Éisteach

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Exploring Light and Shade

- Light by its Nature Creates Shadow: A Conversation on the "Dark Side"
- The Trauma Contagion
- Emotion in the 'Here-And-Now'
- When Grief Gets Complicated

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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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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:

Antoinette Stanbridge

Dear Colleagues,

This first edition of 2015 explores the nuances of light and shade, as well as the vital capacity required of the psychotherapist to integrate various aspects of self into awareness - ever a dedicated work in progress.

In this edition, Eugene Mc Hugh guides us through the many layers of the psyche, an often fragile and precarious process, reminding us of the enormous value of ongoing personal development as we endeavour to embrace those facets of self that make us uniquely human.

Cork based psychotherapist Pat Comerford looks at the role of emotion in his article, 'Emotion in the 'Here-and-Now', inviting us to examine the nature and function of emotional terrain within the therapeutic space.

Graham Gill-Emerson approaches the subject of trauma , not only how it can affect the professional who is working with it in the form of Vicarious Trauma, but of Trauma Contagion and how it can impact those who are emotionally and physically close to a primary trauma survivor.

Dr. Susan Delaney of the Irish Hospice Foundation sheds light and provides insight into the distress of Complicated Grief in her article '*When Grief gets Complicated*'. As well as delving into the hardwiring of our attachments, she provides of an overview of the most up to date and relevant CGT treatment paradigms and protocols, appropriately celebrating the work of The Irish Hospice Foundation in leading the field of evidence based CGT practise in Europe.

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A conversation on the "Dark Side": The Shadow or just who we are?

by Eugene Mc Hugh

"Light by its nature creates Shadow, if we care to see"

Eugene Mc Hugh 2014

How comfortable am I with my dark side and can I allow it to be seen? This question arose when a personal process diary was removed and read by a family member.

Self Knowledge or Self Deception

In evolutionary terms we, as a species, had to be able to survive by any means possible. Carl Jung named this ability as *"Archaic, meaning primal or original"* (Sabini. 2008, p. 99). This ability has got humanity to the level of sophistication that the species has reached. Has the perception that we must be good in the last millennia, facilitated a pushing underground of part of our psyche which is important, and which has caused a split that one can see in clients? Though we use the term 'Shadow', this author agrees with Jung, it is just what we are, encompassing all that we are, as human beings. Jung (2006) tells us, "what is commonly called self knowledge is a very limited knowledge as most of it is dependent on social factors" (p. 6). Terms like Ying and Yang, Light and Dark allow us to niceify what is, an integral part of ourselves as humans. Using these terms, do we run the possibility of thinking that we are safe and that "evil" is in someone else, but not in us? In the therapeutic environment, how would this belief affect the relationship with a client who may be very aware of this shunned side of man? When looking at these human qualities Costello quotes Freud,

> *The inclination to aggression is an original, self subsisting instinctual disposition in man, … It constitutes the greatest impediment to civilisation … man's natural aggressive instinct, the hostility of each against all and of all against each, opposes this programme of civilisation (2002, p. 23).*

Treatment:

Jung commented on the persona as being useful in a professional sense, "… because the persona is usually rewarded in cash" (cited in Matoon, 2005, p. 18). The persona is highly visible; it is the face we show the world, it allows the adaptations which one needs to be in the world. Without the development of this social face it is hard for the person to adapt to the social environment they find themselves in. Jung spoke of the formation of the ego as being a conflict between a person's bodily needs and their home environment. This developing ego carries the early experiences in which we connect to the past and provides cohesion for us in the present. There are a number of forces that determine what we think and feel. The family environment sets up specific learning that, through the eyes of a child, can have a different perspective than what may actually be happening. This individual perspective sets up a template for what is good, proper and moral, and what is mean, shameful, and immoral. Zweig & Abrams (1991, p. xvii) tell us that "The Shadow acts like a psychic immune system,

defining what is self and what is non self".

In therapy, the visible persona is the one that most people try to understand to resolve the conflict between the internal and external world. This author considers that a client may find resolution for their life issues at this point and will end therapy. However, is this end point enough for a therapist, if a client wants to go deeper in the search for the self? How can a therapist accompany them if they have not gone further into their whole being, into the hidden psyche? Carl Rogers points out that, "… this can only be done by persons who are secure enough in themselves that they know they will not get lost in what may turn out to be the strange and bizarre world of the other, …"(1995, p. 143). Irvin Yalom also comments on the same point when he states, "Therapists must be familiar with their own dark side and be able to empathize with all human wishes and impulses" (2001, p. 40). The persona will do its best to hide or block the shadow and the perceived evil that might be visible to the outside world to present a socially acceptable face. Storr (1983) quotes Jung commenting on

Freud's embracing of Eros (Love), its opposite, hate, and Phobas (Fear), Jung postulates that consciousness seeks its unconscious opposite, stating that *"Life is born only of the spark of opposites".* Jung comments that without this opposite the mind is

"doomed to stagnation, congestion, and ossification" (in Storr. 1983, p.159). He goes on, *"We refuse to endow it with any positive life force; hence we avoid and fear it"* (p.160).

Hidden Psyche

The shadow tends to remain invisible for fear of been seen as wicked or evil, but is it really? Jung talked of the shadow as being *"collective – part of humanity's heritage"* (Matoon, 2005, p. 28). This shadow may not even be acknowledged due to fear. This side of a person may only be seen when alcohol or drugs are present, the ego is suppressed allowing the alter ego to take over. Mattoon quotes Jung as *"the shadow is a necessary component of a three dimensional body"* (2005, p. 29). He goes on to speak about Germany's experience and how Nazism reflects unconscious contents that have potential in all of humanity. In Jungs' work 'The Undiscovered Self' he tell us *"the bigger the crowd the more negligible the individual"* (2006, p. 14). It is, as if, when the Zeitgeist allows, it is permissible to unleash it. We see this in many of the world's areas today where 'normality' is what is considered as evil to our developed World.

Awareness of personal darkness allows a position of understanding for the darkness in the other, which may not be evil. This author is drawn towards Nietzsche's' expression for these inner turmoil's when he wrote,

> *Among a hundred mirrors before yourself false …*
> *Strangled in your own net*
> *Self knower!*
> *Self –executioner!*
> *Crammed between two nothings,*
> *A question mark …*
>
> (cited in Kaufman, 1975, p. 197)

Zweig and Abrams quote Jungian analyst Liliane Frey-Rohn saying, *"this dark treasury includes our infantile parts, emotional attachments, neurotic symptoms, as well as our undeveloped talents and gifts"* (1991, p. xvii). She goes on to state "The shadow retains contact with the lost depths of the soul, with life and vitality – the superior, the universally human, yes, even the creative can be sensed there". When Mark Hederman discusses the idea of art in 'Underground Cathedrals' and how it can open up thinking and a way forward for humanity. He talks of the historical establishment, civil and religious, imposing a type of censorship on free expression of the artist who seeks to express their individual quality. Hederman poses the view that this free expression can evoke two reactions, one which can become "a vision statement of a group" or "public uproar", but how it can become a valid expression of an, "… excavation of a reality which lies in the underbelly of the life of each one of us" (2010, p. 128). Antonio Damasio also comments on art being important to the understanding of the full organism, "Ultimately, because the arts have deep roots in biology and the human body, it can elevate humans to the greatest heights of thought and feeling …" (2010, p. 296).

Dramatic Portrayal of the Dark Side

Looking at the portrayal of this "underbelly of life" by the artist, one can see that even before Freud, Robert Louis Stevenson in 1886, developed the idea of Jekyll and Hyde from a dream. The kind Jekyll turns into the violent Hyde. Recently this author considers a similarity in the film, The Black Swan. In the film one can see the battle that happens when the personality is split. Albeit dramatised, one can see Schizophrenia, Dis-associative Disorder, and depression, however, it is a useful metaphor for the purpose of this discussion.

The film shows Lily in her pink and fluffy bedroom, the good girl, striving to be the perfect ballerina, no ability to be passionate holds her back. The director observes that to get the part as the Swan Queen she must lose the good girl and allow herself to be taken over by the Black Swan. We see her looking in a mirror where she sees her dark side. This happens in the wardrobe department and again in the studio where her reflection separates. After a night of alcohol

and drugs we see her making love to her alter ego which tries to smother "the sweet girl". Throughout the film we can see her being taken over by her shadow where black feathers seem to sprout from her back and mother asks "where's my sweet girl gone", Lily's alter ego replies "she's gone". The director commands her to "lose herself" before she goes on stage. This progresses to the point that she tries to kill her good side shouting "it's my turn, it's my turn" hiding the good girl's body. However, she notices she has stabbed herself, but continues to the end as the Swan Queen where she throws herself off a cliff. Ending the scene stating "I was perfect", passionately bringing the White and the Black Swan together to become perfect.

While the film depicts the battle between the black and white with the idea that one side must die in order to be present, there is a more positive possibility between these two complimentary energies. Bringing these two elements of the psyche together can facilitate Individuation where a person can assimilate the Persona and the Shadow, the anima and the animus, and the typology (dominant and non dominant functions) of the individual. This allows better functioning in the life of the person in their internal and external worlds. It is important for mankind, that we do not see the other as the only one that has the capability to be evil. When Jung (2006) reflects on historic atrocities in dictator states he comments,

> *… the evil, the guilt, the profound unease of conscience, the obscure misgivings are there before our eyes, if only we could see.*
>
> *Man has done these things, I am a man …, he goes on, we do well to have some imagination in evil* (p. 95).

He speaks of the benefit of having this personal insight which involuntarily impacts on the environment around them. On this he says "It is an unintentional influence on the unconscious of others" (2006, p. 109).

Working with the Dark side

How can we work with the dark side with our clients or with ourselves? Using the physical body as a metaphor, we look in a mirror we only see our front side; we have to turn around to see our back fully. One side is outside our full awareness at all times even though we obviously know its there. Likewise, we can see this other side in other people as a projection or reflection; we dislike or hate the other person when we recognise something that we reject in ourselves. Owning these projected traits we can start to befriend our dark side, we can then use the positive aspects of the shadow, e.g. anger becomes assertiveness. However, if, as a therapist, the "stagnation congestion and ossification" is present, how can this facilitate flexibility in working with the client? Storr informs us that Jung writes on this development of personality as being "… much more than the hatching forth of monsters, or of isolation. It also means fidelity to the law of one's own being" (1983, p. 197). Jung in his work 'Modern Man in Search of Soul' talks of clients being stuck at a period in therapy where treatment ends, but where development begins. As mentioned, this may be the point where clients decide they have had enough of therapy and leave.

Vocation or Existential Growth

What is it then that pushes somebody internally to go that extra mile? Jung writes that he considers this extra drive is about vocation "an irrational factor that destines a man to emancipate himself from the herd and its well worn paths" (cited by Storr, 2006, p. 199). Speaking on this he explains that the person is following his own law, the internal voice that calls him (the original meaning of vocation) to delve deeper. It is at this point in time that the therapist must be able to accompany the client in that deeper exploration of the shadow that may hold fear and terror for both. So how else do we access this side of ourselves? Jung tells us that "dreams are an expression of your inner life, and can show you through what false attitudes you have landed yourself in this blind alley" (cited in Sabini, 2008, p. 188). These spontaneous dream narratives are outside our conscious control so are directly accessible as a way into the unconscious.

From personal and professional experience one can see the creativity of these unconscious made conscious processes. Processes as individual as each client, but yet holding a common theme when explored. It is astonishing how alike these archetypal images are for each client. They talk of locked doors, tidal waves, trees in oceans, cliffs, caves, churches, mansions, etc. etc., but one thing that is held initially for these images is fear sometimes bordering on terror. As they process these fears, a core is found which enables them to find a trust and integrity which facilitates free expression without fear. It is not a place without feeling, it is a place full of feeling, but without fear. A natural flow of thoughts, images, urges, and emotions can be experienced without guilt. In this, one can speculate that this is the language of the arts where expression is the individual being expressed without censorship either internally or externally. Stephen Diamond writes,

> *Psychotherapy is one way of coming to terms with the daimonic. By bravely voicing our inner "demons" – symbolizing those tendencies in us that we most fear, flee from, and hence, are obsessed or haunted by – we transmute*

> *them into helpful allies, in the form of newly liberated, life giving physic energy, for use in constructive activity* (Zweig & Abrams. 1991, p. 185).

The person can allow the flow of thoughts without censorship and guilt of the persona and society. The individual can use this liberated energy to explore the world in a new way where they have the ability to choose a way of being which is right for them.

The one big change in this existential place is choice. The purpose of therapy is to enlarge choice so that the person can navigate the journey between the poles with ease. When van Deurzen-Smith talks of recognising these opposite sides of the person she says, "… recognizing opposites is not about choosing one or the other: it is about making movement between these two poles" (1988, p. 60). This movement allows a more holistic experience for the person, and in the therapist, allows an understanding of the clients' world as they grapple with coming to terms with their whole range of experience rather than compromising their way of being. This author can resonate with the sentiment of Friedrich Nietzsche when he writes "The great epochs of our lives are at the points when we gain courage to rebaptize our badness as the best in us" (cited in Zweig & Abrams. 1991, p. 238).

The Question

In answering the initial question posed as to how comfortable is one with the dark side and can one allow it to be seen? The reply that surfaces is that one is comfortable with this darker side of self. The author has chosen a profession that requires one to be in contact with this side of humanity. If one shies away from this holistic self, then one would suggest that the client is not served as fully as possible. This position allows one to adopt a position of being non-judgemental in a more informed human way, still connected to the Persona, but also present to the possible in another environment. However, another part of the question then comes to light in how comfortable one is to have this part of self, publicised or used in another environment. Again, like the artist one must have the courage to face society and be open to an important part of being human in how one exists in present day society. As Jung says if one is true to self and exists with the full potential of being human it will have "an unintentional influence on the unconscious of others". This influence may be the way we consciously choose to be in the world, which can have a positive influence on the people that surround us, which in turn influences the people around them. Surely this exploration then is a gift not just for us as therapists, but all that we come in contact with. Madisyn Taylor an inspirational thoughts author writes "When we present ourselves to the world without a mask and keep it real, we offer the same opportunity for others to do the same" (www.dailyom.com/articles/2014/45691.html).

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The Trauma Contagion

by Graham Gill-Emerson

Introduction

Traumatic experiences hold a central place in the therapy room. As therapists, we are acutely aware of the difficulties trauma brings to the everyday lives of our clients and are mindful of the delicate journeys that need to be negotiated in our client's trauma recovery. So too are we aware of the impact trauma can have on ourselves as practitioners, emphasising our use of self-care to stave off the onset of vicarious or secondary traumatisation that may potentially lead to burnout.

Less time however may be given to acknowledging the impact trauma can have on the survivor's broader system of care. This article focuses on the belief that 'if a helping professional can become vicariously traumatised when listening to the story of a client relatively unknown to them, the trauma survivor's significant other is also (and possibly more) likely to experience such issues'. Yet, how often have we included partners in therapy as co-survivors or spoken to survivors about their partners' needing their own individual therapy? Ultimately, can we increase efficiency of therapeutic success by including the partner in the recovery process? And if so, what form would this take?

Background

Descriptions of trauma widely agree that its cause lies in an event that is experienced as being a powerful psychological shock significant enough to overwhelm and through which one can lose their sense of control, connection and meaning.

In a small yet significant proportion of the population, trauma is followed by the onset of Post Traumatic Stress Disorder (PTSD). This psychiatric diagnosis, is largely framed as the residual manifestation of trauma occurring for longer than one month post a traumatic event. Its lifetime prevalence in the adult population of the United States is 8% (DSM IV-TR, 2000), while the prevalence of probable PTSD in the North of Ireland is thought to approximate 10% of the population after a protracted period of political conflict (Muldoon & Downes, 2007). Its characteristic symptoms include the persistent conscious and unconscious avoidance of stimuli which remind the individual of the event, a heightened sense of arousal to triggers, and impairment in social, occupational and other areas of the victim's external world. It can occur where one experiences, witnesses or learns of a serious threat to life, injury or physical integrity to themselves or those around them.

PTSD is recognised in this article for both its origins in and pertinence to trauma and for its recognition of the trauma experience extending beyond that of the primary trauma survivor to a third party

> *learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate* (DSM IV-TR, 2000 p.463).

These third party aspects of the trauma experience are termed 'trauma contagion' and have the potential to occur within trauma cases whether PTSD is present or not.

Trauma Contagion

Trauma can be conceptualised as infectious by both physically witnessing a victim's trauma or by learning about it. Despite this, much of our trauma literature has been compiled on the effects of trauma upon the primary survivor.

> *Emotional contagion refers to the individuals' tendencies to mimic the emotional expressions of others* (Feldman & Kaal, 2007 p.22.)

This emotional contagion can be broken down into the two concepts of 'vicarious trauma' and 'secondary trauma'. Though much has been written over the past number of years on these concepts, there has been a

lack of clarity between the two terms. The similarity between vicarious and secondary trauma is evident in their characteristic of being communicable. They can be differentiated from each other with vicarious trauma concerning itself with alterations in the individual's usual ways of understanding themselves and their world, i.e. perspective; while secondary trauma locates itself within the mimicking of trauma symptoms, i.e. the felt sense.

The term vicarious trauma was introduced by McCann & Pearlman (1990) and can be understood as

> *related both to the graphic and painful material trauma clients often present and to the therapist's [or listeners] unique cognitive schemas or beliefs, expectations, and assumptions about self and others* (McCann & Pearlman, 1990 p .131).

Vicarious trauma research has largely focused on how the professionals that work with trauma survivors or within traumatic environments (such as first responders and therapists) are impacted.

However, stress symptoms can also be communicated to those close to the trauma survivor, who can become 'infected' with similar trauma symptoms (Goff et al, 2006 p.451). These Secondary Traumatic Stress Reactions (Figley, 1983) posit that at a foundational level, being a family member or engaging in a deep caring relationship predisposes us to being emotionally vulnerable to the catastrophes which impact loved ones.

Thus a ripple effect is generated where people connected to the victim also experience a trauma, mimicking the trauma survivor's symptoms.

In this way, the traumatic experience can go on to impact the "psychological, emotional, physical, operational, social and spiritual subtypes of intimacy" (Mills, 2001 p.198) for both the individual and/or the couple involved.

So how can we treat trauma? We often work with individual clients, speaking about the importance of the extra-therapeutic support people. As outlined above, these people too may be affected, reducing their ability to support and increasing their potential to be reactive as a co-survivor. To treat a traumatised client in a loving relationship may be akin to treating someone individually for a contagious disease (e.g. Tuberculosis) in a sanitised environment before sending them home to their infected family. In this scenario, one would imagine that recovery would be slow at best!

What does the research tell us?

Research in the area of trauma emphasises the need for self-care throughout, be it for the client, the therapist or the survivors support network.

The effects on child sexual abuse survivors and their spouses of common treatment modalities were explored by Reid, Wampler and Taylor (1996). Each of the modalities explored excluded partners. The authors point out that the literature provides much evidence around treating the child abuse survivor with limited consideration being given to the partner's role in the dyadic process of recovery. They warn that ignoring current issues in the relationship when treating the survivor of childhood sexual abuse ignores how the abuse issues are replayed within the current relationship.

Current literature and conceptual explanations of PTSD-like symptoms in female partners of war veterans were explored by Nelson & Wright (1996).

The study stated that assisting and supporting female partners through treatment may be essential to the overall aid of both partners in the treatment of PTSD. It expanded on this by stating that

> *Effective treatment should involve family psycho-education, support groups for both partners and veterans, concurrent individual treatment, and couple or family therapy* (Nelson and Wright, 1996 p.462).

In attempting to identify how intimate relationships are affected when there is a history of trauma exposure, Goff et Al (2006) argued that any treatment of solely the trauma survivor may potentially miss the consequences for the couple and larger family in addition to couple interactional patterns which may exacerbate symptoms in the primary survivor. Thus in the provision of clinical treatment, it is critical to identify the fallout of trauma upon the couple's functioning in order to promote healing for both the primary and secondary survivors and to prevent further systemic damage from the trauma. It was the study's contention that adjunctive conjoint sessions with the couple are essential to adequately address dyadic issues and to reinforce the partner's support in the healing process. The authors warn that most therapists will struggle to maintain a balanced focus in this sort of couple therapy, often shifting their emphasis to the survivor and may "fail to acknowledge the partner's experience as a co-victim" (Reid, Wampler and Taylor, 1996 p.451).

Finally, Henry et Al (2011) outlined how interactional patterns within the couple and/or family may be symptomatic of the primary trauma. They argued that there are a variety of mechanisms that affect functioning in relationships where at least one partner is a trauma survivor, and that understanding the effects of trauma within a couple and family system will improve therapists' abilities to facilitate successful interventions.

Trauma Recovery

Returning to a previous state of being prior to a trauma is commonly referred to as recovery. This recovery

can be conceived as the fundamental shift that occurs in our being when we successfully renegotiate trauma. These fundamental changes occur in our nervous systems, feelings and perceptions as one makes the transition from a traumatic to a peaceful state (Levine, 1997).

In the therapy room, trauma recovery is facilitated through three steps (Herman, 2001). The central tasks of these steps are:

1. To establish safety.
2. Remembrance and mourning.
3. Reconnection with ordinary life. (Herman, 2001)

Despite this linear presentation, the journey of recovery is not straightforward but instead oscillates, defying any attempt in applying order to the experience. However, it should be possible to

> *"recognize a gradual shift from unpredictable danger to reliable safety, from disassociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection"* (Herman, 2001 p.155).

Though Herman's (2001) stages of trauma recovery are written for the benefit of therapists working with primary trauma survivors in resolving PTSD, this does not preclude its application in treating secondary survivors.

However, Remer & Ferguson (1998) present a thorough six stage model representing the steps and complexities involved in the healing process of the secondary trauma survivor (see Fig. 1.0).

Pre-Trauma:

This stage acknowledges the primary and secondary survivor's assumptive world views, noting that we are social beings impacted by how we perceive the world through individual, social, personal and cultural contexts. The more alike the two partners' histories, the greater chance their pre-trauma stages will be alike. The influences of this pre-trauma stage may remain hidden within a relationship unless amplified by the occurrence of a significant stressor. When such an incident does occur the effects of this stage will permeate throughout the recovery process.

Trauma Awareness:

The secondary survivor's healing is going to be impacted by how much and how soon they become aware of the trauma. The more aware of the whole trauma, the more able the secondary survivor will be able to spot and manage its repercussions.

Crisis and Disorientation:

Once the trauma is recognised, it can now be addressed. Shock, confusion and denial may follow, with periods of the secondary survivor feeling off balance and confused.

Outward Adjustment:

This marks a brief return to the previous life of the couple pre-trauma. It is based on the partner dichotomous positioning of disowning the impact of the primary survivors traumatic experience, while at the same time endeavouring to be fully supportive.

It will manifest at both the personal and relationship level. At a personal level, defence mechanisms will dominate while established role patterns will present at a relationship level. These two levels will interact significantly and will continue for as long as both the personal and relationship aspects coordinate in the maintenance of this cosmetic façade.

Reorganisation:

The same two aspects occur at this stage. At a personal level, the defence mechanisms that maintain the particular schema involved in adaptation will be addressed and renegoti-

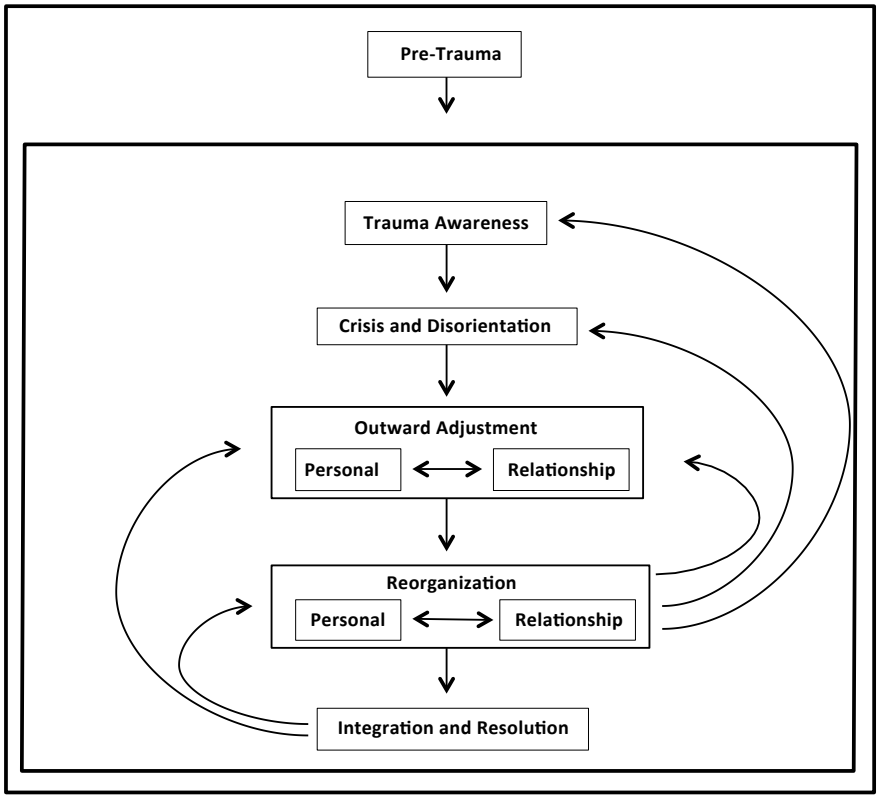

Figure 1.0 Processional Stage Model of the Secondary Survivor Healing Process. Remer & Ferguson (1998, p.145)

ated. At a relationship level new roles will be developed and implemented. Effectiveness at this stage will result from the couple's ability to negotiate and coordinate such changes. The difficulty level involved in these changes will be partly determined by the couple's pre-trauma relationship.

Integration and Resolution:

Integration involves accepting the trauma and making it part of the secondary survivor's personality. Resolution refers to the individual's ability to spot the enduring aspects of the healing process as they progress, perhaps forever.

Earlier in the process, memories and insights often recycle back into crisis and disorientation, while new information at the final stage will likely recycle back to the reorganisation stage where new information is managed and worked through quicker and more effectively.

Though it is not the focus of this article, it is worth noting that some individuals experience a positive outcome as a result of trauma. This trauma thriving or post traumatic growth has the potential to leave people in a better psychological state as a result of their ordeal. Such positive change spans the three broad categories of self-perception, interpersonal relationships and philosophies of life (Tedeschi & Calhoun 1996 p.457).

Conclusion

It would seem that there is a general consensus among helping professionals around the existence of trauma contagion in the form or vicarious and secondary trauma leading to a need for greater self-care when dealing with such cases. It would seem that we as professionals give less thought to how this contagion may be affecting the client's broader system of care, utilising those close to the client in trauma treatment as a support while often failing to identify and treat them as co-survivors. It is hoped that this article has increased therapist awareness on the effects of trauma within client's relationships through the focus on how this trauma may be experienced by the partner and how this may in turn slow the process of recovery for both client and those they relate to. It offers a framework for trauma recovery for the client and their partner as well as charting a brief summary of suggested approaches brought forth by research in this area.

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Emotion In The 'Here-And-Now'

by Pat Comerford

This article is dedicated, with gratitude, to the memory of Brendan Connolly, M.I.A.H.I.P., an inspiring human being, teacher and supervisor.

Introduction

In all counselling practices time will be spent exploring a client's emotions or feelings. This article will examine what it means for both the psychotherapist and client as they investigate and delve into the experience of emoting. This in turn challenges the professional to have a clear understanding of emotions to effectively engage in this important exploration. This article is an effort to bring greater clarity to both the work and to enrich the way of relating in the professional and personal domains.

Defining: A phenomenological Challenge.

The fourth edition of 'The Penguin Dictionary of Psychology' states that in defining the term 'emotion:'

> *"Historically this term has proven utterly refractory to definitional efforts…."*
>
> (Reber, Allen, and Reber, 2009, p.256).

In the 'Dictionary of Counselling' the term 'emotion' is defined as "feeling, affect, excitation …." (Feltham and Dryden, 2004, p.71) albeit the same authors acknowledge that:

> *"The term emotion is used imprecisely and usually synonymously with FEELINGS…."*
>
> (Ibid. 2004, p.71)

This article is an invitation to psychotherapists to have greater clarity on what is meant in the use of the term 'emotion' in their work, to understand the functions of emotions and how these feelings can only be experienced, known, and used in the "here-and-now" (Rank, 1945, Chapter iv; Perls, Hefferline, and Goodman, 1951, p.32) of all relationships, whether they are professional or personal.

Exploration of a definition of emotion

One example of a definitional effort of emotion is:

> *"The word "emotion" quite literally means the outward expression ("e" from the Latin "ex") of that which moves us, whether by way of an external stimulus or an internal need"*
>
> (Howe, in Pesso and Crandell, 1991, p.5).

The latter part of this definition

clearly points to a duality about the origin of emotion – the external or the internal. It is this duality which has contributed to the construction of what Miller, Duncan and Hubble (1997, p.1) has called a Babel-like tower of theories and beliefs in the field of counselling and psychotherapy. While this vast and rich source of knowledge is important to developing an understanding of what it means to be human and how to be psychotherapists, it could also be considered that we have become "trapped in Babel" (Ibid. 1997, p.1) which is a complex maze of theory.

Rather than add to this complex maze the goal of this article is to simplify. It is proposed in this article that emotion is the outward expression of only an internal 'that' which is unique and personal to each client we meet. It is being posited that emotion is not a response to a set of external stimuli. A more relevant and useful definition of emotion that is consistent with the tenor of this article is:

> *"An emotion or an affect can be considered as the felt tendency towards an object judged suitable or away from an object judged unsuitable, reinforced by specific bodily functions."*
>
> (Arnold and Gasson, 1954, in Gross, 2010, p.145).

To grapple with, understand, and know the internal 'that', its associated meanings and judgements, in the above definitions, has been undertaken as an existential or life task by humanity (Russell, 1996). In the context of psychotherapy this 'that' is an internal driving force of needs and wants. It is this driving force which influences how we relate to ourselves personally, and with the world. It is crucial for psychotherapists to make sincere efforts to know the client's 'that' and to understand the relationship between their 'that' and their experience of emotion in the 'here-and-now' as they engage with clients. Irvin Yalom's (2002) work provides a compelling framework for how psychotherapists can address the particular psychodynamic and existential relationship between the meaning of the 'that' and the 'here-and-now' experience of emoting by clients. To understand the process of emoting it is first necessary to understand the experience of emotion for human beings.

The Four Fundamentals of Experiencing Emotion

The following four fundamentals could be regarded as common sense for those of us in 'the trade.' These fundamentals, however, are central tenets for an integrative, or holistic, approach to psychotherapy.

One: All emotions are embodied. We can only know and experience emotion through the bodies we have. We can observe emotion expressed in the behaviours and bodily movements of the individual. Emotions generally find expression, and these expressions can be visible, and if not, can be inferred ("Empathy," Rogers and Stevens, 1967, p.110) from the tone of voice, changing skin tone, involuntary physiological responses like perspiring, breathing rate, and from a multitude of other responses, especially if you have the exceptional acuity skills of Milton Erickson (Haley, 1973).

Two: Emotions are experienced only in the 'here-and-now' of the present moment. Otto Rank (op. cit.) believed that all emotional life is rooted in the present. We cannot experience emotions in the past tense since emotions are only experienced in the 'here-and-now.' Similarly, we cannot experience emotions that are future-based as emotions can only be known in the 'here-and-now.' What mediates emotions in the present are the meanings (Yalom, 1980), or interpretations, created about the past, and future; but these meanings, in turn, can only be known and created in the present moment of the 'here-and-now.' Meanings may also include the cognitive legacies from the past of ideas, beliefs and a frame of reference held on to since childhood, but still used as a basis for living in the 'here-and-now.'

Three: Because emotions are embodied, it is the body then in which all emotions have their origins. No external agent is the cause of emotion; rather the individual is the first and last cause of emotion – it is their unique and personal outward expression. It is the person who generates all emotion. No outside agent can put emotion into the person. This is both a physical and technical impossibility.

Four: Our bodies are always in a state of flux. Therefore, in varying degrees, emotions involve movement internally, and in terms of behavioural and bodily responses. It is reasonable then to conclude that none of the emotions we generate remain static or are permanent.

Evolution has clearly shown survival to be the primary goal of any species and it is this primary urge, the personal 'that,' which underpins the experience of emotion (Dugatkin, 2006). This survival, like our coming into existence, is dependent upon connection and relationship with another. During gestation, survival in the womb is predominantly physiologically based, and emotions, in terms of physiological feedback, are generally an excellent source of feedback for this purpose (Blott, 2009). From the time of birthing, however, it is not a sufficient source of survival feedback. With birth we must now deal with an external world of personal, individualised wants as well as the wants of others. We have entered a world of external relationships, a world Martin Buber calls the "I and Thou" (1958, p.20). This new world of relationships requires us to urgently develop the skills of sense-making and relating. Emotion provides the necessary feedback in developing the skills required for relating to others and for continued survival.

The Importance of Emotion in Human Survival

What is the primary purpose of emotion for humans? I suggest that emotions are primarily a source of survival feedback for:

One: Our existence in the world from the moment of our conception.

Two: Originally it is a source of information about our connection with another, and our place in the womb. With birthing we are required to begin to make sense of and understand a new place or environment, and of being separated and separate (Rank, 1999). This separation is a loss of the first connection and our first home.

Three: Supplying us with information as to whether or not we are getting what we want in our lives, particularly in the new world of relationships.

Four: Providing us with information about both the effectiveness of behaviours that we employ in the pursuit of our personal wants, and of those wants we have in personal relationships.

All of this feedback is experienced by the person in the present-time context of the 'here-and-now.' Consequently, the 'here-and-now' context of the therapeutic relationship becomes the primary vehicle through which the particular 'that' of clients can be explored in full.

The 'Here and Now'

A clear meaning of the term 'here-and-now' has been presented in 'The Gift of Therapy':

> *"The here-and-now refers to the immediate events of the therapeutic hour, to what is happening here (in this office, in this relationship, in the in-betweenness – the space between me and you) and now, in this immediate hour."*
>
> (Yalom, 2002, p.47).

What is emotionally known and experienced is only possible in the 'here-and-now.' There are theories about the past and future and that is what they are and will remain: theories. The past has already passed and emotionally can only be experienced in the present moment of the 'here-and-now' through our memories and the constructed meanings about personal life events created in the 'here-and-now' (Yalom, 1980). From the psychotherapy perspective what matters most is what is being done in the present moment, the now, and not what has been done in the past or can be done in the future. It is important to understand the meanings and judgements the client has created about their past and how these, in turn, have been allowed, or used, to impact and influence the 'here-and-now' of their living and lifestyle – this is understanding the client's personal 'that' or driving force. And, for clients, to learn the skill of evaluating the usefulness of these created meanings and judgements lived in the 'here-and-now' is essential in order to survive and to live a useful and worthwhile life.

Viktor Frankl (2011) advocates a viewpoint of 'that' in his account of the time he spent in Auschwitz. He believed that we choose our attitude(s) in each moment of our lives and this influences how we will decide to live and relate in the 'here-and-now.' Equally, in the present moment, we cannot emotionally experience and know the future, but we may have theories about it. In any book about world religions you will find an array of beliefs about the future and what is in store for the human race (Matthews, 2011). Eckhart Tolle

has made his view explicit with his challenge to us to focus on the "Now" (1999, p.5) Similarly Anthony de Mello's invitation is to "wake up" (1990, p.20) in order to achieve awareness in the present. Carl Jung once said: "who looks outside dreams, who looks inside awakens," (Owen, 2002, p. 84) and this too requires a sense of the present.

Developing different psychotherapy models and theories is useful if it helps professionals and clients to live in the 'here-and-now.' As psychotherapists we can only engage with clients in the therapeutic alliance in the 'here-and-now.' It is essential to empathically know the emotions the client is generating in the 'here-and-now' so as to better understand what it is they want now from their lives and relationships and even from their relationship with the therapist. To know the client's wants is to understand their personal driving force and how this informs them in the way they choose to behave and to relate in their lives. For the therapist to know what they are wanting in their lives and to be aware of the behavioural choices they make to achieve their wants is fundamental to an effective therapeutic alliance. Babette Rothschild's (2000, 2003) work with trauma and post traumatic stress disorder, a past experience, is an excellent example of working with clients in the 'here-and-now.' It is because of her focus on the 'here-and-now' that she successfully prevents re-traumatisation of clients.

More Simply: The Twofold Purpose of Emotion

After thirty four years of clinical practice, during which I purposefully listened to and observed my experience of emoting and the emotings of others, I have come to believe that as we are aging, and especially since puberty, in addition to the need for survival, emoting eventually comes to have only two purposes.

First, emotions provide people with feedback on their wants being satisfied or not in the 'here-and-now.'

Second, emotions are a source of feedback on the relative success or failure of the behaviours employed to get what is wanted in the 'here-and-now.'

It needs to be reiterated that the feedback of emotions is critical to survival, even in the context of satisfying wants. Failure to understand and effectively deal with emotions as feedback at a personal level will lead to the physical demise of the individual, and failure at a collective level will lead to the demise of our species.

A Simple Definition of Emotion:

Following from the above review I propose a simple definition of emotion:

> *Emotion is the outward of expression of our wants being or not being satisfied and equally a measure of the success or failure of the behaviours we have chosen to satisfy those wants.*

An Example: Alfred Adler's Existential Understanding of the Client's 'that' in the 'here-and-now'

Alfred Adler, as an example, has provided us with a theory and clinical framework to understand how individuals go about scripting their 'that' by personally making sense of their world through the development of what is called "Private Logic" (Ansbacher and Ansbacher, 1964, p.102). Private Logic is a set of ideas, beliefs, or conclusions created during childhood about the world and relationships based on personal contact with that world and those relationships encountered. This experience-based knowledge may be used to form and inform how to relate to the 'I' and others. It can also be the framework that is employed by the clients to satisfy their wants in their lives. For example, if the client has many memories of being pampered in childhood they may believe that life, and relationships, is about receiving and taking, and consequently relate in this fashion to satisfy their wants. If the client reports repeated memories of unreliable and inconsistent contact with the world, they may conclude or believe that living and relating in their world are not safe and therefore one has to be always guarded in pursing wants. This example of exploring childhood memories, or "early recollections" (Clark, 2002, p.7) is one useful approach to understanding the unique meanings, or the 'that,' clients employ as they conduct their 'here-and-now' lives.

Concluding and Inviting

It behoves us as psychotherapists to work and relate with clients in the 'here-and-now' and in this context to understand how they experience emotion and their 'that' because this is what we can only know with some degree of certainty. It is essential that we fully understand the client's wants and how these are directly linked to their 'here-and-now' emotings and behaviours. To relate in any other way, one might as well start interpreting rune stones, practicing clairvoyance, and reading horoscopes. It is a necessary and essential part of our professional practice to know the simple and sublime ways of relating to the client that are not only client-centred but also present-moment centred, and thus be facilitative of emotional and behavioural responsibility. (Rogers, 1961, Yalom, 1992, 1996)

Jiddu Krishnamurti (1969) advocated that we cultivate a freedom from a rigid adherence to established theories of knowledge and to instead live in the 'here-and-now.' We may listen to client's theories about their pasts and futures, and we may ourselves theorise along with them, but this will be a fruitless exercise if it is not anchored in the 'here-and-now' reality of emoting and the personal living experience of the therapist-client relationship.

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When grief gets complicated

by Dr. Susan Delaney

Abstract

Much has been written, argued and debated about whether complicated grief exists and whether we are merely pathologising a natural event when we attach a diagnosis to it. This article provides an overview on current thinking about the role of attachment in how we grieve, it introduces an evidence-based protocol which has been shown to provide better treatment results and considers how the research in therapy efficacy relates to working with clients presenting with complicated grief.

Introduction

Popular notions about how we grieve, including the idea of fixed stages of grief and the importance of closure have, for the most part, now been discarded as research evidence has failed to support their validity. Neuro- imaging findings have reawakened an interest in human attachment and researchers, such as Mikulincer, have refined the early work undertaken by John Bowlby to explain the central role of attachment in our lives and in our losses. As human beings we are hard-wired to attach to others throughout our life span. We thrive emotionally and socially when we have attachment figures in our lives who provide a safe haven for us. These attachment relationships help to regulate important aspects of our functioning- from sleeping and eating to feelings of self-esteem and self-confidence. Well-functioning adults will typically have about five significant figures in their lives at any one time. We seek out these people when we need comfort and feel confident in exploring the world knowing they "have our backs". We develop a mental representation ("working model") of these figures which are updated as changes occur in the relationship.

Grief is a natural consequence of forming these emotional bonds to others; we grieve when we lose someone (or something) that is important to us. When we experience the loss of an important person in our lives, our physical and emotional well-being is disrupted; we resist accepting the finality of the loss and struggle to make sense of what has happened and how to live without that person.

If our attachment figures are so central to our functioning, then how do we ever learn to manage without them? Is grief so destabilising that we can never recover from it?

Bowlby recognised that a successful period of mourning consisted of acknowledging the finality of the loss and its consequences, revising the internal representation of the person who died and redefining life goals. This is echoed in William Worden's more contemporary work on grief tasks. Research by George Bonanno highlighted the role of resilience and added significantly to our understanding of grief trajectories by evidencing the fact that failure to integrate grief was the exception rather than the rule. We now know that in parallel to our physical immune system, we also have a psychological immune system which facilitates emotional healing. So although grieving can be a very difficult experience, most people find their way through their grief journey with the support of family and friends. As we process the loss, our acute grief gradually becomes integrated and no longer dominates our emotional landscape, but is incorporated into our understanding of ourselves and our world view. The working model is

updated to reflect the loss and we find new ways to remain connected to the person who has died, recognising that death ends a life not a relationship.

Complicated grief

However, for a small number of bereaved individuals this adjustment does not occur. Instead of the grief integrating, the process is derailed, sending it into a repetitive loop with intense yearning, avoidance and preoccupation with the death predominating the emotional and cognitive landscape. The bereaved person has little enthusiasm for life and cannot imagine a time that they will ever feel joy or passion in their life again. This is what is known as complicated grief (CG). The analogy of a train can be a useful way to explain complicated grief; if grief is imagined as a train journey, then each bereaved person finds their own route, stopping at different stations for different lengths of time and arriving at their own destination. When someone has CG it is as though obstacles have caused the train to derail and no progress can be made until the debris is removed from the track. To work effectively with CG practitioners must recognise and attend to the debris so that the train can get back on track and the grief journey can continue. The incidence of CG is low; estimates range from 2% to 20% and most cases are still unrecognised and untreated.

DSM-5 has included CG as a recognised disorder under the title Persistent Complex Bereavement Disorder. Lack of an agreed set of criteria resulted in the disorder being placed as a condition for further study, however must researchers agree that key features include a bereavement reaction out of proportion or inconsistent with cultural/religious or age-appropriate norms and a level of disturbance that causes clinically significant distress of impairment of functioning in social or occupational settings. It is expected that the disorder will also appear in the new edition of the ICD due to be published in 2015.

CG- as it continues to be called by clinicians- can be diagnosed using standardised inventories coupled with a thorough grief history and assessment. DSM-5 sets 12 months post bereavement as the minimum time frame for diagnosis; however Holly Prigerson's work indicates that it may be diagnosed as early as six months post bereavement. The inclusion of the disorder has been criticised by some as an attempt to pathologise grief- in this author's opinion, it merely confirms what most practitioners have long been aware of; the failure of a small number of clients to progress in therapy despite everyone's best efforts. Wherever we position ourselves on the debated-diagnostic categories ultimately serve only one purpose and that is to reduce the suffering, incapacity and misery of clients who seek our help.

Treating complicated grief

The acceptance of CG as a disorder has led to the development of innovative treatment protocols, most notably that developed by Shear (2006) known as CGT, which has been shown to reduce symptoms of grief and improve level of functioning when compared to more traditional talk therapy. CGT is based on attachment theory and integrates strategies drawn from Interpersonal Psychotherapy, Cognitive-Behavioural Therapy and Motivational Interviewing. It is a 16 week, strengths-based model which mirrors the Dual Process Model (DPM) described by Stroebe and Schut. DPM recognises the importance of oscillating between focusing on the grief and defensive exclusion to allow for restoration work. People with CG frequently struggle to dose their grief; they have likely developed strategies to avoid their grief, because they feel overwhelmed when they do attend to it. CGT models this oscillation in the therapy work and allows clients to develop the capacity to move towards their grief and away from their grief.

The CGT protocol uses strategies and techniques which facilitate the three main processes of grief resolution; acknowledging the death and its consequences, revising the mental representation of the person who has died and redefining life goals in light of the life changing events. Sessions are structured and follow a similar format, beginning with a review, moving on to particular exercises focusing on the death and consequences, then shifting to activities of restoration and ending with plans for the following week. Clients are active collaborators in the process and are asked to engage in daily activities of grief monitoring, goals work and self-compassion. Both imaginal and situational activities are utilised as well as structured memory work, photographs and an imaginal conversation with the deceased. Progress is monitored regularly and feedback is used to structure the protocol to the client's needs and to refine the understanding of why the grief process became stuck. As the instinctual healing process is activated, the working model updates and the grief begins to integrate.

Of course protocols and techniques alone don't heal people, and effective treatment will always be predicated on the ability to form a strong therapeutic alliance and

tailor treatment interventions to fit with the client's experience and interpretation of the problem. Duncan Hubble and his colleagues provide an excellent overview of what makes for effective therapy in their book; The heart and soul of change. They break down the effectiveness variance into; 40% -client factors, 30% - therapeutic relationship, 15% accounted for by the instillation of hope and expectation and 15% accounted for by the techniques utilised. One of the best predictors of negative outcome in therapy is a lack of focus and structure, when working with CG it becomes even more important to have a clear hypothesis rooted in bereavement theory and a therapeutic approach with an evidence base. To ensure that bereavement therapy is both effective and self-sustaining David Morawetz recommends that therapists focus on using the relationship to empower the client both in and outside of session, generate realistic hope without minimising the difficulties and utilise relevant and proven techniques to ensure that the therapy is effective and self-sustaining.

CS Lewis reminds us in A grief observed; *"Bereavement is a universal part of the experience of love… it is not the interruption of the dance, but the next figure of the dance"*. People with CG erroneously believe that they need to hold tightly to their grief as a way of staying connected to their loved one, they fear forgetting and can become locked in a vicious cycle of either feeling bad or feeling bad if they start feeling better. The truth is that we are forever connected in a deep way to those we love, but it is possible to remember them with love rather than with pain and it is possible to reconnect with life and find meaning and joy after bereavement. Again CS Lewis in observing his own grief noted; *"I have learned that passionate grief does NOT link us with the dead, but cuts us off from them….. It is just at those moments when I feel least sorrow that H rushes upon my mind in her full reality"*.

With the establishment of the Complicated Grief Programme at the Irish Hospice Foundation, Ireland has taken a lead in providing evidence-based treatment for people presenting with complicated grief and is one of only two sites in Europe providing treatment and training in CGT. With growing awareness and better understanding of the principles of effective intervention there is now hope for this debilitating condition.

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Dr Susan Delaney

Dr Susan Delaney, Clinical Psychologist is the Bereavement Services Manager in the Irish Hospice Foundation. She has practised and taught in the area of loss and bereavement for over 20 years. She has been awarded the title of Fellow in Thanatologyby ADEC (Association of Death, Education & Counselling) for her contribution to the bereavement field and is the editor of Irish Stories of Loss and Hope , a book about bereavement experiences. Susan is a member of the international Train-the Trainers group with Dr Kathy Shear at Columbia University and is the Director of the Complicated Grief Programme in the Hospice Foundation. This newly-established programme provides clinical services, training, education and research in the area of complicated grief.

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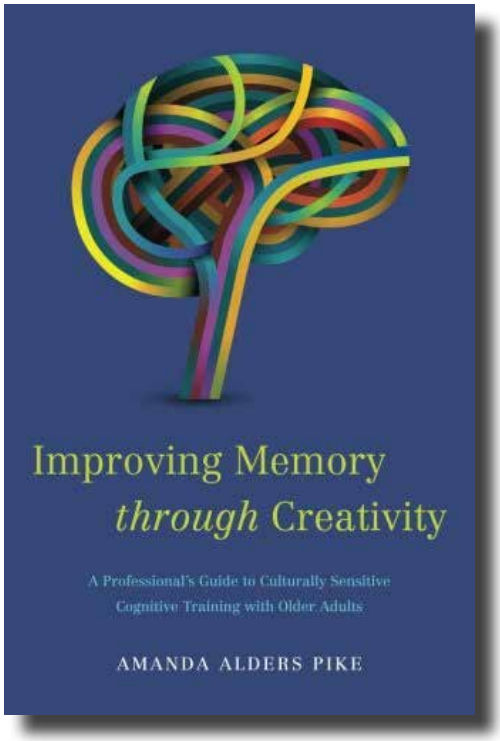
Book Review

Title:	*Improving Memory through Creativity* A Professional Guide to Culturally Sensitive Cognitive Training with Older Adults.
Author:	Amanda Alders Pike
Published:	2014
ISBN:	978-1-84905-953-4
Reviewed by:	Cynthia Quinn, MIAHIP; SIAHIP; MIAPTP; ECP Pre & Peri-natal Psychotherapist/ Supervisor and Play-therapist

As the title suggests this is a guide on how to stimulate older adults mentally and emotionally through creative Cognitive Training. Creativity is known to stimulate anyone both mentally and emotionally and this guidebook outlines strategies that are useful and effective in clinical work with older adults.

In a world where the number of older adults are increasing, plus those with Dementia and Alzheimer's disease too; cognitive training has become an important part of helping those with these conditions. The author combined her background in Art Therapy and the various theories, together with Cognitive Training to produce a very versatile approach to aid older adults improve their memory.



The neuroscience of normal and abnormal aging is easily explained, together with the risk factors. The primary risk factor of interest in this book is lifestyle factors, mental stimulation, decreasing stress and improving socialization and mood. Thus the creative approach takes into consideration the older adults mental/cognitive well-being needs; these are related to five key areas: physical, social, emotional, spiritual and mental.

With simple exercises aimed at these factors and needs they are broken down into several steps and explained together with graphs charts and tables that show how artistic creativity can parallel cognitive training that will provide benefits to a wide audience of older adults. Everything from introducing art materials and techniques, to enhancing cross-cultural interaction is outlined in detail and each encourages self-reflection as to what the images and symbols means to each person personally.

The author has coupled this with an understanding of how art making, affects brain waves and neurotransmitters; and how this may help the professional to positively affect older adult's internal stimuli, thus enhancing their mood. To achieve this three neurotransmitters (and corresponding brain waves) that relate to both happiness and creativity are Acetylcholine (gamma waves) which enhances memory, Dopamine (beta waves) which creates motivation and Serotonin (alpha waves) which calms the mind. So what exercise would achieve all this? A MANDALA!

The repetitive strokes in a confined area improves hand/eye co-ordination, while the focusing on the sensation of the materials give a bodily pleasure, while deep breathing connects the mind/body and the choosing of colours without self-judgement improves self-esteem and that's just the serotonin release!

I really liked how this book built on information from the previous chapter, gave step by step guidelines for one session to several weeks together with information on the elements that create a successful session, from length of session to the number of weeks that are most beneficial. The charts, graphs and diagrams are very simple and explain key factors, especially the neuroscience link. All this is also accompanied by online material for use in sessions and workshops making it a vital resource to all professionals who work with older adults.

Workshop Review

EVERYDAY MINDFULNESS

Presenter: Aoife Valley
Date: 15th November 2014
Organised by: Northern Ireland Regional Branch IACP

Reviewed by: Gerry McCanny
Venue: City Hotel Derry

Aoife introduced herself by saying that she had studied meditation and mindfulness in the Buddhist tradition over the past five years. She outlined the plan for the workshop which included a series of meditations interspersed with presentations and group discussions. It was obvious from the way Aoife composed herself before the workshop began and by her calm demeanour that she was practicing the mindful philosophy that she preached and her audience was fully engaged from the beginning.

The first meditation was a meditation using our senses and and we were reminded of the meaning of "coming to our senses" as a way of returning our attention to the present moment. Following some group discussion Aoife introduced her audience to a meditation focussing on awareness of breathing and then to some mindful movement exercises similar to Tai Chi and yoga movements. We were reminded that each individual may find different meditations and mindful exer cises useful at various times and that it was important to adapt these to our unique requirements.

The next meditation consisted of a body scan where we were asked to visualise the various parts of our bodies from the top of our heads down to our toes and to imagine each part smiling as we focussed on that particular area.

The last meditation involved the repetition of statements including "May I be free" and "May I be at peace". The facilitator then asked us to think about someone whom we felt neutral about i.e. not having strong negative or positive feelings towards them. We were then asked to repeat "May you be free" and " May you be at peace" while thinking about that person. This progressed to thinking about someone with whom we had difficulties and repeating the above statements with them in mind. This exercise produced a really interesting debate on the meaning of forgiveness and its relevance within the counselling process.

In the final exercise we broke into dyads and one person was asked to speak for 3 minutes while the other simply listened attentively without any comment at all. Roles were then reversed and afterwards participants fed back on their experiences of this exercise. The exercise exemplified the Buddhist method of "being with" the other person without deliberately trying to respond or fix the problem.

The workshop ended with a plenary discussion on the value of various types of meditation and mindfulness practices and on how mindfulness can be incorporated into our counselling work.

Overall the workshop was very competently presented with a useful balance between experiential exercises, information giving and group discussion. I would strongly recommend it for those interested in learning more about mindfulness and who especially enjoy experiential learning.

Workshop Review

SEXUALITY: LET'S TALK

Presenters:	Gillford D'Souza and Karen Ward	Reviewed by:	Clara Slattery
Date:	28th November 2014	Venue:	Avila Centre, Dublin 4

A day seminar exploring our attitudes and beliefs around sexuality that influence how we support others in the exploration of their sexuality.

On the 28th November I attended the above workshop on sexuality, and I am glad I did. I work with the organisation Ruhama supporting women affected by prostitution and women trafficked into sexual exploitation. My experience is that it is difficult for many clients to look at their sexuality and sexual relationships. I decided it was important for me to explore this further to better support my clients.

A large part of this workshop focused on the participants and exploring our sexuality. We looked at what sexuality is; levels of comfort and discomfort on certain themes; our sexual script; and sexual desire. The later part of the day looked at client work. The workshop was interactive, alternating between full group and small group discussions. It highlighted how sexuality touches off so many aspects of ourselves and how these aspects connect and interlink.

I enjoyed the workshop immensely. It felt refreshing to sit in a room with practitioners who spoke so frankly about sexuality, and to learn about their feelings, opinions and experiences - but also where they struggle, both personally and in their client work. This in my experience does not happen often and is not always easy to do, even though sexuality is a significant part of us. The desire to engage was palpable, and participation was tremendously helped by the facilitators' ability to make the group feel at ease. Gillford and Karen shared their own experiences, helping to lead the way. They were gentle in their approach and deeply respectful of individuals' experiences, contributions and varying levels of participation. And the workshop was fun! So while the work was serious and at times painful, we also laughed. There was great energy in the room and it felt natural to talk about this part of ourselves. But most importantly, the space felt safe.

The section on sexual scripts I found particularly valuable. It was an eye opener to learn about generational and cultural scripting. We were reminded of the huge role family and society play in shaping sexuality and our relationship to it.

The facilitators were adept at keeping the workshop on track and to the point. However, for myself I would have liked more small group discussions - perhaps even role playing - and a deepening of some of the topics raised. In relation to the section on client work there is scope for further development.

This workshop was a very good introduction to exploring sexuality in a group setting. I am already seeing a difference in my client work. I look forward to Gillford and Karen's follow-on workshop in the spring. It was a privilege to explore with my fellow participants something as personal as our sexuality. Thank you Gillford and Karen for making that possible.

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