From the Editors:

Dear Readers,

Hello and welcome to our Winter Edition of Éisteach.

In this edition, our last of 2016, we present an eclectic mix of articles covering a variety of topics designed to invite you to explore and reflect on a range of subjects with the broad theme of 'New Horizons'. The articles chosen for this issue each suggest in their own unique way the potential horizons that may lay ahead in our profession or in professional practice areas. We hope you enjoy them.

Indeed, the first article "Coming Out or Staying In – The Persona and Shadow of being gay, and its relevance to psychotherapy in modern Ireland" by Simon Forsyth is the 2016 winner of the Martin Kitterick Award for excellence in academic writing. It explores several topics through time from decriminalisation to post-Marriage Equality and some fascinating original ideas on the subject of being gay today.

Next, we present a piece by Roisin Whelan entitled "Counselling and the Big C", based on her recent personal and professional experience and some qualitative research into the idea of working with cancer patients/survivors. She presents some intriguing results and the implications of such for the future development within our field of work.

Following her question from the floor at the recent IACP/ACA Conference, Gráinne Clancy writes in a letter to the Editor, on the ever-topical contemporary subject of the definition and use of the terms 'counselling' and 'psychotherapy'. Gráinne wonders if real or perceived differences between these terms create confusion in clients and a 'two-tier system' within our profession.

Written by Maeve Dooley from the IAHIP, our next article explores this very subject and presents a case for a distinction to be made between these two terms. This debate has run for many years within our profession and one which is likely to come into very sharp focus in the coming months due to the current Minister for Health's call for submissions on Statutory Regulation. Interestingly, this article came in response to an Éisteach position paper back in 2013 which states that there is no material difference between counselling and psychotherapy.

As well as this fascinating mix of articles, we on the Editorial Committee of Éisteach wanted to take some time in this issue to brief you on what we've been doing to improve Éisteach this year and explore our plans for the future, looking at the new horizons we envisage for our journal.

With that mix of material and content, we hope that there is something of interest to you. As always, we on the Editorial Committee would be delighted to hear from you whether this is in the form of letters to the Editor, responses to articles published, new material or papers you have produced or indeed any suggestions for the future.

So until the first edition of 2017, we wish you, your families, your clients and all of our readers a very Merry Christmas and Happy New Year.

Mike Hackett MIACP **Donna Bacon MIACP**

'Coming Out or Staying In?': The Persona and Shadow of Being Gay, and its Relevance to Psychotherapy in Modern Ireland

Simon Forsyth

Introduction

On May 22, 2015, Irish voters went to the polls to decide whether or not to legalise same-sex marriage in their country. In the build-up to the referendum, the topic saturated the political and everyday landscapes, with both Yes and No sides fervently fighting their corners through newspaper columns, television and radio debates, and social media platforms. The lives and fundamental rights of Irish gay people were arguably under greater scrutiny than at any other point in history, both nationally and internationally. On May 23, the outcome became clear – Ireland, a country that had only decriminalised homosexuality in 1993, was now the first in the world to approve same-sex marriage by popular vote, with a majority of 62 percent voting Yes (Ó'Caollaí & Hilliard, 2015). Succinctly contextualizing the impact of the result for future generations, Michael Barron, founding director of youth support group Belong To, announced, 'We've changed forever what it means to grow up LGBT in Ireland' (cited in Carey, 2015, p.1). And yet this joyous proclamation has a shadow side.

Personal accounts from both public figures and private citizens throughout the campaign illuminated the reality of growing up gay in Ireland, with acceptance, pride and resilience often standing side-by-side with fear, isolation and sadness. Many highlight the pain of being aware of one's true sexual nature but feeling unable to honour this publicly, for a variety of reasons and for varying lengths of time – for some, indefinitely. In an Irish Times article (Halligan, 2015) that proved particularly resonant, respected journalist Ursula Halligan came out at the age of 54, her story heavy with the regret of living a life not fully true to itself. The deleterious effect that concealment, or the desire for it, can have on the psyche is not restricted to those who are still 'in the closet,' however. In a speech that in some ways foreshadowed the beginning of the marriage debate proper, in February 2014 Rory O'Neill, in his guise as celebrity drag artist Panti Bliss, eloquently told of the internal shame he experiences on 'checking' himself for outward signs of homosexuality in public (Connolly, 2014). The 'whys' of such situations, such as why one might feel the need to disguise an innate aspect of oneself and present as something else, form a crucial element of the oppressiveness gay people can still feel in Ireland today, even when 'out.' The divide between what one chooses to portray to the world and what one hides from it, either consciously or unconsciously, is also at the heart of the Jungian concepts of persona and shadow – the former, a mask we wear to negotiate with society; the latter, a storeroom for all the aspects of ourselves that we deem shameful and unfit for public view. As such, I propose that these concepts can be readily applied to the lived experience of being gay in Ireland today, offering a complementary lens to

existing psychotherapeutic practices regarding gay and lesbian clients. Three key areas of gay experience – homophobia, assimilation, and coming out – shall be considered.

Homophobia: The Shadow in Action

Homophobia may be best described as a 'fear, dread or hatred of homosexuals or homosexuality' (Davies, 2012, p.18), and 'in the case of homosexuals themselves, self-loathing' (Weinberg, 1972, cited in Davies, 1996b, p.41). Society inherently queries any deviation from heterosexuality, with gay people historically labelled as sinful by organised religion, mentally ill by the medical professions, and unequal or criminal in the eyes of the law (George & Behrendt, 1987). There have been forward strides in each of the above areas, but full acceptance is by no means a reality – homophobia, in one guise or another, remains a constant in the lives of gay people the world over. The internalisation of these wider attitudes can negatively impact on their mental wellbeing, with possible outcomes including low self-esteem, isolation, depression, self-medication through drug and alcohol abuse, and for a significant minority, self-harm and suicidal behaviour (Cormier-Otaño & Davies, 2012; Maycock, Bryan, Carr & Kitching, 2009). Though it would be unwise to assume that every gay person will encounter the above in their lives, or that they will react to adversities in a uniform way (Malyon, 1982; Maycock *et al*., 2009), mental health professionals such as counsellors and psychotherapists have a duty to at least be aware of the hallmarks of growing up with a stigmatised identity.

In Jungian terms, homophobia can be thought of as a 'shadow dynamic.' As Hopcke (1993) elaborates,

> Fear and hatred of homosexuality are derived directly from cultural values which insist that heterosexual marriage alone is normative and good, all else aberrant and bad… [This] all but determines that homosexuality as a phenomenon and homosexual individuals specifically will become the carriers of all the shadowy aspects of sexuality that do not fit into this heterosexist schema. (pp.78-79)

In 1993, a survey showed that 64 percent of Irish people opposed the decriminalisation of homosexual acts. Twenty-two years later, nearly the same percentage voted in favour of same-sex marriage equality. Seemingly out of nowhere, Ireland has found itself on the vanguard of global LGBT social change.

In other words, homophobia can be seen as the collective shadow projections of the heterosexual majority onto the homosexual minority. The minority then psychically integrates these projections into their own self-concept as internalised homophobia. In turn, inherent restrictions on the rights of the minority serve to reinforce assumptions and stereotypes. For example, Davies (1996b) cites the contradiction of presupposing the instability and promiscuity of gay relationships when gays and lesbians are, in most countries, legally forbidden from marrying and therefore deprived of the opportunity to present society with an alternative image. Other myths include the linking of homosexuality to paedophilia; that gay people are destined to live sad, unfulfilled lives; and that lesbians are only with women because they can't 'get a man' (Romesburg, 1995). Unfortunately, due to isolation, lack of information and the effect of internalised homophobia, gay people themselves are at risk of believing negative myths also, particularly when they are younger (Hetrick & Martin, 1987). In Rodgers' (2016) thorough study on the lived experience of being a gay man in Ireland, one participant used the word 'inbuilt' to describe his sense growing up that same-sex attractions were wrong. As Rodgers identifies, this highlights how shame can *feel* inherent to the gay person, when in fact it is a product of anti-homosexual socialisation.

Kort (2004) and Margolies (1987, cited in Davies, 1996b) list some potential signs of internalised homophobia that the counsellor can watch out for and therapeutically challenge. These include the fear of being identified as gay by others; discomfort with 'obvious gays;' unease regarding gay parenthood; and repeated pursuit of unavailable (e.g. heterosexual) love objects. A common example of one of the above is so-called 'camp-shaming' – the disapproval or even revulsion that many 'masculine' gay men display towards their more recognisably 'gay' (i.e. effeminate) counterparts (Stone, 2015). Through seeming to live up to societal stereotypes of what a gay man looks and acts like, such men are dismissed as 'giving the rest of us a bad name' (Davies, 1996c, p.74). However, it is quite possible that this is more accurately reflective of an internalised homophobic suggestion that gays are fundamentally unmanly, weak, etc. (Stone, 2015). Thus, the fear of embodying the same characteristics

A common theme in the Irish literature is the reluctance of out gay couples to engage in public displays of affection.

in oneself projects outwards from the shadow as a negative judgement of the *too*-gay other. Sophie (1987) suggests that cognitive restructuring is the foundation for reappraising such negative internalised messages and moving towards a positive gay identity. As such, she found that techniques drawn from cognitive behavioural therapy, such as challenging irrational beliefs and exploring the reality of a diverse gay community, were particularly useful in her work with lesbian clients[1].

Assimilation: The Persona in Action

While most sources suggest that awareness of one's homosexuality typically occurs around puberty (Kennedy, 2014; Maycock et al., 2009; Romesburg, 1995), public disclosure as gay may not occur until much later, if at all. What happens in the interim? Most commonly gay thoughts and feelings will be perceived as shameful and therefore repressed, forming a particularly hostile part of the personal shadow that will haunt the person's consciousness. The major resultant coping mechanism is what deMonteflores (1986, cited in Davies, 1996b) terms 'assimilation' – the donning of a carefully constructed mask in order to 'pass' as heterosexual and evade discovery. This is in keeping with the idea that the persona necessarily embodies qualities opposite to those in the shadow (Stevens, 2001). Jung's (1928, cited in LaFontaine, 2011) likening of the ego to an army commander fighting on two fronts seems particularly suitable here – 'before him the struggle for existence, in the rear the struggle against his own rebellious instinctual nature.'

The mask may provide the gay or lesbian adolescent with a means of survival, but it carries a price. As Hudson (1978) points out, using the persona as a coping mechanism for anxiety is dangerous, as in time this process will yield an anxiety of its own. This can manifest in numerous ways, including constant monitoring of self for signs of homosexuality; purposeful limiting of interests; and (often self-imposed) isolation and emotional distance from others (Hetrick & Martin, 1987). Thus, maintaining a straight persona negatively impacts on social, psychological, and sexual development (Kort, 2004; Malyon, 1982), and can lead to an increased vulnerability to depression and suicidal behaviour (Davies, 1996d). In their study of LGBT mental health in Ireland, Maycock and colleagues (2009, p.17) found that the period between realisation and disclosure of homosexuality was experienced as 'difficult, daunting, and traumatic' by a majority of participants. In addition, an extensive survey by the EU's Fundamental Rights Agency (cited in GLEN, 2013) found that 86 percent of Irish LGBT youth 'always or often' concealed their minority identity in school. General research on openness in the workplace, meanwhile, found that even today many Irish gay men and lesbians keep their identity hidden or restricted to a few close colleagues (Bielenberg, 2015).

Coming Out: Meeting the Shadow, Dropping the Persona

At some point or other, many gay people passing as straight reach an internal acceptance of their homosexuality and tire of the constant need to suppress themselves. They may thus begin the often difficult process of 'coming out,' through which they will finally reveal their true sexuality to the world. In Jungian terms, this may be seen as the removal of the persona-mask and a conscious shining of light on the shadow – the embracing of the latter sparking a gradual dismantling of the former (Miller, 1990).

Many start with one trusted family member or confidante, and from then on coming out is an ongoing occurrence – given society's general assumption of heterosexuality, the gay person will frequently have to weigh up the timing, appropriateness, and level of disclosure commensurate to each new social environment (Cormier-Otaño & Davies, 2012). It may also be the case that they are purposefully out to some people but not others, thus retaining some old cloaking habits. They may even feel the need to create new masks (regarding fashion and body image, for example) so as to find acceptance in the gay community (Cormier-Otaño & Davies, 2012; Kennedy, 2014). Davies (1996c) suggests that, lacking alternative role models, many younger gay people feel that in order to identify as gay they must conform to established presentations, such as the 'butch dyke' or 'bitchy queen.' Those in long-term partnerships, meanwhile, may feel subtly pressured into hiding any relationship difficulties, lest they 'let the side down' by seeming to uphold a negative stereotype of gay unions as unstable (Simon, 1996). Such behaviours may be seen as carrying the vestiges of previously internalised homophobia – evidently, even when the shadow has been illuminated,

[1] Davies (1996a) suggests that Sophie's findings can also be applied to gay men.

some darkness remains.

A good example of this, even in post-Marriage Equality Ireland, is continued fear of visibility. Having consciously repressed their instincts and passed as heterosexual for a prolonged period of time, many out gay men and lesbians continue to carry a residue of anxiety towards being publically identified as gay. If they become aware of this inclination, they may experience feelings of shame and anger at being ashamed, as captured in Panti's 'Noble Call' speech (cited in Connolly, 2014):

> Have you ever been on a crowded train with your gay friend and a small part of you is cringing because he is being so gay, and you find yourself trying to compensate by butching up or nudging the conversation into 'straighter' territory? This is you who have spent 35 years trying to be the best gay possible and yet still a small part of you is embarrassed by his gayness. And I hate myself for that.

Una Mullally (2015, April 27) echoes these sentiments, recalling the anger and embarrassment she felt upon hesitating to reveal to a nurse that her next-of-kin was another woman.

A common theme in the Irish literature is the reluctance of out gay couples to engage in public displays of affection, with a survey by GLEN (2013) suggesting that three-quarters would refrain from holding hands in public for fear of harassment or violence. Finnegan (2015) acknowledges the courage it can take to be openly affectionate with one's partner, but suggests that only when such displays are commonplace will Ireland have become a truly inclusive society. On this note, Casement (2003) proposes that the more a person learns to live with their shadow out in the open, the easier it will become

Irish society has changed largely for the better in terms of gay rights, psychotherapists working with gay and lesbian clients still need to be acutely aware of the unique issues they face in their daily lives, as well as past challenges that may continue to inform their mental wellbeing

to keep the persona-mask off. This is well illustrated by one of O'Carroll's (2014, February 16) respondents who, upon realising that he is 'checking' himself, defiantly resolves to not reach for his mask and 'butch it up for the benefit of others.'

Summary - A Five-stage Model

This article proposed that the Jungian concepts of persona and shadow can be successfully mapped onto the experience of being gay, providing an adjunct tool to existing methods of gay affirmative therapy. By way of summary, the following is a suggested five-stage model of gay and lesbian development through the above lens. Though generalised and not intended as prescriptive, it nevertheless offers a concise overview of the main points raised that may be of interest and use to psychotherapists working with gay clients.

A proposed model of gay and lesbian identity development from a Jungian perspective

1. Gay Shame: The majority of gay people become aware of their orientation in puberty. By this point they will have unconsciously internalised society's negative shadow projections related to homosexuality and may experience shock, confusion, fear and repulsion upon realising that these messages may in fact describe themselves.

2. Shadow Formation: In keeping with the idea that we repress anything which does not tally with our desired self-image, they will move these negative ideas into their personal shadow, where they will solidify as internalised homophobia. I would argue that the contents of this particular area of the shadow will not be unconscious – on the contrary, the young gay person is likely to be hyperaware and ashamed of their sense of difference.

3. Persona Implementation: The response to this shame is to deny the legitimacy of the shadow by adopting a persona that fits the social convention, namely by wearing the mask of heterosexuality. What is left in the middle is a torn and isolated ego – the grotesque contents of the shadow are too frightening to integrate, but the persona makes a fraud of them every day. This combination exacts a psychological toll.

4. Shadow Integration & Persona Dissolution: The only true way to overcome this double bind is to find the courage to take off the mask and meet the shadow, most commonly achieved through the process of coming out. This moves the gay person closer to individuation, or becoming their most authentic selves.

5. Shadow Remnants & Persona Fluidity: Due to its long gestation, shameful vestiges of the shadow may remain even after coming out, while the overarching societal assumption of heterosexuality makes coming out itself an ongoing occurrence. On this front, the gay person is likely to keep their straight mask close by at all times, and may voluntarily don it when circumstances demand (or

appear to demand). This can lead to anger and embarrassment towards self or society that is unlikely to ever be fully resolved, but in no way precludes the individual from living a happy and fulfilling life as an out gay man or lesbian.

Moving Forward

In 1993, a survey showed that 64 percent of Irish people opposed the decriminalisation of homosexual acts (Bielenberg, 2015). Twenty-two years later, nearly the same percentage voted in favour of same-sex marriage equality. Seemingly out of nowhere, Ireland has found itself on the vanguard of global LGBT social change. In spite of the many challenges presented, Rodgers (2016) and Maycock and colleagues (2009) ultimately found that the Irish gay people in their samples were more happy than unhappy in their lives. They displayed high levels of resilience, felt a greater sense of freedom, and were able to form positive meanings from their personal struggles. Furthermore, with easier access to information and increased support from society, members of the younger generation are coming out at an ever-earlier age – in fact, some don't go into the closet at all (Bielenberg, 2015; Sweeney & Cashin, 2014; Ferriter, 2009). It is highly possible that future generations' experiences of the persona and shadow will be very different from now. In the meantime, Irish counsellors and psychotherapists can offer a confidential, non-judgemental, gay-affirmative space for those facing difficulties around their sexuality, one in which they can safely explore their identities and hopefully move closer to individuation. Ultimately, though Irish society has changed largely for the better in terms of gay rights, psychotherapists working with gay and lesbian clients still need to be acutely aware of the unique issues they face in their daily lives, as well as past challenges that may continue to inform their mental wellbeing. LGBT Helpline reported that in 2015 the majority of their calls looking for information were related to 'LGBT-friendly' counsellors and psychotherapists (Condon, 2016), clearly highlighting the demand for gay affirmative therapy in Ireland today. As with any client, the therapist may experience this duty of care as a challenge, a privilege, or both, but whichever the case, we must show members of our gay and lesbian community the utmost respect for the road they have had to travel.

References

Abrams, J. & Zweig, C. (Eds.). (1991). *Meeting the shadow: The hidden power of the dark side of human nature*. New York: Penguin.

Bielenberg, K. (2015, January 25). Gay nation: Are gay people still living in the shadows in Ireland? *Irish Independent*. Retrieved from http://www.independent.ie/life/gay-nation-are-gay-people-still-living-in-the-shadows-in-ireland-30929752.html

Carey, A. (2015). *Belong to Yes: Voices from the marriage equality campaign*. Dublin: Belong To Youth Services.

Casement, A. (2003). Encountering the shadow in rites of passage: A study in activations. *The Journal of Analytical Psychology* 48(1), 29-46. doi: 10.1111/1465-5922.t01-2-00002

Coleman, E. (Ed.). (1988). *Integrated identity for gay men and lesbians: Psychotherapeutic approaches for emotional well-being*. New York: Harrington Park Press.

Condon, D. (2016, February 2). 2015 was LGBT Helpline's busiest year. *Irish Health.* Retrieved from http://www.irishhealth.com/article.html?id=25193

Connolly, S. (2014, February 8). Buttimer and Panti drown out empty rhetoric in homophobia debate. *Irish Examiner*. Retrieved from http://www.irishexaminer.com/viewpoints/columnists/shaun-connolly/buttimer-and-panti-drown-out-empty-rhetoric-in-homophobia-debate-258117.html

Cormier-Otaño, O. & Davies, D. (2012). Gender and sexual diversity therapy. In Pink Therapy, *Collected studies on GSDT* 2012-2013 (pp. 4-14). Retrieved from http://www.pinktherapy.com/portals/0/CourseResources/PT_Papers_eBook.pdf

Davies, D. (1996a). Towards a model of gay affirmative therapy. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients* (pp.24-40). Buckingham: Open University Press.

Davies, D. (1996b). Homophobia and heterosexism. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients* (pp.41-65). Buckingham: Open University Press.

Davies, D. (1996c). Working with people coming out. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients* (pp.66-85). Buckingham: Open University Press.

Davies, D. (1996d). Working with young people. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients* (pp.131-148). Buckingham: Open University Press.

Davies, D. (2012). Sexual orientation. In Pink Therapy, *Collected studies on GSDT* 2012-2013 (pp. 15-24). Retrieved from http://www.pinktherapy.com/portals/0/CourseResources/PT_Papers_eBook.pdf

Davies, D. & Neal, C. (Eds.). (1996). *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients*. Buckingham: Open University Press.

Ferriter, D. (2009). *Occasions of sin: Sex and society in modern Ireland*. London: Profile Books.

Finnegan, B. (2015, July). Editor's letter. *Gay Community News* (307), 3.

GLEN (Gay and Lesbian Equality Network). (2013, May 17). *Major new EU study shows daily life for many Irish LGBT*

people can be very difficult. Retrieved from http://www.glen.ie/attachments/Media_Release_-_EU_FRA_Study_Results_-_May_2013.pdf

George, K.D. & Behrendt, A. E. (1987). Therapy for male couples experiencing relationship problems and sexual problems. In E. Coleman (Ed.), *Integrated identity for gay men and lesbians: Psychotherapeutic approaches for emotional well-being* (pp.77-88). New York: Harrington Park Press.

Gonsiorek, J.C. (Ed.). (1985). *A guide to psychotherapy with gay and lesbian clients*. New York: Harrington Park Press.

Halligan, U. (2015, May 15). Referendum led me to tell the truth about myself. *The Irish Times*. Retrieved from http://www.irishtimes.com/opinion/ursula-halligan-referendum-led-me-to-tell-truth-about-myself-1.2212960

Hetrick, E.S. & Martin, A.D. (1987). Developmental issues and their resolution for gay and lesbian adolescents. In E. Coleman (Ed.), *Integrated identity for gay men and lesbians: Psychotherapeutic approaches for emotional well-being* (pp.25-43). New York: Harrington Park Press.

Hopcke, R.H. (1993). Homophobia and analytical psychology. In R.H. Hopcke, K. Lofthus Carrington & S. Wirth (Eds.), *Same-sex love and the path to wholeness* (pp.68-87). Boston: Shambhala.

Hopcke, R.H., Lofthus Carrington, K. & Wirth, S. (Eds.). (1993). *Same-sex love and the path to wholeness*. Boston: Shambhala.

Hudson, W.C. (1978). Persona and defence mechanisms. *The Journal of Analytical Psychology* 23(1), 54-62. doi: 10.1111/j.1465-5922.1978.00054.x

Kennedy, I. (2014). Homosexual men: A journey from shame to authenticity. Éisteach: *The Irish Journal of Counselling and Psychotherapy* 14(3), 8-13.

Kort, J. (2004). *Queer eye for the straight therapist: Creating an affirming practice for gay clients*. Retrieved from http://www.joekort.com/var/joekort2/storage/original application/0b42aec2a665129e60b84c167db617d1.pdf

Lafontaine, L. (2011, September 18). *Carl Jung quotations: The shadow and persona anthology* [Web log post]. Retrieved from http://carljungdepthpsychology.blogspot.ie/2011/09/carl-jung-quotations-shadow-and-persona.html

Malyon, A.K. (1982). Psychotherapeutic implications of internalized homophobia in gay men. In J.C. Gonsiorek (Ed.), *A guide to psychotherapy with gay and lesbian clients* (pp. 59-69). New York: Harrington Park Press.

Maycock, P., Bryan, A., Carr, N. & Kitching, K. (2009). *Supporting LGBT lives: A study of the mental health and well-being of lesbian, gay, bisexual and transgender people*. Dublin: GLEN. Retrieved from http://www.glen.ie/attachments/SUPPORTING_LGBT_LIVES_-_Main_Report.pdf

Miller, D.P. (1990). What the shadow knows: An interview with John A. Sanford. In J. Abrams & C. Zweig (Eds.), *Meeting the shadow: The hidden power of the dark side of human nature* (pp.19-26). New York: Penguin.

Mullally, U. (2015, April 27). It's hard to accept yourself when your country doesn't. *The Irish Times*. Retrieved from http://www.irishtimes.com/opinion/una-mullally-it-s-hard-to-accept-yourself-when-your-country-doesn-t-1.2189642

Ó'Caollí, É. & Hillard, M. (2015, May 23). Ireland becomes first country to approve same-sex marriage by popular vote. *The Irish Times*. Retrieved from http://www.irishtimes.com/news/politics/ireland-becomes-first-country-to-approve-same-sex-marriage-by-popular-vote-1.2223646

O'Carroll, S. (2014, February 16). Bullied, egged, kicked out and beaten up: Homophobia in real life. *The Journal*. Retrieved from http://www.thejournal.ie/homophobia-ireland-1313875-Feb2014/

Pink Therapy. (2012). *Collected studies on GSDT* 2012-2013. Retrieved from http://www.pinktherapy.com/portals/0/CourseResources/PT_Papers_eBook.pdf

Rodgers, G.P. (2016). *A phenomenological research study of gay men in Ireland – From disrespect to respect: The power of social critique for self-transcendence* (Unpublished DPsych thesis). Dublin City University, Ireland.

Romesburg, D. (Ed.). (1995). *Young, gay and proud!* (4th ed.). Los Angeles: Alyson Publications.

Simon, G. (1996). Working with people in relationships. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients* (pp.101-115). Buckingham: Open University Press.

Sophie, J. (1987). Internalized homophobia and lesbian identity. In E. Coleman (Ed.), *Integrated identity for gay men and lesbians: Psychotherapeutic approaches for emotional well-being* (pp.45-52). New York: Harrington Park Press.

Stevens, A. (2001). *Jung: A very short introduction*. Oxford: Oxford University Press.

Stone, J. (2015, July 9). Does London have a homophobia problem within the gay community? *Evening Standard*. Retrieved from http://www.standard.co.uk/lifestyle/esmagazine/does-london-have-a-homophobia-problem-within-the-gay-community-10376715.html

Sweeney, T. & Cashin, D. (2014, October 12). 'The day I came out': Members of the Irish LGBT community share their stories. *Irish Independent*. Retrieved from http://www.independent.ie/life/the-day-i-came-out-members-of-the-irish-lgbt-community-share-their-stories-30654517.html

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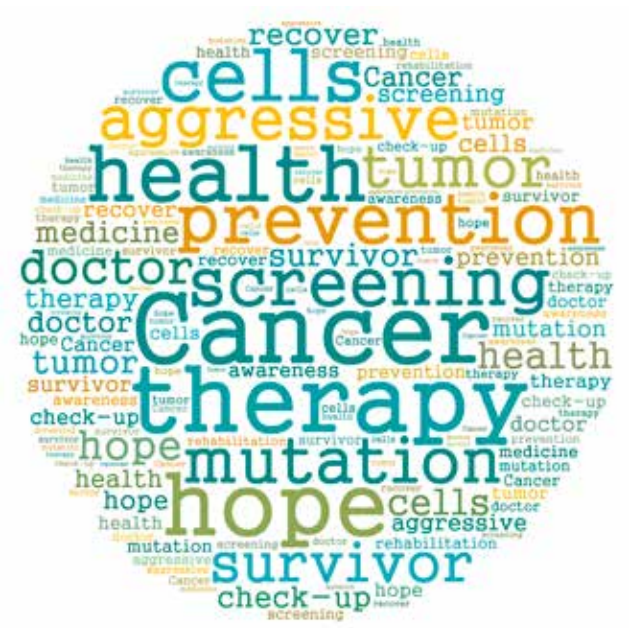
Counselling and The Big C

Roisin Whelan



Although a diagnosis of cancer may not mean a death sentence, counselling a client who has been diagnosed with cancer involves working with loss and the grief associated with that loss (Barraclough, 1999; Guex, 1994; Wiggers et al., 1990)

Introduction

It has been said that many therapists and counsellors are drawn to their work from their own life experiences (Tartakovsky, 2016). We all carry with us our story with the hope that our experiences will help our clients to grow and to heal (Black & Kennedy, 2010). The stories we carry not only influence how we work with clients, they keep us focused and remind us of why we choose this path (Wheeler, 2007).

This article is drawn from a piece of research I conducted for my undergraduate degree. My own story was the reason I chose to research the subject of cancer, as thirteen years ago I too was a patient. What was highlighted to me at the time of my illness was the lack of emotional and psychological support available. When you're diagnosed with cancer, the focus is on the physical effects (Kelley et al., 2014, Larsson et al., 2011; Street et al., 2009). What wasn't highlighted were the psychological and emotional effects both during and after treatment, and for me they were the most difficult to come to terms with (Whelan, 2013).

The aim of this article is to explore and identify factors, which may enhance the skill set and the effectiveness of counsellors working therapeutically with cancer patients. Conjointly, this article briefly discusses the different psychological issues that clients present with, the therapeutic approaches used by psychotherapists and both the benefits and stressors that exist for those working therapeutically with people diagnosed with cancer.

Cancer in Ireland

Cancer is the second most common cause of death in Ireland (NCRI, 2013). Furthermore the risk of developing cancer is increasing by approximately one percent every year while the risk of dying of cancer is falling by the same amount, thus highlighting the increased rates of cancer survival (ICS, 2013).

Statistically in Ireland one person in every three will develop cancer during their lifetime - that equates to thirty thousand people every year (NCRI, 2013). The National Cancer Registry (NCRI) predicts that this number will increase to forty thousand by 2020.

Issues Relating To A Cancer Diagnosis

According to Guex (1994) feelings of anguish, worthlessness and depression are classic reactions for someone who has been diagnosed with cancer. Death anxiety, fears of recurrence, social isolation, decreased physical energy, and alterations to body image are further issues a cancer patient will face (Dankert et al., 2005; Holland, 2003).

Since the formal development of psycho-oncology in the 1970s of research has focused on the

psychological impact of cancer on a patient and the effect of psychological interventions (Moorey, 2013; Holland, 2000). To date a number of studies have been conducted on medical staff and palliative care teams experiences' of working in an oncology and palliative care setting (Rassouli et al., 2015; Quinn, 2003; Comer, 2002). Unfortunately there is limited research relating to psychotherapists' working knowledge of working in an oncology setting, as well as their experiences working with clients who have been affected by cancer.

Emotional Support & Referral Process for Cancer Patients

As previously mentioned, cancer rates are increasing and with the population growing older and advances in technology, cancer patients are living longer. Therefore the likelihood of therapists working with cancer patients is increasing. The need for psychological support for cancer patients is clearly highlighted in the research (Bor, 2010; Barraclough, 1999; Greer, 1984). Few patients and their families who suffer high levels of distress are referred for further psychological support (Hutchison, 2010; Pascoe, 2000). This would suggest that based on so few referrals, there may be an increasing number of cancer patients and families who seek counselling support (Carlson et al., 2004; Greer, 2002; NHS, 1996).

An Irish study entitled 'Psycho-oncology best practice guidelines and a service perspective', found that "ongoing prioritisation of referrals is essential and patients not categorised as priority patients may be invited to attend psycho-educational/group interventions and may avail of the psychosocial support offered by other departments" (Coleman, et al., 2011, p 85). Although this does not specify independent counsellors and psychotherapists, it does suggest that cancer patients are offered adequate support on some level.

The aim of this research study was to gain an understanding of the participants experience of working therapeutically with cancer patients.

Working therapeutically with cancer patients

Although a diagnosis of cancer may not mean a death sentence, counselling a client who has been diagnosed with cancer involves working with loss and the grief associated with that loss (Barraclough, 1999; Guex, 1994; Wiggers et al., 1990). Every person will experience feelings of loss at some stage during their cancer journey (Anderson, 2002). One of the aims of this research was to show that working with clients who have cancer or those who are terminally ill poses different issues than working with someone who is bereaved. The predominant difference to working with bereavement is that the psychotherapist will not have known the person who has died.

Reflective practice and supervision are essential in order for psychotherapists to consider ways to remain curious and creative (McLean, 2011). If psychotherapists do not take care of their own self-care, it may be difficult for them to care for others. It has been noted by Gilchrist and Hodgkinson (2008) that although working with cancer patients can be rewarding it can also create high levels of burnout in psychotherapists.

Several theoretical frameworks exist which can help psychotherapists working with ill populations and those experiencing death anxiety, the most common being Cognitive Behavioural Therapy (CBT), Person Centred Therapy (PCT), Mindfulness Based Stress Reduction (MBSR) and Group Therapy. By conducting this research the author hoped to explore which model may be beneficial to include in the basic training of counselling and psychotherapy courses for issues relating to cancer, whilst possibly highlighting more useful interventions for those working with cancer patients.

This writer believes that an integrative approach to counselling a person with cancer would be most appropriate. A fusion of the person centred approach and CBT, or two contrasting modes of functioning which give the client the opportunity to come in and out of the emotional aspects, while dealing with practicalities of their current situation.

Methodology

The aim of this research study was to gain an understanding of the participants experience of working therapeutically with cancer patients. All participants were female psychotherapists and psychologists, ranging in age from 25 to 65 years. All had experience working in the area of oncology varying from 11 months to 17 years. All therapists that participated in this research project had

experience working therapeutically with cancer patients in a hospital setting, with two participants working with cancer patients and their families in a private setting. Regarding their training, one participant held a Higher Degree in Counselling and Psychotherapy, one participant was a fully trained Group Analytic Psychotherapist, and one was studying for a doctorate in Counselling Psychology.

The in-depth semi structured interviews were approximately twenty to thirty minutes long. Ten open questions were posed to the participants and interviews were recorded using a Dictaphone and later transcribed verbatim. These questions where derived from the review of the literature, and included topics relating to referrals, client issues, interventions and the joys and pitfalls of working in the area of cancer. Transcripts were analysed using Thematic Analysis (TA), a qualitative method used for 'identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006).

According to the participants, men tended to be more stoical and usually prefer treatments that do not require them to reveal too much about themselves.

The Findings

The key findings of this study that will be discussed in this section are referrals, presenting issues, the therapeutic process, therapists' needs, and the benefits and stressors of working in the field.

Referral Process

The participants all spoke about the referral process of clients. In a hospital setting, some participants spoke about how the patients referred to them were first assessed by their consultant or clinical nurse specialist, and then signed off by a medical doctor. Patients that were distressed but not assessed as requiring psycho- oncology services were not mentioned. This would suggest that there are a number of moderately distressed cancer patients in Ireland whose needs are over looked, which supports the current literature showing that few patients and their families are referred for further psychological support (Hutchison, 2010; Pascoe, 2000).

Participants that worked in a private capacity reported working with both a mix of cancer patients and their families. The referrals received were through other psychologists in hospitals, by former patients, friends and family, or doctors that had previously referred patients. Participants highlighted that the majority of these patients were extremely distressed, anxious and dealing with end of life issues. Once again, this finding supports the literature which suggests that moderately distressed cancer patients may not be provided with psychological support, and that patients may be offered other psycho-educational/group interventions and psychosocial support offered by other hospital departments (Coleman et al., 2011). This shows that both psychotherapists working privately and in a hospital setting reported that clients can be overlooked and may not be receiving psychological support. Furthermore, it highlights the need of psychotherapists to be equipped with the skills to work therapeutically with this cohort of patients if they present to counselling.

Presenting Issues

Participants reported loss as a major topic presenting with clients affected by cancer. Loss related to different aspects of the clients life post diagnosis. When relating loss to treatment, there may be a loss of body structure, of body function and disfigurement (Barraclough, 1999). The participants mentioned how appearance issues like hair loss, physical scars, weight loss, or weight gain can be particularly distressing for clients.

Other issues reported placed an emphasis on the practicalities of having the disease. This related to patients worrying about telling the kids, or how they would tell their partner. The social factors highlighted further issues for cancer patients the fact that people are often dependent on two people working for a mortgage or other financial matters. The current literature indicates that financial stress from a cancer diagnosis can severely affect the psychological well being of cancer patients (Sharp et al., 2013). It also suggests that cancer patients with financial burdens have adverse health outcomes, and have a poorer quality of life compared to those who are financially secure (Whitney et al., 2016). This shows us that experiencing financial stress further exasperates feelings of anxiety and distress in cancer patients.

The participants described clients having no control be it over their

body, the illness itself and/or their treatment or their future. Perceived control over their disease, and patients having a sense of loss of control has been documented in the literature (Chapple et al., 2004; Jenkins & Burish, 1995; Wallston et al., 1987). Death anxiety was identified as a predominant theme and continued through every aspect of each the individual interviews.

The participants indicated that whilst working therapeutically with clients who have a cancer diagnosis, therapists need to be aware of vast amount of issues relating to cancer, terminal illness and death. Jevne and Miller (1999) suggest that clients who have been diagnosed with cancer, or those who are currently going through treatment or in remission require someone who is not afraid of cancer or death.

Presenting issues reportedly differ depending on gender showing that men are less willing than women to seek support in situations where they need help for physical or emotional issues (Winerman, 2005). According to the participants, men tended to be more stoical and usually prefer treatments that do not require them to reveal too much about themselves. Instead of 'talk' therapy, it was revealed that mindfulness and meditation groups work well with male cancer patients because they do not rely heavily on discussing their emotional responses to cancer.

This finding corresponds well with the current literature, suggesting that men prefer to receive more factual, scientific information rather than emotional support (Bergerot et al., 2014; Hagedoorn et al., 2000). This suggests that when working with men, therapeutic processes need to be tailored so that the focus is not solely on the emotional responses to cancer.

It is essential for the therapist to understand their clients' perspective. To do this, it is vital for a therapist to consider the challenges that a client will face during their various stages of treatment. The loss associated with a cancer diagnosis triggers one to question the meaning of their existence.

Therapists Needs & Experiences

Participants reported using a plethora of therapeutic approaches from CBT, Humanistic, and Gestalt to Emotion Focused Therapy and Compassion Therapy. All therapists acknowledged having a basic humanistic approach. Although CBT was indicated as an effective first-line treatment for working therapeutically with cancer patients in the current literature (Greer, 2002), the participants viewed their approach as being pluralistic, tailoring therapy to the needs of individual clients (McLeod & Cooper, 2007).

All therapists were unified when they spoke about the importance of building a solid therapist/client relationship and providing a supportive environment where the client can talk about their responses to cancer. The emotional support provided by therapy has been linked to a positive outlook and wellbeing of the patients (Shanker et al., 2013; Montgomery & Schnur, 2010; Speigel et al, 1989; Yalom, Speigel & Bloom, 1981).

The participants' view on self-care, and the importance of looking after ones psychological well-being was found to be significant to their personal and professional lives. Firstly, it highlighted the importance of having good quality supervision and personal therapy. Moreover it emphasised the need for therapists to know themselves and to recognise when they needed timeout. Feelings of stress, exhaustion and dissatisfaction have been identified as causing burnout, severe anxiety and depression amongst those working in the area of oncology (McLean, 2011; Jones et al, 2010). There is an emphasis on the importance of self-care in the literature with one study indicating that burnout can lead to emotional withdrawal from patients (Ghetti et al., 2009). If therapists do not pay heed to their own self-care, it may be difficult for them to care for others.

Interestingly the majority of participants recognised that training in the area would require them to gain hands on clinical experience. With a high number of inpatients being referred to psych-oncology services (Coleman et al., 2011), and the limiting size of the psycho-oncology departments there seems to be a growing need for cancer support. Despite the prevalence of cancer, there are only a limited number of training courses available in Ireland. The current statistics state that cancer rates are increasing (ICS, 2013) therefore it may be useful for current training programs to have a focus on cancer support.

Conclusion

Although the physical aspects are addressed, there is little support available for people suffering with

the emotional difficulties of such a disease. As with all forms of psychotherapy, it is essential for the therapist to understand their clients' perspective. To do this, it is vital for a therapist to consider the challenges that a client will face during their various stages of treatment. The loss associated with a cancer diagnosis triggers one to question the meaning of their existence. Although there is an individualistic piece to how one relates to a cancer diagnosis, there is a need for all therapists to be equipped with the basic skills to work therapeutically with clients coping with a cancer diagnosis. This writer is aware that this was a small piece of research and recognises the need for further studies to be conducted with the hope that it may encourage psychotherapy-training colleges to provide adequate courses to their students and contribute to improving the emotional support for cancer patients.

References

Chapple A., Ziebland S., McPherson A. (2004). *Stigma, shame, and blame experienced by patients with lung cancer: qualitative study.* The British Medical Journal, *328*, 1470.

Anderson, A., Baum, A. (2002). *Psychosocial Interventions for Cancer.* Washington : APA.

Barraclough, J. (1999). *Cancer and Emotion Tird Edition .* Chichester. John Wiley & Sons.

Bergerot, C.D., Araujo, T.F., & Tróccoli, B.T. (2014). *Assessment of Distress Among Chemotherapy Patients: A Comparative Study of Gender.* Universidade de São Paulo Brasil *24* (57), 57-65.

Black, S.A., Kennedy T. G. (2010). Life Outside the 50-Minute Hour: The Personal Lives of Counsellors. *Canadian Journal of Counselling and Psychotherapy , 44* (4), 421–437.

Bor, R. Eriksen C. (2010). *Coping with the Psychological Effects of Cancer.* London: Sheldon Press.

Boulton, M., Boundini, M., Mossman, J., Moynihan, C., Leydon, G., Ramirez, A. (2000).

'Dividing the Desolation' Clients views on the benefits of a counselling cancer service. Cancer BACUP . London : John Wiley & Sons Ltd.

Braun, V., Clarke, V. (2006). Using Thematic Analysis in Psychology . *Qualitative Research in Psychology* (3), 77-101.

Carlsson, S., Sandin, F., Fall, K., Lambe, M., Adolfsson, J., Stattin, P., Bill-Axelson, A. (2013). Risk of suicide in men with low-risk prostate cancer. *Eur J Cancer , 7* (49).

Ghetti, C., Chang, J., Gosman,G. (2009). Burnout, Psychological Skills, and Empathy: Balint Training in Obstetrics and Gynecology Residents. *J Grad Med Educ* , 231–235.

Comer, J. (2002). Nurses' experiences of cancer. *European Journal of Cancer Care, 11* (3), 193 - 199.

Spiegel, D., Bloom, J.R., Yalom, I. (1981). Group support for patients with metastatic cancer. A randomized outcome study. *Arch Gen Psychiatry,38* (5), 527 -33.

Herschbach, P., Dankert, A., Berg, P., Duran, G., Engst-Hastreiter, U., Waadt, S., Keller, M., Ukat, R., Henrich, G. (2005). Fear of progression in chronic diseases: psychometric properties of the Fear of Progression Questionnaire. *Journal of Psychosomatic Research, 58* (6), 505-511.

Greer, S. (2002). Psychological Intervention - The Gap Between Research and Practice . *Acta Oncologica, 41* (3), 238-243.

Guex, P. (1994). *An Introduction to Psycho-Oncology (English Version).* (H. Goodane, Trans.) London: Routledge.

Hagedoorn, M., Buunk, B.P., Kuijer, R.G., Wobbes, T., Sanderman, R. (2000). Couples dealing with cancer: role and gender differences regarding psychological distress and quality of life. *Journal of Psychooncology , 9* (3), 232-42.

Holland, J.C. (2003, December). American Cancer Society Award Lecture. Psychological care of patients: psycho-oncology's contribution. *JournalOf Clinical Oncology* , 253–265.

Holland, J.C., Andersen, B., Breitbart, W.S., Buchmann, L.O., Compas, B., Deshields, T.L., Freedman-Cass, D. (2013). Distress management. *Journal of the National Comprehensive Cancer Network , 11* (2), 190-209.

Hutchison, S.D., Sargeant, H., Morris, B.A., Hawkes, AL., Clutton, S., Chambers, S.K. (2010). A community based approach to cancer counselling for patients and carers: A preliminary study . Queensland, Australia: *Wiley Online Library.*

ICS. (2013, December). *Cancer Statistics*. Retrieved March 23, 2014, from Irish Cancer Society: http://www.cancer.ie/about-us/media-centre/cancer-statistics

Larsson, I.E., Monika, J.M., Sahlsten, M., Segesten, K., Plos, KA. (2011). Patients' Perceptions of Nurses' Behaviour That Influence Patient Participation in Nursing Care: A Critical Incident Study. *Nursing Research and Practice* (Article ID 534060).

Jevne, R. F., & Miller, J. E. (1999). *Finding hope: Ways to see life in a brighter light.* Willowgreen Publishing.

Kelley, J.M., Kraft-Todd, G., Schapira, L., Kossowsky, J., Riess, H. (2014). The Influence of the Patient-Clinician Relationship on Healthcare Outcomes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *PLoS ONE , 9* (4).

Hodgkinson, K., Gilchrist, J. (2008). *Psychosocial Care of Cancer Patients: A Health Professional's Guide to what to Say and Do.* Sydney: Ausmed Publications.

Wallston, K.A., Strudler-Wallston, B., Smith, S., Dobbins, CJ. (1987). Perceived control and health. *Current Psychology , 6* (5), 5-25.

Carlson, L.E., Angen, M., Cullum, J., Goodey, E., Koopmans, J., Lamont, L.,

MacRae, J.H., Martin, M., Pelletier, G., Robinson, J., Simpson, J.S., Speca, M., Tillotson, L., Bultz, B.D. (2004). High levels of untreated distress and fatigue in cancer patients. *British Journal of Cancer* (90), 2297–2304.

Sharp, L., Carsin, A.E., Timmons, A. (2013). Associations between cancer-related financial stress and strain and psychological well-being among individuals living with cancer. *PsychoOncology , 22*, 745-755.

MacCarthy, D., Mills, L. (2013). *Word of Mouth - Coping with and Surviving Mouth, Head and Neck Cancers.* (Vol. 1). Dublin: Kazoo Publishing Services.

Rassouli, M., Zamanzadeh, V., Ghahramanian, A., Abbaszadeh, A., Alavi-Majd, H., Nikanfar., A. (2015). Experiences of patients with cancer and their nurses on the conditions of spiritual care and spiritual interventions in oncology units. *Iran Journal Nursing Midwifery Res., 20* (1), 25–33.

McLean, P. (2011). Balancing Hope and Hopelessness in Family Therapy for People Affected by Cancer. *The Australian & New Zealand Journal of Family Therapy , 32* (4), 329-342.

McLeod, J., Cooper, M. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. Counselling and Psychotherapy Research. *Counselling and Psychotherapy Research , 7* (3), 135 - 143.

Montgomery, G.H., Schnur, J.B. (2010). A systematic review of therapeutic alliance, group cohesion, empathy, and goal consensus/collaboration in psychotherapeutic interventions in cancer: Uncommon factors? *Clinical Psychology Review , 30* (2), 238-47.

Moorey, S. (2013). I know they are distressed. What do I do know? *Psycho-Oncology, 22*, 1946-1952.

NCRI. (2013). *Cancer in Ireland 2013: Annual report of the National Cancer Registry*. Retrieved April 20 , 2015, http://www.ncri.ie/sites/ncri/files/pubs/CancerinIreland2013AnnualReportoftheNationalCancerRegistry.pdf

Coleman, N., Hession, N., Connolly, A. (2011). Psycho-oncology best practice guidelines and a service perspective: conceptualising the fit and towards bridging the gap. *The Irish Journal of Psychology , 32* (1-2), 72-89.

Clarke, N., Sharp, L., O'Leary, E., Richardson, N. (2009). *A Report on the Excess Burden of Cancer among Men in the Republic of Ireland.* NCRI , ICS & IT CARLOW. Dublin: HSE.

Parkes, P. M. (1998). Coping with loss - Surgery and loss of body parts . *Education & Debate*, *316*, 1086.

Quinn, B. (2003). Exploring nurses' experiences of supporting a cancer patient in their search for meaning. *European Journal Oncology Nursing , 7* (3), 164-171.

Shanker, R., Rajagopal, N., Ankur, B. (2013). Effectiveness of Group Psycho-education on Well-being and Depression Among Breast Cancer Survivors of Melaka, Malaysi. *Indian Journal of Pallative Care , 19* (1), 34–39.

Street R.L., Makoul, G., Arora, N.K., Epstein, R.M. (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling, 74* (3), 295-301.

Salander P, Hamberg K. (2005). *Gender Differences in Patients' Written Narrative about Being Diagnosed with Cancer.* Department of Public Health, Social Welfare Sweeden. Sweeden: Wiley.

Pascoe, S., Edelman, S., Kidman, A. (2000). Prevalence of psychological distress and use of support services by cancer patients at Sydney hospitals. *Australian And New Zealand Journal Of Psychiatry Iss. 5,2000 , 34* (5), 785-791.

Smith, M., Redd, W., Peyser, C., Vogl, D. (1999). Post- Traumatic Stress Disorder in cancer: A review. *Psycho-Oncology , 8*, 521–537.

Spiegel, D.B. (1989). *Effects of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer.* Lancet.

Tartakovsky, M. (2016, May 17). *Therapists Spill: Why I Do What I Do.* . Retrieved October 07, 2016, from Psych Central: http://psychcentral.com/lib/therapists-spill-why-i-do-what-i-do/

Weisman, A.D, Worden, J.W. (1977). *The existential plight in cancer: Significance of the first 100 days.* Retrieved March 30, 2014, from American Psychological Association: http://psycnet.apa.org/index.cfm?fa=search.displayRecord&UID=1977-06188-001

Wheeler, S. (2007). What shall we do with the wounded healer? The supervisor's dilemma. *Psychodynamic Practice , 13* (3), 245-256.

Whelan, R. (2013). Word of Mouth: Coping with and Surviving Mouth, Head and Neck Cancers . Mills. McCarthy. Dublin : Kazoo Publishing Services .

Whitney, R.L., Bell, J.F., Reed, S.C., Lash, R., Bold, R. J., Kim, K., Joseph, J.G. (2016). Predictors of financial difficulties and work modifications among cancer survivors in the United States. *Journal of Cancer Survivorship : Research and Practice., 10* (2), 241 - 250.

Wiggers, J.H, Donovan, K.O., Redman, S., Sanson-Fisher, R.W. (1990). Cancer patient satisfaction with care. *Cancer 66* , 610-616.

Winerman, L. (2005). Helping men to help themselves. *American Psychological Association , 36* (6), 57.

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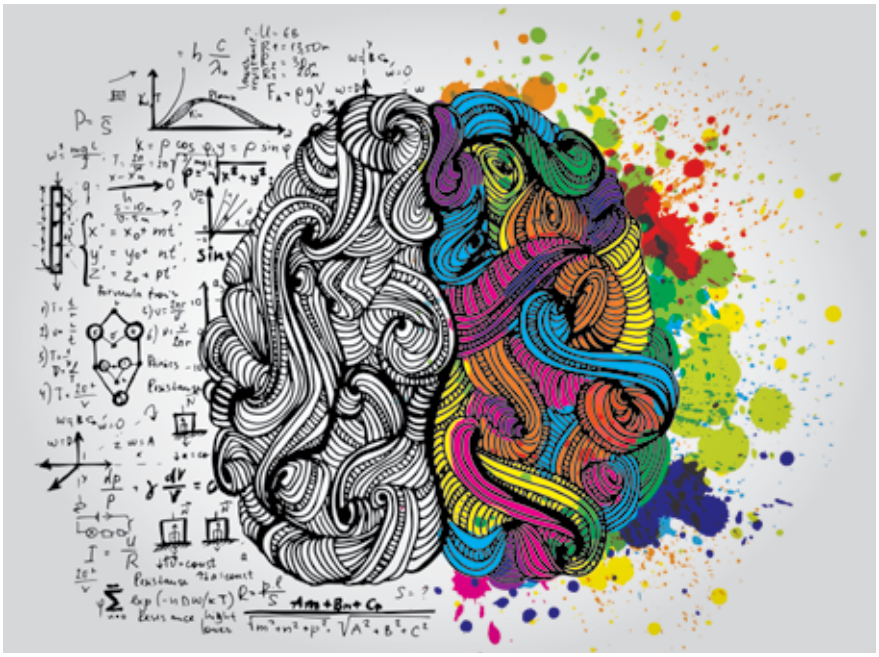
Does Psychotherapy = Counselling? A View on Some Defining Differences

Maeve Dooley



Abstract

The practice of counselling and that of psychotherapy can seem on the surface to be very similar. Described simplistically both, stereotypically, take place in a room with two chairs, a therapist, a client, and a presenting issue/difficulty to be resolved. Counselling has tended to be described as a shorter term process with psychotherapy being a longer term process, often having a greater focus on childhood experience as a source of the presenting difficulty. There are some who would hold the view that the professional definitions are indeed largely the same and inter-changeable. There are others who hold the opposite view. As we approach Statutory Registration the definitions of counselling and psychotherapy as being much the same or significantly different, has taken centre stage. This article sets out to explore and define some of the very clear differences between these two professional practices and why it is appropriate that the professional titles of 'counsellor' and 'psychotherapist' attain separately recognised Statutory Registration.

Does psychotherapy = counselling?

The much-debated question of the difference between counselling and psychotherapy has come under the spotlight recently. With the impending possibility of Statutory Registration the question has arisen, surprising many of us, as to whether they will be treated as a single profession or as two separate professions. Enquiring further, I came across a recently released document outlining a viewpoint that there is no difference between the practices of counselling and psychotherapy, no proficiency difference, and that both professions should be regulated with the same baseline qualifications for practice (Irish Association for Counselling and Psychotherapy, 2013). Further to this was an article in the Summer 2014 edition of Inside Out (Boyne, 2014a) pointing out some concerns for psychotherapy and the protections of standards should such a viewpoint prevail.

This has stirred some energy into the cauldron of vagueness that has indeed seemed to surround how counselling and psychotherapy are defined. Is there now a real possibility that counselling and psychotherapy might be blended into some kind of soupy mix? How do we (IAHIP) meet the challenge now posed by the viewpoint that regards psychotherapy and counselling as the same? There is, I believe, a clear need to distil the essence of each of the professions out from this apparent 'gloop' of interchangeability and blurred understanding. Dr. Bill Shannon, a former President of the Irish College of General Practitioners, in the Spring 2014 edition of Inside Out described how, the "psychotherapy profession must establish itself enough to be taken seriously…" and cease "… to be a kind of Cinderella profession" (Boyne, 2014b, p. 8).

A counsellor-turned-psychotherapist

Having completed a professional training in counselling and psychotherapy in the mid-1990s, I began in practice using the professional title of 'counsellor'. I used this term as it seemed to be the most familiar professional term at the time and also because I sensed that psychotherapy, as a depth-orientated developmental process, required further exploration and integration to have due integrity in practice. My first supervisor was a Jungian psychotherapist and this ignited my interest in the deeper meaning inherent through the Jungian therapeutic lens. Through my own continuing therapeutic process and other experiential work, I deepened my insight into unconscious process and only then felt a competency to expand the definition of my work to include psychotherapy. I have since specialised in Jungian sandplay, becoming a registered member of the International Society for Sandplay Therapy. My language and perspective is largely framed by my Jungian specialisation which I hope is not overused here and translates across other psychotherapeutic approaches.

Difficulties in defining 'psychotherapy'

Having used both terms in my professional practice, I have on many occasions sought exacting definitions for both counselling and psychotherapy. The proliferation of the dual professional identity of counsellor/psychotherapist, with practitioners emerging from a myriad of schools and approaches, has created confusion and difficulty in defining specific differences, beyond what has been a generalised understanding. This somewhat nebulous understanding describes psychotherapy as a longer-term and a more deeply engaging process, while counselling is described as a process that is generally shorter in duration and primarily issue-focused.

A psychologist familiar with the practices of counselling and psychotherapy, used the analogy, familiar to many, of doing home renovations. Elaborating somewhat, she described that counselling would be like getting in the painters and decorators, while psychotherapy would be like getting in the builders.

One of the difficulties in arriving at a clear definition of 'psychotherapy' is that the word itself has a very broad meaning and is therefore open to wide and varying interpretation. The basic origins of the word are 'psyche', meaning soul, mind or spirit, while 'therapy' translates as healing, cure or remedy. Therefore, in effect, any activity that remedies, cures or heals the soul, mind or spirit can perhaps describe itself as 'psychotherapy'. This makes it very difficult for us as psychotherapists in an IAHIP context to protect our professional definition of the term 'psychotherapy' and so possibilities from broader interpretations can lead to confusion and blurring of the professional practice.

While we (IAHIP) hold a clear definition of psychotherapy and fasten down our requirements and restrictions for professional practice, we cannot prohibit or negate other interpretations. This means, in effect, that those who hold the view that there is no difference between counselling and psychotherapy may be able to show some validity to this. Counselling may well provide such a healing or remedy experience and therefore lay claim to being psychotherapeutic. However, this is not the same as saying that counselling, a word derived from 'counsel' which is defined to mean advice, opinion or instruction (http://dictionary.reference.com / browse/counselling), is the same as psychotherapy, as professionally defined.

For the purposes of this article I will use the term 'psychotherapy' to refer to the definition supported by the IAHIP as described on the Irish Council for Psychotherapy (ICP) website. Humanistic and Integrative psychotherapy:

> …invites people to develop awareness as to what may be preventing them from accessing their own true nature in the inner and outer expressions of their life. It is aimed at the person as a whole: body, feelings, mind and psyche. It invites people through the therapeutic relationship to develop awareness and insight leading to an integration of the internal and external self. It explores each person's own resources and capacity for self-determination and ability to improve their lives.
>
> (ICP, 2014a)

This definition clearly illustrates that psychotherapy is primarily a

Psychotherapy, with its developmental focus, can support individuals to discover more about their own innate identity, gaining a more complete sense of self which can also be therapeutic, effective and a very enlightening experience.

developmentally-focused process, which is intrinsically different from what I describe in this article as the issue-focused process of counselling.

I came across a recent description from a psychologist familiar with the practices of counselling and psychotherapy, saying how she had explained her understanding of the difference to a colleague. She used an analogy, familiar to many, of doing home renovations. Elaborating somewhat, she described that counselling would be like getting in the painters and decorators, while psychotherapy would be like getting in the builders. This is an analogy that offers a lot of scope for amplification and debate. For my purpose here it illustrates clearly that while both professions can be seen to have a role in the same space, they nonetheless have a significantly different focus, impact and outcome.

So how are counselling and psychotherapy actually different?

Counselling and psychotherapy are both relational processes. In addition they are closely aligned within the broader group of 'helping' professions. Indeed it is understandable that for those unfamiliar with the inherent differences, they can appear from their similar settings to be the same. The relationship between client and therapist is fundamental and central to both disciplines, however it is the focus of the work within that setting that is intrinsically different. In this article I am going to illustrate this through two primary aspects that define this difference. The first aspect relates to how each profession views psychological disturbance/ issues and the second looks at key differences in relation to the place and use of boundaries in the practices.

Difference in addressing disturbances/issues

One of the defining aspects of psychotherapy is that it offers a place where people can safely focus on exploring their deeper developmental needs and difficulties. It is a process that takes place when a psychotherapist, with their specialised skilful awareness, works with a client in exploring disturbances (which may arise through presenting issues), drawing attention to aspects of conscious and unconscious experience. I use the word 'disturbance' here to refer to a kind of noticeable experience that can seep through the dynamics or symptoms of the client's presenting concerns. Such disturbances often become 'visible' through the therapist's relational experience with clients, including transference and counter-transference possibilities.

Counselling as a similar 'relational' therapy also has an impact on internal development, as indeed do other relationally-based helping initiatives and intimacies. It is the focus and understanding however, that defines the difference here. While both counselling and psychotherapy generally begin from a presenting issue or concern as described by the client, they part company soon after. The counselling process moves forward by focusing on the client's presenting issues/ concerns and working towards their resolution. The approach here is to explore with an emphasis towards resolving the disturbance. Counselling, therefore, can be said to focus primarily on helping the client to re-establish equilibrium and a return to an experience of well- being. Psychotherapy however works differently, slowing down to take detailed notice of the disturbance, heightening attention and interest there and moving to amplify and explore the possible unconscious dynamics within the experience. In psychotherapy such disturbances are explored as possible entry points into the client's unconscious need, through which as yet unmet developmental aspects may be worked with. Such entry points present a type of portal or opportunity for deeper developmental exploration and growth and access to a greater sense of self, which is a primary and deeply-rooted human urge.

Resolving an issue in a focused way through counselling can be therapeutic, effective and a very satisfying experience. Psychotherapy, with its developmental focus, can support individuals to discover more about their own innate identity, gaining a more complete sense of self which can also be therapeutic, effective and a very enlightening experience. For psychotherapy, calling in the builders is a

commitment to possible upheaval and distress as the 'structure' generally has to be taken apart, to allow the creation of the sought-after individualised design to take shape. For counselling, the surrounding structure is felt to work well but there is a difficulty with overt aspects and focusing on redressing them may be the most effective and appropriate approach. Psychotherapy and counselling can therefore be seen here to be very different practices within the same space.

Difference in the place of boundary holding

The 'firm but kind' holding of boundaries and the meaning attributed to them is considered to be a pillarstone of psychotherapy and something that also differentiates it from counselling. Boundary holding and issues that may interrupt it are explored in the psychotherapeutic process and considered intrinsic to its efficacy. The counselling process, on the other hand, views boundaries from a practical and purposeful perspective, with their emphasis centered mainly on the overt safety of the work. Within counselling more space may be allowed for negotiating and setting boundaries around the conscious needs, external interruptions and the wishes of the client. In this setting it is the focus on the presenting issue that may set the requirements, pace and length of therapy. Counselling as a process draws from its detailed attention to the myriad aspects which are gleaned largely through conscious experience. As such, the need to address boundary issues does not necessarily require significant attention beyond the conscious aspects, which include the clear holding of ethical standards, confidentiality and provision of a safe space.

Psychotherapy views boundary creation as a 'foundation footprint' (the concrete platform upon which a structure is built) for the process. This largely disappears from sight as the building rises while it nonetheless remains in place, supporting the weight and protecting it from any underlying destructive forces.

Returning to the building analogy above it could be said that psychotherapy views boundary creation as a 'foundation footprint' (the concrete platform upon which a structure is built) for the process. This largely disappears from sight as the building rises while it nonetheless remains in place, supporting the weight and protecting it from any underlying destructive forces. In the context of psychotherapy, boundaries also answer the conundrum of providing 'open containment'. They support the work of open exploration of unconscious process, while containing this against the pulls of the ego (conscious), including the wish to remain within the familiar (and in this respect there are two vulnerable human beings in the room). If boundaries are too easily moved and changed, then the psychotherapeutic process is without reliable enough support for its work with unconscious process and unmet developmental need. Left unquestioned, flexible changes in boundaries will likely mean that unconscious possibility will be lost in this loosened holding. Requests from clients to take a break, finish, meet less frequently, arriving late to sessions, payment issues, cancelling/rescheduling, etc., are seen in the context of psychotherapy to hold possible underlying meaning and unconscious expression. The psychotherapist takes time to explore possibilities and attunes to possible transference/countertransference issues therein. While undoubtedly there are realities to these types of requests, it is also incumbent upon the psychotherapist in their understanding of suffering, and its place in the developmental process, not to unquestioningly collude. It is more deeply therapeutic, when appropriate, to look at how difficult, frightening and undermining it can be to look at one's true experience, and the sacrifices that this can mean. The psychotherapist does this, holds support for the unconscious awakening and acknowledges the developmental opportunity for the client, but it is the client's choice whether they wish to pursue this or not.

Exploring the deeper meanings that arise through boundaries and their 'breaches' has frequently been misunderstood. It has at times been seen as an aspect of psychotherapy that is 'rule-based' and 'punitive' and only relevant to pure analytical-style processes. It is likely, however, that a therapist's understanding of boundaries and their place in the psychotherapeutic process will largely depend on their own experience of deep therapeutic containment. The familiar adage

quoted by therapists that 'you can only take a client as far as you have gone yourself' could be added to with '…and you can only offer a client the containment that you have experienced yourself'. Boundary holding based on 'rules' is difficult and can be experienced as harsh and cold by clients. However, boundary holding based on a fundamental understanding of, and a respect for, unconscious process can be experienced as providing the essential 'safe and reliable support' for depth processing. Boundary holding in psychotherapy is not easy and often brings the therapist and client into some form of suffering, which is indeed usually a very difficult part of the work.

seeks to know what exists there while we also fear its contents, a primary dilemma often expressed by clients in psychotherapy through various forms of hesitation and comments related to uncertainty around continuing.

Once unconscious contents emerge into consciousness they must be met and managed somehow. Such emerging contents do not decipher between right and wrong, good and bad, or indeed between therapist and client. Support in this process requires very skilled and delicate holding and a response that will have minimal intrusion from the therapist's own inner anxiety, fear and defensive responses. These contents need to be supportively and safely processed in the context of the client's world, then later by the therapist in supervision, and separately, as appropriate, by the therapist in their own therapeutic process. Psychotherapy is very difficult in practice. It is difficult to hold the containment in its idealised essence, as the therapist is also a vulnerable, struggling human being and mistakes and failures in practice are inevitable. It is the willingness and available support to acknowledge and address these that is crucial for the well-being of the client, therapist and the practice of psychotherapy.

Those who view the disciplines of counselling and psychotherapy as distinctly different, may soon find themselves in a 'Galileo-like' experience should the prevailing view regard them as the same. Is psychotherapy to be subject then to a type of 'Roman Inquisition', perhaps born of a naivety that does not as yet grasp the intricate depths of the inner world?

Psychotherapy: a specific discipline

In both of the aspects highlighted above, I have made a number of references to unconscious process as being a central focus for psychotherapy. 'The unconscious' is a much-used term and frequently referred to by psychotherapists. This contrasts somewhat with the reality of the very complex and difficult-to-comprehend entity that we call 'the unconscious'. Our conscious experience struggles to grasp it and gains mere glimpses in focused moments. Our human urge

Any lessening of requirements would weaken the necessary process supports and result in a dilution and a possible defeat for our definition of 'psychotherapy'. Practising psychotherapists are encouraged to continue with their own exploration of unconscious material and developmental issues. It is only in this way that we can truly experience in ourselves the ego-suffering that must be worked through in order to come into true connection with a core sense of self. This is at the heart of our definition of the psychotherapeutic process. It is the nurturing of this heart that is behind the request for completion of 250 hours (minimum) in process work as a requirement to become a member of the IAHIP (Bye Law 11, clause 3.3). While it must be noted that quantity of hours is no guarantee of quality of therapeutic experience, it is a strong indicator of what is needed. Indeed, practitioners have argued, and understandably so, that personal therapeutic process should be put at the top of our CPD requirements (O'Halloran, 2010). In contrast with this, it is possible for people to get professional recognition to practice psychotherapy with a minimum of 50 hours' personal process work. Given what is required in the actual practice of psychotherapy as I describe it, this would be very unlikely to provide the therapist with the level of support and depth of understanding to hold and contain the dynamics of this psychotherapeutic process.

I recently came across a newspaper article about someone who described herself as a 'psychotherapist' and indeed had attended a well- known training institute included on the IAHIP's

list, also achieving a Master's level qualification. The article was focused on the work of a voluntary organisation offering counselling. Despite describing herself as a 'psychotherapist', the individual referred to her work as counselling and spoke in the language of counselling, primarily focusing on conscious experience and solving issues to create a resolution. While the work sounded effective and helpful with positive outcomes, it was not psychotherapy in an IAHIP context. It could be asked here, how seriously do we take our definition of psychotherapy? Has it been allowed to become some sort of counselling/psychotherapy blend?

The Peter Weir film, The Truman Show, (1998) depicts how a man, unaware of a world beyond the one he knew, contentedly assumed the limited one he was in was the complete world. The film illustrates how difficult it can be to get beyond the known and assumed reality and scripted answers. Those who view the disciplines of counselling and psychotherapy as distinctly different, may soon find themselves in a 'Galileo-like' experience should the prevailing view regard them as the same. Is psychotherapy to be subject then to a type of 'Roman Inquisition', perhaps born of a naivety that does not as yet grasp the intricate depths of the inner world? Perhaps some people see no need for the depth work I describe, however for those who do, negating it is not acceptable. The distress and upheaval caused by the appearance of a reality that challenges existing structures, desires and perceptions is ironically familiar to those of us who have engaged in deep therapeutic process. As psychotherapists we respect and know that it is no easy task to accept such realities and the consequences of the changes that they may bring about. However, and at risk of overstating but with the intention of absolute clarity, we as psychotherapists do need to assert that the practice of psychotherapy must not by dilution or blurring slip from its essence to become "an overwhelming failure or frustration…or even a vague sense of an unlived life" (borrowing from ICP's description of challenges in the move towards wholeness, 2014b).

References

Boyne, E. (2014a). *Conversation*. Inside Out, 73, 3-8.

Boyne, E. (2014b). *Conversation*. Inside Out, 72, 3-8.

Irish Association for Counselling and Psychotherapy (2013). *The Irish Association for Counselling and Psychotherapy (IACP) position paper on statutory regulation and the difference between counselling and psychotherapy*. Retrieved 01 December 2014 from http://www.iacp.ie/files/UserFiles/IACP-Position-Paper.pdf.

Irish Association for Humanistic and Integrative Psychotherapy. *Criteria for accreditation of humanistic and integrative psychotherapists* (Adopted 2010 – Amended 2013). Bye Law 11, clause 3.3.

Irish Council for Psychotherapy (2014a). *Humanistic and integrative psychotherapy*. Retrieved 01 December 2014 from http://www.psychotherapy-ireland.com/ disciplines.

Irish Council for Psychotherapy (2014b). *The nature of humanistic and integrative psychotherapy*. Retrieved 01 December 2014 from http://www.psychotherapy-ireland.com/disciplines/humanistic-and-integrative-therapy.

O'Halloran, M. (2010). *IAHIP CPD requirements: Some comments*. Retrieved 01 December 2014 from http://www.iahip.org/inside-out/issue-60-spring-2010/iahip- cpd-requirements-some comments.

Weir, P. (Director) & Niccol, A. (Writer) (1998). *The Truman show* [Motion picture]. United States: Paramount Pictures.

Further Reading:

Bradway, K. & McCord, B. (1997). *Sandplay: Silent workshop of the psyche*. London: Routledge.

Boyne, E. (Ed.). (1993). *Psychotherapy in Ireland.* Dublin: Columbia Press.

Cunningham, L. (2013). *Sandplay and the clinical relationship*. California: Sempervirens Press.

Edinger, E. (1972). *Ego and archetype*. Boston: Shambhala Publications.

Murgatroyd, S. (1992). *Counselling and helping*. Exeter: BPCC Wheatons.

O'Farrell, U. (1988). *First steps in counselling*. Dublin: Veritas.

Storr, A. (1990). *The art of psychotherapy.* Oxford: Butterworth Heinmann.

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Maeve Dooley is an accredited psychotherapist and supervisor with the IAHIP. She has a B.A. (Hons) in psychology from UCD and is a graduate of the Tivoli Institute. Maeve has been in private practice in Drogheda, Co. Louth since 1997. While she practices from a humanistic and integrative approach, her particular area of interest is Jungian and post-Jungian psychotherapy. In addition to this she has trained in Jungian Sandplay with the British and Irish Sandplay Society (BISS). She is a member of both BISS and ISST (International Society for Sandplay Therapy). She is currently involved in initiatives to support the development of Jungian Sandplay therapy in Ireland.

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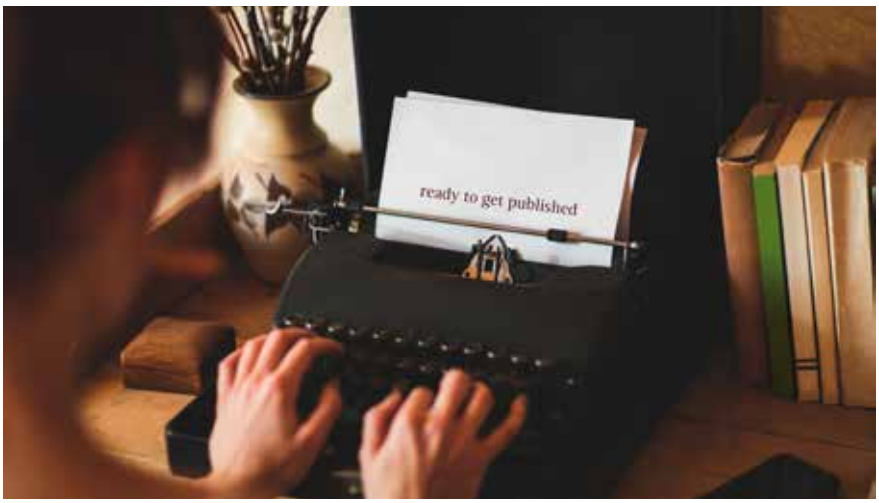
Maeve can be contacted directly at maeve@focuspsychotherapy.ie

Editorial Team Update

Mike Hackett



This year marks the thirty second birthday of what we now know as Éisteach. Since its early days and its first incarnation as The Newsletter of the Irish Association for Counselling published first in September 1984, Éisteach – The Irish Journal of Counselling and Psychotherapy has undergone many changes in that time. The father of the original newsletter - Carl Berkley wanted to ensure that there was "…a sounding board … [and something to represent] … the voice of the IAC [the then name for the IACP], to put ourselves on the map." (Feldstein, 2011, p. 17). Today, this ethos remains the core tenet of our remit as the Editorial Committee of our journal.

As a voluntary committee, working to a quarterly publication cycle, we are utterly reliant on our members to contribute to Éisteach and for an organisation of our size; the nature of our work and the relative youth of our profession, one might imagine that members of our association would have much to say. This however is not the case when it comes to content. Each quarter, we have found it increasingly challenging to source original, publishable articles, papers and other materials which would meet the noble objectives envisioned by Carl Berkley back in 1984. Growing our journal (and by extension, our profession) into one of International standing thus becomes a constant and exceptionally challenging one. Though it is likely there are many root causes this situation, we believe passionately in Carl's original vision and have worked on your behalf to further evolve our Journal on the road worthy of International standing.

With this in mind, we begin by outlining our editorial submission standard. These guidelines have been stored on the iacp.ie website for quite a while but inside the members' area of the site. In this issue, we place these guidelines front and centre so that potential contributors can understand what is required in advance of the effort required to be published. Further, we would like to clearly state the categories of work which would be considered for publication. These should ease any anxiety contributors may feel and any disappointment should pieces require significant revision. Additionally, doing so will hopefully make the experience of publication more enjoyable and the goal more accessible to members and the wider community of stakeholders. Finally, we are announcing an endowment for all published authors. This is an exciting development as it represents a clear intention to improve quality, raise standards, better educate and inform readers, contribute more widely to the development of our profession and ultimately, delivering on the vision of the founders of our organisation. Details of the endowment can be found in the guidelines.

This quarter will also see some more changes to the structural elements of the journal.

1. In order to value your contributions in a very real way, and with the full support of the Executive, we are delighted to announce that we will henceforth both commission articles and pay for work submitted which ultimately gets published in Éisteach. Full details are listed in the Guidelines for Authors below.
2. We are delighted to further announce the addition of a new section (from our Spring 2017 issue) called Student Corner in extending an ear to the voices of our developing therapists. Today's students are tomorrow's therapists, supervisors, committee members, influencers, educators and authors.

3. In terms of improving accessibility, over the summer months, we have been working to make all issues of Éisteach available to all members online. You will now find the complete published version of each quarterly journal since Spring 2012 in the members' area of our website.
4. From this issue onward, we will move the Noticeboard, Workshop Reviews and Renewal of Accreditations Notices from the quarterly journal to the IACP website. This will speed communication and free up vital space for articles, papers and other material without increasing cost of publication.
5. It is with great excitement we announce that our Summer 2017 issue of Éisteach will be a bumper edition focussed on Research. This will be the first time in our history that we both edit and publish an entire edition focussed on contributing to the knowledge base of our profession in the tradition of the scientific method. We will shortly issue a call to action through our Newsletter and the IACP website as well as through direct email soliciting contributions from as broad a base in our field as possible.
6. In terms of editorial relationships, we are at present planning to create reciprocal publishing and sourcing arrangements with our colleagues at IAHIP (The Irish Association of Humanistic and Integrative Psychotherapy), the BACP (British Association for Counselling and Psychotherapy), the ACA (American Counselling Association) and others. This should further broaden our base and elevate our standing in the broader international field.

At this point we feel it is important to thank all of those who have contributed to Éisteach over the many years of its illustrious history. It is due to the passion and commitment of our volunteers on the committee, ongoing support and investment from our Executive, the passion of our writers and the appetite of our readers that we look forward to the next thirty or so years of echoing the voices of our membership while simultaneously delivering quality and passion worthy of a place on the map Carl so powerfully advocated.

The Éisteach Editorial Committee

Dr. Cóilín Ó'Braonáin, Chair. Donna Bacon, Áine Egan, Mike Hackett, Maureen Raymond-McKay and Antoinette Stanbridge.

References

Feldstein, S. (2011). *The Irish Association for Counselling & Psychotherapy - Celebrating 30 years*. Bray, Co. Wicklow: Irish Association for Counselling and Psychotherapy.

Guidelines for Submitting Articles for Éisteach

Éisteach is the official publication of the Irish Association of Counselling and Psychotherapy and is published quarterly. It publishes a broad range of clinical, research and educational material for counsellors and psychotherapists. We seek to provide content relevant to, and reflective of, the diversity within the counselling community. We welcome articles that promote improvement in clinical practice, research and that provoke thinking on the wider issues, to include the social, cultural and philosophical relevant to counselling and therapy. We also welcome letters to the Editor, therapist's issues and questions, book and workshop reviews.

Manuscript Submission

To submit an article to Éisteach, please send your manuscript electronically by e-mail attachment to; eisteachjournal@iacp.ie

Articles:
1000-3000 words max.

Book Reviews:
600 words max.

Workshop Reviews:
500 words max.
(Please note that workshop reviews will be published on the IACP website and not in the journal).

Therapist's issues and questions:
300-500 words max.

Letters to the Editor:
200 words max.

Payment for Articles.

A fee will be paid to authors of articles published, as follows:

- Circa 3000 words - €250
- Circa 1500 words - €150
- Circa 1000 words - €100

Manuscript Format & Structure

Please forward your work in Microsoft Word format, Times New Roman font, size 12, double-spaced. Do not send .pdf files. All articles submitted to Éisteach should also include the following;

Introduction: 150 words which outlines the content of the article.

Division: Divide article into sections using subheadings (in bold, left justified).

Autobiographical statement: 100 words describing your qualification, experience and background.

Contact details: Mailing and e-mail address, mobile and landline phone numbers.

***Note:** please indicate how much contact information you wish to be included upon publication of your article.*

Acceptance of a manuscript for publication

Copyright: Authors submitting an article do so on the understanding that the work has not been published prior to its publication in Éisteach, without such information being disclosed to us, nor is it being considered for publication elsewhere at the time of submission.

Should there be any reproduction of the article elsewhere, which is permitted after six months following its publication in Éisteach, its prior publication in Éisteach should be acknowledged.

***Note:** Manuscripts in an incorrect format will be returned to the author.*

The Publication Process

Please be aware that the Éisteach editorial board consists of IACP members working in a voluntary capacity, and that the board meets approximately five times a year. The journey from submission to print is a slow process, and you can expect months to elapse before publication.

Each article is anonymised and reviewed by two members of the board and their feedback is collated and sent to you by the chairperson. Usually, some revision is necessary. (Not every submission is accepted). Once an article is ready for publication, it is held on file. The date of publication will depend on how many articles are on file, whether or not the subject matter is similar to other articles recently published and other factors. Consequently, any given article could be published quickly or may be held on file for some time. Patience with the process is appreciated.

Steps in the Publication Process:

- Submit the article to eisteachjournal@iacp.ie
- Receipt of article will be acknowledged.
- Article will be blind reviewed by two members of the board.
- Feedback will be sent to the author and the article will be accepted or declined.
- If accepted, revision is usually requested.
- On receipt of the revised draft, the Editorial Board will decide on the date of publication, or the article may be held on file for a future edition. You will be informed of that decision.

Disposal of documents

Documents received by IACP will be destroyed after an appropriate period of time as per the IACP Retention policy. Keep a copy of any articles / correspondence you send to IACP for your own records.

References:

Referencing is a system whereby the author acknowledges the work of other writers and the sources of information cited in the article. Your own views and opinions need not be referenced, but any substantial statement of fact should be supported by evidence, in order to give your work more creditability. For example an opening broad claim, such as, 'Clients are increasingly presenting with various anxieties since the economic recession took hold.' The above claim may seem to be obviously true, but it should nonetheless be supported with references from such sources as the HSE, economic organisations, newspaper articles, books, webpages or academic articles. By supporting the claim with evidence, the following article will carry more weight. It's also possible that the claim is not true overall, in spite of your belief or experience. By referring to authoritative sources, you can be sure.

There are many styles of referencing, but Éisteach follows the American Psychological Association (APA) reference style. The full guidelines are published in the APA Publication Manual of the American Psychological Association, Sixth Edition which is available via Amazon or another bookseller of your preference. There is also a useful Concise Guide available. To aid you in applying the basic rules of the APA Style, we have included a referencing summary below which will help you apply the standard. Please note, that in order to avoid plagiarism, all work should be cited and the authors(s) credited as per the standard.

Citations

Citations refer to the mention of a source in the text, usually at the end of a sentence. If the author (surname only) is mentioned in the sentence, only the year of publication and page number (in the case of a direct quote) are included in parentheses.

1. **The structure of a citation is as follows:**
   a. In text citation: (Surname, year).
   b. In-text citation at the end of a direct quote (Surname, year, page number).

      For example: (Snowdon, 2010) or (Snowdon, 2010, p. 8) or (Snowdon, 2010, pp. 8-11).

   c. Paraphrasing means putting

an author's ideas into your own words. Paraphrased citations follow the same format as above: (Surname, year) - page numbers are not technically required for paraphrased material but including them would be beneficial.

d. Citation inserted into the body of a sentence:

For example: Snowdon (2010) states that 'Jung had a strong belief in God,' (p.12).

2. Use of *et al*.;

a. When a work has more than six authors, cite only the surname of the first author followed by et al. – ensure that the references at the back of the manuscript contains all authors of the paper

b. When there are three to six authors of a source, the student must cite the entire list of names the first time encountered, and then subsequently use (Surname et al.). Again, the complete list of authors must be present in the references at the back of the paper.

For example: 'An illustration was given by Bradley, Ramirez and Soo (1999). Bradley *et al*. went on to give further examples….. (1999).'

3. A Group or organisation;

a. Provide the full name of the group in the first time it is cited, abbreviated versions are acceptable after the first instance is stated

b. E.g. "… Ireland's National Public Service Broadcaster, Raidio Teilifís Éireann (RTÉ) in a case …"

4. Anonymous;

a. If the piece has no attributable author … ("name of the piece/article/work", year) or

b. If the book or other source has no identifiable author … the book "name of book" (year).

c. Or, "quote" (Anonymous, year)

d. In all cases for Anonymous, ensure that Anonymous is added to your references in the usual format, that is, use the word 'Anonymous' in place of the author's name.

References

At the end of the article a list of all works cited in the article should appear in alphabetical order by author surname, in a list entitled 'References' (in bold and centred at the top of a new page). No bullet points or numbering are used. Only works cited should be referenced and all references must be cited in the article. Sources that you read but did not cite, should not be listed.

1. For an entire book:

a. Surname, Initial. Initial. (year). Title of work. Location: Publisher.

(note that only the first word in the title in capitalised, unless there is a subtitle also).

For example: Van Deurzen-Smith, E. (1997). Everyday mysteries: Existential dimensions of psychotherapy. Hove: Routledge.

E-books can be referenced as follows:

b. Surname, Initial. Initial. (year). Title. Retrieved from http://….

An edited book:

Surname, A. A. (year). Title of chapter or entry. In A. Editor, B. Editor, & C. Editor (Eds.), Title of book (pp. xxx-xxx). Location: Publisher.

Journal Article:

Surname, A. A., Surname, B. B. & Surname, C. C. (year). Title of article. Title of Periodical, xx, pp-pp.

For example: Nevin, A. (1990). The changing of teacher education special education. Teacher Education and Special Education: The Journal of the Teacher Education Division of the Council for Exceptional Children, 13(3-4), 147-148.

['13' above refers to the volume number and 3-4 to the issue number].

A video:

Name of Production Company (Producer). (year). Title of video [DVD]. Available from website. (website refers to an outlet where the DVD can be bought such as www.amazon.co.uk).

2. A song or piece of music:

a. Writer, Initial. Initial. (year). Title of song. On Title Of Album [CD]. Location: Label.

b. Citation: "Song Title" (Singer, year, track number).

3. Podcast:

Surname, Initial. Initial. (Producer). (year, month, day). Podcast name [Audio podcast]. Retrieved from http://…

4. A DVD:

Surname, Initial. Initial. (Producer). (year). Title [DVD]. Available from http://…

5. Blog Post:

Surname, Initial. Initial. (year, month, day). Title of post [description of forum]. Retrieved from http://…

6. A You Tube Video:

Poster, Initial. Initial. (year, month, day). Title of video [Video file]. Retrieved from http://…

Letter to the Editor

Dear Editor,

Regarding the question of whether we call ourselves a counsellor or psychotherapist? At the recent IACP/ACA conference, a keynote speaker suggested that we should be clear on our role, not one for holding back on questions I asked: "What in their view, was the difference?". She did not address the question directly but threw it open to the floor. The silence was deafening, no response!

As a newly qualified, pre-accredited member of IACP I have thought about the reply. Initially, I was embarrassed to have asked the question; I do not see a difference between counselling and psychotherapy. Why, might you ask? What is psychotherapy? My research on the internet proved interesting. The European Association for Psychotherapy and the European Association for Counselling both exist. I do not believe that it is the word therapy that provides the differential. Consultation of a dictionary meaning of psyche was "The human soul, mind or spirit." When a client sits in front of us, we meet the client where they are. Finnerty (2006) writes "It has both a process i.e. client/therapist interaction, and content i.e. the thoughts, feelings, behaviours and experiences both client and therapist bring to the encounter." Whether we call ourselves a counsellor or a psychotherapist at the centre of our work is a person who is in psychological pain and has come to therapy. Do we want to confuse the general public even more between the difference between a counsellor and a psychotherapist or do we want to improve the understanding of our profession?

A founding goal of IACP was to have legislation in place. This is ever closer due to the recent proposal by the Minister for Health, Simon Harris TD. Asking us for our input regarding including Counsellors and Psychotherapists for inclusion under "Social Care Professionals Act, 2005". As the keynote speaker was suggesting, we need to be clear about our role, should the term include counselling or should it include psychotherapy or both? I wonder if the deafening silence and resulting embarrassment were because those present felt embarrassed or had not thought about the difference? Should the difference be as a result of your level of education? Those with QQI Level 8 Honours Degree be called a counsellor and those with Level 9 Masters be called Psychotherapist? I wonder would this cause a two-tier system?

As a group, we are sitting on the edge of monumental change, but being able to move forward and ensure legislation becomes law we need to be protective of our identity and professionalism. Dialogue and replicating Rogers' core conditions that we afford our clients on a daily basis need to be in place. Moving forward, we need to have a clear understanding of our role to feel proud to call ourselves an appropriate fitting name be that counsellor or psychotherapist, or both.

Gráinne Clancy

References

Department of Health. (2016, October 03). http://health.gov.ie. Retrieved from http://health.gov.ie/blog/publications/proposed-regulation-of-counsellors-and-psychotherapist-under-the-health-and-social-care-professionals-act-2005/: http://health.gov.ie/blog/publications/proposed-regulation-of-counsellors-and-psychotherapist-under-the-health-and-social-care-professionals-act-2005/

Finnerty, M. (2006). Counselling and Psychotherapy: A perspective on past history, current trends, and possible future directions. *Éisteach*.

Useful Websites

European Association for Psychotherapy http://www.europsyche.org/

European Association for Counselling http://eac.eu.com/