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Between research and lived practice: Reflecting on therapist pregnancy from a pluralistic perspective

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From the Editor:

Dear Colleagues,

Welcome to the Spring 2026 edition of the *Irish Journal of Counselling and Psychotherapy (IJCP)*. This edition is dedicated to women's health and its significance for therapeutic practice. This theme feels particularly timely following the Minister for Health's recent landmark announcement of €2 million in ringfenced funding for women's health research across 2026 and 2027. This marks the first time Irish research funding has been dedicated specifically to women's health.

Acknowledging longstanding gaps in women's health research, this investment aims to redress historical deficits in understanding by opening the door to relevant and nuanced research rooted in women's lived experiences. The funding prioritises areas where evidence gaps are particularly significant, including postpartum mental health, endometriosis, menstruation, and culturally sensitive women's healthcare.

As therapists, these issues are far from abstract. The historical sidelining of women's health research inevitably permeates therapeutic work, shaping how we perceive and engage with women's experiences in therapy, and, in turn, how clients present their experiences to us. This funding announcement represents a welcome and broader shift towards recognising the complexity of women's bodies and experiences. Situated at the intersection of physical and mental health, the articles in this edition make a meaningful contribution to this evolving conversation, offering practitioners insights that challenge clinical assumptions, support more effective therapeutic practice, and invite valuable reflection.

Our first article, by Valeria Lorenzi, explores the important and under-researched topic of experiencing pregnancy as a therapist, informed both by lived experience and relevant literature. The article considers the therapeutic obstacles this can present and uses a pluralistic lens to reframe therapist pregnancy as a relational event whose meaning is shaped through dialogue and collaboration, rather than predetermined as disruptive.

This is followed by Maria Brunt's qualitative research article, which draws on interviews with nurses working in the Neonatal Intensive Care Unit (NICU). Adopting Foucauldian and psychoanalytic frameworks, it examines how maternal identities are negotiated in this extraordinary environment of medical surveillance and urgency. From this unique standpoint, the research carries valuable clinical implications by highlighting how therapists can support clients who have experienced the NICU to challenge idealised narratives of motherhood and reconstruct maternal identity.

In our third featured article, Rebecca Krist offers an insightful examination of the familiar, and often harmful, social scripts surrounding menstruation. Drawing on her own experience as a client and extending into her clinical work with women, she invites readers to consider the psychological cost of pathologising or dismissing women's emotional experiences as "just PMS". The article encourages therapists to reflect on how internalised misogyny may show up – and be subtly reinforced – within the therapy room.

Our edition concludes with Emma Cleary's qualitative study exploring psychotherapists' experiences of menopause in the therapeutic space. Grounded in a commitment to centering women's voices, the article challenges the narrow, biomedical understandings of menopause and highlights the value of adopting a bio-psycho-socio-cultural framework when providing therapeutic support to women experiencing this highly individual transition.

I hope you will find this edition a timely and informative contribution to the evolving discourse on women's health and therapeutic practice. I would like to extend my gratitude to all the Spring 2026 contributors, and offer particular thanks to Assistant Editor, Jayne Leonard, whose guidance has been invaluable during this process.

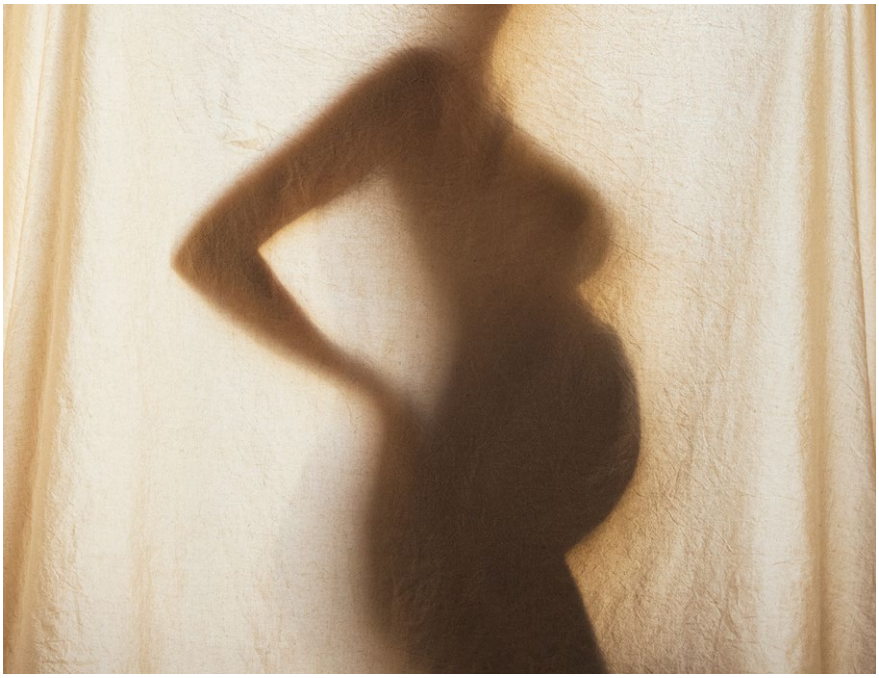
Rosie Woolfson (Pre-Accredited Member IACP), Editor

Jayne Leonard (MIACP), Assistant Editor

Practitioner Perspective

Between research and lived practice: Reflecting on therapist pregnancy from a pluralistic perspective

By Valeria Lorenzi



Pregnancy reshaped not only my body, but my clinical practice. Working while pregnant unsettled familiar therapeutic assumptions, and raised ethical, emotional, and relational questions. A pluralistic perspective proved vital, enabling reflexivity, flexibility, and collaborative meaning-making as I navigated changing boundaries, professional identity, and therapeutic presence

Introduction

> A woman discovers she is pregnant. Having taken root in the uterine space the minuscule, fertilized ovum will have a far-reaching influence in drawing the woman into the depths of her psychic space, tap-rooting powerful unconscious representations from her inside story which begin to pervade her dreams, fantasies and emotional life. (Raphael-Leff, 1993, p.7-8)

Just like that. I was pregnant, and instantly, everything changed. Becoming pregnant felt sudden and disorientating, and my sense of self, both personal and professional, shifted rapidly. From a pluralistic perspective, these shifts can be understood as holding multiple, and at times contradictory, meanings that are shaped by context, relational dynamics, and developmental stage. At that time, I experienced profound changes in how my body felt and in how I thought, accompanied by a strong sense of excitement and uncertainty.

Although adding a second baby to my family was deeply desired, the prolonged journey to conception meant that when I did become pregnant, I was in the midst of my master's dissertation and clinical placement. While I anticipated this period would be challenging, I did not expect it to be so immersive and transformative for my developing practice as a therapist. In particular, it has reshaped my understanding of pregnancy from a singular event to a relational experience, the meaning of which is continually negotiated within therapeutic and professional contexts.

Pregnancy may be one of the most rewarding, challenging, and, to a certain extent, scary events in

a woman's life. It is a moment of transition in which she "negotiates her personal and professional identity, adjusts relationships and develops a new relation with her baby during the preparation of motherhood" (Schmidt et al., 2015, p.51).

In the context of counselling and psychotherapy, the pregnancy of the therapist seems to be extremely relevant, considering its prevalence in clinical practice. Psychotherapy is, in fact, a profession largely dominated by women. Among those female therapists, a number of them are in their reproductive years, and some of them will likely get pregnant and start a family while practicing (McCluskey, 2017). In Ireland, according to an Irish Association of Counselling and Psychotherapy report (IACP, 2018), 78% of IACP-qualified therapists were women, and 26% of them were under the age of 44.

The psychotherapist's pregnancy is a unique moment within the therapeutic process that brings its own challenges. The literature indicates that pregnancy and maternity leave impact the treatment by stimulating many transference and countertransference reactions (Way et al., 2019). On one hand, clients may experience feelings of abandonment and rejection, sibling rivalry, and oedipal striving (Cullen-Drill, 1994). On the other hand, therapists need to deal with issues such as the "exposure of anonymity and their sexuality, anxiety about their patient's reactions and the attempt to integrate the psychotherapist with the role of the mother" (Schmidt et al., 2015, p.51). My clinical experience as a pregnant trainee therapist corroborated many of these issues, including self-protectiveness, fear of clients' reactions, and the wish to avoid their hostility.

It opens the door to implicit disclosure from the therapist, including her wish to form a family and the likely presence of an intimate partner in her life.

The pregnant psychotherapist's experience of navigating therapy

Pregnancy is a major life event that entails physiological changes impossible to hide, as well as emotional changes that may affect the therapist's performance (Cullen-Drill, 1994). Way et al. (2019, p. 450) defined pregnancy as a "therapeutic transgression" that inevitably draws attention to the therapist's personal life in the therapy room. It opens the door to implicit disclosure from the therapist, including her wish to form a family and the likely presence of an intimate partner in her life.

Although research has highlighted that pregnancy may facilitate the change process in some contexts (Katzman, 1993), studies have indicated that pregnancy and maternity leave interfere with the therapeutic process (Fuller, 1987). Notwithstanding this, "literature has mainly focussed on the reaction of clients to the therapist's pregnancy. Even when the therapist does discuss their client's reaction, they omit to comment on their personal experiences of pregnancy and their experience with clients" (Dyson & King, 2008, p.28).

The state of pregnancy, however, stimulates strong reactions and poses new challenges on the part of the therapist. First-time mothers, child therapists, and trainee therapists seem to be the most affected (Way et al., 2019).

The pregnant therapist struggles with several factors that may interfere with the therapeutic stance. For instance, Cullen-Drill (1994) considered that an increased vulnerability of the therapist during her pregnancy may have an impact on her ability to identify her countertransference reactions. This inability to recognise the client's ambivalence as well as her own may lead not only to denying "the effect of pregnancy on the client", but also to difficulties in interpreting the material related to the issue (Cullen-Drill, 1994, p. 11).

Way et al. (2019) pointed out that the development of a new identity as a mother can sometimes create a conflict with the existing professional identity as a therapist. In this delicate moment, the pregnant therapist may challenge and review her perception of her clinical role, leading to a shift in the maternal and protective feelings from the clients to the unborn child (Way et al., 2019). In addition, Underwood (1976) highlighted that preoccupation with narcissistic concerns are quite common during pregnancy and, if not adequately and quickly addressed, this may have an impact on the therapeutic work. According to Underwood (1976), this natural psychological shift experienced by many expectant mothers involves a temporary state of sensitivity and focus on the unborn child that may drive the therapist to renegotiate her own history and identity.

Research has also discussed therapists' feelings of guilt related to their decision to become pregnant and their subsequent feelings of "abandoning their patients to care for a new baby" (Bienen, 1990, p.608). In order to

alleviate these feelings, therapists tend to use protective strategies such as withstanding verbal aggression, agreeing to share personal information, or going overboard to meet their clients' needs (Way et al., 2019).

Another struggle affecting therapeutic work relates to difficulties in attending to the task of listening to clients (Fuller, 1987) and in dealing with "triggering issues" (Lyndon, 2013, p.93), including disclosures of child abuse or abusive parenting practice, and fantasies of harm and miscarriage (Way et al., 2019).

Last but not least, the disclosure of pregnancy is clinically complex and it is often associated with feelings of anxiety from the therapist. According to McCluskey (2017), there is a tendency to wait until later in pregnancy to tell clients, due to the fear of losing therapeutic anonymity. However, this delay in sharing the news may not give clients enough time to process what the pregnancy means to them, increasing the risk of their premature termination of therapy (McCluskey, 2017).

The client's experience of the pregnant therapist

Despite the fact that a therapist's pregnancy inevitably has clinical implications for the client, there is a dearth of available literature on the topic, and it is generally quite dated (McCluskey, 2017; Schmidt et al., 2015).

According to Cullen-Dill (1994), the pregnancy affects treatment by stimulating transference in clients. Katzman (1993) noted that the disclosure of pregnancy to clients may lead to strong behavioural reactions, such as the premature termination of therapy, not attending sessions, gaining weight, or even becoming "accidentally" pregnant. Feelings of "loss and abandonment, competition, dependency, jealousy and the desire for children" may also emerge (McCluskey, 2017, p.302).

Male clients tend to underestimate the impact of pregnancy on themselves and on the therapeutic work. They may feel too embarrassed to discuss the pregnancy with their therapist, leading to an increased risk of dropping out prematurely

Female and male clients tend to respond differently to pregnancy disclosure. Male clients, who do not directly experience pregnancy, may use cultural and social norms to interpret this event, while female clients tend to focus on their own experiences and expectations of pregnancy (Chiaramonte, 1986). On this basis, female clients are more likely to show curiosity towards the pregnancy and to share their observations about it sooner (Cullen-Drill, 1994). Identification also seems to be a dominant issue for women (Underwood, 1975) – it involves a complex transference reaction of the client which often brings up themes such as motherhood, loss, and dependency.

Conversely, male clients tend to underestimate the impact of pregnancy on themselves and on the therapeutic work. They may feel too embarrassed to discuss the pregnancy with their therapist, leading to an increased risk of dropping out prematurely (Cullen-Drill, 1994).

An evidence-based solution

The therapist's pregnancy affects the treatment in a variety of ways. Elements such as the resistance of the client, the stage of the treatment, the level of trust in the alliance, the psychotherapist's countertransference, and her way of intervening are essential in determining how the pregnancy will influence the therapeutic process (Schmidt et al., 2015). In this context, the pregnant therapist needs to be highly prepared to deal promptly with any combination of these complex challenges (Underwood et al., 1975).

Research recognises that when issues are addressed effectively, the therapist's pregnancy provides a rich opportunity for growth – for both the client and the counsellor (Cullen-Drill, 1994; Fuller, 1987; McCluskey, 2017). Despite this, little professional guidance is available on how to navigate the clinical issues that may arise as a result of the therapist's pregnancy (Way et al., 2019). Korol (1996) suggested that trainee therapists often feel the pressure to deny the effect of the pregnancy during their professional training.

In addition, the literature highlights the lack of supervisory and organisational support available for pregnant therapists, as well as a trend indicating dismissive or even hostile attitudes towards pregnant colleagues (Baum & Itzhaky, 2006). In this regard, Fuller (1987) pointed out that a supportive working environment, combined with the availability of senior female supervisors as objects of identification, play a pivotal role in the way the pregnant therapist manages this delicate and challenging situation in her professional life.

A pluralistic strategy to facilitate the therapeutic process

When I found out I was pregnant, I

was thrilled and deeply frightened. Given my history of recurrent miscarriages in recent years, I found myself holding a mixture of opposing feelings. At times, I felt cautiously optimistic, while at others, I experienced overwhelming anxiety and hypervigilance, closely monitoring my body for any possible sign of miscarriage. This ongoing emotional fluctuation was exhausting and it began to impact my way of being in the therapy room.

Consistent with Fuller's (1975) observation that during the first trimester the therapist may struggle with a range of physical and emotional factors affecting their clinical work, I noticed moments in sessions where my attention was drawn towards my own concerns. At times, I struggled to remain fully attuned to the clients and to make a conscious effort to refocus on the task of listening. This perceived interference with the therapeutic process evoked feelings of guilt and professional self-doubt. From a pluralistic standpoint, such experiences highlight the importance of therapist reflexivity and ongoing evaluation of what may be most helpful for both therapist and client within a given context.

Disclosing my pregnancy to my supervisor and seeking guidance on how to best manage the situation felt so liberating. This step marked a shift towards recognising support-seeking as an ethically grounded and pluralistically informed practice, rather than a personal failure. Through supervision, I began to appreciate that working as a pregnant therapist requires preparation and responsiveness to both the therapist's emotional processes as well as those of the client, with particular attention to how needs, goals, and relational dynamics may change across the different stages of pregnancy. Way et al. (2019) suggest beginning an exploration of the pregnancy in supervision before disclosing it in the therapy room. This preliminary discussion could "subsequently serve as a template for a therapist's conversation with her clients" (Way et al., 2019, p.461). In this sense, supervision and reflective dialogue worked as pluralistic strategies to support flexibility, collaboration, and responsiveness within the therapeutic process.

Adopting a pluralistic framework enabled me to engage in open and collaborative conversations with clients, in which space and time were intentionally created to explore the impact of my pregnancy on our work together

In addition, Cullen-Drill (1994) believes that disclosing pregnancy at an early stage with long-term clients may be beneficial, as it allows clients sufficient time to process their feelings and thoughts about the pregnancy and the forthcoming separation. Similarly, McCluskey (2017, p.304) reported that many clients "seemed to have a greater sense of trust in their therapist when they were transparent about their pregnancy at an early enough stage and showed thoughtful care in giving their clients different options regarding how to proceed".

In my experience, the process of disclosure varied considerably depending on the nature of the therapeutic relationship, the stage of therapy, and the individual client. Adopting a pluralistic framework enabled me to engage in open and collaborative conversations with clients, in which space and time were intentionally created to explore the impact of my pregnancy on our work together, alongside the options and supports available to them. Viewing clients as "autonomous, purposeful and informed" (McLeod, 2019, p.305) appeared to enhance their confidence and agency in making decisions about how to continue therapy. The use of metacommunication (communication about communication) "to encourage reflection on the client's intentions and reactions" (McLeod, 2007, p.2) was essential in facilitating a collaborative dialogue while discussing the pregnancy.

The pluralistic way of being combines a strong sense of personal authenticity with relational and scientific values, alongside a broad socio-political commitment to equality (Tilley et al., 2015). In this specific context, the client's sociocultural background was particularly relevant. I noticed that gaining an understanding of the client's cultural norms regarding pregnancy was essential in order to navigate the emotions that emerged from that exploration with them. This is also supported by McCluskey (2017), who recognised that clients' reactions to the news vary, depending not only on their cultural and socio-economic status, but also on the quality of the interaction between the client and the therapist.

Research suggests that greater openness regarding pregnancy is associated with improved client outcomes (Way et al., 2019). Exploring the pregnancy through open dialogue can be "very powerful" in generating new therapeutic materials

(McCluskey, 2017, p.7), positioning the therapist's pregnancy as a potential opportunity for clients to engage with themes such as separation, identity development, and transference dynamics (Drill-Cullen, 1994). To work in this way, careful consideration must be given to the client's needs and to the specific relational dynamic within the therapeutic dyad (Schmidt et al., 2015). The pluralistic approach to psychotherapy offers a particularly relevant framework, as it emphasises collaboration, responsiveness, and flexibility in tailoring therapeutic methods to the individual client (Cooper & McLeod, 2011). This requires ongoing assessment of the client's developmental level, the origin of the difficulties, and the nature of the transference in order to co-construct an appropriate therapeutic plan in the context of the therapist pregnancy (Drill-Cullen, 1994).

Finally, how the therapist plans and navigates their maternity leave is critical to maintaining a positive therapeutic alliance (McCluskey, 2017). Clinical judgment is required to determine whether a client may benefit from working with an interim therapist during the leave, or whether the provision of crisis contact is sufficient. In my experience, this decision was often complex, as disclosure of pregnancy often elicited strong emotional responses from clients, including oscillations between dependence and independence. However, research suggests that the therapist's pregnancy may enhance the client's sense of agency, especially when clients are supported to develop greater self-sufficiency (McCluskey, 2017).

McCarty et al. (1986) pointed out that the use of an interim therapist can be beneficial in the treatment of clients with high transference reactions, including issues with attachment, separation, and loss. The literature provides some guidelines regarding the role of the interim therapist in this context. Cullen-Drill (1994) suggested that it is important for the interim therapist to be introduced to the client in advance of the separation and to familiarise themselves with the client's therapeutic history before the handover. This set of actions not only contributes to reducing any sense of guilt that a pregnant therapist may hold for taking time off, but it also guarantees continuity of treatment for the client.

Professional guidance on how to navigate the therapeutic challenges associated with pregnancy is also scarce, creating uncertainty about when and where to seek support

Chiaramonte (1986) clarified that the objective of the interim therapist is to focus on the short-term goal of supporting the client to return to the previous therapist once she returns from her maternity leave. In practice, this transition from therapist to interim therapist was often met with resistance, highlighting the importance of dedicating time to exploring fears and concerns in advance. As McCarty et al. (1986) emphasised, addressing such resistance proactively can facilitate a smoother therapeutic transition and protect the therapeutic alliance.

Final considerations

Although therapist pregnancy is common in clinical practice, the research base remains limited (Way et al., 2019), with much of the literature over 20 years old. It is important to acknowledge that several of the sources drawn upon in this discussion were published prior to the widespread integration of social media into our professional and personal lives. In contemporary contexts, there is an increasing trend towards greater transparency and the humanisation of the therapist role, with clinicians more visibly presenting aspects of their identities within and beyond the therapeutic setting.

Furthermore, clients now commonly use online forums and social media platforms to share accounts and evaluations of their therapeutic experiences, including experiences of working with a pregnant therapist. Such developments may shape client expectations, perceptions of professional boundaries, and the therapeutic relationship in ways that are not adequately captured in the existing literature. Further research is needed to explore how digital and social media practices intersect with therapeutic relationships in this context.

Professional guidance on how to navigate the therapeutic challenges associated with pregnancy is also scarce, creating uncertainty about when and where to seek support (Way et al., 2019). As a result, the pregnant therapist may be left to manage pregnancy related clinical issues with limited guidance and support. Gerber (2005) pointed out that it can be difficult to maintain objectivity during the heightened sensitivity of pregnancy. This can interfere with the management and delivery of the therapeutic plan. However, regular supervisory sessions

and peer consultations can be extremely helpful in identifying personal issues, maintaining appropriate boundaries, and adjusting the way of intervening to the specific circumstances of the case (Gerber, 2005).

Revisiting this paper after a period of time, while pregnant with my third child, has inevitably drawn me back to earlier experiences of practicing while pregnant, which has reactivated a complex combination of emotions alongside reflections on ethical responsibility and best practice. Reengaging with this issue prompted a central reflexive question for this paper: how do I now experience myself as a qualified therapist while pregnant? From this position, I notice a shift towards greater confidence in my professional identity and an increased capacity to seek support, both personally and professionally. Importantly, this journey has also reduced my fear of disclosing my pregnancy to clients, allowing this conversation to be approached with greater openness, transparency, and collaborative intent.

From a pluralistic perspective, this reflects a movement towards recognising pregnancy not as a disruption to the therapeutic process, but as a relational event whose meaning is negotiated within the therapeutic dialogue, informed by both research and lived practice.

Valeria Lorenzi

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Alongside a master's degree in pluralistic counselling and psychotherapy, Valeria obtained a master's degree in human rights, and a degree in international and European law. Her professional work has focused on issues related to immigration, intercultural dialogue, education, and women's equality in Ireland, Italy, Ghana, and the United Kingdom.

Valeria is based in Dublin, where she lives with her husband, her children, and her rescue dog. In her spare time, she enjoys travelling and spending time with her family.

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Academic article

When motherhood meets medicine: Discursive constructions of maternal identity in the Neonatal Intensive Care Unit

By Maria Brunt

Drawing on qualitative interviews with neonatal nurses, this article examines how maternal identity is constructed and negotiated within the NICU. Using Foucauldian and psychoanalytic frameworks, it explores how medical authority, surveillance, and cultural ideals of motherhood shape early maternal subjectivity and highlights how therapists can support mothers during this transition

Introduction

Motherhood is often imagined as a seamless transition characterised by intimacy, instinctive bonding, and joy. Yet within the Neonatal Intensive Care Unit (NICU), this transition is disrupted by medical urgency, surveillance, and institutional routines. Instead of assuming the role of primary carers, mothers frequently find themselves positioned at the margins; their identities mediated through protocols, technology, and professional oversight.

This article draws on qualitative interviews with neonatal nurses to examine how motherhood is constructed and negotiated within the NICU. Nurses hold a dual position: they are both agents of medical authority and witnesses to the fragile, emergent identities of mothers at the bedside. Using thematic and Foucauldian discursive analysis, supported by psychoanalytic perspectives, this study explores how cultural ideals of motherhood intersect with clinical practices: producing fractures, tensions, and, at times, unexpected forms of resilience.

For counsellors and psychotherapists, these insights carry important implications. They highlight the psychic ruptures that can emerge at the very beginning of maternal life and point to the ways in which therapeutic support and reflective healthcare practice can help women reconstruct their identities under extraordinary circumstances.

Literature review: Motherhood as a cultural and discursive construct

Motherhood is not solely a biological state but also a cultural identity shaped through discursive and symbolic systems. In Ireland,

Catholic iconography has long established the Virgin Mary as the archetype of maternal perfection: pure, selfless, serene, and devoid of sexuality (Thurer, 1994; Woodward, 2002). This "good mother" ideal continues to exert influence, regulating women's self-understandings and informing social judgments of maternal adequacy (Schmidt et al., 2022; Verniers et al., 2022).

Historically, women who deviated from this ideal were subjected to institutional discipline, most notably in the Magdalene Laundries. These Church and State-run institutions operated in Ireland from the 18th to the late 20th century, confining women who were unmarried mothers, perceived as "fallen", or otherwise considered to have transgressed moral norms. Within their walls, women endured forced labour, loss of identity, and systemic shaming (Mercier, 2013). From a Foucauldian perspective, the Laundries exemplified carceral institutions that used silence, surveillance, and control of the body to enforce compliance (Foucault, 1977). Crucially, maternal identities were not nurtured but erased: women were separated from their infants and denied the opportunity to mother, reinforcing a cultural logic that equated morality with conformity to narrow ideals of maternal purity (Mercier, 2013).

Contemporary culture carries subtle echoes of these dynamics. When Catherine, Princess of Wales, appeared on the steps of St. Mary's Hospital following the birth of Prince George, dressed in pale blue with her infant in her arms, she visually reproduced centuries of Madonna and Child iconography. However, such imagery risks idealising motherhood to an unattainable degree, thereby marginalising mothers whose experiences do not align with this fantasy, and, particularly in the context of premature birth and medical intervention, intensifying feelings of inadequacy.

Women were separated from their infants and denied the opportunity to mother, reinforcing a cultural logic that equated morality with conformity to narrow ideals of maternal purity

From a Foucauldian (1977) perspective, the monarchy functions as a disciplinary institution, offering powerful visual reinforcements of idealised femininity and motherhood. These representations exert soft power by promoting internalised expectations of maternal behaviour: calmness, selflessness, and immediate bonding. In this way, public performances of royal maternity may operate as a form of cultural regulation, subtly shaping how women experience and perform motherhood, even in highly medicalised environments like the NICU, where such ideals may feel painfully out of reach. This visual regulation of motherhood echoes more overt forms of institutional control historically exercised over woman in Ireland, most notably in the Magdalene Laundries.

Psychoanalytic perspectives add further depth to these cultural constructions. Freud's (1912/1957) account of the Madonna-Whore complex illustrates how unresolved Oedipal dynamics can divide women into saintly, desexualised mothers or degraded, sexualised others. A well-known cultural example is Elvis Presley's relationship with his wife, Priscilla. Following the birth of their daughter, Presley increasingly struggled to engage with her sexually. Priscilla has explained in her memoir that Elvis made reference to her being "a momma now" (Beaulieu Presley, 2022). In this moment, Priscilla's maternal status rendered her, in Presley's eyes, incompatible with sexual desire. What emerges here is the psychic splitting Freud described: once positioned as "mother", a woman is elevated to purity but simultaneously stripped of erotic identity. This tension illustrates how cultural scripts can weigh heavily on maternal subjectivity, complicating women's lived experiences of becoming mothers.

Anthropological and psychological theories also challenge cultural assumptions of immediate maternal instinct. Raphael (1973) introduced the concept of *matrescence* to describe the developmental process of becoming a mother, comparable to adolescence. Stern (1999) expanded this idea, emphasising that maternal identity emerges gradually rather than instantaneously at birth. Sacks (2017) later reintroduced matrescence to clinical discourse, underlining that the transition involves profound psychological, relational, and embodied change.

Intergenerational dynamics further complicate this process. Vanier (2015) argued that a woman's experience of how she was mothered profoundly shapes how she, in turn, mothers her own child. Maternal identity is thus inscribed through unconscious legacies of care. Language itself also plays a structuring role: what a mother says to her child becomes part of the

child's psychic life, echoing Lacan's (1958/2006) claim that subjectivity is constituted through entry into the symbolic order. Van Wyk et al. (2024) similarly argued that maternal subjectivity is always already embedded in unconscious and symbolic structures that shape experience before it unfolds in lived practice. The NICU becomes a space where these cultural myths, unconscious inheritances, and institutional practices collide. Mothers are expected to embody selfless devotion, yet may be sidelined by medical routines, restricted contact, and the unyielding gaze of surveillance. It is within this environment that the present study situates its analysis.

Methodology

This study employed a qualitative design using semi-structured interviews with five neonatal nurses working in an Irish NICU. Nurses were chosen as participants because of their dual role: they are responsible for clinical care while also facilitating or constraining mothers' early experiences of bonding and caregiving. Their observations provide valuable insight into how maternal subjectivity is negotiated at the intersection of medicine and culture.

Interviews were analysed thematically (Braun & Clarke, 2006), with attention to both manifest content and discursive constructions, that is, how participants used language to make sense of their experiences. A Foucauldian lens (Foucault, 1977, 1978, 1982) was applied to explore how institutional practices and power relations shaped maternal identity. Psychoanalytic perspectives were also drawn upon to illuminate unconscious and intergenerational dynamics (Freud, 1905/2001; Lacan, 1958/2006; Stern, 1999; Vanier, 2015). Ethical approval was obtained through Dublin Business School and the Director of Nursing in the chosen hospital, and participants gave informed consent.

For many mothers, the anticipated joy of birth was replaced by silence, resuscitation, and uncertainty

Findings

Analysis generated six interrelated themes that illuminate how motherhood is discursively constructed within the NICU.

Hope fractured before the first breath

For many mothers, the anticipated joy of birth was replaced by silence, resuscitation, and uncertainty. Nurses described mothers arriving in shock, disoriented by the sudden rupture between expectation and reality. One nurse explained, "One minute you are pregnant, the next minute a team is resuscitating your baby". In these moments, mothers may feel positioned as passive observers rather than active participants.

From a psychoanalytic perspective, Stern (1999) suggested that just as the infant must be born, so too must the mother. In the NICU, this "birth of the mother" is destabilised before it could begin, fractured by medical authority that assumed control of the infant's first moments. Through a Foucauldian lens, this illustrates an early moment of subjectivation (Foucault, 1982), where maternal agency is displaced by institutional power.

Barriers to care: Navigating distance and protocol

Even when crises eased, barriers remained. Incubators, infection control protocols, and medical routines created both physical and symbolic separations (Vanier, 2017). Nurses noted that mothers often had to ask permission to hold or even touch their babies. One participant reflected, "It doesn't feel natural for them when they need permission just to pick up their child".

These barriers were intensified by the sense of being constantly observed. Feeding, changing, and soothing took place under the professional gaze of nurses and the technological gaze of machines. As one nurse put it, "There's always an audience; mothers don't really get the chance to figure it out themselves".

Lacan's notion of the gaze is instructive here (Lacan, 1977). Mothers' desire to gaze upon and bond with their infants was disrupted by the simultaneous clinical gaze that evaluated their caregiving. Foucault's metaphor of the panopticon describes a form of power in which individuals internalise surveillance and begin to regulate their own behaviour, even when no authority is visibly present (Foucault, 1977). It is particularly relevant here as mothers may internalise this surveillance, adjusting their behaviours to align with perceived expectations, often at the cost of confidence in their own instincts (Symonds LeBlanc, 2020).

Motherhood performed under surveillance

Closely related was the theme of performance. Nurses observed that mothers frequently enacted caregiving as though under evaluation. While nurses often intended their presence as

supportive, mothers may interpret it as judgment. This performance of competence could generate anxiety, reinforcing feelings of inadequacy.

Here, Foucauldian concepts of discipline and normalisation are evident. Behaviours were subtly categorised as adequate or deficient, producing hierarchies of maternal adequacy. Interviewees reported that mothers whose caregiving conformed to institutional expectations were affirmed, while others may have felt marginalised or judged.

Pathways to maternal becoming: Diversity and disruption

Maternal subjectivity in the NICU was not uniform but mediated by cultural, social, and logistical differences. One nurse noted, "Traveller women see it as their exclusive role to stay constantly by the baby's side", whereas another explained, "Some mothers depend on buses or partners to get in, and they can't be here every day".

Yet institutional discourses often privileged constant presence as the marker of the "good mother". Nurses noted that those unable to maintain daily attendance felt inadequate. Foucault's (1982) concept of dividing practices is relevant here: behaviours were categorised as compliant or deficient, creating implicit hierarchies of maternal devotion.

Spaces of survival and separation

A further theme centred on how mothers and infants survived amid profound separation. For some mothers, absence was unavoidable due to health, geography, or family responsibilities. Nurses observed that these women often carried deep guilt, describing themselves as "failing" their babies.

Nurses described women speaking softly to their infants through incubator walls or gazing steadily at their child while unable to hold them

Nevertheless, survival strategies emerged. Mothers used photographs, expressed breastmilk, or used rituals of naming as ways to sustain bonds across distance. From a psychoanalytic perspective, these practices can be seen as symbolic substitutions, gestures that preserved connection when physical presence was denied. From a Foucauldian standpoint, they represent small acts of resistance, asserting maternal subjectivity within structures of separation (Borghini et al., 2014).

Holding hope in empty arms

Perhaps most poignant were accounts of mothers who nurtured bonds despite limited or absent physical contact. Nurses described women speaking softly to their infants through incubator walls or gazing steadily at their child while unable to hold them. One nurse recalled telling a mother, "You haven't touched him yet, but you are still his mother".

In these moments, hope itself became a form of resistance. Voice, gaze, and imagination were enacted as maternal practices that sustained identity and attachment. Nurses played a crucial role in affirming these practices, offering discursive validation that helped mothers hold on to their sense of self when arms remained empty

Discussion

These findings illustrate how the NICU reshapes motherhood at the intersection of cultural myths, unconscious structures, and institutional discourses. The transition into maternal identity, already a complex developmental process, is disrupted by medical urgency, surveillance, and separation.

The distance between cultural ideals and clinical realities was starkly visible in participants' accounts. Western iconography – exemplified by the Virgin Mary or media images such as Catherine, Princess of Wales – constructs an image of serene, immediate maternal bonding (Thurer, 1994; Woodward, 2002). Within the NICU, however, mothers encounter wires, incubators, and uncertainty. When constant presence or effortless devotion is presented as the cultural standard, mothers who are absent, distressed, or dependent on others may feel inadequate. This echoes the disciplinary logics of the Magdalene Laundries, where women's maternal identities were erased when they failed to conform to idealised norms (Mercier, 2013).

Psychoanalytic theory deepens the analysis of these fractures. Freud's (1912/1957) account of the Madonna-Whore complex highlights the cultural splitting of women into saintly mothers or degraded others, an unconscious tension that weighs on maternal identity. Elvis Presley's well-documented difficulty reconciling his wife Priscilla's maternal and sexual roles (Beaulieu Presley, 2022) demonstrates the persistence of this psychic split in popular culture.

Lacan's (1949/2006, 1977) reflections on the gaze are particularly relevant. Mothers in the NICU long to direct their gaze toward their infants but

instead encounter glass, wires, and machines. Simultaneously, their caregiving is captured by the clinical gaze of nurses and technology. Maternal subjectivity is fragmented between longing and surveillance.

Intergenerational insights further extend this understanding. Vanier (2015) and Owens (2004) have argued that a mother's experience of being mothered profoundly shapes her own maternal identity, while Lacan (1958/2006) emphasised that language inscribes subjectivity within the symbolic order. In the NICU, where words and gaze often substitute for touch, the symbolic dimension of maternal care becomes especially salient. Van Wyk et al. (2024) likewise remind us that maternal subjectivity is not created ex nihilo but is structured by unconscious and symbolic formations.

The findings resonate with Stern's (1999) and Raphael's (1973) accounts of matrescence, the gradual developmental process of becoming a mother. Instead of immediate unity, mothers in the NICU experience rupture and separation at precisely the moment culture promises wholeness. This collision between fantasy and reality can generate psychic disorientation, guilt, and loss.

From a Foucauldian perspective, the NICU operates as a biopolitical field where life is managed and optimised (Foucault, 1978). Maternal conduct is regulated by permission, surveillance, and institutional expectations. Mothers often internalise these expectations, adjusting their behaviour in ways that transform instinctive caregiving into performance. At the same time, small acts of resistance persist, speaking through incubators, naming infants, imagining survival. These discursive gestures reassert maternal identity against institutional constraint, demonstrating the resilience of mothers and the relational support offered by nurses.

By validating the extraordinary conditions of the NICU, therapists can help mothers reconstruct more compassionate self-narratives

Clinical implications for counsellors and psychotherapists

The findings highlight important implications for both therapeutic practice with mothers who have experienced the NICU and collaboration between therapists and neonatal nurses.

Many mothers carry ruptured narratives of motherhood marked by guilt, grief, and feelings of failure. Therapy can provide space to articulate these disrupted stories and to reframe them as survivals rather than shortcomings. By validating the extraordinary conditions of the NICU, therapists can help mothers reconstruct more compassionate self-narratives.

Findings highlighted that the experience of surveillance was particularly powerful. Interviewees reported that mothers internalised evaluative gazes, often interpreting support as judgment. Psychotherapists can work with clients to explore these dynamics, helping them differentiate between external expectations and their own maternal instincts. Inviting mothers to recall even small acts of instinctive care, such as speaking softly to their baby, can help restore confidence in their capacity to mother.

Therapists should also attend to the cultural and unconscious scripts that shape maternal identity. Clients may struggle with internalised ideals of perfection, with the cultural splitting of maternal and sexual identity, or with the intergenerational legacies of how they themselves were mothered. Addressing these dynamics can deepen therapeutic work, allowing clients to situate their struggles within broader psychic and cultural frameworks.

The concept of matrescence (Raphael, 1973; Sacks, 2017; Stern, 1999) is a valuable tool in normalising the transition into motherhood. By framing the experience as a developmental process rather than a moment of instant transformation, therapists can reduce shame and isolation. This is especially important for mothers whose first experience of motherhood was shaped by rupture rather than seamless bonding.

Collaboration between therapists and neonatal nurses is crucial. Van Wyk et al.'s (2024) meta-analysis found over half of NICU mothers exhibited symptoms of anxiety, depression, or post-traumatic stress. These findings challenge the assumption that successful neonatal outcomes automatically guarantee emotional recovery. Instead, they point to the urgent need for systemic psychological support embedded within the NICU. Nurses play a central role in affirming or undermining maternal subjectivity. Simple but powerful discursive gestures reminding mothers that they remain mothers even when separated from their infants can scaffold maternal identity in profound ways.

Conclusion

Motherhood in the NICU is marked by rupture and resilience. Cultural myths of seamless maternal devotion collide with clinical realities of separation, surveillance, and uncertainty. Yet within this space, mothers and nurses co-create acts of care, voice, and gaze that sustain maternal identity against considerable odds.

The concept of matrescence reminds us that all mothers must navigate a developmental process of becoming. The NICU magnifies these challenges, revealing the cultural, institutional, and unconscious weight borne in the earliest days of motherhood.

For counsellors and psychotherapists, it is essential to recognise these complexities. Supporting NICU mothers involves not only addressing individual distress but also acknowledging the wider discursive, cultural, and institutional structures that shape their experiences. By situating maternal struggles within these broader contexts, therapists can offer more nuanced and compassionate care, holding space for the fragile but enduring process of maternal becoming.

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Reflective Article

Sorry, it's that time of the month: Challenging internalised misogyny in emotional self-understanding

By Rebecca Krist

In this reflective article, I explore the emotional and psychological costs of dismissing our feelings due to it being "that time of the month" and how this fosters shame, disconnects us from our bodies, and erodes trust in our own emotional wisdom

Introduction

> "You seem more emotional than normal, are you on your period?"

That comment, spoken by my former therapist during the height of the COVID-19 pandemic, has stayed with me. It was not just an offhand remark; it was a reflection of a larger narrative that many women know all too well. The tendency to dismiss, pathologise, or minimise women's emotions.

Following this experience, I have noticed how often similar sentiments appear in my clinical work with women. I often hear clients apologise for their feelings, saying things like, "Sorry, I'm emotional today", "It's my period", or " My period is next week". These statements frequently arise when genuine, complex emotions begin to surface, often pointing to something deeper.

As women, I wonder whether this narrative has contributed to the dismissal or pathologisation of our feelings, reducing heavy emotional experiences to "just PMS" rather than recognising them as valid and meaningful. This recurring theme has led me to question: what if we are not simply "PMSing", but are finally allowing ourselves to feel? What if the narrative that frames our emotions as hormonal or "overreactions" is not purely biological truth, but a learned form of emotional invalidation rooted in internalised misogyny? The phrase "It's just my hormones" has become a social script that undermines women's emotional authority.

Cultural and historical context

Across much of Western history, women's emotions have often been framed as unreliable or excessive, something to be managed, explained, or minimised. From the early medical notion of "hysteria" (rooted in the Greek word for uterus, *hystera*) (Paulon, 2022) to contemporary references to premenstrual syndrome (PMS) or being "hormonal", there is a long-standing tendency to associate femininity with

emotional instability (King, 2025). These ideas have subtly shaped not only how society responds to women's feelings, but also how women learn to interpret their own inner experiences. In the 19th and 20th centuries, emotional expression in women was frequently understood through a biological lens (King, 2025). Feelings of sadness, anger, or overwhelm were often attributed to reproductive cycles rather than to life stress, social pressures, or psychological pain (Handy et al., 2022; Shields, 2013).

Although we now have a more nuanced understanding of hormonal influences, the legacy of this medicalised framing remains. In everyday language and media, we still encounter the image of the "overly emotional" or "PMSing" woman – a stereotype that may quietly erode women's confidence in their own emotional wisdom. For many women, these messages can become internalised over time. In my private practice, I often hear apologies such as, "I'm sorry I'm so emotional" or " It must be my hormones". Beneath this statement is often a deep uncertainty about whether one's feelings are valid or trustworthy. When emotions are automatically linked to hormonal fluctuation, they can lose their meaning, in turn reducing them to a biological glitch rather than an important signal from the self.

Feminist thinkers and psychotherapists have long invited us to re-examine these narratives. Writers such as Audre Lorde (2007), Susie Orbach (1978), and Hilary McBride (2017) remind us that women's emotions are not problems to be solved, but sources of information, connection, and wisdom. From this perspective, women's emotional lives are not evidence of instability,

When emotions are automatically linked to hormonal fluctuation, they can lose their meaning, in turn reducing them to a biological glitch rather than an important signal from the self

but of sensitivity, self-attunement, and resilience. Understanding this historical and cultural backdrop allows therapists and clients alike to approach emotional experience with greater compassion. When we begin to recognise how societal narratives have shaped our relationship to feeling, we open space for a different kind of dialogue: one where emotions are not dismissed as "just hormones" but instead received as meaningful expressions of our embodied humanity.

Meeting the self we dismiss

I notice how often the phrases "It's probably just my hormones" or "I think my period is going to be starting soon" slip out – sometimes in my own words, sometimes from clients. They are such familiar lines – almost automatic – and I have started to wonder what happens inside when we say them. There is a part of me that recognises these as a protective gesture, softening the intensity, making my feelings seem smaller so they will not be judged. But there is also another part that feels sad, because I know that in saying these things, we are turning cultural messages inward, quietly telling ourselves that our emotions are too much and fostering potential shame.

There is a tenderness to this realisation. I can see how self-dismissal builds slowly. Every time we explain away a feeling, we risk losing a little of the trust we have in ourselves. That hesitation, that questioning of our own reactions, carries weight. It shows up as shame: "Why am I so sensitive? "It shows up as anxiety: "Am I wrong to feel this way?" It shows up as disconnection and the feeling that our bodies are sending signals we cannot fully follow or understand.

I also notice how these moments build over time. Sometimes, I sit in session with someone and witness their tears, or I sit with my own thoughts and feelings, allowing them to surface. There is a sense of relief in this, a quiet release of what has been weighing heavily.

Yet alongside that relief is an awareness that the overwhelm did not appear out of nowhere. It emerged because something had been avoided: a feeling, a truth, or a need that required attention. And still, the first explanation that often arises is, "It's hormones". As though naming it this way could somehow diminish the reality of how emotionally heavy things had felt, long before a menstrual period arrived.

For example, someone might have spent weeks moving through their days under quiet but constant pressure, managing work, relationships, expectations, and responsibilities, without pausing to check in with themselves. The weight accumulates gradually, almost imperceptibly. Then, as their period approaches, they find themselves crying unexpectedly, snapping at small things, or feeling emotionally undone. Instead of asking, "What have I been holding? What needs care or attention right now?", the reflex is often to open a cycle-tracking app and conclude, "That makes sense, my period is coming". In this moment, the emotional response is explained away rather than explored. The

breakdown is attributed not to weeks of unacknowledged stress or self-abandonment, but to hormones. The menstrual period becomes the acceptable explanation for distress that was already present, offering a sense of relief while simultaneously silencing the deeper emotional truth. What might have been an invitation to listen more closely instead becomes a reason not to listen at all.

This pattern rarely remains confined to our inner world. We often see it ripple outward. Sometimes it shows up in relationships, where setting boundaries feels difficult. Sometimes it appears at work, where confidence falters. Sometimes it emerges in everyday life, where self-doubt quietly creeps in. The emotions that could guide, inform, or protect us, instead become muted, reframed, overlooked, or even judged. It is a subtle but real cost, residing in tension, shame, and the gradual erosion of self-compassion.

I wonder what might happen if we met our feelings with gentleness instead of explanation. If we leaned inwards to what our body and our mind are trying to say rather than apologising for it. If, in the midst of tears or frustration, we simply asked, "What is this trying to tell me?" I have noticed that, in those moments, the intensity changes. It stops being something to hide and becomes something to understand. Emotion becomes a companion, not a problem. And in that, there is a kind of quiet reclaiming that can happen, representing a small step toward trusting ourselves again.

The healing in being seen

After noticing how easily I, or the people I work with, soften or dismiss our emotions, a question often arises: What would it feel like to fully trust this part of myself? To allow the intensity, the heaviness, the sadness, or the anger to exist without needing to explain it away?

This practice is not about denying biology or dismissing hormonal rhythms. It is about seeing them as part of a larger conversation with the body and mind

There is a unique freedom in noticing emotion without immediately labelling it as "hormones" or "too much". It can allow us to shift from self-criticism to curiosity and ask: What is this feeling trying to show me? Sometimes it's a boundary that needs acknowledgment, sometimes a grief that has no easy words, sometimes just the body reminding us that we need rest. In all cases, giving space to the feeling opens the door to self-understanding.

Could simply validating our heavy emotions release something within us? In couples counselling, I often see that partners are seeking validation: of their reactions, of their individual perspectives, and of their need to be truly heard and seen. Our relationship with self is not separate from this concept. Internalised misogyny can make it hard to feel "seen" by ourselves. So, what if intentionally giving ourselves space to acknowledge and witness our own feelings is a form of self-validation? Saying something simple like, "Wow, I've been carrying a lot", or "It's okay that I feel this", even silently, can allow us to feel recognised and held internally. It might be quiet at first but could get louder as time passes.

I have even noticed in my own body how reclaiming emotional authority is embodied. Feeling the rise of anger or the pull of sadness in the body, noticing it, naming it, and breathing with it, can change the experience. It is no longer a threat, but a signal. When emotions are witnessed rather than dismissed, the internal tension eases and a sense of connection to self begins to return. This practice is not about denying biology or dismissing hormonal rhythms. It is about seeing them as part of a larger conversation with the body and mind. Hormones may shape sensation or intensity, but they do not invalidate the meaning of the feelings themselves. When we allow ourselves to feel fully, without judgment or apology, we reclaim an essential authority over our inner lives and embrace a kind of embodied wisdom that has often been overshadowed by cultural scripts.

For me, and for many I work with, this is not a sudden change but a gradual noticing. It begins with small acts: a pause before explaining a feeling away, a breath held in curiosity rather than self-criticism, a gentle acknowledgment that this too is allowed. These small steps accumulate. They remind us that emotions are not weaknesses or flaws, but guides. Creating ways of understanding ourselves more fully, more gently, and with deeper connection to both body and mind.

Reclaiming this authority is ultimately an invitation: to listen, to wonder, and to trust ourselves, even when emotions are intense, complex, or inconvenient. Perhaps in giving ourselves this validation and noticing the motion of what's happening within us, we may experience a form of being

seen that can heal some of the internalised messages we have carried for so long.

Crying without permission

It was at the peak of the COVID-19 pandemic. Living in Ireland, far from home, I felt a quiet sense of helplessness watching the news from the United States. Protests, rising case numbers, and daily updates of loss created a constant, low-level tension that I carried with me everywhere. On top of that, my sister lives in the U.S., and she has cerebral palsy along with other health conditions. I found myself thinking constantly about her safety. Imagining what might happen if someone did not wear a mask around her, every risk she could face, and the weight of that worry pressed steadily against my chest. It was not just concern; it was a deep, underlying sense of vulnerability, a recognition that so much is beyond my control during this uncertain time.

I had been carrying a private heaviness for months. Small but persistent: guilt for feeling overwhelmed when I had privileges, shame for taking up space with emotions I thought were not allowed. I reminded myself repeatedly that others had it worse, that I should not feel this way. I tucked the feelings down, carrying them quietly, letting them accumulate until they pressed against the edges of my body and mind until it was unbearable. As you would assume, thus began my spiralling thoughts. So, I thought, what better way to combat my anxiety then to bring it to personal therapy? At this point I had been seeing a therapist for almost a year – someone I had trusted to process trauma before – so I assumed it would be a safe space to explore what was going on.

That day, I logged on to Zoom, and the tension I had been holding surfaced all at once. My therapist appeared on my screen, and it all hit me. My breath felt short, and tears came before I could form my sentences. My body felt like it was trying to communicate what my mind could not: fatigue, grief, worry, anxiety, and a quiet longing for connection.

Our nervous system learns to expect dismissal, so that even private moments of grief or anxiety can become hijacked by pre-emptive self-judgment

Moon cycle

"You seem more emotional than normal. Are you on your period?" The words landed like a cold weight. In that moment, the loneliness I was carrying, the physical distance, the uncertainty for my sister, and the heaviness of global events became sharper. Shame surfaced quickly, alongside a familiar questioning of myself: Am I overreacting? Am I being too emotional? I even checked my menstrual cycle app, to see if it could explain the feelings coming up. Maybe I was in my luteal phase, or maybe the reality was that a person I trusted made a comment that hurt me, and my response actually had nothing to do with my period.

For the rest of the session, I felt present but guarded, hesitant to speak, hesitant to trust that my emotions were valid. And yet, beneath the initial shock, a quiet awareness began to emerge. I began saying to myself, "you are overwhelmed. It's okay to feel this". That acknowledgment, fragile as it was, became a foothold. Slowly, I was able to hold space for the feelings without needing to justify them, and I felt relief because I did not need a solution.

The emotional labour of bleeding

This experience made me notice patterns, both in my own life and in my private practice. How often do women apologise for feeling? How often do they explain away heaviness as "just hormones" or as being "too sensitive"? How often do we silence ourselves before anyone else has the chance to question or judge us? I began to see how these scripts, internalised over years, shape not only the way we speak about our emotions but the way we inhabit our bodies. Our nervous system learns to expect dismissal, so that even private moments of grief or anxiety can become hijacked by pre-emptive self-judgment.

I also began to reflect on the relational dimensions of validation. In couples counselling, I had seen over and over how essential it is for partners to feel heard and seen. Recognition of another's experience, even without solution, can be transformative. I realised that our relationship with ourselves operates in a similar way. I wondered whether the messages we carry – the quiet scripts that deem our emotions too much, inappropriate, or "wrong" – make it harder to truly feel seen by ourselves. Yet when we pause and gently notice what we are feeling, even just to ourselves, and say something like "I see you, it's okay to feel this", it can create a quiet sense of being held, acknowledged, and understood. In that moment, the heaviness does not have to be carried alone. Simply naming it can make it feel lighter and more real.

Pain without a witness

Even now, I sometimes notice myself softening my presence before I speak, quietly apologising for tears or the weight of my feelings. I recognise the times I fold inward, trying to take up less space, to be smaller, quieter, less visible. Yet that session, as difficult as it was, opened a doorway. It revealed the power of small, gentle acts of self-validation and the importance of truly witnessing our own experiences, even when emotions feel intense, confusing, or uncomfortable. It reminded me that feeling overwhelmed is not a flaw and that allowing our emotions room to exist is a vital step toward trusting ourselves.

As I sit with these thoughts now, I ask myself when was the last time I truly let myself be seen without needing to explain, apologise, or judge my own feelings beforehand. How often do we shrink, soften, or dismiss our emotions before anyone else even has a chance to notice them? How often do we carry the weight of external pressures from family, work, or the wider world, trying to shoulder it all on our own?

Making ourselves smaller on a schedule

And so, I leave this reflection with one invitational thought, almost like a quiet, lingering question at the end of a journal entry. If you notice the heaviness you have been carrying, the tension in your body, or the emotions you have been silencing, what might happen if, for just a moment, you allowed yourself to truly see and acknowledge them without explanation or apology? For those of us in the helping professions, this reflection can also invite gentle curiosity about the ways clients, and even ourselves, pre-emptively minimise or apologise for emotional experiences. Simply witnessing, acknowledging, and creating space for feelings to exist without rushing to explanation or solution can quietly open a pathway toward safety, connection, and trust in one's own emotional truth.

If you notice the heaviness you have been carrying, the tension in your body, or the emotions you have been silencing, what might happen if, for just a moment, you allowed yourself to truly see and acknowledge them without explanation or apology?

Conclusion

For therapists, this reflection underscores the importance of noticing how often clients can feel dismissed or apologise for their feelings, especially when prevailing narratives often label women as "hormonal". Cultural narratives and internalised messages teach women to soften, apologise, or question our own feelings: "It's just my hormones", "I'm overreacting", "It's nothing serious". These scripts not only minimise emotional experience but also make it harder to trust ourselves and fully inhabit our feelings. Simple acts of witnessing and acknowledgment, without rushing to explanation or solution, can help clients and ourselves reconnect with emotional wisdom and begin to challenge internalised patterns of self-dismissal. Instead of framing intense emotions as a problem caused by biology, what if we allowed ourselves to see them as meaningful signals? What if acknowledging heaviness, grief, or overwhelm became an act of self-compassion rather than self-censure?

Your tears are yours, not your period's.

Rebecca Krist

Rebecca Krist is a pre-accredited psychotherapist currently in private practice in Dublin, Ireland. She works predominantly with women and with a large part of the LGBTQIA+ community, supporting clients navigating trauma, emotional processing, challenges such as family estrangement, low contact, or no contact relationships, as well as supporting individuals with premenstrual dysphoric disorder (PMDD), and borderline personality disorder (BPD). Her work is informed by a curiosity about embodied emotional wisdom and how internalised messages shape self-trust and emotional authority. Rebecca aims to help people reconnect with their body to rebuild self-trust, and connection.

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Academic Article

Challenging the silence: Psychotherapists' experiences of menopause in the therapeutic space

By Emma Cleary

'Weaving her Journey' by Gaia Orion

Menopause is a multifaceted bio-psychosocial transition, which uniquely affects all women physically, psychologically, and socially. There is an opportunity for psychotherapists to challenge the narrow, biomedical perspective of menopause and move towards an understanding that incorporates lived experiences, cultural meanings, and psychological adjustments

Introduction

Menopause is a universal experience for all women who reach middle age. The transitional phase of perimenopause lasts approximately 4 to 8 years, and the average age of natural menopause is between 45 and 55 years (Davis et al., 2015). From a medical standpoint, it occurs when a woman has not menstruated for 12 months. However, the term menopause is widely used in western society to describe the transitional process that evolves over years, as fluctuations in hormone production bring about many physical, psychological and emotional changes. These include loss of fertility, cardiovascular risk, osteoporosis, insomnia, anxiety, headaches, depression, poor memory, and brain fog, as well as vasomotor and urogenital symptoms such as hot flushes, vaginal dryness, and incontinence (British Menopause Society, 2022; World Health Organisation, 2024).

Menopause also has implications for working women and has been linked to distress in the work environment (Bodza et al., 2019). Symptoms impact the day-to-day activities of almost 80% of Irish females (Lillis et al., 2021). One in two women in Ireland describe their experience of perimenopause as negative,

and one in three report constant symptoms (Department of Health, 2023). In 2022, in response to calls for improved healthcare for women, the Irish government launched a nationwide menopause campaign to promote services and challenge the stigma surrounding the menopause transition (Health Service Executive [HSE], 2022).

Counselling is a predominantly female profession in Ireland. Four out of five members of the Irish Association for Counselling and Psychotherapy (IACP) are women, with a median age in the mid-fifties (IACP, 2024). Furthermore, 77% of IACP members' clients are also female, with 45% being over the age of 56 (IACP, 2024). Therefore, a substantial proportion of therapists are likely to be experiencing menopause transition themselves, while simultaneously working with a client population that is predominantly female and increasingly older.

By truly listening to women's voices, helping professionals can gain a deeper and more compassionate understanding of what it means to live through menopause (Walter, 2000). This qualitative study explored the experience of menopause within counselling and psychotherapy in Ireland, aiming to understand clients' lived experiences, highlight psychotherapists' perspectives, and identify effective therapeutic approaches for supporting women through the menopause transition.

Theoretical framework

Women's experiences of biological changes and transitions are shaped by the social and cultural contexts of the societies in which they live (Avis et al., 2018; Hvas & Gannik, 2008; Verdonk et al., 2022). In Western societies, menopause has been framed within a medicalised narrative of a failing body, as an illness that can be lessened or eliminated (Krajewski, 2019; Perz & Ussher, 2008) and menopause discourse centres around hormones, cycle changes, problematic symptoms, and medical cures (Honour, 2018; Niland & Lyons, 2011). This narrow focus ignores the broader, more nuanced realities of women's experiences (Hickey et al., 2022; Huffman & Myers, 1999). A bio-psycho-sociocultural model of menopause offers a more holistic view, as it recognises the interplay of biological, psychological, and sociocultural factors that shape how women understand and live through this important life transition (Hunter & Edozien, 2017; Hunter & Rendall, 2007).

A substantial proportion of therapists are likely to be experiencing menopause transition themselves, while simultaneously working with a client population that is predominantly female and increasingly older

Menopause does not always impact psychological wellbeing in healthy women and depressed mood cannot be attributed automatically to the menopause transition (Hunter & Rendall, 2007). However, research consistently highlights a broad range of emotional responses including anxiety, low mood, irritability, relief, empowerment, and identity change (Freeman et al., 2014; Hunter & Rendall, 2007; McNulty et al., 2024). A specifically adapted form of cognitive behavioural therapy (CBT-Meno) may reduce the impact of hot flushes, night sweats, and problematic beliefs linked to depression (Donegan et al., 2022; Green et al., 2019; Hunter & Chilcot, 2021; Rukure & Husted, 2025).

From a person-centred perspective, the psychological impact of menopause could be defined as an emotional response characterised by significant, persistent apprehension, discomfort, or dejection, owing to a perceived inability to cope with the demands and challenges of living with menopause (Kalra et al., 2020). It may be argued that the term "change of life" is appropriate to capture the multiplicity of biological and social changes that occur during midlife, of which menopause is one part (Ballard et al., 2001). Existential exploration of the menopause transition may contribute to the process of meaning-making for women within the context of midlife and ageing by focusing on the givens of human existence, including personal responsibility, isolation, and death (Duffy, 2024; Sommers-Flanagan & Sommers-Flanagan, 2018).

The Irish context

The author of this study was unable to locate any published, peer-reviewed, qualitative studies that explore menopause specifically within the psychotherapeutic context in Ireland. Several studies engaged with Irish women's experiences of the menopause transition. McNulty et al. (2024) explored how menopause shaped motivators, facilitators, and barriers to physical activity among Irish women. The study focused

primarily on physical activity, and study findings are unlikely to be meaningful to all women during menopause, as data was gathered from a small group of participants.

Carolan's (2000) research found that rural Irish women generally regarded menopause as a natural stage of life, with some even feeling a sense of relief. Their experiences were highly individual, shaped by personal and sociocultural circumstances. The study group was narrow in focus, involving six post-menopausal women from agricultural backgrounds in the south of Ireland. Hyde et al. (2010) highlighted how biomedical narratives strongly influenced how women understood their menopausal status and health identity. Their findings underlined the powerful cultural role of medicine in shaping women's experiences of menopause transition. The study included 39 women from varied socioeconomic backgrounds, living in both rural and urban areas.

In Kelly's (2020) research, themes such as loss of identity and control, shifts in self-concept, and the impact of menopause on overall quality of life were identified. The data also illuminated more positive experiences, including increased self-compassion and acceptance. Participants, aged 43 to 54, were recruited online, and many were actively seeking support, which may have influenced the findings.

Despite the growing recognition of menopause as a significant life transition, there is a notable absence of research examining women's experiences of menopause within the therapeutic space in Ireland. This study directly addresses this gap by providing an exploration of menopause as encountered and negotiated within therapeutic practice.

Despite the growing recognition of menopause as a significant life transition, there is a notable absence of research examining women's experiences of menopause within the therapeutic space in Ireland

Methodology

The primary goal of this research was to explore the phenomenon of menopause within the context of counselling and psychotherapy in Ireland. It is supported by a constructivist paradigm, which places emphasis on the participants' concepts of reality, their own constructions, descriptions, and narrations of their lived experiences (Toledo & Shannon-Baker, 2023). Reflexive thematic analysis was used to identify and analyse patterns and emerging themes within the data that was gathered (Braun & Clarke, 2012). The five participants, four females and one male, are all accredited counsellors and psychotherapists working professionally in Ireland for a minimum of one year, and ranged in age from 44 to 59 at the time of the study. Pseudonyms were assigned to participants to protect their anonymity.

Findings

Three subordinate themes and several subthemes were developed following analysis of the data, which comprised both psychotherapists' personal experiences of menopause and their perspectives on the experiences of their clients (see Table 1).

Theme 1 – Knowing the change

The lack of knowledge of menopause in Irish society, along with the secrecy surrounding it, was a prevalent theme. Female therapists who have

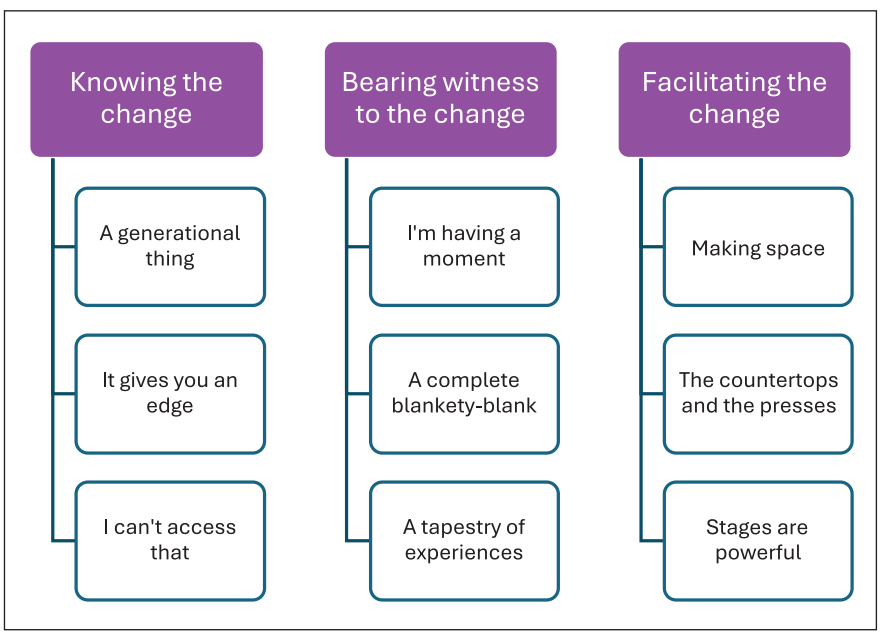

Table 1: Superordinate and subordinate themes

experienced the menopause transition are viewed as wise, in contrast to individuals without lived experience to draw upon as a resource. Participants also reported a changing perspective on menopause in Ireland.

1.1 A generational thing

Interview data highlighted the lack of knowledge of menopause in society. This was attributed, in part, to sociocultural factors, including religious influence over previous generations. James reflected on how "women's stuff" was kept out of the public domain: "There was a time when people just didn't talk about anything like this, and you couldn't ask about it. It's just something that's happening, don't worry, that's happening over there, you leave that over there, don't talk about it". This perspective was corroborated by Maeve, who identified "embarrassment, shyness, and reticence" among older people about discussing intimate issues. Women sometimes looked to their mothers for guidance and advice, but the information was often limited. Constance's mother denied ever going through the menopause, but she remembers her mother's challenges: "And I would certainly say she had a major depressive episode around her late 60s, early 70s, which now, looking back from a place of more knowledge, I would say that's probably what was happening".

1.2 It gives you an edge

The research suggested that having first-hand knowledge of the menopause transition was desirable when working therapeutically with women in midlife. According to Constance, it is advantageous to have had biological experience of menopause:

> But I do think it is one of those lived experience pieces, that you nearly have to go through it to get it. To say that is suggesting that a younger woman couldn't work with a menopausal woman, and that's not true either, but it gives you an edge, certainly.

And it wasn't the part that I couldn't understand it as a male. It was that I didn't join with it, there was something anxiety-provoking in me that was like 'what in the name of god am I supposed to do with this?'

1.3 I can't access that

Therapists who did not have biological experience of menopause due to gender or age interpreted their lack of knowledge as a barrier. James explained that "there was something anxiety-provoking" in him that led to discomfort and avoidance of the issue in the therapy room.

> And it wasn't the part that I couldn't understand it as a male. It was that I didn't join with it, there was something anxiety-provoking in me that was like 'what in the name of god am I supposed to do with this?' It was uncomfortable, it was ... yeah ... it kept me away from it.

Rosie noted that clients may be referred elsewhere due to a therapist's reluctance to explore their menopause with them. She concluded that the lack of training in menopause-related issues was shocking, and admitted that if a client came through the door wanting to discuss their menopause, she did not know if she would feel competent enough to take that journey with them. When asked if menopause had ever come up in a therapy session with a male client, James reflected that it had not, even though some of them were struggling with relationship and marital difficulties:

> I've never asked about it, I am conscious that I have worked with men in their forties and fifties ... and as I think about it, it would have been part of their life experience. So, was it ever an issue for them? I have no idea. Did it come into the room? No. Was it asked about? No. And I do find that interesting.

Three study participants noted a changing perspective on menopause in Ireland, with Constance reporting "more awareness" among her peers and "younger women coming up". James made the following admission: "It's not even about, ok, this is something I'm interested in following, but that it's already in my work. It's already in my work". Maeve expressed scepticism about the depth of this evolving narrative:

> I still think it's a little bit like 'oh my god, I acknowledge you're going through the menopause, but can you still deliver the same deliverables you were delivering anyway? So, while we know it, have we really embraced it?

Theme 2 – Bearing witness to the change

Each woman goes through a spectrum of physical, emotional,

and cognitive symptoms that should be viewed within the context of her life, and interviewees shared how menopause symptoms had impacted their lives professionally and personally.

2.1 I'm having a moment

Psychotherapists may experience physical symptoms during their sessional work. Interviewees thought primarily of hot flushes as a challenging symptom which could potentially be distressing, yet the three therapists with direct experience of menopause highlighted other symptoms. Constance gave an example of how urinary incontinence had affected her during client work:

> I remember one session in particular, standing up ... after being sitting down for an hour and the client said to me, 'do you mind if I use your bathroom?' ... And then, I'm thinking, 'oh my good god, please don't be too long in there' and I had actually stained the chair.

2.2 A complete blankety-blank

Memory lapses and retention of details such as client names and stories were sometimes problematic, as described by three participants. Maeve highlighted that her "cognitive glitches", were "incredible" and "frightening", and led her to question her neurological health:

> I know other colleagues of mine and friends have found it frightening. It creates a certain amount of terror for me, that 'oh my god, is there something else that's happening, something catastrophic?' I'm nearly afraid to say it, but like, I started to go 'oh my god, this isn't anything to do with dementia, is it?'

"I definitely think that the impact of menopause on me as a practitioner meant I had to really change how I worked"

For Constance, the brain fog meant losing her train of thought, or losing a word, or even losing a name. This resulted in discomfort during client work:

> You know, I could have a client coming in and I know it's 'Emma? Emma? Emma?' has her appointment at 2 o'clock, and she's sitting across from me and I'm going 'what's her name? It's gone. It's gone'. And I'm kind of nearly distracted by cycling through the alphabet of trying to remember what the name is.

Veronica received a diagnosis of attention-deficit hyperactivity disorder (ADHD) during her menopause transition, which "really created challenges" that she had not anticipated. While she loved what she had been doing, she found that she "could no longer hold the multiple elements" and took a less demanding job within an organisation:

> Like, the bit that still probably is easiest for me is to sit with a client, like that's probably still the bit I can do more easily. But all of those other parts of being a therapist were all really impacted ... so I definitely think that the impact of menopause on me as a practitioner meant I had to really change how I worked.

2.3 A tapestry of experiences

Symptoms of menopause may intertwine with negative life events, creating a tapestry of emotional experiences. Constance recalled feeling "intense rage and anxiety that were off the scale" as she struggled with her symptoms, familial expectations, and care of elderly parents. Grief was viewed as a primary response to the perceived loss of youth, fertility, beauty, and attractiveness heralded by menopause. Maeve expressed that this could lead to "identity issues", as women were confronted with a changing body, an ageing face, and a growing awareness of their mortality. Veronica was struck by how menopause affected her appearance:

> And sometimes I'm surprised by that when I look in the mirror. I'm like, 'crikey, who's the old one looking back at me? How did that happen?' You know ... Sure, we all still feel young, like most of us do anyway, like still. Well, I do anyway. Somehow, I imagine I'm much younger than I am. So that loss, I understand.

Theme 3 – Facilitating the change

Study participants expressed a preference for person-centred therapy, CBT, and existentialism as beneficial approaches to use, and all therapists promoted an integrative approach to client issues built around the "core conditions" (James). All four female therapists viewed tuning into the body as a central tenet of therapy.

3.1 Making space

Participants emphasised the importance of a safe environment where clients could explore and process what was happening for them. Maeve highlighted nurturing the "therapeutic alliance and building that relationship of trust" as a key component of treatment.

Veronica spoke of compassion and exploration: "I think it's about giving them permission to... to explore all of the symptoms: the internal, the external, the cognitive, the mental emotional … and the physical." Maeve viewed effective therapy through a biopsychosocial lens: "It's about building capacity, putting self-care strategies in place that are going to support, and having support mechanisms in place in terms of psychological support: partners, friends, like a network, and the medical model".

3.2 The countertops and the presses

Three of the five interviewees identified CBT as an effective approach to management of symptoms such as anxiety and hot flushes. Maeve employed CBT techniques to manage her clients' anxiety and sleep disturbances. Constance summed up her approach as follows:

> I use it [CBT] so much now, it just makes sense to me. But I don't use it on its own. It's kind of like, you know, you're figuring out what way they're thinking, but you're also figuring out where are these thoughts coming from. So, it's … the countertops and then the presses.

3.3 Stages are powerful

Veronica saw an opportunity for menopause transition to represent "a developmental stage" and favoured the cultivation of a growth mindset. For Maeve, part of the work consisted of looking at the overall process and reflecting on "the gifts that it brings in terms of wisdom and maybe being comfortable in your own skin."

Rosie identified an opportunity to adopt a Jungian lens and introduce the concept of the hag as an archetype. She observed that men are "stagnant", while women are always changing:

> Women, we're always cyclical and we're always changing, and it's a beautiful thing, it's a positive thing. So, I think I'd like to support them in … welcoming it and seeing how rich it can be for them, and in what way it can be mined for its gold.

Therapists with lived experience are seen as having valuable insight, and this aligns with research suggesting that validation and guidance from health professionals can assist women in understanding and managing menopause symptoms

Discussion

Understandings of menopause in Irish psychotherapeutic practice are shaped by cultural influences, reflecting Western narratives that frame menopause as a period of decline. However, attitudes are changing. This study suggests that younger generations are becoming more knowledgeable as menopause transition becomes less taboo. Therapists with lived experience are seen as having valuable insight, and this aligns with research suggesting that validation and guidance from health professionals can assist women in understanding and managing menopause symptoms (McNulty et al., 2024). Practitioners may end up compensating for deficits in the healthcare system, as some women report unsatisfactory guidance from medical professionals such as GPs (HSE, 2022).

Menopause is described as a highly individual and multifactorial experience, determined by personal, biological, and sociocultural factors. Participants emphasised the uniqueness of each client's journey, consistent with research highlighting the diversity of menopausal experiences and the range of emotions involved (Panay et al., 2021). Some symptoms – such as hot flashes, sleep disruption, mood changes, and decreased libido – were recognised by psychotherapists, though cognitive symptoms were noted primarily by those with lived experience. Menopause transition can significantly impact women's professional lives, and the need to conceal symptoms can heighten stress (O'Neill et al., 2023). The interplay between cognitive difficulties and ADHD was identified by one participant. Studies have shown that menopause transitions intensify symptoms of neurodivergence (Gottardello & Stefan, 2024), while more complex and intense symptoms are experienced by autistic individuals, who also report barriers to accessing appropriate support and care (Brady et al., 2024; Grant et al., 2025). Themes of grief and loss were prominent, reflecting the persistence of deficit-based cultural narratives surrounding menopause and ageing.

Participants viewed person-centred or humanistic psychotherapy as foundational for supporting menopausal clients, with modified approaches, such as CBT-Meno, considered useful for symptom management.

Previous studies have proven that group psychotherapy may be effective in reducing symptom distress, improving mood and sleep, and enhancing quality of life (Bodza et al, 2019; Keefer & Blanchard, 2005; Rukure & Husted, 2025) but it was not mentioned by study participants. From a practical viewpoint, it can serve greater numbers of women and is usually cost-effective (Balabanovic et al, 2013). While studies which explore menopause transition through an existential lens are limited (Duffy, 2024; de Salis et al., 2018), this study identifies an opportunity to approach menopause as a conduit for reflection on ageing, identity, and personal development.

Limitations

As a small-scale qualitative study, the findings have limited generalisability. The study sample was homogeneous, consisting of white Irish psychotherapists aged between 44 and 59. The recruitment of a more ethnically diverse sample may have provided distinct results. Online interviews may mask or inhibit social cues, such as voice and body language that enrich the meaning of data (Opdenakker, 2006). Having conducted extensive research into menopause in psychotherapy, the researcher may have been influenced by pre-established themes. Furthermore, the researcher, a female trainee psychotherapist on her own biological journey, worked alone, increasing the possibility of bias in the findings.

Implications and recommendations

The majority of clients in psychotherapy are women, and the majority of practitioners are women (IACP, 2024; UK Council for Psychotherapy, 2024; Morison et al, 2014). Yet menopause is poorly researched and poorly understood in psychotherapy (Brown, 2017).

Therapists may be advised to reflect on their own assumptions regarding the meaning and impact of menopause

Therapists without knowledge of menopause-related issues may not make important connections between a woman's life stage and the emotional difficulties she is – or they themselves might be – experiencing and could end up contributing to the isolation and shame that many women encounter (Nosek, 2010). This study found that male psychotherapists may feel incapable of understanding a female client's experience of menopause and may decide not to broach the subject with clients of either gender. Male psychotherapists may inadvertently overlook the significance of menopause in their work with male clients.

Similarly, female therapists who have not yet entered menopause may not feel equipped to cater to the needs of female clients in middle age either. They may be impacted by their own menopause transition in the therapeutic space if and when psychological, cognitive, and physical symptoms manifest themselves. Therapists may be advised to reflect on their own assumptions regarding the meaning and impact of menopause, and what implications this may have, if any, for their practice. The need for menopause-specific training for counsellors and psychotherapists previously identified by Bodza et al (2019) remains.

Research into the effectiveness of group CBT for women seeking support in Ireland may be a worthwhile endeavour, given its proven track record and affordability (Balabanovic et al, 2013; Rukure & Husted, 2025). While there is increasing awareness of neurodivergent health needs during life transitions, research on autistic people's experiences of menopause is still limited and warrants further exploration (Grant et al., 2025; Jenkins et al., 2024).

This study confirms that psychotherapists in Ireland will very likely encounter clients and colleagues whose mental health, daily functioning, and sense of self are impacted by their own menopause transition or that of someone close to them. Menopause is a deeply individual life stage, best understood within a bio-psycho-socio-cultural framework that honours personal meaning, context, and lived experience.

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Emma Cleary is a pre-accredited psychotherapist with IACP. She received her master's degree in pluralistic counselling and psychotherapy from IICP in 2025, following many years in the education sector. In the past year she has set up a private practice in her adopted city of Limerick and is embracing the rewards that her journey is bringing.

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IACP Noticeboard

Joint Message from your Cathaoirleach and Chief Executive Officer

Dear Member,

As this edition of the *IJCP* arrives in your postbox, may it bring along with it the promise of spring - lovely weather and a time of hope and renewal.

In the first quarter of 2026 the Board of Directors and the national office team have been focusing on the future direction and strategy to bring our organisation into the next phase – as the therapeutic professional landscape continues to evolve and state regulation moves forward. We're looking forward to delivering enriching and impactful member benefits, resources, and events to you this year.

New Strategic Plan
We have now reached the end of the current IACP Strategic Plan, which has guided our work since 2021. The plan defined several ambitious targets and projects across the areas of Education, Standards, Advocacy, Research, Community, and Regulation. We are delighted to report that we have achieved 97 percent of these objectives.

The development of our next Strategic Plan is close to finalisation and will be officially launched shortly. As part of the development process, we carried out a wide-reaching consultation, including member surveys, committee engagement, Board and national office staff visioning sessions, regional workshops, and input from our external stakeholders.

Our sincere thanks to all members who have contributed: your input will have a real impact on the future direction of the organisation.

CORU Update
We continue to implement and make progress on our action plan to raise our concerns about the CORU Standards and Criteria for Counsellors and Psychotherapists

We have come together with the **Irish Council for Psychotherapy** and **Community Therapy Ireland** in a strategic partnership, joining forces to amplify our organisations individual efforts calling on the Government to pause the CORU regulation process and convene meaningful consultation with representative bodies and frontline practitioners and to conduct both the impact assessment and proportionality assessment of the standards and criteria in line with the requirements of EU and Irish law.

Joint Message from your Cathaoirleach and Chief Executive

There is strength in numbers and we believe this united approach will help us raise more awareness and prompt action by key stakeholders in government and other political parties.

Stakeholder Engagement and Meetings

- At a meeting in December at the Department of Health we continued to raise the IACP's serious concerns and re-iterated our call for a pause to the regulations. We are awaiting an update from the Department regarding our concerns which have been relayed to Minister Jennifer Carroll MacNeill.

- We represented the IACP before the Joint Committee on Health alongside representatives from the Irish Council for Psychotherapy in November at Leinster House. Our testimony focused on the devastating damage - if unchanged - the regulations will have on the availability and quality of mental health services and the future of counselling and psychotherapy.

- Additionally in November we met with Deputy Peter Roche, Fine Gael spokesperson on Mental Health and Deputy Marie Sherlock, the Labour Party spokesperson on Health in Leinster House who both expressed support for our efforts to change key components of CORU's regulations of the counselling and psychotherapy professions.

Communications Supervisor Nicole Mac Dermott, Deputy Maire Sherlock, and CEO Lisa Molloy

CEO Lisa Molloy meets with Deputy Peter Roche

Cathaoirleach Jade Lawless and Innovation and Development Manager Iwona Blasi represent members at a meeting of the Department of Health

Community Therapy Ireland Joint CEO Maira Cleary, Irish Council for Psychotherapy Rúaidhrí O'Connor, CEO Lisa Molloy, and Deputy Sorca Clarke at Dáil Éireann

Joint Message from your Cathaoirleach and Chief Executive

Rúaidhrí O'Connor, ICP, Chief Executive Officer, Belinda Moller, ICP Chairperson, CEO Lisa Molloy, Jacky Grainger, ICP Board Member, John O'Connor, ICP Board Member, and Cathaoirleach Jade Lawless (centre) before the Joint Committee on Health hearing

Emergency Mental Health Services Motion
We were delighted to join with Irish Council for Psychotherapy CEO Rúaidhrí O'Connor and Community Therapy Ireland Joint CEO Maira Cleary in support of Deputy Sorca Clarke's successful Emergency Mental Health Services motion in Leinster House in January.

Deputy Clarke's motion seeks to reshape the way emergency mental healthcare is delivered.

The 2024 Mental Health Commission national survey on acute mental health care found that international best practice is not available in most emergency departments in Ireland. The 50,000 people who present to emergency departments each year in mental health crisis deserve a service fit for purpose.

The commission also found substantial variation in the quality of care available, with access depending more on geography than need. Eight emergency departments do not have an appropriate space to conduct an assessment, resulting in people in distress being assessed in corridors or other unsuitable areas.

The motion calls for every model 3 and 4 hospital to have a dedicated mental health emergency room separate from the general emergency department. However, this is not only about larger hospitals. Model 2 hospitals can support crisis care and that role must be examined and a network of specialist mental health crisis centres established, with ring-fenced investment in crisis teams and community alternatives.

We agree that mental health emergencies must be treated with the same urgency as physical emergencies. By investing in dedicated facilities, strengthening community alternatives, proper staffing and ring-fenced funding, a fully fit-for-purpose acute mental health care system in emergency departments can be delivered.

Launch of New Academic Membership Category
We're delighted to share that applications for the Accredited Academic Membership category are now available. The application form and all information needed to apply is available on our website under the link: Academic Membership. The initiative is a result of the motion that was carried at the AGM in 2024.

We would like to thank the Professional Practice Sub-Committee, which has been working over the last year on the implementation of the Academic Membership category. This work involved establishing a special purpose working group to develop the entry criteria, parameters, and annual requirements for this new membership category. The group consulted with

relevant committees as well as members who had previously expressed their interest in this category. Special thanks go to IACP Members: Kay Conroy, Andrew Harbourne-Thomas, and Jim Hutton for their time given to this project.

EDI Conference
A truly amazing day of sharing experiences and professional development took place in November at **"Le Chéile… Courage Is Strongest… Together!"** – The IACP's second Equality, Diversity and Inclusion Conference held at Dublin City University's School of Nursing, Psychotherapy and Social Care. One of the many meaningful highlights of the conference was the moving and thought provoking presentation: Invisible Until It Hurts: Race, Neurodiversity, and Barriers to Inclusive Mental Health by Emer O'Neill, broadcaster, educator, and anti-racism advocate. The day organised by the EDI Committee also included for the first time a multi-sensory cultural room where members enjoyed a peaceful and welcoming setting with poetry readings, music, visual presentations, and space for quiet reflection. For more information and photos see page 37.

Volunteer Engagement Update
We are excited to share an update from the **Volunteer Engagement Committee**, which was established last year to finalise the **IACP Volunteer Strategy** and to drive both operational and strategic improvements to the volunteer experience. The Committee's work supports the development of an active, connected, and engaged volunteer community.

The strategy will set out a structured and supportive approach to recruiting, engaging, developing, and recognising volunteers at every stage of their journey - from initial membership to active involvement in committees and initiatives and through to continued engagement after formal volunteering roles have ended.

Alongside strategy development, the VEC has been focused on enhancing volunteer events and engagement opportunities. The first volunteer event, "Harness, Energise, Engage and Connect – An Event for IACP Volunteers," took place online on 27th September 2025, providing a valuable opportunity for volunteers to connect, share experiences and learn

EDI Committee Chair Jim Hutton, Aseia Rafique, BACP EDI Lead, CEO Lisa Molloy; Cathaoirleach Jade Lawless; Emer O'Neill, conference presenter; Steve Mulligan, BACP Four Nations Policy and Engagement Lead at the EDI Conference

from one another. In addition, an interactive online workshop for members interested in volunteering with the IACP is scheduled for 21st February. Highlights include: the IACP volunteer structure, regional and sub-committee roles, personal and professional development value, how to get involved.

Men's Aid Ireland National Conference

Shane Kelly, Men's Aid CEO with Niall Kelly, Finance Manager at the launch

Finance Manager Niall Kelly attended the landmark event launching the findings of "Men Call Help", a national research project led by Trinity College Dublin and Men's Aid Ireland, exploring the experiences of men seeking help for domestic abuse in Ireland. It also marked the publication of Men's Aid Ireland's Annual Report and highlighted the importance of inclusive, evidence-based support for all victims of domestic abuse. It was great to connect again with Shane Kelly (CEO Men's Aid and former IACP staff member for many years).

Looking Ahead:
We're delighted to announce the theme for this year's annual conference is **"The Many Faces of Love: Connection, Heart and Healing in Counselling and Psychotherapy."** The all-day event and IACP Awards Ceremony will take place on **Saturday 18th April** at the **Johnstown Estate, Co. Meath**. Please see page 34 for additional details.

The **National Supervisor Forum** is being held in **the Galway Bay Hotel, Co. Galway**, on the **16th May 2026**. This year's theme is "Creativity in Supervision," and will include a workshop, theatre, and rich opportunity for discussion and reflection.

Please save the date **Tuesday 14th July** for the **10th Counselling and Psychotherapy Conference organised by the IACP and DePaul University - Chicago**. We will be celebrating a decade of our transatlantic collaboration, and we hope you can join us again in Trinity College for this exciting conference.

All bookings can be made via the events page on iacp.ie

We're looking forward to engaging with you all either at the conference or another event very soon.

In closing it's your commitment to our profession and to the IACP community that strengthens our mission every day, and we are truly thankful for your dedication that makes our collective work possible.

Sincerely,

Jade Lawless
Cathaoirleach, IACP

Lisa Molloy
Chief Executive, IACP

IACP Noticeboard

IACP Annual Conference 2026

Our Annual Conference is being held in The Johnstown Estate, Co. Meath, on the 18th of April and this year's theme is "*The Many Faces of Love: Connection, Heart and Healing in Counselling and Psychotherapy*," which centres on how love in its many expressions shapes the therapeutic process.

Our theme invites counsellors, psychotherapists, other mental health practitioners, writers, and researchers to reflect on love as both a universal human experience and a powerful clinical force.

Love is present in connection, compassion, and empathy; in the steadiness we offer clients; and in the self-kindness that sustains us as practitioners. It is also woven through grief, which so often reflects the depth of love, and in the courage it takes to accompany others through loss, growth, and transformation.

We are delighted to announce our conference speakers and share their bios.

Louise Yourell, MIACP and Caitriona O'Meara

Presentation:
Healing with Horses and the Animal Human Bond

Louise Yourell is a qualified and accredited psychotherapist and supervisor in private practice since 2003. She is the founder and Director of Westmeath Counselling Service and Healing with Horses. Louise is an Eagala certified practitioner in equine assisted psychotherapy and is an active member of the Irish network.

Caitriona O' Meara is a secondary school teacher and guidance counsellor. She is a member of the IGC and the teaching council. Caitriona is an equine specialist with a background in Natural Horsemanship and is an Eagala certified practitioner. Caitriona is the Eagala Irish network co-ordinator.

Louise and Caitriona and their wonderful team of horses, provide equine assisted psychotherapy in both Edenderry and Mullingar.

Karen Murphy, MIACP

Presentation:
Holding the Thin Line Between Love and Hate: Neutrality at the Heart of Couples Therapy

Karen is a psychotherapist, supervisor, and relationship specialist with a deep passion for exploring and understanding the complexity of intimate connection and conflict. She is the founder of the Institute of Couples Therapy, created in response to a widespread need for

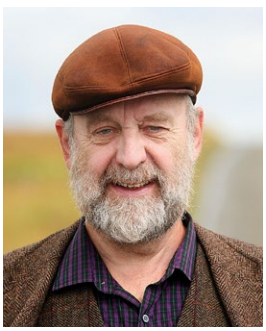
high-quality, training in couples work. Her work is grounded in a deeply relational approach, with a particular interest in translating theory into skilful and effective therapeutic interventions.

Caroline McGuigan, MIACP

Presentation:
The Power of Love

Caroline McGuigan supports people worldwide to find meaning, purpose, and hope when life has been shaken by loss, suffering, and profound change. At the heart of my work is walking alongside people as they face reality – even when it is brutal – with honesty, courage, and clarity.

Caroline is psychotherapist, mental health advocate, group facilitator, activist and the founder and CEO of Suicide or Survive, focused on suicide prevention and mental health. For more than 30 years she has offered compassionate, meaning-centred support to people experiencing anxiety and depression; trauma, grief, and loss of hope; suicidal ideation and self-harm; addiction, abuse, and domestic violence; chronic illness and health-related distress; relationship difficulties and loneliness.



Michael Harding

Presentation:
On Tuesdays I'm a Buddhist

Michael Harding is the author of three novels and 10 acclaimed books of memoir. His podcasts on patreon.com/hardingmichael bring a fresh and light hearted dimension to the practise of faith in ordinary life. He has been a regular columnist with the Irish Times for almost 20 years, and has written five major plays for the Abbey Theatre. The recipient of numerous awards for his writing and performance both on stage and in film, He lives in Arigna county Roscommon with his wife, the sculptor Cathy Carman.

Panel Discussions
Two panel discussions are planned, and the aim is to bring these diverse perspectives into conversation, exploring how love is experienced across modalities, relationships, lived experience, and narrative meaning. The panel discussions will be facilitated by Michael Ryan, whose experience and thoughtful presence will help guide meaningful conversation, encourage reflective dialogue, and support a rich exchange between speakers and participants.

Michael Ryan (MA/MIACP)

Michael is a counsellor/ psychotherapist, author, and lecturer who works with adolescents in secondary schools as well as having a private practice for adults in West Dublin. He lectures on counselling/psychotherapy courses and occasionally provides training and presents talks on mental health. He regularly contributes to media debate on mental health, wellness, neurodiversity, and LGBTQIA+ topics and has also spoken at regional, national, and international conferences on these topics.

We look forward to welcoming you at the conference! To avoid disappoint book your conference place today on iacp.ie

Date for your Diary

IACP Annual Conference 2026

Saturday 18th April
Johnstown Estate, Co Meath.

IACP Noticeboard

EDI Committee Update:

Equality, Diversity & Inclusion Matters

Keynote Panel Discussion at Le Chéile Conference
A historical panel discussion of senior representatives from the disciplines of psychiatry, psychology, and psychotherapy provided one of the significant highlights of the widely praised second IACP Equality, Diversity & Inclusion Conference held at DCU's Glasnevin Campus in Dublin.

In his opening remarks, Dr. Lorcan Martin, President, College of Psychiatrists of Ireland, thanked conference coordinator, Jim Hutton for initiating the opportunity for open and shared dialogue between the sister disciplines who were represented on the keynote panel discussion and he looked forward to continued communication and cooperation into the future.

The panel also included, Dr. Geraldine McGuinness representing The Psychological Society of Ireland and Aseia Rafique, author and the BACP's Senior EDI Lead. Facilitating the plenary panel discussion was educator, author, and broadcaster Emer O'Neill, who captivated conference delegates earlier in the day with her fascinating presentation entitled, Invisible Until it Hurts - Race Neurodiversity and Barriers to Inclusive Mental Health.

As a follow up to the initiative undertaken by the EDI Committee, Dr. Martin invited the three largest organisations representing psychiatry, psychology, and psychotherapy in Ireland to meet for a discussion around Artificial Intelligence (AI) with the aim of presenting a joint statement in response to recent harmful developments around the potential danger and harmful impact of AI apps influencing vulnerable people as exampled recently with the death of a young person in the United States.

The planned statement aims to model the successful launch in June 2024 of the Memorandum of Understanding by the three organisations, seeking legislation banning the practice of Conversion Therapy and was supported by LGBT Ireland. An update on this initiative will appear in the next edition of the *IJCP*.

EDI Committee members Attend Launch of Talha AlAli's New Book 'Decolonised Minds - When Radical Becomes Rational'
The Vice-Chair of IACP's EDI Committee, Ravind Jeawon and fellow committee member, Alan Kavanagh were honoured to attend the launch of Talha AlAli's book recently at Connolly Book Store in Temple Bar, Dublin. Talha was a presenter at the IACP's 2nd EDI Annual Conference, Le Chéile… Courage Is Strongest …Together!

Talha AlAli, author and Pre-Accredited Member with EDI Committee member Alan Kavanagh at the book launch

Talha is a pre-Accredited Member of IACP and a former mental health activity manager with Médecins Sans Frontières (MSF). His book, Decolonised Minds, is an eye opener on the modern legacies of colonialism, for students and practitioners in counselling and psychotherapy and is described as, "…a powerful message in a critical time in global history". Ravind Jeawon who participated in a panel discussion at the launch spoke compellingly about his own experiences in therapy training and offering of tokenism EDI workshops without feeling real change or shifting of views.

Four New Appointments to the EDI Committee
We're delighted to welcome four new appointments to the EDI Committee and look forward to working with you on the committee's priorities. They are: Paula Fagan, Niamh Jimenez, Louise McDonough and Paul O'Beirne.

EDI Le Chéile Conference

EDI Committee members, IACP staff and speakers celebrate the conference

A video presentation of most of the workshop presentations and discussion which took place at the Le Chéile Conference are available to IACP members and DCU Students of Nursing and Psychotherapy on the members area of IACP's website - www.iacp.ie

German psychologist, Chris Webber speaking at the 2nd EDI Conference

Keynote Panel Facilitator, Emer O'Neill, surrounded by (from L to R): Jim Hutton MIACP, Chair IACP's EDI Committee; Dr. Lorcan Martin, President, College of Psychiatrists of Ireland; Dr. Geraldine McGuinness, Psychological Society of Ireland and BACP's UK EDI Senior Lead, Aseia Rafique

Dr. Karen Ward, key presenter at the Culture Room events, carries out a shamanic ritual cleansing for the Culture Room Curator, Ishita Sangra, who initiated the eclectic and colourful Culture Room concept with the assistance of fellow EDI Committee members Ejero Ogbevoen and Alan Kavanagh

CEO Lisa Molloy adding her heart inspired message on the Tree of Wishes in the EDI Conference Culture Room

Research Highlights

Research Committee Round-Up 2025

Chair, Aisling O'Connor created this end of year visual summary of the wonderful accomplishments of 2025. With thanks to Aisling and the Research Committee for all their work and to our members who engaged with and contributed to events and resource development throughout 2025. 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.

General Public Survey – Some Key Findings

In Q4 of 2025 the IACP commissioned Ipsos B&A to carry out a general public survey in the area of mental health and counselling/psychotherapy. Here are some of the key findings:

1 in 4 Irish adults often feel stressed and almost 2 in 3 feel stressed at least some of the time. Higher rates of feeling stress in the under 25s. The 3 top causes of stress for Irish adults are work, money/debt, cost of living crisis. 1 in 5 describe their symptoms of stress in the last year as severe.

1 in 5 Irish adults often feel anxious and almost 3 in 5 feel anxious at least some of the time

More than 1 in 8 Irish adults often feel lonely and more than 2 in 5 feel lonely at least some of the time. This is more common in the under 25s, in urban areas and in females.

1 in 3 Irish adults have seen a counsellor or psychotherapist themselves and almost 2 in 3 know someone else who has (in their immediate family, in their wider family or a friend/colleague).

Anxiety, depression and stress/panic difficulties are the top 3 areas that Irish adults have sought counselling/psychotherapy support for. Relationship difficulties and issues related to family are the joint 4th top area that Irish adults seek support for – with 1 in 4 mentioning these issues.

Almost 1 in 5 have been directly affected by suicide in their immediate or wider family. More than 1 in 3 have been affected by suicide amongst friends/colleagues or in their local community.

The vast majority (8 in 10) of those who have attended counselling/psychotherapy would recommend it to a friend/family member.

Almost 3 in 5 say they would be likely to see a counsellor/psychotherapist themselves if they found themselves struggling with their mental health in some way. However, affordability would be a barrier for 1 in 2 people.

'Through my GP' is the top way people would go about making an initial appointment for counselling/psychotherapy (more than 1 in 2) and this is followed by searching online (more than 1 in 3).

Difficulty talking about issues despite a growth in a general sense about the acceptability of talking about mental health issues, personal disclosure remains a difficulty. Almost 2 in 3 would find it difficult to speak to an employer about personal mental health and more than 1 in 2 would not want others knowing if they were experiencing mental health problems.

Almost universal support (9 in 10) for the provision and funding of counselling and psychotherapy in schools with greater support for this amongst women.

Widespread agreement that counselling/psychotherapy should be included as **a tax relief/benefit** similar to other areas (almost 9 in 10); state funded for all people experiencing mental health difficulties (8 in 10); a benefit of private health insurance (3 in 4).

For the full report and to see further insights into the areas of the mental health and wellbeing of Irish adults and attitudes towards counselling/psychotherapy please visit the Research page of iacp.ie

Winter Research Journal Club – Complicated Grief

We had a huge turn-out for our 10th Research Journal Club in December with close to 150 IACP members attending to reflect on and discuss research on complicated grief. With deep gratitude to our guest, Dr Anne Dodd, MIACP who presented her research in this area, to Research Committee Chair Aisling O'Connor and Research Committee member Kevin Bailey who facilitated the event and to our attendees for the great questions and discussion.

Winter Research Journal Club team, clockwise from top left - Dr Ellen Kelly IACP Research Lead, Iwona Blasi IACP Innovation and Development Manager, Kevin Bailey Research Committee member, Aisling O'Connor Research Committee Chair, Dr Anne Dodd, guest presenter

Here's a taste of what attendees had to say:

> *"Very informative and well explained conversation. Thoroughly enjoyed it and Anne Dodd's empathy on prolonged grief was so impactful to me personally and I will hopefully use her experience with my future clients."*

> *"Excellent event on a topic which is so interesting and relevant. A series of further events on the subject would be very welcome … As always, thank you so much to all who worked so hard to provide this event."*

> *"It was a fantastic session. I got so much out of it and look forward to the next one like it. Really appreciative that you organise these and find it invaluable for my practice."*

We hope to see many of you again at our March Research Journal Club. For further information and to book your place please visit the Events page of iacp.ie

Research Glimpses: Sharing Insights from Current Research

For our 15th Research Glimpses, Research Committee Vice Chair Dr Caitriona Kinsella selected the research paper "Exploring potential mechanisms underpinning the therapeutic effects of surfing" by S.G. Moreton et al, published in the *Journal of Adventure Education and Outdoor Learning, 22(2), 117–134*. Reflecting on the research paper Caitriona said:

> *"I initially chose this paper as something light to ease us into the new year. However, it actually covers so many concepts that I know we as therapists have been coming across more and more often lately - cold water immersion, sunlight exposure, and its impact on our mental health, nature therapy and 'prescribing' exercise … Therapists sometimes feel like advice-giving and prescribing are outside of our remit. However, with the research behind us it is important that we engage in knowledge-sharing with our clients. When we know from various studies that natural light, immersion in nature, and exercise have really tangible positive benefits it is our responsibility to at least relay this information to those seeking help".*

You can read Caitriona's full Research Glimpses, along with a link to the research paper, when you visit the Members Area Research Corner.

In Memoriam

In Memory of David Madden

The West North West Regional Committee wishes to acknowledge the passing of our former committee member, David Madden, who served from 2021–2022. David, who died unexpectedly on 17th May 2025, was a deeply valued IACP member.

As CEO of the Sligo Rape Crisis Centre, David was widely respected for his commitment to providing a safe, compassionate, and trauma-informed space for survivors of sexual violence. His leadership was marked by integrity, empathy, and a deep belief in the power of healing.

David was also a devoted husband to Jane and a loving father to Ríona and Lucia. A gifted poet, artist, and passionate biker, he brought creativity, warmth, and strength to all aspects of his life.

David's legacy lives on in the lives he touched and the healing spaces he helped to shape.

IACP in the Media

16th January 2026 – *How to keep the spark alive when you've both been in tracksuits since 2020* in the *Irish Examiner*, featuring Orlagh Reid

7th January 2026 – *Calls to ban 'conversion therapy' grow as practice persists in Ireland* on *theoutmost.com*, mentioning the IACP

1st January 2026 – *What if?* featuring Leo Muckley in the *West Cork People*

22nd December 2025 – *Counsellor: Christmas isn't always merry – here's how to protect your mental health* featuring Christopher Place in *The Journal*

17th December 2025 – *Dealing with family tensions over the Christmas holidays* featuring Linda Braethnach in *The Echo*

12th December 2025 – *Sanity Claus: How to survive a Christmas crack-up* featuring Majella Kenneddy, Linda Breathnach and Christopher Place in the *Irish Examiner*

10th December 2025 – *Money Talks: How to 'fight better' at Christmas when it comes to money-related rows* featuring Majella Kenneddy, Linda Breathnach and Christopher Place in the *Irish Independent*

26th November 2025 – *Proposed new standards for psychotherapists will 'place the public at great risk'* in *TheJournal.ie*

25th November 2025 – *Joint Committee on Health to meet for engagement on standards for education and training* on *oireachtas.ie*

Radio
Joe Heffernan featuring weekly on C103
Dr. Karen Ward on Henry McKean programme on Newstalk

IACP Accreditations

First Time Accreditation

Denis Bolger Aboud	Co. Dublin
Jenny Bardon	Co. Wicklow
Annemarie Bennett	Co. Dublin
Muriel Bennett	Co. Kilkenny
Johann Berger	Austria
Joseph Bowden	Co.Dublin
Eadaoin Brennan	Co. Westmeath
Sheila Burton	Co. Wexford
Stephen Butler	Co. Limerick
Nichola Butler	Co. Carlow
Aisling Byrne	Co. Dublin
Lauren Carter	Co. Cork
Siobhan Casey	Co. Kerry
Aideen Clare	Co. Louth
Aoife Clarke	Co.Dublin
Emer Colgan	Co. Dublin
Jen Conefrey	Co. Dublin
Kathie Connolly Bree	Co. Dublin
Mary Cooney	Co. Limerick
Catherine Cormican	Co. Dublin
Gillian Cotter	Co. Dublin
Mark Crummy	Co. Dublin
Ann-Cathrin Daly	Co. Dublin
Rachel Davis	Co. Limerick
Damian Devonish	Ontario (Canada)
Fay Dolan	Co. Mayo
Anne Donaghy	Co. Tipperary
John Doyle	Co. Wicklow
Tenille Drummond-Clark	Co. Donegal
Brendan Dunleavy	Co. Galway
Karen Esmonde	Co. Dublin
Darragh Finlay	Co. Louth
Sarah Finnerty	Co. Kerry
Michelle Fitzgerald	Co. Kerry
Paula Flynn	Co. Cork
Cristina Galvin	Co. Galway
Michael Garvey	Co Kerry
Patrick Gately	Co. Westmeath
Emma Gavin	Co. Dublin
Shauna Geoghegan	Co. Laois
Jacqueline Geoghegan-Mangan	Co. Limerick
Lynn Gerty	Co. Dublin
Cara Gibbons	Co. Clare
Danielle Gibson	Co. Leitrim
Davnet Grogan	Co. Mayo
Tracey Harrington	Co. Kildare
Laurence Heffernan	Co. Dublin
Mark Herman	Co. Dublin
Louise Horan	Co. Dublin
Hazel Horseman	Co.Dublin
Trish Howard	Co.Dublin
David Keane	Co. Laois
Elaine Keaveney	Co. Galway
David Kelly	Co. Dublin
Rosina Kelly	Co. Kilkenny
Rachel Keogh	Co. Dublin
Lydia Kernan	Co. Monaghan
Sarah Kiernan	Co. Kildare
Heidi Kinsella	USA
Donald Knox	UK
Carmen Kuhling	Co. Limerick
Mary Lee	Co. Galway
Emma Jane Lennon	Co. Dublin
Carol Loran	Co Westmeath
Ciara Lyons	Co. Dublin
Aisling Mac Carthy	Co. Laois
Nicole Maguire	Co. Cork
Deimante Malisauskaite	Co. Dublin
David Martin	Co. Galway
Joan Martin	Co. Kilkenny
Linda McCarthy	Co. Cork
Mary McCormack	Co. Dublin
Ciara McEvoy	Co. Meath
Laura McHugh	Co. Sligo
Laura McHugh Harrington	Co. Westmeath
Janet McManus	Co. Longford
Yvonne McWey	Co. Dublin
Dearbhla Mealy	Co. Dublin
Derek Morgan	Co. Dublin
Colm Morris	Co. Galway
Deirdre Mulcahy	Co. Tipperary
Lisa Murphy	Co. Dublin
Kefilwe Ncube	Co. Waterford
Eileen O'Sullivan	Co. Kildare
Emelda Obidike	UK
David O'Brien	Co. Waterford
Reynagh O'Brien	Co. Dublin
Diane O'Brien	Co. Dublin
Jennifer O'Kelly	Co. Dublin
Ray O'Neill	Co. Dublin
Paul Ó'Riada	Co. Meath
Angela O'Rourke	Co. Waterford
Anne O'Sullivan	Co Kerry
Laura Porritt	Co. Clare
Paul Price	Co. Dublin
Suzanne Purcell	Co.Dublin
Sam Reardon	UK
Jennifer Samuels	Co. Donegal
Christopher Saunders	Co. Dublin
Eóin Shanahan	Co. Dublin
Lyndsey Shannon	Co. Cork
Martina Shannon	Co. Cavan
Alice Sheridan	Co.Dublin
Magdalena Skorowska	Co. Meath
Karen Sweeney	Co. Dublin
Caragh Thompson	Co. Cork
Julie Tiernan	Co. Clare
Joanne Upsdell	Co.Kilkenny
Áine Walsh	Co. Dublin
Aoife Walsh	Co. Clare
Kate Waters	Co. Limerick
Mary Wickramasekera	USA
Michael Wilkins	Co. Mayo

Newly Accredited Supervisors

Maggie Boyd	Co. Dublin
Anthony Burke	Co. Kildare
Grainne Coffey	Co. Wicklow
Will Cronin	Co. Dublin
Brian Duncan	Co. Cork
Allen Gilhooly	Co. Sligo
Davnet Grogan	Co. Mayo
Geraldine Hagan	Co. Wexford
Ann Keenan	NI - Co. Down
Emma Kelly	Co. Dublin
Veronica Rose Mahon	Co. Dublin
Louanne Martin	NI - Co. Down
Donna McArdle	Co. Dublin
Helen McGeough	Co. Galway
Deirdre McGill	Co. Kildare
Maurice Shortall	Co. Dubin
Helena C. Simon	Co. Galway
Jackie Slattery	Co. Tipperary
Aoife Smith	Co. Wicklow
Ruslana Verkhola	Co. Dublin