is a helpful or unhelpful direction. Since countertransference appears to be largely unconscious as a dynamic, an inkling may be as good as we can hope to get.

But I believe that in fostering an ability to detach from habitual thinking, countertransference...
helps us to get a somewhat larger inkling than would otherwise be the case.

e) **Makes you aware of your goals for your supervisee and for the supervisee’s client.** Therapeutic relationships are fluid and hard to pin down and don’t usually run along neat parallel tracks. It’s fine to think that the supervisee’s client really ought to leave her husband. However, expressing that without mindful restraint could derail the therapy if the supervisee takes this as the required way to approach the matter with the client. You may feel that the supervisee really ought to lay down the law with a client who habitually arrives five minutes late and runs ten minutes over. But for all you know your insistence, if too strongly put, could end up demoralising the supervisee without necessarily solving the problem of time-keeping. What a more mindful approach does is to help you to see your goals for the supervisee’s work and to make a cool assessment as to the extent to which you should or should not promote them.

f) **Helps you to be compassionate and to temper that compassion where necessary.** Supervisees can suffer the same pangs of self-doubt as anybody else. Sometimes the self-doubt points to an issue the supervisee needs to deal with but often, in my experience, it is unjustified and may occur because the client is travelling more slowly than the therapist wants him or her to travel; because the client is obstructing the therapy, in the eyes of the therapist; or because the therapist generally brings an attitude of self-doubt to his or her interactions with the world. The mindful supervisor will recognise this and will help the supervisee to explore his or her self-doubt with compassion and in a way, that is more likely to be useful than simply denying or ignoring it. If the supervisee’s self-doubt is justified, then compassion needs to be tempered with the duty to help the supervisee to correct his or her approach. Mindful detachment can enable the supervisor to navigate these tricky waters.

g) **Cultivates self-compassion in the supervisor.** Supervisors, too, have a need for their own compassion, in other words for self-compassion. A supervisor may feel that he or she is not as good a therapist as the supervisee, may feel nervous about telling the supervisee something that he or she does not want to hear, may feel exasperated by the supervisee’s habitual responses and so on. In all of these, kindness towards the self can be a form of practical self-care for the supervisor. Mindfulness promotes both compassion and self-compassion. In this way it can help the supervisor to spot unjustifiable self-criticism or to treat oneself with kindness where the criticism has a grain of truth in it. Self-compassion is not only a question of being kind to oneself - as described by Dr Kristin Neff in Self-compassion (2011), it also involves recognising one’s common humanity. In this case, recognising common humanity involves acknowledging that other supervisors probably feel the same way from time to time. This breaks through the sense of isolation or being uniquely faulty.

**Conclusion**

The above are just some of the ways in which mindfulness can make an important contribution to the supervision relationship. Perhaps as importantly, mindfulness can contribute much to the well-being of the supervisor as a person. It is by adopting mindfulness practices and attitudes, such as those outlined here, that one can begin to experience those benefits.

**References**


**Padraig O’Morain**

Padraig O’Morain MIACP is the author of three books on mindfulness, Mindfulness on the Go, Mindfulness for Worriers and Light Mind. He teaches mindfulness in Ireland and the UK and presents the Therapeutic Use of Mindfulness course for the Irish Association for Counselling and Psychotherapy as well as a workshop on mindfulness for supervisors. He also contributes on mindfulness to the Master’s Degree in Pluralistic Counselling and Psychotherapy at the ICP. His daily mindfulness reminder, the Daily Bell, is received by approximately 10,000 people every day and is available free of charge via www.padraigomorain.com, as are other free mindfulness resources. He can be contacted at pomorain@yahoo.com
My personal experience of Grief and Loss and learning to live in the NOW.

Marian Staunton

I thought I knew what grief and loss felt like. From past experiences of death, knowledge gained, trainings and the privilege of being with others who were grieving, to date I knew I could empathise with others as they shared their thoughts and feelings. I knew and had felt before now, the different stages according to; Elizabeth Kubler Ross; of shock/numbness, sadness, depression, anger and acceptance. I felt confident and comfortable sitting with, listening to and accompanying clients as they journeyed their paths into, in and through their grief and loss experiences.

Then I received a phone call which was to change my life and the lives of everyone in my family. My brother not yet 60 had just received a diagnosis of a terminal illness; he had colon and advanced liver cancer. No option for surgery or chemotherapy—only a short time left. A remote possibility to participate in a trial drug and only if he were a suitable patient, which he did, giving him and all his family valuable time to live, grieve, accept, time together and to complete all he and we could complete before his physical life ended. Feelings of shock, numbness, fear, sadness, powerlessness, along with horror and disbelief erupted and swirled in my body and rushed to the surface, all at the same time, leaving me feeling overwhelmed.

Trying to comprehend that in a very short time my brother would no longer be in this realm was an enormity almost too great to bear. With acute awareness I watched his life’s energy ebb and flow from health to sickness over and over again until such time as the dreaded death itself became a reality. I witnessed my brother’s physical strength weaken and his body deteriorate and at the same time his inner spiritual strength develop and grow. The grief and loss stages became constant unwanted companions. I watched his failing health and his huge determination to live and at all times feeling the loss of whom I had known him to be. My view of life and the after-life changed many times as I travelled my journey through this time. My past experiences of death were of little comfort now as I witnessed my brother just one year older than me die a little more each day. I felt utterly powerless.

Day and night brought my emotions, feelings, thoughts swirling and crashing into each other— all vying for their own space. Words like no hope, too advanced, drugs, procedures, tests, and results very quickly became the new normal in every day vocabulary. Despite all this an overall feeling of hope was ever present and cushioned a stark reality that kept us all going. Being “in the moment” took on new meaning and gave a sense of power in an otherwise overwhelming situation.

Together we began to reflect on life, and the sharing of memories...
of our times together- when we played, laughed, disagreed, fought with each other, were in competition with each other, all became bitter sweet. Cramming as much of these times into each day along with visits, phone calls, texts, chats with him and other family members, when we travelled the length of the country to be with him was difficult but, I had much gratitude that I could do it. I truly valued the times when he was capable of interaction and response and when he was not able we sat with “presence and stillness”. Now I could be truly with me in the moment and without any effort. A treasured and privileged space in which I was storing memories that “has” to last a life-time. Journeying the four hours home after each hospital visit was often the most painful because the reality of how he was on that particular day could now be really felt and also a glimpse of the future I did not wish to see. His deteriorating health, his struggle to stay alive, his-physical pain, weight loss, at times not able to engage left me with a harsh reminder that the inevitable was going to happen. Nevertheless, I wished I could hold onto the now and that time would stand still. Denial, (another of the grief and loss stages according to Kubler Ross), served me well and was most welcome and had a very valuable place in my life. During these trying times my heart felt sore and heavy. Tears of deep sadness brought some relief. I witnessed my brother living and dying consciously, choosing how he wanted to live the last few months he would be on this earth and in so far as he could choose, how he was going to die. He rarely talked about his diagnoses or dying. His response when asked “how are you?”; was always the same, “sure what can I do – I’ll do what the doctors tell me and I could have dropped dead from a heart attack or be killed on the road”. He would then talk about life and living and remembering the past became part of all our conversations. Not sharing about how he felt and/or death definitely helped him to live and die in his own way. Kubler Ross states “that we all live, grieve and die in our own way”. Journeying and walking with “another” took on new meaning and staying present was all that was needed.

As I watched his enthusiasm in telling a story it was obvious that he enjoyed and got great satisfaction at recalling and remembering events in his life so far. Happy, funny, difficult and challenging and above all rewarding times – his view and experiences in life. I so so treasured those times together.

His dreams, projects, aspirations for the future now took precedence. He continued to plan for his family’s future, a future he knew he would not be here to experience. No time now for him to wait or have patience. This time he was in a hurry and it seemed his joy was in being able to share with them his wishes for when he would no longer be in this realm with them. Always a worker- a hunter gatherer, he planned and arranged turf for the following winter- organised the refurbishment of the range he would not see again but, it was sufficient now for the job to be completed. This was a huge change for him given that he had always been task orientated and would always see a job through to the end and then stand back and admire it. Now the planning for some-one else to do it was enough and he “was in the moment”. In this I am reminded of the stage of “chaos” according to “Kubler Ross and others” when thoughts feeling emotions are all experienced together with no acceptance of something that is very fearful. It is a time when powerlessness is truly felt and to engage in life and doing gives some sense of order and power. Next he decided to organise a really big project the replacement of the septic tank at his home. He had already thought about this job but, had been waiting for “good weather, longer and brighter days and a few weeks off work”. Now there could be no waiting and he organised and arranged this job from his hospital bed and in between tests and procedures. The project that normally would take a number of weeks maybe even months, was completed in record time. He had a purpose at a time when I have no doubt he often wondered about life and purpose. Through the seven months from diagnosis to his death he engaged in a crash course of guidance and advice for his two boys telling them, many things about his life, how to go forward with theirs and how to look after each other and their mam. During this time I and other family members who were present felt an overwhelming and deep sadness and an acute awareness of the reality of his limited physical time on this earth. Giving life and whatever energy he had to his plans seemed to bring comfort, satisfaction and fulfilment. Grief, loss, failing health, spiritual, profound, were all together in each moment. Straightening his affairs – the making of his will also became part of completing his life’s journey and creating closure, before he travelled on. For me, each day was welcomed as a new beginning and at night I felt a grief that we had one less day as sister and brother in this lifetime.

His refusal of certain pain relief medication which would leave him sleeping more and less conscious, was his daily choice and decision. He wanted to and did live his life to the full and up until his last day.
True to who he had always been there was work to do and he was completing his journey in his own way. His power to complete and leave in his own conscious time was comforting to witness despite my sadness and I had immense gratitude that I could spend more time connecting with him, before he slipped into unconsciousness and eventually coma. During those times I saw again the man and brother who lived life to the full and to the very end. At the same time I was living my own parallel journey of feelings, emotions and thoughts all taking on their own form and expression. I was letting go and experiencing all the stages of death before it happened. Life and death were now as one, with a new and most profound awareness, “that one is the opposite side of the other just as a coin has two opposite sides”.

A deep and real sense of spirituality surrounded and enveloped me and I could feel it within and without. Watching him fade away whilst, he was living life as fully as he could, brought comfort. His body dying and his soul fulfilling its purpose was sad, frightening, humbling, and a privilege to be part of. Mourning for the past, relishing in the present, longing to hold onto the now and fearing for the future we would not have together in this realm. This heightened awareness gave birth to an acceptance of “this is it” “the now” is all I and each one of us has. His grief and loss was for the death of his physical body, death of the future that up until now he thought he would have and most of all leaving his family. Mine was for my brother as I knew him. I was letting go of the healthy man and very soon I would also be letting go of the sick man, and letting go too of future family times together.

The ordinary everyday happenings and activities helped during this time. I had an acute awareness of everything. Sounds seemed louder, smells, taste, touch, were all heightened, lights were brighter, my work as a therapist became more meaningful and real. Love and support from family and friends felt supportive, comforting and wholesome and gave profound meaning to living and being in the now. I felt at a very deep level the meaning of living in the NOW. Awareness of my own limitations and energy levels had to be considered and right alongside this was a fear for my own mortality and of course the fragility of life.

I had thought I knew, and felt deep within my psyche, what it felt like, to be in the moment but, now I have been brought to new depths in my own being. All this brought me to trust and acceptance - trust in the process, trust in my journey; my brothers journey, in all our journeys - trust in the purpose of life, trust in the length of time each of us will have in the physical realm - trust in our souls journey. Trust became my new and close friend. My brother was just one year older than me. As he was slipping away from this life, this world, we all joined hands around his bed and included him in our conversation as we chatted about life, told jokes, laughed and cried together. It was only when he did not take his next breath that I knew he was gone - a beautiful death and a really spiritual time - one moment life and the next moment death.

Two years on I am still grieving, facing the many stages of grief, now that my brother has died. It has not been an easy time. It certainly is not the same as other losses which I have experienced throughout my life. Acute awareness of my own mortality surfaces often. The loss of my sibling has left me feeling, vulnerable, sad, questioning life and life’s meaning repeatedly. And in the midst of all my feelings, emotions and thoughts is, “a deep and heart felt loss for my sibling my brother”. I miss the ordinary things – the phone calls, the banter and healthy teasing, our times together around mine and his kitchen tables where we drank copious amounts of tea/coffee and one meal ran into the other. The day trips to a local town where we always bought something perhaps a jacket which he liked to wear especially when it was bought in our home county – a dress or piece of jewellery for me. Precious visits, times, fun and craic that can never be repeated now. A gift in his death for me is “to live life to its fullest”.

Before he died my greatest fear was that our connection to each other would be severed forever but, throughout the past two years of grieving I have also experienced a parallel process of “loss and at the same time connected”, connected in a way I had not felt during his life, and his to me, is our spiritual connection. My memories remain special and will last me my lifetime.

Marian Staunton works in private practice as a psychotherapist and supervisor in Castlebar Co Mayo. Having completed her training in 1998 Marian has continued to pursue various studies in her search for deeper meaning and in 2007 she completed her training in Holotropic Breathwork tm facilitation and Family Constellation facilitation in 2013. Her interest in trauma has led her to offering supervision and support to Rape Crisis Centres in Mayo and Sligo.

Accrediting bodies; IACP and PT UK.

Marian’s contact details; email address is; mmstatunton@yahoo.ie and tel no is 087 269 3025.
Thrive’ is a UK publication which highlights the double standard in treating psychological disturbance compared to physical illness. Layard & Clark, one an economist and the other a psychologist, provide copious evidence that many people do not receive help with psychological problems. Society still has trouble taking mental illness seriously in spite of its prevalence. For example, the World Health Organisation (WHO) has found that 40% of all illness in rich countries is mental, while cancer, stroke, heart disease, lung disease and diabetes together account for 20% of illness.

In advocating psychotherapy, the authors favour evidence-based therapies, and in particular refer to CBT, given the large body of empirical support which exists for CBT. The average cost of treatment, per client, of CBT in the UK is about €1,200, whereas the cost of untreated patients being on sick benefit, or losing their jobs is twice that amount. Obviously, human suffering is also reduced, and ‘Thrive’ points out that mental pain is as real as physical suffering. Indeed, both types of pain are experienced in the same regions of the brain; the anterior cingulate cortex and the anterior insula.

A discussion of the efficacy of therapy follows and the question regarding the effectiveness of anti-depressant treatment versus psychotherapy is addressed. The National Institute for Health and Care Excellence (NICE) is quoted as finding that only severe depression is ameliorated by medications. Consequently, only psychotherapy is recommended for mild and moderate depression. Nonetheless, an astonishing 8% of European adults are taking anti-depressants when most of them are not in the severe range.

Another interesting point made concerns whether it is the therapist or the therapeutic modality which effects successful treatment? Research has found that therapist training greatly determines the outcome, not the therapists’ personal qualities, e.g., empathic ability. In one study, the difference between therapists who had varying degrees of effectiveness was eliminated when they received a 3-day intensive CBT training following by 8 months of supervision. Another interesting fact is that patient choice of modality has an effect on outcomes. That is, given a choice of two types of effective therapy, clients will do better with the therapy they find more credible, than they will with the other equally effective therapy.

Finally, ‘Thrive’ looks at the underpinnings of mental illness taking into account the effects of work place-stress, parenting styles, parental relationships, and consumerism on our collective levels of happiness. This foray into the realm of positive psychology is quite broad and less measurable, but nonetheless addresses the substrate of mental health. It is noted that richer countries with lower levels of cooperation and higher levels of competition for position have higher rates of psychological problems. The pressure to be financially successful in very stressful work environments is, in fact, counter-productive to well-being.

In contrast, a study of the ‘100 Best Places to Work’ in the USA over 25 years found that share values of those companies were worth 50% more than a control sample. It seems that happy workers are even good for business! The fact that higher incomes does not necessarily increase well-being is highlighted by a UK finding, that family income per head has no effect on whether children are happy or not.

This book is a valuable tool in presenting the importance of psychotherapy and in advocating for greater availability of therapy. A strength of the book is that the material presented is itself well-grounded in research. This very readable book is a useful resource for therapists wishing to address doubts raised by clients about the efficacy of counselling, and also for students wishing to broaden their training to the socio-political realm.
Deborah M. Plummer is known for her work with children and adolescents. At present she is a writer, imagework practitioner and workshop facilitator. She also has an extensive experience as a senior lecturer at De Montford University in Leicester in the area of health psychology and counselling. Formerly she worked as a lead speech and language therapist within the NHS. Her many books focus on personal development, play, imagination and mindfulness to enhance emotional well-being of children and adolescents. The books offer resources to not only professionals who work with children and adolescents but also for parents.

In this book Plummer outlines her belief that “self-esteem is a complex, multi-faceted aspect of life; a primary component in the building and maintenance of physical, emotional and spiritual well-being” (p.13). She explores “Self-esteem” and brings in diverse theories and studies. Plummer explains how to gain a healthy self-esteem and the possible consequences of neglecting low self-esteem. She cites Virginia Satir when quoting: “Since the feeling of worth has been learned, it can be unlearned, and something new can be learned in its place. The possibility for this learning lasts from birth to death, so it is never too late. At any point in a person’s life he can begin to feel better about himself” (p.18). Plummer considers eight “foundation elements” that contribute to a good self-esteem, social and emotional well-being. These are: self-knowledge, self-awareness, self-acceptance, self and others, self-reliance, self-expression, self-confidence and beyond self.

The book is divided into two parts: theoretical and practical. In the theoretical part the author looks at Self-Esteem and Well-Being. She examines what happens with well-being if a person’s self-esteem is low and how learning and the process of change could be facilitated. It also includes “neuron nuggets” that provide the reader with information about different stages of the adolescent's brain development. The practical part consists of activities with guidelines on how to help young people distinguish what healthy and low self-esteem is. All the eight foundational elements are introduced and explored widely. Comprehensive and abundant exercises and activities are presented such as worksheets on “Working on Avoidances”, “Desensitization”, and “How I Normally Express Emotions”, to name a few. This part provides different tools that could be used while working with young clients with a variety of issues including building self-awareness, building self-acceptance, learning assertiveness, creative problem solving, setting and achieving goals and many more. Relaxation/visualisation and breathing exercises are contained in the Appendix. Given that the author has provided appropriate guidelines or the work-sheets these could be used in one to one counselling and group work.

I found Chapter Three relating to “Working with Imagery and the Imagination” very interesting as an introduction to Image-work. Imagework is explained as “developing the receptive ability to tune into the images that guide us, and the active ability to create new images that enhance our health, happiness, and creativity” (p. 30). Plummer believes that people who are firmly grounded in reality might greatly benefit from engaging with imagery and workings of the unconscious at the level of “make sense” without going into the depths. Personally I believe that section three called “Who am I?” was the most helpful. An additional advantage of this book is that many pages are intended for photocopying. Another aspect of the book that caught my attention were illustrations. Alice Harper pictured some of the emotions expressed on the faces of teens as well as variety of other things that are both supportive and refreshing while using the book.

Overall, for those who work with adolescents and young adults this book could be an excellent resource. For those not working in that field, reading this book could offer benefits through stimulating new ideas and perspectives or by possibly refreshing their current knowledge.

I am most grateful to the IACP allowing me to borrow this book. The review of this book has been a lengthy process but a most interesting and rewarding experience. Having read and reviewed this book I believe that the book offers practical interventions for therapeutic work and would be a great resource to store on your bookshelf.
Dear Members,

Spring is here and as usual at this time of year our thoughts and actions turn to the new and looking forward. At IACP there is a lot to look forward to in 2017 and we can do so with the confidence that our organisation goes from strength to strength and remains the largest accrediting member organisation for Counsellors and Psychotherapists in the country.

We have our new Head of National and Member Services, Ken and we will begin rolling out the Strategy 2017-2020, with many exciting developments during 2017 and in the years ahead. Our staff at Head Office are looking forward to the programme of activities that will support the 2017-2020 strategy and their enthusiasm and hard work is greatly appreciated. We can look forward to a fantastic two day Conference in Kilkenny on October 20th and 21st and a schedule of workshops nationwide that will provide both CPD and networking opportunities with colleagues, as well as our AGM on April 21st. Our Regional Committees are vamping up their activities and all the sub-committees of the Board are engaging in ongoing work and new developments. We can look forward to progress in relation to the regulation of the profession and enhanced collaboration with counselling and psychotherapy bodies nationally and internationally. And so we can all look forward to a busy and fruitful period of growth and development at IACP.

While Spring is the time for embracing change and looking ahead, I would like to take this opportunity to indulge in a little reflection as my tenure as Chair of the Board draws to close and to express my gratitude and joy at having held this position on behalf of you the Members for the past two years. It has been a privilege to have chaired the Board with my esteemed colleagues and to have worked with each of these dedicated individuals who created a fantastic team that in all respects made my position as Chair easy and for that I am grateful.

It was a further privilege to have represented you the Members of IACP on many occasions nationally and internationally. To have been afforded the opportunity to meet with so many IACP volunteers, whose professionalism and colligate approach to volunteerism for your Member Organisation is one of the most outstanding examples I have encountered in a professional organisation. To have been able to engage with new members, and those longstanding members who have been loyal to IACP for decades and whose breadth and depth of knowledge continues to contribute to our body of knowledge and professionalism. Thank you all for the work you do, the time you give, the clients you support and the difference you make. My hope springs from knowing that there are over 4,000 IACP Counsellors and Psychotherapists and the potential that can bring to individuals and communities in Ireland and beyond.

Moira Sharkey
Cathaoirleach
Dear Members,

The last 3 months have been very busy for myself and the team in Head Office. The approval by the Board of a new 2017-2020 Strategy at its last meeting is very important as it gives guidance and structure to our organisational development in the next period of time. We will be making available the Strategy document soon once final edits are made. Amongst the changes you will see soon is the reorganisation of our committee structures and the establishment over the next 9 months of 5 new sub committees of the Board (Professional Practice, Operations & HR, Finance & Risk Management, Development & Innovation and Member Care and Communication. More information will follow and there will be opportunities for members to serve on these new sub-committees of the Board.

We will soon be developing a new Member Care Policy which will focus on how we enhance our communications with members. So if you start getting phone calls from us asking how you are don’t be surprised. We are driving a number of new initiatives this year. We are establishing a Student & Pre-Accredited Member Forum and to start this we are holding 2 career information evening for Student and Pre-Accredited Members: in Limerick on 3rd March and in Dublin on 10th March. Online booking for these free events are on our website www.iacp.ie. We will be asking for volunteers to help us establish and steer the set up of this forum following these events.

Later this year we hope to establish a Professional Practice Forum to allow self-employed Counsellors and Psychotherapist to discuss their specific needs and training requirements. We would hope to run a number of business-related workshops and training in Autumn for those in professional practice. If you are interested in helping us establish and guide this process then please contact me at ken@iacp.ie or on 01 230 3536.

Another interesting development is the focus on member-interest groups. An example is the Gender and Sexual Equality Interest group being established by members of the Dublin Region. They will be having an initial meeting on Thursday 9th March in Head Office from 11.00 am until 1.00 pm. If you and a few other members are interested in establishing a special-interest group either nationally or in your region then please contact me and we can give you some guidance and assistance on how to progress your idea.

I have enjoyed meeting so many members at regional meetings over the past few months. There were nearly 100 people at the Dublin Regional AGM in January. Our AGM will be held in the Maldron Hotel Tallaght on Friday evening 21st April 2017. Registration at 6.30 pm for 7.00 pm start and followed by social evening. I look forward to meeting as many of you as possible at the AGM and other upcoming meetings.

I hope you are having a successful 2017.

Ken Germaine
Head of National & Member Services
Notice of Change of Date for AGM in April

Please note that the AGM has been changed to **Friday the 21st of April at 7pm in the Maldron Hotel Tallaght**. Refreshments will be served.

The IACP Board apologises for the change. A Notice to this effect has been sent to all members with full details.

Conference 2017

The Board of IACP is happy to announce that Conference 2017 will be held in the **Newpark Hotel, Kilkenny October 20th and 21st**.

The Conference team is currently working towards announcing the theme and speakers in the coming weeks.

Hope to see you there. Please Keep the Date.

Strategy Plan Agreement

Members of the Board are pictured with Head of National and Member Services following the signing off of the Strategy Plan 2017-2020.

Australian Opportunities for IACP

To start off the New Year and to look at possible liaisons with Australia, myself and Sheila Haskins, our Regional Director, met with the Australian Counselling Association’s, Industry Liaison Officer, Tom Parker while he was in Dublin.

We discussed the similarities between our two professional associations and what we can learn from each other. Their CEO, Philip Armstrong whom I have met at international conferences has also been very helpful to us. One of their most important achievements has been the placement of 1800 counsellors into full time employment within their health and education services. We will continue to follow up on possible areas for agreement which may assist some of our members who wish to relocate.

Eugene Mc Hugh, Vice Chair.

Taxing Matters

As your annual membership fee to IACP is necessary in order to allow you to practice your profession, the full amount paid is allowable as a tax deduction in your annual accounts. (Please see full article by Martin Ryan, CPA, CTax in Member Pages on our website).
The sixth Annual IACP Newly Accredited Members’ Social took place in Dublin on Friday 27th of January 2017.

The event was held to acknowledge and celebrate the achievement of the IACP Members who gained their accreditation in 2016. It was also an opportunity for First Time Accredited IACP Members to meet with each other, the IACP Staff, The Accreditation Committee and representatives of the Regional Committees and the Board of Directors, in an informal setting.

IACP Cathaoirleach Moira Sharkey and newly appointed Head of National and Member Services Dr Ken Germaine gave a warm welcome to over 60 attendees. Nicky Ryan from the Accreditation Committee congratulated all Newly Accredited Members on their recent accreditation, which was followed by welcoming the past Carl Berkeley Memorial Award Recipients and past Cathaoirleach and presenting them with custom made gifts to recognise their work and dedication to the profession of Counselling and Psychotherapy.

The past Carl Berkeley Memorial Award Recipients and past Cathaoirleach included: Ursula O’Farrell, Eoin Stephens, Dr Patricia Kennedy, Dr Damian Davy and the Family of late Vincent Humphreys.
### IACP Accreditations

#### First Time Accreditation

<table>
<thead>
<tr>
<th>Name</th>
<th>Location 1</th>
<th>Location 2</th>
<th>Location 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Trower</td>
<td>Dublin 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne Claire Noat</td>
<td>Dublin 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne Murphy</td>
<td>Co. Galway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne O’Doherty</td>
<td>Co. Cork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne Marie McQuaid</td>
<td>Co. Antrim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audrey Rabbitte</td>
<td>Dublin 24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbara Hanbridge</td>
<td>Co. Wicklow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bernie Collins</td>
<td>Dublin 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brid Fitzgerald</td>
<td>Co. Cork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cathy O’Toole</td>
<td>Co. Wicklow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colette Kelly</td>
<td>Co. Galway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conor Igoe</td>
<td>Dublin 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denise Byrne</td>
<td>Dublin 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dionne Caffrey Madden</td>
<td>Dublin 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eamonn Meaney</td>
<td>Co. Waterford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edel Mulligan</td>
<td>Dublin 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edmond D’Alton</td>
<td>Dublin 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elva Glynn</td>
<td>Co. Galway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiona Callinan</td>
<td>Co. Cork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgios Grigoriou</td>
<td>Dublin 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Izabela Garkowska Morris</td>
<td>Co. Wicklow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jennifer Gaynor</td>
<td>Dublin 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joan Murphy</td>
<td>Co. Cork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Moran</td>
<td>Co. Offaly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jonathan Byrne</td>
<td>Dublin 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Josephine Kelly</td>
<td>Co. Kildare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joyce Williams</td>
<td>Dublin 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joyrena O’Donoghue</td>
<td>Co. Kerry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathleen Forrestal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linda Bolger</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorraine Henchion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mairéad Leonard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marie McGeal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martina O’Donnell</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Mullins</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary O’Farrell</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Walsh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael O’Carroll</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michelle Keenan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Tomás Morley</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patricia Therkelsen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robert McKeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robert O’Malley</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandra Anderson</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandra Barry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah Cox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah Traynor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shauna Impy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sile Leech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinead McKiernan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stewart Geddes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sue O’Donnell</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susan Nevin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suzanne Joubert</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracy Barker</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Newly Accredited Supervisors

<table>
<thead>
<tr>
<th>Name</th>
<th>Location 1</th>
<th>Location 2</th>
<th>Location 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bernadette Carroll</td>
<td>Co. Offaly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eileen Judeth Mulcahy</td>
<td>Co. Louth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eugene McHugh</td>
<td>Co. Wicklow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gisela Cornelius</td>
<td>Co. Leitrim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isobel Mahon</td>
<td>Dublin 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jacqui Kehoe</td>
<td>Co. Wexford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathleen Savage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margaret Acton</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Beirne</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael Fitzgerald</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thady Walshe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### BACP Reciprocity

<table>
<thead>
<tr>
<th>Name</th>
<th>Location 1</th>
<th>Location 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Keaveney</td>
<td>Co. Roscommon</td>
<td></td>
</tr>
<tr>
<td>Mary Houlihan</td>
<td>Co. Limerick</td>
<td></td>
</tr>
<tr>
<td>Patricia Martin</td>
<td>Co. Wexford</td>
<td></td>
</tr>
</tbody>
</table>

The following error was noted under New Accredited Members in our Autumn issue of Éisteach.

James Logues, Co. Derry was spelt incorrectly and should read James Logue, Co. Derry.
Accredited Supervisors - Dates for Your Diary!!

Supervisor Forum Meetings 2017

Please note: Bookings for Supervisor Forums must be done online.
Format of the National Supervisors Forum to be confirmed.

Please book your place for Supervisor Forums at www.iacp.ie/events
Registrations from 9.30. (Tea/Coffee & Biscuits will be served from 9.45 a.m.)
CPD Certificates will be emailed to all participants after attendance at the Supervisor Forums.

Please refer to the IACP Web Page under “Events” for the updated list of all Supervisor Forums. This is updated weekly and all forthcoming Supervisor Forums will be listed thereon.

IACP presents Workshops (Full Details available at www.iacp.ie)

<table>
<thead>
<tr>
<th>COMMITTEE &amp; DATE</th>
<th>EVENT TITLE, PRESENTER &amp; LOCATION</th>
<th>TIME</th>
<th>PLACES</th>
<th>PRICE</th>
<th>IACP STUDENTS (£)</th>
<th>CPD HOURS</th>
<th>TRAINING LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MEMBER</td>
<td>NON-MEMBER</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IACP</td>
<td>STUDENTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STUDENTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NORTHERN IRELAND REGIONAL COMMITTEE</td>
<td>Network Evening (Open Forum) Maldron Hotel, Butcher Street, Derry, Nth Ireland Northern Regional Committee</td>
<td>19:30 - 21:30 Reg. 19:00</td>
<td>50</td>
<td>FREE IACP Members Only</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>SOUTHERN REGIONAL COMMITTEE</td>
<td>Network Evening Topic What is Jigwaw? Recovery Haven, Kilee Road, Tralee, Co. Kerry Jimmy Mulligan (Project Manager)</td>
<td>19:30 - 21:30 Reg. 19:20</td>
<td>50</td>
<td>FREE IACP Members Only</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Network Evening Topic: Pieta House: what we do; referral pathway, myths &amp; facts of self-harm &amp; suicide Vienna Woods Hotel, Glanmire, Cork Christophe Von Raesfeldt</td>
<td>19:30 - 21:30 Reg. 19:00</td>
<td>30</td>
<td>FREE IACP Members Only</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Organising the Healing Field: Practices &amp; Principles for Relational Trauma Practice Riverside Park Hotel, Macroom, Cork Rosie Burrows</td>
<td>10:00 - 16:30 Reg. 9:30</td>
<td>30</td>
<td>FREE IACP Members Only</td>
<td>-</td>
<td>-</td>
<td>6.5</td>
</tr>
<tr>
<td>MIDLANDS REGIONAL COMMITTEE</td>
<td>Holding the Golden Thread “Working with Trauma” Tuair Ard Arts Centre, Moate, Co. Westmeath Rosie Burrows</td>
<td>10:00 - 16:00 Reg. 9:30</td>
<td>30</td>
<td>FREE IACP Members Only</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Presence &amp; Present Moment (Integrating Mindfulness in Clinical Practice) Tuair Ard Arts Centre, Moate, Co. Westmeath Gerry Cunningham</td>
<td>10:00 - 16:30 Reg. 9:30</td>
<td>30</td>
<td>FREE IACP Members Only</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>WESTERN REGIONAL COMMITTEE</td>
<td>Two day Workshop - Anger Management Connacht Hotel, Old Dublin Road, Galway Dr. Fergus Heffernan</td>
<td>10:00 - 17:00 Reg. 9:30</td>
<td>40</td>
<td>€145</td>
<td>€200</td>
<td>€120</td>
<td>14</td>
</tr>
</tbody>
</table>
Take the Next Step in Your Career

PCI College is introducing a range of Masters and Postgraduate programmes aimed at helping you develop mastery and skill in a unique area of expertise, specific to the Irish market, while earning a Level 9 (NFQ) Masters Qualification validated by Middlesex University. The approaches presented are a blend of experiential learning, cutting-edge theory and evidence-based techniques, designed to enhance and expand your practice of Counselling and Psychotherapy.

- **MSc in Child & Adolescent Counselling & Psychotherapeutic Skills**  
  (Validated by Middlesex University) Gain specialist training in counselling & creative psychotherapeutic techniques for children and young adults under 21.

- **MSc in Addiction Counselling & Psychotherapy**  
  (Subject to validation by Middlesex University) Specialist training equipping you to work effectively in contemporary settings with individuals and families struggling with addiction.

- **MSc in Family Therapeutic Skills**  
  (Subject to validation by Middlesex University) Specialist training, providing the learner with knowledge, skills and expertise to work with Families, Couples and Individuals using Systemic Family therapeutic skills.

- **Advanced Diploma in Supervision**  
  (Validated by Middlesex University) For beginning or experienced supervisors who want formal training that meets the criteria of the IACP for accreditation.

Athlone - Belfast - Cork - Dublin - Kilkenny - Limerick

PCI College

Excellence & Innovation in Mental Health & Wellbeing

CELEBRATING 25 YEARS

1991/92 - 2016/17

01 4642268 • info@pcicollege.ie • www.pcicollege.ie

The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.
Suicide or Survive is leading the way with a range of powerful, innovative programmes designed to help both you and your clients reflect on your mental health, learn practical ways to improve your wellness and sustain good well-being on your life journey.

We offer the following programmes:

Breaking Stigma
Suicide Prevention
Mental Health Wellness
Recovery

Connecting For Life

Facebook
Twitter
LinkedIn

We offer the following programmes:

Wellness Workshop
A one day workshop for you to take time out and learn a wide range of practical tools and tips that you can use in your everyday life to improve your own wellness. Independently evaluated by Trinity College, Dublin.
“Simple practical tips, hope of recovery, meeting others and sharing ideas, very important to see mental health being openly discussed”

Eden Programme
Provide a safe space for people who have contemplated or attempted suicide. This is an educational programme with a therapeutic element that runs one day a week for 6 months and aims to help people move away from suicide as an option of choice in times of crisis. Independently evaluated by DCU.
“I experienced hope for the future, there is one”

WRAP - Wellness Recovery Action Plan
2½ day programme that helps you develop your own personally tailored Wellness Action Plan you can use on a day-to-day basis to manage your wellness and to restore it if you become unwell.
“This was an excellent programme with lots of information I can use each day”

Supporters Programme
2½ day programme for people who are supporting friends, family members, neighbours, colleagues who are struggling with their mental health. It teaches supporters practical skills they can use to support others, provides information on what supports are available and how they can be accessed, and teaches supporters how to look after their own mental health.
“All of the content was very relevant to where I am and my experiences of supporting my husband balanced with looking after myself”

t: 1890 577 577
www.suicideorsurvive.ie
www.wellnessworkshop.ie
info@suicideorsurvive.ie

As a charity seeking donations from the public Suicide or Survive complies with the Statement of Guiding Principles for Fundraising. In this regard we refer you to our Statement of Commitment and Donor Charter which are available on our website www.suicideorsurvive.ie or to obtain a hard copy you can phone us on 1890 577 577.

Dublin Rape Crisis Centre
Continuing Professional Development Training Programmes

Venue: DRCC, 70 Lr. Leeson St, Dublin 2 9.30am - 4.30pm

Childhood Sexual Abuse: Issues in the Therapeutic Process
Wed 10th and Thurs 11th May, and Wed 31st May and Thurs 1st June 2017
This practical in-service 4 day course is for those working as psychosynthesis counsellors or in a counselling role with adolescents and adults who have experienced childhood sexual abuse, rape, sexual assault and sexual harassment. The programme is designed to validate, enhance and develop the existing knowledge, understanding and skills of participants when working with these issues, and to allow those working in specialised areas, such as addiction, to feel equipped to deal with issues of sexual violence appropriately as they arise with their clients. The learning is relevant also to working with clients who have experienced other trauma.

Issues of Sexual Violence: the Counselling Process
This course will run for twelve days in six two day modules on Wednesdays and Thursdays from November 2017 to February 2018
This in-depth 12 day programme is provided for counsellors and psychotherapists and others providing in-depth support who wish to enhance their understanding and skills in working with clients who have experienced childhood sexual abuse, rape, sexual assault and sexual harassment. The programme is designed to validate, enhance and develop the existing knowledge, understanding and skills of participants when working with these issues, and to allow those working in specialised areas, such as addiction, to feel equipped to deal with issues of sexual violence appropriately as they arise with their clients. The learning is relevant also to working with clients who have experienced other trauma.

This training programme is informed by trauma therapy, attachment theory, neurobiology, mindful self-awareness, cognitive based approaches, sensorimotor psychotherapy, body centred psychotherapy and other theories and methodologies. It is a practical in-service training focused very much on the work with the client. There is a strong emphasis throughout the training on vicarious traumatisation and strategies for maintaining the psychotherapist’s own well being.

This programme is recognised for CPD purposes by the Irish Council for Psychotherapy

Comprehensive written handouts are provided with all DRCC training programmes to support the learning and to act as an ongoing resource.

Further information and application forms are available on our website www.drcc.ie or contact the Education & Training Department 6614911 etadmin@drcc.ie

DIPLOMA IN STRATEGIC HYPNOTHERAPY
with Hypnotherapy Business Academy

Flexible Weekend Based Diploma Courses held in University of Limerick | NUI Galway | DCU Dublin

Affordable Skills Building Taster Days March, April and May 2017

“Invaluable resource for working with clients in psychotherapy. Blends seamlessly with a wide range of issues. Excellent balance of theory and practice in a supportive and enjoyable learning environment.”

Liam Cannon, MA Supervisory Practice, IACP Accredited, HBA Diploma Past Graduate

ORDER THE FULL PROSPECTUS
Text or call 086 343 2992
www.resultsxo.com

The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.
2-Year Advanced Post-Qualifying Diploma in Gestalt Adolescent Psychotherapy

Commencing: September 2017
Course Director: Bronagh Stars MIAHIP
Guest Faculty: Mark McConville Ph.D.
Venue: Dublin, Ireland

Full course description and application forms are available by visiting our website www.dctc.ie or by contacting Dublin Counselling and Therapy Centre info@dctc.ie

The Irish Hospice Foundation in association with the Royal College of Surgeons in Ireland (September 2017 – March 2018)

Professional Certificate in Children and Loss (Level 9)

This training course is recommended for professionals who work with children or adolescents experiencing loss such as; teachers, chaplains, nurses, social workers, social care workers, psychologists, counsellors and others who work with bereaved children. It aims to equip practitioners with an informed understanding of loss and how best to support grieving children and adolescents. The training combines both didactic and experiential learning and covers topics such as; working with traumatic loss, loss in families, group work, and using the creative arts.

This part-time course meets monthly over a seven-month period. Closing date for receipt of completed applications is Friday, 5th May 2017.

Applicants must hold an honours primary degree. Consideration will be given to applicants without a primary degree who can demonstrate equivalent educational or work experience in a relevant area.

For further information or if you would like to be added to the mailing list for this course please contact:

Iris Murray
Irish Hospice Foundation
Morrison Chambers, 4th Floor, 32 Nassau Street, Dublin 2, D02 YE96.
Tel: 01 679 3188 Fax: 01 673 0040 Email: iris.murray@hospicefoundation.ie
Website: www.hospicefoundation.ie and www.bereaved.ie
www.rcsi.ie

Psychotherapist required for Referrals

At the Elmwood Centre for Counselling and Psychotherapy we have beautiful rooms available to rent to professional psychotherapy practitioners who are qualified, fully accredited and are members of professional bodies, such as IACP, IAHIP, ICP, PSI and FTAI.

Due to an increased demand for our services, we are currently looking for experienced professionals who might be interested in renting rooms from us and taking referrals.

We are interested in psychotherapists who provide individual and couples therapy in particular.

22 Upper Baggot Street, Dublin 4. T: 01 667 6928
E: info@elmwoodcentre.com www.elmwoodcentre.com

The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.
The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.
CERTIFICATE IN SUPERVISION
“Working at one remove” - using a Gestalt framework in supervision
An 18-month programme beginning September 2017

The programme teaches the Gestalt approach in supervision (clinical, coaching, organisational) and using experiential learning and theory.

- Year One: 10 tutor-led workshops
- Year Two: 6 x 3-hour sessions of supervision practice in small groups, 2 assessment practice tutorials and 1 one and a half-day assessment workshop.

GESTALT PRACTITIONER CERTIFICATE
Applying Gestalt theory, methodology and practice to your working context
A 2-year programme beginning in September 2018

Open to anyone working directly with people - not exclusively psychotherapists and counselors.

The learning is experiential through group participation.

- Year One focuses on working with individuals
- Year Two focuses on working with groups.

Faculty: Dr Seán Gaffney, Brid Keehan, Joëlle Gartner and Marie Query

For full details, dates, costs and application pack, contact
info@gestaltbelfast.org
or tel: 0044 (0) 7803169174 or 0044 (0) 07974683509
Also Gestalt Centre Belfast page on
Facebook and www.gestaltbelfast.org

The Novara Centre
HEALTH & WELLBEING

Professional Space Available
The Novara Centre, Bray, Co. Wicklow

Professional Space available to rent for suitably qualified and experienced Psychotherapists, Psychologists and Relationship / Family Therapists.

The Novara Centre is located in a beautifully restored, well maintained, light filled, Victorian building on Bray’s sea-front.

It enjoys being close to the promenade with sea-views, the DART and affordable parking as well as numerous coffee shops and eateries.

The Novara Centre provides a multi-disciplinary environment and professional setting, currently having three strands of practitioners who use the space:

- Therapists/ Coaches; Integrated Health Practitioners and Class Teachers of Mindfulness, Yoga and Pilates etc.

Please contact: info@thenovaracentre.ie
www.thenovaracentre.ie / phone 01 276 1745

The Healing Road
Psychotherapy Clinic
1 Flood Street, Galway, Ireland H91 H21W +353 91 566 712

Harvey R. Wasserman, BSc MD, Psychotherapist
www.harveywasserman.ie harveybear2@me.com

Advanced Neuroplastic Psychotherapy Workshops 2017
11 Feb, 11 Mar, 8 Apr, 13 May, 10 June, 8 July
€35 per workshop. Limit 20 participants

The second Saturday of each month starting 11 February, I will be doing a workshop from 10 am to 4 pm, at my office, limited strictly to 20 participants.

These workshops are appropriate for anyone in any field of healing and helping human beings. A few people who are passionately interested in their own development will enrich the therapeutic atmosphere, even if they are not professionals in a healing field.

The cost of attending is €35

Reservations are being taken through Eventbrite.

https://www.eventbrite.ie/e/advanced-neuroplastic-psychotherapy-workshop-tickets-30561540390?ref=elink
The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.

Co-dependency, Narcissism and Addiction – What’s the Link?

“Co-dependency as a condition is often misunderstood - and its crucial link with narcissism and addiction missed by many helping professionals. As 95% of clients are affected, this is a detrimental loss.

However, experience shows that when the co-dependent realises how co-dependency, narcissism and addiction feed into each other, they then fully understand how to take their power back! Our job as helping professionals is to help them see that.

Through my work I have developed a helpful model that addresses this triad and it is my client’s experience (young and old) that the model works. Now, your clients can benefit too!”

- Margaret Parkes

Programme Outline:
This intensive and experiential programme is based around a therapeutic model for working with co-dependent adults and young people who come from an emotionally abusive and neglectful family of origin. It also highlights how co-dependency can be central to many addictions. Being goal focused, this model encourages the helping professional to take an interactive role - (check www.margaretparkes.ie for more information).

Facilitator:
Margaret Parkes (Dip. Psych., BA, MSc.) has practiced as a psychotherapist and systemic practitioner for over 15 years. She is a qualified and experienced facilitator and has experienced significant success with this model.

Course Dates and Times:
Cork 30th & 31st March 2017 Vienna Woods Hotel, Glanmire, Cork
Tralee 6th & 7th April 2017 Manor West Hotel, Tralee
Galway 4th & 5th May 2017 Connacht Hotel, Dublin Road, Galway
Dublin 11th & 12th May 2017 Louis Fitzgerald Hotel, Naas Road, Exit 1A. Dublin

Time: 10.00am – 5.00pm each day
Course Fee: €195 Early bird: €180
Booking:
Email: margaretparkes@eircom.net or Website margaretparkes.ie/index.php/courses

Gottman Method Couples Therapy Training
...is coming to Ireland in 2017

Presented Live by Master Trainers in Gottman Method Therapy

Level 1: Bridging the Couples chasm  
Level 2: Assessment, Intervention and Co-Morbidities
Level 3: Practicum Training

Trainings will be offered in May and November. Complete 1, 2 or all 3 levels in 1 year.

..or attend THE ART AND SCIENCE OF LOVE
a weekend Gottman workshop for couples.

This workshop produces positive results for 86% of couples attending based on exit surveys. See Gottman.com for more information **

CONTACT:
SINEAD@EASTBAYRELATIONSHIPCENTER.COM
for more information and registration details

www.eastbayrelationshipcenter.com
Practice Development Workshops

Establishing & Growing
A Thriving Therapy Practice
Are you starting out as a therapist?
Are you thinking of starting your own practice?
Are you already in practice but stuck in a rut?

6 Day Practice Development Workshop Series
6 Saturdays from 11 March 2017
Each module covers a different aspect of self-employed therapy practice, what you need to know and do, and the resistance that gets in the way.

Venue: Dun Laoghaire, Dublin
Cost: €625 (Payment options)

Presenters:
Jude Fay, Psychotherapist, author “This Business of Therapy”
Monica Haughey, Psychotherapist and Supervisor

Further details:
Web: http://monicahaughey.com
Phone: Monica on 086 6061015
Email: jude.fay@thisbusinessoftherapy.com

BODY PSYCHOTHERAPY COURSE
6-day training in how to read and work with the body in psychotherapy, covering:
* The Body and Attachment
* The Body and Character Structures
* The Body and Trauma
* Reading the Body
* The Body and Awareness: Mindfulness and Focusing
* The Body and Expression: Gestalt and Psychodrama
* The Body and Shame

For enquiries or bookings call
Thomas Larkin MA, MIAHIP
on 085 7283697, or see
www.thomaslarkin.ie

Time: 9.30am - 4.30pm Cost: €550
Venue: Oscailt, 8 Pembroke Road, Dublin 4.

DIPLOMA IN COUNSELLOR SUPERVISION

with Vicky McEvoy, Andrea Wigglesworth & Viv Murtagh

Venue: Firststown Castle Hotel, Lucan DUBLIN
Dates: 23rd - 26th August 2017 - Cyclical Model
20th - 21st October - Process Model
17th and 18th November - Group Supervision
2nd and 3rd Feb 2018 Creative Techniques, 11th and 12th May Practice issues

Cost: €1,500 paid in instalments
100 hours (designed to meet IACP standards)
Application form: www.vitalconnexions.net
Call Vicky 086 2790252

Introduction to Holistic Counselling and Psychotherapy
Venues – Athlone & Galway – Spring 2017

Personal Development Course – 10 Weeks
Venues – Athlone & Galway – Spring 2017

B.A. in Holistic Counselling and Psychotherapy
Venues – Athlone and Galway – September 2017

Inner Child Workshop
Venue – Athlone – May 27th 2017
Booking is essential

Working with Clients with Suicidal Ideation and Self-Harm
Venue – Athlone – Spring 2017

A Range of Short Online (CPD) Courses

ICPPD
A College with a Difference!
Athlone – Belfast – Dublin – Galway – Wexford

Visit www.icppd.com
Tel: 0906470484 Email: info@icppd.com

36
The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.
Positive Neuroplasticity: Hardwiring Happiness

Join New York Times bestselling author Rick Hanson for a deep experiential exploration of lasting positive brain change – the essence of self-reliance and lasting inner strength and peace in a topsy-turvy world.

Positive Neuroplasticity Training:
Hardwiring Happiness into Your Life
6 – 8 June 2017

Take charge of the structure-building processes of your own brain – hardwire happiness into your life!
Learn in the Positive Neuroplasticity Training how to turn your experiences into lasting inner strengths, be kinder to yourself, let go of anxiety, frustration, and resentment, build resilience and self-worth, heal old wounds, and refuel and nourish yourself each day.

20% Early bird ends 31.3.2017  € 405
Full price  € 506

Professional Training Course:
Practical Applications for Hardwiring Happiness
6 – 11 June 2017

The Professional Training Course includes the Positive Neuroplasticity Training plus practical applications for hardwiring happiness into your professional and private life. Deepen your practice and help others change their brains for the better. The professional course is perfect for those who are working with others: therapists, doctors, nurses, human resources trainers, coaches, educators, and mindfulness teachers – as well as parents!

Learn how to explain the science, teach the methods, use practical tools to change habits and build motivation, and help people with stress, loss, relationship issues, and trauma.

20% Early bird ends 31.3.2017  € 842
Full price  € 1,053

Avail of Early Bird offer - Ends 31 March 2017

For more information & to book go to RickHansoninIreland.org or search for Rick Hanson on Eventbrite

SENSORIMOTOR PSYCHOTHERAPY INSTITUTE®

Professional Training in Somatic Psychology

Level I: Affect Dysregulation, Survival Defenses, and Traumatic Memory 2017

Course Description
Level I of The Sensorimotor Psychotherapy™ Training Program in Affect Regulation, Attachment, and Trauma equips therapists to better understand the symptoms and issues related to trauma and traumatic attachment and to work with them in a more effective way. With a neurobiological understanding of the presenting problems of these clients and equipped with interventions that speak directly to how the issues are driven by the body and the nervous system, students will be able to work with clients with a range of challenges from stabilization to resolution and integration.

The Level I Training presents simple, body-oriented interventions for tracking, naming, and safely exploring trauma-related, somatic activation, creating new competencies and restoring a somatic sense of self. Students will learn effective, accessible interventions for identifying and working with disruptive somatic patterns, disturbed cognitive and emotional processing, and the fragmented sense of self experienced by so many traumatized individuals. Techniques are taught within a phase-oriented treatment approach, focusing first on stabilization and symptom reduction. Sensorimotor Psychotherapy can be easily and effectively integrated into psychodynamic, cognitive-behavioral, and EMDR-focused treatments.

This Training consists of approximately 80 contact hours.

Training Dates:

Times: TBC
Location: Ashe House, Corduff, Lusk, Co. Dublin
Trainers: Christina Dickinson, CAC, II, Anthony Buckley
Venue: subject to change depending on enrollment.

Tuition: 2,700 EUR. A non-refundable registration fee of 20.00 EUR. A deposit of 400.00 EUR is due to hold your place in the training.

Local Contact: Anne M Kirwan, 00 353 (0) 87 205 524
info@ashehouse.ie www.ashehouse.ie

Contact: SPI Student Services, studentservices@sensorimotor.org
www.sensorimotorpsychotherapy.org
**CHILD & ADOLESCENT PSYCHOTHERAPY**

Postgraduate Diploma Play Therapy  
Fully Accredited and Academically Validated

MA Creative Psychotherapy  
Ireland’s ONLY Complete Play Therapy & Psychotherapy Training  
(Level 9 NQAI) QQI Awards

**Therapeutic Play Skills Certificate** (Level 6, QQI)  
Kerry, Limerick, Claremorris, Mountmellick, Galway, Dublin, Donegal

**Principles of Art Therapy Certificate**  
Validated 1 year course, Level 8, Dublin €1450  
CTC and CIT Crawford College of Art & Design

Adlerian Play Therapy and Family Play Therapy with Terry Kottman 10th – 13th April 2017

A Playful Dance through Neuro-Dramatic-Play and EPR  
Final opportunity for training with Dr Sue Jennings  
26th June 2017 – Dr Jennings’ retires this year. This is her last stand alone training in Ireland. Don’t miss it!

**CPD Courses**  
- Responding Therapeutically to Child Sexual Abuse 13th – 17th Mar 17  
- BASIC Ph Model of Resiliency & Coping (Dr Mooli Lahad) 20th -21st Apr  
- Legal Issues for Psychotherapists and Play Therapists 22nd April (Leixlip)  
- Play Therapy Techniques (Limerick) 12th May 17  
- Creative Therapy with Adolescents & Adults 9th – 13th Oct 17

www.childrenstherapycentre.ie  
childrenstherapycentre@gmail.com  
Phone: 087 6488149

QTI Awards  
International Recognition  
APT Approved Provider 11-294

---

**Reading Group**

Are you interested in reading Psychoanalytic Texts to facilitate a deeper understanding of Psychodynamic theory and practice?

<table>
<thead>
<tr>
<th>Time</th>
<th>Venue</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every Tuesday</td>
<td>City Centre</td>
<td>1 hour meeting, small groups of 5/6, open to pre-accredited and fully accredited therapists.</td>
</tr>
</tbody>
</table>

Contact: cathy_os@hotmail.com for further enquiries

---

**Advertise with Éisteach**

2017 Advertising Rates  
(unchanged since 2005)

<table>
<thead>
<tr>
<th>Format</th>
<th>BLACK/WHITE Price</th>
<th>COLOUR Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Page</td>
<td>€600</td>
<td>€720</td>
</tr>
<tr>
<td>Half Page</td>
<td>€360</td>
<td>€480</td>
</tr>
<tr>
<td>Quarter Page</td>
<td>€240</td>
<td>€360</td>
</tr>
<tr>
<td>Eighth Page</td>
<td>€120</td>
<td>€180</td>
</tr>
</tbody>
</table>

**FLYERS Price**  
(supplied by advertiser) €720

All prices are exclusive of VAT @ 23%

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

---

**Working therapeutically with children requires special skills!**

In many cases children with emotional, behaviour and mental health problems can’t or don’t want to talk about them. Extensive research, based on over 111,000 sessions, shows that, when children are given a choice, only 7% of the time is spent talking.

**An alternative to talking therapies is needed - extend your range.**

**Become a Registered Certified Practitioner in Therapeutic Play Skills and then a Registered Play Therapist**

Registration is very important. The Play Therapy UK Accredited Register of Play and Creative Arts Therapists fully meets the standards of the Professional Standards Authority. Join the many Play Therapy Ireland practitioners, who are already included in this Register, it will add to your credibility with clients and employers. www.playtherapyregister.org.uk

The APAC courses are the only ones to meet the Register standards. Run at Marino College, Dublin, Ennismore Retreat Cork, each with two intakes a year and at a Summer School in Galway. Academic awards by NUI Galway. Professional certification by Play Therapy UK, on behalf of Play Therapy Ireland.

**PG Certificate in Therapeutic Play Skills: Cork: 12th May 2017,**  
**Summer School 2017 Galway:** 4th July - 1-day Introduction  
**Dublin 22nd April 2017**

Full 28 page course brochure and application forms from: Dee Rose  
Administrator  
APAC - The Coach House - Belmont Road – Uckfield - TN22 1BP  
UK +44 (0)1825 761143  
email: mokjiep@aol.com  
www.playtherapy.ie  
www.playtherapy.org.uk

See how we work with children - regular One-day Introduction to Play Therapy courses.
Fri 5th May – Sat 6th May 2017
Marymount University Hospital & Hospice, Cork
€150 (incl lunch & refreshments)

RESEARCH:
FRIEND NOT FOE!

KEYNOTE SPEAKER:
PROFESSOR MICK COOPER

Book at conference@corkcounsellingservices.ie or visit www.corkcounsellingservices.ie today. This conference is run in conjunction with Coventry University.

The appearance of an advertisement in this publication does not necessarily indicate approval by the IACP for the product or service advertised.
WORKING WITH THE FRAGMENTED SELVES OF TRAUMA SURVIVORS: OVERCOMING SELF-ALIENATION

JANINA FISHER, PHD

23–24 JUNE 2017

ASHLING HOTEL, PARKGATE STREET, DUBLIN 8, IRELAND

BOOK YOUR TICKETS AT: WWW.PCPSI.IE/SHOP  E: LIAM@PCPSI.IE  M: 087 1091195