Éisteach

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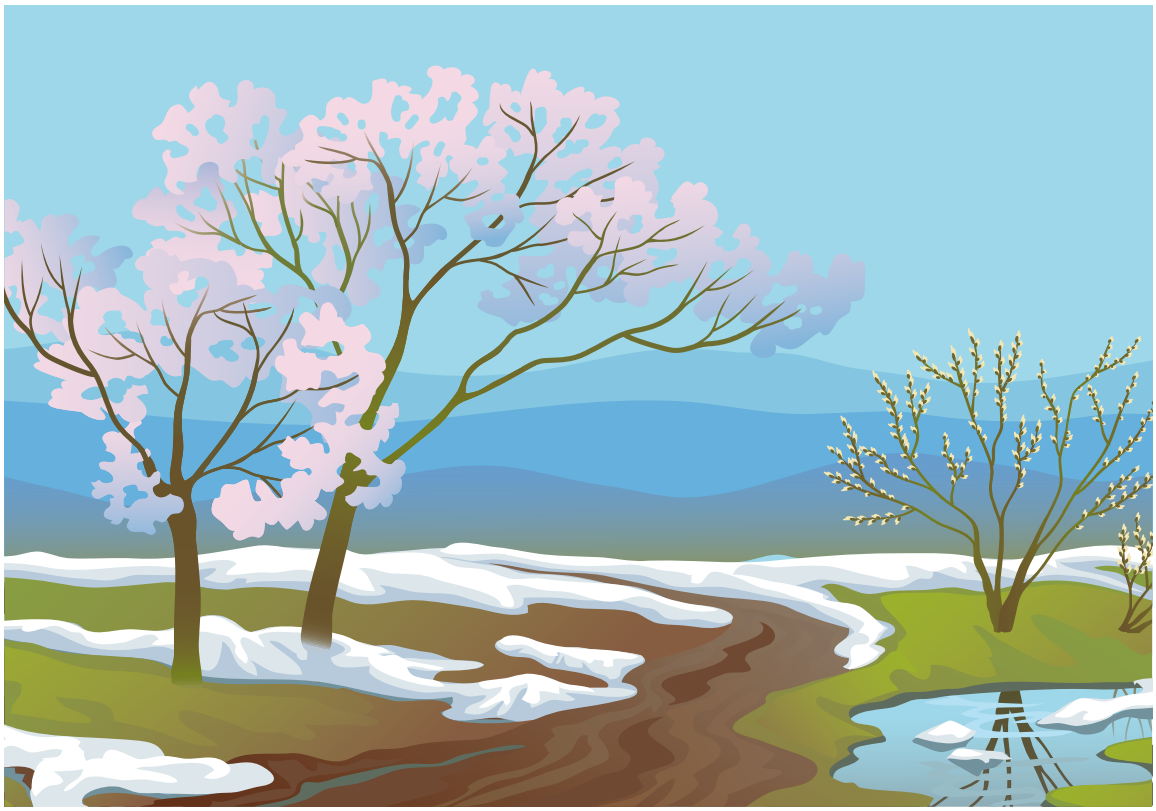

So you're starting a Therapy or Counselling Practice?

- **Vocation, or the work of a Technician, or both?**
- **Factors in GP Referrals**
- **'Holding'**
- **Mental Health Matters**

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Irish Association for Counselling and Psychotherapy

Contents

So You're Starting a Therapy or Counselling Practice? 4
By Jude Fay

Is Counselling and Psychotherapy a Vocation or the work of a Technician, or both? 7
By Christine Moran

Primary Factors Involved in Referral from General Medical Practitioners to Psychological Therapies 10
By Donagh Ward

Protecting our Mental Health 17
By Claire Gallagher

"Holding" 19
By Jim Cantwell

Mental Health Matters 23
By Alison Lane

Workshop Reviews 25

Book Review 28

Therapist Dilemma 29

Noticeboard 30

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

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

From the Editor

Alison Larkin

Dear Colleagues,

Welcome to the first edition of 2014, the Spring edition of Éisteach.

All the articles in this edition come from you – the Members of IACP. We thank you for your contribution.

A very general overarching theme of this issue is setting up a practice for the first time. Some of the articles are from people who have long-established practices who offer insight and perspectives, which may not only be helpful to newly accredited counsellors, but also to all of us working in the counselling and psychotherapy field.

The first article by Jude Law 'So you're starting a Therapy or Counselling Practice' offers practical information about setting up a counselling business. She also addresses the question about what sort of practice we would like to create. Will it be in a specific area, for example with young people, people with various physical illnesses, or a more general style of practice? This article should be of interest to everyone.

Christine Moran's article comes from a perspective that is both interesting and informative. Asking whether counselling and psychotherapy is a vocation or are we mere technicians - or perhaps both - brings together therapy room practice and training room, well, training. The article also introduces and explores the many differences and similarities in Eastern and Western cultures in the area of healing and treatments for emotional and mental distress, both from the traditional and modern methods.

Donagh Ward's very practical article 'Primary Factors involved in Referral from General Medical Practitioners to Psychological Therapies' introduces us to the world of referral from GPs. Why or why not a GP might or might not refer for counselling is examined. This article should be of particular interest to those of us who pursue referrals from GPs.

Keeping with the general theme, the next article written by Jim Cantwell, entitled 'Holding', is written from the perspective of the professional counsellor or therapist. It serves as a reminder of what is important about who we are as therapists.

The focus and perspective of the last two articles offers us something different. The first, entitled 'Protecting our Mental Health' is taken from 'The Clare People' (with permission), written by journalist Claire Gallagher, following an interview with one of our colleagues, therapist Eamon Fortune. It reminds us that counselling is becoming more acceptable, relevant and important in our society today.

We finish with an article, 'Mental Health Matters' by Alison Lane. This introduces us to the Dean Clinic in Cork and the community-based mental health clinic which is run there.

I hope reading these articles gives to those newly-accredited counsellors some insight into the possibilities that the future in the area of counselling / psychotherapy holds. For those already with established practices, it opens possibilities for expanding practices and perhaps how other organisations work.

As counsellors or psychotherapists, whatever path or journey we find ourselves on, I believe the words 'Carpe Diem' still hold true. To seize the day and engage in the journey both with ourselves and our clients is the way forward.

Alison Larkin, MIACP

So You're Starting a Therapy or Counselling Practice?

by Jude Fay

Whatever the reason you are choosing to go down this path, good for you!

It is a big step towards what will hopefully be a rewarding and satisfying career for you. In setting up a practice, you will be making available to the public the specialist knowledge and skill that you have developed over the years of your training. As you continue to practice, you will be offering the benefit of your ongoing growth and learning, on the job, or through additional training or CPD. You will be offering to your clients not only your presence and your attention, your care and your support, your interest and your commitment, but an opportunity to grow together in a relationship unlike any other. Do not underestimate what a huge gift to your clients this really is. Some clients will never have had the luxury of being listened to before, and many will never have received quality time and attention devoted just to them and their concerns.

What sort of practice do you want to create?

Your first task in setting up, is to decide what sort of practice you wish to create. This may strike you as an odd sort of question, but I would encourage you to look around you. Counselling and therapy practices come in all shapes and sizes, how do you want yours to be? What are your "must haves" and what are your "like to haves"?

If your training has been specific to a particular issue or population type, such as bereavement counselling, or play therapy, then you may already have some idea of what your practice will look like. If your training has been more general, you may have not given any thought to how you might like it to be. Take a moment now to reflect on those clients you have worked with up till now, and ask yourself what work do you enjoy doing? What clients do you enjoy working with? And why? This will be really helpful for you when you begin to look for work, as it gives you a focus.

Other issues to be considered include whether your work will be purely one-to-one sessions with individual clients, or whether you also intend to work with couples or groups. Will your practice focus exclusively on therapy or counselling work, or might you like to provide other services as well, such as training or education?

So you will be getting the message here that it helps to have an idea of what you want to get from your practice. There may be any number of reasons why you are choosing to go self-employed. Perhaps you

are looking for a new challenge, or wanting to give something back to the community, meet a need or fulfil another social responsibility. Perhaps you want to earn your own income, or supplement what you currently earn. You may be looking to have independence and freedom to control your time and your income, and flexibility to make your own schedule and decide who you want to work with and when.

All of these factors and more may be affecting your decision. However, it is worth spending time thinking about your main motivation, because what you are hoping to get will in large measure determine the direction you go. If this is to be a full time occupation for you, then your decisions may be different than if you simply wish to supplement your income from another job. If your main intention is to provide a social service, to help people in distress, rather than one where you will be relying on the income it generates, then your approach will be different again.

What Structure to Choose?

Most therapy practice is sole practice, i.e. one person practising on their own. A much smaller number operate as partnerships, and still fewer as limited liability companies. In legal terms, the main difference between these choices relates to what happens in the event of insolvency. In a sole trade, the individual is personally liable for all the debts of the business, so if a sole practice goes bankrupt, the practitioner may be in danger of losing their home, even if they did not practice from it. In a partnership, each of the partners may be liable for all the debts of the practice. In a limited liability company, the extent of the liability is generally limited to the amount of capital invested, unless there has been fraud.

A company provides the most protection, a sole trade the most flexibility. It is a question of weighing the risk and choosing the most appropriate vehicle for the practice, as there are significant implications (cost and other) attached to establishing and running a company. I am greatly simplifying what is a complex issue here, so do get legal and financial advice about what is the best structure for you.

House Keeping Tasks

In order to set up a self-employed practice, there are a number of "housekeeping" things you need to do:

1. ***Register your business name***, if you intend to practice under anything other than your "true" name. So if I trade as Judith Fay, or even just as Fay, I do not need to register, but if I trade as "Jude Fay, Counsellor & Psychotherapist" or (as I do) as AnneLeigh Counselling & Psychotherapy, I need to register the business name with the Companies Registration Office. It costs €20 online at CRO.ie.
2. ***Notify the Revenue:*** whether or not you expect to have a tax liability. It is your responsibility to ensure that returns are made and any tax owing is paid, and not the Revenue's responsibility to chase you. Income Tax is payable on 31st October each year for the estimated liability for the current calendar year and for any balance due for the preceding calendar year. (So tax is payable on 31 October 2013 for the year end 31 December 2013 together with any balance due for the year end 31 October 2012.)
3. ***Obtain appropriate insurance:*** You should have Professional Indemnity Insurance, and Public Liability Insurance. If you practice from home, you should check with your insurer whether your home insurance needs to be amended. You might also consider whether you need some form of income protection insurance, (in case you become ill or unable to work for an extended length of time,) and a pension.
4. ***Comply with any requirements of your professional organisation***: Update your profile with your professional body and ensure any required information is provided (such as copies of insurance certs). The main professional bodies retain and publish online directories of practising members where the public can find an accredited therapist or supervisor in their area.
5. ***Find somewhere to work from:*** Issues to consider include: the suitability (is it quiet, private, comfortable), the cost (expect to pay between €12 and €18 per hour on an hourly basis, or a little less if you pay for a block of hours), safety (are there other people around in case a client becomes violent?), convenience for you (and for your client), privacy (this may be a huge issue in small country towns). You may decide to opt for a transitional decision in the short term until you become established.
6. ***Start keeping appropriate financial records:*** At a minimum, your records should include details of your income and your expenditure, and supporting receipts and invoices. Keep records and documents for a minimum of six years. Records should be capable of showing the state of your business at any point in time, i.e. they should be current. Learn what expenses are and are not allowable for tax purposes. See Revenue.ie for details or consult your financial advisor. Typically, expenses incurred wholly, exclusively and necessarily for the purposes of your business are allowable, so the cost of renting a room will be allowed, but your personal therapy will not.

7. ***Arrange for supervision:*** check with your professional body to ensure your supervision meets their criteria, for hours and accreditation.
8. ***Hire professional advisors if necessary:*** for example, an accountant to complete and submit your accounts to the revenue, or a solicitor to advise on legal aspects.

Build It and They Will Come

Having decided where you are going to practice and put the framework in place, you will want to get some clients to work with. This is where having an idea of what you'd like your practice to look like really helps. There is a saying that if you are marketing to everyone, you are marketing to no-one. For example, if you know you want to work with children, that will largely shape how and where you market your services. You will look to where parents, guardians, or teachers of children in difficulty are likely to be. The same principle applies for any other work. While many therapists are reluctant to be too specific about the type of work they want to attract, fearing that this will mean they will be pigeonholed, this is not true in practice.

Also, try to think broadly about who might be a possible source of referrals for you. Many therapists confine their ideas to doctors, and while GPs and other health professional can certainly be a good source of work, many potential clients will not think of their doctor when facing a problem. Anyone you know: friends, family, work colleagues past or present, other therapists and any professionals in a caring or helping role are potential sources of referral for you. For more thoughts about this issue, visit my website at www.thisbusinessoftherapy.com for a free copy of my report "Five Ways to Boost Your Therapy Practice."

How do you get the word out there?

There are many, many ways in which to let the world know that you are open for business. Business cards, brochures, advertisements, entries in professional and local directories, sponsorship of local activities, articles in local newspapers or magazines, presentations or workshops, your own website, and social media are all ways in which practices can highlight their services. Have a look at what others are doing, and see what appeals to you.

In deciding on how best to present yourself, it is useful to reflect on what makes you different from other practitioners providing what appears to be a similar service. This may be a particular training or qualification you have that perhaps others do not. It may be your own personal story, to which others may relate (e.g. that you work with families of cancer patients, because of your own experience in this area). It may be your values or beliefs that bring a particular flavour to your work. Whatever makes you unique, use it directly or indirectly to convey something of yourself to your prospective clients. Clients begin to form a relationship with you from the first time they see or hear your name, which may be long before they pick up the phone to make an appointment. What would you like them to know?

Looking After Yourself in the Work

The last topic I would like to cover in this short article is perhaps one of the most important. There is a serious danger in this work that the practitioner's needs become eclipsed by the needs of her clients. Look after your own needs, and balance them with the needs of those you seek to help. You cannot give what you do not have, or what you do not allow others to give you. This means respecting what you have to offer your client, and placing a fair value on that in terms of your fee. It means giving space to your own needs and desires. It means being clear about your own values and boundaries, including how you deal with fees, cancellations and no-shows. It means allowing yourself to own what you want, and knowing that it is okay to want it, rather than settling for less.

Looking after yourself not only means all the practical stuff such as exercising, taking appropriate breaks and rests, and practising disciplines that help you to manage the stress and impact of the work. It also means giving yourself a free choice when it comes to deciding whether you want to work with someone or not, and not judging yourself harshly for your choice. It means acknowledging that you are as important as your family, your friends and your clients. It means supporting yourself, giving yourself the benefit of the doubt, and being kind and compassionate to yourself when you get it wrong. It also means allowing others to support you.

So take care of yourself. You are, after all, the most valuable asset in your practice!

Conclusion

I hope this article has given you some food for thought, and will help you to begin to create a practice that will reflect who you are and who you want to be. You will find more details and resources on many aspects of your practice at my website www.thisbusinessoftherapy.com

Jude Fay

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Is Counselling and Psychotherapy a Vocation or the work of a Technician, or both?

by Christine Moran

As part of my studies and research recently I was reflecting on counselling and psychotherapy both in the counselling room and in the training room. I was reading a book by Dr. Sudhir Kakar who is a psychoanalyst and is from India. He explores the many differences and similarities in Eastern and Western cultures and the multitude of ways of healing and treatments for emotional and mental distress using both traditional and modern methods. The following passages impacted on me.

"It is generally forgotten, for instance, that not too long ago, the ministrations of the priest on the deathbed and the doctor on the sickbed were both termed clinical. However, with the irresistible march of scientific naturalism over the last one hundred years, the domain of the clinical has been finally and firmly usurped by the doctor, and the priest forced into exile."

I am interested in the area of spirituality and counselling. The above triggered the question again – Is counselling a vocation or a set of techniques used by a clinician? This question of course continues to be discussed by many within the field and by the various orientations and approaches that help ease psychological distress. I am also remembering that "psyche" refers to the soul. Most agree that clients are unique and so whatever aids and works for each individual is what is important.

I am drawn back to another passage from Kakar "The whole weight of the community's religion, myths and history enters sacred therapy as the therapist proceeds to mobilise strong psychic energies inside and outside the patient which are no longer available in modern society. How closely do such views depict reality and how much are they an expression of a Western mourning at the loss of the Sacred? How do sacred therapies really work? What are the major differences between sacred and profane psychotherapies?"

These questions could be asked of every trainee counsellor and on every personal development course. It provides fodder for discussion, critical enquiry and opens the mind and heart to other views and ways. It struck me while writing this article that it is the attitude with which therapy is facilitated that makes it sacred. I almost wrote "with which

Clients are unique and so whatever aids and works for each individual is what is important.

therapy is done" but of course I don't believe that I "do" therapy with clients, which would give the impression that I am the expert on their lives. You as my client are a unique creation so why would I have your answers?

The therapist who is working at the level of sacredness is humble in the presence of this unique being with a story, a life and history that is uniquely theirs. The client needs someone who is human, caring, compassionate, self aware and trained to be able to meet them in their distress without burdening or contaminating the space. Gaining a client's trust has a semblance of gaining the trust of a child in some ways. Why should this sound strange when often it is the inner child, the hurt child that is before us in adult form? The responsibility it carries may at times frighten us and take us away to safer levels of interaction.

The trust required for a safe therapeutic relationship, where authentic relating at a deep level can take place, is a process of loving invitation by a therapist who has engaged with their own Hero/ Heroine Journey. (Joseph Campbell wrote about the Hero's Journey). This is a therapist who has been initiated into their journey of self discovery, a person of courage who has crossed the threshold and embraced the unknown territory of the "other world" and has built relationships with their shadow aspects, survived the "dark night of the soul", found their resources and are living examples of their truth. This is no mean feat and is not for the fainthearted. This is the work of the therapist who wishes to offer and hold sacred space, where a profound healing experience may transpire.

The acceptance, congruence and love required to facilitate this kind of sacred climate emerges from a deep place of compassion, kindness and respect for another's

"...not too long ago, the ministrations of the priest on the deathbed and the doctor on the sickbed were both termed clinical..."

history, choices, pace, and journey. This level of understanding for human strengths and limitations is a mirror of the therapist's self acceptance and reflection on their previous and continuous personal and professional development. This asks further questions as to how many accredited counsellors/ psychotherapists/supervisors are in personal therapy or engage in some form of personal growth activity to deepen their self knowledge and self awareness.

Because I am passionate, I need to be mindful of other views and perspectives and be open to further learning. In the counselling training room I remind myself that I do not wish to unduly influence trainees' perspectives. I prefer to ask questions such as Kakar's, this encourages and allows for lively discussion, meaning-making and questioning, and trainees find their own styles and approaches. I love this work of being a midwife and I love our learners who trust our college. It is a privilege to accompany them and see them grow personally and professionally.

Back to Kakar, "There are many in the West today who regret the disappearance of the sacred from the healing sciences and its removal generally from the world of everyday life. As far as psychotherapy is concerned, these people feel that a psychotherapist in a traditional culture may be greatly aided by the continuing presence of the sacred in his society." I can only speak for myself, in my awareness, today.

The sacred in the counselling room for me means that I am dedicating the next hour to you, to your issues and I am reverently present to all of you, to all aspects of you as you journey towards wholeness. I endeavour to create a sacred space that has boundaries, where I am sincere, and open to creative inner and outer expression, some of which we may not comprehend. I am here to trust your innate and organic urge and to support your struggle towards integration. I can only be present to you if I am present to myself. This requires self awareness and self care, both are professional requirements in my code of ethics.

In our daily lives are we losing a sense of the sacred? By being mindful and aware we get many opportunities to recall the sacred. Being grateful, expressing love, sorrow, fear, encourages holy interactions. Loving and making love to the world, our work, our people, and our lovers brings us in contact with a reverence and awe for a force beyond measure. When my intention is to love you, then if I hurt you I am sad and unhappy too. Through the ages, the ancients have appreciated the interconnectedness of all creation. As a society it seems sometimes we have become disconnected and alienated from the earth, nature, each other and ourselves. We try to be normal as others prescribe until it becomes the unquestioning norm decreed by a group who may be closed to other realities and possibilities.

As I write I am seeking to remain open to alternative norms and it's not so easy. As a therapist I am required to be open to other norms, e.g. belief systems, sexual behaviours, cultures and traditions. Every day I see small children having their clothes changed two, three times a day because they "are dirty", they are not allowed splash in puddles, and fear is

Who could be more important than the person who is here with you now?

ingrained at an early age. I sat on the rocks in Doolin, Co. Clare yesterday. A young couple with their children who were on holiday were standing nearby. They spoke to and requested their children be safe. They didn't look at or speak to each other as adults; they were busy texting on their phones. The passengers from the Happy Hooker and two other boats were disembarking at the pier close by. The area was full of people enjoying the beautiful day and a dolphin was swimming with a few swimmers. Yet this couple were interacting with someone who was not here, it seemed that neither of them were here either.

I am not judging them and I know nothing about them, but I pondered who could be more important than the person who is here with you now? I have asked the same question when out for dinner and the couple at the next table are both on their phones, there are four people at the table, albeit two are invisible, is there a loss?. There is a loss of sacred sharing, of time and presence, of genuine communication and appreciation of another. At these times I am reminded to be present to the person I am with and to what I am doing in this moment, to mind my own business!

I wonder about addictive behaviours, mine and others, which I see as creative distractions and defences to connecting and owning our inner and outer pain, distress and power. I think about them in relation to Kakar's view, "In most parts of the world, the belief in possession by spirits and demons has been historically the dominant theory of illness and especially of conditions that we call mental illness". I wonder what modern day "spirits and demons" are possessing us and disturbing our mental health and wellbeing? This is another question for further discussion and brings me to a final quote by

My hope is that there will be openness to, respect for, and equal support for all perspectives of helping and healing.

Kakar which takes me back to the beginning of this article.

"The real line of cleavage, cutting across cultures and historical eras, seems to be between those whose ideological orientation is more towards the biomedical paradigm of illness, who strictly insist on empiricism and rational therapeutics and whose self image is close to that of a technician, and others whose paradigm of illness is metaphysical, psychological or social, who accord a greater recognition to arationality in their therapeutics, who see themselves (and are seen by others) as nearer to the priests".

Nearly twenty years ago, counselling and psychotherapy training attracted me not because I felt holy, in fact it's laughable, I felt the opposite at the time, and I was in need of connecting to the sacred within me. Through a wonderful therapist I eventually made this connection. As a child I wanted to be a teacher or/and a preacher, a healer, someone who made a difference (clever, insightful child!). I became and continue becoming a therapist and teacher out of a desire to serve, a wish to accompany and a willingness to love another towards holistic wellbeing.

This is a philosophy, a vision, an ethos and like all ideas it is open to constant change, difficult to apply and embody. These are some of the core questions and challenges that face all of us therapists, training colleges and our accrediting professional bodies, and especially the statuary regulatory bodies of the future. My hope is that there will be openness to, respect for, and equal support for all perspectives of helping and healing.

The client is the jewel, the focus and the reason for everything else that happens in the counselling and psychotherapy arena. The support scaffolding around this precious being comprises of therapists, supervisors, professional bodies, future regulatory body and training colleges, all of which share the responsibility of witnessing, shielding, safeguarding, and protecting our clients, our psychological therapists, our wonderful profession of counselling and psychotherapy.

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Christine Moran

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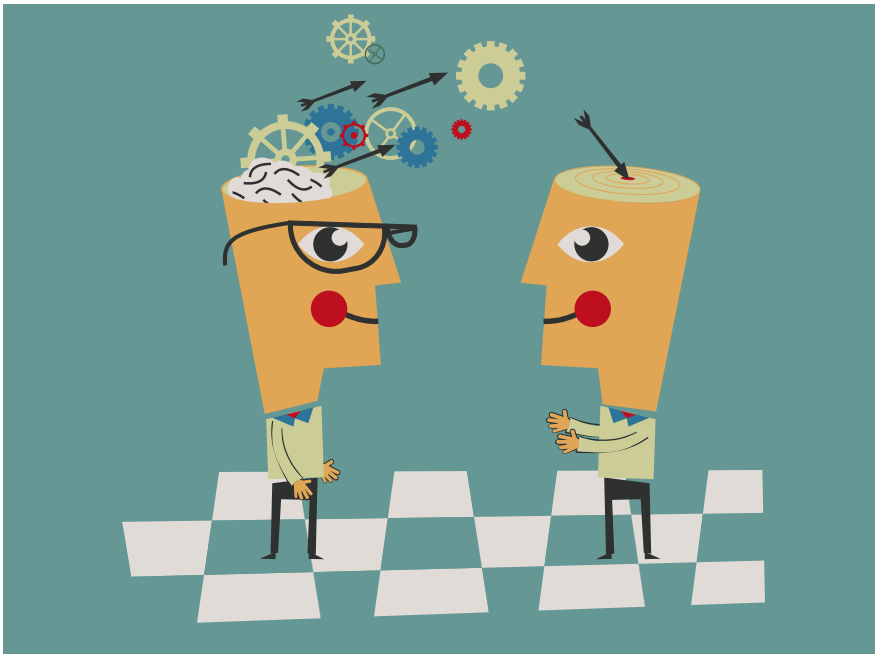
Title: Fallen Angel, Artist Teresa Gammell, permission for publication granted

Primary Factors Involved in Referral from General Medical Practitioners to Psychological Therapies

by Donagh Ward

Abstract

GPs are the primary care gatekeepers for health services throughout the world. Many people who go to their primary care doctor present with symptoms of psychological and emotional distress. The presenting rates in primary care of common mental health issues are on the increase globally. This article conducts a systematic and thorough review of the literature written in the past decade on the significant factors which influence a primary care medical practitioner's decision to refer a patient to a psychotherapist.



Introduction

Patients are presenting themselves to primary care providers with psychosocial problems in ever increasing numbers (Schafer et al., 2009). General practice plays a vital role in the detection, assessment and treatment of emotional and psychological health problems, yet less than 10% of those presenting with these issues will be referred to a mental health professional for further treatment (Whitford & Copty, 2005). GPs in the UK have stated a requirement for assistance in treating people who have mental health issues and patients, in turn, are requesting referrals to therapy more frequently than at any other stage in the past (Fakhoury & Wright, 2001).

The past 20 years has seen a steady rise in primary care practitioners referring to psychological therapies (van Orden et al., 2009). The decision-making process underlying referrals from general practice to counselling can be complex (Rushton et al., 2002). Ten main considerations were identified in this research relating to GP factors which influence referral patterns to psychological therapists. A further four considerations were identified relating to patient factors and another two aspects were discovered with regard to GP/counsellor collaboration. The focus of this work examines GP factors.

Decision-making process underlying referrals... Ten main considerations were identified in this research relating to GP factors which influence referral patterns to psychological therapists.

Gatekeeping role

Primary care practitioners are considered to be the 'gatekeepers' to almost all primary and secondary health services (Herrington et al., 2003). Many people visit their doctor because of emotional, psychological or psychosocial issues (Huibers et al., 2007; Walders et al., 2003) and the function provided at primary health care level by GPs is increasingly recognised to play a key role in mental health care (Sigel & Leiper, 2004). Whereas some of these consultations involve relatively minor occurrences of anxiety and depression, a considerable amount involve more persistent and acute difficulties with associated psychosocial, emotional, behavioural, psychological and medical morbidity (Buszewicz et al., 2006).

In Britain more than 50% of patients present purely with somatic symptoms but attribute their physical symptoms to bodily illnesses (Sigel & Leiper, 2004). As 25% - 40% of GP presentations in primary care have a significant psychological element (Bushnell, 2004), the central role that the "family doctor" plays in the identification of people with mental health issues is universally acknowledged (Shield, Campbell, & Rogers, 2003; Sigel & Leiper, 2004). In Ireland 95% of emotional and psychological health problems are supported and treated within general medical practice and less than 5% are referred onto more specialised psychological health services (Whitford & Copty, 2005). In the United Kingdom 9% of patients presenting to their GPs with emotional health issues received a referral to counselling (Fitch et al., 2008). Internationally, GPs provide the majority of treatment for psychological and emotional issues of people in the general population (Bushnell, 2004).

Kierans & Byrne (2010) state that the high volume, varied case-mix, and sometimes complex nature of mild-to-moderate mental health presentations continue to stretch the capacity and competence base of most GPs. Bea & Tesar, (2002) acknowledge that many psychological and emotional issues can be dealt with effectively in the primary care environment as many require either no intervention or are self-limited.

Therapeutic relationship between doctor and patient

Decision-making with regard to referral to psychological therapies is a process that occurs within the context of the doctor/patient relationship and referral decisions can be affected by the nature of this relationship (Knight, 2003). Buszewicz et al. (2006) found preliminary evidence that primary care patients have better clinical outcomes where there is a positive therapeutic relationship with their doctor. In this particular study of patients' experiences in presenting psychological and emotional issues to their GP, the authors reported that all of the patients surveyed remarked on how characteristics of the relationship with their doctor helped or restricted them in opening up about their emotional issues and that this was fundamental to their consultation experience.

Cape (2000) states that a positive collaborative relationship between doctor and patient is beneficial to the patient when disclosing emotional difficulties. Chew-Graham et al. in their 2002 exploration of the management of depression in primary care found that GPs recognise the importance of the therapeutic relationship with their patients and the importance of listening to them when psychosocial issues are presented. However, they qualified this with the problems of accommodating this service within the practical constraints of their workload.

GP training

Research studies investigating the success rates of GPs' recognition of mental health issues in their patients has suggested that, internationally, up to 50% of individuals with emotional or psychological issues who present in primary care do not have their symptoms identified, and this can constrain the optimal delivery of adequate treatment or appropriate referral to a mental health professional (Kessler et al., 2002).

Herrington et al. (2003) state that GPs who have a greater interest in psychiatric disorders, are concerned about the emotional health of their patients and who feel greater responsibility for helping patients to resolve these issues are better able to recognise emotional, behavioural and psychological difficulties.

However, the commonly repeated assertions regarding GPs missing up to half of common psychological issues in their patients has been

In Ireland 95% of emotional and psychological health problems are supported and treated within general medical practice and less than 5% are referred onto more specialised psychological health services.

challenged by Bushnell (2004) as an oversimplification. Bushnell's research showed that GPs identified 67.3% of psychological symptoms in the course of a consultation. In a previous review of the existing literature from 2003, Herrington et al. stated that GPs often fail to either inquire into or interpret cues for the presence of anxiety and depression, even though these symptoms may clearly be present.

Bea & Tesar (2002) found that, in general, GPs do not have training or expertise in counselling skills and prescriptions for psychotropic medication is often more widely dispersed than information about counselling and psychotherapy. In addition to this, they say that many of the clinical practice guidelines for GPs in the United States emphasise pharmacologic management of psychological difficulties.

An Irish study into the counselling referral process in primary care methadone treatment found that with regard to GP training, counselling interventions and other psychological management techniques are not covered in general medical training in Ireland (Kenny, 2007). With one exception, all GPs who discussed the topic at interview were of the opinion that their formal training did not give them insight into the role of counselling (ibid).

Access to psychological therapies

For the vast majority of GPs surveyed across all of the literature explored in this study, the main factor which prevents them from referring patients to counselling is the lack of availability or accessibility to appropriate services. (Alexander & Fraser, 2008; Kenny, 2007; Rushton et al., 2002; Ward et al., 2008). Telford et al., (2002) found that speed of response to referral and access to the preferred professional were the two most problematic issues for British GPs when referring to psychological therapy services.

Characteristics of the relationship with their doctor helped or restricted them in opening up about their emotional issues and that this was fundamental to their consultation experience.

The subsequent stigmatisation of patients who have emotional, psychological or psychosocial problems in being referred to psychiatry discourages further referrals (Whitford & Copty, 2005). Knight (2003) found that a number of GPs expressed concerns regarding waiting lists and the length of time it can take for individuals to be seen by some therapeutic services. These doctors felt that services need to be accessed within a reasonable timeframe, otherwise when a service is not available when required, it is not subsequently utilised.

However, in a Norwegian study, Mykletun et al., (2010) assert that if a substantially larger number of patients who present to GPs with symptoms of anxiety and depression were to be referred to psychological therapies, the current system would come under too much pressure and collapse. One of the problems of managing treatment of mental health issues in primary healthcare in Great Britain has been the high level of unmet need for psychological therapy, awareness of which has resulted in calls for an improvement in access to psychological treatments for people with common mental health problems (Boardman & Walters, 2009). To counteract this, (Mykletun et al. (2010) refer to an alternative approach to this public health challenge which is being trialled in the UK. The 'Improved Access to Psychological Therapies' (IAPT) project involves the establishment of psychotherapeutic treatment centres across the UK to deliver evidence-based, solution-focussed and low threshold therapies.

Up to 50% of individuals with emotional or psychological issues who present in primary care do not have their symptoms identified.

In Ireland, it is hoped that the Counselling in Primary Care (CIPC) service which was launched by the HSE in July 2013 will go some way towards increasing access to counselling for people.

Attitudes towards counselling

GPs can play a considerable role in informing their patients about different types of psychotherapy and helping to find a good match between patient and counsellor is vital to positive outcomes (Bea & Tesar, 2002). Fitch et al., (2008) acknowledge that historically, GP attitudes towards counselling have been considerable barriers to the referral process. These attitudes have included the stigmatisation of those who seek counselling, the failure of various groups of doctors and counsellors to respect each other's work and scepticism amongst GPs about the efficacy of therapy (ibid.).

Telford et al., (2002) found that existing guidance criteria, which recommend that counselling should routinely be considered as a treatment option, are seldom followed by British GPs. Nettleton et al., (2000) found contrasting attitudes of different primary care practitioners towards psychological therapies so that the decision-making process can be quite random as to whether patients with similar issues receive a referral. Raine et al.,

In a Norwegian study, Mykletun et al., (2010) assert that if a substantially larger number of patients who present to GPs with symptoms of anxiety and depression were to be referred to psychological therapies, the current system would come under too much pressure and collapse.

(2005) in a study on GPs' opinions into access to mental health care found that some GPs interviewed doubted the empirical legitimacy of counselling approaches to mental health and questioned the difference between psychotherapeutic treatments.

Kenny (2007), in undertaking a study on the psychological therapy referral process in primary care methadone treatment in Ireland, found a more positive attitude towards psychological therapies amongst the practitioners interviewed. He states that GPs recognise counselling as an important intervention in the holistic treatment of methadone patients.

Reasons for referral

GPs' referral decisions about psychological therapies and other mental health services appear to be influenced by a range of factors. GPs are more likely to refer 'high risk' patients, such as those who are suicidal, to mental health services, sometimes out of a desire to share responsibility or have another service take over a patient's care (Sigel & Leiper, 2004). Vagholkar et al., (2006) in their Australian research, found that the patients who were referred from general practice to psychological therapies were predominantly female with the majority aged thirty or over, peaking in the thirty-to-forty-nine age range. They go on to state that this is consistent with other Australian research on issues pertaining to psychological and emotional issues which show that such conditions tend to decrease with age, and that females are more likely to present to their GPs with anxiety and depression and they account for the majority of mental health presentations in primary care, while males more commonly present with substance abuse and addiction issues.

It has been found that GPs who work in primary care health centres are more likely to refer people to counselling and that the referral ratio grew in proportion to levels of urbanisation (Herrington et al., 2003; Knight, 2003).

Cape & Parham, (2001) and Kadam et al. (2001) found that depression and anxiety were the most common psychological problems referred by GPs to psychological therapies. They state that relationship difficulties and emotional problems relating to bereavement were rated as more common in patients seen by counsellors, while panic disorder, phobias and obsessive compulsive disorder were rated as more common in patients seen by clinical psychologists. Canadian research into this topic established that younger people were more likely to be referred to mental health specialists but that only a small proportion of patients with a major depressive episode were referred to mental health professionals,

GPs are more likely to refer 'high risk' patients, such as those who are suicidal, to mental health services, sometimes out of a desire to share responsibility or have another service take over a patient's care.

with a significant proportion not receiving any mental health services (Wang et al., 2003). Kendrick et al., (2005), in a British study of GPs' treatment decisions for patients with depression, found that in phase one of the research the participating GPs diagnosed depression in thirty cases (49%), prescribed psychotropic medication in five (8%), and a referral to a mental health professional in ten (16%). Equivalent data for phase two of the study showed that depression was diagnosed in nine cases (35%), psychotropic medication was prescribed in nine (22%), and referral to psychotherapy was offered in three cases (7%). The authors state that it is noteworthy that depression was not even discussed by GPs in fifty seven of the one hundred and one cases, let alone treatment or referral options offered. Amongst the forty four patients with whom their condition was discussed, fourteen were offered medical intervention, and a referral to psychological therapy was offered to thirteen.

Sensitivity towards psychological issues

Psychological-mindedness amongst GPs is central to therapeutic alliances as it can serve to encourage primary care doctors who, having little prior education in the area, take a keen interest in counselling and psychotherapy (Fitch et al., 2008). A patient may present with physiological, psychological, emotional, behavioural and psychosocial issues or various combinations of these and a GP's sensitivity to this presentation plays a central role for correct diagnosis and subsequent appropriate referral to psychological therapy (Herrington et al., 2003). Further to this, the study found that GPs who did not consider psychological care as falling within their remit tended to refer more people than those who did not and that those GPs who displayed more interest in psychological matters

had a tendency to refer less frequently and offered counselling to their patients themselves. This piece of research also stated that the patients, seen by GPs who assigned greater importance to psychological factors, reported higher satisfaction ratings after consultation (ibid.).

Provision of counselling by the GP

This study has identified that some GPs prefer to provide counselling themselves rather than refer to a psychological therapist. Counselling is frequently used in general practice (King et al., 2002; Knight 2003) with most GPs providing counselling to their patients in the form of general advice (Collins et al., 2006). In the Netherlands, guideline criteria for the treatment of depression advocate the prescription of psychotropic medication and/or various forms of psychological therapy. Where counselling and psychotherapy is required, the primary care doctor can choose to work therapeutically with the patient themselves or refer the person to a mental health professional (Piek et al., 2011). Stavrou et al., (2009) determined that GPs reported some patients felt comfortable with just seeing their doctor and were not seeking further help. The majority of primary care practitioners who participated in a British qualitative study conducted by Cocksedge & May (2006) stated that they had no desire to act as counsellors to their patients and preferred to refer the patient to therapy if possible.

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The role of emotive responses

Sigel & Leiper (2004) suggest that referral decisions are prompted when the relationship with the patient becomes difficult or evokes negative emotional responses in GPs. Nandy et al. (2001) similarly state that some reasons for referral from general practice to psychological therapies include lack of improvement and a poor relationship with the patient, which, in many cases, are accompanied by sentiments of annoyance or anger on the part of the doctor. Nandy et al. found that those GPs who initially contained but then referred after a period of management by themselves alone, the role of feelings as a trigger for referral was often prominent. GPs would use their own feelings (e.g. frustration or irritation) as a gauge that progress was not being made or that they were not the right person to be dealing with this patient.

Herrington et al. (2003) found that GPs who had a tendency to blame patients for causing, overstating or extending their depression, assessed these difficulties less, and were less accurate in identifying psychological or emotional suffering in their patients.

GPs may be hesitant to enquire about and investigate concerns about their patients' potential mental health problems due to other demands upon their time, coupled with the subsequent emotional burden that they themselves may experience...
Research from the United States - 92.5% of the respondents concurred with the statement, "Consideration of psychological problems will require more effort than I have to give".

Workload and time constraints

A significant factor in whether a patient receives a counselling referral relates directly to the GP's workload and limited consultation times. Chew-Graham et al. (2002) found that although in Great Britain there has been an increased awareness on emphasising the identification and diagnosis of depression, it has been said that GPs may be hesitant to enquire about and investigate concerns about their patients' potential mental health problems due to other demands upon their time, coupled with the subsequent emotional burden that they themselves may experience. In Great Britain general practice consultations are shorter by international standards with the mean in the UK being 8.4 minutes, in comparison to 15 minutes in Canada and 21 minutes in Sweden (ibid).

Research from the United States published in 2010 by Anthony et al., explored the factors which are influential in GPs' decisions to refer depressed patients to psychological therapies. The researchers in this study found that 92.5% of the respondents concurred with the statement, "Consideration of psychological problems will require more effort than I have to give", and 50% concurred with the statement, "Investigating psychosocial issues decreases my efficiency".

Knight (2003) found evidence showing that one common reason for GP referral counselling was because of constraints upon of doctor's time which didn't allow them to tend to the more difficult and intractable problems which their patients were experiencing.

Appropriate referrals from general medical practice to psychological therapies are increasing and greater awareness of the referral process from the perspectives of both the patient and the doctor will benefit all of the stakeholders.

Conclusion

There are multiple factors involved in the referral process from general medical practitioners to psychological therapies. Constructive aspects which aid the referral process include a healthy therapeutic alliance between doctor and patient; early recognition of symptoms of mental health issues by the general practitioner; GP time constraints; GP sensitivity towards psychological difficulties; and positive attitudes towards counselling by both doctors and patients.

Negative factors which serve as barriers to the referral process include non-recognition by primary care practitioners of psychological and emotional distress symptoms; an unhealthy doctor/patient relationship; lack of GP education and sensitivity regarding emotional or psychosocial problems; negative attitudes towards counselling by patients and GPs; and difficulty in accessing timely and appropriate psychotherapeutic treatment options.

Access issues are being addressed by initiatives such as the CIPC service here and other barriers to the referral process can be attended to by additional training and education programmes for general practitioners and increased public mental health awareness campaigns. There is a need, in particular, for further research into Irish general practitioners' attitudes and perceptions towards psychological therapies. Appropriate referrals from general medical practice to psychological therapies are increasing and greater awareness of the referral process from the perspectives of both the patient and the doctor will benefit all of the stakeholders and consolidate and increase such referrals into the future.

In view of the fact that the occurrence and presentation of mental health issues is increasing globally, continued research to aid understanding of referral patterns to psychological therapies is essential for the future emotional and psychological well-being of society.

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Donagh Ward

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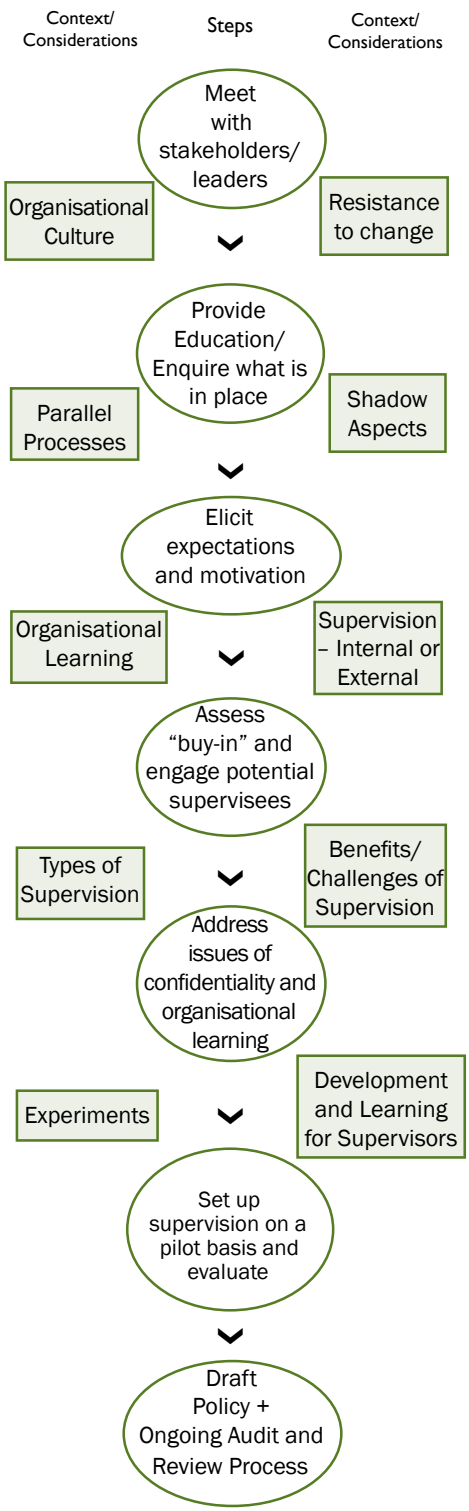
Erratum: Complete Diagram from 'Developing a Supervision Policy within an Organisation' by Mary Dwyer (Issue 4,Winter 2013):

Program for Developing a Supervision Policy within an Organisation



Protecting our Mental Health

by Claire Gallagher

Ennis-based counsellor and psychotherapist Eamon Fortune says that protecting our mental health must become as important as caring for our teeth.

Eamon Fortune spoke to Claire Gallagher.

"Talk about it get it out there - suicide is killing our young people and older people as well. Get it out there. Speak about it. People know it is happening anyway."

That is the message from Ennis-based counsellor and psychotherapist Eamon Fortune who maintains that protecting and caring for our mental health must become as commonplace as caring for our teeth.

The adolescence and adult counsellor said that counselling should be part of our lives, without any stigma, judgement or fear.

Going to a counsellor should be spoken about in the same way, as people would discuss going to the dentist, doctor or even hairdresser - just a normal activity that is undertaken for the wellbeing of the person.

The counsellor believes that only then will people be able to care for their mental health and start to take action before issues gets to emergency proportions.

Reducing suicide is something we have to talk about without fear, he told *The Clare People*, if society is to bring it into the open and deal with it.

"It is about getting society to talk more about suicide and understanding what brings a person to that point," said Mr Fortune.

"People must seek help through therapy rather than self-medicate through drugs and alcohol or both."

"What strikes me is there are a lot of sites (internet) and information that will tell you what to do when you are feeling suicidal. A lot won't steer you in the right direction long before you get to that point."

Mr Fortune, who spent most of his training placement working in an Ennis secondary school, said that getting into schools and making counselling part of young people's lives is the only way to "normalise it", even as they grow into adulthood.

"If we can get more involved in the schools and nip it in the bud. I believe there should be counsellors in every school.

"It was very interesting to see while working there [school], the stigma around counselling was almost dispelled. You would hear them talking in corridors about 'I am going down to see my counsellor'. There was no stigma around it at all.

"The service is there in the school, the ethos is in the school. It is normalised, so I think it is something that should be in every school, but what is happening in schools is that they are cutting the hours. It is interesting that they are doing the opposite to what they should be doing.

"It is easier to get to the root of a problem with a teenager rather than someone my age because we add layers and layers over it and bury it.

It takes a lot of counselling to peel back the layers to get to the root of the problem. It is different with a teenager they are not as long in this life," he said.

Mr Fortune has called on the Government to do a more in-depth study on mental health and suicide. "If they did a bit more advertising about the number of deaths out there it would help. They did a huge campaign around roads deaths."

The Clare counsellor believes that getting men in the door of the counsellor's office is particularly difficult, and maintains that if this can be "normalised", particularly for this gender, lives could be saved.

"It is about getting rid of the stigma for men that it is ok to talk about it and reducing the number of suicide," he said.

Having worked in the construction industry for years, this now qualified counsellor is well aware of how difficult men find it to ask for help. Now as a mental health professional, significantly more women seek his assistance as opposed to men.

"You don't see as many men as women coming in relation to domestic abuse for example," he explained.

"I can only remember off the top of my head one man coming to see me around my own age (40s - 50s). I'd say 99 per cent are women or young women. I have young men coming in which would be an increase in that percentage as well, but that figure is still very low compared to women. There would be cases where children are quite young [and they seek help] and one was a young man. The young man came in off his own bat and the others came through parents."

Quoting a national report from 2005, Mr Fortune said six per cent of men and 15 per cent of women suffer extreme domestic abuse; 26 per cent of men and 29 per cent of women suffer domestic abuse, where severe abuse and minor incidents are combined; 13 per cent of men and 13 per cent of women suffer physical abuse or minor physical abuse; and 29 per cent of women, one in three, and only five per cent of men, one in 20 report it to the Gardaí.

So why the chronic under reporting by men?

"There is the whole thing around a fear of being ridiculed. You don't report this. There is a fear that they will be told 'will you ever go back and cop on and stand up to her'. 'How are you allowing this to happen?'" he said.

"I am wondering because of the under-reporting with men, and it is less likely of men coming in to talk about it as well, and that in itself can link to suicide.

"These men are thinking 'Where do I go with this? Do I tell my friend my wife is beating me? What do I do about this?' These questions all add more pressure," he said.

These men need to know there are counsellors there to help he said.

"They don't do that however, and the figures speak for themselves. We are the fourth highest suicide rate in the EU. In 2010 the CSO figures show 486 deaths from suicide - 386 were male and 100 were female. The stats would suggest that it is mostly men that do not deal with their issues."

"There are not as many services in Clare as other counties that is why it is important for people to know what services there are out there to help. Clare seems to get skipped over a lot," he added.

Mr Fortune said that for many the first port of call is to the GP who then refers the person for counselling.

He explained it was important people accessed that help.

"Talk to someone like me. Don't hold in all the pressure. Release it. Look after your mental health. Realise that it is becoming a more common issue and you can do something to stop it. It is changing but very slowly. People are going in with their issues but very, very slowly.

"It is okay to talk to someone about suicide and understand more about what brings our loved ones to this final stage where they think it is the only way out," he added.

People must start speaking openly about mental health and suicide if it is to be normalised he maintained.

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I am an Ennis, Co. Clare-based Counsellor/Psychotherapist working with adults and teenagers for the past four years. I qualified as a therapist in 2010 in PCI College and went on to receive my honours degree in Counselling and Psychotherapy through Middlesex University. I work with clients who present general issues such as bullying, sexuality, domestic abuse, depression, anxiety, sexual abuse, anger behaviour, relationships, bereavement, eating-disorders, low self-esteem, stress and trauma. My client base would come from referrals from General Practitioners and also from a local domestic abuse service. If you have any views or discussions you may like to have on the above article, I can be contacted at eamonfortune@ymail.com

"Holding"

by Jim Cantwell

Abstract:

Recent developments in standards of professionalism (QQI) have set challenges to the field of counselling and psychotherapy. As a profession we might want to become recognised as professional and often such standards are rooted in academic rating systems. However, as practitioners we are also aware that personal development rooted in the practitioner's own work on the self provides a governing quality to any academic training element undertaken to become a qualified therapist. Questions and reflections about counselling and psychotherapy most definitely will raise many opinions among practitioners all around the country. What academic standards will be considered as baseline for counselling and psychotherapy? What level of personal development, practice skills development, life development, personal readiness, personal therapy, supervision and so on, must accompany the academic standards set as a baseline? This article is a discussion of the 'holding' concept from D.W. Winnicott's work, in the context of our decisions as a profession going forward. Within that journey, 'holding' might serve as a reminder of what is arguably important about who we are as therapists.

Introduction:

It may seem obvious to state, but an academic standard of training is a measure of just that – academic skills such as writing skills, study skills, memory skills to demonstrate theoretical understandings developed over the course of studying. For practice and practitioners it may be more arguable that the more poignant skills set are the ones grown from the other elements of counselling and psychotherapy training, It was from such considerations at a recent debate on the issue that the following article was inspired.

Whatever definition counselling and psychotherapy generates at the end of all our deliberations, for us as practitioners one of the primary concerns is that we can 'hold' the space with the clients that we sit with on 'the journey'. Equally whatever standards are ratified, they must arguably be ones that can produce practitioners that have 're-birthed enough of the self', as one of my trainers use to say, to be able to generate a 'holding' contact with clients. This article is a reminder of the concept of 'holding' and the gift of truly being able to connect with clients in such a way.

This article is a reminder of the concept of 'holding' and the gift of truly being able to connect with clients in such way.

As a model of contact?

There is (or arguably should be) an expectation that when clients come into a therapy space with a therapist a certain experience will be generated between the client and therapist. The acknowledged therapeutic style of contact is imbued with qualities of empathy, non-judgment, openness, acceptance, and confidentiality. When ingested on an experiential level by the client, this type of contact feels like a safe relationship to work on self and any issues or challenges, arising. Once such relationship conditions are generated by the therapist and client, the therapist facilitates the client to work.

As therapists, we work within the model of self that the client currently uses to function as a person – consciously and unconsciously. To be truly present with the client's model of self, the therapist is challenged to be able to tolerate compassionately, remain open to and work with the style and contact of the client self. This ability in the therapist can be demanded to varying degrees, depending on how the type of process and work brought by the client interacts with the therapist's own process. This ability to join a person in his / her 'state of aliveness' (Ogden: 2004) has been demonstrated and recognised as important in other forms of therapeutic relationships (Ainsworth, 1969; Ainsworth, Bell & Strayton,1974; Bowlby, 1958; Bowlby, 1988; Winnicott, 1957)

A powerful image of such relationship abilities / qualities in practice was explored in the 'good enough' mother model of relationship contact (Winnicott, 1958). The donation of realising the gift of a process, such as attachment, being delivered and experienced through the relational contact between people, truly reinforces the importance of the relationship in the therapy space. The value of a timely meeting of needs, in a consistent way, through compassionate relationship style, has been significant to practitioners as a pathway to establishing therapeutic supportive relationships within client work.

The concept of 'holding' in mother–child relationship:

D. W. Winnicott (1896-1971) helps us to focus on the qualities of the mother–child relationship that produce specific therapeutic opportunity. Within the body of research and literature, Winnicott identifies the concept of 'holding'.

"Holding can be done well by someone who has no intellectual knowledge of what is going on in the individual; what is needed is a capacity to identify, to know what the baby is feeling like" (Winnicott: 1990: 28).

He noted the product of a 'good enough' mother-child relationship was observable in the experience of the child. The child experienced a personal sense of being held.

Holding a child within the nature of her being is conceptualised by considering how a mother facilitates the emotional growth of a child as she grows in the experience of being alive. Exploring the concept of holding within the parent-child relationship reflects on: how the parent responds to the sense of the child's experience of her continuity of being; and how that sense of being is sustained over time (Ogden: 2004).

The time component of the holding concept encapsulates staying within the continuum of the developmental stages of growth and the personal, social and relational sense involved for the child.

"Remember the individual child, and the child's developmental process, and the child's distress and the child's need for personal help, and the child's ability to make use of personal help", (Abram: 1996).

Winnicott reflected on how the mother manages the different states of being experienced by the child from the 'earliest states of aliveness' (Ogden: 2004). Ogden uses the phrase of 'being in the infant's time', which encapsulates the task of the mother (2004). This ability allows the mother to attune to the experience of the child; the mother 'feels herself into the infant's place' (Winnicott: 1956: 304). This ability to attune to the child's qualities of aliveness throughout the developmental stages is a key skill identified by Winnicott in the provision of a 'holding' relationship and environment.

An example of attunement: The earliest form of immersion into the infant's world by the mother is an example of strong attunement. Winnicott called the state of being for the mother the 'primary maternal preoccupation',

"a state of heightened sensitivity... she becomes preoccupied with her child to the exclusion of other interests, in a way that is normal and temporary" (Winnicott in Jacobs: 2003: 48).

In this time of 'holding' the mother enters into the infant's sense of

The value of a timely meeting of needs, in a consistent way, through compassionate relationship style, has been significant to practitioners as a pathway to establishing therapeutic supportive relationships within client work.

time and being. As Ogden puts it the mother 'transforms for the infant the impact of the otherness of time and creates in its place the illusion of a world in which time is measured almost entirely in terms of the infant's physical and psychological rhythms' (2004).

The mother in her act of 'holding' is in an emotional state of psychological and physical holding which insulates the child. This has an emotional and physical cost to the mother which Winnicott termed as "almost an illness... and a woman must be healthy in order to develop this state and recover from it as the infant releases her" (Winnicott: 1956: 302). This period from just before the infant is born and for some months after is where the mother enters the infant's sense of time for eating, sleeping, play, company, etc., which is totally different to the general time and schedule followed in the course of her adult life. The mother is pivotal in Winnicott's theory of emotional development. He saw mother as the child's first environment, biologically and psychologically. He concluded that how the mother behaves and feels in relation to the child will influence the child's health (Jacobs: 2003). Addressing mothers in 1969, Winnicott said:

"The environment you provide is primarily yourself, your person, your nature, your distinguishing features that help you to know you are yourself. This includes all that you collect around your self, your aroma, the atmosphere that goes with you..." (Building up of Trust" in Abram 1996: 199).

It is the appropriate holding from parents, in time with the child's needs, throughout the child's continuity of being, and maintained over time, (especially in the early stages of life), that are internalised by the child.

This has an emotional and physical cost to the mother which Winnicott termed as "almost an illness... and a woman must be healthy in order to develop this state and recover from it as the infant releases her" ... The mother is pivotal in Winnicott's theory of emotional development.

Holding in the therapy space – reflections from Ogden (2004):

Winnicott's concept of the mother who has enough personal capacity to be the holding environment for her child – 'the good enough mother' – is also seen as way of understanding what could be provided in the therapeutic relationship of therapy (Abram: 1996). Transposing the qualities of maternal care to the therapeutic relationship, 'holding' can be seen as the conceptualising of the therapist's role of safe guarding the continuity of the client's experience of being and becoming over time. As with the mother-child holding, maturation is achieved when the individual has the capacity to generate and maintain for himself a sense of his being over time (Ogden: 2004).

In the therapeutic situation, the mirror of the mother's primary maternal preoccupation is in the therapist's attention and the physical environment of the therapy space (Abram: 1996). The therapy space becomes the provision of a psychological space in which the feelings and the experience of the client are accepted and understood (Ogden: 2004). The holding space within the therapy space can also be seen as a metaphorical holding. In an imaginative phrase – 'the gathering of bits' – Ogden describes the provision of a place in which the client may gather himself together (2004). Winnicott saw this as a client's need to be known in all his bits and pieces by one person, the therapist (Winnicott: 1945 in Ogden: 2004). When this form of holding is transposed on to the qualities of maternal care it mirrors the state of primary maternal preoccupation.

It is quite simply the therapist being that 'human place in which the client is becoming whole' (Ogden: 2004). This is a place that requires no interruptions and interpretations on behalf of the therapist and much depends on the therapist's ability to tolerate the feeling that no work has been done (Ogden: 2004). Like mother, the therapist provides space, with secure boundaries, in which trust in relationship can be experienced (Jacobs: 2003).

"Common to all forms of holding of the continuity of one's being in time is the sensation based emotional state of being gently, sturdily wrapped in the arms of the mother. In health that physical / psychological core of holding remains a constant throughout one's life" (Ogden: 2004).

Ogden's turn of phrase creates a deep sense of the holding relational contact as it could be applied to client work – how the practitioner manages a client's 'state of aliveness; being in the client's time; and the practitioner feeling herself into the client's place.

Holding as a form of Management:

When considering the issue of young people who can't look after themselves and need professional care, Winnicott referred to holding as a form of management (Abram: 1996). The management offered to these young people is a holding environment. This environment in theory mirrors important aspects of the environment provided by 'the good enough mother'. As such the

It is quite simply the therapist being that 'human place in which the client is becoming whole'.

environment for treatment of these young people is set up to ensure it runs smoothly. According to Docker-Drysdale (1993) the environment establishes good boundaries that are well maintained; in this environment disturbing intrusions are prevented or the effects mitigated; the relationships in this environment allows for the regression often required in this treatment. Regression is facilitated through the emotional availability in staff and by providing young people with a temporary re-experience of maternal preoccupation. The opportunity to re-experience what was interrupted in the young people's continuity of being is offered to the them through special relationships with staff members.

Once therapeutic relationship has been established between a staff and a child they are carefully supported by the other staff members as needs arise (Docker-Drysdale 1990). In offering this holding environment the operation of the institution as a whole is significant. Docker-Drysdale (1990) argues that the management of the staff and the organisation affects the role models that the staff presents through themselves to the children. It is to this role model that the children come to identify. The hypothesis about the young people's and adolescents' problems is that they began in the first years of life, in some failure in primary maternal care (Docker-Drysdale: 1993).

Beginning work on a problem established for quite a while is seen by Docker-Drysdale (1990) as the most difficult aspect of working with these young people. In these circumstances the original problem has been layered and exacerbated by other life experience by the time a holding environment is offered to the young person. But even with the layers of other issues that present when working with emotionally deprived children, with their pain and their needs, to provide a place where those needs can be met, where broken childhoods are acknowledged, understood and re-made is the primary therapeutic task (Docker-Drysdale: 1990).

In Conclusion:

"Holding' as a felt sense can be generated by how the practitioner uses herself and the environment in the contact with the client. So much can be communicated through that generated felt sense that clients can use for security and growth. Practitioners should arguably question how we as therapists grow our abilities to provide holding relationships and environments in our client work and question how we can include such outcomes in the trainings we set up for future therapists?

Perhaps the 'why' of needing to set academic standards (and HETAC accreditations) for training as therapists does not address enough the journey needed to grow the abilities to be able to 'hold' a space with our clients? I hope that future changes and developments do not in any way undermine such therapeutic journeys and replace them as learning outcomes on module descriptors.

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Mental Health Matters

by Alison Lane

Mental Health Matters Dean Clinic is a relatively new service providing Mental Health Care in the community setting.

St Patrick's Hospital was founded by the vision and bequest of Jonathan Swift, Dean of St Patrick's Cathedral. He saw, more than 250 years ago, the need to establish proper care, treatment and protection for sufferers of mental illness.

"He gave what little Wealth he had,
To Build a house for Fools and Mad:
And Shew'd by one satiric touch,
No Nation wanted it so much"

Today, St Patrick's Mental Health Service (SPMHS - formerly St Patrick's University Hospital) is driven by that same combination of vision, energy and the will to provide the best and most effective treatments and services and promote and protect the rights of everyone who suffers from mental illness.

SPHMS is person-centred in its focus, striving to understand and meet the needs of people with mental health issues. We are keenly aware of our not-for-profit status and philanthropic purpose. The hospital is guided by the principles of its founder, Dean Swift, the values of the Mental Health Act 2001, the European Charter for Human Rights and the United Nations Principles for the protection of persons with mental illness and the improvement of mental health care. The hospital is committed to the principles of the Government's policy 'Vision for Change' and to meeting all of the Mental Health Commission's regulations and standards.

A Strategy called Mental Health Matters was developed and one of the main priorities was to increase access for people to mental health care within their own community.

A number of community mental health clinics have been established to date – in Dublin (St Patrick's, Lucan, Donaghamede, Capel St and Sandyford) and regional clinics in Cork and Galway.

There are also Associate Deans working in other areas to increase and improve access to the Community Service. These associate Deans include Dr Michelle Cahill, Glasnevin, Dublin 9, Dr Aideen Moran, Naas, Co Kildare and Dr Abbie Lane, Sandyford, Dublin.

A further Dean clinic in UCD was established in September 2013 where SPMHS provide the mental health service on campus as part of the Student Health Services and works in collaboration with the service's GPs. Dr Martina Ryan provides this service on behalf of SPMHS.

In Dean Clinic Cork we provide a service designed to meet the mental health needs of the community within a Multi-disciplinary setting. The MDT is comprised of Dr Treasa O'Sullivan, Consultant Psychiatrist, Alison Lane, Clinic Coordinator & Psychotherapist and two CBT Therapists, Dr Carmel Mc Auliffe and Edel Foley. An OT is due to join the team shortly.

The Multi-Disciplinary Team operates on Recovery Principles (hope, personal responsibility, education, self-advocacy and support) thus ensuring the experience of the Service is one of empowerment, hope and recovery. The Dean Clinic is very committed to working closely with GPs and Practice Nurses, recognising the central role that the Primary Care Team plays in delivering mental health care. We also liaise closely with other professionals working with the people who attend our Service, eg Psychotherapists and Counsellors working in private practice.

High quality Mental Health Assessment and treatment for people over the age of 18 is provided. A wide range of mental health problems are catered for, including Depression, Anxiety, Eating Disorders, Bipolar Mood Disorder, Addiction and Stress Related Disorders.

"He gave what little Wealth he had, To Build a house for Fools and Mad: And Shew'd by one satiric touch, No Nation wanted it so much"

Referral Pathway:

A referral is made by the GP. The clinic operates on an Appointment-Only basis. Referral forms can be downloaded from the hospital website www.stpatricks.ie. Alternatively the central referral line can be contacted on 01 2493535. All referrals go through a central pathway. An additional letter attached to the Referral Form with extra information is always helpful in preparing to meet the new client.

Once the referral is received, it is triaged and an appointment is sent to the client within a few days. Assessments are offered to suit geographical area. There is a 'Bundled Care' package with a defined care plan. This means the Initial Assessment (1 and ½ hours) is free of charge. A follow-up session is also free of charge if in-patient treatment is required. All other therapies and Consultant reviews are fee-based. Second Opinion is available at GP request.

Initial Assessment:

A detailed mental health assessment will take place with one of the members of the MDT. A full background history is taken and a collateral history from a family member if available. Information is sought on presenting problems and relevant history, risk events history, medication use (current and previous), family history, childhood history, educational background, previous and current occupations, marital history, including children, alcohol/drug use, social circumstances, finances and debt, pre-morbid personality and mental state examination. The Consultant Psychiatrist will also meet the person as part of this Assessment.

Following the initial assessment, a range of treatment options will be considered. These include ongoing mood review, medication review (if applicable), general counselling, addiction counselling, psychotherapy, cognitive-behaviour therapy (CBT) and OT.

In collaboration with the client, the Multi-Disciplinary Team prepares an Individual Care Plan which usually incorporates one or more of these options. The Dean Clinic, Cork also has the full support of a range of day and in-patient specialist services on the campus of St Patrick's and St Edmundsbury Hospital, if required. Therefore if admission is required, it can be facilitated without undue delay.

We liaise regularly with the referring agent and other relevant Professionals involved in the provision of care through verbal and written correspondence, regarding progress of the client. It is often through this close liaison that meaningful insights develop and above all the client receives the highest quality of care.

It is important to mention 'Walk in My Shoes' which is St. Patrick's Mental Health Foundation's leading awareness and fund-raising campaign which was established after a 16-year-old attending St. Patrick's University Hospital said he wished his friends could put themselves in his shoes and gain a better understanding for mental health difficulties. 'Walk in My Shoes' raises funds to provide services, support and information to vulnerable young adults in Ireland with mental health difficulties. 'Walk in My Shoes' is a year long campaign promoting early intervention, offering mental health education and aiming to tackle the stigma that surrounds mental health.

Funds raised are directed to our one-of-a-kind national support and information line which is available to the public and manned by mental health professionals who can listen, support and offer professional advice to anyone, anywhere in Ireland. This is the only support service in Ireland manned by mental health nurses. Contact details - 01-2493333 or email at info@stpatricks.ie. Through our 'Walk in My Shoes' 2013 campaign, St. Patrick's Mental Health Foundation funded the St. Patrick's Support and Information line and further services for vulnerable young adults in Ireland. The Support and Information line saw its busiest year in 2013 with calls increasing by 29% and email enquiries increasing by 46%.

Anyone can get involved in our campaign by sharing our mental health information packs, challenging the stigma and fundraising to support vulnerable young adults in Ireland. There is a really good new clip with Walk in My Shoes highlights- http://vimeo.com/81636083.

Much needed funds can be raised by hosting a 'funky shoe day' at work, in the community or in school/college. This year May 9th is Funky Shoe Day nationwide. Those taking part are asked to step out of their comfort zone and wear shoes they normally wouldn't for the day- wellies to work, slippers to school or mismatched shoes for the day. Each person donates just €2. There is also an official walk taking place in Cork and Dublin which we are hoping the public will support. The following is the message we are hoping to convey:

"Our message is simple. You don't have to wait to enjoy life again. Every day you live with a mental health difficulty that can be managed and resolved, no matter what stage it's at, is a day you haven't lived to its fullest. People experiencing mental health difficulties should not only believe that recovery is possible but should expect recovery. Everyone has a right to good mental health." *Paul Gilligan, CEO of St. Patrick's, (January 2014)*

For further information on this or any aspect of the Dean Clinic Cork, please contact Alison Lane, Dean Clinic Coordinator on 021-4614460, or email admindeancork@stpatsmail.com

A quarterly newsletter is available by sending details to communications@stpatricks.ie

Workshop Review

SEXUAL ORIENTATION AWARENESS

Presenters: Bernadine Quinn and John Ruddy

Date: 7th of December 2013

Reviewed by: Kate Maguire

I attended a workshop organised by the North East Region entitled Sexual Orientation Awareness. The workshop was presented by Bernadine Quinn and John Ruddy from Dundalk Outcomers, a Lesbian, Gay, Bisexual and Transgender support group based at 8 Roden Place, Dundalk Town. They provide information, support and advice to LGBT people in the North East Region including counties Louth, Meath, Cavan and Monaghan. They can be contacted on 086 162 5030 or www.outcomers.org.
Belongto, 13 Parliament St, Dublin offer the same service and can be contacted on 01 6706223.

The morning began with a guided meditation on stereotypes although we weren't told this to begin with. The meditation began in a park where we were to imagine a child playing ball with its parents, a couple having a picnic, passing a smiling couple holding hands, etc. We were then asked questions to test our prejudice, like whether the couples we imagined were heterosexual or same sex and whether the child playing ball was male or female. Bernadine continued to test us with an exercise that included us having to call out popular words to describe LGBT people like Fairy, Dyke, Tranni, etc. This was difficult as there was not one single positive word said to describe LGBT people. These thought-provoking exercises made us reflect on how programmed we are to see stereotypical norms in our society and also how language is used to further negative views of LGBT people.

Bernadine pointed out that South Africa was the first country in the world to include a clause in its constitution explicitly forbidding discrimination on the grounds of sexual orientation, yet the practice of "Corrective Rape" is widely carried out. There is a belief in Africa that sexual orientation can be changed by raping a woman. Twenty six year-old Duduzile Zozo was raped and murdered in June this year because she was a Lesbian. The person responsible has not been brought to justice. At his recent concert in Moscow, Elton John condemned Russia's anti gay laws calling them "inhumane and isolating". In Ireland, attitudes towards LGBT people are the most liberal in Europe. Homosexuality was decriminalized in 1993 and Irish law forbids incitement to hatred based on sexual orientation. The Civil partnership and Certain Rights and Obligations of Cohabitants Act 2010, came into force on the 1st of January 2011, a major step forward for LGBT rights.

When asked how we as a profession can help alleviate the suffering of people of different sexual orientations, Bernadine suggested that we must never assume that someone is heterosexual and that we could include the question, "would it have anything to do with your sexual orientation", in our initial assessment. Respond positively when people disclose their sexual orientation and be informed of the issues relating to LGBT people. We must also be aware of local LGBT groups and develop a working relationship with them, as well as displaying contact details, posters and literature of local and national LGBT services in our waiting rooms and local doctors' waiting rooms. Build your knowledge and skills through LGBT awareness training and, if unsure of appropriate language, ask LGBT support groups for guidance. Finally, address unacceptable, offensive or discriminatory comments/or actions relating to LGBT people in your community.

This was an excellent workshop providing much needed information and guidelines on how to work with and support LGBT clients.

Workshop Review

INTRODUCTION TO MENTALISING AND ITS DEVELOPMENT

Presenters:	Gerry Byrne and Dr Evelyn McCabe	Reviewed by:	Barbara Dowds
Date:	30th November 2013	Venue:	Marino Institute of Education

What is mentalising? When we mentalise we can interpret our own and other people's mental states (desires, needs, feelings, beliefs and reasons) with some accuracy. Thus mentalising is similar to empathy except in being oriented towards self as much as other. It concerns the meanings we attribute to our own and others' actions and shapes our understanding of others and ourselves and how we interact and make sense of misunderstanding. Even secure relationships contain a very high incidence of misunderstandings, but we are willing and able to correct the other and – except when distressed - don't need the other to fit our script. Implicit mentalising is non-conscious and unreflective, such as mirroring; explicit mentalising is conscious, verbal and reflective, such as explaining. In 'mind blindness' we may either fail to mentalise by being excessively concrete and egocentric, or we may suffer from distorted mentalising whereby we project and demonise. In tests of explicit mentalising, autistic people score no better than random and 'normal' people score quite high, but not as high as psychopaths. However psychopaths only score high explicitly, but they don't care how the other is feeling, i.e. they fail in imaginative empathy.

The workshop was primarily delivered by Gerry Byrne, an Oxford-based psychoanalyst and trainer who assesses and treats severe parenting problems including child abuse and neglect. The mother who believes that her two-month old baby is crying to deliberately frustrate her is failing at mentalising because she is not seeing the experience through the baby's eyes. Conversely, sensitively attuned parents are good at mentalising and raise children who can themselves mentalise well: this is one of the outcomes of secure attachment. Gerry offers mentalisation-based-therapy (MBT) to parents and children to try to break the cross-generational transmission of poor mentalisation with its associated neglect and abuse. Being misunderstood generates coercion, withdrawal, hostility, over-protectiveness and rejection – and indeed shame and mistrust. Without mentalising, repeated acting-out is inevitable in relationships. Insecure attachment damages 'epistemic trust' - that the information relayed by the teacher can be relied upon: 'mentalising is a generic way of establishing epistemic trust'.

Because it is vital in MBT for the therapist to model mentalising, the relationship must be transparent: the therapist needs to be willing to name what is happening to himself and to be patient enough to elicit from the client what is going on for them. In other words, it requires constant monitoring of one's own and the client's affect. Key questions to the parent undergoing MBT are: 'what do you see?'; 'what do you feel?'; 'what do you think the child is feeling?' Part of the work in MBT is the monitoring and regulation of arousal levels, because mentalising works well only at intermediate levels of arousal, neither too high nor too low.

The last hour of the day comprised a lecture and video from Evelyn McCabe, a Mayo-based psychiatrist who practices MBT. She showed how to translate theory into practice in MBT using an empathic, not-knowing, active-questioning stance, staying in the moment and modelling courage and honesty. Patients with borderline personality disorder find mentalising difficult, and there is a temporary loss of mentalisation in cases of suicide and self-harm. Dr McCabe's video of doing MBT with a borderline patient who has attempted suicide demonstrated the patience and restraint required by the therapist in helping such a client to mentalise.

The workshop was packed with interesting ideas, fascinating and moving anecdotes, adult attachment exercises and illustrative video clips. While the way of working is very similar to person-centred therapy, the MBT programme is more structured and the agenda far more explicit and targeted. Clients come into therapy because of blind spots in affective awareness and difficulties in relationships through not understanding others. I will be far more sensitive in future to viewing poor mentalisation – not as a block to therapy – but as the purpose of therapy for a large group of clients. I highly recommend this workshop which was a one-day introduction to MBT.

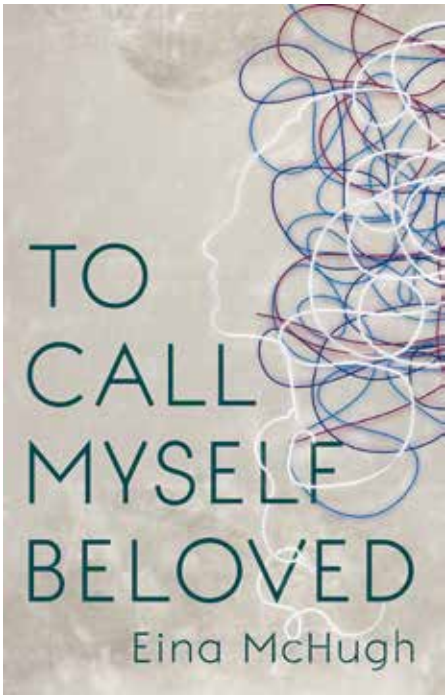
Book Review

Title:	*To Call Myself Beloved*
Author:	Eina McHugh
Published:	2012
ISBN:	978-1-84840-184-6
Reviewed by:	Cóilín Ó Braonáin PhD

In her book entitled *'To Call Myself Beloved'*, Eina McHugh offers us a fascinating account of her own experience of undergoing nine years of psychoanalytic therapy in Belfast during the height of the troubles. She lived as a child in a house opposite an RUC police station that was bombed several times, and the ensuing trauma forms the background of her therapy. The house literally collapsing around her as a child was mirrored in the adult fear of her 'self' imploding. The theme of death had its parallels in therapy, where Eina, lost in her own suffering is told that in order for her to 'give up suffering... a death is required.' However, McHugh is 'terrified of being real,' which is not surprising, given that the real world in which she grew was so dangerous. The political thread in this book, however, takes a backseat to the psychological theme.

Perhaps unsurprisingly, the therapy itself focussed on trust and intimacy, issues which are familiar to many clients with less dramatic beginnings. In the Freudian manner, Eina attended three psychotherapy sessions a week, plus one group therapy session, four in all. Her narrative (recorded in 200 letters written to her therapist) recounts a journey that underlines the courage and integrity of the client's commitment to her own well-being and happiness.

Eina's therapy is framed around the concept and method of transference, wherein her relationship with the analyst, 'J.' is central. Initially she attempts to be 'good enough' for J., then she uses him as a father figure and later he serves as a fantasy lover. Indeed, McHugh's terror of romantic relationships is a dominant theme throughout. However, for the most part, Eina fights her therapist, wanting him to provide her with the love that she denies herself. 'We are locked in a vicious war. J is not of this mortal world'. The necessity of her conflict is endorsed by a quote from Carl Jung; 'unless both doctor and patient become a problem to each other, no solution is found.'



The importance of, and difficulties around ending long-term therapy are explored in an insightful way. Eina correctly intuits that her therapist 'J' has become attached to her and is reluctant to finish. Ending is presented as a two-way street and the longer therapy lasts, it seems the more difficult is the ending. A solution is found when Eina gives meaningful presents to 'J' and her fellow group therapy members: two apple trees to 'J' as reminders of both their relationship and the cross-pollination which occurred between them. Because 'J' in the Freudian tradition maintains a blank screen for the most part, we can only guess at how he perceived his relationship with Eina. But it seems clear that both client and therapist leave their mark upon each other.

Ultimately, this book is both a reminder of the power of psychotherapy and the extraordinary courage of the client. After many years sitting in the therapist's chair, it is rewarding and instructive to be reminded of the client's experience. The book's title, which at first glance seemed somewhat cloying, sits comfortable at the story's end.

And did you get what
You wanted from life, even so?
I did.
And what did you want?
To call myself beloved, to feel myself
Beloved on the earth.

Therapist Dilemma

Research with our readers showed that one of the main sections you enjoy is our Therapist Dilemma. We are eager for your involvement, your ideas and thoughts, and replies to these dilemmas.

Below is new scenario for you to consider...

Send your Dilemma and / or replies to this issue's Dilemma to:

Dialogue, Éisteach, 21 Dublin Road, Bray, Co Wicklow or eisteach@iacp.ie

Dilemma from Winter 2013 Issue:

Dear Editor,

Concerning some clients who attend my office at the behest of a spouse or partner, I have found them to be less than forthcoming as to the issues affecting their relationships. A typical scenario is that of a man 'sent' to therapy because he is supposedly drinking too much. However, as described by the client, his drinking appears to be within Irish social norms.

I used to be patient with such dilemmas and simply wait for a more complete picture to emerge. However, I have begun to invite the client's partner to attend the second session, in order to obtain a more balanced view of the problem. Generally, my understanding of the client's difficulties is greatly clarified by this method.

However, I have doubts. In so doing, am I compromising the therapeutic relationship by, in effect, not trusting my client's perspective? If I am true to my humanistic principles, should I not bide my time and wait for the client to develop his insight and discover his own truth? On the other hand, information from third parties does tend to speed up the process and lead to positive outcomes. I am curious to hear opinions on this dilemma.

Cóilín Ó Braonáin

Response:

Dear Editor,

The following offers a response only to the specific scenario of "a man 'sent' to therapy because he is supposedly drinking too much." In such situations, the wise old saying, "you can take a horse to water but you cannot make him drink" always comes to mind. Furthermore, to what degree this person being sent? Is their partner/spouse giving them a gentle nudge or are they threatening to end their relationship if they do not attend therapy?

Of the many variables influencing a positive outcome from therapy, can there be any more crucial than the willingness and readiness of the client to engage fully in the therapeutic process? To help us explore this in the initial sessions, useful questions might include; What brings you to therapy now? How do you feel about being here today? What would you like to think that you might get from this process if we were to work together? What are your goals for therapy?

Where our client displays some ambivalence, or is clearly not ready to commit to therapy at this point, then to continue to work with them would surely be foolish and unethical. If, on the other hand, our client is clearly ready and willing to engage in therapy, then we must make sure to do so collaboratively. Working in such a manner, we (therapist and client) may well agree that it would be beneficial to their stated goals to invite their partner/spouse to attend one or more of their sessions.

Finally, where client and therapist agree to invite a partner in, it is important for the therapist to work to always stay focused on who the client is (the individual or the couple?), and the stated goals for therapy of our client.

Rosario Nolan, MIACP, Navan, Co. Meath

Dilemma for Spring 2014:

Dear Editor,

A client initially presented for counselling with complex family issues. The client struggled with feelings of abandonment, being a burden on her family, anger with her biological mother and fear of being alone.

The client was extremely dependent on people around her for security and self-assurance. The client continued in weekly counselling sessions for eight months and made good progress. The client then lost her job and there was a deterioration in her coping skills. After a number of late cancellations the client discontinued counselling.

Five months had passed since the client attended counselling sessions. The client then made contact with the counsellor, there was a risk of suicide, and the counsellor supported the client through this and got her to a safe place which involving emergency services.

The counsellor received a number of calls from the client in distress over the following months. The client continued to get support on the phone making appointments to resume sessions but then continued to cancel the sessions.

The counsellor has stopped engaging in telephone support and is encouraging client to make an appointment. The client agreed but has still not secured an appointment to date.

The counsellor has concern for the client and the approach that they took. The questions and concerns that have arisen for the counsellor are as follows;

1. Have boundaries been blurred due the counsellor engaging with the client in telephone support?
2. What is the obligation of the counsellor in the above circumstances?
3. The counsellor is uncertain around the ethical issues in this situation, is there any?
4. The counsellor still holds concern for the safety and care of the client and would appreciate any input from her peers.

Cathy Power, MIACP.