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‘Merely existing’: A personal reflection of living with anorexia and the journey towards recovery

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Our Title
In Spring 2017, our title changed from "Éisteach" to "The Irish Journal of Counselling and Psychotherapy" or "IJCP" for short.

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From the Editor:

Dear Colleagues,

Welcome to the Spring 2025 edition of the *Irish Journal of Counselling and Psychotherapy (IJCP)*. Springtime brings with it a sense of renewal and growth. It is also a time when many turn their thoughts to new goals, particularly around health, diet, and exercise, with these themes frequently presenting in our therapy rooms. This edition's focus on body image feels especially relevant as we navigate these conversations with our clients.

Research suggests that body image distress is increasing, with factors such as social media use potentially playing a significant role. As therapists, we are likely to encounter this growing trend in our work, and, with Eating Disorders Awareness Week 2025 taking place from February 24 to March 2, this feels like an opportune time to reflect on how we can deepen our understanding of these issues and enhance our practice.

Our first piece is by Mary Rea, who shares her deeply moving story of recovery from anorexia, and how it has shaped her work as a therapist. It seems fitting to begin with this personal account, especially with the theme of Eating Disorders Awareness Week being *"All Stories Matter"*. Mary's journey of breaking free from the grip of anorexia to find healing and hope is both powerful and inspiring.

Next, we hear from Emma Murphy, an eating disorders specialist, who shares her perspective on the implications of classifying obesity as a disease. Emma examines how the medicalisation of weight can affect clients, particularly in terms of weight stigma, mental health, and treatment options. She also explores how therapists can create a supportive space for clients dealing with these issues, while empowering them to advocate for their needs in medical settings.

Our third article comes from Grace Harrison and Cristina Galvin, who co-developed an innovative eating disorder recovery group programme for college students at the University of Galway. They discuss the background to the programme and share valuable participant feedback, offering insights that can deepen our understanding of what clients may find helpful or less helpful when working with eating disorders and body image issues.

In our fourth featured article, Mou Sultana explores body image and body dissatisfaction during the perinatal period, from pre-conception through to several years after birth. She discusses both the theoretical and clinical considerations for therapists working with clients navigating the transition to motherhood, with a particular focus on body image. Mou also introduces her integrative perinatal counselling framework, "The Becoming Model", offering a practical approach for therapists supporting clients through this transformative life stage.

The final article is by Susi Lodola, who shines a much-needed light on body image among midlife and older women – a population often overlooked in discussions around body image, yet one that experiences significant change in body shape and function. In addition to exploring the relevant literature, Susi provides a range of practical, evidence-based interventions to support therapists working with midlife and older women facing body dissatisfaction.

While this edition explores body image across different life stages, one notable gap is the absence of research on body image in men. Unfortunately, no submissions were received on this topic, reflecting a broader trend where male body image concerns remain under-researched and often less visible in clinical discussions. However, with body dissatisfaction increasingly affecting men, this remains an important area for further exploration.

I would like to extend my thanks to everyone who contributed to this Spring 2025 edition. The *IJCP* and the research it publishes are invaluable resources for IACP members and the wider counselling and psychotherapy profession. If you would like to contribute to the *IJCP*, please consider submitting an article for review, or, for those with strong writing and editing skills, apply to join our Editorial Committee. Contact iacpjournal@iacp.ie for more information.

Jayne Leonard (MIACP), Editor
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We encourage you to consider writing for the IJCP – email iacpjournal@iacp.ie for author guidelines. We look forward to hearing from you in the future.

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Practitioner Perspective

‘Merely existing’: A personal reflection of living with anorexia and the journey towards recovery

By Mary Rea

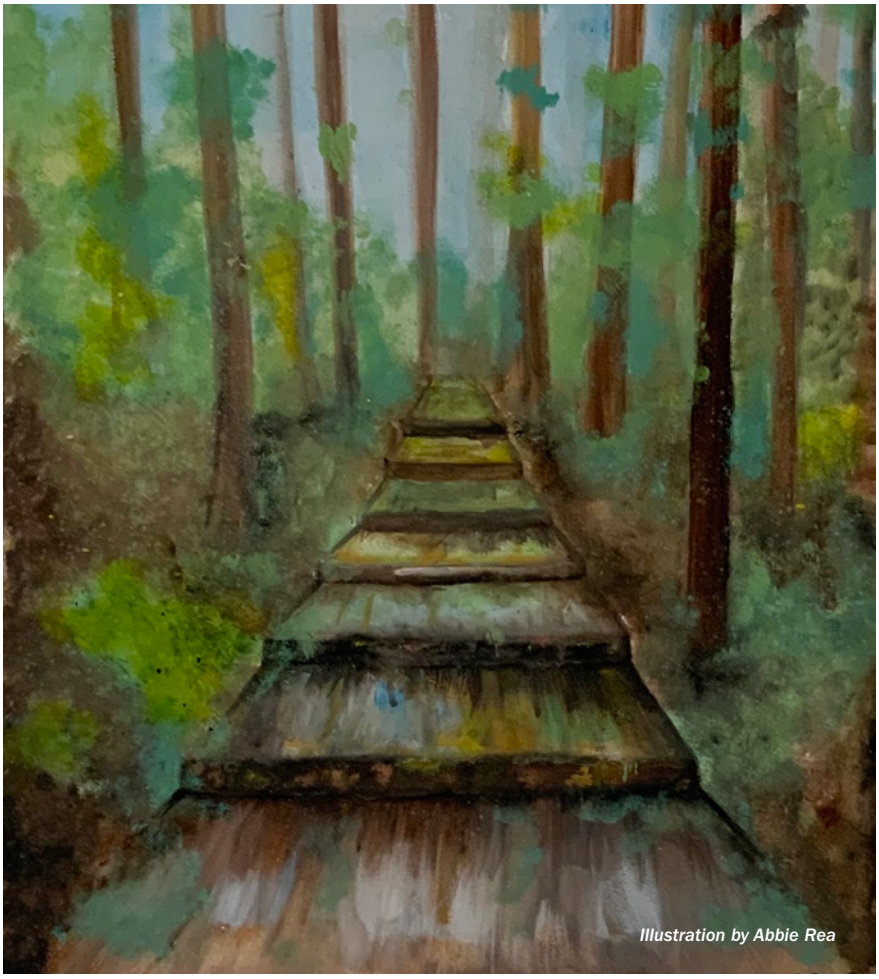

Illustration by Abbie Rea

Anorexia is a complex mental health disorder, intertwined with identity, emotions, and self-worth. This reflection explores the profound impact of anorexia nervosa on my therapeutic approach, shaping how I work with clients experiencing eating disorders. It highlights the disorder’s depth beyond food restriction and the pursuit of thinness

Introduction

In this article, I share my lived experience of having and recovering from anorexia nervosa, framed within a historical, societal, and cultural context. It has taken many years to overcome the shame, stigma, and self-blame attached to this illness, but perhaps my story can foster understanding and support for others who may be facing similar challenges.

Anorexia nervosa is recognised in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) as a severe psychiatric disorder characterised by persistent restrictive food intake, severe emaciation, and a perception of being overweight despite a dangerously low body weight. The mortality rate in anorexia nervosa is one of the highest of all mental health disorders, with an elevated risk of suicide, and complications as a result of prolonged starvation, as reported by the World Health Organisation (WHO, 2021). The causes of anorexia nervosa are multifactorial, and include biological, behavioural, psychological, and sociocultural influences.

Seubert and Virdi (2019) explain that early life adversities can significantly affect the brain. Chronic stress, gene expression, and early attachment experiences

all play a role in increasing the risk of developing various psychiatric disorders, including eating disorders (Connan, 2003). Bowlby's attachment theory, as explored by Gander et al. (2015), highlights the roles of family characteristics, interpersonal functioning, and emotional regulation. These factors can influence adolescent development and potentially contribute to the onset of eating disorders.

The Health Service Executive's (HSE, 2018) National Clinical Programme for Eating Disorders – a collaboration between the HSE, the College of Psychiatrists of Ireland, and BodyWhys (the Eating Disorders Association of Ireland) – outlines a treatment protocol for anorexia nervosa. This protocol involves a multidisciplinary team led by a psychiatrist, and includes a GP, a dietician, and a family-based therapist. However, it can take 12-18 months to establish a multidisciplinary team (McWilliams, 2024). Accessing treatment is further complicated due to the overwhelming increase in eating disorders, which now account for the highest number of admissions of those under 18, alongside depressive disorders, signalling a 43% increase in the last five years (Daly et al., 2024).

Unfortunately, many people are left untreated due to extremely long waiting lists and overstretched medical resources. Stigma also remains a barrier to seeking help, with misconceptions about anorexia nervosa being self-inflicted, as noted in research by Roehrig and McLean (2009), and supported by a scoping review study by Brelet et al., (2021).

My journey

In my late teens, I was completely unaware that what seemed like a simple decision to "lose a few pounds and get fit" could

As I was getting thinner, my world was getting smaller until it reduced to a narrative of fear and deprivation

have such devastating and profound consequences, not just personally, but also for my family and friends in the years that followed. The psychological underpinnings of my eating disorder can be traced back to the untimely death of my father when I was 13. It was almost impossible to comprehend his loss; a figure who represented unconditional love, support and stability, as well as fun, wit, and humour. My father had always been my primary caregiver due to my mother's long periods in hospital following an accident when I was a child. When he died, my world was thrown into disarray; the foundation of my identity shattered, leaving a void that was filled with overwhelming grief. The rural farming community gathered around in shock and support, but it was in an era where children were seen and not heard. I grieved in silence. My mother was heartbroken and worked extremely hard following his passing. Whilst I certainly did my share on the farm, her exhaustion and stoic nature left no time for emotional support.

Already thinking that life was at rock bottom, I was soon to discover that "rock bottom had a basement". I learned that a sexual predator could hide amongst the crowd. This violation shattered my already fragile sense of self-worth and self-esteem and compounded my feelings of hopelessness and vulnerability. I had been reduced to a state of profound shame, fear, and revulsion. My trust was broken. Nowhere was safe. Once again, I suffered in silence.

Looking through the lens of my life,
Lost in a fog, numb as a stone
It felt wet and cold, wandering confused and alone
What's happening? What have I seen?
It shouldn't be this hard, I was only fifteen
'There has to be a way out', an inner voice said
Is this what it feels like to be dead…?
The pain hurt so bad,
I didn't feel the abuse
No one would believe me
So what was the use
Aching inside, but I smile all the way,
Tomorrow may be a better day…

(My 15-year-old self).

Anorexia's entrance

An opportunity to live in London presented itself during my late teens, which I seized with both hands. A fresh start, although nerve-wracking, promised excitement and freedom. On the positive side, new friendships provided a multicultural, social dimension to my life and ignited a passion for exploring and experiencing cultural differences. However, London also provided a paradoxical experience of both acceptance and insecurity which surfaced from the depths of my being. I soon realised that past trauma had taken up internal residence. Anxiety, shame, and self-disgust lurked within, accompanied by feelings of inadequacy that were ready to raise their ugly heads at any given moment.

Society's pervasive portrayal of "thinness" as the ideal body type, equated with an image of health, beauty, and acceptance, – "Get the 'London Look!'" – influenced

me greatly. Within weeks, I was severely restricting my food intake and combining it with exercise, and my weight began to drop. The more I increased workouts, the more validation I felt. This sense of accomplishment soon became addictive. Weeks turned into months of eating less and less, constantly pushing myself that little bit further. For a time, it felt exhilarating, clothes felt so much looser, and I was shopping for smaller sizes. But as I was getting thinner, my world was getting smaller until it reduced to a narrative of fear and deprivation, consumed by thoughts of food, weight, and self-loathing.

The findings of the infamous Minnesota Starvation Study in 1944-1945 by Ancel Keys highlight how easily restrictive food intake can develop into a fully-fledged eating disorder (Kalm & Semba, 2005).

What began as compliments from others soon turned to concern about my rapid weight loss, but a protective defence mechanism emerged: denial. It soon became an intrinsic part of my daily life. My self-worth was now defined by the number on the weighing scales. My exercise rituals grew extreme, and I continued my early morning gym workouts despite feelings of overwhelming fatigue. I pounded and pushed through, unable to deal with the intense anxiety and guilt that I felt if I lost control and gained weight.

However, as the months and years slipped by, this relentless pursuit of perfection became unbearable to sustain. The once euphoric feelings from severe restrictive food intake and extensive exercise were now replaced by feelings of depression, anxiety, chronic fatigue, and emotional exhaustion, all while constantly shivering. The cold penetrated my every cell, a haunting hollowness became my new normal. Palpitations replaced a regular heartbeat, and I was quite literally running on empty. The daunting realisation of my aloneness set in. I was completely isolated from family and friends due to the immense anxiety and stress I faced, and I was avoiding meals and eating out. Now, I was trapped in a self-constructed mental prison, merely existing.

The joy of living had been stolen by this illness, which had once given me a fleeting sense of exhilaration

Recovery

My body was so weak that trudging upstairs to my flat caused frequent fainting spells. I was unable to function, at times struggling to stand up. It felt like I was losing this battle. Perhaps, I thought, the time had come to move back home to Ireland. I cannot remember that journey home, but a pivotal and poignant moment is still vivid: waking up in bed to find that the weight of my grandmother's handmade quilt was too heavy for my body – I didn't have the strength to lift it. My mother's eyes filled with tears as she helped get me up. Again, I felt that my life was reduced to merely existing. This was my turning point. Yet the recovery journey that followed was every bit as arduous and excruciating as the illness itself.

Two of the major challenges I experienced during that journey were vocalising my horrific internal struggles, and the overwhelming fear of eating and gaining weight. Controlled by a destructive inner critic, I could not find the words to explain it. I was unaware that my distorted thinking was the result of reduced brain volume (Van den Eynde et al., 2011) and disruption to normal neurotransmitter function, caused by prolonged starvation (Kaye et al., 2013).

On occasions, the patience of my mother and brothers at mealtimes became a source of major discomfort. Nobody was coping, and I held my head in shame.

My recovery was far from linear. It was filled with trials and challenges, roadblocks and dead ends but, nonetheless, it was a journey that had to be taken. In our close-knit rural community, there appeared to be a sense of belonging, yet prevailing attitudes towards mental health issues were viewed within a narrow context. Discussions about eating disorders were poorly understood and virtually non-existent, and I could sense the awkwardness my mother had to endure.

I vividly recall a hospital appointment where I was on the receiving end of looks of perplexed bewilderment and disdain that seemed to echo the sentiment: "Take your silver spoon, dig your grave" (Fleetwood Mac, 1977). Humiliation and shame ravaged through me like an inferno. My repeat prescription, "there is no time for a self-inflicted eating disorder here".

In the months that followed, I endured long periods of apathy, depression, self-loathing, and loneliness. It felt surreal, almost as if I was observing the world around me through a lens, watching everyone live, eat, speak, and behave "normally" while I was there but so far away, feeling translucent and detached. Not only was I a stranger to my family, but I was a stranger to myself. The joy of living had been stolen by this illness, which had once given me a fleeting sense of exhilaration and reassurance.

Juggling fear and hope

One of the most profound supports I received was from a retiring country GP, who never actually retired. His empathy, compassion, and non-judgmental approach provided a secure base from which recovery was possible. Somehow, I gradually began to tolerate the almost unbearable bodily changes that occurred as I slowly began to eat, dealing with severe bloating and the sensation of being enormous. I had frequent panic attacks that triggered relapses, creating a vicious cycle.

However, the yearning for a life worth living slowly emerged, and I began to live again in the moment, my existence no longer controlled or defined by the scales. Eventually, I experienced improvements in cognition and physical strength, along with gradual self-acceptance. The old anorexic voice was dialled down frequently but not easily. At times, it felt like "a great freight train" (Springsteen, 1984) was in my head.

My focus shifted, and where once I was so dissociated from my body, I began the process of reconnection. Intense, gruelling runs were now replaced with rambles through the woods with my dog, where the tears could flow, and fond childhood memories were reignited, alive again with the sounds and smells of nature. Gradually, I began to see the wood for the trees. The loneliness lifted, and I accepted social invitations once more.

A few years later, my marriage mirrored my teenage years, only this time the abuse took the form of coercive control. Once again, food was used and my body abused. Binge eating and purging were used to release the floodgates of fear, anxiety, and uncertainty. I felt trapped. An inner knowing told me that I had to find safety, survive, and protect my children. Fleetwood Mac's (1977) reminder to "break the chain" finally forced me to seek help. I uprooted layers of past trauma, entangled in a warped shame that had flourished relentlessly in secrecy and silence (Bradshaw, 2005). I confronted overwhelming guilt, worthlessness, and vulnerability.

It was never about the food, but about what lay beneath

As I began to take responsibility for my part, the pennies dropped. I began to piece together the once-scrambled jigsaw of my life. I was now finding my voice and putting an end to the cycle of abuse. Eventually, I reached a place of safety, both physically and psychologically, and I discovered an incredible desire to understand human behaviour, which opened up the door to study and learn.

What did I learn?

Looking back on my eating disorder, I recognise it as a trauma response – a loss of an emotional sense of self due to overwhelming life experiences that I could not integrate (Oldershaw et al., 2019). I struggled to navigate the world around me, and I adopted maladaptive emotional regulation strategies. With a poor understanding of my own needs and emotions, I relied on external validation, which Bruch (1973) describes as a "blind search for identity".

My recovery rests in the support I received from that retiring country GP many years ago, and a therapist who helped me explore my emotional baggage through various avenues, including music, art, and somatic healing. It was never about the food, but about what lay beneath.

As therapists, each one of us has our unique way of nurturing and supporting our clients. Our role is to help them reconnect with their own true authentic self, to remove the stigma of an eating disorder. We can encourage clients to live without fear and shame, and provide them with coping strategies to overcome whatever challenges they may face. One of the key aspects in the recovery journey rests in recognising the complex embodiment of trauma which manifests in a multitude of ways, that potentially can provoke the development of an eating disorder.

Now as a therapist, my position is undeniably rooted within the trauma field, owning my biases and seeking knowledge, driven by an insatiable yearning for social justice. With new understandings, I adopt a non-judgmental approach towards each client, welcoming their biopsychosocial genome. I honour how each client internalises their traumatic experiences and employ various coping strategies, remaining deeply aware of their vulnerability. I recognise my role in the moment-to-moment intersubjective dance between myself and my client: the attunement required, which Erskine (2011) describes as a delicate balance – "touching" the client, supporting them, understanding them, and being with them to cultivate a unique sense of therapeutic safety. My approach echoes that of Cooper and McLeod (2011) "through metacommunication, collaboration, and the therapeutic alliance", along with Norcross and Wampold's (2019) assertion that "the therapeutic relationship is central to healing".

> "If you want to raise a man from mud and filth, do not think it is enough to stay on top and reach a helping hand down to him. You must go all the way down yourself, down into mud and filth. Then take hold of him with strong hands and pull him and yourself out into the light." (Hasidic saying, cited in Buber, 2002).

Conclusion

Anorexia nervosa is a lonely, destructive illness that can creep in like an alluring mist, offering exhilarating dopamine hits and leaving a longing for more. It keeps one chasing the thrill, the illusion, while secretly stealing the joy of life and health. It literally reduces one's entire existence.

For those struggling with anorexia, it is impossible to describe to others the captivating, domineering control this illness has. It is equally difficult for family and friends to understand or comprehend the ruthless grip of anorexia. But there is so much hope, so much healing to be done. Recovery is a genuine possibility. There is help now available from the HSE's National Clinical Programme for Eating Disorders, while psychiatrists in the United States, including Dr. Guido Frank (2024) are now investigating anorexia nervosa through a metabolic disorder lens, with the possibility of new interventions.

Anorexia nervosa is a psychiatric illness, not a lifestyle choice. It is intertwined with one's self-worth, emotions, and identity

A major turning point towards recovery rests in honesty, self-acceptance, and the courage to admit that one is struggling with an eating disorder. Anorexia nervosa is a psychiatric illness, not a lifestyle choice. It is intertwined with one's self-worth, emotions, and identity. As therapists, let's remove the barriers of stigma and shame, as we meet each client with compassion and understanding.

Mary Rea

Mary Rea holds an MSc in Pluralistic Counselling and Psychotherapy from IICP College, and she is also a clinical hypnotherapist, following seven years of study with ICHP Ireland. She holds a specialist diploma in eating disorders and is a Reiki practitioner. Mary is passionate about her work within the broad sphere of trauma and eating disorders, and works with adults, children, and adolescents in her private practice in Cavan. Contact Mary at maryrea28@gmail.com

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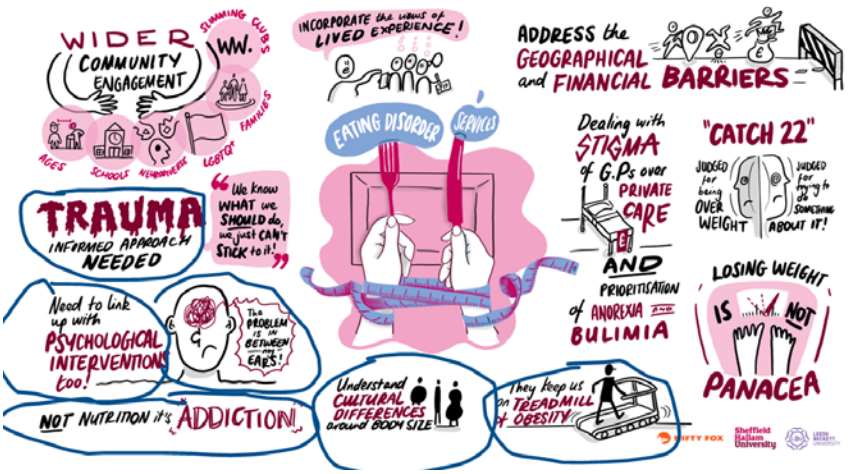
Practitioner Perspective

The implications of classifying obesity as a disease: From vested interests to individual impacts on access to care, self-concept, and body image

By Emma Murphy



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The recent adoption of the "obesity as a disease" narrative, along with the medicalisation of weight, may contribute to weight stigma. This shift could lead to the prioritisation of medication over healthy eating and exercise, with potential consequences for physical and mental health. What role can therapists play?

Introduction

In 2022, one in eight people globally were living with obesity (World Health Organisation [WHO], 2024). Since 1990, worldwide adult obesity has more than doubled, and adolescent obesity has quadrupled (Phelps et al., 2024). According to the Healthy Ireland Survey in 2016, just 37% of people in Ireland had a "normal" weight, 37% were medically overweight, and a further 23% were medically obese (Health Service Executive [HSE], 2016). Those numbers have likely followed a global upward trend since the survey was taken. For instance, in high income populations, severe obesity is expected to double its prevalence from 10% to 20% between 2020 and 2035 (Koliaki et al., 2023).

In the past number of years, there has been a significant movement to reduce weight stigma and fat-bias across healthcare and society in general. Movements and groups promoting body positivity and anti-fat bias and ending weight stigma have emerged, with one of the most impactful being the Health at Every Size (HAES) movement (Suárez et al., 2024).

These appear to have had a positive impact on our narratives around weight, dieting, and body image. Social media platforms from Facebook to Instagram and Pinterest have either banned or tightened up regulations for advertisements promoting weight loss (Chang, 2024; *The Guardian*, 2021). Commercial businesses have adopted a more weight-inclusive approach in advertising, with Dove and Victoria's Secret being two examples. Larger bodies are more regularly represented in advertising and in clothing retail, with more diverse sized mannequins; and in sport there is better representation and inclusion of all body sizes (e.g., Nike, 2023).

There has been a significant reduction in the promotion of dieting and restriction as the solution to higher weight as the HAES movement has gained traction (Huddy, 2023) – a welcome shift for those of us working with clients struggling with disordered

eating (DE). The efficacy of calorie restriction as a long-term weight loss strategy has been disproved (Hall & Kahan, 2018; Rothblum, 2018), and focus has shifted from restriction to the quality of food we eat, such as by following a Mediterranean diet or "Blue Zones" diet. However, despite these societal changes, the reality is that weight bias and stigma in healthcare settings continue to impact self-concept, access to care, and health-related outcomes for individuals with higher body weight.

Given the current numbers of adults medically classified as "overweight" and "obese", it is likely that a similar percentage of clients in therapy are of higher weight, yet it is unlikely that the direct impact of this is deeply explored during therapy. With over 15 years' experience as a specialist in DE, I regularly hear that when clients raise the topic of their weight, therapists and healthcare professionals either avoid discussing weight, offer unsolicited weight loss advice, or provide incorrect guidance on weight management and emotional or binge eating – contributing to stigma and leaving clients feeling unheard. Clients more likely present in therapy with related concerns like anxiety, low mood, stress or social isolation, and they may not voluntarily disclose emotional eating (a common co-occurring condition), or raise their lived experience of higher weight. Therapists may not feel comfortable raising or exploring the client's experience of living in a larger body, or they may not feel they have the appropriate language or understanding of lived experience of obesity or emotional eating.

In this article, I explore how the current healthcare narrative is perpetuating the stigmatisation of people in larger bodies, reducing personal agency and ignoring psychological factors such as emotional eating and binge eating disorder (BED). By gaining a better understanding of the environment experienced by clients in larger bodies, practitioners can enhance their knowledge of relevant topics, offer informed support to clients, and identify areas for further education.

Weight bias and stigma in healthcare settings continue to impact self-concept, access to care, and health-related outcomes

Definition of weight stigma

According to the United States National Eating Disorders Association (Edwards-Gayfield, 2023), "Weight stigma, also known as weight bias or weight-based discrimination, refers to the negative attitudes, beliefs, stereotypes, and discriminatory behaviors directed towards individuals based on their body weight or size".

People in larger bodies often encounter social stigma. Unconscious internal bias and conscious external bias from others mean they are discriminated against in the workplace, in education, and in healthcare (Saxena et al., 2024).

Commonly, weight stigma arises from societal narratives, including those that blame the person and regard higher weight as an individual responsibility. This narrative is pervasive and does not account for the role of genetics, biology, social environment, family environment, and a history of DE. A belief that "*eating less and moving more*" would result in permanent weight loss has been comprehensively disproved over years of research, with a meta-analysis of 29 long-term studies reporting that, within five years, more than 80% of lost weight was regained (Anderson et al., 2001, as cited in Hall & Kahan, 2018).

The current narrative on weight in healthcare

Overweight and obesity are characterised as abnormal or excessive fat accumulation that poses a risk to health, with a body mass index (BMI) of over 25 being considered overweight, and over 30 being obese (WHO, 2024).

The current healthcare narrative positioning obesity as a chronic disease was officially passed by the American Medical Association in 2013 (Kyle et al., 2016). This decision was not universally endorsed – the AMA's own Council on Science and Public Health cautioned that "medicalising" obesity could promote excessive reliance on pharmacological and surgical interventions, and potentially take the focus away from more holistic approaches to promoting healthy behaviours (Engber, 2024; Tanner, 2013). In 2021, experts in obesity from both Ireland and the United Kingdom published a report outlining arguments for and against the determination of obesity as a disease (Luli et al., 2023). To date, neither Ireland nor the U.K. officially classify obesity as a disease, although it is a priority area of focus for the health services in both countries (HSE, 2016; National Health Service [NHS], 2019).

The classification of obesity as a disease in the U.S. and other countries has resulted in significant funding from pharmaceutical companies, who have heavily invested in developing and marketing weight-loss drugs. Pharmaceutical manufacturers have provided funding to patient advocacy and obesity action groups, some of which emphasise pharmacological solutions over preventative or behavioural interventions in the treatment of obesity (Bombak et al., 2022), and, according to media outlets, this is not limited to the U.S. (e.g., Corrigan, 2023; Matthews et al., 2024).

The 'obesity is a disease' narrative and weight stigma

Labelling obesity as a disease on the surface aims to move the focus from individual responsibility to biological and environmental factors, which should result in a more compassionate approach to treatment. However, critics argue that positioning obesity as a disease may actually intensify, as opposed to reduce, stigma.

Research suggests that nearly 88% of people living with obesity report experiencing stigma and discrimination, both within and outside of healthcare environments, leading to severe psychological and physiological impacts (Brown & Flint, 2024). A large-scale study comprising 13,996 individuals across various countries found that at least 66% of those experiencing weight stigma also encountered it from healthcare providers (Puhl et al., 2021)

One interesting perspective relates to the promotion of person-first language (PFL) in obesity. The PFL initiative for higher-weight people was initiated by the US non-profit organisation, Obesity Action Coalition (OAC). Significant funders of the OAC are Novo Nordisk, Eli Lilly, and Pfizer (OAC, 2023) – all pharmaceutical companies who manufacture the new GLP-1 weight loss drugs (e.g., Ozempic, Mounjaro). The OAC recommends the use of terms such as "person with obesity", "person affected by obesity", and "person with overweight" as new descriptors of a person in a larger body.

An independent patient advocate and outspoken critic of the medicalisation of weight, Ragen Chastain, recently wrote on this topic in her newsletter. She suggests that the issue with using PFL in this area is that it causes us to discuss higher-weight bodies differently than other bodies. "We don't say 'Oh good, my friend with tallness is coming over, now I can finally change that lightbulb' or 'That man affected by thinness getting on the bus - I think I know him!' (Chastain, 2024). Chastain further suggests that the avoidance of accurately describing higher-weight bodies actually causes more stigma. "This also has the impact of suggesting that the 'problem' is higher-weight people existing and so we don't need to solve the actual stigma that higher-weight people experience and that harms them" (Chastain, 2024).

Chastain chooses to identify as fat, and this is also the chosen identifier for many people in larger bodies, but the word "fat" as an identifier has been almost completely excluded from the obesity language lexicon.

Baker (2015) suggests that "the word 'fat' is not inherently bad. It's an adjective … we don't need to stop using the word 'fat', we need to stop the hatred that our world connects with the word 'fat'."

Other critics of this narrative suggest that it emphasises body weight as a defining aspect of health, detracting from non-weight-focused, holistic health goals. Additionally, health professionals over-attribute health issues to patients' weight, which can reduce the quality of care by leading providers to dismiss symptoms unrelated to weight (Puhl et al., 2021).

The problem with the current narrow definition of obesity is that it is based on only one factor: the person's Body Mass Index (BMI). BMI does not account for other important measures of metabolic health, which focus less on overall weight and more on the distribution of adiposity (fat) within the body. Essentially, a normal-weight adult can have high levels of adiposity around their stomach area where many important organs are, and this is a greater health risk than the risk a higher weight adult with more fat around the hips and thighs may have (Jayedi et al., 2020). BMI also does not account for fitness or cardiac health. A person in a larger body may be a regular exerciser and have a high muscle-to-fat ratio which contributes to size and weight, whereas a "normal" weight or underweight person can be unfit and unhealthy with far higher health risks (Ortega et al., 2016).

Misclassification of BMI is especially important for racial and ethnic minorities (Rao et al., 2015). Asian adults have higher metabolic risk despite being more often in the "normal" BMI range (Palaniappan et al., 2011), whereas Black adults have a higher life expectancy than white adults when BMI measures are the same (Fontaine et al., 2003).

Weight stigma as a barrier to accessing healthcare

Weight stigma significantly impacts healthcare access, as individuals with higher weight frequently delay or avoid seeking medical support for health issues due to fear of judgment and blame. This avoidance can result in delayed diagnoses and inadequate treatment, exacerbating health issues that might have been more manageable or even reversible with earlier intervention (Cohen et al., 2008). Many patients report that health professionals often focus exclusively on their weight, regardless of the presenting issue, leaving patients feeling overlooked and disrespected (Talumaa et al., 2022).

Healthcare providers' implicit biases can further reduce the quality of care given to patients in bigger bodies. Implicit Association Tests (IATs) (Greenwald et al., 1998; Project Implicit, n.d.) reveal that both healthcare students and practising professionals hold substantial unconscious biases against people with higher body weight (Brown & Flint, 2024; Saxena et al., 2024). These biases are often unrecognised by the professionals themselves, yet they shape behaviours such as

spending less time with patients, providing unsolicited weight-loss advice, and demonstrating lower levels of empathy (Talumaa et al., 2022).

The role of pharmaceutical companies and weight-centric healthcare

Some have suggested that pharmaceutical companies may be contributing to a weight-centric narrative within healthcare. Over recent years, the promotion of long-term weight loss medications appears to have increased alongside growing industry support for framing obesity as a disease.

One could argue that the current focus on weight-loss medications not only skews healthcare resources but also fuels patients' weight-related anxiety. Instead of promoting sustainable, holistic health practices through psychoeducation and support for behaviour and lifestyle changes, healthcare professionals often direct patients toward weight-loss medications, which do not address the root causes of higher weight. When medication alone is the "solution", there is the potential for exercise and other healthy lifestyle changes to be minimised. I believe that healthy eating and exercise should never have been associated with weight loss to begin with; they are behaviours we all need to incorporate generally to maintain good overall health.

Daniel Engber's (2024) recent article in *The Atlantic* highlights concerns that doctors may now rely solely on medication, which, in my opinion, will have significant negative health implications in time.

The impact of weight stigma in higher weight healthcare

Weight stigma is linked to psychological distress, depression, anxiety, low self-esteem, and body image disturbances, often leading to decreased health motivation and maladaptive coping such as avoidance of timely healthcare, social isolation, reduced physical activity, and DE behaviours (Talumaa et al., 2022).

Internalised weight stigma can also exacerbate DE, such as binge eating and emotional eating, as individuals turn to food as a coping mechanism. The Cyclic Obesity/Weight-Based Stigma (COBWEBS) model (Lee et al., 2024) describes this as a feedback loop: stigma leads to greater release of cortisol (a stress hormone) and emotional eating, both of which separately contribute to weight gain, resulting in further stigma. Such cycles often trap patients in weight-based distress, increasing the psychological burden these patients may already be carrying due to a history of DE, and contributing to long-term health issues (Talumaa et al., 2022).

Along with higher-weight healthcare practitioners perpetuating weight stigma, there is a lack of psychological screening and limited access to specialist support. Despite BED entering the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) as a classified eating disorder with a defined set of criteria for diagnosis, some research suggests that fewer than half of healthcare providers report using DSM criteria to diagnose BED, 27% do not recognise it as a discrete eating disorder, and over 40% never assess for binge eating at all (Supina et al., 2016).

Other tools such as the BEDS-7 (Herman et al., 2016), the unfortunately named SCOFF questionnaire (Morgan et al., 2000), the Three-Factor Emotional Eating Questionnaire (de Lauzon et al., 2004), and others are all available as assessment tools. However, despite the availability of these measures, we see the combined impact of weight stigma in a healthcare system that is meant to support patients: a lack of screening for psychological factors in higher-weight individuals, limited specialist support, and a reduction in guidance and support on healthy lifestyle changes in favour of medication. What will the long-term implication of this over-medicalisation of higher weight be, and what can we do to mediate these impacts?

Extensive and ongoing research by Leeds Beckett University (LBU) gathers feedback from adults in larger bodies with lived experience of weight stigma in healthcare. LBU established the Obesity Institute to explore the psychological factors in obesity and campaign to have specialist support integrated into healthcare treatment pathways. The image accompanying this article represents a subset of feedback received, reinforcing the lack of focus on psychological factors in UK healthcare services.

A systematic review of literature on body image and bariatric surgery highlighted greater body dissatisfaction post-surgery in patients with DE behaviours, compared to those without DE behaviours (Ivezaj & Grilo, 2018). This supports the importance of psychological intervention as part of higher weight medical treatment, preferably prior to surgery. This, to me, is obvious – if an adult is carrying higher weight to the extent that surgery is required, it is almost certain that there are psychological factors at play. However, I have had personal experience of a bariatric surgery programme first exploring the idea of introducing DE screening and support into their service, then rejecting the idea on the basis that patients might drop off the waiting list should their underlying issue with food be resolved. I mention this experience in particular, as I believe that, as therapists, one of the ways we can challenge and change the current healthcare model is to empower patients to demand the specialist

support they need as part of their medical treatment.

In one post-operative study included in the review by Ivezaj and Grilo (2018), patients who received six weeks of acceptance and commitment therapy (ACT) post-surgery showed significant positive effects as compared with treatment as usual on ED behaviours, body dissatisfaction, psychological flexibility and quality of life (Ivezaj & Grilo, 2018; Weineland, 2012).

In the past year, my organisation – Eating Freely Ltd. – has completed an initial pilot research programme in partnership with LBU, due to be published in early 2025. This research looked at the impact of psychological support for higher-weight patients who meet the criteria for emotional eating or BED. The research group participated in a 6-month group programme that blended self-directed learning through an online digital programme, and weekly group calls via Zoom. The programme contains 16 modules, incorporating four pillars of support: cognitive behaviour therapy (CBT), nutritional rehabilitation, neuroscience, and mindfulness and self-compassion. There is no focus on any form of food or calorie restriction or weight loss in the programme. A common theme among all participants was the positive impact the programme had because the focus was not on weight or weight loss.

Participants have given their consent for us to share the following feedback from the programme:

> I really appreciated the fact it wasn't focused on weight. It was focused on health and well-being. I would say there has been a 75% drop in binge eating, the programme has definitely helped with that (Catherine, 63).

> Something has clicked. Whether it's the simplicity, whether it's different ways of looking, whether it's just being kind to yourself and realising I don't need to beat myself up if I don't get this perfect … and I think realising the key thing … is there's no good or bad foods anymore. It's [just] food. (Aly, 53).

> I don't need food anymore to celebrate and commiserate. For me, [it] has just been an absolute game changer … so before it would absolutely have been at 100% for emotional eating. Now? I wouldn't even say it's 15/20% of the time. (Kate, 39)

Therapists can provide a non-judgemental, safe space for clients to talk about their experiences of living in a larger body and weight stigma

Although sample sizes are small in both the ACT research and Eating Freely's research with LBU, the results are promising. They indicate that a focus on the person themselves, not their weight, has a positive effect on outcomes, particularly in self-acceptance and self-care. It is my intention, through ongoing collaboration between Eating Freely and LBU, to continue with further research on support that does not focus on weight and weight loss for adults in larger bodies who meet the criteria for emotional eating or BED.

The role of counsellors and psychotherapists in supporting clients

Counselling and psychotherapy can play an important role within the healthcare pathway for patients with weight-related health issues. However, much work is needed to ensure this support is integrated as standard into healthcare services for higher-weight patients.

Therapists may choose to undertake continuous education in one or more areas relevant to this topic. From training in body image or working with emotional eating and BED, to doing more reading and research around obesity, weight stigma, and body positivity, practitioners can build a toolkit of resources and supports for clients in larger bodies. Practitioners may also choose to specialise in this area, as it is clear there is much work to be done and many clients to be supported.

With or without further training, practitioners can support clients who are living in larger bodies in several ways. The first step could be to include questions about clients' relationship with food as part of every intake. Voluntary self-disclosure can be challenging for clients struggling with DE, as there is significant shame associated with DE behaviours. As research (Brown & Flint, 2024; Puhl et al., 2021) suggests, fear of stigma and judgement can further act as a barrier to disclosure. If a client does disclose, therapists can assess if it is within their competencies to provide support to the client. If the disclosure involves an ED such as bulimia or BED that is outside the therapist's competence, they can refer to specialist supports.

Therapists can provide a non-judgemental, safe space for clients to talk about their experiences of both living in a larger body and any weight stigma they have experienced both within and outside of healthcare services. It is common for therapists to ask about medications and medical conditions as part of an intake. Should clients disclose a higher-weight-related health issue, such as Type 2 diabetes or cardiac disease, or share that they are taking a weight-loss medication, asking relevant questions about clients' experiences of healthcare

can open up a discussion. This allows the client to feel heard and seen, while exploring any impact that weight stigma has had on them. I recommend including these questions at intake:

1. "Do you ever eat for emotional reasons? If yes, would you ever describe it as binge eating?"

2. If the client confirms binge eating, ask: "Do you ever purge?" to assess if bulimia is a concern.

3. "Do you regularly diet or restrict your food?" as dieting and restriction can contribute to low mood and elevated cortisol levels.

Therapists are well-placed to empower clients to advocate for themselves within the healthcare system. As therapists, we can explore what would empower each client, and hold space for them to disclose weight-shaming experiences they have had in medical settings.

Supports may include guiding a client through a role play where they can give feedback to medical professionals who cause offence, hurt, or shame when discussing the clients' weight. Clients can be supported to ask medical professionals if it is medically necessary to weigh them in the context of their presenting issue, or to refuse to be weighed (as is their right). Where it is medically necessary, clients can ask their medical professional to weigh them facing away from the scale so they do not see the numbers, and to not share their weight with them.

Therapists can also explore their own biases around higher weight within supervision or as a self-reflective exercise. Taking the Implicit Association Test for Weight may also be helpful (see Project Implicit, n.d. for test link).

Clients may also wish to explore the option of taking weight-loss medication with their therapist. Therefore, some therapists may wish to complete further research or training on the potential effects of these medications, including within the context of DE, so they can explore the implications of taking such medications with the client. If a client is already taking a medication for weight loss, a therapist may wish to recommend a reputable nutrition professional to support the client's eating and dietary requirements and have referral pathways for clients who require other types of specialist support.

Supporting clients to make behavioural and lifestyle changes that holistically advance their goal of better health is well within the remit of therapists, and this work can be done with both clients who are taking weight-loss medications and those who are not. I recommend exploring any other interventions they have been offered or advised on, such as exercise, nutrition, and other lifestyle changes. If this is minimal or absent, therapists can help clients explore these alternatives.

Conclusion

It is clear that a focus solely on weight loss as the solution to better health has many limitations, as does an over-reliance on weight-loss medication. From influencing self-concept and body image to creating barriers to accessing more timely healthcare, the combined impact of both weight stigma and a lack of psychological support in higher-weight health continues to fuel a cycle of shame and avoidance for higher-weight people.

Pharmaceutical companies' promotion of a weight-centric narrative might complicate the issue by shifting focus away from holistic health toward approaches that may align with commercial interests. The long-term impact of an over-reliance on medication and a decrease in focus on behavioural and lifestyle change has yet to be fully realised and understood.

Practitioners can help reduce weight stigma and encourage health and wellbeing by supporting clients to adopt practices that prioritise overall health over weight loss and to build a toolkit of resources that provide holistic support for mental, physical, and emotional health. Therapists can also empower their clients to self-advocate in healthcare settings to address and reduce weight-stigmatising language and behaviours from health professionals.

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Since 2017, Emma and her team have been providing in-person and online training for health professionals and, to date, Eating Freely has trained over 300 practitioners across 10 countries, who have supported thousands of clients in resolving emotional eating and binge eating disorder. Contact Emma at emma@eatingfreely.com or visit www.eatingfreely.com

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Academic/Research Article

An innovative eating disorder recovery group programme for college students: Development and evaluation

By Grace Harrison and Cristina Galvin

This article highlights the lack of services for people with serious eating disorders and discusses the effectiveness of a newly developed eating disorder recovery group programme at the University of Galway, aimed at supporting college students

Introduction

Eating disorders (EDs) are complex and serious mental illnesses, characterised by an unhealthy preoccupation with food, exercise, body weight, and shape, which negatively affect physical, psychological, and social function. They may be understood as a coping mechanism for emotional pain, often rooted in developmental trauma. EDs affect people of all ages, genders, ethnicities, and backgrounds.

In recent years, there has been a significant rise in the prevalence and severity of EDs. Studies have highlighted the increasing number of children, adolescents, and men presenting with EDs, with less common forms coming to the fore. Statistics indicate that services in Ireland have long been underdeveloped, under-resourced, and ill-equipped to provide the necessary care for people with EDs and their families. Given the serious physical and psychological consequences of EDs, prioritising the provision of treatment and prevention services is essential.

Literature review

EDs carry the highest mortality and morbidity risk of all mental health disorders (Kerswill et al., 2023). They account for 80 deaths annually in Ireland (Department for Health and Children, 2006, p.255). According to a retrospective cohort study published in *The Lancet*, there appears to be an increased rate of suicide in individuals with anorexia compared with the general population (Hercus et al., 2024).

EDs are the second leading cause of mental health disability for adolescent girls and young women (Stice et al., 2021), and numbers are growing among men (Räisänen & Hunt, 2014; Reid et al., 2010). Indeed, approximately 25% of ED cases in the United Kingdom are among men (Manning & Greenfield, 2022) and international data show that one in five women (19.7%) and one in seven men (14.3%) are estimated to experience an ED by the age of 40 (Ward et al., 2019).

The prevalence of EDs among American college students is 12%-16.4% (Egbert et al., 2024). The most common age of onset is 12-25 years old, making emerging adulthood a high-risk period, with an elevated prevalence in college populations (Manning & Greenfield, 2022). Research indicates that these conditions

(including anorexia, bulimia, and binge-eating disorder [BED]) affect 13% of women and girls and 6% of men and boys, and are associated with serious physical and mental disability, poorer academic performance, and an increased risk of depression, obesity, suicide, and death (Stice et al., 2013).

The Irish context and COVID-19

Approximately 190,000 people in Ireland will experience an ED in their lifetime, equating to a lifetime prevalence of 4% of the population (Health Service Executive [HSE], 2018, p.13); and approximately 1,800 new ED cases occur annually (HSE, 2018). Since the beginning of COVID-19, there has been a higher incidence of EDs in Ireland (Katzman, 2021; O'Driscoll et al., 2023; Rafferty et al., 2024). There was a reported 66% increase in hospital admissions for EDs during the pandemic, well above the international average of 48% (Barrett & Richardson, 2021). Data from hospital admissions in Ireland in 2022 indicate that there were 210 hospital admissions for EDs – the highest level in a decade (Health Research Board, 2023). Studies show that COVID-19 also worsened symptoms (Kahn et al., 2024; Murray et al., 2024) and contributed to an increase in referral complexity, with a higher proportion of individuals reporting suicidal ideation and eating psychopathology (Rafferty et al., 2024).

The pandemic had a marked impact on referral rates of children and adolescents with EDs (Murray et al., 2024; Rafferty et al., 2021). The incidence of EDs in childhood increased (McDonnell et al., 2022) and remains at a high level (Health Research Board, 2023, 2024). A recent report from the Health Research Board (2024) stated that, for the first time, EDs accounted for the highest number of all child admissions to psychiatric units, and the proportion of admissions with a primary diagnosis of EDs for all under 18s has progressively increased from 11% in 2019 to 24% in 2023. Despite the growing incidence of early-onset EDs, a majority remain untreated (Sanzari et al., 2021).

In the 19 years since the publication of the government's first mental health policy document (Department of Health and Children, 2006), which outlined the pressing need for ED-specific services, nothing has changed. There remains a chronic shortage in ED provision. Currently, there are only three designated specialist beds for the treatment of adults with EDs in the Irish public health system, all based in Dublin (Niazi, 2022). This falls far short of the 24 beds recommended in the 2018 Model of Care for Ireland report (HSE, 2018). There are still no dedicated ED inpatient beds in the 20-bed Child and Adult Mental Health Service (CAMHS) facility in Galway (Mental Health Commission, 2024), and the region remains without an adult specialist ED team and unit.

The fact that 95% of ED cases occur in the 12-25 age-group (Hesseling, 2023; Ward et al., 2019), with most going untreated, makes the college-age population an important target group for prevention and treatment measures. Early-stage intervention is key to mitigating the likelihood of subclinical EDs progressing to more chronic and treatment-resistant forms (Le Grange & Loeb, 2007).

Programme overview

The authors, Cristina Galvin and Grace Harrison, collaboratively developed the Eating Disorder Recovery Group Programme in 2023. Drawing upon 20 years of research at Stanford University, the programme was designed to support female students with an ED. These include anorexia; bulimia; BED; avoidant/restrictive food intake disorder (ARFID), which involves restrictive eating unrelated to body image (such as due to a lack of interest in food, previous traumatic experiences of eating, or sensory sensitivities); and orthorexia, characterised by an obsession with healthy eating; along with other specified feeding and eating disorders (OSFED). The programme aims to reduce body dissatisfaction and ED behaviours and, as the first initiative of its kind on a college campus in Ireland, it seeks to address some gaps in ED support services.

Prior to this pilot programme, in 2022 the authors launched The Body Project Treatment Programme, a manualised 8-session, dissonance-based ED treatment programme. In this group-based treatment, people with body image concerns and ED symptoms (as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* [5th ed.; DSM–5; American Psychiatric Association, 2013]) engaged in a series of verbal, written, and behavioural in-session and home-based exercises. Participants discussed body dissatisfaction, ED behaviours, and the costs of pursing the "thin appearance ideal". The aim was to encourage participants to challenge the distorted thinking which fuels the pursuit of unrealistic appearance ideals. Based on The Body Project Treatment Programme evaluation findings, the authors developed this new 8-week programme that incorporates many alternative modalities to offer a more holistic approach to recovery.

The newly designed experiential 8-week group programme offers a warm, supportive space for female students to tackle their struggles with food and body image through group sharing, expressive art

activities, psychoeducation, yoga, and body-oriented exercises. It incorporates components such as specialist dietitian input and a guest speaker with lived experience of an ED, in order to support participants to build a strong foundation for recovery.

Aims of the programme

The programme aims to support students who struggle with EDs to:

(a) become aware of the seriousness of the condition;

(b) understand some of the underlying issues;

(c) challenge unhelpful patterns of thinking and behaviour; and

(d) make behavioural changes in recovery, including drawing on specific supports for ongoing assistance.

Pilot study

In autumn 2023, The Eating Disorder Recovery Group Programme was launched on the University of Galway campus as a pilot study.

Recruitment and participants

Participants were recruited through student support services (i.e., the student counselling service, the student health unit, student support officers, the students' union, and the disability support service). All support services were provided with information sheets and posters on the programme, and suitable referrals were requested.

The group counsellors conducted individual assessments with referred students to determine their readiness and suitability to take part; and the students were provided with an overview of the programme, the requirements for participation, and the attendance policy to sign. The attendance policy stated that students had to attend at least six of the eight sessions and to engage to the best of their ability in the programme activities. Participants were offered letters of support to be excused from lectures or university placements, where necessary. Underweight students (i.e., those with a body mass index [BMI] of less than 18.5) were required to sign an agreement to attend their GP a minimum of three times during the programme for weight and medical monitoring.

Participant engagement

Three groups took place during the academic year 2023/2024. Sixteen female participants (aged 18-26 years old) began the programme (eight per semester) and 15 completed it due to one student dropping out. The majority of those who completed the programme reported making positive changes related to both ED specific behaviours and broader self-care activities. All participants honoured the attendance policy and showed up for a minimum of six out of eight sessions. Participants actively engaged in the group activities, including completing the assigned home exercises. Those who missed sessions cited illness, medical appointments, and compulsory lectures or placement as reasons for being unable to attend. The fact that only one dropped out suggests overall programme effectiveness, thoroughness of the assessment, and the participants' connection with their peers and therapists.

Pilot programme evaluation

A service evaluation of the programme was carried out by assistant psychologist Christina Gleeson. A simple qualitative research approach was employed, using semi-structured interviews to allow flexibility in modifying questions based on participants' responses. This approach enabled the richness and depth of the participants' experiences to emerge (Eatough & Smith, 2017). Interview questions centred on participants' overall experience of joining the programme; their initial thoughts; the most helpful and least helpful aspects of the programme; and their recommendations for improving future groups.

All 15 participants consented to sharing their contact details with the assistant psychologist for the purpose of participating in an interview as part of the programme evaluation. Of those, 11 participated in a semi-structured interview lasting approximately 35-40 minutes. Nine interviews were conducted in-person, and two were conducted online using Microsoft Teams, as the participants were out of the country at the time of the interview. All interviews took place within six to eight weeks of programme completion. Participants' identities were anonymised, and they were informed that all data would be stored on a password-protected computer for up to seven years following the interview, in line with the record-keeping and retention guidelines of the Irish Association of Counselling and Psychotherapy (IACP, 2018).

Participants provided consent via email during the initial contact and they consented to audio recording prior to the interview. Participants were not given remuneration for taking part. The interviews were transcribed and analysed by the assistant psychologist.

Key findings

For this article, findings are summarised into three categories: the most helpful aspects, the least helpful aspects, and the participants' recommendations for future improvements.

Most helpful aspects

The following are the aspects of the programme deemed most helpful: the dietitian's assessment, the peer community, the programme structure, the guest speaker, an increase in insight and self-compassion, and the counsellors' input.

Dietitian

The majority of participants reported that the dietitian was particularly helpful. Benefits included her specialisation in EDs; her ability to tailor meal plans specifically to the individual and their lifestyle, culture and context; and the role of the meal plan in countering the "eating disorder voice" which urged participants to engage in disordered behaviours, and instead encouraging them to eat.

> I could sort of calm the eating disorder voice down and say, 'You know this isn't unhealthy, this is how much you're meant to eat in a day, a professional is telling you this so you can't argue with that'. (Sally)

Peer community

All participants reported that the peer community was especially helpful. Being able to relate to others' experiences and feeling understood lessened their feelings of isolation and boosted their motivation to move toward recovery.

> It made you feel like you weren't alone. (Lisa)

> As soon as you could see someone getting better, all of us strived to get better. (Grainne)

> I didn't have to explain as everyone understood. (Jean)

Showing up for others helped participants to "show up" for themselves, and giving and receiving support and advice fostered a deep bond that led to a support system that endured beyond the group. This was especially meaningful for participants.

> They need me to be there. (Alison)

> It was a support system I didn't expect to find. (Eimear)

> The kindness of the girls, they would soak in every single word I said. (Stephanie)

> Hearing everyone else's stories and celebrating their little wins with them was really nice. (Sally)

> We even created an Instagram group. (Pamela)

Four participants named the diversity in group members as being a key aspect that spurred hope and inspiration.

> I also found it so beneficial having people in the group that were at different stages of recovery … they gave a lot of hope. (Alison)

> It wasn't just people who had struggled with undereating or the opposite. It was very mixed and I thought that was quite good … we could learn from each other. (Rita)

Programme structure

Many elements of the programme structure were reported as being "most helpful" including the time commitment involved (the consistency and length of the programme) and the pacing of group sessions; the small group size; home exercises; and the variety of modalities used, including psychoeducation, art, yoga, mindfulness, and group sharing.

> The home exercises would keep recovery at the forefront of your mind and also just give you something to work towards. (Eimear)

> I also really liked the way it was small … if there was a bigger group … I feel like I probably would have felt a bit lost in it … it was like a community. (Rita)

> The art … just peace for a while as … a lot of talking can be very heavy. (Gráinne)

> I'm not big into arty things … I do find the talking sometimes more beneficial. (Lucy)

Guest speaker

Four participants reported that the guest speaker from Overeaters Anonymous (OA) was helpful. They found her recovery journey to be inspiring, and it grounded them in the reality of what ED recovery entails: that it takes time and it is about is progress, not perfection.

> It made me realise there's no quick fix. (Stephanie)

Insight and self-compassion

Many participants reported that gaining greater insight and self-compassion was another helpful aspect, and some of this stemmed from hearing and connecting with others' experiences.

> I could sympathise with myself and be a lot kinder. (Svetlana)

> It helped me find out things like my eating disorder more came from anxiety … it turned into being more about control. (Sally)

Counsellors' input

Lastly, the group counsellors' input was reported as helpful by four participants. They felt that the counsellors took the participants

seriously; that they showed care and understanding towards everyone's experiences equally; that they created a safe space; they kept the group on topic; and they provided psychoeducation.

> Nothing was belittled or anything. Every experience was valued and listened to and respected. (Jean)

Least helpful aspects

Four main aspects of the programme were reported as "least helpful": the length of the programme and the timing of some interventions; specific interventions within the programme; elements of the guest speaker's talk; and communication within the group.

Programme duration and timing of interventions

Many students reported that they would have liked the programme to run for longer.

> I found it very difficult at the end of the eight weeks, it was just like … done. It would be nicer to have it a bit longer or more spaced out. (Lisa)

Two participants reported that the timing of the dietitian assessment was unhelpful (either too early or too late) and two participants stated that it would have been more helpful to have more than one dietitian appointment during the programme.

> I don't think I was ready for that stage … it would have been really helpful maybe now … she was giving me loads of alternatives and I was like, 'I'm not gonna use that'… it was just a bit like too advanced. (Alison)

> If you see the dietitian at the fifth session, then you have just three weeks to go to follow up. I think this is where people start to realise how to cope with the food and then they immediately lose the support. (Svetlana)

Specific interventions

Specific interventions such as the food diary and some art expressive exercises were each reported to be unhelpful by two participants, and some activities that focussed on challenging eating-disorder-related thoughts and on connecting to feelings were each reported to be unhelpful by one participant.

> The food diary made me more aware of how much I was eating and my eating disorder brain was switched on … I was like, 'oh no, I can't go back to that place of tracking everything I eat'. (Pamela)

> I get why they're asking about [feelings at] the same time, I don't think it was always needed to know what feeling was connected to certain things that we talked about. (Lucy)

Elements of guest speaker talk

Two participants reported that elements of the guest speaker's ED recovery story were triggering – namely that she spoke about sugar as addictive for her and consequently a substance she avoids in recovery.

> For me, and I think other people in the group maybe shared the same, we were trying to undo those thoughts of some food groups being off limits. And then it was kind of disheartening being like, 'well, maybe that's the only way'. (Stephanie)

Communication within group

Five participants reported that certain aspects of the group communication were unhelpful, such as occasional silences, one student being more dominant at times, and feeling sometimes misunderstood by the counsellors.

> One girl … she liked to speak a lot … the weeks that maybe she wasn't there … we got a lot out of it. (Gráinne)

> Sometimes, I felt like I was being misunderstood [by counsellors] … they were trying to make us see the positive side but sometimes it felt maybe a little forced. (Rita)

The final two unhelpful aspects reported were: insufficient diversity in terms of gender and less common ED types (reported by one participant); and the appearance of the counsellors (being slim), reported by one student, who believed this was an indicator that they wouldn't understand what it's like to be overweight and, as a result, they could not relate to her story.

> I struggle mostly with ARFID … whereas they were more like a binge/restrict so they would talk about that a lot … [I] felt a bit silly for being there sometimes. (Lisa)

> It would have been great if the counsellors didn't look like the stereotypical ideal of what a woman should look like. (Pamela)

Participant recommendations for future improvements

All participants said they would recommend the group to others who were experiencing an ED.

> It's been the biggest support I've had, so I'd 100% recommend it to someone who is struggling with an eating disorder. It gave me a lot more insight into the triggers and it made me feel like I wasn't alone. (Lucy)

> I've tried a lot of stuff but this is definitely one that worked the best because it just felt like they really knew what they were doing … and it was so respectful and well-researched. It was really refreshing. (Lisa)

Participants reported a few changes that they would like to see in future developments of the programme, including increasing the length of the programme, having counsellor support between sessions, and having greater frequency of follow-up sessions to better support progression in recovery and relapse prevention.

> It was like you joined the group or you have your counsellor, you had to pick one … during the week I would have loved someone to talk to. (Stephanie)

> They're inviting us back in September [for a follow-up session] but one to two sessions in between would be important, even online, so no one's gone off track. (Lucy)

Participants reported that they would like some additional interventions to be included in the programme, such as exploring physical activities for enjoyment, providing psychoeducation on exercise, incorporating a different guest speaker's story, and allowing more time for informal chatting.

> Maybe a bit more [information] about exercising and gym culture … I struggled a lot with over-exercising to compensate. (Jean)

> [It] would have been nice to learn a few different techniques for emotion regulation. (Eimear)

> Another story from a guest speaker could be just as powerful and show the same things without being so triggering. (Alison)

> We would have benefitted from a bit of informal chatting and getting to know each other. (Rita)

Three participants reported that greater diversity in gender and ED types would be appreciated in future groups.

> I don't know if the group would have been able to speak to the experiences of men or gender non-conforming women as much as it did amongst this group of cis women. (Svetlana)

Limitations

The limitations of this study include the small group size and the limited gender diversity of participants (i.e., only one participant identified as non-binary and all the others identified as cis-women, meaning individuals assigned female at birth who identify as women). Future developments of the programme may benefit from greater gender diversity and the inclusion of men in order to evaluate its effectiveness with a broader student population. The timeframe of the programme was another limiting factor; a longer programme duration may potentially bring about more lasting changes for participants.

Recommendations

Based on the evaluation of the pilot programme and incorporating participant-suggested improvements, future developments will include the addition of:

- Information on the various types of EDs, including lesser-known types like ARFID and orthorexia.
- Psychoeducation on compulsive exercise, gym culture and movement for enjoyment.
- Mindfulness and other emotional regulation resources.
- Experiential activities involving movement for enjoyment.
- Unstructured times in sessions for informal chatting to facilitate participant connection.
- Additional guest speakers from OA representing diverse presentations.
- Frequent follow-up sessions.
- Programme content to ensure relevance for those of different genders.
- Broader referral range, inviting men and all other genders.

Conclusion

The findings of this ED recovery programme were shared at the 2024 Student Affairs conferences both in Ireland and abroad. Having received positive feedback and significant interest from representatives of other higher education institutions, it is anticipated that the model – since amended according to past participant recommendations – may be replicated on other college campuses.

Grace Harrison

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Specialising in EDs and neurodivergence, Grace co-designed and delivers specialist group counselling programmes for students in both of these

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Practitioner Perspective

Body image in the perinatal period

By Dr. Mou Sultana

Perinatal body image is a complex and evolving issue that can remain unaddressed in therapy. This article explores how counsellors and psychotherapists can better support clients through key theories, practical strategies, and the introduction of the "Becoming Model" *– an innovative integrative framework for perinatal counselling*

Introduction

This article addresses the current knowledge gap within counselling and psychotherapy in relation to perinatal body image. Drawing from some of the key scientific literature on this topic and the author's clinical experience, this article blends practice-based research with research-based practice. It also outlines the major theoretical frameworks and hands-on clinical considerations, and it introduces the *"Becoming Model"* as a potential framework for use within the therapeutic setting.

Key terms in body image research

Several key terms are used to capture and explore the complex experiences and phenomena of body image. Among them, "body dissatisfaction" is often used to describe experiences related to a person's body image. This term suggests that "the perception of body image and its idealized image can lead to body dissatisfaction" (Mallaram et al., 2023). Within the realm of research, "body dissatisfaction" seems to best capture the body-image-related challenges experienced by most women during the perinatal period.

This article uses the terms "body image" and "body dissatisfaction" interchangeably.

The following section highlights other key terms that therapists can explore further:

- Misperception: A common phenomenon and "an important component of various mental illnesses like obsessive–compulsive and related disorders and eating disorders" (Mallaram et al., 2023).
- Weight misperception: Includes "concerns regarding body image, eating disorders, as well as harmful eating habits" (Mallaram et al., 2023).
- Body image distortions: On the higher end of the spectrum of body discomfort. Research on body image distortions tends to capture the effect on "physical and psychological health and impact [on] self-esteem, mood, and social and occupational functioning" (Mallaram et al., 2023).
- Body shame: A phenomenon where "an individual perceives themselves as a failure because they cannot reach a specific body ideal, such as the thin-ideal for female bodies perpetuated by Western cultures" (Papini et al., 2022).
- Body surveillance: Refers to the negative impact on one's appearance-related self-esteem due to the "the continual self-monitoring of the body to ensure it is aligned with cultural

expectations of physique and beauty" (Papini et al., 2022).

Where to start?

During the perinatal period, especially during pregnancy, women's bodies go through significant changes in relation to their weight; size; and sense of strength, stability, and flexibility. Therefore, pregnancy is often "associated with an increased vulnerability for the development of body image dissatisfaction" that is further "linked to adverse health outcomes for mother and child" (Linde et al., 2022).

From a counselling perspective, three key considerations arise when addressing this topic:

1. How should the perinatal period be defined?

2. How can body image dissatisfaction be understood and contextualised?

3. What insights from the perinatal counselling field can help therapists address client difficulties within the therapeutic setting?

Defining the perinatal period

Definitions of the "perinatal period" vary, from 22 weeks of gestation to seven days after birth (World Health Organisation [WHO], 2016), or 20 weeks of gestation to 28 days after birth (Australian Institute of Health and Welfare [AIHW], 2005). Perinatal mental health research suggests that the onset or relapse of psychiatric disorders may occur during pregnancy and the first two years post-delivery (Howard & Khalifeh, 2020; Sultana, 2021; Sultana, 2023; Womersley & Alderson 2024). The Health Service Executive (HSE, n.d.) states that women with a pre-existing mental health problem can ask to be referred to a perinatal psychiatrist for advice when planning a pregnancy.

Furthermore, based on the author's experience of working within the field of domestic violence and abuse, it seems that most family or couple conflicts arise while people have children under the age of five. Thus, from a counselling perspective, it may be clinically beneficial to conceptualise the perinatal period as commencing around the time of conception (from when someone is actively *thinking* about conceiving, regardless of the *doing*) until five years post birth (regardless of live birth or otherwise) (Sultana, 2021; Sultana, 2023).

Making sense of "nonsense"?

"You have just had a baby, you will bounce back in no time", "your bump is so neat", "you have that pregnancy glow", "you look beautiful". Regardless of compliments or others' perceptions, body dissatisfaction is a common phenomenon after birth. The accounts and experiences of some women post-partum may seem as if they defy logic and truth. Perinatal clients can recall experiences where their partners, friends, or family members have referred to their dissatisfaction with their body as "nonsense". Even with good intentions, loved ones may dismiss these concerns as illogical. Even when illogical, the person may still feel a high level of dissatisfaction about their body, and no amount of knocking on truth's door will change that perception.

It is essential that counsellors remember that "truth" can be multiple, contradictory and, at times, seemingly nonsensical, but that the client always makes sense in their own way. Rushing to offer a different perspective to the client – such as complimenting or acknowledging that they look beautiful – can damage the therapeutic alliance. Such actions are often driven by the practitioner's own anxiety or eagerness to help.

Rodin et al. (1984) extensively studied "women's preoccupation with thinness and their pursuit of beauty" within the context of stereotypes, gender roles, and cultural norms and attitudes. They coined the term "normative discontent" to describe the high prevalence of body dissatisfaction among women. Such preoccupation with one's appearance, they argued, "comes out of shame and social pressure and leads to psychological consequences such as decreased self-esteem, distorted body image, and feelings of helplessness and frustration in response to unsuccessful dieting efforts" (p. 267).

Mallaram et al. (2023) suggests that body image is "a complex concept including self-observations, cognitions, emotions, memories, fantasies as well as behaviours related to an individual's body, both conscious and unconscious". It is about "how an individual considers or imagines their body and how it appears to others... A person has a poor body image when they are preoccupied with the fictitious flaws of their physical appearance" (Mallaram et al., 2023). There are multiple factors and levels of complexity involved in making sense of a person's suffering related to their body image, especially for women. Not all of these may seem obvious to the therapist.

The perinatal period adds further complexities, with unique psychological changes taking place in a woman's mind during this time. Stern (1999) developed the concept of "motherhood mindset" to describe this unique shift in psychological makeup and identity:

> A person's mindset is thought to last a lifetime … No one thought that a woman's mental life can fundamentally change with the arrival of a baby … In the course of becoming a mother I realized

> a woman develops a mindset fundamentally different from the one she held before, and enters a realm of experiences not known to non-mothers. No matter what a woman's previous motives, vulnerabilities, and emotional reactions, when she becomes a mother, she will, for a time, operate from an entirely new mindset. This motherhood mindset pushes her pre-existing mental life aside and rushes forward to fill the centre stage of her inner life, giving it a different makeup entirely. (p.5)

The complexities of being a woman, combined with the frequent dissatisfaction of living in a body subject to scrutiny (whether by oneself or others), become even more pronounced during the perinatal period, particularly with the added phenomenon of becoming a mother. Raphael (1975) coined the term "matrescence" (similar to "adolescence") to theorise these changes. Raphael believed that, just as a child undergoes adolescence, a woman goes through transition as she becomes a mother. A woman's internal world (e.g., her psyche, mind, and brain) and external world (e.g., her body, social, and relational world) undergo immense change (Sultana, 2023). This can make it difficult for a therapist to make sense of the client's body image dissatisfaction. However, it can be achieved if they build a therapeutic bond that is strong enough for the client to let the therapist in, and if the therapist attempts to makes sense of the client's experiences – even if they initially seem "nonsensical" – through multiple theoretical lenses.

One essential theoretical lens involves addressing questions that largely remain unuttered: What happens when a woman becomes a mother? What makes a woman a mother? Who is a mother? How does a child affect the mother? These questions explore the impact of becoming a mother, the markers of motherhood, and the transition to this new role. Even though the presenting problem is body-image related, if the client is in their perinatal period, therapy may be enhanced by broadening the focus of the work. This suggestion is primarily based on the fact that no other discipline focuses exclusively on the woman, her transition, and her sense of self during the perinatal period.

Perinatal psychology and infant mental health usually focus on the impact of the mother (e.g., her behaviour, choices, and emotions) on the child. Attachment theory and other relational psychology theories also focus on the impact of the mother's choices and behaviours on the child. While perinatal psychiatry in Ireland used to focus on the mother in relation to perinatal loss (i.e., the impact of a loss of a child on the mother) (HSE, 2017), it now primarily focuses on the mother in relation to the management of psychiatric disorders. Within the scholarly world, it seems that the focus on the woman during this period shifts away to other elements.

The author proposes the following in light of the above:

1) The focus should solely be on the mother, particularly in relation to how the child or the idea of the child impacts the mother, not just how the mother's behaviour and choices impact the child. This includes her identity as a woman, including her physical identity (i.e., how her body looks and feel as she transitions to motherhood); her social identity (i.e., how she feels about her friends and the wider world's perception of her); her sexual identity (i.e., her sense of self as a sexual partner and in relation to intimacy); her identity as an employee or a member of the labour market (i.e., her productivity, employment, and economic contribution); and her identity as a family member (i.e., how others in the family perceive her) (for details, see Sultana, 2023, p. 35-43).

2) Due to the significant psychological changes one goes through in the perinatal period, the impact of becoming a mother needs to be explored even in the absence of psychiatric disorders. Expectations of the perinatal period – such as the assumption that having a healthy baby (especially after IVF, loss, or previous birthing difficulties) means the woman's struggles have suddenly ended – need to be rethought. Counsellors should expect the unexpected, as sessions may shift away from body image issues and not return to them.

3) Alongside questioning what happens to a woman when she becomes a mother, it is important to ask what defines a mother. Motherhood is not an immediate status achieved at conception or birth; one may feel like a mother without a live birth, while others may not, even with a living baby. The term "becoming a mother" (Sultana, 2023), using the continuous tense, better reflects this ongoing transition, which can extend far beyond five years' post-birth – sometimes even decades. Simple questions like "What makes you a mother in your own mind?" can help therapists understand each client's unique experience and struggles.

General theories of body image

Rodgers et al. (2023) reviewed the major theoretical frameworks on body image and suggest that most of the literature defines body image as a "multidimensional construct

encompassing the thoughts, feelings, and behaviours of an individual related to their own appearance". This field has evolved to explore various dimensions of body image, each addressing distinct aspects of the construct. Some theories view body image through "an evaluative aspect (satisfaction or concern with appearance) and an evaluation of the centrality of body image to an individual's identity" (Rodgers et al., 2023). These theories focus on the factors that influence the levels of dissatisfaction or concern that one may have with their body image. Other theories focus on factors that influence body dissatisfaction.

Other major discourses include the "deficit lens" and the "positive psychology lens". The deficit lens is where a person focuses on what they do not have, rather than focusing on what they do have, and where they perceive the situation as a deficit or lack on their part. Viewing body image through a deficit lens may be "a risk factor for poor mental health and psychopathology including eating disorders and other mental health concerns" (Rodgers et al., 2023). The positive psychology lens explores the "ways in which positive body image can be related to well-being" (Rodgers et al., 2023). It focuses on strength, empowerment, cherishing, and amplifying what the person has, rather than what they may not have.

In addition, body image has been studied from the "nonappearance dimensions of body image, such as functionality and embodiment" (Rodgers et al. 2023). Body functionality is the body's ability to perform tasks such as internal processes, movement, sensory experiences, creativity, communication, and self-care (Alleva & Tylka, 2021). Theories of embodiment focus on the lived experience of being in the body, which can either be positive or disrupted by various factors (Alleva & Tylka, 2021; Piran, 2016).

Considering these perspectives, two major practice implications emerge: "the prevalence of body image concerns worldwide is high", and "these concerns are robustly linked to mental health concerns" (Rodgers et al., 2023). Hence, it is imperative that counsellors remain open to being guided by their clients and remain flexible in exploring these lines of enquiry.

Major considerations during pregnancy and post delivery

Tarchi et al. (2023) found that body image dissatisfaction among pregnant women increased with gestational age. However, Wu et al. (2024), did not find evidence for that. Instead, they report that a "moderate level of body image dissatisfaction in women" exists "at three different stages of pregnancy", with no significant changes between stages. The increase in one's body size during pregnancy is intricately connected to difficulties in adjusting to the physiological changes of pregnancy, such as decreased metabolism and lifestyle changes, including reduced physical activity. This, in turn, impacts the women's weight and shape.

Furthermore, maternal metabolism is a key health factor that changes significantly during pregnancy and the postpartum period (Lain & Catalano, 2007). Obesity, which the WHO has declared a global pandemic (James, 2008) is an important consideration, with maternal obesity rates increasing significantly and posing health risks for both mothers and babies (Kalantari et al., 2024).

Maternal obesity, defined by a body mass index (BMI) over 29.9 kg/m^2 (HSE, 2013), is a well-documented risk factor and health professionals need to be mindful of its implications. Yager et al. (2023) argued that "health professionals who work with women in pregnancy and postpartum are rarely educated in psychosocial aspects of body image and mental health, despite this being a time of significant bodily change for women". Their comprehensive survey with health professionals from 16 European countries found that mainly open-ended questions and comments were being used during the perinatal period "within the context of encouraging weight loss" (Yager et al., 2023).

This would indicate that, although the professionals could see the need and opportunities for including the topic of mental health and body image in their conversations, they believed that there remained "a need for training about 'what to say' to mothers, as well as recommendations for diagnostic and referral pathways, and more general information about postpartum body image and mental health" (Yager et al., 2023). This training need also exists among counsellors and psychotherapists, especially when it comes to talking about a client's sexual health, including (dis) satisfaction.

Perinatal sexuality is another important consideration, particularly as it is a multidimensional phenomenon. A 2021 systematic review by Grussu et al. divided sexual health issues into two categories: those arising during pregnancy and those in the postnatal period. Issues can range from "deterioration in desire, orgasm, lubrication, satisfaction, and pain in the third trimester" (Grussu et al., 2021, p.3) to dyspareunia, a medical term for painful sexual intercourse, which can occur throughout pregnancy or post birth.

Further complexities may arise from post-surgery complications; birth-related difficulties (e.g., forceps delivery or perineal tearing); and breastfeeding (Sultana, 2023). Body image concerns must be understood in light of these factors, including

physical and sexual health, and in the aftermath of the battle that a woman's body goes through during this period.

Functional versus aesthetic dissatisfaction

Fuller-Tyszkiewicz et al. (2020) compared body dissatisfaction between four groups: pregnant women in the first trimester, second trimester, and third trimester; and non-pregnant women. They found that dissatisfaction related to one's weight, shape, muscle size, and tone, as well as their stomach, thighs, and hips, was common and similar in frequency among all four groups. However, dissatisfaction with arms, ankles, calves, legs, and shoulders were more common among all pregnant women in terms of functional dissatisfaction (e.g., flexibility, fluid retention, pain) rather than with weight and shape-related aesthetic dissatisfaction (i.e., how that body part looked).

Aesthetic dissatisfaction with weight and shape is more common in non-pregnant women, including postpartum women. The author's own clinical observations suggest that weight- and shape-related aesthetic dissatisfaction is common among both post-partum and non-pregnant women, along with breast-related aesthetic dissatisfaction. However, pregnancy usually enhances breast size and, hence, breast-related aesthetic dissatisfaction is less common during pregnancy but becomes more common postpartum.

Breastfeeding adds another layer of complexity to this topic, and it can decrease or increase breast-related dissatisfaction, both in terms of their aesthetic and functionality. Pain from cracked nipples, cuts from baby's teeth, pain from engorgement, and leaking breasts; and the dissatisfaction from those who are unable to produce milk are some of the major functional dissatisfactions of the postpartum period. Aesthetic dissatisfaction can relate to changes in the breast or nipple shape post-breastfeeding. It is important that therapists do not assume that these are "problems" and to ask the person about their unique experience.

Other factors like back pain, neck pain, heartburn, incontinence, postpartum hair loss, stretch marks, and loose skin are also common causes of dissatisfaction during the perinatal period. Weight-related dissatisfaction is the most common one, and it can contribute to depressive and anxiety symptoms, with the effects of such dissatisfaction appearing mild around the third month postpartum, but becoming more severe around 12 months postpartum (Hartley et al., 2018). While individual differences in body attitudes cannot be a reliable predictor of depressive and anxiety symptoms during the first-year post-partum, "women with poorer body attitudes would experience more severe depressive and anxiety symptomatology at the end of the postpartum" (Hartley et al., 2018).

Overall data on the changes in body image throughout pregnancy and the postpartum period are mainly inconclusive (Hodgkinson et al., 2014). Body image dissatisfaction can heighten during the first three months; remain same during the pregnancy period; heighten during the last trimester; heighten post-partum during the first year; and, for some, ease off after birth as breastfeeding begins (Hodgkinson et al., 2014).

Most studies and practice-based research suggest that functional dissatisfaction is common among pregnant women and aesthetic dissatisfaction is common among post-partum women (Fuller-Tyszkiewicz et al., 2020).

Expecting the unexpected and remaining open to learning from the client about their difficulties can enhance the effectiveness of therapy.

Culture of perfectionism

Without considering the cultural context and the time in which the client exists, the conceptualisation of their suffering will be less effective. Being a woman and a mother in 2024 is very different to even 20 years ago. Furthermore, one's "gender, maladaptive perfectionism, and psychological wellbeing may act as risk factors for body image dissatisfaction" (Hicks et al., 2022).

Today, women are bombarded by media that glorifies motherhood, presenting unrealistic and idealised images – happy, content, well-groomed, toned mothers holding smiling babies – which set unhealthy expectations. In reality, these portrayals are far from the truth. The author's clinical experience suggests that therapists can help clients recognise the gap between media and reality, as excessive screen time often reduces awareness of unrealistic standards. Asking clients about their screen time can help them become more aware of their usage.

Finally, the author's clinical observations would also suggest that the impact of seeing "happy, perfect" mothers on social media can be a source of misery for clients, as it forces them to compare themselves with those around them. The "Instagram supermom" concept is a real concern from a counselling perspective, as it promotes perfectionism, at times to a harmful extent.

> Instagram supermom: a nurturing, organized, sexy-but-modest multitasker who glows during prenatal yoga and seems unfazed by the challenges of leaking breasts, dirty laundry and sleep training. This woman is a fiction. (Sacks, 2017)

The "Becoming Model"
Finally, the following diagram highlights the vastness and complexity of the perinatal period. The "*Becoming Model*" (Sultana, 2023), the only integrative counselling model in the field of perinatal counselling, consists of 10 major themes and 40 sub-themes. Body image issues can affect any of these areas, and difficulties within any of these themes could contribute to body image issues.

Conclusion

This article outlined key theoretical, practical, and clinical considerations for therapists working in this field. Perinatal mental health is an emerging area, and body image issues within it require special attention. To advance the field, counsellors must strive for a balance between practice-based research and research-based practice, while engaging in knowledge-sharing.

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Academic/Research Article

The role of body image in eating disorders and disordered eating among midlife and older women: A biopsychosocial perspective

By Susi Lodola

The relationship between body image, body satisfaction, and disordered eating in midlife and older women is explored through a biopsychosocial lens. The discussion highlights how societal beauty ideals and ageing-related changes contribute to these challenges and it examines evidence-based approaches to support well-being in this population

Introduction

Body image and body satisfaction are central to an individual's self-concept and significantly impact overall psychological wellbeing (Merino et al., 2024). Body image refers to an individual's perceptions, thoughts, and feelings about their physical appearance, while body dissatisfaction emerges when there is a perceived gap between one's actual body and an idealised version of it, often shaped by societal and cultural standards (Quittkat et al., 2019). This dissatisfaction not only affects mental health but also plays a pivotal role in the development of disordered eating (DE) and eating disorders (ED). Consequently, people who are dissatisfied with their bodies are likely to be at greater risk for psychological distress.

The distinction between clinically diagnosed DE behaviours and EDs is well-documented in academic literature. EDs are recognised mental health conditions with specific diagnostic criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013). In contrast, DE encompasses a range of irregular eating behaviours that may not meet these criteria but can still negatively impact physical and mental health.

While these issues are well-researched in younger women, there remains a gap in understanding how they affect midlife and older women (Hockey et al., 2021). This article seeks to address the prevalence and impact of body dissatisfaction on EDs and DE among midlife and older women, examining contributing factors through a biopsychosocial lens, and evaluating evidence-based treatment strategies.

Prevalence

The prevalence of EDs and DE among midlife and older women has been steadily increasing, yet these issues remain underdiagnosed (Samuels et al., 2019). Mangweth-Matzek and Hoek (2017) suggest that ageism and societal perceptions play a significant role in the under-diagnosis and under-treatment of EDs in older women. They highlight the need for more inclusive diagnostic criteria and treatment approaches that account for the unique experiences of ageing women. These findings underscore the importance of addressing age-related barriers to ensure that older women receive appropriate and effective care for EDs.

Body dissatisfaction remains a significant driver of DE and EDs, with patterns in midlife women closely mirroring those seen in younger populations (Samuels et al., 2019). It has been suggested that the psychological and physical changes associated with ageing and menopause may parallel the changes associated with puberty, producing eating and weight-related concerns that are similar in the different age groups of women (Gupta & Schork, 1993). Large-scale studies underscore the widespread nature of these challenges. The Gender and Body Image (GABI) Study (Gagne et al., 2012) surveyed over 1,800 women aged 50 and older and found that 61.8% reported concerns related to eating, weight, or shape, with 70% expressing dissatisfaction with their current weight and shape compared to their younger years.

Similarly, a survey by Mangweth-Matzek et al. (2006) surveyed over 1,000 women aged 60–70 and found that nearly 90% felt "very" or "moderately" fat. This was irrespective of their body mass index (BMI), a standard measure that uses weight and height to estimate body fat. Additionally, 45.2% reported that their self-esteem was closely tied to their weight and shape, underscoring the strong connection between body image and self-worth. Even among women with a BMI classified as "normal" (18.5–24.9), 50.6% reported body dissatisfaction, suggesting that concerns about body image are pervasive and not limited to any specific weight category. This concern is further reflected in a large-scale study of over 31,000 participants, which found that dieting behaviours were most prevalent among women aged 35–65 years, illustrating how dissatisfaction with body image influences behaviours across a broad age range (Slof-Op't Landt et al., 2017).

In contrast, a more recent longitudinal study involving over 15,000 adults (63% of whom were women) by Hockey et al. (2021) identified a slight increase in body satisfaction among women, particularly beyond the age of 60. One explanation offered for this stabilisation of body image concerns is the influence of shifting societal trends (Hockey et al., 2021). Over the past two decades, feminist perspectives have increasingly challenged societal beauty ideals, aiming to disconnect a woman's worth from her appearance (Murnen & Smolak, 2009) and promote inclusivity and body acceptance (Bacon & Aphramor, 2011; Wood-Barcalow et al., 2010).

Body image and body dissatisfaction: A biopsychosocial view

The biopsychosocial model provides a holistic approach to understanding the link between body dissatisfaction and DE and EDs**.** This framework moves beyond single-cause explanations, showing how physical changes, emotional vulnerabilities, and societal influences work together to shape body image concerns.

Biological factors

Research indicates that BMI is a significant biological factor influencing body dissatisfaction, dieting behaviours, and problematic eating patterns in midlife women. Women with higher BMI are more likely to report a stronger drive for thinness, greater body shame, increased dieting behaviours, and heightened preoccupation with food (Forrester-Knauss & Zemp Stutz, 2012; Gagne et al., 2012; Sarwer et al., 2005; Tiggemann, 2004). These patterns are not limited to midlife women; Hockey et al. (2021) found similar links between BMI, body dissatisfaction, and unhealthy eating behaviours across a broader adult population, emphasising that these challenges are widespread across different age groups.

In addition, hormonal changes during menopause, particularly the decline in oestrogen levels, contribute to shifts in fat distribution, such as increased abdominal fat, which can heighten body image concerns among postmenopausal women (Lovejoy et al., 2008). Similar to the pubescent transition from childhood to adulthood, the shift from reproductive years to menopause is proposed to be a high-risk phase where body dissatisfaction and related symptoms are particularly likely to emerge (Baker & Runfola, 2016).

These physical changes, combined with menopausal symptoms such as vasomotor symptoms (e.g., hot flushes and night sweats) and psychological issues, have been strongly associated with heightened body dissatisfaction (Becker et al., 2001). Chronic illnesses, mobility limitations, pain, and declining physical abilities further exacerbate negative body perceptions and impact overall well-being (Clarke et al., 2008).

Furthermore, neurobiological factors may also influence body dissatisfaction in ageing women. Although much of the research has focused on younger populations, where neurotransmitter imbalances

such as serotonin and dopamine are linked to body dissatisfaction and eating disorders (Kaye et al., 2013), it is plausible that similar mechanisms are at play in older women.

Psychological factors

Depression and anxiety can serve as both triggers and consequences of body dissatisfaction, creating a self-perpetuating cycle that reinforces DE behaviours (Sharpe et al., 2018). This cycle can be further perpetuated by negative self-talk (Keel et al., 2007), with women internalising harsh criticisms of their appearance, leading to diminished self-esteem and greater body dissatisfaction (Liechty & Yarnal, 2010).

This internalised criticism often extends beyond appearance to behaviours, as shown by Cash and Pruzinsky's (2005) exploration of food moralisation. Societal norms that categorise foods as "good" or "bad" can lead women to internalise blame when they perceive themselves as failing to adhere to restrictive dietary standards. Such moral judgments reinforce feelings of guilt and shame, deepening the cycle of self-criticism and psychological distress that perpetuates body dissatisfaction and DE.

A systematic review by Slevec and Tiggemann (2011) explored predictors of body dissatisfaction and DE in middle-aged women, identifying key contributors such as depression and anxiety. The findings highlight the significant role of psychological factors in shaping these issues in this demographic.

Building on this, Jackson et al. (2014) examined the relationship between body image dissatisfaction and depression in a diverse cohort of 405 women aged 42–52. The study found that women dissatisfied with their body image were nearly twice as likely to experience clinically significant depressive symptoms compared to those satisfied with their appearance, regardless of racial background.

More recently, Kilpela et al. (2023) investigated the longitudinal associations between body dissatisfaction and health and wellness behaviours in women aged 50 and above. Their findings revealed that higher levels of body dissatisfaction were strongly linked to increased depressive symptoms and poorer health-related quality of life over time, underscoring the enduring impact of body image concerns on mental health and well-being in later life.

Additionally, ageing anxiety has been identified as a significant contributor to body dissatisfaction and mental health challenges among midlife and older women. A study of 331 women aged 45-65 revealed that higher levels of ageing anxiety and body dissatisfaction were strong predictors of depression (Carrard et al., 2019).

Social factors

To explore the causes and effects of thin-ideal internalisation and body image concerns, it is helpful to draw on established theoretical models. The Tripartite Influence Model (TIM: Thompson et al., 1999), a widely validated sociocultural framework for understanding body dissatisfaction, suggests that societal beauty ideals are primarily transmitted and reinforced by three key sociocultural influences: peers, family, and the media. These influences promote thin-ideal internalisation and appearance-based social comparisons, both of which can intensify body dissatisfaction. Body dissatisfaction is, in turn, linked to DE and subsequent psychological distress. Hockey et al. (2021) applied the TIM in a study of 206 women aged 40–55, finding that media pressures drive appearance comparisons and the internalisation of thin ideals, ultimately increasing body dissatisfaction. Notably, Hockey et al. (2021) found that family pressure directly predicted body dissatisfaction, bypassing appearance comparisons and thin-ideal internalisation. These findings suggest that family dynamics play a distinct and significant role in midlife women's body image issues and should be considered in treatment interventions.The emphasis on thinness, youthfulness, and specific body proportions creates an ideal that is continuously amplified by media and advertising, setting unattainable benchmarks for appearance (Goldbach et al., 2022). Reinforced by cultural narratives, these ideals shape women's self-perception, often linking self-worth to physical appearance. As women age and their appearance increasingly diverges from these societal standards, feelings of inadequacy can intensify (Clarke, 2001).

Media plays a particularly profound role in shaping women's body image. From traditional outlets, such as fashion magazines, to newer platforms, such as social media, women are inundated with images of idealised body types, often digitally manipulated to convey perfection (Barene et al., 2022). Such comparisons frequently result in body dissatisfaction, driving cycles of negative self-evaluation and unhealthy behaviours in the pursuit of unattainable ideals (Grabe et al., 2008).

Neoliberal and ageist narratives further intensify these challenges by promoting the notion that ageing equates to a decline in health and vitality. Such narratives encourage behaviours like restrictive dieting or anti-ageing treatments, not only to maintain health but also to delay visible signs of ageing (Laliberte Rudman, 2015). While some practices, such as healthy eating and physical activity, offer benefits, they may lead to heightened body

monitoring and appearance anxiety. These behaviours can drive unhealthy patterns, including restrictive dieting and social withdrawal, contributing to further psychological distress (Zhao et al., 2024).

While societal pressures can significantly contribute to body dissatisfaction and related mental health challenges, the role of social support networks in mitigating these effects is critical. For example, Fairweather-Schmidt et al. (2014) found that social support mediated the relationship between DE and quality of life (QoL), underscoring the importance of fostering strong support systems to buffer against the negative impacts of societal ideals.

Eating disorders and disordered eating in midlife

A lifetime of engaging with diet culture and internalising societal ideals has normalised DE for many women. This persistent "language of fat", as Samuels et al. (2019) describe, coupled with biological, psychological, and social influences, perpetuates body dissatisfaction and DE in later life.

When examining EDs in later life, researchers have identified three primary pathways: chronic, lifelong EDs, where the disorder persists from adolescence or early adulthood into later years; remission-relapse cycles, where individuals experience periods of recovery interspersed with episodes of recurrence; and late-onset EDs, which typically emerge in midlife or later adulthood, often triggered by significant life transitions such as menopause, divorce, or the loss of a loved one (Baker et al., 2019).

Pruis and Janowsky (2010) found that women aged 45–60 who reported higher levels of body dissatisfaction were more likely to engage in behaviours such as binge eating and restrictive dieting in an attempt to regain control over their changing bodies. Similarly, Mangweth-Matzek et al. (2006) demonstrated that body dissatisfaction in older women frequently leads to unhealthy DE behaviours, such as extreme dieting or purging. The GABI study further highlighted the prevalence of DE in midlife women, when Gagne et al. (2012) reported that many participants engaged in frequent weight loss attempts and restrictive dieting and, in some cases, resorted to unhealthy methods such as use of laxatives and diuretics.

The lasting impact of DE on QoL has been well-documented in longitudinal research. Fairweather-Schmidt et al. (2014) conducted a 14-year study of over 12,000 women and found that those experiencing DE consistently reported poorer mental and physical QoL compared to those without DE. This was particularly significant in midlife women, who faced declining physical health compounded by depressive symptoms. Supporting this, Hilbert et al. (2012) identified a second peak in DE behaviours among women aged 45–55, suggesting that midlife represents a vulnerable period for the resurgence of EDs.

Treatment

Addressing body dissatisfaction requires a comprehensive approach that integrates biological, psychological, and social factors (Guest et al., 2022). The following section examines a range of evidence-based treatment options aimed at addressing these interconnected factors.

Cognitive Behavioural Therapy (CBT)

CBT has been identified as providing effective interventions for improving not only body image and reducing DE, but also addressing a variety of other mental health concerns (Zhao & Yin, 2024). Interventions focus on challenging distorted beliefs by applying Socratic questioning and using behavioural experiments. One example of a behavioural experiment is mirror exposure (González-Sánchez et al., 2024) which directly addresses body image concerns by guiding participants to view themselves in a mirror while practicing neutral or positive self-talk.

CBT for Eating Disorders (CBT-E), recognised for its transdiagnostic effectiveness, is particularly suited to addressing a wide range of ED symptoms (Fairburn, 2008). Clinical interventions may benefit from targeting appearance comparisons and thin-ideal internalisation to mitigate their negative effects. Cognitive dissonance-based programmes have been shown to reduce thin-ideal internalisation, body dissatisfaction, dieting behaviours, and bulimic symptoms in younger women (McLean et al., 2011; Stice et al., 2000).

Acceptance and Commitment Therapy (ACT)

ACT complements CBT by encouraging women to accept their thoughts and feelings about ageing and appearance without judgment, while committing to values-based actions. For example, ACT uses mindfulness exercises, such as observing body sensations without labelling them as "good" or "bad", to reduce the emotional intensity of body image concerns (Seekis et al., 2020).

Research demonstrates that the ability to experience body-related thoughts without acting on or avoiding them is associated with greater self-compassion and, this ability – which emphasises how individuals relate to their thoughts rather than their content – can reduce reliance on maladaptive behaviours such as restriction or binge eating (Hayes, 2004),

Interpersonal psychotherapy (IPT)
IPT can address body image concerns by focusing on interpersonal factors that influence self-perception, helping individuals understand how social interactions and societal expectations impact their body image. By exploring and improving relationships, this approach fosters healthier interpersonal dynamics to enhance self-esteem and reduce body dissatisfaction (Duffy et al., 2021).

Mind-body interventions
Interventions such as yoga practices and dance movements that emphasise mindfulness, breathwork, and gentle movement have been shown to improve body satisfaction and reduce anxiety (Tylka, 2019).

Psychoeducation
Psychoeducation plays a vital role in addressing body image concerns and DE by empowering individuals through improving knowledge about the psychological, biological, and social influences on their mental health. Providing information about societal pressures, such as unrealistic beauty ideals and the pervasive impact of diet culture, helps individuals critically evaluate the external influences contributing to their body dissatisfaction (Cash & Pruzinsky, 2005).

Furthermore, educating women about the natural changes associated with ageing, such as hormonal shifts and changes in body composition and their impact on mental health, can reduce anxiety and foster acceptance (Gupta & Schork, 1993). By understanding how psychological factors, like negative self-talk and anxiety, exacerbate body image distress, women can begin to break harmful thought patterns (Government Equalities Office, 2021).

Compassion focused therapy (CFT)
People with body image issues often struggle with feelings of shame, self-blame, and a harsh inner critic. CFT (Gilbert & Simos, 2022) works to counteract these patterns by encouraging individuals to develop a compassionate inner voice, which promotes acceptance and understanding toward their bodies.

Group therapy
Group therapy has been shown to be effective in addressing body image concerns and various mental health issues among women. For instance, a study by Mehrabi et al. (2024) evaluated the impact of group CFT on body image and interpersonal stress among women with breast cancer. The findings indicated that group CFT significantly improved body image and reduced interpersonal stress in the participants.

Nutritional guidance
Psychotherapists can provide a space for clients to discuss healthy nutrition but should refer clients to a nutrition expert should personalised, evidence-based dietary advice be required. Such experts can help women better understand the physiological changes that come with ageing.

Hormone replacement therapy (HRT)
HRT may address menopausal symptoms like mood changes and body composition shifts, which contribute to body dissatisfaction. Consultation with a GP is necessary to ensure HRT is safe and appropriate, making it a potential component in a holistic treatment approach.

Screening and outcome measures
Screening for EDs and body image issues can be a valuable tool in identifying concerns early and enabling timely intervention, particularly for older women who may not recognise their symptoms. Instruments such as the Screen for Disordered Eating (SDE) assess emotional eating, control over eating, and distorted self-perceptions (Maguen et al., 2018). The Body Image Disturbance Questionnaire (BIDQ; Cash et al., 2004) evaluates negative body image, appearance investment, and functional impairments due to body image concerns.

Part of evidence-based best practice and treatment is incorporating validated outcome measures to monitor the effectiveness of interventions. Examples of measures that can be used to evaluate eating behaviours and body image concerns include the Eating Disorder-15 (ED-15; Tatham et al., 2015), Binge Eating Scale (BES; Gormally et al., 1982), Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008) and the Body Shape Questionnaire (BSQ; Cooper et al., 1987).

Additionally, tools like the Beck Depression Inventory (BDI-II; Beck et al., 1996) and the Generalised Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006) effectively assess co-occurring psychological issues.

Conclusion
Body dissatisfaction, mental health challenges, and DE form a deeply interconnected cycle that significantly impacts the well-being of midlife and older women. The biopsychosocial model provides a comprehensive framework for understanding the complex interplay between biological, psychological, and social factors contributing to these issues. Biological changes, such as menopause-related hormonal shifts and age-related weight redistribution, intersect with psychological vulnerabilities like negative self-talk and anxiety, as well as social pressures rooted in

unattainable beauty standards. Together, these factors amplify body dissatisfaction and drive DE behaviours.

Effective treatment requires a multifaceted, evidence-based approach that addresses these interconnected dimensions. Additionally, therapists must remain mindful of client nondisclosure, approaching the topic of body image and EDs with sensitivity and trust-building to uncover underlying concerns. Incorporating validated outcome measures further enhances the effectiveness of interventions, providing essential feedback to tailor treatment approaches.Ultimately, addressing body dissatisfaction and its associated challenges is not just about improving physical and psychological outcomes but also about empowering midlife and older women to redefine their sense of self-worth beyond societal standards of appearance. A holistic and compassionate approach to treatment has the potential to foster long-lasting resilience, enhance QoL, and support women in navigating the complex interplay between body image, mental health, and ageing.

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IACP Noticeboard

Cathaoirleach's Letter to Members Spring 2025

Dear Member,

I always think of spring as a season of renewal and hope, as the buds start peeking out from grey tree branches and the daffodils and tulips bloom. Now is the perfect time to start fresh – reflect and recentre ourselves emotionally, physically, and mentally and bring a new energy to our clients and ourselves.

One way I plan on carrying out this intention is to attend the IACP's Annual Conference, 'The Lived Experience: Enriching Practice through Connection and Reflection' in April. I hope to reconnect and see many of my fellow colleagues in Cork this year for a day of reflection and replenishment.

New Board Members

The Board of Directors met on 31st January and I'm happy to share that after a robust process that we have filled the four vacant Board positions.

I'm delighted to welcome our new board members Marcella Finnerty, Brian Holohan, Anita Lynch and external member John Cummins. Their exceptional knowledge and diverse skills will be great additions to our talented board and benefit all of us at the IACP and I look forward to collaborating together with the national office team to achieve our goals of advancing the counselling and psychotherapy profession.

The IACP received seven nominations for the Board of Directors for 2024-2025 prior to the AGM. The board consists of not less than seven and not more than eleven members. At the AGM, our outgoing Cathaoirleach Séamus Sheedy announced the plan to recruit three IACP members and to promote diversity of experience on the Board, one external person to fill the four vacancies.

After the call went out to members we received a wonderful number of expressions of interest for the IACP member vacancies. I really appreciate the enthusiastic response of our members and the willingness to step-up and contribute to the leadership of our organisation.

Board members (left to right) Edward Boyne, Gael Kilduff, Leas Cathaoirleach Christopher Place, CEO Lisa Molloy, Cathaoirleach Jade Lawless, Executive Administrator Aidan O'Leary, Company Secretary Andrew Harbourne-Thomas, Regional Director Liam Neville, and attending online Caroline Kehoe at the January board meeting

Cathaoirleach's Letter to Members

The Board was supported by the advice and counsel from an external governance consultant to guide the process and ensure good governance best practices were followed.

To aid in the recruitment of the external member, Boardmatch, a registered charity that works to upskill charity and not-for-profit boards by connecting enthusiastic and skilled volunteers with organisations that have board vacancies, was utilised.

When reviewing the applications, the Board Co-Opting Panel used a framework to evaluate each candidate considering, for example, demonstrated experience relevant to furthering our strategic needs, previous non-profit board experience, diverse and relevant applicable skills, experience serving on IACP committees, and leadership qualities. We are delighted to confirm that our four new members have plenty to offer across each of these criteria.

AGM Motions Update

I'll now take the opportunity to provide an update on the motions approved at the AGM in October, which have been of much interest to the membership.

Motion 1: To create a new membership category called Academic Member

This amendment creates a new category of memberships called Academic Membership. To amend the Bye-laws (as amened October, 2019) as follows:

- 1:10 Academic membership is available to those who hold current Accredited or Supervisor Membership in good standing who are engaged in counselling psychotherapy academic activities meeting the criteria laid down from time to time by the Board of Directors.

- The Board of Directors and the Professional Practice Sub-committee are currently working on the criteria and application process for this new category and we hope to confirm more details and launch this new member category in the coming months.

Motion 2: To allow pre-accredited members a choice to continue with their existing supervisors.

The Board have ratified the inclusion in the Accreditation Policy giving members a choice to continue with their existing supervisors after completion of their core course.

Changing supervisor upon completion of the core course is no longer a requirement of first-time accreditation with the IACP.

Thank you to everyone who put forth an amendment/motion at the AGM. The motion and amendment process is an important one for our professional body as it is the vehicle for members to have their voices heard regarding policy or other issues of concern that they believe should be discussed by the wider membership at the AGM.

As I sign off on this issue, I want to encourage you to take full advantage of your numerous membership benefits.

Visit IACP.ie to learn more about your benefits and to view upcoming in-person or online events for networking opportunities and workshops and check out the CPD online portal to grow professionally. If you have a particular interest that you would like to explore there are several committees looking for volunteers and you would be very welcomed and supported, to learn more take a look at the committee section of the website. Another fantastic resource is free-access to the EBSCO research database and the EBSCO Psychology ebook collection offering more than 650 popular titles in psychology, psychotherapy, counselling and more. A big thank you to all those currently serving on our committees and working to further our profession.

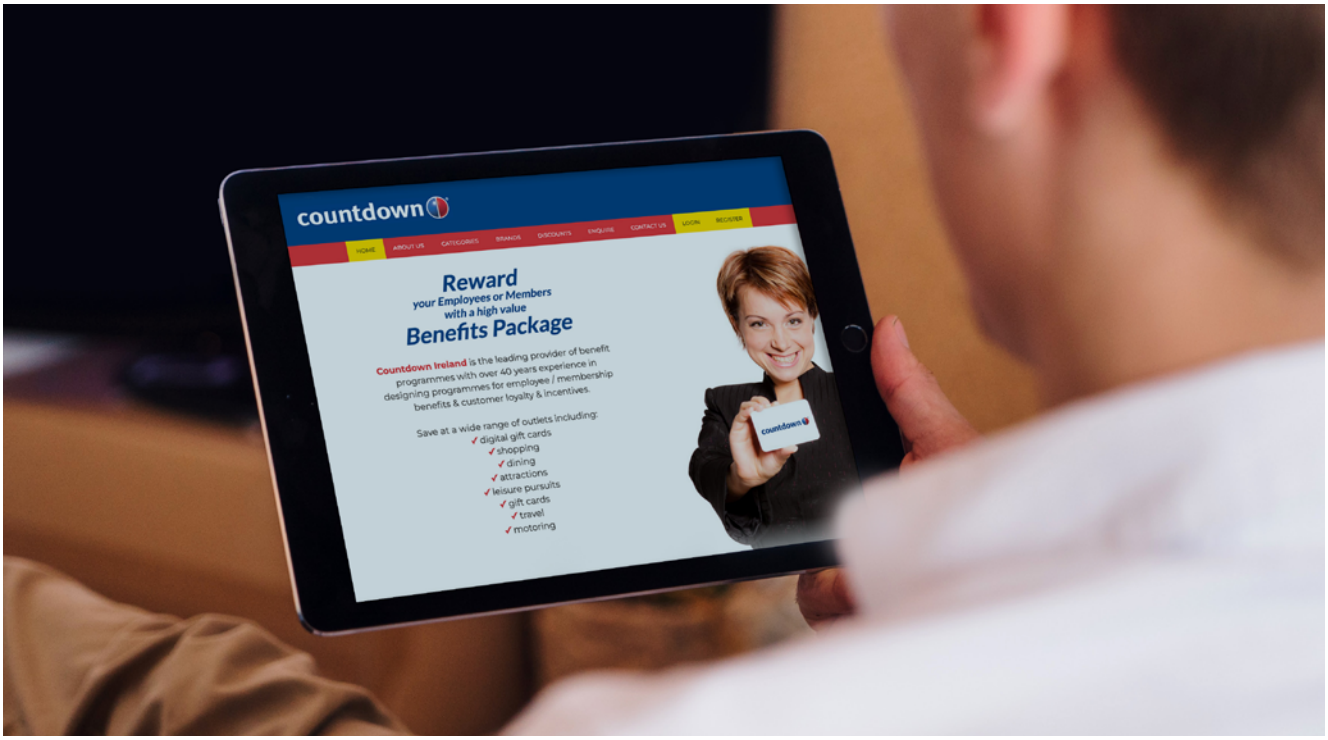
Another valuable IACP membership benefit to be aware of is the Countdown Benefits Package. The Countdown service includes discounts in top high street stores, supermarkets, international hotels, holiday accommodation both at home and abroad, leisure activities and much more.

Remember that as an IACP member you are part of a vibrant, supportive, and caring community. Best wishes for a lovely springtime and I hope to see you soon.

Yours sincerely,

Jade Lawless

Jade Lawless
Cathaoirleach, IACP



A message from the Chief Executive

A Message from the Chief Executive Spring 2025

Dear Member,

I hope that springtime brings with it pleasant and warmer weather to you all around the country after the challenging winter.

At the national office the team has been focused on planning, developing and refining our activities and priorities for the year to enhance your IACP membership.

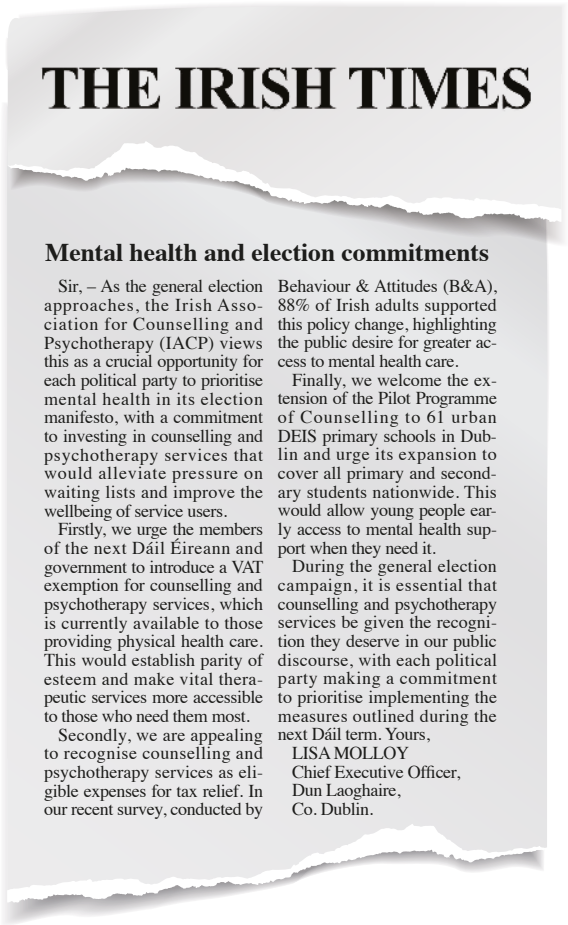
I wanted to take this opportunity to provide you with some important updates on our continued engagement on your behalf.

Outreach/New Government

Leading up to the general election the IACP urged political parties and government officials to prioritise mental health funding and programmes in their election manifestos and in the new government. We also reiterated our long-standing call to bring in the application of the VAT exemption to counsellors and psychotherapists in line with the exemption currently available to psychologists and other health professionals. To expand tax relief for counselling and psychotherapy services to be deemed an eligible expense in line with other health expenses, and finally for the School Counselling Pilot to be extended to all primary and secondary schools in the country.

Our public affairs and lobbying strategies are proving effective in getting our voices heard at a national and local level.

I'm happy to report that all of the major parties included mental health as priority in the health care sections of their manifestos. Both the Labour and Social Democrats parties called for the introduction of the VAT exemption for counselling and psychotherapy services in their 2024 manifestos.



THE IRISH TIMES

Mental health and election commitments

Sir, – As the general election approaches, the Irish Association for Counselling and Psychotherapy (IACP) views this as a crucial opportunity for each political party to prioritise mental health in its election manifesto, with a commitment to investing in counselling and psychotherapy services that would alleviate pressure on waiting lists and improve the wellbeing of service users.

Firstly, we urge the members of the next Dáil Éireann and government to introduce a VAT exemption for counselling and psychotherapy services, which is currently available to those providing physical health care. This would establish parity of esteem and make vital therapeutic services more accessible to those who need them most.

Secondly, we are appealing to recognise counselling and psychotherapy services as eligible expenses for tax relief. In our recent survey, conducted by Behaviour & Attitudes (B&A), 88% of Irish adults supported this policy change, highlighting the public desire for greater access to mental health care.

Finally, we welcome the extension of the Pilot Programme of Counselling to 61 urban DEIS primary schools in Dublin and urge its expansion to cover all primary and secondary students nationwide. This would allow young people early access to mental health support when they need it.

During the general election campaign, it is essential that counselling and psychotherapy services be given the recognition they deserve in our public discourse, with each political party making a commitment to prioritise implementing the measures outlined during the next Dáil term. Yours,

LISA MOLLOY
Chief Executive Officer,
Dun Laoghaire,
Co. Dublin.

My letter to the editor raising these important priorities appeared in Irish Times, The Echo, and Irish Examiner in November.

We will continue to work to raise awareness about the importance of mental health and the vital role that the counselling and psychotherapy professions play in Ireland's healthcare delivery.

At press time, the new Government was finalising their cabinet. We're looking forward to working with Jennifer Carroll MacNeill, the new Minister for Health and local Fine Gael TD for the Dún Laoghaire

constituency. Previously she served as Minister of State for European Affairs and Minister of State at the Department of Finance and also worked as a solicitor and barrister within the public service as well as a government special advisor.

We were delighted to see that Mary Butler was appointed Government Chief Whip and Minister of State attending cabinet with special responsibility for mental health. This is a historic moment as it is the first time that the interests of mental healthcare will have a voice and representation at the cabinet table. We congratulate Minister Butler, and we look forward to working with her and continue to build on the strong relationship that has developed over the years.

"I'm also very proud to say that I played a role in elevating mental health to the cabinet table for the first time ever. Mental health will have a standalone voice at cabinet, and I can finish my work on the Mental Health Bill, a more modern, person-centred approach to mental health legislation." said Minister Butler in the Irish Independent 28th January 2025

Welcome New Board Members

Congratulations and a warm welcome to our newly appointed board members, IACP accredited members, Marcella Finnerty, Brian Holohan, and Anita Lynch, and to our external board member John Cummins. Their experience and expertise will add immense value to our board and wider organisation as we pursue our strategic vision, and I look forward to working with them. It was wonderful to see the high level of interest in these board roles. Our members are the heart and soul of our organisation and your commitment to get involved and give of your time on our board and committees is inspiring.

Stakeholder Engagement Update

I am happy to share that a new CEO/Registrar of the Health and Social Care Professional's Council (CORU) was appointed in December.

Ms. Claire O'Cleary, a pharmacist, joined CORU in 2020 and has most recently served as Head of Education. She has previously held roles with Allcare Pharmacy and The Irish Institute of Pharmacy.

I have arranged to meet with Claire to discuss the progress of the opening of our registers and I look forward to providing you with an update in due course.

In addition, we have reached out to the Irish College of GPs, the professional body for general practice in Ireland to further explore ways that we can connect our members to each other to support patients seeking counselling and psychotherapy services.

The ICGP is the representative organisation for education, training and standards in general practice, with 4,500 members and associates comprising over 85 percent of practising GPs in the Republic of Ireland and 1,191 GPs in training.

Volunteer Strategy

Our highly valued internal stakeholders, our volunteers, continue to be our focus through the development of our Volunteer Strategy. Following extensive member consultation, valuable feedback has been gathered and incorporated into a draft strategy. This strategy will be supported by several key actions to improve the volunteer experience.

One of the first initiatives will be the development of a series of engagements to promote the various volunteering opportunities available. Other opportunities to participate in the IACP besides committee membership e.g. media panel, writing opportunities, and representing the IACP at various events will be highlighted along with the valuable professional and personal benefits that can be realised as a volunteer.

Upcoming Events

I want to bring to your attention an exciting event for your diary, the IACP's Tenth Annual Conference is scheduled for Saturday 12th April 2025 in The Maryborough Hotel, Cork. The theme is 'The Lived Experience: Enriching Practice through Connection and Reflection'. The conference is a wonderful opportunity to take time away from your normal

A message from the Chief Executive

Attendees at the Northeast Regional Committee AGM at the City North Hotel, Co. Meath marking the stepping down of Chairperson Jim Hutton

routine to learn something new by cultivating and enriching your professional development. Attending the event in person is the perfect opportunity to reflect, re-connect and network with fellow members. We also take the time to honour the outstanding accomplishments of our members at the awards ceremony. Please see page 43, for full details and speaker bios.

In closing, I'm very much looking forward to the upcoming Accreditation Ceremony, IACP's annual celebration of newly accredited members and supervisors. It's a special evening held in February to honour and recognise all the great achievements our members have made on their accreditation journeys.

I hope to be seeing you soon at one of our many upcoming events.

Sincerely,

Lisa Molloy
Chief Executive, IACP

IACP 2025 Annual Conference

The IACP Board of Directors cordially invites you to attend the 10th Annual Conference, taking place on Saturday 12th April 2025 in the Maryborough Hotel, Cork.

The conference is an in-person event, and we are happy to announce this year's theme is 'The Lived Experience: Enriching Practice through Connection and Reflection'.

This event offers a unique opportunity to engage with like-minded professionals, share stories, and gain fresh perspectives that deepens understanding and enriches your practice.

Through meaningful connections and thoughtful reflection, we'll explore how lived experiences shape and enhance our approaches to work and life. Don't miss this chance to be part of an empowering dialogue that celebrates shared wisdom and fosters both, personal growth and professional development. Seven CPD points will be awarded for attendance.

We have an impressive lineup of speakers that promises a rich exploration of the conference theme. IACP member, Linda Breathnach will facilitate two speaker panel sessions.

After the conference, please join us for the IACP annual awards ceremony honouring your fellow members. Award categories include:

- **Regional Awards**
- **Research Awards & Research Bursary**
- **Charity Partner**
- **Public Inspiration Award**
- **Carl Berkeley Memorial Award**
- **Past Cathaoirleach Award**

Additional details about the conference, hotel bookings, and the dinner are available on iacp.ie.

2025 Conference Guest Speakers

Richard Hogan – 'The therapist and their work' – Hope in the therapeutic process.

Richard Hogan is a systemically trained Family Psychotherapist and Clinical Director of the award-winning Therapy Institute. A weekly columnist for the Irish Examiner, he is the author of two bestsellers: Parenting the Screenager and Home is Where the Start Is, both critically acclaimed and the latter shortlisted for an Irish Book Award. Richard was awarded a Fulbright scholarship in 2020, conducting research on inclusion in schools at a leading American university. A frequent media contributor, he appears on RTÉ's Raised by the Village, Virgin Media's Eating With The Enemy, and various radio and TV shows, promoting mental health strategies.

Eina McHugh – 'Twelve years on: A reflection on my experience of releasing a client's authentic account of therapy into the world as a creative act and in support of others.'

How has this experience surprised, challenged and touched me and what have I learnt about myself, other humans, therapy and creativity?

Eina McHugh leads at the forefront of experiential learning and human development in creativity, creative leadership and innovation. An Entrepreneurial Specialist at University College Dublin's Innovation Academy, an Irish Fulbright Scholar and a private coach, Eina helps people, from all backgrounds, to unlock creativity in life and leadership. She more than 30 years leadership experience in the cultural arts and creative industries.

Eina is also author of the acclaimed memoir, 'To Call Myself Beloved' first published by New Island Books in 2012.

IACP Noticeboard

Margaret O' Connor – 'The unacknowledged lives of people without children'

Margaret O' Connor is an IACP accredited counsellor and psychotherapist based in Limerick. She runs the 'Are Kids For Me' counselling service for people who need support with the decision of whether to have children or not, and to support those who have decided to be childfree. She hosts the 'Are Kids For Me' podcast to share stories of people's experience of grappling with this question. Please see www.arekidsforme.ie for more information. Margaret is also BSc Programme Leader with PCI College where she oversees the running of the degree in counselling and psychotherapy. She is a strong believer in adult education and upholding high standards of training in the counselling and psychotherapy profession.

Paraic Barnes – 'Reflecting on a personal journey from sightedness to sightlessness: More than meets the eye'

Paraic is a practising counsellor/psychotherapist; and an accredited member of the IACP. He runs a private practice in Ennis, Co Clare. In addition to his private case lists, Paraic is also contracted to provide counselling services to a wide range of organisations within the disability sector. He has also worked part-time as a lecturer with PCI College; and is currently training to become a clinical supervisor. Prior to losing his sight in 2011 he worked in the areas of education and psychology where his remit included extensive mentoring and coaching roles. Since 2011, he has continued this work and achieved a BSc (1st honours) in Counselling and Psychotherapy. He is a strong advocate in promoting a broader understanding of disability and has published articles on diversity and inclusion in national newspapers. He has been guest lecturer and speaker at conferences and university inclusion symposiums and is a regular contributor on local and community radio where he supports the work of well-known charities such as Vision Ireland and Irish Guide-dogs.

Linda Breathnach – Panel Facilitator

Linda Breathnach, MIACP lives in Navan with her husband and four children and has been working in private practice there as well as in the greater Dublin area since 2006. Accredited by the IACP, Linda is a psychotherapist, lecturer, trainer, and supervisor across professions.

She enjoys hearing from new people and is looking forward to facilitating what hopes to be interesting and thought provoking panel discussions.

IACP 10th Annual Conference

Saturday 12th April 2025
in The Maryborough Hotel, Cork

Research Highlights

IACP Research Committee – 2024 Visual Summary

The Research Committee had a wonderful year with amazing attendance at its many events and through the development of fresh resources for members. With thanks to Chair Aisling O'Connor, Vice Chair Dr Caitriona Kinsella and the committee members for all their work, as well as to our members who engaged with and contributed to events and resources throughout 2024. We look forward to another great year – in which we hope to explore further opportunities to foster and embed an evidence-based research culture within IACP and our profession.

7th Research Journal Club – Focus: Food and Mood
IACP's Research Journal Club is a popular quarterly event which is going from strength to strength. The topic for our Research Journal Club on 2nd December was Food and Mood and the paper under discussion was qualitative focus group research which explored the links between food and mood directly with members of the public.

Joining Research Committee facilitators – Chair Aisling O'Connor and Vice Chair Dr Caitriona Kinsella – was IACP member Jayne Leonard who shared insights from her qualitative research with professionals in this area, exploring counsellors' and psychotherapists' understanding and use of nutrition in the therapy room. Jayne is the IACP Research Excellence Award winner of 2024 and her paper was published in *Counselling Psychotherapy Research*, *August 2023, 1–13*.

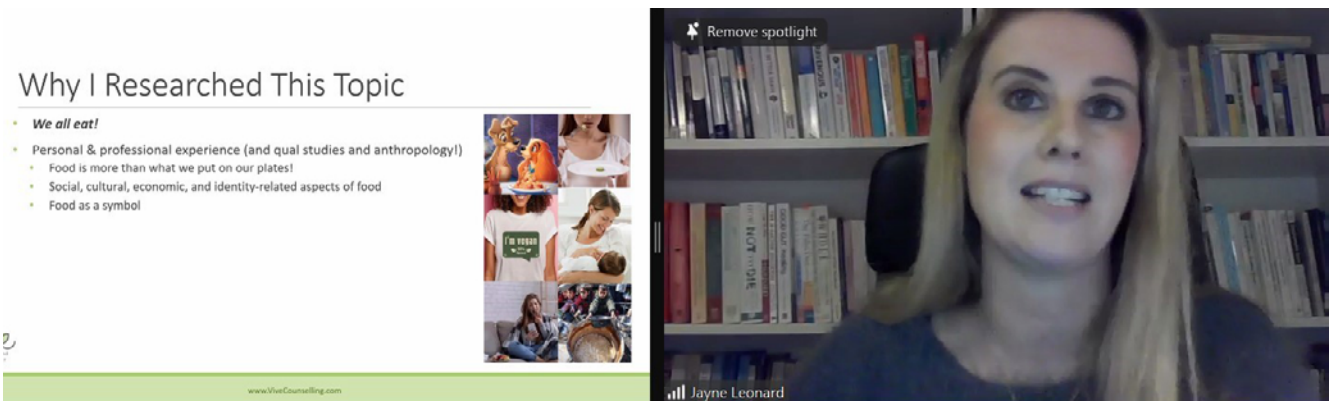
This was an excellent and well attended event. The feedback survey showed satisfaction levels at 100% across all areas – *practical to my needs and interests; well organised; content at the right level; structure of the event; length of the event; enjoyment of event; presentations.* 100% also said they would attend another Research Journal Club.

With thanks to our Research Committee, to Jayne Leonard and to all who attended and contributed to this being another highly stimulating evening.

A recording of the Research Journal Club Food and Mood presentation is now available in the IACP CPD portal**.**

8th Research Journal Club – Focus: Neurodivergent clients – accessibility and affirmation
The research paper under discussion at our eighth Research Journal Club on 3rd March is *"Accessibility and affirmation in counselling: An exploration into neurodivergent clients` experiences"* by Jones, F., Hamilton, J., Kargas, N. from ***Counselling and Psychotherapy*** *Research,* 2024, 1-16. doi: 10.1002/capr.12742

Joining Research Committee facilitators – Chair Aisling O'Connor and Vice Chair Dr Caitriona Kinsella – will be Research Committee member Monta Ramina who selected the paper and has carried out research in this area from the therapists' perspective. Our



Jayne Leonard (MIACP) speaking at the 'Food and Mood' - Final Research Journal Club of 2024

guest for the evening is Dr Mary Doherty. Mary is a consultant anaesthetist and an autism researcher. Mary will present on Autistic SPACE – a novel framework for meeting the needs of autistic people in healthcare settings.

We're looking forward to seeing many of you at this stimulating evening.

10th Research Glimpses – Focus: Process Groups in Training

Research Committee member Laura Maybury selected a current research paper in the area of process groups in training for our 10th Research Glimpses – "How do counselling trainees describe group process and does this change over time?" Counselling and Psychotherapy Research, 24 (1), 219 -229 by Murphy, R., & Schofield, M. (2024).

Laura says: "Working as an experiential training group facilitator with student counsellors, I am oftentimes intrigued by how differently individual students experience and describe any given group process. I hoped that the current article might further my understanding of how students experience the training process and how group experiences affect personal development and professional effectiveness".

To read Laura's review and to access the paper, please visit the Research Glimpses section of the Research Corner in the Members Area of iacp.ie.

IACP's First Undergraduate Research Excellence Award

Enhancing our strategic journey of promoting and embedding a research culture in the organisation and the profession, the IACP is delighted to add an undergraduate research excellence award to our annual Research Awards. This new award is in recognition of excellent research carried out by undergraduates for their dissertations. Colleges with an IACP accredited BSc/BA undergraduate course in counselling/ psychotherapy have been invited to nominate one student for this award. As with all Research Awards, IACP's Research Committee will adjudicate and recommend to the Board of Directors. A presentation will be made to the winner at IACP's Annual Conference.

Resource: Research Issues and Policies Part 2 – Publishing your Research In line with IACP's Research Strategy 2021 – 2025, the Research Committee has worked hard to supply resources for members to aid them on their research journey. A Research Issues and Policies Part 2 – Publishing your Research document now accompanies Research issues and Policies Part 1 in the Members Area – Research Corner. In it you will find an overview of publishing guidelines as well as helpful examples of specific requirements from key journals. You will also find an infographic Path to Publication resource in the Research Corner.

Third Online Research Conference

IACP's Research Committee has begun the planning process for the Research Conference 2025 – IACP's third online Research Conference. Following on from the huge success of the first two online research conferences – and with an attendance of 550 members last year, the committee is delighted to be able to offer this opportunity to members again. Provisionally the conference will take place at the same time as it did last year, in the final week of September. Further updates will be available in the coming weeks.

IACP's Member Survey 2024 – Introductory Video

IACP's Research Committee have produced a video introducing key aspects of the Member Survey 2024 results that they found most interesting and helpful. The video was sent to all members by email in December for the launch of the survey, but it is also now available to view as a resource in the Members Area – Research Corner. Seeing IACP member colleagues talking about the results really brings the Member Survey alive – so please visit the page and view!

Any research related questions or suggestions – please send in to research@iacp.ie

EDIC Update:

From the IACP Equality, Diversity & Inclusion Committee

The establishment and protection of Equality, Diversity and Inclusion (EDI) for all of humankind has been a fundamental cornerstone in the positive development of contemporary human history. This innate desire to promote peace and to avoid conflict has been energised most especially by the widespread determination to insure humanity never again endures the horrors and appalling scale of death and destruction experienced or inflicted on humankind during the First and Second World Wars.

The United Nations Declaration of Human Rights (1948), the establishment of The European Court of Justice in 1955, the adaption of The International Bill of Human Rights in 1966 along with the founding of the World Health Organisation (WHO) in 1966, are key milestones in establishing protections for all the peoples of the world by the then leaders of the world.

We, the living generations since, have inherited the collective wisdom, desire and experience of our forefathers and foremothers and the power of care and compassion for all of humankind. Through their insight we have learned to advocate for the fundamental concept of *equality* for all, to experience the joy in the *diversity* of the peoples of our earth and the naturalisation and value of *inclusion* for everyone. Recent equality legislation in our own country and our open arms of welcome to people under threat or suffering from immeasurable harm in other jurisdictions is a proud testament to our collective compassion and to those worthy principles.

Unfortunately, relatively recent events both locally and on the international stage seem to have impacted the harmony of a society-wide, positive atmosphere towards the continued realisation of EDI. It seems quite shocking how quickly these events have manifested into violence and intimidation, virtual and real, threatening the peace and harmony in some of our neighbourhoods, our cities and some of our townlands.

Pictured at the, Voices From the Field Seminar in Sligo were from L to R - Dr. Tamsin Cavaliero ATU Sligo, Ejiro Ogbevoen EDIC, Ravind Jeawon EDIC Vice-Chair, Mabel Chah Sligo Leadership Partnership, singer songwriter; Michael Norton HSE Recovery & Recovery Programme Lead, Elaine Mears, Sexual Violence and Prevention Officer ATU Sligo and data support Coordinator, Rape Crisis Network Ireland. The poignant symposium explored the lived experience and co-production from a practitioner based perspective at the Atlantic Technological University Sligo Campus

IACP Noticeboard

Dr Ray O'Neill of DCU and the EDI Conference Steering Group and EDI Committee member, Ejiro Ogbevoen at the recent Evening of Impact dinner held to help fund AkiDwa which provides counselling for those effected by FGM (Female Genital Mutilation) and to aid other projects that support migrant women

It might also prove easy to become consumed with concern, frustration and polarising views over the current level of war and conflict in our world, with violent disharmony on our streets, and in recent retrograde developments in the United States and other countries, in areas of Equality, Diversity and Inclusion.

So many media outlets, are becoming a hot bed of anxiety, focusing on crises, trauma, death and destruction or negatively impacting news. Some exaggerate, bend the truth or engage in biased, uncorroborated stories full of misinformation. That, we are told, sells advertisement space and influences change. Consequently, the wonderful unheralded harmonious work carried out by hundreds of millions of people every single day, all across the globe can be removed from our conscious mind. Millions of altruistic people through their inclusion and kindness give voice to those who are not heard. Give visibility to those who are rendered invisible. Offer purpose and fulfilment to those who are in despair and equity to those who are physically or emotionally challenged.

We, in our purposeful work each day hold a golden opportunity, to shine this light, to be advocates for the magnitude and magnificence of the daily reality of this wonderful work of respectful inclusion. Please, share this light and carry that torch whenever and wherever you can. As the saying goes… a candle loses nothing by lighting another candle!

Members Free Access to Recordings of EDI Conference Workshop Presentations

A very welcome bonus to last year's inaugural EDIC "…LeChéile…Exploring Our Differences, Together" conference is funding by the IACP and securing presenters' permission to record most of the workshop presentations and the availability of these free of charge to the IACP membership. The conference morning sessions are already available in the members area of the IACP web portal. The afternoon presentations will soon follow.

EDI Committee member Bairbre Kelly was invited by the North East Regional Committee to present her workshop entitled, ADHD - My Lived Experience, at City North Hotel, Co Meath

IACP in the Media

14/01/2025 – 'I know people who were happy they got caught' – the aftermath of cheating – Helen Brown in the Irish Independent.

11/01/2025 – Death and grief in the digital age featuring Margaret O'Reilly–Carroll in The Irish Times.

07/01/2025 –Talking about mental health is different in Ireland – Jared Gottlieb on Newstalk Breakfast
05/01/2025 – Enjoy the silence, but never be afraid to talk about your pain in – Jared Gottlieb Irish Independent

19/12/2024– Reach out this Christmas – Bethan O'Riordan in the Cork Independent.

17/12/2024 – Can a multi – generational Christmas be peaceful? – Cathaoirleach Jade Lawless in the Irish Examiner.

12/12/2024 – Navigating Christmas Challenges: Coping strategies for what might be a difficult season featuring Séamus Sheedy – Tullamore Tribune.

08/12/2024 – People with SAD should avoid common morning habit, according to psychotherapist – Susi Lodola in RSVP Magazine.

07/12/2024 – How to reduce stress, loneliness and guilt this Christmas, according to psychotherapist – Susi Lodola in RSVP Magazine.

07/12/20244 – It's Good To Talk: Christmas – a time to recharge and be kind to yourself – Tracy McKeague in donegallive.ie.

29/11/2024 – Tidings of comfort and joy? – Leo Muckley in the West Cork People.

28/11/2024 – Shortage of male therapists making young men reluctant to seek help counsellor warns Geoffrey McCarty – Irish Examiner

22/11/2024 – Putting men's mental health under the spotlight – Mary Lynn in the Galway City Tribune.

19/11/2024 International Men's Day: Breaking the Stigma on Men's Mental Health – Séamus Sheedy in topic.ie.

19/11/2024 Seasonal Affective Disorder: How to deal with SAD – Majella Kennedy in VIP Magazine.

09/11/2024 It's Good To Talk: How to manage loneliness – Tracy McKeague on letterkennylive.ie.

1/11/2024 – Pulling back the curtains on shame – Leo Muckley in the West Cork People.

04/11/2024 – Mental health and election commitments – Letter to the Editor from IACP Chief Executive Officer Lisa Molloy in The Irish Times.

04/11/2024 – Mental health plea – Letter to the Editor from IACP Chief Executive Officer Lisa Molloy – the Echo.

02/11/2024 – Counselling and psychotherapy call – Letter to the Editor from IACP Chief Executive Officer Lisa Molloy in the Irish Examiner.

Bi–Monthly – Current Psychotherapy Issues Dr Karen Ward interviewed by Henry Kean on the Sean Moncrieff Show – Newstalk

Quarterly – Mental health wellbeing articles by Dr Karen Ward – Naturally Good Health and Irish Holistic magazines

Weekly – Joe Heffernan featuring on Cork Today C103

C103 Echo.ie Trusted Local News Irish Examiner
Irish Independent WESTMEATH Topic

Event Spotlight

National Supervisor Forum

The IACP's National Supervisor Forum will be held on 17th May 2025, in the Ashling Hotel in Dublin. The theme for this year is a holistic approach to supervision, presented by Christine Moran. Christine is an experienced IACP accredited supervisor, counsellor and psychotherapist. She is the Founder and a Director of ICPPD, International College for Personal and Professional Development and of New Beginnings Holistic Counselling and Psychotherapy Centre. This year's forum will focus on a body, mind, heart and spirit approach to the work and relationships of supervision.

MORE INFORMATION CAN BE FOUND ABOUT THIS EVENT AND OTHERS ON THE EVENTS PAGE OF IACP.IE

IACP Accreditations

First Time Accreditation

Kate Acton	Co. Dublin	Kerry Hadlow	Co. Cork	Jane Murphy	Co. Wexford
Fiona Alexander	Co. Westmeath	George Henderson	Co. Waterford	Sheila Murray	Co. Waterford
Yvonne Barnewall	Co. Dublin	Chirstopher Heraghty	Co. Galway	Jelena Mustapic	Co. Clare
Joan Brady	Co. Galway	Declan Hester	Co. Galway	Joe Nally	Co. Dublin
Lisa Brennan	Co. Kildare	Shane Horan	Co. Cork	Andrea Napier	Co. Wicklow
Rhonda Browne	Co. Dublin	Kate Hynes	Co. Cork	Sinead Nolan	Co. Cork
Caroline Browne	Co. Meath	Louise Joyce	Co. Galway	Bernadette O'Boyle	Co. Kildare
Siobhan Buckley	Co. Limerick	Ilona Kachniarz	Co. Kilkenny	Isabel O'Brien	Co. Cavan
Laura Buckley	Co. Cork	Viktorija Kaprale	Co. Dublin	Kevin O'Byrne	Co. Dublin
Sean Byrne	Co. Offaly	Ann Marie Kavanagh	Co. Dublin	Karen O'Connor	Co. Dublin
Áine Byrne	Co. Carlow	Emma Kavanagh	Co. Dublin	John O'Connor	Co. Kildare
Eucharia Cashman	Co. Cork	Aoife Keating	Co. Dublin	Kathleen O'Hara	Co. Laois
Aoife Cassidy	Co. Dublin	Kester Kenevey	Co. Galway	Petra ONeill	Co. Dublin
Sara Chiodaroli	Co. Cork	Jessica Keyes	Co. Clare	Sahra O'Neill	Co. Dublin
Deirdre Clune	Co. Meath	Ruth Lambert	Co. Wexford	Jimeve O'Neill	Co. Cork
Cathy Costello	Co. Cork	Rachel Landers	Co. Dublin	Caitriona O'Neill-Boyd	Co. Dublin
Marcus Cowzer	Co. Dublin	Mary Larkin	Co. Dublin	Eileen O'Shea	Co. Cork
Rita Coyne	Co. Cork	Dion Lloyd	Co. Kildare	Ellen Parkinson	Co. Waterford
Amy Creegan	Co. Sligo	Jane Lynam-Treanor	Co. Dublin	Iryna Pilkevych	Co. Dublin
Richard Cuddy	Co. Cork	Paula Lynch	Co. Wicklow	Wendy Quinn	Co. Dublin
Deborah Daly	Co. Dublin	Laura Macken-Posavitz	Co. Dublin	Kristin Rogers	Co. Wicklow
Aisling Dearle	Co. Dublin	Aoife Maguire	Co. Dublin	Richard Ryan	Co. Tipperary
Marie Dempsey	Co. Galway	Joanne Mahon Smyth	Co. Meath	Louise Smith	Co. Cavan
Cait Diver	Co. Meath	Leanne Malone	Co. Meath	Daiana Sobih	Co. Dublin
Valerie Dolan	Co. Galway	Elaine Marrett	Co. Louth	Valentina Spagnesi	Co. Dublin
Darcy Donnellan	Co. Longford	Elaine Martin-Sullivan	Co. Cork	Antonia Splini	Co. Kilkenny
Darcy Donnellan	Co. Longford	Michelle Mason	Co. Kildare	Mary Stobie	Co. Meath
Miren Elustondo	Co. Cork	Donna Mc Cafferty	Co. Dublin	Rosalind Sweetman	Co. Kildare
Kathryn Ephrave	Co. Meath	Ann Mc Neill	Co. Kildare	Farrah Tayob	Co. Dublin
Elizabeth Ferris	Co. Dublin	Philip McCarthy	Co. Wexford	Kim Thompson	Co. Cork
Maria Fitzgibbon	Co. Kildare	Naomi McCartney	Co. Roscommon	Therese Tighe	Co. Dublin
Paul Fitzsimons	Co. Kildare	Jackie McGann	Co. Cork	Mark Wall	Co. Galway
Denis Foley	Co. Kerry	Teresa McGing	Co. Galway	Eddie Weafer	Co. Dublin
Steve Gannon	Co. Dublin	Marian McGuire	Co. Kildare	Aoife Whelan	Co. Dublin
Kevin Gilligan	Co. Dublin	Hilary McIvor	Co. Meath	Dewi Williams	Co. Wexford
Alia Gomez Ben-Issa	Co. Kildare	Ashley Morgan	Co. Dublin	John Woods	Co. Louth
Daniela Gonzales Ares	Co. Wicklow	Juliana Murphy	Co. Mayo		
Hazel Greene	Co. Galway	Elaine Murphy	Co. Meath		

Newly Accredited Supervisors

Caroline McDonagh	Co. Offaly	Anne Graham	Co. Cork	Peadar Murphy	Co. Waterford
Yvonne Barnewall	Co. Dublin	Elizabeth Griffin	Co. Dublin	Tara Niemeyer	Co. Sligo
Imelda Buckley	Co. Dublin	Mariah Hassett	Co. Clare	Noeleen O'Callaghan	Co. Dublin
Patricia Buckley	Co. Tipperary	Kathy Kavanagh	Co. Dublin	Majella Phelan	Co. Kikenny
Catriona Byrne	Co. Dublin	Colette Kelly	Co. Dublin	Patrick Plant	Co. Wicklow
Geraldine Campbell	Co. Kilkenny	Anne Malone	Co. Tipperary	Cormac Quinn	Co. Mayo
Lee Casey	Co. Dublin	Desera McCabe	Co. Galway	Mary Spring	Co. Galway
Ann-Marie Collins	Co. Galway	Dr. Melanie McGovern	Co. Galway	Olive Talbot	Co. Dublin
Marie Cunnane	Co. Dublin	Tina McGrath	Co. Meath	Geoff Tugwell	Co. Galway
Helen Dunne	Co. Wexford	Moya Mohan	Co. Sligo	Deirdre Whyte	Co. Cork
Amanda Farrell	Co. Dublin	Deirdre Murphy	Co. Louth		
Paula Gately	Co. Dublin	Helen Murphy	Co. Cork		