Éisteach

The Irish Journal of Counselling and Psychotherapy

Volume 16 • Issue 1 • Spring 2016

The Mind: Knowable or a Puzzle to Behold?

- Challenges of Formulating and Implementing Evidence-Based Practice in Counselling and Psychotherapy
- Is Bio Energy Therapy a Viable Resource within the Counselling Setting?
- Dream to Live not Live to Dream
- Let's Make Friends with the DSM

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Irish Association for Counselling and Psychotherapy

Contents

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Design and layout:
GKDesign.ie

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ISSN:
1393-3582.

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

Our Title

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

Disclaimer:

Next Issue:

1st June 2016

Deadline for Next Issue:

24th March 2015

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:

Dear Colleagues,

In this edition of Éisteathatch, we have a mix of material ranging from the objective to the subjective ends of the counselling spectrum. Two articles address the issue of research in counselling and the objective description of psychological difficulties as defined by the DSM-5. On the other hand, the experiential therapy of bio-energy is considered as potentially complementary to counselling work. Furthermore, we look at dreaming in the sense of imagining a future and working towards wholeness and actualisation.

I am grateful to Ramesh Ramsahoye for his passionate and detailed rebuttal of my own past article in which I advocated for therapist research on the efficacy of counselling. Ramesh raises a number of points which need to be considered including some potential difficulties such as the course of action to be taken if such research showed that some modalities were more effective than others. Also, he raises the difficulty of finding an agreed language, with which to describe client issues, without resorting to the use of the DSM-5, which is in itself something of a moveable feast. In order to research, must we first diagnose and if so, is that in the clients' best interests? However, Ramesh does acknowledge the need to know which therapeutic modalities work best and which practices may be harmful under some circumstances. His point is that maybe enough research already exists and that Irish research would not add anything of significance to the pot. Perhaps, he argues, more direct efforts are needed to convince medical doctors of the value of psychotherapy psychotherapy which may be a more beneficial use of resources.

On a different note, Laureen Taylor makes a case for considering the use bio-energy treatment in conjunction with psychotherapy as a form of treatment for psychological issues. It appears that it can be beneficial to introduce body therapy as an adjunct to counselling. A strong argument is made for viewing the person as repository of energy, given the observations of quantum physicists that all apparently solid matter is actually composed of energy. From this base point, Laureen claims that some attention needs to be given to energy levels and flow in the body, in addition to the more mainstream psychotherapeutic modalities.

The concept of 'dream' as in an imagined future is extolled by Michael O'Shea in a well-structured argument in favour of future-oriented therapy. The theoretical base of his article is the very influential work of Paulo Freire, who was appalled at the living conditions of indigenous peoples in Brazil at the hands of European colonialists. Freire realised that a significant factor in the oppression of people was to rob them of any hope for a better future, or 'dream,' as O'Shea puts it. Correctly, in my view, he proposes that the need to facilitate individual clients to dream for a better future can be equally liberating. In order to work towards happiness, it may well be necessary to imagine what that happy life would look like, in order to manifest the reality.

To close this edition of Éisteach we have another thought provoking piece of writing, in this case advocating the use the DSM-5 in counselling practice. Denise Mullen recommends the use of the Diagnostic and Statistical Manual of Mental Disorders as a means of counsellors being better informed of the criteria for mental disorders and as a tool for use in referral of clients who may need psychological or psychiatric help. No doubt some readers will disagree with this suggestion, nonetheless, a sound opinion is perhaps based on prior consideration of all points of view. For those interested in learning more about the DSM-5, Denise is running workshops on this very topic.

Cóilín Ó Braonáin, PhD

Challenges of Formulating and Implementing Evidence-Based Practice in Counselling and Psychotherapy

by Ramesh Ramsahoye

Introduction

In response to the call for a debate on the posited need for Evidence-Based Practice (EBP) within the field of counselling/psychotherapy (Ó Braonáin, 2015), this author would like to offer a few thoughts on some of the problems implicit in the adoption of a new counselling paradigm. This essay will set out an alternative, and to an extent opposing, perspective to Dr Cóilín Ó Braonáin's article, *The Research-Engaged Therapist: Why Counsellors Need to Embrace Systematic Investigation*. In the following discussion, some of the problems presented to the counselling profession in adopting EBP are considered, including challenges facing individual practitioners, as well as related ethical concerns, in light of what seems to be a radical, inevitable and imminent rethinking of how counselling operates in Ireland. Funding and resource issues are highlighted and some tentative proposals are advanced concerning how counselling might successfully collaborate with its sister professions.

The problems of counsellor-led research

Firstly, there would seem to be an inescapable paradox inherent in the proposed endeavour of counsellors making the case for the effectiveness of counselling via research that they themselves conduct (Ó Braonáin, 2015, p. 22). How can a profession that so often eschews the diagnostic criteria and concomitant labelling of modern psychiatry claim to be evidence-based? Is it not the case that many of its practitioners purposefully choose not to organize their working methods around an established body of knowledge and scientific orthodoxy pertaining to the same mental health problems? The DSM-5 (American Psychiatric Association, 2013), contains a plethora of new (some additions are concealed as subtypes), and in the view of many, (Glasser, 2003, Shakeh, 2012, Frances, 2013, Pearce, 2014, & Kirk, Gomory and Cohen, 2014), spurious 'mental health disorders', and is, supposedly, the result of decades of research. If there is indeed consensus amongst 'scientists' that the categories in the DSM and the World Health Organization's ICD-10 (1992) have been empirically validated, then these documents would necessarily have to form a key component of counsellor training and a starting point for future research efforts - particularly if the desired outcome is for counselling to be accepted by its associated professions. If counselling is to fit in with current medical opinion, extensive research would have to be conducted in order to establish it as an Evidence Supported Treatment (EST) for identified mental health disorders. In fact, matching particular client problems with different counselling models is described by Sexton as the "basis of an evidence-based model of counselling" (1999, p. 1). Such a project could easily eliminate counselling, or a particular approach, as appropriate treatment for a condition, having the effect in some cases of restricting a person's access to potentially beneficial psychotherapy (American

Psychological Association, 2006, p. 273). Is the profession ready to have some doors shut, in order that others may open? As the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) noted, the "use and misuse of evidence-based principles in the practice of health care has affected the dissemination of health care funds, but not always to the benefit of the patient" (p. 274).

Sorting out our terminology

Furthermore, if there is to be a constructive debate, current confusion around the signification of our terminology would need clarification in order for research to be conducted utilizing clear and unambiguous frames of reference. For example, when it is stated that there is a larger body of research pointing to the efficacy of Cognitive Behavioural Therapy (CBT) (as indicated on the BACP website), is it always genuinely the case that that this research is operationally differentiated between CBT and other therapeutic modalities? As CBT is normally delivered in the context of a relationship, is it even possible to do this? Can it ever really be postulated that it was the CBT as opposed to the relationship that helped, or vice versa? Equally, proponents of CBT cannot justifiably absorb into their territory the claimed ingredients of that approach when counsellors with a more person-centred orientation also work with 'cognition' and 'behaviour'. Rogers' account of the fully functioning person (1979, p. 118) describes a person capable of performing a complex process of cognition, assessing - in the moment - thought, sensing and feeling. Is it not the role of the humanistic counsellor to facilitate the development of such cognitive and sensing capacities, even though their methods might be less procedurally determined than in therapy that is more easily recognized as 'CBT'?

Is the profession truly prepared for the implications stemming from an accumulation of counsellor-specific data, stored on a central database? (Ó Braonáin, 2015, p. 21)

Focussing research in Ireland

If a solid body of evidence already testifies to the effectiveness of counselling (Ó Braonáin, 2015, p. 19, citing Carr, 2007, BACP, 2013, & McLeod, 2007, citing Wampold, 2001) then when some GPs are stubbornly sceptical, as Ó Braonáin rightly highlights, they are not behaving like scientists or observing EBP. Surely the solution is not endless research aimed at their persuasion, but rather intervention from the Health Service Executive (HSE) instructing these doctors to facilitate for their patients a proven treatment. Do the professional bodies have a greater role to play in that much needed dialogue, as advocates for this profession? The notion that Ireland-based research will be more compelling to those remaining dubious, despite the evidence, perhaps underestimates the extent to which cultural attitudes need to shift, as opposed to scientific understandings. If a cancer drug is shown to be effective in US and UK trials, the Irish medical profession does not resist it because it has not been shown in studies to work in Ireland on Irish people. It is a nonsense to make this demand of counselling. Rather, do we not need nuanced research on what can be shown to work best in culturally-specific contexts, with particular client presenting problems, age-groups and minorities? If a new research effort is to be launched in Ireland, please let it be properly and appropriately focussed, rather than duplicating studies simply to pander to an establishment prejudice that should ideally be overcome through other means.

What counts as evidence?

As a profession, we also need to consider what we mean by 'evidence'. Do we mean statistical data primarily? Are research findings based upon subjective experience, gathered via qualitative research, or mixed methods, to be given equal status? Arguably, they should be, in a professional activity that concerns itself with the uniqueness of a person's experience - yet within modern psychiatry quantitative data reigns supreme when treatment effectiveness is evaluated (Williams and Garner, 2002, p. 9). The APA (2006) commendably embraces multiple research designs. And what is to be the standing of data originating in specific clinical settings? An innovative, though complex, model for integrating research evidence by giving equal recognition to a) the level of evidence, b) the context into which evidence is implemented, and c) the method of facilitating change, was advanced by Kitson, Harvey and McCormack (1998) – a method that counselling may wish to consider. Barkham and Mellor-Clarke (2003) presented a cogent argument for the co-existence and relevance of multiple research paradigms, urging against a fracturing of the research effort due to the perceived dichotomy between evidence-based research and practice-based evidence.

Another salient issue is that of how data acquired through research is to be utilized? Is the profession truly prepared for the implications stemming from an accumulation of counsellor-specific data, stored on a central database (Ó Braonáin, 2015, p. 21)? Should an accredited counsellor whose CORE-OM results indicate that their clients show no measurable improvement, or

even demonstrate greater levels of distress at the conclusion of treatment, automatically have their accreditation renewed? A doctor shown to be repeatedly botching operations or failing patients has their licence to practice revoked – why shouldn't the same happen to a counsellor? Would unseemly league tables inevitably result? How will training institutions justify their certification of a counsellor as qualified in circumstances where subsequently acquired data appears to identify that practitioner as ineffective, acting unethically or even causing harm to vulnerable people? Could that data itself be suspect and misleading if a therapist is working in a challenging area with 'at risk' clients? The more collaborative model of the Practice Research Network (PRN) recommended by Margison et al., (2000) may be more acceptable to many counsellors.

Is it not the case that counselling considers science - but is not bound by it; that it evaluates evidence, whilst appreciating the spiritual dimension to life, that it embraces mystery – without needing to reduce the universe to atoms?

Another key question that emerges is that of how counsellors' methods should be informed and guided by evidence? For example, some counsellors might, as part of their conceptualization of the therapeutic process, entertain rather vague and unproven notions such as 'energy' and 'chakras' or concepts from alternative systems such as Reiki healing like 'spiritually guided life force energy'. The author has heard counsellors make highly controversial claims, like being able to "smell trauma in the room" etc. Concepts like 'projection' or 'transference', based upon subjective experience and perception, are seemingly impossible to establish as 'real' phenomena that could be agreed to be actually occurring by all objective observers, yet the therapeutic process in a particular instance might hinge upon such an unverifiable supposition. Without scientifically validated evidence for these ideas, should they be excluded from an evidence-based approach? Despite these obstacles, the effectiveness of specific interventions or Verbal Response Modes (VRMs), defined by De Stefano et al. (2001) as "the actual technical operations or techniques of the therapist" (p. 261) can be studied and measured (Margison et al., 2000, pp. 124-125) and that data can be drawn upon in the delivery of counsellor skills-training.

Evidence-based need not mean evidence-driven

Notwithstanding these problematic questions, there is a strong case to be made for research-led interventions, as Lilienfield (2014) succinctly explains:

> By constraining clinical selections to interventions that at least have some modicum of research support, evidence-based practice increases the chances that clients will receive treatments that work, and decreases the chances that clients will be exposed to interventions that are ineffective or that can cause harm.

However, if psychologists and psychiatrists are purportedly already using research-led interventions, does that mean that counselling should automatically follow? Is it not one of the great strengths of counselling that it is already guided by research, but not *constrained* by it. Sackett et al. (1996) opined that evidence-based medicine entailed "integrating individual clinical expertise with the best available external clinical evidence" (p.71), according primacy to the practitioner's clinical judgment (the issue of the availability of research evidence to counsellors is addressed below). Although this could mean setting aside a statistically indicated approach, 'going against the data' is only EBP if the practitioner is *informed* about research. That does not mean practicing as one would please, in ignorance of research findings. But how often have Éisteach readers heard a client utter words to the effect: "I have seen psychiatrists and psychologists for years, but no one has been able to help me"? In such cases, wasn't it something novel, something creative, something arising from the understanding formed during a genuine relationship that, in the end, helped? Another issue is: how would a revised Code of Ethics that incorporated research findings actually look? Does it suddenly become unethical to utilize an approach to a mental health issue that differs from established 'best practice' and what has been shown to be most frequently effective *for other people*? Recording evidence in a rigorous and systematic way would also mean following uniform guidelines for note-taking. Current IACP guidelines are helpful, yet vague. Would a counsellor, in certain circumstances, be advised to justify in their notes why their interventions are, or are not, sourced in relevant research?

The role of intuition in the counselling process as a factor guiding effective therapeutic intervention also needs to be considered. Many counsellors rely upon their sense of what is 'appropriate' or 'feels right' without being able to directly relate their methods to research. If such spontaneity becomes de-emphasized, does the evidence-

based practitioner inevitably end up performing a role that is already occupied – in other words, could following data prompt the counsellor to work within the parameters of the psychologist? This begs the fundamental question of whether counselling is a science at all. Can it be? It is this author's contention that counselling is by its very nature an art. It is, amongst other things, the art of positive, nurturing, healthy, loving human relating. Is it not the case that counselling considers science - but is not bound by it; that it evaluates evidence, whilst appreciating the spiritual dimension to life, that it embraces mystery – without needing to reduce the universe to atoms? However, this author's admittedly romantic position is somewhat confounded by evidence that shows manualized therapies to be highly effective in specific contexts (Margison et al., 2002, p. 127, citing Crits-Cristoph, 1992).

Rather than the profession seeking to align itself with those who are bound by evidence in relation to categories that are themselves perilously mutable (as the reclassification of particular 'mental health disorders', and proliferation of new ones, in DSM-5 demonstrates), should we not realise that the uniqueness of counselling lies in its relative freedom from evidence-driven thinking, its capacity to tear up the rulebook and examine a problem with fresh eyes? Even in only a few years of professional experience, the author has witnessed terrible damage done to people by prescriptive 'evidence-based practice' within the medical profession - human beings needlessly medicated and wearing the uncomfortable, ill-fitting label of a condition they turned out not to have. And here we encounter the crux of the problem in integrating counselling with the mental health care system – would counsellors not find themselves often taking a totally different perspective from the psychiatrist directing a care plan? The potential for friction instead of harmony is immense and could be terribly destructive to the profession.

And here we encounter the crux of the problem in integrating counselling with the mental health care system – would counsellors not find themselves often taking a totally different perspective from the psychiatrist directing a care plan?

However, in order to secure funding, counselling needs to acquire a more esteemed status in western medicine than alternative therapies like acupuncture. Many GPs are happy to recommend that treatment, without concerning themselves with its premises. The HSE website states that there is "evidence that acupuncture works for a small number of conditions" but warns that "there is little or no scientific evidence that acupuncture works for many of the conditions for which it is often used." Despite this official stance, this author's GP recently recommended this treatment for his back pain. The Treatment, he would have to fund himself. At this point in the analysis, money enters the equation. In order to obtain resources and advance the profession, counselling services have to show that their activities really do help people. Nevertheless, it is clear that rigid forms of Evidence-Based Practice may not be in the best interest of clients. It is this author's belief that the future for counselling is best secured by promoting strategically targeted research whilst maintaining some independence from western psychiatry and its sometimes inflexible procedures, questionable diagnoses, uncertain conclusions and undisclosed financial relationships with pharmaceutical companies (Cosgrove and Krimsky, 2012 & Whitaker and Cosgrove, 2015).

Valuing client-based evidence

At this juncture, a question we must address is what alternative suggestions might ensure quality in the profession? Perhaps Cooper and McLeod's (2007) concept of a pluralistic approach to counselling offers one possible way forward. It is "based on a philosophical and ethical commitment to valuing multiple perspectives, and therefore holds that the client's view on what is helpful and not helpful in therapy is as valid as the therapists [sic]" (p. 11). A model of EBP could be devised that is entirely compatible with a pluralistic approach that respects the autonomy and dignity of the client. (IACP Code of Ethics 1.0 & 1.1.14). When defining clinical expertise and effective decision–making, the APA (2006) lists interpersonal expertise and responsiveness to patient feedback as essential elements (p. 276). Similarly, Sackett at al. (1996, p. 72) advise that any external guideline should be integrated with clinical expertise in deciding "whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied" (p. 72). More recently, Norcross and Lambert (2011) argued that client feedback constitutes a form of evidence that should be esteemed, warning against "therapist centricity" and asserting that the client's contribution to psychotherapy outcomes is greater than is often recognized. The diverse components of a pluralistic EBP are nicely expressed by Cormack (2002) in relation to Sports Therapy, thoughts that transfer well to psychotherapy practice:

> Incorporation of EBP into practice does not mean adopting cookbook practice. Each patient problem

> is a distinct entity. Patients respond to intervention differently based upon the pathology, the course of the problem, the socio-cultural-economic background of the patient, the goals of the patient, and the skill level of the therapist. All of these patient-specific considerations must be combined with research evidence and expertise for the therapist to formulate a decision, in conjunction with the patient, on best care.
>
> (p. 484)

This view is echoed in the APA's recommendation that "clinical decisions should be made in collaboration with the patient on the basis of the best clinically relevant evidence" (2006, p. 280). Building more systematic feedback into client work may help in this regard. However, this model of ethical treatment planning would place a heavy demand on the counsellor, whose responsibility it becomes to be informed about available evidence in any given case. Making research methods and a dissertation component compulsory on training programmes may help to ensure that counsellors have some of the necessary *skills*. However, to mitigate again personal interest bias in the type of research that a particular counsellor will be familiar with, there would need to be some form of annually updated guidebook, containing the systematic reviews of research cautiously advocated by Shlonsky and Mildon (2014). A whole new industry would be needed to complete such a colossal project. The resourcing of this enterprise will only be forthcoming when the already compelling evidence for counselling is propagated through effective lobbying.

Practicalities

When writing the article, this author was unable to make his arguments as evidence-based as he would like. His access to academic journals was restricted by his financial means. Thus, this writer takes issue with the statement by Ó Braonáin (2015, citing McLeod, 2013) that "the publication of research is a reliable and accessible way to share knowledge, and gain new insights, all of which informs practice and can increase the effectiveness of treatment" (p.18). Much research is neither accessible by being affordable, nor by virtue of the manner in which it is written. Should the IACP subscription include library and journal access? How could counsellors be reasonably expected to adopt a truly evidence-based approach in a sphere in which their income is so often limited, not by client demand for counselling, as is often suggested, but by current HSE restrictions privileging a narrow field of counsellors meeting the criteria of "Health and Social Care Professionals" (HSE Counsellor/Therapist (National Services) Grade Code 3028). A fairer system would arguably empower the *patient/client* to choose their own therapist, irrespective of whether or not they hold a first degree in Social Care or a related field. In addition, profit-making corporations currently soak up available resources for the provision of counselling services. In relation to these corporate structures it is significant that in relation to EBP the APA "recognized the risk that guidelines might be used inappropriately by commercial health care organizations not intimately familiar with the scientific basis of practice to dictate specific forms of treatment and restrict patient access to care" (2006, p. 271).

Conclusion

A dubious presumption prevails in this debate, which is that western science is itself stringently evidence-based. Why is evidence that contradicts accepted scientific thinking so often summarily dismissed? Why are anomalous archaeological artefacts simply shelved and hidden away in the darkest corridors of museums (Cremo and Thompson, 1993). Why did Professor Richard Dawkins, celebrated exponent of modern Darwinism, while filming 'The Selfish Gene' in 2007, refuse to even consider Cambridge Professor Rupert Sheldrake's research on psychic phenomenon with the dismissive refrain "extraordinary claims require extraordinary evidence"? A lot can be learned from Sheldrake's response:

> "This depends on what you regard as extraordinary", Sheldrake replied. "Most people say they have experienced telepathy, especially in connection with telephone calls. In that sense, telepathy is ordinary. The claim that most people are deluded about their own experience is extraordinary. Where is the extraordinary evidence for that?"
>
> (Sheldrake, 2016)

In a professional activity that so often invites people to trust in their own experience, evidence from the client's and the therapist's experience must surely be honoured and incorporated into any model of EBP that is to have a reasonable chance of gaining traction. Successful implementation of EBP needs to overcome barriers and include incentives and we still lack the knowledge about how best to proceed (Grol and Wensing, 2004). So, an unavoidable conundrum emerges from the above discussion: either we adopt a *methodologically sound* evidence-based approach and confront all of the issues outlined above, and others not here discussed, or we do not. If we do not, we remain free to cherry-pick according to what we sense is in our client's best interest, harnessing our intellect, our personal knowledge of research, our intuition, our sensory impressions and our clinical experience, at liberty to share

"all expressions and manifestations of that which is alive" in us (Fromm, 1957/1985 p. 19). That can be a fabulous freedom to have – it allows for the full expression of the individual personality of the therapist, but it is one that may, in some instances, let a client down. Clarity and transparency with clients about what we are offering as individuals in relation to EBP is surely an ethical requirement, as the profession finds its way.

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Ramesh Ramsahoye

Prior to commencing his counselling career, Ramesh worked as a tutor and Director of Studies in leading London sixth form colleges for 15 years. He holds a BA (Hons) degree in Art History and Theory, a Masters in History of Art from the Courtauld Institute of Art and a PGCE in Art and Design. Working with young people as a Personal Tutor, a pastoral care role, inspired Ramesh to go into counselling. He obtained his diploma in 2012 and went on to complete a BA (Hons) degree in Integrative Counselling and Psychotherapy at the IICP, Dublin in 2014. He works in a local family resource centre and is currently a Pre-Accredited member of the IACP. Ramesh's research interests include crying in the therapeutic relationship, personal development and the role and power of client and therapist 'presence'.

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Is Bio Energy Therapy a Viable Resource within the Counselling Setting?

by Laureen Taylor

Introduction

This article proposes that the practice of bio energy therapy can add value to a client's process within a counsellor's practice. Additionally, counsellors and psychotherapists are well placed to incorporate bio energy therapy within their practice as they work with clients, and are accountable and professionally trained in standards and code of ethics (IACP Info Sheet No 7). Counselling is a talking therapy that allows clients focus on challenging issues affecting the quality of their life (Fernandez, 2013). However, bio energy therapy has the potential to add another dimension in that it taps into universal energies and accelerates the process of healing and integration on all levels for people (Hunt, 1996). Every counselling and bio energy session is particular to the individual client in their uniqueness; no two sessions are alike. Counselling and bio energy therapy are separate therapies however, the author contends they can be used successfully in conjunction with one another. Furthermore, bio energy therapy is a holistic non-invasive therapy which works to create emotional, mental and physical harmony (Hunt, 2008).

Background

Historical records document energy healing over 3,500 years ago. "Pyrenees' cave paintings from 15,000 years ago and ancient Egypt rock carvings from 2,700 BC show laying on of hands helping the sick" (Dossey and Keegan, 2015 p.190). Ebers papyrus writings from 1,552 BC describe hands on healing, while Eastern healers have studied the human energy system for thousands of years and have mapped out its structure in great detail (Bryan, 1930). Bio energy therapy does not contravene any personal religious beliefs, because it is not based on any religion but on the existence of energies within and outside the body which have been proven to exist (Lipton, 2005; Anando, 2014).

Energy Perspective

From an energy perspective, all life forms, including human beings, are made up of layers of vibrating energy, each with their own specific vibration (Brennan, 1998). What quantum physics has shown is that everything is composed of energy, including ourselves (Griffin and Bent, 2015). At the quantum

level, everything that exists in the universe is vibrating at different rates. These vibrations are carried through the field in small packages, quanta, which appear to us as particles (Joint Quantum Institute, 2013).

Patterson (1998) contends that we are all part of the natural harmonious energy of the universe. Within this universal energy field is a human energy field that is intimately involved with human life, often called the aura (Peterson, 1998). Wikipedia (2016) states that Kirlian photography is a photographic technique that involves shooting a high voltage charge through an object that is connected to a photographic plate. The resulting image typically includes a coloured aura around the object. Kirlian photography is often cited as evidence for the existence of energy fields unique to living things (Patterson, 1988). Patterson (1988) contends that the seven layers within an aura, each with its own colour, have been recorded using Kirlian photography. One of the reasons for the change in outlook on bio energy therapy is that sensitive instruments have been developed that can detect the minute energy fields around the human body (Benor, 2004).

The physical body consists of energy that vibrates very slowly, which is why it appears to our physical eyes to be solid. Our energy systems surround us, are inside of us, and penetrate us completely.

These include

- Our aura which surrounds us and penetrates our physical body
- Our chakra system that allows the universal energy to flow through us
- The meridian system, a system of energy channels within us through which all energy moves throughout our body.

Brennan (1998)

What is bio energy?

When we speak about energy that is vibrating within and around the human body we call it Bio Energy (Nikolic, 2006). This flow of energy within the human body is generally continuous and smooth. When an imbalance takes place the flow of energy is agitated, often leading to a blockage. This can allow disease, ill-health and emotional blockages to manifest. Bio energy therapists are trained in techniques which are designed to effect change in the energetic body, which can create change in the physical body (Nikolic, 2006). Therapists are trained to become sensitive to feeling these blockages and through using a series of hand movements they work to release the blocked energy (Nikolic, 2006). That technique improves impaired energy flow thus allowing the body and emotions to balance naturally. We are unaware of what issues we are carrying at an unconscious level. However, bio energy therapy works on the surface first, but goes deeper over time, like peeling layers of an onion (Hunt, 2008). Bio energy therapy helps us maintain our energetic health and physical, emotional, and mental balance (Nudel and Nudel, 2000).

Energy flows through our bodies in much the same way as water flows through a hose. Physical and emotional trauma, some of which we don't even realise we carry, can disrupt the flow of energy the same way a break, bend, or clog in a hose can interrupt the flow of water. Energy flow can be disrupted in many ways; it can be blocked, out of balance, split, undercharged, stagnant, torn or held (Hunt, 2008). When this happens disease can result which may manifest in the physical body in many forms.

Hurwitz (2001) contends that energy based therapeutic techniques move energy through and around the human body. Every individual is surrounded by an energy field and their energy field is dynamic, it moves and flows (Hurwitz, 2001). Furthermore, the energy field can be perceived and the ability to perceive energy is a learnable skill. Disorder or an imbalance of one's energy field is associated with disease. Hurwitz (2001) also contends that orderly re-patterning of one's energy field restores balance, creating an improved environment in which healing can occur. One's energy field exists within a universal energy field and that the client and the practitioner are not separate but are interconnected and integral with the universal energy field (Hurwitz, 2001).

Touch Therapy

Bio energy therapy is non-invasive, with minimal physical contact and can be administered without touch (Benor, 2004). Clients remain fully clothed with the exception of their shoes. Guidelines exist with regard to physical touch between client and therapist, ensuring client safety (Ethical Framework, 2002). Guidelines to do with

touch, however, are not clear-cut matters of right and wrong. Some therapists do not touch clients while some would advocate it has a place within the therapeutic relationship. For many clients "touch can be a powerful tool for increasing awareness; overcoming resistance and rigid defences; and mastering the developmental phases of attachment, dependence and trust" (Smith et al. 1998).

What are people likely to feel during a bio energy session?

Usually clients will feel warmth, maybe a tingling sensation, and for some they can feel cold. The majority of clients will feel completely relaxed and will go into what some people described as a peaceful state. Bio energy therapy goes to wherever it's needed. Everyone is different so the experience is not the same for everyone (Griffin and Bent, 2015).

Boundaries, Standards & Ethics

A boundary is an edge or limit that defines a person as separate from others and is the framework within which the therapist/client relationship occurs (Katherine, 2000). "Codes are written in fairly general and abstract terms in order to condense the experience and thinking behind them and to make them as widely applicable to a variety of circumstances as possible" (Bond, 1993 p.44).

According to the Irish Association of Counselling and Psychotherapy (IACP) the purpose of the Code of Ethics (2005) is to encourage optimum levels of practice, to establish and maintain ethical standards, and to inform and protect those who seek and use the services of practitioners. Counsellors and psychotherapists apply appropriate boundaries within the counselling relationship in order to provide safety for the clients and counsellors. Counsellors and psychotherapists are best placed to incorporate bio energy therapy within a counselling setting as they continually monitor the boundaries in their relationships with clients and can act as role models, providing important value for those who have inappropriate boundaries.

Self-Care

Wellness is one of the critical factors in being a healthy counsellor and bio energy therapist. The helping professional, who is aware that compassion fatigue and burnout are givens in the therapeutic work, is well placed to recognize and respond effectively when they experience the impact of these stressors (Sanders, 2011). Ultimately, self-care for all helping professionals is crucial so that they can continue to meet the needs of their respective clients with maximum effectiveness.

Self-care is an ethical requirement for both the counsellor and bio energy therapist. Self-care is covered in the code of ethics clause 4.1 of the IACP code of ethics and practice information sheet 7 (2005). The ethics code advocates engaging in self-care activities in order to avoid burnout which could result in impaired judgment and to avoid harming others.

A valuable resource for the author's self-care regime is to engage in regular bio energy sessions. From the author's personal experience, counsellors and clients who have undertaken bio energy sessions typically report a better quality of sleep, a clear mind and improved focus, increased self-confidence, a reduction of stress and anxiety, acceleration of healing and relief or elimination of emotional and physical pain. Also reported was a greater clarity of their own issues in a non-threatening way, a strong sense of peace, well-being and improved health.

Sanders (2011) contends counsellors need to be aware of the emotional demands of the work and when they are feeling overwhelmed it may lead to burnout. Anecdotal evidence suggests that counsellors who have experienced bio energy sessions reported working well with their clients and were better able to meet the demands of the work. Nudel and Nudel (2000) contend that having bio energy therapy sessions are just as important to our self-care as eating healthy, exercising and getting enough rest.

Bio Energy Therapy Complements Counselling

Bio energy therapy and counselling are two distinct modalities and can be used in conjunction with one another. A session of bio energy can successfully be administered for twenty minutes (Griffin, and Bent, 2015) and could therefore form part of a counselling session. The author contends that counselling and bio energy therapy is a very personal, private and confidential process for each individual client. Maintaining a professional attitude throughout the process enables the counsellor

and bio energy therapist to assist the client, to the best of their ability.

There is a realization in the current challenging times that our emotions can affect our health (Hunt, 2008). Humans experience an array of emotions, anything from happiness to sadness to extreme joy and depression. Emotional well-being and mental health concerns are major health issues in their own right and can contribute to a host of physical ailments including sleep disturbances and lack of energy (Barry, 2012). Through the releasing of negative emotions and negative thoughts we can allow ourselves to heal. Clients who have experienced bio energy sessions reported their physical and emotional pains were eliminated or reduced (Griffin and Bent, 2015).

Within a counselling and psychotherapy session, a client's negative thoughts and belief patterns can emerge (Sanders, 2011). This new awareness may leave some clients with feelings of depression, sadness, grief or anger. Bio energy therapy assists clients in releasing expressed or unexpressed emotions and blockages that are uncovered using bio energy techniques resulting in a positive sense of relief for clients which in turn allows them to realise and fulfil their true potential (Griffin and Bent, 2015).

Guilt, worry and fear are common emotions for all (Sanders, 2011). Sanders (2011) contends that these emotions can be challenged to enable us to be more present, authentic and ultimately more content. By facing the things we fear in life we become stronger. Knowing what is holding us back and why, may be important. However, this information is useless if we do not act upon it. Counsellors encourage clients to rely on their own resources and inner power (Sanders, 2011). In a bio energy sessions this source of inner power and strength is tapped allowing new awareness and understanding for the client (Nikolic, 2006). This new knowledge can help clients to take responsibility and actively implement positive changes in their life.

Self-Awareness

The Oxford English dictionary describes self-awareness as conscious knowledge of one's own character, feelings, motives and desires (Allen, 1990). Self-awareness for counsellors and bio energy therapists is valued because it involves continued learning and personal development. When we have bio energy sessions we move beyond the usual drama and fears in life and gain a new understanding of ourselves (Benor, 2004).

Bio energy aids people in gaining insightful self-awareness which supports them in making major adjustments in their life (Benor, 2004). People who have experienced bio energy session speak about what they can only describe as having a light bulb moment (Benor, 2004). For example, they describe this as having gained some insightful self-awareness which made perfect sense to them as to how and why they were sabotaging themselves by continually behaving and repeating the same patterns over and over again (Benor, 2004).

One client stated they worried for years about what other people thought of them and how they worked hard on all their relationships, always worried and turning things over in their mind whether people really liked them. While having a bio energy session they had an insightful self-awareness, that is, they had to like themselves first (Benor, 2004).

Conclusion

The author is a counsellor and bio energy therapist and proposes that incorporating bio energy therapy as part of a counselling session can be an effective and invaluable intervention for both client and counsellor. The author and founder of bio energy therapy training Ireland regularly receives positive feedback from clients telling of how well they feel and are better able to meet the demands of life.

Counselling and psychotherapy help increase a deeper understanding for clients on personal, painful and difficult issues. Careful listening is the largest part of what all counsellors do (Sanders, 2011). They ensure clients have clarified the issues in their own terms and help them define what they wish to do next. Some counsellors are more active, working with client's goals towards resolution of their issues. While others use less interventions and work at the client's pace. Bio energy therapy is a therapy which comprises specific knowledge, skills and techniques. Bio energy therapy helps individuals move beyond their emotional issues, accelerates healing and relief or elimination of pain (Nudel and Nudel, 2000).

Bio energy therapy is now being studied systematically under rigorous research conditions (Hunt, 1996). Gradually this therapy will be integrated into other practices. Research on bio energy therapy can lead to much more complete understanding of clients' issues and healing. The author proposes that using bio energy therapy in conjunction with counselling can contribute to effective changes for clients within the counselling process. This article aims to raise awareness around the effective use of bio energy therapy with clients. It also hopes to open up a discussion for its inclusion within the counselling and psychotherapy framework.

In summary, counsellors, psychotherapists and bio energy therapists work to the same agenda that is to support their clients in working through their processes in order to improve the quality of their life.

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Dream to Live not Live to Dream.

by Michael O'Shea PhD

Introduction

The general thrust of this discussion lies with the concept of 'dream'. The 'dream' referred to incorporates a positive vision of self together with an optimistic image of what is possible for the future. The effects of absence of 'dream,' which may culminate from a negative self-image will be explored. The significance of 'dream' as a conduit for positive life change will also be discussed. Reference will be made to the absence of 'dream', which, in the view of this writer, results in a fatalistic, helpless vision of self and life. Life then becomes a tragedy; a combination of loss of self and missed opportunities.

The Concept of 'Dream'

August 28th 1963, standing on the steps of the Lincoln memorial in Washington DC, Martin Luther King delivered his 'I have a dream' speech to over two hundred and fifty thousand civil rights activists. Whilst this speech epitomised the quest for equality for the African-American population, it also provided listeners with a vision for the future. The 'dream' that King spoke of was one which was free of the racist bigoted society which was ingrained in much of American culture at that time. King's 'dream' prophesised an alternative life standard within which equality and mutual respect for all would become embedded in a new social order. Who then would have considered the possibility of an African-American President in the White House which is located only a short distance away from where King stood that August day to deliver his iconic speech. The 'dream', as visualised by King, became a foundation stone which underpinned a more inclusive and equal social structure. What resulted was the uplifting of black people to some positions of power and authority even extending to the highest office in the county, that of President of the United States. The 'dream' can come true and has come true for some.

Like King, Brazilian educationalist Paulo Freire noted that social transformation begins with the 'dream' of something more than that which the predominant social structures currently offer (Freire, 1999, pg126). During the 1950s' and 1960s; Freire held the post of Director of the Department of Education and Culture of the Social Service in the State of Pernambuco, Brazil. He was very touched by the suffering of the poor with whom he came into contact. His subsequent educational programmes aimed at reaching out to and communicating with the more socially deprived. Freire was of the view that personal transition can be considered a vision or 'dream' of what is possible beyond one's present life circumstance. However, the 'dream' should not be simply interpreted as a form of escapism. Instead, 'dream' becomes an initial phase in the struggle to re-create one's personal world. It has been suggested that such a dream is impossible without some form of hope (Freire, 1999, pg91). For Freire, the hope of something better to come provided the oppressed with the necessary determination to persevere in the cause for personal transformation (1998b, pg35). As a result, he rejected any form of fatalism. According to Freire (1998b), one common feature

that germinates among people in desperate situations is the lack of hope. In fact, he described such fatalistic tendencies as an 'existential weariness' (Freire, 1998b). Individuals' harbouring fatalistic attitudes believe that their future has already been predetermined. Freire observed that, in every desperate situation, there dwells the possibility of hope even if the possibility of advancement, escape or achievement is obscured by current life circumstances (Freire 1998b, pg41). In fact, he was of the view that hope exists as a natural requirement for human beings (Freire 1998b, pg44).

Nevertheless, the notion of hope does not imply that change has already taken place. Instead, hope offers the possibility for change in the future. Rather than focus one's attention on one's desperate situation, it has been suggested that one should adopt a position of 'critical optimism' (Freire 1998b, pg58). 'Critical optimism' can be described as a rational appraisal of one's current life circumstance together with a realistic vision for future positive change (Freire 1998b). To uphold a positive outlook in life implies that one is prepared to engage in the process of personal transition. A realistic vision of what may be possible separates 'dream' from fantasy. Freire theorised that such questioning and examining the variety of possible answers provides more avenues towards further curiosity-generated exploration (Freire 1998b, pg31). Throughout this procedure, the individual gradually begins to reflect upon his/her 'cultural reality' (Freire 1998b). In fact, Freire observed that this form of personal reflection opens the door to a new outlook in life and thus, occupies much of the client's process within the therapeutic forum (1986, pg17). To remove the psychological and emotional obstructions which impede the living of 'dream' may be one goal of therapy insofar as 'dream' is constructive to the client's self-concept. Furthermore, the essence of 'dream' is only purposeful insofar as the quest pertains to concrete life situations (Freire, 1999, pg126). Otherwise, 'dream' remains a hypothesis or fantasy.

'Dream', as understood for the purpose of this particular discussion, is the 'dream' of something other than one's current life situation. This 'dream' requires that one remain wide awake to one's present life circumstance and to one's own self-concept. In other words, a level of self-awareness and honesty with oneself is necessary if one is to vision some positive transformation for the future. For Freire, '*conscientisation*' involved the deepening of one's awareness to the reality of the situation within which one exists. The gradual process of '*conscientisation*' involves a progressive movement from maintaining a naïve consciousness to a more critical awareness (Freire 1986, pg81). A person '*conscientised*' will obtain the ability to distinguish myth and fallacy from social reality (Freire 1998b, pg48). '*Conscientisation*' evolves, therefore, through addressing real issues that offer an alternative to the blind acceptance of psychological manipulations or ideological propaganda (Freire, 1974, pg48). The process of '*conscientisation*' is considered more than just the identification of dehumanising structures existing within one's world. It also involves a radical denunciation of dehumanising structures accompanied by the proclamation of a more positive life structure (Freire, 1985, pg85). Furthermore, positive transformation cannot be handed to an individual on a silver platter. The individual is required to partake in the re-shaping of his/her own world. Only then is he/she free to be autonomous. Take the case, for example, of a client who is in an abusive relationship. A client conscientised has attained a new level of awareness and will not only begin to see the relationship as not-normal but will actively begin to refute the abuse as part of normal living. Through a process of therapy, the client will gradually begin to mould a new life and possibly live the 'dream' never thought likely. The therapist is not a rescuer in this process.

Ironically, Russian novelist Fyodor Dostoyevsky observed that an enlightened society is a society enslaved (1972, pg53). Within such a society, traditional cultural values and supports are replaced by radicalism, a reduced sense of community, an emphasis on industrialisation and increased productivity targets, together with a heavy reliance on scientific discovery to explain the essence of being. In such a world, the masses succumb to the 'dream' of the entrepreneur and the individual searches for self-worth and purpose (Dostoyevsky 1972, pg86). To be a slave is to give up one's free will, whereby some people over-indulge in order to escape from unhappy lifestyles (Dostoyevsky 1972, pg90). This observation could be construed so as to imply that increased drug use and other addictive activities constitute a means of escape

'Dream', as understood for the purpose of this particular discussion, is the 'dream' of something other than one's current life situation.

from a purposeless existence. Within such a culture, a person is not given the freedom to pursue dreams and act upon intuitions. Instead, a person without will or desire becomes just a small part in a bigger machine (Dostoyevsky 1972, pg34). Self-worth comes from what others think of you or by your income. Society is very unforgiving and never allows an individual to bury his/her past (Dostoyevsky 1972, pg99). The concern which remains is whether significant purpose in life is to be brought to awareness or do we simply exist as slaves to life circumstances (Dostoyevsky 1972, pg90). In other words, to be human is to choose who we are and how we respond to life circumstances.

Implicit to this debate lies the distinction between 'dream' and fantasy. Critical to the concept of 'dream' are visions and goals which are both tangible and obtainable (Freire, 1999, pg126). Dream' becomes fantasy when expectations and ambitions are non-realistic or irrational. In short, fantasy could be described as a form of escapism whereby, the individual chooses to live in a world removed from reality. Freire observed that a person with a 'dream' is ready to take action to achieve the dream (1999). In contrast, a person who experiences fantasy is not ready to undertake such proactive measures and, as a result, displays a resignation to his/ her current life situation. Indeed, fantasy could be considered a form of escapism and, subsequently, a removal of the self from reality. Instead, 'dream' provides one with a vision of an alternative life situation which is both obtainable and tangible in the real world. In short, 'dream' provides a blueprint for personal achievement, motivation and direction (Freire, 1986, pg20). In addition, the pursuit of a life 'dream' may also provide the essential ingredient for finding meaning in life. For instance, one's purpose in life may be focussed on family or on one's chosen vocational path suggesting that the 'dream' becomes the foundation stone for discovering one's life plan and purpose. It may be argued, therefore, that 'dream' and individual purpose are closely intertwined. It is for this reason that 'dream', that is, the quest for purpose, is essential to life and marks a point of demarcation between living and existing.

In contrast, a person who experiences fantasy is not ready to undertake such proactive measures and, as a result, displays a resignation to his/ her current life situation. Indeed, fantasy could be considered a form of escapism and, subsequently, a removal of the self from reality.

The absence of hope thus resulting in the non-existence of 'dream' therefore, is considered the antithesis to the quest for personal achievement. Dostoyevsky (1972, pg74) once observed that lack of achievement was closely associated with lack of self-confidence. Describing life as a 'tragedy', Dostoyevsky suggested that a person without a 'dream' sits by and watches the world pass by while those actively participating in worldly affairs progress. As transition takes place, a person without 'dream' remains stagnant and in a condition of stalemate. The world stops for the person with no 'dream'. Such a person feels worthless and of no consequence (Dostoyevsky 1972, pg43). A life without 'dream' is a life resigned to the impossibility of hope. In short, the absence of 'dream' may constitute a fatalistic view of life and of oneself. Dostoyevsky highlighted the plight of one individual who is so critical of his surrounding social constructs he removes himself from society. To live in 'the underground' suggests that one can create one's own world and remain there alone. One may remain lord and master in one's own world (Dostoyevsky 1972). The opening lines 'I am a sick man, I am an angry man, I am an unattractive man' sets the tone for the whole story (Dostoyevsky 1972, pg17). The subject remains pessimistic in that he is what he is and he cannot be changed. Despair, he stated, is 'to be conscious of the hopelessness of one's situation.' As a result, one remains powerless to escape from one's preconceived or predetermined life situation (Dostoyevsky 1972, pg22).

In contrast, existentialist Viktor Frankl spoke of 'learned meaninglessness' that can only be described as a learned nihilistic view of one's own self-worth (1984, pg177). Frankl, a Jewish psychiatrist, witnessed the effects of purposeless life on those incarcerated in Auschwitz (1984). He was of the view that, despite his/her life situation, each individual can find a purpose to live. The potential for danger arises when an individual places his/ her life's meaning within oneself only to discover that "oneself" has been devalued in some way (Frankl 1984, pg17). Frankl was of the view that it is critical to dedicate one's efforts in life to a greater cause than oneself during those difficult moments in life. He advocated a policy whereby, the client in therapy could find potential meaning within the existential realities of his/her own personal existence. In contrast to a meaningful life, there exists despair, a state of existential distress, in other words a sense of self-worthlessness

Through the therapeutic process, the individual may become more enabled to act freely and responsibly. Freedom, in this context, is liberation from the shackles of past negative conditioning agents towards self-emancipation.

(Frankl 1984, pg25). Frankl invoked the term '*existential vacuum*' to describe life that is meaningless (1984, pg28-29). Vacuum suggests emptiness whereby, the individual may resort to other superficial modes of escape such as drugs or alcohol. One classic example of such meaninglessness is when an individual lacks the free will to choose for oneself and spends his/her life conforming to what others want. In this case, the individual experiences inner emptiness that results in a 'will to money', 'a will to power' or sheer boredom (Frankl 1984). The search for meaning in life is a journey of self- discovery as meaning can only be discovered, it cannot be invented (Frankl 2000, pg113). Given the fact that the search for meaning in life involves some soul-searching on the part of the individual, no one person can freely hand out meaning to another. Each individual is responsible for finding his/her own meaning for life's journey (Frankl 1984, pg119). The search for meaning allows the individual move from 'what is' to 'what can be'. One must hold out some possibility of hope for the future rather than submit to what otherwise would become a hopeless situation. Meaning in life must be realistic. Meaning in life built upon false hopes is inadvisable for it can result in total despair (Frankl, 1986, pg99).

Frankl's interest lay very much in our freedom to choose our response to the situations we find ourselves in. Given the fact that we may find ourselves plunged into life and death or life-changing situations, the therapeutic process often helps individuals to recognise that they are not always mere victims of circumstance (Corey 2001, pg143). To some extent, we are whom we choose to be in any given circumstance. Rather than submit to external forces and thereby, remain passive victims of circumstance, the aim of therapy is to empower clients to direct the course of their lives (Corey 2001, pg145).

Individual 'Dream' and the Therapist:

'Hold fast to dreams, for if dreams die, life is a broken-winged bird that cannot fly'.

Langston Hughes

Consider this hypothetical case; a client presents himself/herself despairing over what he/she feels is a life lacking purpose and fulfilment. Two possible scenarios arise. Firstly, the client is experiencing the absence of 'dream', the possibility of something more and is thus caught in a fatalistic view of life. The expression 'This is my lot in life' offers no hope of improvement which often results in a grave sense of despair and resignation. Freire noted that the apparent absence of hope becomes more noticeable in times of social struggle (1998b, pg42). Deborah Condon (2011) suggested that the psychological impact of recession is 'severe'. Those who are unemployed are two to three times more likely to die by suicide. Unemployment increases the risk of depression insofar as an individual measures his/her self-worth in terms of vocational and financial security (Condon 2011). As a result of recession, the inevitable rise in suicide rates become evident as experienced during the recent economic downturn. Another possible scenario is that the 'dream' is unachievable in the eyes of the subject. A number of issues have already been discussed concerning the necessity of 'dream' in life and the importance of 'dream' being both obtainable and tangible. To achieve 'dream' is significant to the therapeutic process so long as 'dream' is rational and achievable.

The second possibility is that the client is aware of 'dream' but lacks confidence or visualisation to pursue 'dream'. Frankl observed that human freedom is not necessarily 'freedom from' but 'freedom to' (1986, pg52). Freedom is freedom to be something else, we need not be totally conditioned by background, origins or circumstances (Frankl 1986, 79). In other words, life need not be totally conditioned by past experience but can remain open to the possibility of new experience brought to awareness by 'dream'. One noteworthy objective of therapy, therefore, is to empower the client to transform 'dream' into living meaningful reality. Frankl was of the view that '*Tragic Optimism*' is the ability to 'Say yes to life despite everything' (1984, pg161). Through the therapeutic process, the individual may become more enabled to act freely and responsibly. Freedom, in this context, is liberation from the shackles of past negative conditioning agents towards self-emancipation. In short, Corey is of the view that therapy attempts to help the client escape form a '*Restricted Existence*:' to develop new values, habits and insights for a more fulfilled existence (2001, pg143). While much emphasis is placed on past or childhood experiences in order to understand the present, to fully understand the present helps the individual to reshape his/her future.

For Frankl, humanity is not only 'Is' but principally what the person decides 'What/Who he/she is' may be unclear (1986, pg21). In any situation, the last freedom one has is the freedom to choose one's attitudes and human life has the potential to hold meaning in any situation. Frankl's vision of therapy is very much future orientated and looks at what life can hold for the future (2000, pg114). While the human condition is essentially involuntarily fashioned by past experience, therapy, with its emphasis on future, also tries to deconstruct the anomalies and possible misjudgements of the past. Responsibility subsequently remains with the individual to re-shape, re-invent or re-construct his/her self-concept and life experience. Frankl was of the view that neurosis is often the product of 'existential frustration' which itself is caused by absence of meaning (1984, pg123). While 'dream' and meaning in life are closely associated, absence of meaning, thus, absence of 'dream' may fabricate certain neuroses such as fatalism, fanaticism, fear of responsibility or collective thinking as opposed to self-responsibility (Boeree, 2006). Frankl was of the view that lying to the soul by the sheer search for pleasure or superficial meaning often results in a neurosis or illness of the soul (Frankl 2000). It stands to reason, therefore, that a healthy soul constitutes a more positive self-concept together with a more constructive vision of one's place and purpose in the world.

Conclusion:

King's 'dream' of a more integrated society is not necessarily actualised in all aspects of life in the USA. Nevertheless, the speech in itself draws attention to the fact that individual transformation often begins with a 'dream'. When contextualised in this manner, 'dream' becomes a starting-point for something new and something more from life. Therapists are continually engaging with clients whose lives appear to them to be aimless, without purpose or direction. Those seeking therapy may harbour some form of 'dream' of something more for the future. Pragmatic, psychological or emotional obstructions may hinder the client in his/her quest for a new life. Others may be accepting their current life situations with a fatalistic or despairing mind-set. Therapy, as a healing process, can endeavour to enable the client to discover his/her intrinsic meaning in life and pursue that 'dream' which is integral to meaning. In short, the soul, the essence of being, often scarred by life experiences, thus becomes the focal point for self-healing and personal transformation. The soul, the spring from which 'dream', comes to life, 'dream' the keystone to meaning, meaning or life-purpose root of life-fulfilment. The challenge for the therapist, nevertheless, is to work with that client who says 'Dear Therapist, I have no dream' to develop some level of self-empowerment in order to effect change and live the 'dream'.

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Michael O'Shea PhD

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Let's Make Friends with the DSM

by Dr Denise Mullen

Introduction

There is a very hefty, intimidating sounding book out there that can make all the difference to your professional life. You might not have encountered it while working on your course, or you may have a passing knowledge of what it offers. But nearly all of us can afford to know this book more thoroughly. It is the Diagnostic and Statistical Manual of Disorders, recognized as the Bible of the psychology world (APA, 2013).

From travelling throughout Ireland these past few years, doing workshops and interacting with a variety of psychotherapists, counsellors and social workers, my hunch is that a wide range of potential clients are being encountered and then lost, largely because of a lack of clear knowledge of how to diagnose properly.

I have heard various reasons why people are reluctant to make use of the DSM; they feel it labels people, or perhaps they practice from a Rogerian perspective and the disorders described by the DSM fall outside their scope… But don't the people coming to our practice expect us to have a wide base of knowledge? We don't need to treat everybody, but we do need to know what they are presenting so that we can clearly define their need and give them the best possible referral. Additionally, if we want to be on board with our psychotherapy and counsellor peers in the EU and the US, then we need to embrace the DSM.

Recently my car broke down on the road, with white smoke billowing out of the exhaust. The man who towed it to the mechanic was certain that I had put petrol in the tank of a diesel engine. He was adamant that the smoke coming from the exhaust pipe could only result from the wrong fuel entering the tank. That is what he told the mechanic, who then spent several days testing fuels and trying to assess the damage done to the vehicle. He also ran a diagnostic test which immediately told him that the problem was a valve in the emission system, not fuel. But because the tow driver was so certain, he continued to test the fuel for contamination. I paid for several days of labour, lost the use of the car for a week and worried ceaselessly that I had ruined the car. When the diagnostic test proved correct, the part was ordered and the car fixed and returned with apologies for the several hundred Euros and time it had cost. Without be-labouring this further, we need the diagnostic equipment (in our case the DSM) in order to assess accurately the presenting issues.

We were probably drawn to the discipline of psychotherapy by a wish to find answers to life's difficulties and a desire to understand familial issues and address our own injuries. Most of us like the pursuit of

knowledge and enjoy the process of learning. If we've stuck it out long enough to earn a diploma and become accredited, then we must have a fair amount of stamina and perseverance. We have encountered difficult client issues and endured some very unusual circumstances that many people couldn't begin to relate to. The groundwork, therefore, is already laid; we have the mental chops, the courage and the curiosity required to be in this field and so are in a good position to take it to the next level.

We have at our fingertips the collective work and knowledge of hundreds of predecessors (Regier, 2009); they've done so much of the hard work for us. We simply need to familiarize ourselves with the material. Have you ever wondered about the clinical differences between distortions, delusion and psychosis? They are clearly defined in the DSM. Have you puzzled over how to distinguish between peculiar traits in a client and a full blown Personality Disorder? Through years of debate in committees and round table discussions, these important differences have been clarified in the DSM (Szalavitz, 2013). During the early years it mirrored primarily a Freudian perspective; over time the committees moved to encompass more of a medical model. They've done the work of removing a judgemental tone and derogatory descriptions which originally peppered the terminology.

History

The beginnings of the DSM date back to the 1840s when a census was taken in the US and attempts were made to collect data on mental illness: then broadly termed idiocy and insanity (Tartakovsky, 2011). Through many iterations the US Bureau of the Census continued to gather statistics and attempted to define the categories of mental disorders. By 1942 there had been 10 editions, but there was still a need for a classification that minimized the confusion between the various diagnostic systems of the day. From a two word description (idiocy and insanity) in 1840 up to 1952 when the 1st edition of the DSM was published, there were 106 disorders defined – in those days with a psychoanalytic slant. With each new edition of the DSM there has been an increase in the number of disorders, and the clarity of descriptions and criteria needed to define them.

By 1980 when the DSM-III was published there was a huge shift away from a psychodynamic orientation and a movement toward empiricism (specific data proved by observation or experiment) (APA, 2016).

The DSM identifies traits and lists specific criteria needed to diagnose accurately the individuals we have coming to see us. It is not a subjective rendering; neither is it solution oriented. It largely spells out what we are looking at and is our best source of help in sorting pathology in order to unlock, manage, and understand what we are encountering. In the most recent edition: DSM-5, there is a new inclusion of "tools and techniques to enhance the clinical decision-making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study" (Ferranti, 2013).

However, because the list of traits can be so daunting and many of the words so off-putting, many people are reluctant to dig in deeply and make practical use of it. The truth is, it is an essential tool for moving forward professionally, especially since so many psychotherapists have not had instruction courses on working with personality disorders. If only to define our true scope of practice, in order to know when we should refer a client, we need a working knowledge of the DSM. Otherwise we could find ourselves operating from a vague grasp of a few terms, throwing around diagnostic labels such as "narcissist," "borderline," and "psychotic," inaccurately and unhelpfully, if not dangerously. Traits described within the diagnostic category, such as entitled, lacking empathy, grandiosity, dissociative, abandonment issues, impulsivity, etc., could be used without knowing where they fit. A similar analogy would be that of an engineer attempting to construct a bridge without the benefit of carefully drawn blueprints. Scary to think of crossing the river on that bridge!

With the advent of the internet, some lay people are outdistancing counsellors and psychotherapists as they look online and search out the criteria. Just this week I received an email from a family member of a client I had yet to meet and they said the individual met 8 of the criteria for borderline personality disorder and I ought to be made aware of this. Another situation comes

to mind, from the early days of my training. I was working as a Psychological Assistant (a pre-licensed Psychology student, while completing my PsyD), in a psychiatric hospital in Southern California. A woman was assigned to me with a disorder I had only encountered in a classroom setting: trichotillomania (APA, 2013). I could barely pronounce it, let alone cope with her needs and underlying causes. She was hospitalized because of the extreme nature of her condition. Nearly all her hair follicles from the neck down were destroyed from her incessant plucking with tweezers. She had nowhere left to pluck except her eyebrows and scalp and had already damaged much of the hair on the back of her head. The first source I turned to was the DSM, which grounded me and led me to a number of questions to ask her. This gave us a beginning point; she felt I had a basic grasp of her condition as the DSM indicated specific tendencies. This led to an uncovering of the genesis of her disorder, which built a relationship between us. I ended up seeing her for over a year after she left the hospital. She made significant progress and began to deal more openly with the extreme anxiety that led to such an expression of her desperation.

So, this is an invitation to you to become the expert, to overcome any areas of confusion and insecurity about the various mental disorders and become close friends with the book that can make a great difference in your measure of confidence: The Diagnostic & Statistical Manual of Disorders. You can buy it online, new or used. Because the criteria change minimally from one revision to the next, it is nearly as useful to buy a used copy of an old edition and do the homework on what has changed. You can also find the DSM online at www.psychiatryonline.org. If the book looks huge, imposing and scary to wade through... then don't. Look at what you specifically need: is it a clear definition of depression or adjustment disorder, or exactly what constitutes a diagnosis of narcissistic personality disorder? Casually look at the descriptive portion, allow room for the stuffy sounding words and keep going. Then look at the list of criteria and, more importantly, how many need to be ticked in order to warrant the diagnosis? Then take a client that you feel meets a lot of the criteria and carefully attempt to match their specifics with the listed descriptions. This practical, do-able exercise will teach you a great deal in a short period of time. There is also the option of attending the workshop I will give in September in Dublin for the IACP. It will be a full day on the use of the DSM, using an interactive and creative approach that will keep people engaged throughout. However you decide, whatever is best for your style, I hope you will crack the cover of that marvellous volume and discover a world of help in your chosen profession.

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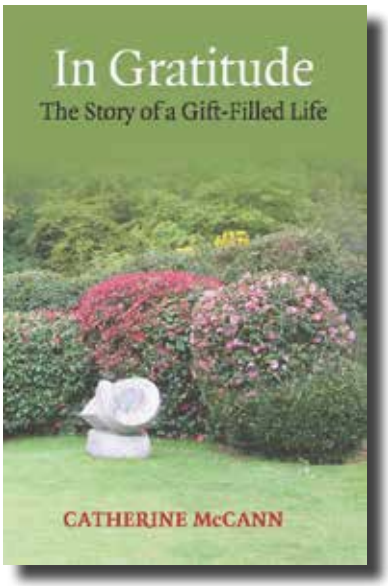
Dr Denise Mullen

Dr Denise Mullen (PsyD, MIACP) is a consultant psychologist with experience in a wide range of settings including individual and group therapy, in-patient psychiatric care, university lecturing and workshop presentations. She has studied extensively in the areas of attachment theory, psychodynamic and object relations theories as well as developmental psychology. With 26 years combined clinical practice experience in both California and Ireland, she is known for bringing compassion and wisdom to each situation she is involved with.

Book Review

Title:	*In Gratitude: The Story of a Gift-Filled Life*
Author:	Catherine McCann
Published:	2015
ISBN:	978-1-909895-76-8
Reviewed by:	Anne Doyle MIACP

At the time of writing this book, the author Catherine McCann is in her eightieth year. This is her autobiography, interwoven with reflections on her inner journey and the themes of service, friendship, lifelong growth, and gratitude for her faith as a consistent source of strength in her life. She also provides some fascinating insights into two very different worlds. One is that of a large family home in the suburbs of Dublin in the 1930s and 1940s, with indoor and outdoor staff where 'everyone involved was somehow making the enterprise work'. The second is the world of the religious congregation of the Irish Sisters of Charity, from the 1950s to the 1970s.



In telling her story, the author shares the 'opportunities that were open to me and the gifted life I have experienced'. She describes the doors that appeared to open before her at different stages of her life, and the learning and growth she gained through those experiences.

She was open to these opportunities for growth, and so continued her life of service to God and to humanity in her individual way. I found myself feeling curious to find out what she was going to do next, as no endeavour seemed beyond her. The author shares how learning through experience helped prepare her for later challenges. For example, her experience of boarding school life in her teens seems to have helped prepare her for life in the institution of the Sisters of Charity.

An example of her attitude of positivity and perseverance comes when she bought her cottage in Wicklow shortly after leaving formal religious life. She notes in retrospect it was fortunate she had not realised the amount of repair work needed, as she may have been daunted. However she embraced the work and it turned out she was very happy there and created a place of retreat and reflection that still remains open for the public (p. 117).

What a life this attitude of openness led her to – including formal religious life as a nun, training as a physiotherapist, participating in establishing a new medical rehabilitation centre in Dublin, studying theology in Rome for three years, starting a prayer group that still runs to this day, running annual/bi-annual pilgrimages to the Holy Land, buying the house in Wicklow that would become Shekina (a place of retreat and reflection), writing books, giving workshops, graduating with a PhD, travelling, living the gifts of love and friendship.

The author addresses one of my concerns when she writes that rather than narrating her life story in a linear way, she instead recalls particular incidents and their significance for her personal and spiritual development. I found this slightly disjointed narrative style was in danger of detracting from the story of her quietly extraordinary life. However, it is also the very ordinary conversational way the author relates her story that transmits a sense of her quiet courage and simple attitude of always engaging with life, never becoming passive or idle. It is also relevant that her autobiography is as much about her spiritual journey through life as about her year-on-year chronological history. While in the introduction the author writes she does not know who this book is for, by the final pages she is clear that 'I hope that those who choose to read this book will be alerted to valuing their own story with whatever ups and downs it contains'. She describes how religious faith has given her a sense of richness and security in life. One reason for telling her story was to share this experience and her belief that this depth and security can be available to all.

I was moved by this depiction of one woman's life – that includes love in many forms, and which it seems clear to me is a life lived to the best of her capacity, standards and ethics, sustained by her faith. There is a beautiful arc to the story of Catherine McCann's life from growing up in a place steeped in centuries of religious lives, as the family home place was previously home to religious orders for centuries, to entering her eighties still active in her life of service. Throughout it all she has reached so many people and been herself enriched by her experiences and her enjoyment of life. This is an inspiring life story, plainly told. I recommend this book to anyone wondering how to find a sense of purpose for their life, or wondering if they can dare take an opportunity in their life to create meaning.

Workshop Review

PRE & PERINATAL PSYCHOTHERAPY-AN INTRODUCTORY WORKSHOP

Presenter:	Miriam Foley	Reviewed by:	Marie Nolan
Date:	Saturday 14th November 2015	Venue:	Ardboyne Hotel, Navan, Co. Meath
Organised by:	North East Regional Committee		

There is a tribe in Africa where the birth date of a child is counted not from when they were born, nor from when they are conceived but from the day that the child was a thought in its mother's mind. And when a woman decides that she will have a child, she goes off and sits under a tree, by herself, and she listens until she can hear the song of the child that wants to come. And after she's heard the song of this child, she comes back to the man who will be the child's father, and teaches it to him. And then, when they make love to physically conceive the child, some of that time they sing the song of the child. (Welcoming Spirit Home: Ancient African Teachings to Celebrate Children and Community, by Sobonfu Some).

Presenter Bio: Miriam Foley trained and qualified in Primal Integration and Regression Therapy and in Pre & Perinatal Psychotherapy; she is an accredited psychotherapist and clinical supervisor with IAHIP and is well known as a lecturer, workshop co-ordinator and holistic healer.

Miriam's introduction gave us a brief glimpse into the history and theory of Pre and Perinatal Psychology. Sigmund Freud maintained that what happens to us in childhood shapes who we become as adults but he stopped short of expanding on this in favour of the Oedipus complex. The Pre and Perinatal view is that our very early experiences imprint and shape our human characteristics not as commonly thought at birth, but we have awareness from the moment of conception, and it's suggested we have a sense of our energy pre-conception.

Our brain starts to grow and develop, 13 days after conception, before the mother realises she is pregnant. This reptilian brain is imprinted with our survival instinct, from this point we can feel safe or unsafe from external stimuli. The question is when does consciousness/awareness start? Modern day imagining of the early life in the womb is now showing reactions from very early stages of life and this is leading to a new interest in Pre and Perinatal Psychology.

The emphasis, and aim of the workshop through the experimental element was to introduce us through visualisation and art, how as psychotherapists, we can address and work with clients who may be carrying trauma from that period. This was a light introduction to Pre and Perinatal therapy, not intended to be a deep process, and sharing of experience was a personal choice.

Personally this was a fascinating and engaging workshop the respectful and empathic approach of the presenter created a safe and holding environment for a deep and personal journey in a conference room of a busy hotel. Notes were made available to all the participants at the end of the workshop.

Workshop Review

THE TARA APPROACH FOR THE RESOLUTION OF SHOCK AND TRAUMA: FOUNDATIONS COURSE.

Presenter:	Stephanie Mines, Ph.D	Reviewed by:	Phyllis Hunt, Psychotherapist
Date:	October 17-21, 2015	Venue:	Star of the Sea Retreat Centre, Mullaghmore, Co. Sligo.
Organised by:	Suzie McGreevy, OT		

After reading Dr. Mines' book ***We Are All in Shock: How Overwhelming Experience Shatters You and What You Can Do About It***. I started to use some of the methods she described in her book, her synthesis of neuroscience and applied touch particularly appealed to me. I have a deep interest in finding non-invasive interventions to stabilize the nervous system as I frequently address trauma in my practice. Dr. Mines is a personable and erudite presenter. She has conducted clinical trials using her methodology and she is the author of numerous books and articles. Weaving compassion with data, Dr. Mines made the science of epigenetics user friendly. She helped participants understand the mechanisms of re-traumatization and how to avoid that by assessing the tendencies towards sympathetic and parasympathetic responses to trauma and shock. Her emphasis on building strong therapeutic relationships was evident through out in the way she interacted and made connections with everyone. This along with the regular reading of poetry created a lovely resonance in the group.

The TARA Foundations course balanced didactic and experiential learning perfectly. Course content included the impact of shock and trauma on the nervous system; the role of early attachment and bonding in shaping neuronal patterns; information on how neurotransmitters are aroused and how their wiring can become dampened or habituated. I discovered there are many layers to the approach. Over the five days we learned about the bioelectrical system of the body, pulse listening, pre and perinatal psychology, developmental themes, energy meridians, a non-activating re-discovery process, resourcing, working with missing experience, and the re-patterning and re-organization of traumatic injury. We had ample time for dyadic practice which built a strong sense of community. In essence this practice is one of deep mindful listening. Dr. Mines created an environment of mutual respect which was inspiring and encouraging. Texts and handouts were provided for follow up study.

Dr. Mines is a Neuroscientist, Psychologist/ Therapist, Poet & Writer. She is a pioneer in the Field of Neuroscience blending applied touch techniques into her understanding of the brain. Her forthcoming book tackles the difficult topic of PTSD and Traumatic Brain Injury (TBI), an area of Dr. Mines' expertise. She is interested in the epidemic of polytraumas in the modern world in military and civilian populations. Because of her work with shock Dr. Mines has also cultivated an expertise in the treatment of burnout and secondary traumatization.

Having developed a particular affinity for Irish Culture Dr. Mines will return to Ireland in 2016. I look forward to further training with her. Website www.Tara- Approach.org. Dr. Mines' books include: Sexual Abuse/Sacred Wound: Transforming Deep Trauma; We are all in Shock; New Frontiers in Sensory Integration and They Were Families, How War Comes Home.

Phyllis Hunt: figgih@gmail.com