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The Emerging Self

- The Twilight World of IVF Treatment
- Breaking Free from OCD - An Interactional Approach
- The Role of Emotional Awareness in Couple Relationships
- In Defense of The Self

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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.'

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

From the Editor:

Cóilín Ó Braonáin PhD

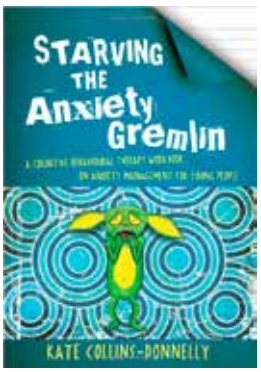
Dear Colleagues,

The winter edition, on this occasion, offers a broad selection of articles on diverse topics. Increasing, in my practice, clients are presenting with issues concerning the stress involved in seeking In Vitro Fertilisation (IVF) treatment. While it is easy to empathise with such clients, it is impossible to comprehend what the felt experience of the IVF world is like, for a world of its own it certainly is. However, a window of understanding has been opened by Attracta Gill on this subject, which makes it possible to glimpse the ordeal that IVF becomes for many people.

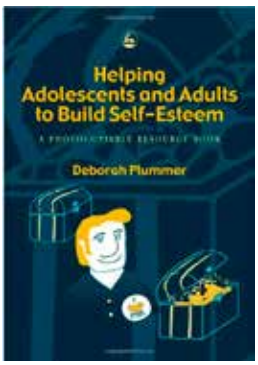
On another topic Padraic Gibson presents an alternative to Cognitive Behaviour Therapy and Exposure Therapy for the treatment of Obsessive Compulsive Disorder. A very well referenced articles suggests and claims success for a rather counter-intuitive treatment! In contrast to the somewhat prescriptive approach of Gibson, Michael McGibbon's contribution argues against 'technical' treatments in psychotherapy and advocates the continued use of 'self' as a therapeutic tool. Indeed, McGibbon sees great danger in the trend towards systemised therapies.

On a different note again, Mary Beirne offers original research on the role of emotional awareness in couple difficulties. Gender differences in emotional awareness and expression play an important part in the couple's problems, but knowledge of the problem can be an effective tool in therapy.

Finally, the editorial board has decided to invite members to review books for the journal. Complimentary copies of the books will be supplied. Currently, two are available.



1) **Starving the Anxiety Gremlin** by Kate Collins-Donnelly, and



2) **Helping Adolescents and Adults to Build Self-Esteem** by Deborah M. Plummer.

Requests may be sent to Deirdre Browne at deirdre@iacp.ie.

Cóilín Ó Braonáin PhD
Chair of Éisteach Editorial Board

The Twilight World of IVF Treatment

by Attracta Gill

"Pain is the doorway to the here and now. Physical or emotional pain is the ultimate form of ground, saying, to each of us, in effect, there is no other place than this place, no other body than this body, no other limb or joint or pang or sharpness but this searing presence. Pain asks us to heal by focusing on the very center of the actual torment and the very way the pain is felt"

David Whyte

Abstract:

In this article I share with the reader my own personal experience of infertility and subsequent IVF Treatment. I hope to give you an insight into the complex suffering and pain that accompanies this process. But most importantly I have written this in order to share my humanness and my belief and experience that transformation out of hopelessness, despair and deep pain can happen; that is with the support and love in relationship, and our capacity to go into deep resonance with the suffering of the other. My experience informs what I had already learned in practice; that technique is not pivotal in psychotherapy rather it is the new emotional experiences that the client feels in his/her body, within the secure relationship with the therapist that prove helpful.

Background:

I stumbled into the dark world of IVF treatment through a series of misfortunate circumstances. My husband was diagnosed with prostate cancer just a year after we married. As the only life-saving option available for him was a full prostatectomy this would have serious consequences for our future together. In order to remove the cancer and save his life my husband would lose the ability to produce sperm. This threw us into a huge tailspin and it was only 2 days before his operation that we banked a small amount of sperm in a fertility clinic. Thankfully my husband made a full recovery and all cancer was removed from his body. He spent a year in recovery and then we embarked on what was to be the start of 4 horrid years of fertility treatment and 9 negative cycles of IVF.

Treatment:

IVF treatment is a strange animal. It builds you up full of hope and promise only for your heart to be broken time and time again. The first time I cycled I was full of hope and enthusiasm and of course youth was on my side. I breezed through all of the twice-daily injections, scans and hospital visits. It had little impact on my work or social life. As one of the world's most natural optimists I just knew we would succeed. And I was right. I got pregnant first time and couldn't believe how easy it all had been. Naturally I didn't change my busy schedule of client work, teaching, training etc. in any way. What was the need? Our first scan was scheduled for the 8-week mark and the day before this, I happened to be working with a group of students in the country. During the class I suddenly felt a strange sensation of unease and disconnection from my baby. I knew

something was wrong, very wrong. And yet I continued teaching and drove home feeling full of dread for what might lay ahead. The next morning we arrived at the hospital and I shared my fears with the nurse. She didn't seem too worried and said that the scan would put all of fears at ease. During the scan I remember the silence, the stony look on the nurse's face and the humiliation of being in such a vulnerable position physically and emotionally. It seemed forever before she broke the silence and said 'I can't locate the heartbeat'. I remember crumbling on the examination seat, my legs still straddled in the air, I could not ground myself, I couldn't breathe and so I went into deep shock and trauma. I sobbed my little heart out, in this same humiliating position, for about 20 minutes. I felt degraded, cheated, bereaved, exposed, heartbroken and utterly bereft all at the same time. I was broken.

We were told that this was what was known as a 'missed miscarriage'. Our baby was still perfectly formed in my womb and it could take days or weeks to pass the little fetus. They recommended that I try to pass him/her naturally and I was sent home with some neurofen plus for pain relief. I was petrified and numb and had no idea what to expect over the next week or so. It was 2010 the Winter of the terrible snow in Ireland and as we live in the middle of the countryside we became totally isolated and my family were unable to visit and comfort me in any way. I sat in my conservatory, with my log burner, staring out at the snow and watching the little birdies feed from our bird feeders and I waited. I waited and waited for a week. During this time I let my tears fall until I felt there were none left, I prayed, I cursed and I sat in the unknown wondering would I ever smile again. I travelled to the pit of despair deep inside my body and then, just when I felt I was lost forever I would come back up for air and have a small reprise; only for it to start over and over again. And then the bleed started, followed by the most horrid pain and contractions. My body spent 3 days expelling all our hopes and dreams. And then the deafening silence after the drama; It was all over. One minute pregnant and the next minute emptied.

I had lost our baby and this was to have a deeply profound impact on my life.

When I recovered physically and after a long break we resumed the IVF Treatment. Now despite our best efforts we could not get pregnant. As we continued over the years I felt more and more physically tired. My body was getting older and I started to slow down. The injections began to hurt my body, my optimism had wavered and for the very first time in my life, I felt beaten. This was an alien concept to me. I had always been determined, indeed to the point of stubbornness. I had worked hard in my life to open up possibilities; to transform childhood trauma into resources, to train to the highest standard in my much loved profession, to overcome any adversity in my life, I was always pushing myself forward. I was blessed with a happy and bubbly disposition and nothing ever knocked me for six. That is, until now. I could not control this outcome no matter how hard I tried and throughout 9 IVF Treatments I began to discover what it was like to surrender to my fate and the unknown. I could not control my destiny for this and so it was with great kicking and screaming that I reluctantly stopped, embraced and surrendered to my fate. I realized if I could not succeed I would have to surrender.

Resources:

My wonderful teacher and friend David Boadella taught me that we must always look for the resources out of the trauma or difficulty. Of course I understand that this is a great challenge for all of us human beings when we are faced with such horrid traumas in life. However, I'm relieved to say that throughout this journey I did find many resources within and outside of me. I realized that I could travel to a very dark place inside me that was full of despair and loss but equally I could surface for air and find my breath in the midst of drowning. I discovered a hidden depth to my personality, a compassion and somatic resonance for others and myself throughout their difficulties that I didn't know I had. "Pain is the first proper step to real compassion; it can be a foundation for understanding all those who struggle with their existence. Experiencing real pain ourselves, our moral superiority comes to an end; we stop urging others to get with the program, to get their act together or to sharpen up and start to look for the particular form of debilitation, visible or invisible that every person struggles to overcome", (David Whyte, 2013). I slowed my life down considerably and learned about the difference between my longing in life and ambition. 'Ambition takes willpower and constant applications of energy to stay on a perceived bearing; longing demands a deeper allegiance to unknown elements which are drawing us beyond ourselves, making us larger than an overdrawn, ambitious identity with set, unforgiving goals', (David Whyte, 2001:163). My longing in

life was to realize the ability to work with humans in distress and to help facilitate transformation out of suffering. This had always been my passion in life. However, I now lacked the drive to be 'ambitious' in my career and this felt freeing and joyous. I could let go of trying to get anywhere, as in a way I had already arrived. I learned about the painful art of surrendering to great emotional pain and sitting and trusting in the unknown for long periods. I realised that it is sometimes from this place that resources are created and problems are transformed. I learned about receiving healthy support from others. "In real pain we have no other choice but to learn to ask for help on a daily basis. Pain tells us we belong and cannot live forever alone or in isolation" (David Whyte, 2013). My beloved therapist provided a safe landing place for me throughout my despair. She taught me about unfailing presence and the wonderful mysterious dynamic that Patrick Nolan (2012) reminds us of: the 'potential space' for creativity and the healing that occurs from this place between therapist and client. Interventions of any kind would have been futile with me. It was her ability to sit and meet me in my despair and helplessness, and the strength of our relationship that helped me pull through. I am not ashamed to say that it was through this time of 'holding' that I experienced a deep reciprocal love. And this love helped me to heal. "Pain makes us understand reciprocation. In real pain we often have nothing to give back other than our own gratitude, a smile that looks half way to a grimace or the passing friendship of the thankful moment to a helpful stranger, and pain is an introduction to real friendship, it tests those friends we think we already have but also introduces us to those who newly and surprisingly come to our aid", (David Whyte, 2013). My supervisor supported my work with great humanity and professionalism. I cut back on my client hours, stopped my teaching work and with her support I created more time for my wonderful husband and myself.

I remember feeling strangely stigmatized throughout the whole process of IVF. It was almost like IVF was a dirty word...

Throughout the process I also discovered that some people were uncomfortable when I would even touch on the subject of IVF. It helped me greatly to talk about the process and I guess because I'm a therapist I believe in being open and discussing life's challenges. However I began to notice that some friends, colleagues and family would look to the ground or try to change the subject. Worse still, some people would ignore the word IVF altogether and not acknowledge what I had just said. I learned not to force the subject but equally I remember being bitterly disappointed in not being met in some way. Over time I learned not to take it personally and would remember a quote my friend had shared with me many times, 'Don't go to the goat house looking for wool'. I am relieved to say that I have become an expert at walking away from goat houses.

I was also very blessed at the time to be working with David Boadella in Switzerland and was training with him in Biosynthesis Somatic Psychotherapy. My body and mind were suffering greatly throughout this emotional rollercoaster and David helped me enormously through his wonderful process work and his profound understanding of how trauma impacts on the human being. I learned that connection on all three levels of body, mind and essence (spirit) helps us overcome trauma. I developed healthy boundaries in relationships and learned how to look inward and outward for support and love. I started to write my poetry again (it had been nearly 20 years since I stopped) and this became a great resource for helping me express my pain and isolation. Most importantly myself and my husband became closer and learned how to support each other whilst also giving each other space to mourn separately. I also learned that the inclusion of the body in psychotherapy is of great importance or has simply become indispensable and that recent brain research corroborates this: the body and mind are in constant exchange (Schore, 2006). I will always be incredibly grateful for David's humanity and his influence on my life and my work.

There are many reasons as to why I felt compelled to write this article. I dislike stigma of any kind and yet at the time I remember feeling strangely stigmatized throughout the whole process of IVF. It was almost like IVF was a dirty word that some people did not want to hear or talk about. Of course people will have their projections and judgments concerning the whole process and I can accept

I realized that I could travel to a very dark place inside me that was full of despair and loss but equally I could surface for air and find my breath in the midst of drowning.

that. However, I refused to feel shamed in any way. I saw it as one of life's difficulties to overcome and/or surrender to and like any trauma it was an opportunity to find resources within and to build resiliency. Coupled with this, IVF can be very isolating as it happens in between our busy lives of work, families, special occasions, birthdays, Christmas etc. It happens behind our closed doors at night and in the Medical Clinics and Laboratories that leave you feeling cold, inhuman and worthless. It happens as family members, friends, clients and colleagues all become pregnant and have babies. In those moments I remember the stinging feeling of a knife slicing through my heart. I remember being conflicted within; one side feeling devastated, hard done by and jealous and another side feeling happy for their news. It was during those times that compassion and kindness for myself was paramount. It was important to embrace and welcome the jealousy, the hatred, the disappointment and the anger. When I allowed this to happen I found life again and this gave me space and courage to try another cycle.

I would like to be able to reach out to others that may be struggling with this process. I also believe that maybe in some of our core trainings in psychotherapy precedence is given to interventions, theories or models. Yes, these have a place and are vitally important for the therapists training and for professional standards, however throughout my 4 years of IVF treatment, 3 core psychotherapy trainings spread over 12 years and 9 years of sitting in the client's chair, it is clear to me that relationship and strong therapeutic alliance is paramount to affecting healthy change. What mattered deeply to me as client was to be met in love as a human being that was going through an existential crisis of enormous proportion. Everything else was secondary to this meeting. Let's find creative ways of helping our trainee therapists develop this inner compassion, this ability to sit and contain human suffering whilst supporting the client to find resources and pathways forward. Indeed it is not something you can learn from a book. However, as I felt inspired to write this from a human being's perspective and not from a clinical one I will leave my hope's and vision's for the future of psychotherapy trainings for another day.

What mattered deeply to me as client was to be met in love as a human being that was going through an existential crisis of enormous proportion.

Conclusion:

I wrote this article so that I could come out of the shadows and twilight world of IVF and share my story of how I came through the other side a fuller human being with deep compassion for human suffering. Infertility is a very complex process that calls on every fiber of our being in order to remain sane and emotionally well. It is a process that is deeply unjust and robs you of your ability to create a new life with your beloved partner. It is a miracle in itself not to become bitter and twisted. In my life's work I am inspired and look forward to helping some of my fellow human beings not only survive the trauma of infertility treatment but also to emerge with resources they never knew they had.

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Breaking Free from OCD - An Interactional Approach

by Padraic Gibson

If you desire to see learn how to act

(Heinz Von Foerster)

Obsessive-Compulsive Disorder Treatment

This paper sets out a rationale and logic for effective systemic-constructivist intervention in the treatment of OCD and builds upon the outcomes of research in an Irish context. Around the world there are literally millions of people suffering from Obsessive-Compulsive Disorder (OCD), with 50% of cases falling into the severe category. OCD is characterized by the presence of persistent thoughts and/or repetitive behaviors significantly interfering with the individual's daily routines, work, family or social life, then causing marked distress. A wide range of comorbidities is also usually associated with the disease, specifically major depressive disorder. Cognitive–Behavioral therapy (CBT), including exposure and response prevention (ERP) techniques, represents the gold standard for the treatment of OCD. However, individual suffering and functional impairments, as well as the economic cost associated with the disease still remain substantial. Brief Systemic and constructivist therapy for OCD has recently been developed, showing encouraging results (Gibson et al; 2013).

The metaphorical image that best represents the underlying logic of OCD is gleaned from a story told by Paul Watzlawick *"A man claps his hands every ten seconds...and when asked about the reason for this strange behavior, he explains: 'I do it in order to scare away the elephants.' When told there are no elephants present, the man responds: 'well, there you go. See, it works so!''.* Obsessive-compulsive ideas emerge as repetitive fixations which are often unreasonable but from which the client cannot free himself. The typical perceptual and behavioral system of obsessive-compulsive disorders is based from our experience on fear or on pleasure, which in turn drives the patient to repeatedly react by carrying out specific compulsive thinking, formulas or ritualized actions in an attempt to either reduce his fear or to achieve a pleasurable sensation (Gibson et al; 2013, Nardone & Portelli, 2013; Portelli, 2004).

These attempted solutions, give patients an illusion of full control over a specific situation, and it is only over time that individuals start feeling that what seemed to protect them, is actually overpowering the problem. As Samuel Johnson states (1709-1784): *"the chains of habit are too weak to be felt until they are too strong to be broken".* People usually only ask for help or seek therapy when they begin to lose the power to control their own actions and thoughts and the problem becomes diffused, affecting most aspects of their life. As with our action research project for developing effective systemic treatments of the other main pathologies, (Gibson et al., 2014) we noted that in the case of OCD it carries its own specific commitments and unique phenomenology. There are no simple cases of OCD for a clinician

because their initial port of call is usually the medical route, which can in the initial phases reduce the symptoms. However many also drop out of CBT treatment and due to the lack of optimism from professionals in the outcomes for OCD and the lack of knowledge about the effective systemic treatment for this problem, many do not seek further help and suffer in silence.

Fear runs along a spectrum from pure fear (monophobia) to Fear with control (OCD) to pure control (Obsession). OCD patients are usually the type that only seek help from the specialist and therefore the clinician must bear this in mind when working with them. They are looking for confidence in the therapist and someone who has the tools to help them, these problems are notoriously resistant to change using rationalistic explanations. In order to resolve these complicated problems it is important that therapeutic success be built on the use of ***a non-ordinary logic***. In order to re-orient the symptom towards its self-annulment it is necessary to first convey to the patients ***that what they think and do makes sense, but then we must give them the illusion of holding a more efficacious way to manage the situation***. In other words, therapists need to follow the logic that underlies the patient's ideas and actions (Gibson and Portelli 2013, 2014, Gibson and Ray 2014, Portelli, 2005) to change it and to avoid any inherent resistance. These are after all patients that have sought control and found it as far as they are concerned, so if you are going to remove their solution, you'd better be confident in the option you are providing.

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder characterized by recurrent or persistent thoughts, impulses or images that are experienced as

"The chains of habit are too weak to be felt until they are too strong to be broken". (Samuel Johnson)

intrusive or distressing (obsessions), and repetitive behaviors or mental acts (compulsions) often performed in response to an obsession (M. Keeley & Storch, 2008). Epidemiological studies report a lifetime prevalence of 1-4% in the general population (J. S. Abramowitz, Taylor, & McKay, 2009; Foa, 2010; Karno, Golding, Sorenson, & Burnam, 1988), equal for men and women, although the disorder is most commonly found in boys than girls (J. S. Abramowitz et al., 2009; Geffken, Storch, Gelfand, Adkins, & Goodman, 2004). Co-morbid psychological disorders associated with OCD include major depression (Doron, Moulding, Kyrios, & Nedeljkovic, 2008), additional phobias, panic attacks, generalized anxiety disorder (M. L. Keeley, Storch, Merlo, & Geffken, 2008) as well as severe occupational, social and family dysfunction (J. S. Abramowitz et al., 2009; Nardone & Portelli, 2013; Storch, Abramowitz, & Goodman, 2008). However because of the subtle nature of the disorder and because of the seemingly common sense logic that underlies these rituals, many patients go undiagnosed with OCD. (For example: health anxiety, general anxiety-patient here)

Just Stop it! Exposure and ritual prevention

In cognitive and Cognitive-Behavioral Therapy primary processes used for the treatment of OCD are Cognitive Restructuring (CR), rational emotive behavior therapy or Beck's cognitive therapy and self-instruction training (van Oppen et al., 1995). In order to interrupt the vicious circle that maintains the problem, widely used CBT techniques are also Exposure and Response Prevention (EX/RP or ERP) strategies (J. S. Abramowitz, 2006; Doron et al., 2008; Meyer, 1966), which essentially lead the person to systematically face the feared stimuli and to experience anxiety without performing any rituals (Lewin et al., 2011). CBT including EX/RP was found to be effective in a number of clinical trials, both in adults and children suffering from OCD, obtaining best outcomes in comparison with other forms of psychotherapy and placebos (J. S. Abramowitz et al., 2009). Also, findings from several studies have shown CBT improving OCD symptoms more than pharmacotherapy, as well as being especially durable after treatment withdrawal and efficient in providing safety (J. S. Abramowitz et al., 2009; Geffken et al., 2004).

However, although ERP techniques have demonstrated good follow up rates of success, they often provoke anxiety in individuals and about 25% of people drop out or refuse the treatment (J. S. Abramowitz et al., 2009; Storch et al., 2008). Also, from the other 75% who continue receiving the intervention, only 25-40% reach some recovery, while most of the subjects remain symptomatic even after the full therapy course (Storch et al., 2010). Similar results have been found in a meta-analytic review of 16 studies with EX/RP in OCD patients, with 48% of them having symptom reduction (M. L. Keeley et al., 2008) as well as in another review study examining the efficacy of CBT for pediatric OCD, revealing that 50-75% of receivers remain somewhat symptomatic (Boileau, 2011). Also

You can avoid doing it at all, but if you do it once, you must do it no more and no less than five times.

when we strip back the jargon and professional language used in CBT we are essentially left with the naked fact that EX/RP is essentially telling the patient to 'stop it' which is nothing short of what the patient has tried unsuccessfully to do most of his/her life. Moreover from our study in The Bateson Clinic we can see the paradoxical effect of using this type of rational advice, it actually increases the ritualized behavior. Who hasn't gone on a diet only to discover that what we were avoiding is even now more attractive? So we can see that OCD lies within a completely different type of logic to common sense or rational language and this is where Bateson (1973) and Watzlawick et al. (1967) come to our aid, with their work on paradoxical interventions. Another factor predicting poorer outcome is family invlovement, and specific treatment forms have been developed, like cognitive-behavioral family therapy (Doron & Moulding, 2009; M. L. Keeley et al., 2008; Storch et al., 2007). The involvement of the families of children with OCD has been shown to have a beneficial effect (Barrett, Farrell, Dadds, & Boulter, 2005).

Rigorous But Not Rigid Interventions

Our model of brief systemic and constructivist therapy (BST), has shown effective outcome results in treating many forms of psychological suffering when compared to CBT, (Gibson et al., 2014; Nardone & Portelli, 2005). One of the significant differences that exist between the two approaches is that CBT derives from learning theory, whereas the traditional systemic approaches as explained here, base themselves on the assumptions on the theory of change (Watzlawick et al., 1967). In other words, while a cognitive-behavioral therapist guides the patient through a process of awareness and voluntary effort to learn how to fight and handle the disease, the systemic therapist should adopt ad hoc therapeutic interventions in therapy that create a corrective emotional experience, that is accompanied by a felt sense of change. This intervention should transform how the person perceives and reacts to his own reality, thus allowing the individual to later acquire awareness of the problem and the ability to prevent it reoccurring. However, the systemic approach also results in a more efficient, intervention leading to faster healing and reducing relapses long term (Gibson 2014).

Communication is Essential. The Problem of Evidence Based Practice

We live in an era of evidence based practice (Wompold, 2007) and one of the major problems of evidence based therapy or medicine is an orientation towards a belief that the active ingredient in treatment is the 'technique' and therefore many doctors and evidence based therapy models place less emphasis on the relationship and communication.. Differentiating the two models above is also the type of language adopted during clinical dialogue, as well as the language used in the therapeutic prescription phase of the treatment for OCD. In fact, cognitive-behavioral approach is traditionally characterized by a logical-rational communication, a language that is typically one of explanation. On the contrary, systemic therapy outlined here is based on language that is injunctive and performative (Austin, 1962), aimed at making the person *feel* differently before acting differently, *through the use of metaphors, anecdotes and stories and questions with the illusion of an alternative* (Erickson 1971).

It is very hard if not impossible to enable someone experience something by describing it.

To explain it more clearly; if we wished to describe a chocolate cake to someone who had never tasted it we may run into a specific problem; that of descriptive language. It is very hard if not impossible to enable someone experience something by describing it. If however I avoid the sweet, salty, buttery, spongy description and instead provide the other person with a recipe for a chocolate, then they can create and experience it. It is then and only then after experiencing it, can they gain insight into chocolate cake and their experience of it. This is essentially what we are asking practitioners to consider, to give the client access to some actual experience of change, to which they can then refer and reapply to future change.

Systemic Therapy's Helpful History:

Through the use of suggestive and persuasive forms of communication (Gibson 2013 and Gibson and Nardone 2014) (Nardone, 2003; Nardone & Watzlawick, 2005) derived from communication theory developed by Gregory Bateson in an anthropological context and the constructivist developments of the cybernetic theory of Von Foerster and Glaserfeld and Watzlawick et al., and from Milton Erickson's studies on hypnosis and suggestion we now have an effective model of systemic therapy for OCD. Also from the more recent past, we have applied the work of the Palo Alto School (Mental Research Institute – MRI) who first formulated the Brief Therapy model, further developed by Giorgio Nardone, who together with Paul Watzlawick developed

an advanced form of therapeutic technology, presented for the first time in the book entitled ***The art of change*** (Nardone & Watzlawick, 1990) and more recently in ***Winning without fighting*** by Padraic Gibson, Mateo Papantuono and Claudette Portelli (2014).

How Obsessive-Compulsive Disorders Evolve

From our research we can define five reasons that trigger compulsive thoughts and actions: ***1) the doubt that generates the need for reassuring answers; 2) an excess of ideological rigidity as well as extreme moral respect or religious belief; 3) an excess of rational reasoning processes, leading to complete unreasonableness; 4) an extreme health prevention that turns into phobia and 5) the attempt to reduce anxiety and distress generated by a trauma*** (Gibson et al., 2014;Nardone & Portelli, 2013).

For each of these reasons the purpose may be to ***prevent or repair*** something that "might" happen or "has" happened as well as to ***propitiate or ensure*** things continue to go well. After having discriminated whether the basis of the compulsion is ***phobic or non-phobic***, we then set out to interrupt the dysfunctional equilibrium that is self-reinforcing the disorder. At this stage our model focuses on the patients' attempted solutions, which in the case of a person suffering from OCD are typically represented by:

a) *Avoidance of situations that cause anxiety;*
b) *Request for help or reassurance from others in the form of delegation of tasks or in seeking assistance for avoiding contact with fearful stimuli;*
c) *Implementation of specific rituals to manage the situations (Gibson et al., 2014; Nardone & Portelli, 2013)*

Other important discriminations to be made are whether the compulsion is represented by ***repetitive visible actions or by mental rituals***, then whether the ritual ***follows or not*** a specific sequence, either ***numerical*** or ***analogical***.

Depending on the structure of the ritual an essential and unique aspect of our work is we have devised several counter-rituals specifically prescribed to fit the different typologies of compulsive symptomatology (Gibson and Portelli 2013; Portelli, 2005). These counter rituals, when adopted by the patient, paradoxically break the usual behaviors extremely rapidly, as reported in this journal previously in a case of treatment for self-harm, by one of my colleagues (Boardman, 2014).

Similia, Similubus, Curantor: Prescribing The Problem

Changes we experience in our everyday life (that is spontaneous change) occur when our perceptions, relationships or emotions are called into crisis thus leading to some form of growth or maturity (Watzlaiwck 1987). We generally accept such change as valid or appropriate and our training programmes aims at helping psychotherapists to wait for such spontaneous, non-instructive change (Hoffman 1993). However what is to stop us from finding ways to bring this about actively in our work with those that suffer for many years in silence with such problems, with little other hope of treatment?

In the treatment of OCD change is something of real importance, as these patients tend to drop out very quickly if they do not see change. Moreover, this type of complex problem is not based primarily on the relationship with self and others, but with the relationship with self and self; it is a closed system (Maturana, 1987). What is usually perpetuating this problematic system is the logic that the client is bringing to solving the problem. This self-sustaining, self-referential feedback loop maintains the problem, and the solution is achieved by the recognition of the systemic nature of the problem and by a systemically informed therapeutic response.

Counter rituals, when adopted by the patient, paradoxically break the usual behaviors.

What this means is that the client's apparent ***'solution'*** is his problem and his ***problem is at the same time the only solution***. If we try to rationally explain this we will achieve very little. If we attempt to discuss aspects of the client's life not related to solving their OCD, we will soon find ourselves widening the focus of enquiry without success, increasing the client's sense of hopelessness and our own when the client asks at the end of the session what to do about the problem behaviour. Therefore we believe we must introduce a tangible experience of change to the system via an intervention that creates a corrective emotional experience (French and Alexander 1967; Satir, 1977). This is something that will change how the client feels' about their problem, that will create change in how he thinks and acts. In the case of a patient suffering from Obsessive-Compulsive Disorder, for example, using reason to convince him to stop his pathological rituals will not necessarily lead to any result, however a prescription based on the same logic underlying the problem will turn the force of the

This form of systemic approach is essentially aimed at creating a corrective emotional experience, transforming the way in which the person perceives and reacts to his own reality

symptom against the disorder itself, breaking its perverse balance.

With OCD treatment the following prescription is one we regularly use, ***"every time you enact one of your rituals, you must repeat it five times, exactly five times, no more, no less. You can avoid doing it at all, but if you do it once, you must do it no more and no less than five times"***, the injunction to ritually repeat the ritual paradoxically leads the person to construct a different reality from the one characterized by uncontrollable compulsions. We can then request that they can consider the possibility of not performing the ritual, since not uncontrollable spontaneous anymore, but prescribed voluntarily (Gibson et al., 2013; Nardone & Watzlawick, 2005). The logical structure of this apparently simple prescription helps to avoid the usual resistance that comes with this problem typology. If the individual needs to perform the ritual once, he has to do it five times. Therefore it is therapist suggesting how many times he is to repeat it, thus taking control of the symptom and giving to the patient the injunctive permission to avoid doing the ritual. Usually we find that following the prescription literally at first, clients usually suspend the ritual after a few days, not being able to explain why. It is also true that the way the prescription is communicated is fundemental and we must do it is by the use of a redundantly repeated, hypnotic linguistic assonance and of a posthypnotic message expressed in a more marked tone of voice (Erickson 1974).

Conclusion

Results obtained from the empirical-clinical research carried out by the 4 year study at the Bateson Clinic Dublin (Gibson and Casltenuovo et al., 2013) and over 15 years at the Centro di Terapia Strategica (CTS) of Arezzo, Italy have shown Brief systemic constructivist therapy having good outcome results in treating Obsessive-Compulsive Disorder, allowing the systematization of specific treatment protocols (Gibson et al., 2013). Data have shown that even the most obstinate of obsessions and compulsions are usually won over by redefining the situation and by setting up a series of concrete corrective emotional experiences that free the patient from his rigid self-feeding perceptive-reactive system. Despite both CBT and systemic constructivist approaches having been proven to be effective with regard to the cure of this particularly hard-to-treat symptomatology, follow up data have revealed the strategic approach also resulting particularly efficient, leading to faster healing and reducing relapses long term.

Focusing on the individual "attempted solutions", then understanding what maintains and worsens the problem, this form of systemic approach is essentially aimed at creating a corrective emotional experience, transforming the way in which the person perceives and reacts to his own reality. Through the use of ad hoc therapeutic interventions and in-session injunctive and performative language this therapy bypasses the individual's usual rational mechanisms, leading to the self-destruction of the logic that imprisons the mind, then the vicious cycle maintaining the problem quickly comes to be interrupted.

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The Role of Emotional Awareness in Couple Relationships

by Mary Beirne

Introduction

One of our important primary needs is for emotional contact and relationship with others. For adults, exclusive intimate couple relationships provide the potential for the reciprocal expression of feelings and emotions. The key issue for couples seems to be the ability to maintain a context for intimacy and engagement, allowing both partners "experience a sense of trust and security in which they can be safely vulnerable" (Ginsberg, 2004, p 68). Developing and maintaining emotional intimacy depends on each partner's ability to communicate their feelings to each other. The emotions of both partners can affect not only their own actions but also how their partner responds. (Mikulincer & Shaver, 2003). This article outlines a research study carried out at Dublin City University (DCU) as part of a Masters taught degree programme. The study investigated how partner levels of emotional awareness affect the quality of adult, heterosexual, couple relationships.

Emotional awareness is defined as the ability to recognise emotions in ones-self and in others, including recognising that emotion is present and also cognitive reflection on what is being experienced (Lane & Garfield, 1990). This ability develops from early childhood, mainly through parental emotional expressivity, responses to the child's emotions, and emotion talk (Warren and Stifter, 2008). Relationship quality as defined by Busby et al (1995) encompasses three dimensions; consensus, satisfaction and cohesion. Consensus refers to a high frequency of agreement between partners. Satisfaction refers to a low frequency of separation discussions, and a high frequency of shared confidences and positive thoughts about the relationship. Cohesion refers to the sense of connectedness between partners as well as the frequency of shared activities.

Brief Literature Review

Emotional Awareness

In order to have an awareness of others feelings and emotions, one must first develop an awareness of self and one's own feelings. Emotional self awareness can be described as a co-construction.in that it develops through interaction with others (Rochat & Striano, 1999).

Greenberg, (2004) sees emotion as the key component for the construction of the self and what determines a person's ability for self organisation. He suggests that as well as having emotions people are constantly trying to make sense of their emotions. Personal meaning emerges through the self organisation of emotional experience; this involves the integration of reason and emotion.

The development of emotional self awareness in infancy and childhood was described by Lewis, (2000). He suggests that by eighteen months infants have developed a sense of self recognition and begin to experience self-conscious emotions such as shame, pride and embarrassment. This allows a better understanding of the self and allows more complex emotional development. During childhood, children's emotional understanding increases alongside their cognitive development (Conway, 2000).

Parents influence their children's social-emotional development via their own self-awareness of emotion. This is demonstrated through parental emotional expressivity, responses to the child's emotions, and emotion talk (Warren and Stifter, 2008).

Hoffman, (2000) found that empathy appears fairly early in infants and increases across childhood. Empathy and the ability to see the other person's perspective have been

identified as significantly related to the development and regulation of interpersonal relationships (Brackett, Mayer, & Warner, 2004; Lopes, Salovey, & Straus, 2003).

Couple Relationships

Most people desire to be in a happy, personally satisfying romantic relationship, and attempt to realise this desire through commitment to a life-long relationship (Markman & Halford, 2005). A large amount of existing research (e.g., Johnson, 1996; Thomas, Fletcher, & Lange, 1997; Greenberg, 2004; Cordova et al. 2005) indicates that emotion plays a major part in a couples ability to communicate their feelings to each other.

Various theoretical frameworks are used in research literature to explain couple relationships; these include social exchange theory, systemic theory, object relations and the psychodynamic perspective. However, most of the literature reviewed suggests couple emotional interaction can be best explained in terms of attachment processes, (Bowlby, 1980; Hazan & Shaver, 1987; Johnson, 1996, 1999; Mikulincer & Shaver, 2003; Greenberg, 2004).

Both partners are influenced in various ways by their own early relationship experiences with emotionally significant others (Draper, 2000). In couple relationships when partners are emotionally available and respond to the other's attempts at seeking closeness a sense of attachment security is achieved. On the other hand if partners are felt to be emotionally unavailable insecurities and doubts about the relationship surface. In childhood the primary care-giving relationship would seem to have a huge influence on the child's social-emotional development. From relating with significant others, infants become aware of their emotions and develop their sense of self. Parents and caregivers influence their children's emotional development by being emotionally expressive and responding to the child's emotions. With this in mind, if as attachment theory suggests, the primary care-giving relationship is a template for all future relationships, then it would indicate a definite link between emotional awareness and the capacity to form, maintain and define the quality of relationships in adulthood. It is essential however to also consider that patterns of relating learned in the primary care-giving relationship may be modified or altered through experiences in subsequent relationships.

Emotional Awareness in Couple Relationships

Every couple is unique with each partner bringing to the relationship their own personal traits and learned way of communicating. The way in which both partners think and feel about their own worth and the others commitment to them can affect the course of their relationship. Schnarch, (1991) suggested that it is the relationship with ones' self that determines how a person handles their relationships with others, particularly in couple relationships. Both partners must accept and understand themselves rather than trying to get acceptance from their partner. Croyle and Waltz, (2002) found that when couples understand what they are feeling it allows them to engage in other important relationship behaviours such as expressing feelings, enhancing intimacy and problem solving.

Methodology

A quantitative descriptive, survey design was utilised using two self report questionnaires, The Couples Emotional Awareness Scale (CEAS) measuring couple emotional awareness and The Revised Dyadic Adjustment Scale (RDAS) measuring couple relationship quality.

Participants for the study were recruited from the two main organisations offering services to couples in Ireland; Relationships Ireland (formerly MRCS) and ACCORD. The majority of couples were enrolled on pre-marriage courses in these organisations. Data was collected from 46 couples over a five month period. This data was then scored and entered into SPSS software for analysis. Descriptive and inferential statistics were employed to identify the interrelationships between the variables:

Results

Results suggest that emotional awareness has a different role in determining relationship quality for men and women, with male levels affecting relationship quality for both partners while female levels only affect women themselves. When both partners have a high level of emotional awareness they report more satisfying and cohesive relationships, feel more connected and are more likely to share activities together. Relationship quality for men appears to be more about sharing activities and relating on a social level rather than an emotional level. For women the important determinant of relationship quality is the ability to communicate emotionally with their partner.

Men in Couple Relationships

- Men were found to vary greatly in their emotional awareness levels. They were marginally better able to identify emotions in their partner than themselves. This ability increased with the length of time in the relationship suggesting that this aspect of emotional awareness may increase over time through close couple interaction.
- Men's own level of emotional awareness was found to determine their level of connectedness or cohesion with their partners. This included the frequency of sharing activities, exchanging ideas and amount of agreement between the couple. These findings suggest that men with high emotional awareness may have the ability

to invest themselves more in the relationship thereby contributing to relationship quality for both. Likewise men with low emotional awareness are likely to feel disconnected themselves in the relationship and so may reduce couple relationship quality for their partner also.

- For men, relationship quality was not affected by their partner's level of emotional awareness.
- Relationship satisfaction was not affected for men, by either their own or their partners emotional awareness level

Women in Couple Relationships

- Women were identified as being more emotionally aware than men. They were better at recognising more complex emotions and a greater number of emotions in both themselves and their partners. Women also rated their perception of relationship quality slightly higher than men's.
- Women's relationship quality was affected by both their partner's and their own level of emotional awareness.
- Women's relationship satisfaction was negatively associated with men's level of emotional self-awareness. In other words, men who had difficulty recognising emotions in themselves contribute to their partner's dissatisfaction with the relationship.
- For women, relationship quality cohesion or the sense of connection between the couple was positively associated with male emotional awareness. This may be explained in terms of women experiencing higher levels of intimacy, closeness and relationship quality when their partner has a relatively high emotional awareness.

Partner Discrepancies in Emotional Awareness

As the partners in each couple relationship do not typically possess the same level of emotional awareness, one of the objectives of the study was to examine how discrepancies in awareness between partners affect couple relationship quality.

- Partner discrepancies in emotional awareness were found to affect aspects of the relationship for the couple, notably a diminished sense of relationship connectedness for men and relationship dissatisfaction for women.
- Discrepancies in emotional awareness were also identified as having a greater affect on women's relationship quality more so than men's. This would seem to be associated with women generally appearing to make more of an emotional investment in the couple relationship.
- For couples, when either partner had a significantly higher or lower emotional awareness, it caused relationship dissatisfaction for women and a diminished sense of connectiveness for men.

These results suggest that relationship quality may depend on both partners having similar emotional awareness levels. It is possible that a person's need for engagement and closeness may be influenced by their emotional awareness level. Couples with low emotional awareness may not need the same connection and closeness as couples with high awareness levels. This is an area that warrants further study. Dissatisfaction and diminished sense of connection occur when there is a difference in partner emotional awareness levels. Assisting couples in reducing any discrepancies would therefore enhance their relationship.

Recommendations

This study has implications for couple education programmes and also counselling and psychotherapeutic practice. Previous research (Gottman, Fainsilber Katz and Hooven, 1996) found that emotional awareness, self regulation and interpersonal relationships are all enhanced by recognising, accepting and validating emotions.

It would therefore be beneficial for couples to acquire such skills as developing personal insight and a greater awareness and acceptance of emotions. Emphasising to couples the significance of emotional awareness and how discrepancies in emotional awareness may affect relationship quality can only have a positive effect on their relationships.

Couple Communication Programmes

The results of the present study would be helpful in formulating couple education programmes such as Marriage Preparation and Couple Enrichment Programmes. Devising and including self- awareness and interpersonal communication exercises in these programmes offer the potential for enhancing emotional awareness and increasing relationship satisfaction for couples.

Psychotherapeutic Practice

As emotional awareness has been found to contribute to the quality of couple relationships it would be helpful to focus on increasing this aspect of couple communication when working with distressed couples. O'Connor, (2003) identified that emotional distancing was a major factor for distressed couples in Ireland. The present study also identified partner discrepancies in awareness as having a negative influence on the couple relationship. The inclusion of a measure of emotional awareness at initial couple assessment would identify any discrepancies and help guide the therapeutic process. Helping couples to understand and accept any discrepancies in emotional awareness and focusing on techniques to reduce discrepancies between partners would encourage emotional closeness between the couple.

Conclusion

This study has found that the ability to identify and express emotions in oneself and to understand ones partner's emotions is a factor in maintaining intimacy and closeness for couples.

The means of achieving intimacy and closeness seems to differ for men and women, with men valuing shared activities and relational connectedness while women prefer to share thoughts and feelings. Emotional awareness was identified as having a bigger influence on relationship quality for women. This is possibly due to female gender socialisation in childhood.

In the couple relationship it appears that women may become dissatisfied when their emotional need to be understood is not fulfilled. For men relationship quality is affected by their own level of emotional awareness. This seems to determine how much they can invest themselves in the couple relationship. In couples where there is a discrepancy in levels of emotional awareness, both partners experience reduced relationship quality with women reporting relationship dissatisfaction and men a diminished sense of connectiveness.

We are all born with a primary need for connection and relationship with others. While this need to connect with others is innate, the means of achieving it can be nurtured. Being able to identify and express emotion is a learned behaviour – it only requires education and practice. There is the potential for couples to learn how to make use of this form of communication to enhance the quality of their relationship.

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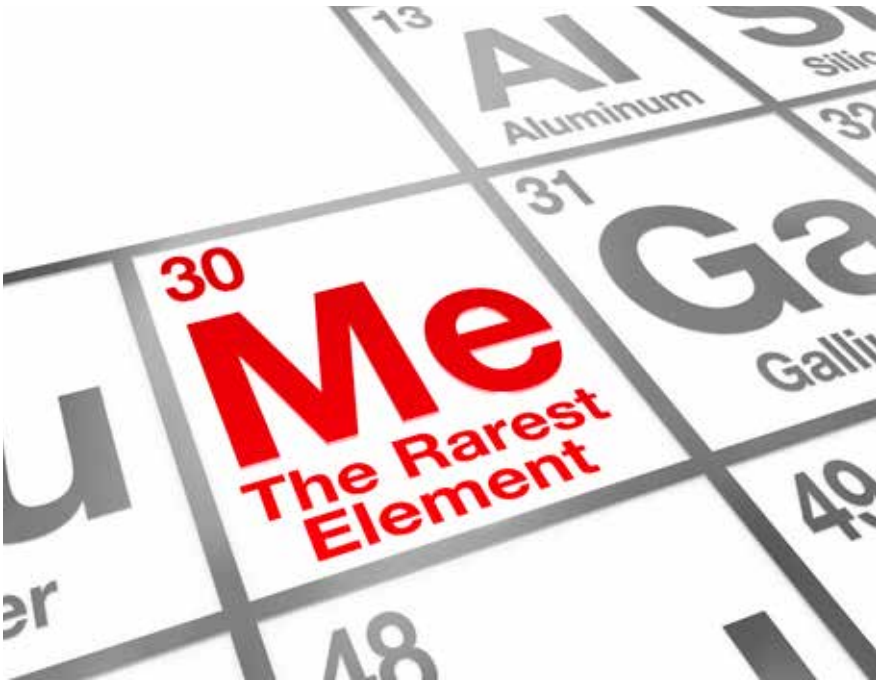
In Defense of The Self

by Michael McGibbon



"Something we were withholding made us weak until we found out it was our selves."
(Robert Frost, 2001)

Introduction

This article begins by emphasising the significance of the therapist's use of self in practice. It then proceeds to offer a tentative description of what possible qualities a therapist who is making effective use of self might manifest in practice. Next, is a section which aims to describe the depth of this practice by recounting the self's rich heritage and charting its emergence as an important variable in practice, outlining its development. The article then proceeds to suggest some approaches that can be used to develop the therapist's use of self in practice. The article concludes with some reflections on the subject by critiquing the current developments of practice in the UK and Ireland. It is hoped that in the Irish context that we can learn from these developments in the UK, and retain a vibrant, relationally based psychotherapy and counselling sector.

The Significance of the Therapist's Self in Practice

Both Wosket (1999, 2001) and Baldwin (2013) have highlighted that any therapist who is working from a relational perspective can be assumed to be using specialised aspects of self in their practice. There is also a plethora of research and scholarly works that directly and indirectly substantiates the impact and relevance of the therapist's use of self in practice (Rowan & Jacobs 2007, Knight 2012, Li & Tottenhanm 2011). This can also be seen in the extensive reviews of psychotherapy and counselling compiled by Lambert (2004) and Cooper (2008). These reviews reveal similar findings; they conclude that the common factors which are related to client change in therapy are located in the arena of relational variables. As referenced by Rowan & Jacobs (2007), any therapeutic approach that operates from a relational perspective, whether it is psychodynamic, humanistic or transpersonal the therapist will be using key aspects of self in practice. In this place it is not just the presence of the therapist's self that generates change, it is the application of the self in a specialized way that catalyses the change process.

Defining The Therapist's Self In Practice

Borrowing from the integrative frameworks of Rowan & Jacobs (2007) and Kottler (2010), they indicate that the self of therapist, relates to the ability to be in touch with emotions, thoughts, soma and intuitions. In relation to these aspects, the findings from Geller et al., (2005) who have researched the impacts of personal therapy on therapists, suggest that therapists should be willing explore their own past and present biographies, with an honest attempt to illuminate and process their own emotional states. Thus in operating from a place of increased awareness, it is posited that the therapist can use these aspects of self in an uncontaminated manner (Casement 2006, Rogers, 1961).

From the position of awareness, therapists are able to differentiate between their own material and that of their clients. In other words, there is not an enmeshed state in the therapy. If they were, then they would be in a state of constant reactivity to the material of their clients. In contrast to this, where the therapist is engaged in a self-reflective process they will be in a responsive state to their clients' material (Steadmon & Dallos, 2009). In this context, therapists can effectively use their capacities of self in a discerning manner, applying their feelings,

thoughts, experiences and intuitions to guide their interventions in the service of the client.

Charting The Developments of The therapist's Self in Practice

With the inception of psychotherapy at the beginning of the 20th century as a treatment method for mental health, there was for the first time a viable alternative of conceptualising and responding to mental distress (Benthall, 2003). The therapist's use of self has increasingly gained recognition throughout the 20th century as it became accepted as a key variable in the therapeutic process. There has been a considerable amount recent research that also validates its contemporary significance in practice (Schore 2013, Siegel, Castonguay & Beutler 2006).

Present Developments

The most contemporary developments in relation to the significance of the therapist's self are to be found in the areas of neuroscience and quantum physics. In describing these developments an abridged version of these processes is presented here. It is hoped that this will enable the reader to capture some of the nuances of these theories. These theories come with a highly technicalised vocabulary and usually necessitate a prior knowledge of the subject.

Both these areas are demonstrating the significance of the therapist's self through the lenses of modern science (Pyllaken, 2010). These approaches validate many of the qualitative theories previously mentioned. By applying the most up to date technologies, these methodologies are producing data that substantiates the influence of relational variables on mental health. Researchers such as Alann Schore (2012), Dan Siegel (2013), and Arnold Mindell (2004) have applied these findings to the field of psychotherapy and counselling. In doing this they have provided therapists with an up to date 21st century model in understanding the implications of the therapist's use of self in relation to their clients.

Beginning with the neuroscientific theories and specifically referring to the 'interpersonal neurobiology' theories of Dan Siegel (2013). Siegel's research and work adequately demonstrates the significance of the relational variables into the healthy development of the brain. It has been shown through FMRI imaging that parts of the brain come online at certain times of development. Thus brain growth does not happen in isolation, it is 'experience dependant' on another self, usually that of the primary care giver. In relation to therapeutic practice with adults, this principle can be successfully mapped into the therapeutic dyad between the therapist's and the client's self. Further neuroscientific research compiled by Fonaghy et al., (2004) has demonstrated that there is life long plasticity in the brain, which means that it has the capacity to change. Schore's (2012) summation of brain imaging research has also demonstrated that if the therapist can congruently synchronize their own self in line with their clients self, then neural activity and growth in their clients brains can take place. Amalgamating all these findings together demonstrates empirically the implications for the therapist's effective use of self in practice.

In relation to the area of quantum physics there is also significant findings that demonstrate the nature of connections between the selves of individuals, dyads and groups (Talbot, 1993, Bohm & Hiley, 1993). In this context quantum theorists have been able to demonstrate the connection in relationships by elucidating the entangled nature of matter. This is an area referred to as 'quantum entanglements' (Bell, 1987). It is understood by quantum theorists that matter is made up of energy which contains both particles and waves. Certain schools of quantum theory have posited that once the particles of matter becomes entangled the there is an on-going reciprocal influence between them, even when they separate (Bohm, 1990, Pyllaken, 2010, Radin, 2004, 2007). Relating this to the psychological field, it is posited that thought and consciousness are also forms of matter, albeit in a more subtle form (Dossey, 2011, 2013).

In applying this research to the therapeutic field theorists such as Pyllaken (2010) have advanced that there is a process of entanglement between the therapist and client's selves. Jung (1955) had also indirectly referred to this type of phenomena in the 1950's when he noticed there was a synchronistic connection between his inner self and that of his clients. These manifested in similar dreams, thoughts and physical phenomenon. His theories where developed by Victor Mansfield (2001), in his work titled 'Synchronicity, Science and Soul Making'. Mansfield suggests that this entanglement may take place when the self of the therapist consciously or unconsciously synchronizes to the self of a client. In therapeutic language, this could be described as the process of deep empathic attunement and congruence.

Both these qualitative and quantitative findings over the last century have highlighted the relevance of the therapist's self in practice. By synthesizing all these findings together it is possible to see the complementary nature of each one of them to the other. In doing this there is a semblance of a developing a unified theory, which further substantiates the significance of the therapist's self in practice. In the next section some suggestions are forwarded into how to develop this central therapeutic tool for practice.

Methods for Developing the Therapist's Self

This section looks at two interrelated themes, firstly, the potential benefits

to the therapist in developing the use of self and secondly, what methods can be used to achieve this.

Benefits

The process of facilitating the development of the therapist's use of self for practice can take place through several mediums, and has several benefits to therapists and clients alike. Pertinent research has alluded to the detrimental effects of working without awareness of self in practice (Rothschild, 2006, Perlman, 1995). Studies from neuroscience between therapists and clients have demonstrated that there is a mirror neuron system in operation between their brains (Staemmler, 2012). In this context, there is a simultaneous activation of parts of the therapist's brain with that of their clients. Thus therapists working with clients who display on-going emotional and mental distress are exposed to affect transmissions from their clients (Brennan, 2004). This is particularly notable in the field of trauma work, and Wilson & Thomas's (2004) research on vicarious trauma, has indicated that therapists who are unable to metabolise and process their clients material successfully and let go of it, can suffer from all types of interpersonal and health problems. Therefore developing the self in practice may act as preventer for therapists in the areas of burn out and a whole host of psychosomatic symptoms.

Strategies for Developing the Therapist's Use of Self in Practice

1. Clinical Supervision- This process, if facilitated correctly can assist therapists with the integration and development of a self-reflective capacity into their practice. This reflective capacity should not be concerned solely with the usage of skill, but be used to explore the therapist's thoughts, feelings and intuitions in relation to their clients. The cyclical model developed by Wosket & Page (2001) and also Shohet's model (2008, 2011) are excellent at helping therapists develop self.
2. Personal therapy- Many therapists have reported this as aiding the growth and use of self as a tool in practice (Geller et al., 2005). The rationale behind this is that it enhances the therapist's self-awareness, and helps to illuminate any blind spots that they may have in practice, thus providing them with insight into their own psychic debris. If unprocessed this debris could be influencing their practice negatively (Casement, 2002). This process also allows therapists to intimately know what it is like to be client.
3. Peer groups- One of the most effective practices is a focused experiential group that integrates clinical material into the process. The model of a co-operative inquiry group developed by John Heron (1996) integrates these processes into its practice. In this group format, therapists are invited to bring case material and explore the material in direct relation to what it activates in themselves. In this group, areas of countertransference, biographical material, defences and parallel processes between themselves and their clients are explored. This can allow therapists to intimately connect with their clients in a deep sense, thus providing an increased awareness of their clients' issues and processes. This type of group has the capacity to be truly transformative for therapists and clients alike. Many participants who engage in this kind of group process report back that it has had a positive impact on their practice (Hazel, 2012).

Applying The Therapist's Use of Self in Practice

In been able to integrate and develop self for practice, it is hoped that therapists will be able to demonstrate a capacity to understand their clients' material from multiple domains. In achieving this state, the therapist should then empathically weave this material into sessions to assist client growth. In relation to the area of client growth, functioning and change, the renowned psychoanalyst Wilfred Bion (Symington & Symington,1996) suggested that the therapist should be able to act as a certain kind of 'psychic container' for their clients material. If the therapist can manage this then they can give shape to the client's unintegrated states. Jung metaphorically referred to the therapist in this place as been 'the rainmaker', a metaphor for the therapist who is able to bring growth (rain) to the barren psychic landscape of the client. According to Sabini (2002), the therapist in this place is in a state of Toa, which clinically translates into congruence with self. It is posited that the client's psychic state will come into sync with the Toa state of the therapist. There are also parallels to Winnicott's (1989) view that the client internalises a part of their therapist, and it is this part which gives them hope and faith. These are very skilled methods of working, which demands that therapists explore, grow and apply their use self for practice. If this process is undertaken successfully then the therapist's self has the potential to be a cathartic change agent in practice.

The Decline of The Therapist's Use of Self

This article so far has aimed at highlighting the important function that the therapist's use of self has in practice. It has also highlighted that this has been substantiated by a long history of practice based research, which is now corroborated by the hard sciences. However, paradoxically in the current UK climate this research seems to be conveniently ignored (Samuels & Veale, 2009). Thankfully at present in the Irish context this isn't the case, this is evidenced by the plurality of models offered by the HSE, National Counselling Service in their Primary Care Counselling Initiative (Cullion, 2013). This new initiative

in its present format only offers a limited amount of therapy sessions to medical card holders. However, it contracts this work out to therapists operating from a variety of therapeutic approaches; this therefore gives parity to the relational approaches. Whilst acknowledging the limitations of this initiative, it is symbolically a progressive move. The Irish approach has veered from a wholesale adoption of the UK model for the delivery of therapy at the primary care level. This should be welcomed.

Presently, in the UK context there is a proliferation of reductionist, prescriptive based approaches permeating the public sector delivery of therapy. These are derived from the recommendations of the national institute of clinical excellence (NICE). The concern about the NICE model is that the research base which was used to assess the efficacy of the differing therapeutic approaches is the same model that is used to asses pharmaceutical drugs. These are known as 'random control trials'. As stated by many researchers and reviewers, these reductionist research methods and approaches only take into consideration a limited numbers of factors pertaining to psychological distress and treatment (Mollon, 2012, Ritz, 2010, Evans, 2012: Guy et al., 2012).

Currently, there is a real risk that the therapist's use of self will soon be a redundant feature as these technical models increase. These types of approaches are removing human agency from the heart of practice. This is exemplified in the growth area of information technology products that are providing therapy via software packages. Soon there mightn't be any need for therapists in practice at all, not mind the use of self. The concern here is not derived out of turf warfare; it regards the nature of how these reductionist models are delivered. They do alleviate symptoms; however the question is by adopting a prescriptive focus, are they really engaging with clients on multiple levels. In Jungian (1969) terms do these approaches produce a 'psychic change' or as Rogers (1957) stated do they 'produce constructive personality change'.

Clark (2009, 2013) and Samuels (2009) have highlighted that much of the research on these technical models have been conducted at the six months period proceeding from the termination of the therapy. There is few longitudinal research studies conducted on the long term efficacy of these models. However, these models marry well to the current socio economic paradigm, they are easily measured. As stated by Evans (2009), above all else they provide commissioners with delineated statistics and thus bed well into the current servo-control approach that permeates the provision of health care.

Conclusion

This article has presented an argument in defence of the therapist's use of self in practice. It has aimed at highlighting the current trend in health provision, with which therapy is increasingly becoming aligned. This is notable especially in the movements that nation states are making to provide therapy as an alternative and an adjunct to psychotropic medication. It is hoped that the case made in this article has managed to illustrate the importance of retaining the relational models, where the therapist use of self is encouraged.

Throughout this article the UK models are referenced, the rationale for doing this is that in the Irish context, lessons that can be learnt from this process. In Ireland as the move towards registration progresses, it is important that a plurality of relational based counselling & psychotherapy approaches can be retained. These approaches although not easily measured by research tools, such as random control trials, are tried and tested methods of practice. They are built on years of experience and a rich reservoir of practice based research (Wosket, 1999). In these times of radical change, these approaches involving the therapist's use of self have proven to provide depth, substance and a long lasting resolution to clients suffering from emotional and mental distress.

Long live the self!

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Michael McGibbon

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Workshop Review

ASSESSING & TREATING SUICIDALITY

Presenter: Dr Eoin Galavan
Date: 4th October 2014
Reviewed by: Gillian Demurtas
Venue: Spencer Hotel, Excise Walk, IFSC, Dublin 1

Dr Eoin Galavan comes with very impressive credentials and an equally impressive flair for presenting a complex subject such as suicidality with incisive clinical insight and compassion. Led by his experience of suicide within the adult mental health services he set out to overcome the very human aversion that we as therapists encounter when suicidality enters into our therapeutic domain. On that journey he became adept at disseminating the many theories and models for treating suicidality and evidently, he mastered the art of intervening in the suicidal crisis.

He began by showing an image of a man standing outside the railings of the Golden Gate Bridge; the man was faced towards the railings, at once seeking to escape from his suffering whilst clinging to life with desperation. Such is the ambiguity of the suicidal state. Suicidality being, in fact, the symptom of a desperate state of mind, which under unbearable "psyche-ache" seeks the fantasy of relief through the destruction of the biological form. He illustrated how our fundamental human need for connectedness can be what saves a person from taking their own life and how isolation can drive us to such self destruction.

He moved me deeply with his encouragement that we should try to confront the suicidal state of mind with empathy, to attempt to understand how the client arrived at the place where suicide is a 'solution'. Confronting with empathy, it made sense. Terms such as "biological death" and "lethal self harm" were used to help pierce the clients' fantasy of suicide and to bring the impulse into stark reality. To help them see that really there is no 'relief' in suicide because when you are dead, you feel nothing. Sobering reality administered with the use of the CAMS Suicide Status Form (David A. Jobes Ph.D) meant that we got to observe and then practice the implementation of the instrument. For me this was a personal revolution, sitting side by side with the client, working through the structured, comprehensive questionnaire; it felt and seemed like a truly powerful way to work with some of the most disturbing clinical material one could encounter.

As a member of the committee that hosted Dr Galavan's workshop, I had the task of reading and collating the evaluation feedback from the attendees and the response was overwhelmingly favourable. The workshop provided such a high standard of training and expertise that many expressed a desire to learn more. Dr Galavan exceeded our expectations and raised the bar in terms of the level of training we seek. I would strongly encourage our fellow members to attend his training when you have the opportunity.

Gillian Demurtas, Sutton Cross Surgery, Sutton Cross, Dublin 13. 087-2853084

Letters to the Editor

Dear Sir,

The predominant theme in Mr. Devlin's article seems to be that erectile dysfunction can be treated by any therapist. He refers to Masters and Johnsons model and also appears to refer to Kaplan's, omitting Bassons' and Perlman's models.

As a GP I found it worthwhile to do the psychosexual therapy training programme, due to the fact that my ability to help patients presenting was limited to out ruling any physical cause and writing a prescription. If the ED was psychogenic I had nowhere to send the patient at that time.

The European Ageing Study states that over one third of men over 40 can experience ED. I have no figures for younger men. ED even when not psychogenic will have a psychogenic element especially if it is a regular occurrence. Current advice from the ESSM, European Society of Sexual Medicine and EFS, European Federation of Sexologists, includes counselling and medications. Masters and Johnsons sensate focus is the basis of treatment combined with CBT and couple therapy if relationship problems exist.

I would not have attempted to treat psychogenic ED without training. Dr. Coby Reisman of The ESSM and Dr. Francesca Tripodi of The EFS both agree that therapists need to stay within the area of their training and expertise when treating clients. We can identify problems if people open up to us but should refer to a qualified, experienced therapist for treatment.

Yours faithfully,

Dr. Mary Rogan.

Dear Editor,

In brief reply to Dr. Mary Rogan:

The predominant theme in my article "Erectile Dysfunction: Entering the conversation" was to highlight the fact that as therapists in general practice, we are very likely to work with clients who live with Erectile dysfunction (ED). This disclosure might come before therapy starts, at any point along the therapeutic journey or unfortunately, not at all if we as therapists are not prepared or are unable to have or to initiate the conversation with our clients. The article recognises that we will have limitations to our understandings of ED and indeed a myriad of presenting issues but asks that we address these limitations in a "safe but courageous way." If we know our place in the conversation around ED, we will also know our limitations but perhaps more importantly, we might also recognise our potentials for working successfully with clients who present with ED.

The main motivation behind the article was to encourage the reader to enter their own conversation around Erectile dysfunction and as such, I offer a heartfelt thanks to Dr. Rogan for taking up that gauntlet.

Yours faithfully,

Luke Devlin.

Poetry

The Shadow of You

Wherever I go
Whatever I do
I'll always be running
And hiding from you
The only relationship
I've ever known
You've made me do things
That are bad to the bone
But I've had enough now
The truth be told
I will earn back
The soul that I have sold
And gain all the wisdom
That holds all the keys
This prison of isms
My ugly disease
But make no mistake
It lies dormant in me
You wait at the gate
For the day that I leave
Watching and waiting
Waiting to see
Waiting to strike me
Back down to my knees

For the real fight begins
When I wander astray
You're just here for the spar
As my counsellor would say
So when you come calling
Me back to the pain
I'll have to refuse
I'll have to refrain
Wherever I go
Whatever I'll be
The shadow of you
Will loom over me

Michael Dunford

Silent scream

Words unspoken
Spirit broken
Betrayal of the soul
Hold the mask on tight now
The blind unfocused goal

Perform the social niceties
Watch those p's and q's
Cover up the livid scars
Do not reveal the bruise

No place to pause and take a breath
Illusion kept intact
This world built on deception
Foundations deeply cracked

Sleepless nights tangled sheets
Thoughts go racing round
Fear a faceless monster
A snarling pacing hound

This prison is a hell hole
Voices echo from the deep
Scenes in technicolor
Secrets sworn to keep

Unfolding slowly on the edge
A light begins to dawn
A scream of desperation
A call to return home

Relief it breaks through chaos
A decision has been made
A way out of the darkness
Fear begins to fade

Glint of steel enticing
The promise that it holds
Attention narrowed down now
Skin becoming cold

Fading into darkness
Ringing in the ears
Shouting in the distance
Salty taste of tears

A gentle voice a soft caress
A warm connecting touch
Flashing lights siren sounds
Doors slamming in a rush

Stinging of a needle
Blissful numbing state
Fading into nothingness
Help has come too late

Awaken in a quiet room
Light is soft and dim
Sheets pulled tight across the bed
Sunshine peeking in

Footsteps moving quietly
Smiling eyes so startling blue
Speaks the words I longed to hear
Hello how are you?

Mary Quinn
Ph 0879369111
I work as a counsellor/ psychotherapist in
The Healing House
24 O'Connell Avenue
Berkeley Road
Dublin 7

Book Review

Title:	*Getting the Best Out of Supervision in Counselling and Psychotherapy* *A Guide for the Supervisee*
Author:	Mary Creaner
Published:	2014
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Reviewed by:	Reviewed by Cóilín Ó Braonáin PhD

Mary Creaner's guide offers a general overview of the supervision experience for trainees and those looking for an introduction to supervision. Supervision is a discipline which has largely evolved organically, in tandem with the growth of psychotherapy itself. As a consequence there is a confusing array of definitions as to what supervision actually is and no agreed understanding of how supervision should work. However, most definitions tend to share the view that the goals of supervision are to protect the client's welfare, to further develop the supervisee's skills and competence, and to provide support to the supervisee.

However, some trainees have felt that supervisors can overemphasise their gatekeeping role and have found that supervision is sometimes too high on gatekeeping (determining who is competent) and too low on support. In order to minimize supervisees' anxieties about gatekeeping, Creaner proposes that supervisors take a facilitative role and adopt the andragogical theory of 'Lifelong Learning,' which takes as its premise that adults learn differently to children. Adults are said to need to know why they are learning any given material and they also need to assimilate the learning with their life's experience. Teaching adults therefore requires a democratic collaborative approach on the part of supervisors.

Perhaps surprisingly, therefore, one section of the book is quiet prescriptive. Given the sub-title of the book, Chapter 8: 'How to prepare for a Supervision Session' was a disappointment. Trainee supervisees are often anxious, as Creaner acknowledges, and need a lot of structure in order to settle into the supervisory process. As such, Chapter 8 may well have been expected to form the pragmatic heart of the book. Surprisingly, this chapter is very short on practical advice and is only six pages long in total. The principal recommendation is that supervisees present their clients by using session transcripts, or audio or video recordings of sessions. While such resources could be very useful for the supervisor, the practicalities involved are considerable and unlikely to be feasible for many. The time and additional work involved in transcribing sessions is immense. Furthermore, the distractions caused by cameras and the inevitable technological problems can be considerable. Also, the potential for clients consenting to recording but nonetheless being inhibited by the recording process is not addressed. Nor is the impact upon supervisees of having their anxiety raised by such intrusive methods considered.

However, very useful information appears in a strong Chapter Ten on the quality of supervision and of the impact of supervisee characteristics on the supervision process. A list of the supervisee attributes which contribute to excellent outcomes serves as a handy checklist for supervisees concerning their personal growth and maturity. On the other hand, a list of the principles of 'lousy supervision' is useful for letting supervisees ascertain when problems in supervision are not necessarily their fault. Furthermore, unhelpful characteristics of supervisees are also listed, making this chapter quite well balanced in emphasising that both parties have a responsibility to make the most of the supervision experience. At this point, Creaner returns to the lifelong learning theme, in advocating a person centred approach to supervision whereby the supervisor acts as a facilitator rather than teaching supervisees pedagogically. However, supervisors are cautioned of the danger of using 'facilitation' as a device to avoid taking overall responsibility for supervision.

Many, if not all, supervisees experience evaluation anxiety especially when in training, given that supervisors have considerable power and influence over the training outcome. Up to a point, as Creaner mentions, anxiety is a normal and helpful state which can encourage diligence and hard work. However, too much anxiety can be counter-productive to learning. Perhaps the most anxiety-laden aspect of supervision is that of receiving feedback from supervisors and Chapter 12 addresses the topics of feedback and evaluation. The subject of feedback in supervision is somewhat ambiguous given that strictly speaking, direct observation of the supervisees work is necessary in order to evaluate that work. Consequently, feedback and evaluation are probably most pertinent in the context of supervising trainee therapists. The supervision of qualified therapists is dependent upon the client work presented, how that work is presented, and a considerable amount of skill and intuition on the supervisor's part. Consequently, perhaps, this chapter is quiet short and broad in substance. Finally, 'endings' are discussed in the context of opportunities. Mary Creaner focuses on the positive side of endings as opposed to the usual emphasis on loss, and she stresses the opportunities that are opened up by moving on from a given supervision experience.

Finally, given that Creaner is an assistant professor in Trinity College Dublin, it was disconcerting to find that the BAPT code of ethics was referenced throughout without use or acknowledgment that the IACP code is the predominant Irish counselling standard. Questions of legal liability referenced English law which was compared to US law on occasion. Irish readers may well wonder to what extent Irish law may differ from that discussed in this book. While the book is an English publication and presumably aimed mostly at the UK market, perhaps some space could have been accorded to Irish variations in supervision norms and the legal connotations concerning supervision?

All told, Creaner's book is a comprehensive, well referenced and constitutes a substantial introduction to supervision best suited to trainee counsellors.