From the Editor:

In this issue, 'relationship' arises as a strong theme across the articles. Relationship is often seen primarily as a one to one encounter, especially in therapeutic settings. However, there are many facets of relationship as can be seen clearly in this edition of Éisteach. Siobhán Rock explores the highly complex web of relations in families blighted by alcohol abuse. She quite rightly points out that too much focus can be placed on the drinker in the family, on the assumption that once the alcohol is removed, that the family system will recover spontaneously. However, the dysfunction established by addiction in the form of co-dependence runs deep and unseen, and can last a lifetime without treatment.

Isla Jeffers & Dr. Coleen Jones introduce an entirely different type of relationship to the discussion, in the form of therapy dogs. They advocate the presence of a dog during counselling as a catalyst, which can ease the anxiety of some clients, especially adolescents. Coincidentally, I myself have had the privilege of teaching a counselling trainee, whose guide dog was usually present in the classroom. The dog certainly had a calming and comforting effect on both the students and myself, so much so that we missed him on the occasions when he was absent.

Another assumption that I believe we tend to make is that relationships are between the living, exclusively. The bereaved, however, would beg to differ. An excellent student article by Alan Kavanagh addresses the very difficult task of those coming to terms with the suicide of a loved one. Such a relationship is often confused by the fact that the deceased could not find sufficient strength and support in the living in order to continue on. Intensive soul-searching can be necessary for the bereaved, as a consequence. Alan focusses on the conundrum that men are more prone to suicide (but not suicidality) than women and why that may be.

Perhaps, the most profound relationship of all is that which exists between the mother and infant. We can agree, I think, that the quality of one's first relationship is likely to have long reaching effects on how we relate throughout our lives. The centrality of the mother-child bond, therefore, makes the problem of Post-Natal Depression (PND) especially poignant. Patricia Allen-Garrett's professional and personal journey through this landscape is both powerful and inspiring. The depths of suffering which PND cause are beyond anything that I had imagined prior to reading this article.

Cóilín Ó Braonáin PhD
Chair of Éisteach Editorial Board

Editorial Team Update

A reminder that the next edition of Éisteach will be a double-sized research edition featuring the very successful research conference held in Cork in May and hosted by Cork Counselling Services. The two-day conference entitled 'Research in Counselling: Friend not Foe' featured Professor Mick Cooper, a leading exponent of the need for evidence-based practice. We invite research based articles for inclusion in the Autumn edition.

A further point to keep in mind is that the title of Éisteach will change in the Autumn to give prominence to 'The Irish Journal of Counselling & Psychotherapy.' The purpose of this change is to make the journal more easily recognisable and accessible to a broader audience, some of whom would not relate to the Gaelic.

Academic Article

"Living in the Bottle"

An exploration of the family system and how it has affected the adult children who have a parent with an alcohol addiction.

Siobhan Rock

"Alcoholism isn't a spectator sport; eventually the whole family gets to play"

(Burditt, 1978).

Introduction

According to Alcohol Action Ireland (2012), one child in eleven reported experiencing a negative impact on their lives due to their parents' drinking. The organisation's National Audit of Neglect Cases indicated that alcohol misuse was a factor in sixty two percent of cases of neglect. The Steering Group Report on a National Substance Misuse Strategy stated that alcohol was a risk factor in seventy five percent of Irish teenagers who were taken into care. In Ireland there are over a quarter of a million children under the age of fifteen who are living with a parent who abuse alcohol (Murphy, 2012).

Brown and Lewis (1999) highlight an important fact in relation to alcohol abuse. They suggest that historically, treatment focussed primarily on the drinker and not on the family as a whole. The thinking was that once the drinker became sober, the family would automatically be okay. They suggest that rehabilitation is a necessary factor which should include the whole family (Brown & Lewis, 1999). The National Drug Strategy, interim report 2009 – 2016, took a new approach in relation to drawing up this report in that they consulted with people around Ireland at public consultation meetings in fifteen locations. They set up focus groups which included people who had undergone treatment for addiction and also met with addiction specialists. They added a new pillar - rehabilitation (National Drugs Strategy, 2009-2016).

The Hidden dynamics at play

In families with alcohol addiction, roles and rules within the family are different. The boundaries are often too fluid and uncontaining for the children, with the family system becoming blurred and enmeshed. The result of these conditions leads to chaos, confusion and poor family function (Brown & Lewis, 1999). The organisation Adult Children of Alcoholics (ACOA) says that parental alcohol abuse is, for the offspring: "A disease that infected you as a child and continues to

affect you as an adult" (ACoA, 2016).

Roles in the family are usually static, the parents are in charge and the children can normally predict how the family functions. In dysfunctional families, this is often not the case. Walker (1992) talks about the dysfunctional family system being like a baby's mobile; when one part moves, the other parts are moved also in order to compensate for the disturbance in the system. He adds that when the members of the family unit have all shifted to a new position, each member reacts from a complicated defence system that guards the true emotions (Walker, 1992). The adjusting process that takes place for the children within the family with addiction is problematic for them; they develop defence mechanisms in order to cope, such as denial and projection (Doweiko, 2009).

Life with the non-drinking parent

Much of the research to date in this area has explored the adult child's relationship with his or her drinking parent. There has been little research carried out on the relationship between the ACOA and his non-drinking parent. Some of the literature would suggest that living with a parent with codependent characteristics is perhaps as damaging to the child as having a parent with alcohol addiction (Bernstein, 2014; Sher, 1997). Codependency often goes beyond focussing on alcohol addiction to focussing on issues like poor mental health, poor physical health or immaturity. The codependent individual has a conscious wish to help their significant other to get better, yet an unconscious draw to keep the person dependent (Walshe, 2015). When codependent tendencies prevail into adult life and the underlying issues are not worked through, these individuals can latch onto their children and demand compensation from them (Blackmore, 2015).

The non-drinking parent may be caught up in a cyclical drama involving his or her own issues from their family of origin. These people unconsciously fell in love with somebody who held the lost parts of themselves. They found a partner who would help them to co-create or re-enact the childhood drama where mum or dad's absence or their addiction was interpreted as a lack of love, but this time the ending would be different; it would be re-written (Hendrix, 2001).

As this happy ending is not panning out as planned, the non-drinking partner can work harder and harder to try to create this. When their partner gets more detached from them and more attached to the alcohol, this can be interpreted as a lack or a failing in the non-drinker; they must do more. The non-drinking parent can become sader and more hopeless as the relationship continues to function in a dysfunctional way.

Characteristics of the Codependent Personality

The problems of codependency arise from having clearly rooted deficits from early childhood in relation to nurturing, where parents were neglectful, abusive or had addiction issues (Frank & Golden,1992). Codependent parents see their children as extensions of themselves rather than separate, unique human beings. These children can be indoctrinated to meet their parent's needs and support their parent's self-esteem. These children must find a way to adapt and survive; they often feel that their own needs and feelings are wrong, especially if they do not meet with the approval of their parent. The child loses touch with his innate cues and responses and the healthy growth of his autonomous self is impaired (Lancer, 2014).

Codependent individuals allow other peoples' behaviour to affect them. They can be overly focussed on controlling their partner's behaviour (Beattie, 1992). One element of codependency is 'enabling' which is fixing problems for others and doing so in a way that interferes with growth and responsibility (Bernstein, 2014). There is a greater likelihood for the spouses of individuals with alcohol addiction to have enabling tendencies (Rotund et al, 2004).

Parent – Child role reversal

Janet Woititz talks about the child in the alcoholic family system linking feelings of guilt with being responsible; being responsible means that they can do something to fix the situation. She says that giving up guilt means giving up control and this, for the child living in such a family, can lead to disaster; it will change the family dynamic, the give-take system where the child gives and the parent takes. It should be the job of parents to take care of their children so that the children don't have to take care of their parents (Woititz, 1990). When a child takes on or assumes an adult-like role, this is defined as parentification (Fitzgerald, et al., 2008).

In dysfunctional families, children are often rewarded for 'wrong attributes' or 'wrong actions' such as parentification, thus cementing their self-esteem issues and their skewed coping mechanisms; the negative effectives of which are long lasting (Bedrosian & Bozicas, 1994). It is very often the oldest child that takes on the hero role, the child that is most likely to take on the parentification, while their

peers are enjoying the carefree world of childhood (Robinson & Rhoden, 1997). The taking on of this role comes at a very high price – their childhoods (Chase, 1999).

Ideally, children should be encouraged to be children and enjoy their childhoods, however, when support is lacking for parents, they can look to their children for this support. When a parent loses his or her partner through death or addiction, this opens up a vacancy for a 'surogate spouse'. Very often one of the children is encouraged to fill this role (Adams, 2011). The slipping into an adult role is, for these children both strong and frequent in families with addiction and it is usually the oldest girl that takes up this role. There is an unawareness in these individuals in later life, when they go for therapy, of any connection between their childhood role and experience and their present difficulties (Ewart,2012). When children take on the role of being parents to their own parents or to their siblings, it comes at the expense of their own development (Chase, 1999). The child needs to prop the parent up in order to keep some semblance of functionality in the family. Parentification takes place within the context of insecure attachments (Byng-Hall, 2002). Sharon Wegscheider-Cruse (1981) wrote about the survival roles that children follow in order to cope with addicted family members. Such roles include: hero, mascot, scapegoat, and lost child. Usually the oldest child is the hero, achiever or helper and one of the middle children the scapegoat (Wegscheider-Cruse, 1981). Children can get locked in to a role that can originate from their birth order or the fact that they were seen as an 'easy child' from birth (Middleton-Moz & Dwinell, 2010).

The instillation of Guilt and Shame

Guilt and shame may be seen as similar, but there are very important differences between the two, particularly in relation to their onset. Guilt is more complex and more based in language than shame is. Guilt can be related to unacceptable behaviours; it can be linked by the child to certain actions or inactions - to what they have done or to what they have failed to do. Shame however is a very different phenomenon. Shame is an emotion that is internalised at a young age, before the child is able to discriminate between himself and his behaviour (Cozolino, 2010). Guilt, being based in language seems to develop at a later stage than shame does. Shame is more an internalised feeling that is owned as part of the self, it seems to have developed perhaps at a much younger, preverbal stage of the child's development. The shamed person is bad as opposed to the guilty person who has done something bad (Cozolino, 2010). Guilt therefore is an emotion that is easier to live with, the child can usually do something to make amends as it is usually clear to them what the source of this guilt is – they have not washed up the dishes or they smashed a cup, they can distance themselves from the guilt. It is much harder to put distance between the self and the shame.

The child who experiences shame feels bad but cannot put his finger on the origin of this bad feeling, it is not linked to an action or inaction. There is a strong tendency for children who experience shame to become codependent; they go around doing good deeds in order to compensate for an imagined committed sin (Cozolino, 2010). Survival guilt exists for the adult child of addiction, particularly if they manage to get out of the family system, leaving others in it (Dayton,2008). Children who grow up in these homes do not have emotional sobriety. They live in a black and white world where they try to make sense of something that does not make sense. Very often, they take on the blame for the problems within the family (Cermak,1991). In their black and white or dichotomous thinking, there is no room for mistakes (Quick, 1990).

Tim Hayes (2015) suggests that children who grow up with a parent with an alcohol addiction have similarities to people experiencing post traumatic stress disorder (PTSD). He uses the term 'ACOA syndrome' to describe the existence of the black and white thinking, hyper vigilance, anxiety, shame and unresolved anger issues present in these individuals (Hayes, 2015). There is often confusion about feelings and issues with control (Nevis, 2000). These control issues help the child to keep the three rules that are usually instilled in the child from their parents – to not speak, to not trust anybody and to not have feelings (Capretto, 2007). This will have a knock on effect on these children throughout their lives; they will have a difficulty in forming relationships (Atkinson & Hornby, 2002). The advice that parents give their children growing up should be given to protect them and keep them safe. Advice such as "look both ways when crossing the road" is very good advice that will serve the child well both in childhood and in adulthood, however advice such as "do not trust strangers" though appropriate in childhood, will not serve a person well in adulthood. If children continue to believe in advice from their parents that no longer serves them well, they can become isolated and lonely (Hay, 2009).

Problems with self regulation cause black and white thinking which involves the child swinging from extremes; they find it difficult to live in the middle ground (Dayton, 2008). There is a tendency, with black and white thinking to reduce overwhelming situations into good or bad, safe or unsafe (Gerlach, 2011). These children can experience a depth of shame; this comes from the veil of secrecy that their parents insist they live under as well as living in a shame based system and the resulting feeling of being contaminated by that shame (Flores, 2007). The antedote of shame is love and acceptance (Helgoe, 2002). Shame emphasises a person's weakness and vulnerability and increases the liklihood of rejection (Lansky, 2005). There is very often a desire to flee the shame-inducing environment (Bybee, 1998). Once these children are old enough, they cope by distancing themselves from the family of origin in order to avoid further interactions with family members that have not been positive (Dunas, 2000).

When a child is told not to speak and not to feel, this causes him to be confused and to not trust his feelings, he then takes on a 'false self' persona. The concept of the false self was first introduced by Winnicott in 1960. When parents impose on their child a need for compliance with their wishes or expectations, the child takes on this false self persona in order to cope with this expectation (Winnicott, 1965). When this happens, children will lose touch with who they are, in a way, they cease to exist (Bradshaw, 1988). The child loses his sense of self; his false-self persona pleases his parent and attains for him validation and security. When a child does not have enough support in order to become emotionally and psychologically separate from his parents he develops a 'codependent false-self' (Weinhold,2012).

If children do not have their love and belonging needs met, they will develop codependent characteristics (Webb, 1992). The need for love and belonging was first described by Maslow in 1943 as one of the elements of what he described as a 'Hierarchy of Needs' (Maslow, 1943). It is important consideration in the recovery of the adult children that each part of them should be addressed and treated (Alternatives in Treatment, 2016).

Conclusion

A briefing was held in July 2016 in Leinster House by the Oireachtas Cross Party Group on Alcohol Harm. The chairperson, Senator Frances Black said that children who come from families with alcohol addiction are among the most vulnerable in today's society. She added that these children suffer from 'hidden harm'; they suffer in silence and do not know where to turn to get help. When children live in homes where a parent abuses alcohol this has a deep and long lasting impact on their lives. Black suggested that more measures are needed to protect these children and to provide early and effective interventions for them (AlcoholAction Ireland, 2016).

An analysis Report carried out by the (Irish) Western Region drugs task force in 2015 looked at supports that were available and availed of by communities in the west who were affected by addiction. The report revealed that barriers to seeking support were identified as feelings of shame, fear of being stigmatised, denial and fear (McDonagh & Reddy, 2015).

Some of the hidden factors that exist in families with alcohol addiction including the element of shame that can exist within the entire family seem to be one of the reasons for the resistance within these families to seek help. Community involvement and support could make a big difference to families who are struggling and may help to lift the lid on the silent, secretive lives some children are forced to live in. "Let's raise children who won't have to recover from their childhoods" (Leo, P, 2008).

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Siobhan Rock

Siobhan Rock's background is in nursing, both General and Learning Disabilities. She trained as a Counsellor/ Psychotherapist twenty years ago with The London School of Counselling. Siobhan went on to train as a couple's counsellor and worked in ACCORD for twelve years. She has recently completed her MA in Addiction Studies with Dublin Business School and now works full time in her private practice as a Psychotherapist and as a Supervisor. Siobhan has a particular interest in childhood trauma and in Imago therapy.

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The Dog in the Room

Isla Jeffers and Dr. Coleen Jones

Photo credit: Zen Tshabangu

Introduction

This article as a form of ethnography recounts the collaborative work done by assistance dog Hallie from Dogs for the Disabled, her handler a psychotherapist, Isla Jeffers and Isla's Clinical Supervisor, Dr Coleen Jones. The project was supported fully by the CEO of Dogs for the Disabled, Jennifer Dowler. The work was located in and welcomed by the YMCA in Cork, Ireland as part of their Youth Counselling Service which is funded by the Cork Local Drugs Task Force through the HSE.

This article is co-authored by Coleen and Isla who present their experiences and their thinking behind the project which aims to make counselling and psychotherapy (from here on referred to as therapy) more accessible to young people and perhaps to others in different circumstances. We frame our delightful experience and scaffold it carefully and ethically by articulating the thinking and theory behind the experiment. So far the experiment makes the working alliance between client and therapist easier to form, allows the therapeutic relationship to develop and normalises the therapeutic space making it more informal and relaxed as it reduces anxiety. There is a caveat here that the dogs used in this pilot have been carefully selected and thoroughly trained by Dogs for the Disabled. It seems that not every dog is suitable to the task.

CONTENT: COLEEN

This project started in the middle of 2016 when Isla introduced the idea of bringing an assistance dog into the counselling room at the YMCA. Thankfully she had experience in handling assistance dogs, as her daughter has a wonderful assistance dog called George. It was necessary for Isla and myself as her Clinical Supervisor to consider what supports were needed, identify what hurdles needed to be cleared, get the support and co-operation of both Dogs for the Disabled and that of Cork YMCA. We spent a lot of time weighing up the risks. In the end it was decided to pilot the project and begin writing it up and collecting insights from October 2016. Quite simply Isla in a very matter-of-fact way introduced the dog Hallie – a two year old Golden Retriever - into Support, Training and Enterprise Programme (STEP) and Work Orientation Training (WOT) – the YMCA's vocational training programmes, as well as into Nino's – the YMCA canteen area at lunchtime. This allowed the young people who were around to make contact, become familiar and begin talking. Then Hallie was introduced into a couple of sessions only if the clients were completely happy with the idea.

CONTENT: ISLA

This pilot programme was initially suggested by Jennifer Dowler – CEO of Dogs for the Disabled, an amazing charity which trains dogs for children and adults with a physical disability. I already had strong links with them through my daughter who has one of their assistance dogs - George. Jennifer was keen to explore new possibilities and proposed introducing one of the charity's dogs in training into the counselling room. I was keen to trial it as were the YMCA – where my counselling service is based. George has had such a positive influence on our family at home that I was keen to see what effect such a dog would have on our YMCA family, specifically

within the counselling space. Following preparatory discussions with Dogs for the Disabled, our YMCA staff, our young people and my supervisor Coleen, we decided to go ahead.

I brought a dog into the counselling room with me one day per week for a total of eight weeks. Hallie – a two year old Golden Retriever in training as a therapy dog came for the majority - seven out of the eight weeks. Hugo, a two year old black Labrador, also in training came once. Hugo was affectionate but got bored and after a while would go over to the door and whine. Hallie was better suited and happy to stay all day – four counselling sessions each day. Over the eight week period a dog, either Hallie or Hugo, was in the counselling room with a total of twelve different young people (aged 18-22) from two different YMCA programmes.

The experience was extremely positive and particularly helpful with regard to the accessibility of counselling. Hallie made that first step through the door so much easier. Any taboo left regarding counselling just melted away at the prospect of the dog being there. More than once I heard, *"I'll definitely go if there's a dog there…"*

Obviously the dog in the room is not for everyone. Not all clients like dogs and preparation prior to the first session was important, *"There will be a dog in the room. Are you ok with that?"*

We did nothing special. Hallie was there in the room and the interaction was natural. We had a water bowl, a blanket and dog treats that clients could give her if they wished. Hallie shunned the blanket in favour of the empty chair! Sometimes she would go over to the client. At other times she curled up in a chair and slept. There was a sharing between us in the simple joy of that, *"Look at her, she's so cute!"* It was so normal. She modelled relaxation perfectly and I was able to make reference to that as I introduced a relaxation exercise, *"So let's begin to relax and take deep breaths. See what Hallie is doing."*

It was during those early sessions that Hallie was most useful. Many of my clients have been let down in the past by other adults and other professionals and so were rightly defensive of me. *"I've been to 12 counsellors and you're number 13. Only one of them was any good and she left after four months…"* As yet another adult, another professional sitting across from them it can take time to build their trust. This process seemed to be eased, even accelerated with the dog in the room. She was a bond between us, an equaliser. They pet the dog, I pet the dog. The fact that the dog trusted me helped them to trust me. This counselling was different. *"She has a dog with her. Ok I might give this a chance…"* I had gone to the effort to have the dog there for them, the extra mile. And that meant a lot. And there were indeed many extra miles spent walking her to and from the YMCA and out at lunchtime for a toilet break!

The dog in the room brought calm, comfort and unconditional positive regard in spades. Hallie responded to emotion. There was a particular joy and freedom in that the dog wasn't restricted by protocol or policy like I was. In fact it was nice for me as the therapist to have a *"buddy"* too. She was able to go over to the client, to touch them, even lick them! If they were upset she would respond and go over to them and also to me. As one client spoke of his difficult childhood it was like he'd pressed the play button and just reeled off his story, seeming to come from his head space not his heart. He wasn't feeling it. I however was feeling it. It was a surprise and a comfort when Hallie came over to me and put her head on my lap and I realised that she was feeling it too. Another client rubbed Hallie's ears as he spoke. It seemed to comfort him, to help him speak, a distraction from the horror of his story.

Many of my clients are presenting with anxiety. Having the dog there brought ease and seemed to calm their stress response.

Hallie also had an impact outside the counselling room. Walking her through the city to the YMCA, passing strangers would spot her, catch my eye and smile. In meetings with colleagues Hallie would lean on them and they'd pet her as they spoke. Bringing her into the training rooms brought energy to the groups. One facilitator said, *"The atmosphere in the group was lovely today,"* and thought it was to do with the dog.

Hanging out with Hallie at lunchtime brought valuable interaction. A lad in for an appointment who usually preferred to wait by himself came in and sat down with the others in the canteen. Hallie went to them all, no favourites, no judgement. She was just being herself, playing, lying upside down, and hiding nothing. She just wanted to be loved and it was wonderful to watch the young people respond. Hallie expressed a delightful openness and heads lifted up from phones! She brought togetherness, a shared joy and I witnessed something of a soul connection. Some young people and a dog - ordinary and yet extraordinary!

CONTENT: COLEEN

In October in supervision we started putting some words, context and theory to what was happening. The immediate attraction to the dog made the connection which helped the clients relax particularly those who would usually be apprehensive of therapy. There was an emotional softening with the dog being there. Hallie seemed to bring with her, and

create a form of safety. Hallie simply walked from one to the other, lay on the floor or at times seemed totally disinterested as she curled up on the free chair in the room. At times Hallie needed toileting or a walk. One would have thought that this would be an interruption, but in a way *"less is more"* because it made the work more earthy and ordinary. This was significant, this "normalising" effect which brought with it EASE. SO often in the medical world there is a focus on a DISEASE model which pathologises and diagnoses (labels) the client in some or other way. For young people starting out in their lives this is less than ideal. We wanted to look at what was happening for them as a lack of ease or DYS-EASE, from the Greek, and normalise their experiences, thoughts and behaviours. For this to happen these young clients needed an atmosphere and climate which felt safe, where they could feel sooth-ed. Patting a dog like Hallie provided just such a tactile, soothing and emotionally calming encounter. Where patting the dog brings with it as part of the flow, a form of touching which is sensual, connecting and initially non-verbal. It was as if the dog, Hallie acted as a co-therapist in a homely and very ordinary and earthy way. The wonderful paediatrician and psychotherapist Donald Winnicott (1960) favoured the creative space where people could meet, play and create. He called this the Transitional Space. It's a space which promotes an energetic flow and good, real contact between people. Winnicott wrote that this connection is brokered by a Transitional Object. Babies mostly have their teddy bears as warm, cuddly objects that hold them until Mother re-appears. The transitional object soothes and reassures the child or person until the links with the significant other are in place. In this way Hallie seemed to be this Transitional Object, securing and hastening the contact in the therapy room. It is not what is said that is always the palliative, but how the therapist is heard by the client who is anxious and confused. The neuroscientist and psychiatrist Iain McGilchrist (2009) differentiates the semantic language from the prosodic language. This means that the anxious client like a newborn baby is less able to understand the words being said and more tuned in to the musicality of language and what is the felt atmosphere in the room and in particular the tone, timbre and warm intentions in the voice of the therapist. Hallie the assist dog brought the "coo-ing and oo-ing" warmth into the room in a very real and felt way. In the words of Carl Rogers (1980) who wrote extensively about Unconditional Positive Regard (UPR) as one of the core conditions for a sound therapeutic alliance and relationship to form. The dog conveys UPR implicitly by communicating trust, warmth, acceptance, loyalty, commitment and non judgement… and Love.

At this point it is important to look at the dog as not only connecting client and therapist but also as serving to integrate and regulate the client's nervous system. In circumstances where the client is hyper-aroused, there is an immediate stress response with the client's system flooding with the stress hormone and other hormones to either cause the client to fight, take flight or freeze. This is generally the case with young clients who are afraid of the therapist and un-knowing about therapy and what it entails. Often this results in stony silence which may be really difficult to thaw. The clients who are often terrified actually can't think of what they want to say or where to begin. In our experiment it seems that the dog, Hallie, as a Transitional Object acts as a distraction, soothes, eases and serves to integrate the Cortex with the Limbic system. The Cortex allows the client to think clearly and have access to high level cognitions and emotional processing while the Amygdala as a part of the Limbic system is focused on survival and will block the client, so that they freeze or get out the door as soon as they can. It is vital that the client is able to have access to the pre-frontal Cortex. But in view of the pain, neglect or terror experienced by many youngsters, their Limbic systems are flooding and primed for survival. It's like driving a car and having access to one gear only, often stalled or the reverse gear. The dog seems to help the client shift through the gears and get moving.

CONTENT: ISLA

Weekly debriefs happened with Jennifer from Dogs for the Disabled when I brought Hallie back to the charity after our day's work. We quickly decided to stop bringing toys for her after the second week when she was distracted. Jennifer understood straight away. *"Was she minding something?"* I remembered, *"Yes, she was cuddling a toy."* There were no more toys and no further problems.

I knew that having the dog present was really working but for both myself and the clients it was difficult to articulate why. "Do you think having the dog here is a good idea?" "Yes definitely." Why do you think it's a good idea?" "I dunno. It's nice like…" Supervision with Coleen was "key" here. She was able to help me work through why it was working and apply relevant counselling theories such as Winnicott's. It was during one such supervision session that I had a moment of epiphany. The experience at work of the dog in the counselling room was actually mirroring our experience of the dog at home with my daughter. In just the same way as Hallie at work, George has brought comfort, acceptance, togetherness and an

indescribable joy to our family at home. This was a striking and deep moment of realisation.

In conclusion, the dog in the room is not vital. The therapy happens anyway, regardless of whether she is there or not. But having her there is a huge help with regard to accessibility, trust, normalising, reduction of anxiety and the intrinsic building of the therapeutic relationship.

CONTENT: COLEEN

It would be true to say that the dog comes into the (therapeutic) space, and surprisingly amplifies the space. The dog can't hurt, can't judge and as such it facilitates the Working Alliance. It gives the therapeutic space depth and opens another dimension. Arnie Mindell refers to this dimension as "hyperspace of the imagination" in his book The Quantum Mind and Healing,

> "a two or three-dimensional perspective is usually sufficient for most purposes in life, but many problems need more dimensions to get resolved. In a hyper-spatial view of yourself, you are not dead or alive, healthy or ill, but an on-going process moving between and through" (Mindell 2004, p 47).

Isla as the handler and therapist is also "modelling" behaviour towards the dog such that there is Joy in how the dog is received. The dog is also a positive object for the client's projections allowing a melting of the defences, which is most useful. Isla regards the dog as another "tool" in her "toolbox" of interventions which helps build trust. She commented in supervision as follows, *"everyone wants to come into the counselling room with the dog there…they suss me out to see how I am with the dog…and there's a deepening in my relationship with them (clients)…. we're sharing the dog together… its equalising when normally its so one sided…there's a lightness… we play…I (Isla) really think it works for the right people…there's a connection beyond the issue…in a way the (clients) think that I am going the extra mile for them".* The dog is not a negative distraction, but requires more work, collecting, grooming, walking and toileting the animal by the handler. What is significant is the way the dog serves to integrate, bring together what would normally be "scattered" when the person's psyche and personality is experienced as disintegrated. Clients often talk about feeling *"in bits"* or feeling *"scattered"* or *"all over the place"*. Integration as clearly articulated by Ken Wilber (1993) is a process of bringing together, linking, cohering and remembering what has been felt, experienced, lost or thought as a result of crises and trauma.

IN CONCLUSION:

Dogs often feature in mythology and story telling from Greyfriars Bobby in Scotland to Gelert the faithful hound of the medieval Welsh prince, Llewelyn the Great who put a sword into his hound's side, thinking it had killed his heir, when the dog's dying yell was answered by the child's cry, indicating that the dog had rescued and protected the child. From this story we see symbolically how "dog" and animal nature serves as a protector of the young. In Greek mythology we know the story of Cerberus a three headed dog guarding the entrance to Hades the underworld allowing spirits of the dead to enter but not leave unless a "sop", a payment was paid to Cerberus in order to transit back to the world of the living. In a creative way the "dog in the room" is hopefully a soul-guide bringing life and hope to these young clients on their way to living more fully.

We thank Dogs for the Disabled and Cork YMCA for taking part in this pilot partnership.

For more information:

www.dogsfordisabled.ie
www.ymcacork.net
#ymcahealth
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Dr Coleen Jones

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Student Article

Penetrating the Silence of Sorrow: Counselling those Bereaved by Suicide.

Alan Kavanagh

Introduction

> Suicidal people are *made*, not born. Suicide is less a decision than a reaction. I believed that if they could learn what is being reacted to, then we would have an opportunity to interrupt the suicidal impulse - Norman Farberow (as cited by Dovel, 2015, p. 661).

It has long been a valued consensus that we are pleasure-seeking creatures and will try to avoid pain at all *costs*. Freud (1922) suggested that all decision-making derives from these two drives. Sadly, for some, the ultimate price to *pay* to cease this pain is to see suicide as a feasible option. The purpose of this article is to present an overview of the psychology and aetiology of suicide and to examine what can be useful when therapists encounter someone who has been bereaved by suicide. Essentially, this article will consider how to best help the bereaved "*break through the walls of silence surrounding*" them, without interrupting the grieving process. Ultimately, for healing to occur, we must trust the importance of just being present with the "inner spirit touching inner spirit" (Rogers, as cited by O'Rourke, 2017a).

The Psychology and Aetiology of Suicide

Therapists are taught that human beings possess a growth tendency, the drive to self-actualise, to become themselves to the fullest degree (Rogers, 2011). How then do we make sense of the suicidal, whose thoughts, feelings and behaviours appear antithetical to this? If, as Francis Bacon proclaimed, knowledge *itself* is power, then therapists would be well served in exploring the psychological and aetiological underpinnings to this *silent*, devastating killer. Furthermore, if we lack knowledge of this soul-destroying phenomenon, what support will we be to survivors – those coping with the '*shock, of water encountering a rock'* after suicide. Suicide is synonymous with silence. For years, it was the greatest taboo, with Ireland being "the last European country to decriminalize it" (Leenars, 2008). Thankfully, times have changed. With the enactment of the Criminal Law (Suicide) Act 1993, our country witnessed a growing willingness to confront the shadows of suicide. Anton Leenars (2008), in his seminal work on suicide around the world, finishes his review of Ireland stating:

> "Ireland, indeed, may well be the best example where there is now a growing healthy balance between death and suicide, even while the country embraces a family/community approach to death and dying. Once more, in an appropriate way, Ireland is an exception" (Leenars, 2008).

Leenars (1995, p.54 as cited by O'Rourke, 2017b) asserts, "Suicide is best defined as an event with biological, psychological, interpersonal, situational, sociological, cultural and existential components." Moreover, suicidologist Edwin Schneidman (1985) emphasised, 'suicide is everyone's business.' Consequently, a deeper understanding of suicide is required. While it is not possible to explore each of Leenars' suggested antecedents, the reader will be presented with a literature review of some aetiological factors.

Substance Abuse

> "No one ever tells us to stop running away…the advice we usually get is to sweeten it up, smooth it over, take a pill,

> or distract ourselves, but by all means make it go away." (Chödrön, 2000, p.5).

If humans are pleasure-seeking creatures, then substance use is perhaps the epitome of hedonism. On the surface, the ingestion of mood-altering substances is an attempt to seek pleasure; however, it is unquestionably often an attempt to avoid pain. Substance use and suicide are inevitably linked. Theodora Fine (2008, p.11) informs us that 90% of individuals who complete suicide have a mental health or substance disorder. Fine (2008, p.12) argues, that substance use is second only to depression as a risk factor. When examining the literature, it becomes abundantly clear that substance use is an "Acute Risk Factor" for suicide (Schatzberg & Nemeroff, 2009, p.6). Substances of some kind have been found in the systems of those who have attempted or completed suicide (Arteine et al, 2015; Wong et al, 2013; Giesbrecht et al, 2015). If Laura Perls (1989, p.11) is correct that "death is the only feasible escape" from the torture of "guilt and worthlessness", then maybe it becomes the person's only escape when substances fail to ease their despair. Holmes & Holmes (2005, p.4) further claim that substance abuse itself may be a "form of slow suicide."

Conceivably, an additional aetiological factor related to substance use is the impulsivity that goes hand-in-hand with drug and alcohol use. Yifrah Kaminer and Oscar Bukstein (2008) remind us that impulsivity is positively correlated to both suicide and substance use. This may be particularly true when considering risk in substance-using adolescents. Research (Allebeck et al, 1991; Bedford et al, 2006) tells us that one third of deaths in young males, especially adolescent males are due to suicide. Furthermore, "somewhere between one and two thirds of these young men are intoxicated when they take their own lives, typically in very impulsive acts" (James, Kearns, Smyth & Campbell, 2014, p. 58). Adolescence is a tumultuous period, characterised by change, impulsivity and uncertainty (Meyerson, 2015). Additionally, today's youth encounter added challenges, as they navigate the shadowy waters of virtual worlds, where "social networks" replace social interaction. Ironically, these digital "tablets" may have the same mood-altering, connection-impairing, addictive attributes of their chemical counterparts (Alter, 2017; Kardaras, 2016).

Social Media and Suicide

> To pursue a goal, which is by definition unattainable, is to condemn one's self to a state of perpetual unhappiness – (Durkheim as cited by Challenger, 1994, p.181).

While this landmark research is dated, it is still relevant to suicidality. Is history repeating itself? In Durkheim's *Le Suicide* (1897) a notable term, "anomie", refers to that lost societal connection and great psychological isolation that occurred during the Industrial Age. Undoubtedly, parallels exist in this modern age of social media, where there is an illusion of *thinking* we are connected, whilst *feeling* isolated. When considering the causes of suicide, it is worth contemplating what role social media might have on our psychological well-being. Mann (1983, p.12) refers to this when he states, "as a society becomes more anomic, the suicide rate increases.' We must be mindful that there is a possibility of anomie present in today's technological age. In *iDisorders,* Larry Rosen (2012, p.13) states that 62% of adolescents check their technologies every 15 minutes, with 51% experiencing anxiety if they cannot check it as often as they want to. The paradox of social media is that it makes us believe we are connected, while relationships are strained by silence, as we stare into our screens. Do we connect with an online stranger before talking with our neighbour? Do we value 'likes' more than 'hellos', and 'emojis' more than 'hugs'? Is it not better to be physically present with another, instead of offering a comment on Facebook?

Research into social media and suicide is new, but raises questions. A 2012 meta-analysis found that "there are several ways that social media can increase risk for prosuicide behaviour" (Luxton, June & Fairall, 2012, p.197). For example, there is a growing literature on links between cyberbullying and suicide (Hinduja & Patchin, 2010; Law et al, 2011) with documented cases of references to social media at inquests of completed suicides (Howard & Surtees, 2016). Studies (Schenk and Fremouw, 2012; Hindjua and Patchin, 2010) found links between online bullying and increased suicide risk and associations between suicidal ideation and online suicide searches (Katsumata et al, 2008; Hagihara, Miyazaki & Abe, 2011; Dunlop et al, 2011). Despite the benefits of social media and the internet, there are definite dangers and further study into potential correlations is warranted. Just as there may be adolescent specific aetiological factors, it is important to consider gender issues, as suicide rates greatly differ between the sexes.

The Changing Role of Men in Irish Society

> Men are motivated and empowered when they feel needed….
>
> Women are motivated and empowered when they feel cherished (Gray, 1992, p.43).

Although women attempt suicide more often, men complete suicide at a higher rate (Bilsker & White, 2011; Qin et al, 2000; Mergl et al, 2015; Lewinsohn et al, 2001; Vörös, Osvath & Fekete, 2004; Tatarelli et al, 2007). Recent times have seen

a shift in gender roles and there are potential links between these changes and rates of suicide. In Sue Sharpe's (1999) research, "*Just like a girl*", she challenged the patriarchal views of society. This study examined how *primers* influenced gender roles. Primers, in this context, are defined as the reading materials that young girls of the time engaged with, which had a hidden curriculum that socially constructed their role in society. O'Rourke (2017c, p.43) suggests that today it "is men who are seen as emotionally crippled and biologically redundant." Reversing Sharpe's research, would primers such as "Men & Motors" really equip men with the language and understanding of emotions? While anecdotally, we hear that women take their lives less than men because they express emotions more; the fact that more women attempt suicide is noteworthy. Nonetheless, the stark reality is that men are more likely to complete suicide. O'Rourke offers one possible explanation for this when he cites Kelleher:

> "…with mental illness … research has found that 80% of women had consulted their doctors and received treatment, whereas only about 20% of men were in treatment at the time of their death" (O'Rourke, 2017c, p.3).

Anthony Clare (2001, p.2) states, "men are renowned for their ability and inclination to be stoned, drunk, or sexually daring, appear terrified by the prospect of revealing that they can be – and often are – depressed, dependant and in need of help." Pollack (2006) calls this 'gender straitjacketing', where we are conditioned to believe emotional communication is less masculine. This is evident in colloquialisms like, "man-up", "big boys don't cry", and "man-flu" or the locker room banter of "drink a cup of cement and harden up." Fear of being mocked when we reach out, even when physically sick, is a common theme in male help-seeking literature. Galdas et al (2005, p.616) found "a prominent theme … implicates 'traditional masculine behaviour' as an explanation for delays in seeking help." Fekete, Osváth & Michel (2004, p.309) discovered, "consultation rates and help seeking patterns in men are consistently lower than in women in the case of emotional problems and depression." If help-seeking for medical issues is difficult, how challenging is it for men in terms of mental health? Hughes' findings (2012, p.6) mirrored earlier research, with males believing that seeking help for mental health is a "sign of weakness and failure."

While a woman needs a shoulder to cry on so too does a man, as feelings do not discriminate between the genders. Granted, we may think differently, but is this due to conditional or biological factors? Eli Newberger (1999, p.51) maintains, "We have diminished the emotional life of boys and men by defining crying so early and decisively as a weakness." This socialised reluctance to share our vulnerabilities may play into gender differences in suicide and into the methods with which men attempt suicide. Perhaps, our inability to express the more vulnerable emotions emerges in anger, and self-violence, leading to drastic and violent methods of suicide (Callanan & Davis, 2010). Newberger (1999, p.52) alludes to this by asserting,

> "Eventually, the code against male crying asserts itself, so crying gets dropped from the combination of activities; from then on, the male who is boiling over with frustration will express his feelings either in violent language or in physical assault, or in both."

After all, what is suicide but the ultimate physical assault on oneself? If disassociation is a factor in male suicide, then learning to cry might be our greatest tool to combat life's difficulties. Judith Nelson (2005), in *Crying and Attachment*, notes, "Crying in solitude contradicts the reason we cry: for connection." Therefore, as therapists, it is incumbent upon us to facilitate our clients in expressing emotions, as "there are many things that can only be seen through eyes that have cried" (Romero, as cited by O'Rourke, 2017c, p. 45).

Counselling Those Bereaved by Suicide

> "I did not know how to reach him, how to catch up with him…. The land of tears is so mysterious" (de Saint-Exupéry, 1995, p.34).

Common words used to describe the suicidal include "lonely", "isolated", "helpless", and "hopeless." Arguably, those bereaved also experience a depth of aching emotion, knowing they were unable to reach their loved one. A duality is present in the helplessness, confusion and despair experienced by both parties. This may be agonisingly true in the case of parents' grief, as Euripides decrees, "what greater grief can there be for mortals than to see their children dead" (Didion, 2012, p.13). How then do therapists penetrate the silence of sorrow, so the client's grief can "melt into words that speak of pain and heartache"? Those grief-stricken can be left in a perpetual state of numbness, or as Didion (2007, p.32) eloquently put it, "I wake and feel the fell of dark, not day." Andriessen and Krysinka (2011, p.24) contend, "The metaphor of a stone thrown into a lake reflects well the wide-reaching impact of suicide. It causes many ripples which turbulently affect the water's surface." Unknowns, related to why their loved one did it and whether they could have prevented it, torment the bereaved. What must this endeavour of searching for an unattainable answer be like? Undoubtedly, grief work must explore unanswerable questions. There is healing in grieving, if it is honoured. Poignantly, Gibran (1923, p.40) reminds us, "the deeper the sorrow carves into your being; the more joy you can contain." For therapists, the Rogerian Core

Conditions are certainly a basis to facilitate grief work.

Elizabeth Kübler Ross's Model of Grieving

When counselling the bereaved, it is important to have a theoretical foundation from which to start. One of the best-known frameworks is Elizabeth Kübler-Ross' Five Stage model. Grief and attachment are also inevitably intertwined (Kosminsky & Jordan, 2016). We do not mourn what we are not attached to, or as Colin Murray Parkes (2009, p.2) writes, "love and loss are two sides of the same coin". Alice Middleton and David Williams, (2001, p. 178) highlight the supposition "that some form of security is damaged by bereavement." Therefore, while giving due consideration to theories of grief, therapists must also consider attachment. Kübler-Ross and Kessler (2014, p.13) remind us that the stages model was 'never meant to help tuck messy emotions in neat packages.' Instead, "with the stages comes the knowledge of grief's terrain, making us better equipped to cope with life and loss.'" It is a model, but it is not necessarily linear. One can easily tumble into an earlier stage, in the moment-to-moment experiencing.

Denial:

> "Your mind will believe comforting lies while also knowing the painful truths that make those lies necessary. And your mind will punish you for believing both." – Ness, From the Motion Picture *A Monster Calls*.

When referring to Denial, Kübler-Ross reminds us that it is not a denial of the death. Instead denial refers to the shock and numbness that is encountered. In suicide, this shock can be amplified. Denial can literally be the psyche's self-protection. As therapists, we should remember, "There is a period of avoidance that is psychologically therapeutic" (Humphrey & Zimpfer, 2008, p.149). In fact, some theorists (Stroebe, Stroebe & Hanson, 1993, p.407) suggest interventions "offered to families immediately following a sudden death" can be counterproductive. Denial may be all that allows the client to cope. We should tread carefully, permitting clients to emerge from denial in their own time.

Anger:

Ann Smolin (1993, p.133) writes, "Anger is a normal response to being abandoned." Often the bereaved "experience themselves as the victim of a very savage assault" (Ainsworth-Smith & Speck, 1999, p.55). Loved ones may also exhibit anger towards helping professionals, wondering if perhaps 'something more might have been done" (Ainsworth-Smith & Peck, 1999, p.55). Jordan and McIntosh (2011, p.149) caution therapists to 'remember that anger is a reasonable, appropriate and understandable reaction to the suicide." Kosminsky (2012, p.30) states, "feelings [like] anger are particularly elevated when losses occur through violent death such as suicide…" Kominsky further observes, "people who come to us after the loss of a loved one are bringing us a problem that we cannot solve." Anger will be present in the work and in the relationships the bereaved person has. William Worden (2009, p.69) calls this 'Angry Attachment' and encourages us to aid the person in expressing it.

Bargaining:

> "…the *whys* and *what –ifs* of his death haunted my every thought. Why did he leave...What could I have done to save him? Did I do anything to bring about his decision to die?" (Fine, 2006, p.5).

Kubler-Ross and Kessler contend, "Bargaining can help our mind move from one state of loss to another" arguing that it "keeps suffering at a distance." Furthermore, they describe it as a thinking process, where thoughts bargain "with all the what ifs…" Possibly, the bargaining stage in survivors manifests in what Smolin (1999, p.32) refers to as the "tortured refrain of 'We should have…', 'We could have…' and 'if only we had…' There is a sense of magical thinking evident in these words, which echo the bargaining usually seen in grief. While CBT is not often considered a viable grief therapy, the one place it may be useful is when the person is ready to challenge distortions that lead to guilt. On its own, it "may not be efficacious for Complicated Grief Disorder among survivors of suicide" however, it can "lower dysfunctional grief symptoms and survivors' beliefs that they were blameworthy" (Parker, 2014, p.497). This suggests that an integrative approach is warranted.

Depression:

> "Our concern must always be for the bereaved; that they may have the support to face, feel and express their pain in whatever way they choose" (Kenneally, 1999, p. 115).

Rita Robinson (2001, p.37) contends that depression "may be tougher on survivors of suicide." There is simply more conflict to deal with, and often a plethora of unanswerable questions. Those bereaved by suicide are at greater risk of developing complicated grief (Jordan, 2008; Prigerson et al, 2011). With complicated grief, comes a higher risk of a depressive disorder (Young et al, 2012). In a 2011 qualitative study of grief reactions in those bereaved by suicide, 71% of parents, spouses, children and close friends identified as depressed (Schneider, Grebner, Schnabel and Georgi, 2011). Unquestionably, therapists must ensure that interventions for managing depression are included.

Acceptance:

> "It is from reaching beyond ourselves, beyond our sorrow, that we are transformed." (Tatelbaum, 1983, p.140, as cited by O'Rourke, 2017c, p.45)

Young et al (2012, p.178) maintain,

"the hallmarks of 'healing' from the death of a loved one are the abilities … to recognise that they have grieved, to be able to think of the deceased with equanimity…and to be able to seek the companionship of others." They go on to assert that from the bitterest of losses can emerge new meaning and wisdom. Teri Madura (2013, p.174) reminds us that "this does not mean that the pain goes away or that approval of the death is granted. Instead, there is acceptance of how one's life has been changed by the loss." Thus, acceptance is more than a word or a search for meaning, it is a way of truly living despite our losses.

> *The war on silence will end in defeat for every heart permitted to beat in the air that hearts make sweet" (Kennelly, 1990).*

Conclusion

As therapists, it is vital that we recognise the grieving journey is unique to each client we encounter, and to the relationship dynamic that existed between the bereaved and the person they have lost. Grief in the aftermath of suicide is more likely to be complex, and the grieving process should not be rushed. In the therapeutic space, we must remember, "there is no typical response to loss as there is no typical loss. Our grief is as individual as our lives" (Kübler Ross & Kessler, 2014, p.14). Furthermore, as always, our role is to walk with the person, at their pace, facilitating a space for client to talk, as they navigate the changing seas of their grief.

> "Give sorrow words. The grief that does not speak whispers the o'erfraught heart and bids it break." (Shakespeare, Macbeth, Act 4, Scene 3)

In summation, if Farberow was correct that suicidal people are made and not born, it is plausible that Kübler-Ross would argue beautiful people are also *made*, not born. Was she alluding to this when she wrote

"The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss and have found their way out of the depths. These persons have an appreciation, sensitivity, and an understanding of life that fills them with compassion, gentleness and a deep loving concern. Beautiful people don't just happen" (Kübler Ross, 1975, p. 96).

Note: All italicised quotations are taken directly from Brendan Kennelly's poem, *May the Silence Break.*

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A Reflective Article

When 'Challenges' Become More Than That:

A Journey of Post-Natal Depression: How can we as humanistic therapists help?

Patricia Allen-Garrett

Some years ago I wrote of the death of my best friend by suicide. I struggled to come to terms with that article because I usually write academically but in it I allowed myself to combine personal grief with its application in therapy. This time I make no apologies for the personal aspect of this article. This is my journey, just as it is the journey of far too many women.

This article has three aspects, facts about post-natal depression (PND), my own journey including therapy; the good, the bad and the useful, and how humanistic therapists can help mothers with and without PND. It also implores person-centred therapists to be aware of the signs of serious distress and remember that non-directive does not equal non-action-taking.

PND – What is it?

PND describes feelings of depression and/or anxiety after having a baby. Clearly having babies brings huge change to parents' lives with many feeling unsure of their new circumstances. Generally for approximately 50-85% of women this changes after a couple of weeks (MGH Centre for Women's Mental Health: n.d.). But for mothers with PND things do not get better quickly and life can become extremely difficult. The timescale for PND to develop is generally within the first few months up to a year after birth but it may also start before delivery. Statistics say 10/15 women in every 100 are affected by PND (Association for the Improvement of Maternity Services – Ireland, n.d.).

Possible causes of PND?

It seems that there is no one cause and but rather influencing factors. These include:

- Birth experience: traumatic/ difficult birth and/or birth that wasn't as good or was different from what was expected.
- Having premature baby/babies.
- Hormonal factors post-delivery.
- Recent stressful events in a mother's life, e.g., bereavement, serious illness, isolation from their families, an unsupportive partner.
- Previous history of depression.
- Images and expectations of motherhood: these suggest mothers should be radiant, energetic, and living in perfect homes with supportive partners. Mothering is perceived as instinctive. Therefore women who find the weeks and months after childbirth difficult often imagine that they are the only ones not coping. This can lead to overwhelming feelings of inadequacy, a sense of failure and isolation that can contribute to deep emotional stress (Postnatal Depression Ireland, n.d.).
- Sleep deprivation.

How do we feel with PND?

Persistently low mood and/or mixture of moods changing from low to high and even elation. Many women feel irritable, angry and/

or exhausted all the time. Many experience difficulty falling and/or staying asleep, even when there is the opportunity, because of worry. Many report loosing interest in themselves and/or not feeling close to the baby(ies). Anxiety is very common as is the feeling of no longer wanting 'this' life. Women may not want to engage with others as well as experiencing changes in or loss of appetite and sex drive and report feeling utterly overwhelmed and unable to cope.

Post-Natal Anxiety (PNA)

Much debate exists as to whether PNA is a different disorder to PND. It has similar factors to PND and additional factors such as having had IVF and babies in Neonatal Intensive Care Unit are thought to influence it. According to Nurture symptoms include:

> *Constant worrying about the baby, parenting skills, partners' parenting skills, the future, feeling dread and having racing thoughts, Dizziness, hot flashes, sweating, rapid heartbeat, rapid breathing, nausea, stomach and digestion problems, tight chest or throat and/or tension headache, feeling you need to be holding or with your baby all the time, feeling afraid to be alone with your baby, feeling like you have to be in control of every situation.*
>
> (Nurture, n.d.)

My meeting with PND

In 2014, following one miscarriage and three unsuccessful IVF treatments, I became pregnant with twins. At seven weeks, following a bad bleed, nurses told me one had died and I grieved the lost little life. Less than a week later the next scan re-found that little heart beat! I was thrilled and confused all at once. I began to worry what would happen at the next scan, the next appointment? I know now this anxiety was a huge factor in what happened after the birth.

Constant nausea until two weeks before delivery, worry about bleeds and from week 21 concern about the disparity in sizes between my pair made this pregnancy difficult. During this time female clients told me of their pregnancies, it was as if my pregnancy opened up a whole new connection between us.

At 26 weeks my consultant was concerned about one of my 'littleys'. He estimated her size as *"tiny"* and every two days I would hold my breath while he scanned me. At 30 weeks I had an emergency C-section.

Ten doctors, nurses and paediatricians, my husband and I awaited these two little ones. I was told to prepare myself as *"the outcome might not be good"*. At 3.54pm my son was born at 3lbs 4oz and at 3.56pm his little sister entered the world weighing just 1lb 9oz. For the next seven weeks, the NICU and Special Care wards were our home. We lived in a maze of monitors, alarms, respirators and incubators. Once again I found myself holding my breath as I rounded the corner each time to go through the alarmed doors.

I look back on photos of two little people, my tiny daughter only needed 15 minutes of help breathing as opposed to a day for my little boy. She contracted jaundice only once while her poor brother was repeatedly sunbathing under the lights! As determined as she had been to live, she seemed determined to show the world she was okay and feisty.

After seven weeks we were all home. That should have been an amazing time, but for me it wasn't. It was the start of a hell that I now know began during pregnancy. Sleep deprivation was huge, I was expressing eight times a day with only an hour-and-a-half sleep in any one stretch. Reflux entered the fray. But more than this, my obsession to ensure everything was 'right' took on epic proportions. Life became a military operation with time as its Sergeant Major. It was my only way to protect these two little lives that I was now responsible for. Very soon, every cry became something to worry over, every feed recorded, I knew I needed to reduce expressing because I was so exhausted but all the medics told me they wouldn't tolerate formula so I became panic-striken at the thought of it. The GP visited me, she recommended anti-depressants. I fought her, eventually took them and felt like a failure.

My twin sister saw me going through this emotional and physical decline and along with three amazing friends came over to help. By this time I was so scared that I couldn't sleep even when I didn't have to feed. Within 11 weeks I lost four stone in weight, panicked when my husband even left me to have a shower. I started to dread waking up from the very limited sleep I was getting. Within 11 weeks I became suicidal. My shame was huge. I work as a group facilitator with people who are suicidal or contemplating suicide. I couldn't put into place any of the things that help, I could only sit and cry in terror and despair.

I found a humanistic therapist who specialised in PND. My experience was dreadful. I was told to breathe, walk, sleep and spend time as a family. I know now these suggestions are useful for mild-to-moderate PND but not when PND is severe which mine was. The therapist failed to understand I was terrified my babies would die. There was no understanding of the terror, just blanket suggestions. I know I was a difficult client – so agitated I couldn't even sit. I paced and it was a relief when the hour was up. Our only agreement was both acknowledging I wasn't going to take on her suggestions. I couldn't, I wasn't capable of taking in information by then. I left far worse than I had going in because whatever hope I had slipped away as the therapist told me there wasn't much point in scheduling another session. My shame was compounded even further. The fear I was going mad and nothing could help, was now a reality.

Two weeks later, on Easter Saturday I was hospitalised with a dual diagnosis of severe PND and

PTSD. More crying, more shame. My sister likened this to my Calvary.

I will never forget my experience within the hospital and what I learned from some patients. I met many women who although now hospitalised for other issues had previously struggled with PND. I was humbled and amazed at the strength of some of the patients I came to know. I discovered the battles so many fight silently and secretly. I came to understand the importance of a kind word and saw incredible humour and fortitude.

With the help of the correct medication, therapy (that I fought for) and much needed rest I began to recover. In our first session, the family therapist said she didn't know when but she knew I would get better. Even though I was doubtful I clung to that hope and on really bad days I reminded myself of it and then slowly I began to feel it. During that time, I developed a grudging respect for my psychiatrist. I initially deplored his authoritarian way, his refusal of therapy. In time he shared his reasoning for this; his belief was that my depth of shame, combined with my physical depletion, not to mention my *"over-achieving"* personality would be a recipe for disaster with therapy and I needed to rest first and foremost. After three weeks therapy began, it was painful, practical and profoundly empathic. Over time we explored some of my anxiety and personality and in all of that I was held with great competence and care.

Ten weeks later I returned to my family, still struggling, but stronger. On World Suicide Prevention Day, September 10th 2014, I returned to work from my maternity leave aware of how fortunate I was.

Our Interventions as Therapists

An important parallel exists between the birth of a baby and rebirth of a woman into a mother. In this I see an opportunity for rich therapeutic work without ever post-natal depression being present. The learning that mother and baby go through is huge. A baby learns to live outside the womb in both a different environment and relationship with his/her mother moving from a 1:1 relationship to a multiplicity of relationships. Mother must learn to attend to this tiny new human being who depends on her for everything.

A new life brings both deep love and corresponding responsibility and this can be a time of great growth for women. It can be an opportunity to connect to ancestoral archtypes of 'Mother' to which she never before belonged. What an opportunity this provides! And what an amazing privilege it is for therapists to walk beside a woman as she experiences this.

We also have a role with women who are suffering from PND. Catterall (2005) looks at central issues of new motherhood and the changes it brings to a woman's identity which undergoes a fundamental shift. I believe we can work with a woman to integrate these shifts into her sense of who she is and work with difficulties that this may entail for some women.

At the societal level we can also explore the impact on a woman of the 'myths of motherhood' where everything 'should' be wonderful, a time of bonding and quiet time at night feeding your child/children, etc. This ignores another reality which is sleep deprivation, isolation and feeding issues, a consistently crying baby, amongst others, which may be present in this new dyad. When a woman experiences this time in her life as difficult she can feel alone, ashamed and terrified. Here is the strength of the humanistic approach. Here is where our commitment to be truly non-judgemental comes into its own. Here, by allowing ourselves to truly meet this woman we can show we hear her and convey that she is not alone. This is priceless and in time I hope would allow our client to be able to face these painful feelings in herself.

We can also help when a woman's locus of evaluation is so externalised that people in her life and society itself dictate what a 'good mother' is and, importantly, explore how she may feel because she is not reaching these often unobtainable heights. She may have struggled with feelings of not being enough previously and now being a new mother may have exacerbated these feelings. Previously I often managed to overcome difficulties as a result of willpower and hard work. But now I could no longer rely on myself to cope I didn't know who I was anymore and that brought huge anxiety because if I didn't know who I was how could I possibly care for two tiny babies who could do nothing for themselves?

However, I also believe that we client-centred therapists may be limiting how we help women who are severely distressed in this case by PND. Mearns and Cooper in their book, *Working in Relational Depth*, say of clients: *"The secret is to meet them on their terms"* (2005: x). This for me is the heart of humanistic therapy. However, sometimes I believe because we (correctly) try not to interfere with the autonomy of the client, a central core message of non-direction has become one of rarely taking action in any circumstances. So how do we deal with the paradox that meeting the client 'on their terms' may in fact mean taking action, with the client's involvement and agreement, if that is what is required if a person is in severe distress?

I fully uphold the core tenants of the client-centred approach that the client has all the answers inside and we can disempower them should we interfere/guide decision-making, and that giving direction to clients on how to live their lives does nothing to help them find/re-instate their own locus of evaluation. However, as a result of my own experience, I am questioning the validity of non-direction when a client is in extreme distress.

As therapists we accept the concept of 'normalising' a client's

experience, helping him/her to realise that they are not going out of their minds when they are experiencing pain. Therefore I believe that psycho-education does not run contrary to the person-centred approach when someone is in distress and neither does it disempower. I believe severe PND may require additional support from a therapist, e.g., the containment aspect of the relationship may need to be stronger than in relationships with less-distressed clients, where the therapist can become an attachment figure in reverse if you like. This is not about forging a dependence but offering a space where women can come to know that they are not *"going mad, not alone in their experience and that they will get better"* (Catterall, 2005, p. 219).

Once we are not rushing in to rescue or being an expert and importantly we are not filling any needs of our own I don't believe this goes against person-centred counselling. For a period of time we are offering a space where there is an element of re-assurance. I believe in time we will be able to work with the deeper dynamics behind the despair and anxiety but this can come later. First anxiety must be reduced before defences against it can be relinquished and it can be used as Rollo May suggests *"as stimulation to increase one's awareness"* (May, 1950, p. 371). Because as Lake says, although anxiety can be constructive: *"nothing is more destructive in those whose power of being cannot contain it"* (Lake, 1991, p. 90).

I am not suggesting we look to fill every: *"possible gap in the woman's experience"* (Catterall, 2005, p. 210). I am suggesting we allow ourselves become part of her support system, exploring the possibility of her joining PND support groups, working with other professionals, accepting we form part of her support. One-to-one therapy may not be enough. This is not a fault of our form of therapy. PND (and other forms of deep distress) may need more than any one support. This is particularly relevant if suicidal feelings are present and we must remember we have a duty of care to both mother and baby.

I fully accept the above may be difficult for us as therapists, I find myself constantly questioning could an unhealthy dependence be forged, could I disempower a woman by working in this way? It is this commitment to my own potentially unconscious processes that leads me to keep therapy healthy and my client's needs to the forefront.

I am now working with a wonderful person-centred therapist who has allowed me to do the things I have suggested above that can exist within a therapeutic relationship. We work with my fears on two levels – a practical level which I call the-learning-how-to-be-a-mother level and, at a deeper existential level, to talk of what these fears mean to me and how they have been present in other ways in my life. The birth of my twins brought these fears to me in a way that was impossible to ignore. In none of these sessions have I been disempowered, I have felt a healthy nurturing of my new role as well as a thorough commitment to understanding what may lie deeper.

In time parents learn to allow their children to take steps on their own. We as therapists can mirror that for women in distress too – our help will become less needed as the new mum gains strength as well as insight. I believe, as therapists, we can offer so much to women as mothers and to mothers who are suffering and in distress from PND.

Three years on my son and daughter are big, blonde, bold, happy and healthy. They are an absolute joy and sometimes an absolute nightmare with their antics times two! There are days I still struggle with anxiety particularly if they aren't eating or sleeping well but I can help myself now through mindfulness, breathing, walking, eating well and seeing friends. I know now it's okay to ask for help and I urge all mothers struggling to do the same. Similarly I urge all therapists to offer that help even if it feels like we are stepping outside of 'how we do therapy' because it will be short term.

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