The Irish
# Journal of Counselling and Psychotherapy

formerly Éisteach • Volume 18 • Issue 4 • Winter 2018


- Response to Eugene McHugh's 'A Conversation on DSM-5 and its Usefulness in Counselling and Psychotherapy'
- Online therapy: A business opportunity for the private practitioner
- Expression, Trust-Building, & Meaning-Making with At-Risk Youth in Psychotherapy
- Exploring The Dynamics of Relational Trauma and the Organic, Energetic Process of Change

## *Practise Perspectives*

iacp
*Irish Association for Counselling and Psychotherapy*

# Contents





Design and layout:
GKD.ie

ISSN:
2565-540X

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



Our Title

In Autumn 2017, our title changed from "Éisteach" to "The Irish Journal Of Counselling and Psychotherapy" or "IJCP" for short.

Disclaimer:

The views expressed in this publication, save where otherwise indicated, are the views of contributors and not necessarily the views of the Irish Association for Counselling and Psychotherapy. The appearance of an advertisement in this publication does not necessarily indicate approval by the Irish Association for Counselling and Psychotherapy for the product or service advertised.

Next Issue:

1st March 2019

Deadline for Advertising Submissions for Next Issue:

1st February 2019

Scripts:

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

Contacting IJCP:

iacpjournal@iacp.ie

# From the Editor:


Dear Colleagues,

A very warm welcome to the Winter Edition of the IJCP. Our edition this quarter builds on our commitment to representing the diverse views and lived experiences of the enormously varied practice contexts in which we work.

Our first paper, presented by Declan Peelow looks at the use of modern technology and the prospect of providing therapy online from a person-centred perspective. As technology marches on and the pace of technological change increases, therapists can struggle to keep up with clients expectations for alternatives to traditional colocated treatment. In this paper, Declan explores the business of therapy, practitioner competence and training, contracts and client suitability, the implications for the therapeutic alliance, client safety and several legal and ethical considerations for those considering this type of therapeutic practice.

Blake Griffin Edwards offers the first of two reflective pieces in this edition. His passion for working with at-risk youth shines through in his case vignettes and call to action when working with this vulnerable client group. The distinction between experiential therapy and Intellectual Nagging is made, along with presenting the voice of the at-risk youth, the nature of the pace, space, trust building and meaning-making in this work. His gentle challenge to us as therapists expresses both the need for courage and the potential to encounter the possible person in practice.

To honour the diverse views and opinions of our profession, Pat Comerford presents a response to Eugene McHugh's article "A Conversation on DSM-5 and its Usefulness in Counselling & Psychotherapy" previously published in our Spring Edition, 2018. Pat argues that in a truly Client-Centred Therapy modality, the DSM-5 is not considered a tool. She raises the need for ongoing discussion within our profession as to the context, role, ethical suitability and positioning of the use of such a manual in our professional practice in Ireland.

Finally, our last piece, the second of our reflective works, comes from Rosie Burrows. It has emerged in response to direct feedback and the wishes of IACP members who have taken part in training around the vast area of trauma in support of their practice. Rosie's expertise and generosity shines through the work in terms of developing and presenting frameworks which can be helpful to those of us in practice who encounter trauma.

So, with all of that experience, expertise and reflective sharing, we hope you enjoy, and indeed provide feedback on our Winter Edition 2018.

**Mike Hackett**

Editor, Winter 2018.

Practitioner Perspective

# Response to Eugene McHugh's 'A Conversation on DSM-5 and its Usefulness in Counselling and Psychotherapy' – The Rogerian Perspective.

*By Pat Comerford*

**Introduction**

Mullen (2016) previously promoted the use of the DSM-5 (APA, 2013). I responded by raising concerns about breach of boundaries professionally, legally and ethically by counsellors using this manual (Comerford, 2016). McHugh (2018) is a recent apologist for DSM-5 use and attempts to show how its use can be considered "person-centred" (p. 24). His use of 'person-centred' is generic, but bears no relationship to Rogers "Person-Centred Approach" (Sanders, 2012a, p. 13).

For my part in the conversation on DSM-5 use I will answer McHugh's question: "What is the resistance of our profession to using the DSM-5 ...as a useful resource?" (2018, p. 21). I will show how his framing of 'Mental Health' and the use of the DSM-5 conflicts with one counselling approach in our profession, the theory and practise of "Classical Client-Centred Therapy", a.k.a. 'Person-Centred Therapy' (Merry, 2012, p. 21).

Professionally, I most closely associate with: "existentially informed person-centred therapy" (Cooper, 2012, p. 131). The 'Humanistic Orientation' (Comerford, 2018) of Client Centred Therapy - CCT henceforth - is the perennially wise antecedent to the "Integrative" (Hegarty, 2014, p. 38) and "Pluralistic" (Finnerty, Kearns & O' Regan, 2018, p. 17) approaches. It is the springboard for and shapes my response to McHugh's promotion of the DSM-5.

**Emotional and Mental Health**

Phenomenologically, users of the DSM-5 represent a: "...dualistic philosophy of separation between the knower and the known..." on the "subjective-objective axis" (Shlein, 2003a, p. 155). McHugh reflects this dualism: "...a differentiation between Emotional Health and Mental Health where the former is a'dis-ease' and the latter is a physical 'disease' within the client." (2018, p. 23). His understanding concurs with that of Dailey, et.al.: "...that mental health disorders are medical conditions" or 'physical diseases' (2014. p. 14, cited in McHugh, 2018, p. 23).

Borrowing from Maslow: "In essence, I am deliberately rejecting our present **easy distinction** between sickness and health..." (2014, p. 17, bold type added). CCT has a dynamic view unlike the psychiatric/medical construction 'mental disorder'. We understand that clients are living at the "difficult

edge" (Warner, 2000, p. 144) engaging in "difficult processes" (Warner, 2017, p. 95). In other words difficulty is: "…when they arrive at the edge of their experience or the limit of their capacity" (Pearce and Sommerbeck, 2014, p.vi).

**DSM-5**

According to the American Psychiatric Association:"The primary purpose of the DSM-5 is to assist **trained clinicians** in the diagnosis of their patients' mental disorders…" (APA, 2013, p. 19, bold type added). This manual is for 'trained clinicians' and has no reference to counsellors and counselling.

The DSM-5 is a medical taxonomy of "symptom-led diagnostic categories" (Sanders, 2012b, p. 18). The manual is grounded in a "medical model" (Mullen, 2016, p. 21) and its use is quintessentially mechanistic (Mullen, Op.cit., p. 20). The 'trained clinician' atomises the person's behaviour so as to arrive at a diagnostic label, this is not regarded as a holistic approach for therapists trained in CCT. The beliefs and practices of CCT are grounded in humanistic values which are directed: "… on the holistic lived experience of the person (individual) and its implications for practice, pushing back on more mechanistic, reductionistic, and dehumanising approaches." (Hoffman, Cleare-Hoffman & Jackson, 2015, p. 42).

While McHugh promotes the DSM-5 my copy of the manual more often gathers dust.

**DSM-5 Promotion**

McHugh promotes this manual as an efficacious 'assessment tool': "I do wish … to look at using the DSM as an assessment tool for **ourselves** and as a communication tool with other **professionals** such as: medical practitioners, insurance companies, Employee Assistance Providers (EAP), psychiatric services, researchers." (2018, p. 23, bold type added).

*The 'trained clinician' atomises the person's behaviour so as to arrive at a diagnostic label, this is not regarded as a holistic approach for therapists trained in CCT.*

His campaigning for the manual is centred in its value as 'an assessment tool for ourselves', and as a 'communication tool' for medics, and the 'professionals' and agencies linked to the medical profession. He explains the 'usefulness' of DSM-5: "To be abundantly clear, I am not proposing that the DSM criteria are discussed with clients, it is about being more proficient in the use of an internationally recognized tool when in discussion with other **professionals and agencies**." (2018, p. 23, bold type added).

His comments buttress an 'expert and client' type relationship; they are "expert-centred" (Wilkins 2017, p. 144). Counsellors who usually do not work in this way then need to evaluate the manual and its 'usefulness' in their practise.

**DSM-5 Evaluated.**

McHugh writes a non-critical "brief history of the DSM" and its "current version" (2018, p. 21-23). Lynch, however, presents us with a comprehensive critique on "…the validity of the DSM…" (2018, p. 5) and concludes:

> Rather than embrace the DSM, I encourage the counselling profession to press for trauma-informed responses, within which experiences and behaviours are accepted and addressed in their own right, rather than repackaged as "mental disorders" within a system whose "bible" is utterly lacking validity. (2018, p. 9).

What Lynch's critique shows is how historically the construction of the DSM-5 was shaped by an epistemology that is "doxic", in turn creating a classification that is arbitrary (Sanders, 2017, p. 16, and p. 28).

In spite of the DSM-5 lacking 'validity' McHugh (2018) writes that: "It is my belief that it is essential that the therapist is trained to consider themselves competent in the use of the manual." (p. 23). He cites Brammer, Shostrum & Abrego (1989, p. 148), who recommend that therapists: "simultaneously understand diagnostically and therapeutically" (2018, p. 24). Does 'competent in the use' mean that all counsellors also need to be 'trained clinicians' before using the DSM-5 as the APA intended?

His belief discords with the humanistic values, the theoretical and professional positioning of therapists in the CCT community. It can be regarded as a defining 'discount'. To 'discount' is when: "… people minimise the significance of parts of themselves, others and the environment" (Feltham & Dryden, 2004, p. 66).

**Discounting and CCT**

It is important to give one fundamental understanding of what CCT is before addressing McHugh's discounting the fact that: "Client-centred therapy is a theory of dynamic change, in directions chosen by the client, not prescribed by the therapist." (Shlien, 2003b, p. 71).

He attempts to address "Issues for Counsellors" using the DSM-5 – namely "assessment" (2018, p. 23-25) and "labelling" (2018, p. 23). But, he simultaneously discounts these two 'issues' which are significant in CCT.

On questioning clients for DSM-5 assessment, he writes: "One can see that these might not be considered as person centred questions and

*"The counsellor must be ready to understand the motives that this client has for his behaviour, without trying to fit him into some preconceived pattern."*

*Rogers and Wallen (1946)*

more from the medical model. They form, **however,** an important part of our hypothesis and **decision making for the client**." (2018, p. 23, bold type added). He presents his discount with his use of the word 'however', justifying asking 'medical model' questions by counsellors and psychotherapists.

He has the additional discount 'decision making for the client' which is divergent to the ethos of CCT and not part of the CCT lexicon. His advocacy is consistent with the view expressed by Mullen (2016) on the use of this diagnostic tool in that: "It…is our best source of help in sorting pathology in order to unlock, manage, and understand what we are encountering." (p. 21). Her use of the word 'what' is an unfortunate objectification of the client.

On assessment questions McHugh states that: "I accept that while all the aforementioned can be argued as not being person-centred, **professionally it is something** that one **does for** the benefit of the client." (2018, p. 24, bold type added). 'Professionally it is something' is a discount in the sense that it is a rationale for DSM-5 questioning. Reinforcing this discount and justification he advocates 'does for'. This assessment approach is contrary to the beliefs of CCT.

To emphasise his advocacy for using the DSM-5, he explains that: "…it does not direct how it is brought to the client, **but** the therapist does use it to understand the client's experience." (2018, p. 24, bold type added). The discounting is achieved with his use of the word 'but' and further, his concluding sentence has two further discounts: "On balance, I believe that with **careful use**, the DSM-5 is a worthwhile **tool** in Counselling and Psychotherapy." (2018, p. 25, bold type added). The 'careful use' of the DSM-5 is at variance with the "non-directivity" of CCT (Levitt, 2005).

To regard CCT as a "relational therapy" (Mearns & Cooper, 2005, p. 1) is essential. And advocating a 'tool' to label persons discounts and flouts the values of the collaborative relationship watermarked in CCT.

**Labelling Discounts, the Contradictions**

McHugh, in the second paragraph of his article, asserts: "I am fully behind the idea of not labelling our clients and in meeting them wherever they are" (2018, p. 21). He immediately discounts what he has just written with the first word of his next sentence: "**However**, I am curious as to how we might use the assessment tools to inform ourselves about our clients' lives and in turn support interventions to aid their emotional support" (2018, p. 21, bold type added). From the CCT orientation, his two statements contradict each other.

In counselling returned servicemen, Rogers and Wallen (1946) disavowed the use of labels: "The counsellor must be ready to understand the motives that this client has for his behaviour, without trying to fit him into some preconceived pattern."(p. 10, bold type added). Labelling clients using the DSM-5 is a contradiction in CCT. It contravenes the humanistic theory and philosophy of Rogers (1959), since CCT is about 'a way of being' with clients (Rogers, 1980).

**Rogerian Theory**

Client-Centred therapists do not use the DSM-5 in order 'to understand the client's experience'. We rely totally on the "**necessary** and **sufficient** conditions" of congruence, empathy, and unconditional positive regard (Rogers, 1957, p. 95, bold type added). These "attitudinal ingredients" (Rogers, 1967, p. 90) enable the client-centred therapist to understand the client's phenomenological experience, their "Internal Frame of Reference" (Raskin, 1996, p. 3). In other words, to understand their "perception" or interpretations of "objects, others and self" (Spinelli, 2005, p. 59-102).

Client-Centred therapists are committed to the core Rogerian belief in the "actualising tendency" (1951, p. 487-491) of every client, as they journey in 'becoming a person' (Rogers, 1961). This belief is articulated as follows: "The person increasingly discovers that his own organism is trustworthy, that it is a suitable instrument for discovering the most satisfying behaviour in each immediate situation." (Rogers, 2015, p. 18).

For CCT therapists:

> Therapy is not a matter of doing something to the individual, or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development, of removing obstacles so that he can move forward. (Rogers, 1942, p. 29).

Schmid (2018) remarking on Rogerian theory noted that: "Rogers focuses on the salutogenetic dimension of facilitating the actualising tendency of the person for growth…not on the psychopathological category of curing from diseases" (p. 134).

This "revolutionary innovation" (Raskin, 2002, p. 105) creates the possibility for CCT therapists to make contact with clients, and, in turn, supporting them to make contact with themselves as they address their 'lost connections' (Hari, 2018, p. 179-261). It supports CCT counsellors to appreciate clients' own directional choices. It safeguards against the disempowerment of clients by 'decision making for' them. It enables 'forward' movement by understanding clients' 'internal frame of reference'.

**Clients' Internal Frame of Reference (IFR)**

I concur with McHugh that counsellors may have impressions about clients from their first moment of contact that may lend to making some guesses about them. I disagree with him on how we address these impressions. Formulating "theoretical maps" and then using the DSM-5 to prove or disprove "our hypothesis" because of the client's "gait, dress, appearance, culture, shape, facial expressions, mannerisms and tone of voice" is not Client-Centred (2018, p. 23).

> In CCT it is:
> ... in the therapist's attention to the client's attitudes and feelings was the idea that the client's frame of reference, which came to be referred to as the IFR (internal frame of reference), was the therapist's basic consideration, rather than his own appraisal of what was going on. (Raskin, Op.Cit., p. 3).

He appears to put more value on the assessment (his own appraisal) of the client, rather than their IFR. This is "psychodiagnosis", which: "...looks at the client, primarily, from an **external frame of reference**" (Boy, 2002, p. 388, bold type added). In other words the focus of assessment is on his hypotheses, and not the clients'.

To counterbalance these 'discounts' an understanding of CCT's perspective and praxis in the area of mental health is necessary.

**CCT and Mental Health**

Sommerbeck (2003) was a Client-Centred therapist in a psychiatric hospital, and in her relationships with clients given a DSM-5 label stated that: "...the client-centred therapist consistently receives and follows the client's expressive process with acceptant empathic understanding. Doing this, the therapist's attitude is non directive, since empathic understanding is post-dictive, not pre-dictive." (2005, p. 170-171).

CCT is unreserved in expressing their disquiet with colloquial terms like 'mental illness' (Joseph, 2017). Sanders opines: "Person-centred therapy suggests an organismic growth metaphor for human distress, and person-centred theorists and practitioners should declare this in juxtaposition to the dominant illness metaphor at every appropriate opportunity." (2017, p. 13).

Using the DSM-5 leads to what Cooper has called an "it-ifying versus humanising" attitude when: "...others may be construed in such object-ifying terms as 'a neurotic' or 'a borderline personality'" (2017, p. 59).

Warner noted that Client-Centred therapists: "...have hesitated to conceptualise clients as having 'characterological' disorders such as narcissistic personality, borderline personality or dissociative identity disorder" (2000, p. 144). She explains that: "Diagnoses of people experiencing these difficult forms of processing tend to be misleading since such diagnoses attempt to characterise the whole person" (2000, p. 145).

**CCT Praxis/Applications**

Prouty created 'Pre-Therapy', a person-centred/experiential approach focused on: "...the development of the psychological functions necessary for psychotherapy" (1994, p. xxix). He developed 'Contact Reflections' (Sanders, 2007). These 'Contact Reflections' are: "...empathic responses that are very concrete and close to the clients' actual words and facial and body gestures" (Warner, 2017, p. 100). They: "...offer the therapist an appropriately concrete way of following the client's overt 'being in the world' with unconditional acceptance" (Sommerbeck, 2005, p. 175).

'Pre-Therapy' enables the Client-Centred therapist to make contact with those clients who: "...are experienced as being 'out of contact' ('autistic')..." (Sommerbeck, 2005, p. 175). Prouty (2008) recorded how 'Pre-Therapy' can be used with persons with 'Special Needs' (Portner, 2008), and those with 'Somatic Hallucinating' (Van Werde, 2008).

Other examples of 'processes' at the 'difficult edge' that Pearce and Sommerbeck (2014) review in CCT are: childhood sexual abuse, psychoses, catatonic depression, trauma, terminal illness, brain damage, adolescent process, and clients with learning disabilities or autism. They declare the intention driving their publication: "We hope...to demonstrate that such edges can be moved considerably by therapeutic practice which is person-centred and incorporates the invaluable example and well-established wisdom of Pre-Therapy." (Pearce and Sommerbeck, 2005, p. vi).

It is worth referencing Morten (1999) who focuses on employing 'Person-Centred' approaches to dementia care.

**Warning: Ersatz CCT**

Self-proclaimed Client-Centred counsellors using the DSM-5 could be perceived as performing "Medical-mimicry" which: "…is the attempt to use a pseudo-scientific justification for the application of a range of approaches according to what the therapist diagnoses as the client's need." (Sanders, 2012c, p. 244).

Sanders wrote: "So it is a 'diagnostic – selection of method – application of method' model and sometimes advocates of such an approach will cite themselves as 'person-centred' as an underpinning to the model." (2012c, p. 245).

He recorded that:

> Dryden (1984) refers to this approach disparagingly as 'hat-trick eclecticism', where, in one variation, practitioners wear different 'hats', e.g., '…a Gestalt hat with one client, a psychoanalytic hat with another, and so on' (p. 351) again depending upon the practitioner's analysis/ assessment/diagnosis of the client's needs. (2012c, p. 245).

Schmid avers:

> To try to justify traditional diagnoses and 'intervention techniques' in person-centred therapy, arguing that modern applied sciences and mainstream health politics require us to do so, and thus **to manualise person-centred therapy** by describing categories of therapeutic techniques, **is simply a contradiction**. (2017, p. 84, bold type added).

**Classical CCT**

McHugh on the use of the DSM-5 wrote: "This will help the client in their self-discovery, which can be argued is a person-centred effort" (2018, p. 24). Classically trained Client-Centred therapists would resist this rationale as a justification for using this manual because employing "…a general category (**is**) anathemous to client-centred therapy…" (Saunders 2003, p. 80, bold type added).

On 'diagnosing', Sommerbeck pointed out that: "…the client-centred therapist sees the **uniqueness** of the client, whereas the psychiatrist sees their **averageness** in relation to a certain diagnostic group." (2017, p. 119, bold type added).

Raymond-McKay (2018) brought to our attention the historical consequence of standardising and averaging, which is: "The individual became anonymous and irrelevant" (p. 4). With DSM-5 use, this means the loss of 'individuality'. Today, more than ever, CCT is an important and indispensable counterweight in the mental health service so as to honour the relevance and uniqueness of each individual.

Sanders commented on the 'Person-Centred' theory and practice of Warner (2000): "This positions her work in the person-centred tradition of critiquing the medical model of mental illness, eschewing symptom-led categories, and letting understanding of distress to be phenomenological, defined and led by the client's experiences." (2012b, p. 18).

**Future Conversations**

CCT therapists using the DSM-5, is like putting a 'square peg in a round hole'. We consider that its use is not classic Client-Centred; ergo, it is not humanistic. Person-centred "Empathy" (Shlien, 2003a, p. 159-161) or "Understanding" (Shlien, 1984, p. 170-173) is our motivation, not 'diagnosing'. For the CCT School of counselling this is central to our 'resistance' to using the DSM-5 'tool'.

I accept for McHugh and 'Integrative' counsellors, with a medical and mechanistic orientation, that they use the DSM-5 to inform and shape their relationships with clients. In CCT practice, however, we do not use this 'tool' to profile our person-centred relationships.

We need more conversations with each other about our different 'humanistic', 'integrative', 'pluralistic' and 'medical' understandings of 'mental health', 'mental disorder', 'assessment' or 'psychodiagnosis', and 'psychiatric labelling'. We need not rush to embrace the DSM-5 as the standard 'assessment tool'.

CCT is truly humanistic in relating to all clients, led by their needs. I believe unreservedly that Client-Centred/Person-Centred/ Humanistic psychotherapists, in Ireland, need to voice our ethical concerns about possible mandatory use of the DSM-5 in our practice.

**Acknowledgement:** I thank J. Murphy MIACP for commenting on earlier drafts of this article.

Pat Comerford

Pat Comerford M.Coun., B.A., H.Dip. Ed., Dip.Catech., R.T.C., D.A.C., E.C.P., M.W.G.I.I.,M.A.N.I., M.I.A.H.I.P., S.I.A.H.I.P., M.W.A.P.C.E.P.C. Originally trained in the Person-Centred Therapy, almost 40 years ago. A Humanistic Psychotherapist, an Addiction Counsellor, a Reality Therapist, and an Adlerian Therapist. Trained in London, under Babette Rothschild in her PTSD model. Worked in H.S.E. and Prison Service in the area of addiction. Visiting Lecturer on C.P.E. course at C.U.H. for 15 years. Supervised groups of Social Workers in the Probation Service and H.S.E. Formerly a Basic Practicum Supervisor in Reality Therapy. Currently working part-time with individuals, couples, and in one-to-one supervision.

## REFERENCES


American Psychiatric Association. (2013). *Diagnostic And Statistical Manual of Mental Disorders, 5th Edition*. Washington, D.C.: American Psychiatric Association.

Boy, A. V., (2002). Psychodiagnosis: A person-centred perspective. In D. J. Cain (Ed.) *Classics in the Person-Centred Approach*. (385-396). Ross-on-Wye: PCCS BOOKS.

Brammer, L. M., Shostrom, E. L., & Abrego, P.J. (1989). *Therapeutic psychology of counselling and psychotherapy.* (5th ed.). Englewood Cliffs, NJ: Prentice-Hall.

Comerford, P. (2016). Humanistic Psychotherapists, Car Mechanics, Shakespeare and the DSM. *Inside Out,* 79, 60-70.

Comerford, P. (2018). Forty Years A Growing: Journeys in heresy and equality. *Inside Out,* 81, 3-10.

Cooper, M. (2017). From self-objectification to self-affirmation: the 'I-Me' and 'I-Self'. In P. Sanders (Ed.), *Tribes of the Person-Centred Nation* (2nd ed.) (131–160). Monmouth: PCCS BOOKS.

Dailey, F. S., Gill. C. S., Karl, S. L., & Barrio Minton, C. A. (2014). *DSM-5 learning companion for Counsellors.* Alexandria, VA: American Counselling Association.

Dryden, W. (1984). *Individual Therapy in Britain.* London: Harper & Row.

Finnerty,M., Kearns, C., & O'Regan. (2018). Pluralism: An ethical commitment to dialogue and collaboration. *The Irish Journal of Counselling and Psychotherapy, 18*(3), 13–20.

Hari, J. (2018). *Lost Connections, Uncovering the Real Causes of Depression – And Unexpected Solutions.* London: Bloomsbury Circus.

Hegarty, D. (2014). Integrative Psychotherapy: An Application. *Inside Out*, 72, 38-53.

Hoffman, L., Cleare-Hoffman, H.P., & Jackson, T. (2015). Humanistic psychology and

Multiculturalism: History, Current Status, and Advancements. In K.J. Schneider, J.F. Pierson, & J.F. Buganda (Eds.), *The handbook of humanistic psychology* (2nd ed.). (41-55). California: Sage.

Joseph, S. (Ed.) (2017). *Person-Centred Therapy and Mental Health: Theory, Research and Practice.* Monmouth: PCCS BOOKS.

Levitt, B.E. (Ed.).(2005). *Embracing Non-Directivity: reassessing person-centred theory and practise in the 21st century.* Monmouth: PCCS BOOKS.

Lynch, T. (2018). The Validity of the DSM: An overview. *The Irish Journal of Counselling and Psychotherapy,* 18(2), 5–10.

McHugh, E. (2018). A Conversation on DSM-5 and its Usefulness in Counselling and Psychotherapy. *The Irish Journal of Counselling and Psychotherapy,* 18(1), 21–25.

Maslow, A.H. (2014). *Toward A Psychology Of Being.* Virginia: Sublime Books.

Mearns, D. & Thorne, B. (2000). *Person-Centred Therapy Today: New Frontiers in Theory and Practice.* London: Sage.

Mearns, D. & Cooper, M. (2005). *Working at a Relational Depth in Counselling and Pychohtherapy.* London: Sage.

Merry, T. (2012). Classical Client-Centred Therapy. In P. Sanders (Ed.), *The Tribes of Person-Centred Nation* (2nd ed.). (21–45). Monmouth: PCCS BOOKS.

Morten, I. (1999). *Person-Centred Approaches to Dementia Care.* Oxford: Speechmark Publishing Ltd.

Mullen, D. (2016). Let us make friends with the DSM. *Éisteach, 16*(1), 20-22.

Pearce, P. & Sommerbeck, L. (Eds.) (2014). *Person-Centred Practice at the Difficult Edge.* Monmouth: PCCS BOOKS.

Portner, M. (2008). Pre-Therapeutic Approaches for Working with People with 'Special Needs'. In G. Prouty (Ed.), *Emerging Developments in Pre-Therapy.* Monmouth: PCCS BOOKS.

Prouty, G. (1994).*Theoretical Evolutions in Person-Centred/Experiential Therapy: Applications To Schizophrenic And Retarded Psychoses.* Connecticut: Praeger.

Prouty, G. (Ed.) (2008). *Emerging Developments in Pre-Therapy.* Monmouth: PCCS Books.

Raskin, N. J. (1996). Person-Centred Psychotherapy: Twenty Historical Steps. In W. Dryden (Ed.), *Developments in Psychotherapy: Historical Perspectives.* (1-28). London: SAGE.

Raskin, N.J. (2002). Rogers' Empathy: A revolutionary innovation. In J.C.Watson, R. N. Goldman, & M.S. Warner (Eds.), *Client-Centred and Experiential Psychotherapy in the 21st Century: Advances in theory, research and practise*. Ross-on-Wye: PCCS BOOKS.

Raymond-McKay, M. (2018). From the Editor. *The Irish Journal of Counselling and Psychotherapy,* 18(1), 3–4.

Rogers, C. R. (1942). *Counselling and Psychotherapy.* Boston: Houghton Mifflin.

Rogers, C.R. & Wallen, J.L. (1946). *Counselling with Returned Servicemen*. New York: McGraw-Hill Book Company, Inc.

Rogers, C.R. (1951). *Client-Centred Therapy: its current practice, implications, and theory.* Boston: Houghton Mifflin.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, Vol 21* (2), 95-103.

Rogers, C.R. (1959). A Theory of Therapy, Personality, and Interpersonal Relationships,

Developed in the Client-centred Framework. In S. Koch (Ed.), *Psychology A Study Of A Science* Vol. 3. (184-256). New Delhi: Isha Books.

Rogers, C. R., (1961). *On Becoming A Person: A therapist's view of psychotherapy.* London: Constable.

Rogers, C.R. (1967). The Interpersonal Relationship: The Core of Guidance. In C.R. Rogers & B. Stevens, *Person to Person*. (89-103). London: Souvenir Press.

Rogers, C. R. (1980). *A Way of Being.* Boston: Houghton Mifflin.

Rogers, C. R. (2015). *Becoming a Person*. Connecticut: Martino Publishing.

Sanders, P. (Ed.) (2003), A Literalist Approach. In P. Sanders, *To Lead An Honourable Life. Invitations to think about Client-Centred Therapy and the Person-Centred Approach. A Collection of the Work of John M. Shlien.* (79-82). Ross-on-Rye: PCCS BOOKS.

Sanders, P. (Ed.) (2007). *The Contact Primer.* Ross-on-Wye: PCCS BOOKS.

Sanders, P. (Ed.) (2012). *The Tribes of the Person-Centred Nation* (2nd Ed.). Monmouth: PCCS BOOKS.

Sanders, P. (2012a). History of Client-Centred Therapy and the Person-Centred ApproachEvents, Dates and Ideas. In P. Sanders (Ed.), *The Tribes of the Person-Centred Nation* (2nd ed.). (1– 20). Monmouth: PCCS BOOKS.

Sanders, P. (2012c). Mapping Person-Centred Approaches to Counselling and Psychotherapy. In P. Sanders (Ed.), *The Tribes of the Person-Centred Nation* (2nd ed.). (233-246). Monmouth PCCS Books.

Sanders, P. (2017). Principled and strategic opposition to the medicalisation of distress and all its apparatus. In S. Joseph (Ed.), *Person-Centred Therapy And Mental Health: Theory, Research And Practice* (2nd ed.). (11-36). Monmouth: PCCS Books.

Schmid, P.F. (2017). Authenticity and alienation: towards an understanding of the person beyond the categories of order and disorder. In S. Joseph (Ed.), *Person-Centred Therapy And Mental Health: Theory, Research And Practice* (2nd ed.). (73-91). Monmouth: PCCS BOOKS.

Schmid, P.F. (2018). Going beyond orthodoxy in an orthodox way? Remarks to Jobst Finke's plea to extend person-centered therapy by pre-Rogerian means. *Person-Centered and Experiential Psychotherapies*, 17(2), 132- 138.

Shlien, J.M. (1984). A Countertheory of Transference. In R.E. Levant & J.M. Shlien (Eds.), *Client-Centred Therapy and the Person-Centred Approach: New Directions in Theory, Research, and Practise*. (153-181). London: PRAEGER.

Shlien, J.M. (2003a).Phenomenology and Personality. In P. Sanders (Ed.), *To Lead An Honourable Life, Invitations to think about Client-Centred Therapy and the Person-Centred Approach. A Collection of the Work of John M. Shlien*. (138-172) Ross-on-Rye: PCCS BOOKS.

Shlien. J.M. (2003b). Macht Therapie Glucklich? Can Therapy Make You Happy? In P. Sanders (Ed.), *To Lead An Honourable Life, Invitations to think about Client-Centred Therapy and the Person-Centred Approach. A Collection of the Work of John M. Shlien.* (69-78).Ross-on-Rye: PCCS BOOKS.

Sommerbeck, L. (2003). *The Client-Centred Therapist in PsychiatricContexts.* Ross-on-Rye: PCCS BOOKS.

Sommerbeck, L. (2005). Non-Directive Therapy With Clients Diagnosed With A Mental Illness. In B. E. Levitt (Ed.), *Embracing Non-Directivity: reassessing person-centred theory and practice in the 21st century.* (170-191). Monmouth: PCCS BO OKS.

Sommerbeck, L. (2017). Complementarity between client-centred therapy and psychiatry: the theory and the practice. In S. Joseph (Ed.), *Person-Centred Therapy And Mental Health: Theory, Research And Practice* (2nd ed.). (116-133). Monmouth: PCCS BOOKS.

Spinelli, E. (2005). *The Interpreted World: An introduction to phenomenological psychology.* (2nd ed.). Los Angeles: SAGE.

Van Werde, D. (2008). The Falling Man: Pre-Therapy applied to somatic hallucinating. In G. Prouty (Ed.), *Emerging Developments in Pre-Therapy.* (39-47). Monmouth: PCCS BOOKS.

Warner, M.S. (2000). Person Centred Therapy at the Difficult Edge: a Developmentally Based Model of Fragile and Dissociated Process. In D. Mearns & B. Thorne, *Person-Therapy Today: New Frontiers in Theory and Practice* (144-171).London: Sage.

Warner, M.S. (2017). A person-centred view of human nature, wellness and psychopathology. In S. Joseph (Ed.), *Person-Centred Therapy And Mental Health: Theory, Research And Practice* (2nd ed.). (92-115). Monmouth: PCCS BOOKS.

Wilkins, P. (2017). Assessment and 'diagnosis' in person-centred therapy. In S. Joseph (Ed.), *Person-Centred Therapy And Mental Health: Theory, Research And Practice* (2nd ed.). (134-153). Monmouth: PCCS BOOKS.

Practitioner Perspective

# Online therapy: A business opportunity for the private practitioner; a Person-Centred perspective

*Declan Peelo*

## Introduction

*We live in a culture where the entrepreneurial spirit is admired and encouraged. Counsellors and psychotherapists must learn how to harness this spirit without losing the compassion and the deep respect for the individual that lie at the heart of their profession. – Brian Thorne*

Over the past 20 years, the mental health community has gradually come to view online therapy as a promising adjunct to traditional therapeutic methods (Monk, 2018; Oravec, 2000; Fletcher-Tomenius & Vossler, 2009).

Online therapy is defined broadly as conducting counselling services over the Internet. In order to distinguish the various types of online therapeutic modalities, Evans (2009) defines online communications conducted in real time as synchronous, and online communication conducted where there is a delayed reaction, as asynchronous. The term "online" covers a number of methods including e-mail, chat-rooms, video and other forms of web-based applications (APPS). Although acceptance of online therapy is not universal, enough practitioners have begun using computer-mediated communication to warrant the IACP to introduce guidelines for an online approach (IACP, 2017), as have their UK (BACP, 2009) and USA (APA, 2013) counterparts. This article focuses primarily on specific issues relating to generic video applications, since many of the difficulties and challenges first associated with online therapy have been eliminated by the pace of change with the evolving technologies.

This article critically evaluates a review of literature on online therapy from a business perspective and considers the legal, ethical and professional practice requirements from a person-centred perspective.

As the pervasiveness of technology in people's lives continues to grow, especially for younger generations, it is reasonable for clients to expect online counselling to be available in line with other healthcare services (Baker & Ray, 2011). It is now incumbent on all practitioners to at least be aware of the impact of online services for their clients and the options available for online counselling provision (Anthony, Jung, Rosenaurer, Nagel and Goss, 2010).

In order to distinguish between online therapeutic modalities, Evans (2009) separates online communication into synchronous, which is conducted in real time, and asynchronous, where there is a delayed reaction. This article will primarily focus on the synchronous modality of generic video applications. However, due to the dearth of research in this area, some of the 'online therapy' research articles reviewed refer to asynchronous modalities, such as e-mail; instant messaging, andother web-based applications.

**The Business of Therapy**

As with most businesses, setting up in private practice as a therapist has substantial advantages, including freedom to be the primary decision-maker, choice in work location, hours, fees and projects. These advantages need to be weighed against the disadvantages that include taking full responsibility for financial matters, inconsistent revenue streams and isolation (Fay, 2014; Harrington, 2013; McMahon, 1994 in Hunt, 1995).

While there may be some discomfort in discussing human distress in terms of a 'profitable business', the discussion is a necessary one as lack of a business plan can lead to a risky practice for clients and leave clinicians in a vulnerable position (Starr & Ciclitira, 2014). According to Reeves (2017) financial issues are an important challenge for private practitioners as "…too many counsellors still have to work for low salaries or no payment at all" (p.45).

From a business perspective, online therapy offers a number of attractions for private practitioners by broadening exponentially the potential client base and overcomes barriers that otherwise may prevent people seeking face-to-face (FTF) therapy (Anthony et.al., 2010; Griffiths & Cooper, 2003; Oravec, 2000). The service can be considered particularly advantageous for young people (Prescott, Hanley & Ujhelyi, 2017) and clients suffering from agoraphobia or PTSD (Thompson, 2016) and other mental health issues, (IACP, 2017; Woodward, O'Brien-Malone, Diamond & Schuz, 2017). Online therapy also reduces costs, optimises marketing expenditure and reduces time wasted on dropouts and no shows (Monk, 2018; Griffiths & Cooper, 2003).

One of the fundamental tenets of business is to meet the demand of the market (Starr & Ciclitira, 2014) and there appears to be overwhelming support for online therapy from a consumer perspective (Thompson, 2016; Monk, 2018; and Richards & Vigano, 2013). Monk (2018), a practising online therapist offers a mix of traditional FTF therapy alongside her online work as a complement to traditional FTF services.

Current trends indicate online therapy will overtake FTF therapy in volume in the near future (Jackson, 2013; Richards & Vigano, 2013). This supports the business argument for including online services as part of a portfolio of options. Therefore, the challenge for practitioners is to find an offering that is legal, ethical, within their competency and suitable for their theoretical orientation.

**Practitioner Competence and Training**

Since modes of communication in relation to online therapy are continuously evolving, it can be argued that traditional core trainings are out of date as they fail to highlight the distinct nature of online therapy, its defining features, culture, dynamics, and issues, which could be achieved effectively in pre-qualification training (Richards & Vigano, 2013; Anthony, 2015). The IACP recognises this aspect and the importance for specialist training for practitioners for online work, suggesting that post-qualification training is increasingly available (IACP, 2017).

Effective work online necessitates proficiency in IT skills (Gamble, Boyle & Morris, 2015), which include awareness of hosting platforms, an understanding of how electronic data is stored and secured, competence in the maintenance of electronic records and the encryption of the platform supporting the service (IACP, 2017; APA, 2013). Of note, the recent General Data Protection Regulation (GDPR) (DPC, 2018) cover some of these as they also apply to FTF practices. The onus of responsibility is firmly on the therapist to ensure the chosen platform complies with current regulations (Dear, 2015; Gamble et.al., 2015).

IACP guidelines outline practitioners should be proficient in the skills to ensure clients' security and confidentiality are never compromised, (IACP, 2017), yet this level of guarantee has proven to be beyond even the most prestigious institutions, such as banks, and Facebook. In a study of 93 therapists practising online, Finn & Barak (2010) expressed surprise that one-third of participants continued practising when confidentiality was known to be in doubt. This report notes an absence in any of the literature reviewed of the consequences for the therapeutic relationship in the event sessions are recorded and posted online.

**Contracts and client suitability**

While Monk (2018) believes clients are more empowered when they can choose a therapist based on an assessment of their online profile, consideration needs to be made as to how to achieve a legally-binding contract where original signatures are not readily transmitted. When offering online services, key aspects require additional information to be presented in advance for clients, such as the additional risks and limits to confidentiality (Corey, 2013; IACP, 2017), a crisis management plan, and a communications strategy in case of network failure (Gamble et.al., 2015). Obtaining important client details, including age and capacity to give informed consent, may prove a challenge using an online medium (Gamble et.al., 2015), for example, a client considered a minor in one jurisdiction may be considered an adult in another (IACP, 2017).

Another important discussion to be held at the outset concerns the client's remote environment (APA, 2013; Gamble, 2015). Practitioners are encouraged to assess the suitability of the client's location

to ensure it is comfortable and conducive for effective delivery of online therapy (APA, 2013; Gamble et.al., 2015).

Unlike conventional FTF therapy, it is reported that certain mental health issues, including self-harm, psychosis, trauma or severe personality disorders, may prove intractable to online therapy (Anthony et.al., 2010; IACP, 2017; APA, 2013; Gamble et.al., 2015, p.295; BACP, 2009). Additionally, clients who present with ongoing problems of addiction or alcoholism, or those who seem reluctant to comply with the contractual requirements of online therapy, may be encouraged to access alternative mediums of support (IACP, 2017).

**The Therapeutic Alliance**

A major consideration for practitioners before making a decision to work online is to establish if their theoretical orientation is suitable or effective using the method. While it has been reported that Cognitive Behavioural Therapy (CBT) appears to have transferred seamlessly to the Internet (Hadjistavropoulos, et al, 2017; Richards & Timulak, 2012; Thompson, 2016; IACP, 2017; Button, et.al., 2012), Bengtsson, Nordin & Carlbring (2015) have suggested that CBT therapists viewed FTF as a stronger experience than online. It must be noted that most of the studies reviewed in which CBT was conducted online used email as the asynchronous methodology.

From a Person-Centred perspective, the therapeutic relationship or alliance is a key aspect affecting the process and outcome of therapeutic intervention (Rogers, 1967) and has been identified as a major concern with online offering (Richards & Vigano, 2013; Baker & Ray, 2011; Hedges, 2014; Hadjistavropoulos, Pugh, Hesser & Anderson, 2017; and Thompson, 2016). Where the therapeutic relationship is considered to be the largest significant single factor affecting the outcome in FTF therapy (Lambert & Ogles, 2004; Fletcher-Tomenius & Vossler, 2009), clients in receipt of online therapy are generally unaware that this relationship is key and are oblivious to it, yet still appear to be satisfied with the online offering (Richards & Vigano, 2013). Some research suggests online therapy creates the 'working alliance' and is similar to FTF therapy (Anthony 2015; Cohen & Kerrand, Cook & Doyle 2002, Reynolds et. al., 2013; Wright, 2002; and Thompson, 2016), although most of these studies used asynchronous approaches. The suggestion that complex aspects of relational cues with interpersonal communication may be limited in online therapy is disputed by some online studies (Balick, 2013; Hedges, 2013), which report online services as a legitimate means of conducting psychotherapy (Reynolds, Stiles, Bailer & Hughes, 2013; Jackson, 2013; Button, et.al., 2012; Finn & Barak, 2010). While these studies provide evidence that support the effectiveness of online services based on outcomes, only a few are related to synchronous modalities. In these cases, the sample sizes were small and there were no longitudinal studies undertaken in the literature reviewed. Other studies were non-committal, preferring to suggest online therapy is different and is useful as an adjunct to conventional FTF therapy (Monk, 2018; Oravec, 2000; Fletcher-Tomenius & Vossler, 2009).

In one study on video therapy, clients felt a low level of connection with the clinician, and clinicians felt it difficult to gain the "relational capital" needed for effective treatment (Neimeyer & Noppe-Brandon, 2012, in Kingsley & Henning, 2015). The ability of "working with people in the very close and intimate relationship" that Rogers called psychotherapy (Rogers, 1967, p.184) can be viewed by practitioners as a limitation with online synchronous therapy. With FTF therapy, relating and responding to physical impingements is recognised as a significant factor in the therapeutic process (Hedges, 2013, p.56), yet this interpersonal dynamic that is different in an online context does not appear to have been addressed in the literature reviewed.

Given the paucity of empirical research comparing FTF versus synchronous (online video therapy), perhaps it is sufficient to accept online therapy is effective for certain individuals in emotional distress and await the outcome of more up-to-date research before concluding the former to be superior to the latter (Griffiths & Cooper, 2003).

**Client Safety**

According to Rogers (1967) it is the personal attitude of the therapist that creates safety in the therapeutic relationship and makes communication possible, and this is also true with online therapy. The setting of a secure environment, a staple in conventional FTF encounters, becomes an 'unknown' factor when transferred to the online medium. As therapists have no input in the remote environment from which their clients engage, this introduces a level of risk not normally associated with FTF therapy. Therapists will have to assess if the online environment poses any potential risks for the client and for the therapy, and if any are identified, then the Therapist is expected to take appropriate steps to mitigate any potential risks or reassess if online therapy is a suitable approach. Most of the studies reviewed related to asynchronous communications, which lacked evidence to suggest the remote environment was even a consideration or that it may have any impact on the effectiveness of the service provided. Further research to establish the impact the remote environment may have with

synchronous communication would be beneficial.

The American Psychology Association (APA) also indicate some initial in-person contact for introductory assessment to facilitate an active discussion on issues such as the client's appropriateness for online therapy, the remote environment, crisis management and back-up communication strategies in case of network failure (APA, 2013).

**Legal and Ethical Considerations**

Practitioners must be aware of a number of additional legal and ethical considerations before considering delivering online services for clients (Gamble, et. al., 2015). The practitioner must be cognisant of any limitations the chosen theoretical orientation may have compared to the conventional FTF therapy and provide clients with explicit and relevant detail of any limitations in advance (IACP, 2017). Due to the paucity of research in relation to synchronous services this poses a challenge, as the extent of limitations of specific online therapeutic approaches are not yet known or fully understood (Richards & Vigano, 2013; IACP, 2017).

Confidentiality, an ethical imperative in psychotherapy, could be compromised with an online offering and practitioners are obliged to inform clients of the possible risks not normally associated with FTF therapy, i.e. potential risks from the client's own remote environment, and unauthorised access by third parties to the digital platform, deliberate or accidental, during an online session (IACP, 2017; APA, 2013). This review suggests there are additional risks to confidentiality and client safety, stemming from the client's remote environment that require focused research in order to develop safety protocols and procedures. In addition there was no mention of, or any consideration shown, to protect either client or practitioner from any unauthorised recording/posting of sessions in the literature reviewed. It is the view of the author that this is of critical importance, not only for safeguarding clients, but for protecting the integrity of the profession itself.

*This review suggests there are additional risks to confidentiality and client safety, stemming from the client's remote environment...*

Being able to work with a client in a different country does not necessarily mean that it is legal or ethical. For instance, in Austria there is a clear distinction between counselling and psychotherapy and psychotherapists working online must be trained by an online trainer that is also a qualified psychotherapist (Anthony et al., 2010). In the US, mental health licences apply state by state and geographical borders prevent crossing state lines to practise (Anthony, 2015) and therapy via Skype is a violation of law as it is not HIPAA compliant (Health Insurance Portability and Accountability Act, 1996). Thus, the onus is on practitioner to be aware of, and be compliant with, the regulatory issues within all of the jurisdictions where their services are being delivered (IACP, 2017).

**Conclusion**

There appears to be a consensus that we will see an expansion of online services in the future, providing unprecedented access to psychotherapeutic services and development of new models of practice (Finn & Barak, 2010; Gamble et.al., 2015; Anthony, 2015; and Richards & Vigano, 2013). The challenge for private practitioners is to decide if online therapy is suitable for them, their theoretical orientation and whether or not the challenges online therapy present can be overcome. While the business case for an online therapy may be attractive, it presents additional legal and ethical considerations not normally associated with FTF therapy. Similarly, from a Person-Centred perspective, online therapy presents professional considerations including relational dilemmas and the therapeutic alliance not encountered in conventional FTF settings. What emerges from reviewing the literature is the need to establish an evidence base to ensure client safety and the integrity of the theoretical approach adopted to deliver online therapy. While further research is needed to fully explore the process of online therapy and the impact on outcomes from a therapeutic perspective, this article supports the research that online therapy is a viable therapy offering in certain circumstances for certain types of clients and further, when regulated and facilitated by trained professionals can be a valuable adjunct to traditional FTF therapies.

Yalom cautions in relation to online therapies and technological advances: "if successful, it would be a pleasant and rare instance of technology increasing rather than decreasing human engagement" (Yalom & Leszcz, 2005, p.524). Only time will resolve this question.

Declan Peelo

Declan Peelo is a mature student entering his third year of an Integrative Counselling and Psychotherapy degree at IICP, Killinarden. Coming from a business background spanning 30 years, Declan is also a trained instructor in Mindfulness-Based Stress Reduction from the Center for Mindfulness in Medicine, Healthcare and Society from the University of Massachusetts Medical School.

## REFERENCES


Anthony, K., Jung, A., Rosenauer, D., Nagel, D. M., & Goss, S. (2010). Interview with Audrey Jung, President of the International Society for Mental Health Online (ISMHO), presented at the Online Counselling and Therapy in Action conference, 25 April 2009. *British Journal of Guidance & Counselling*, *38* (4), 483-494.

Anthony, K. (2015). Training therapists to work effectively online and offline within digital culture. *British Journal of Guidance & Counselling, 43* (1), 36-42.

American Psychological Association (APA), (2013). Guidelines for the practice of telepsychology. *American Psychological Association, 68* (9), 791-800. DOI: 10.1037/a0035001.

Baker, K., & Ray, M. (2011). Online counselling: The good, the bad, and the possibilities. *Counselling Psychology Quarterly, 24* (4), 341-346.

Balick, A., (2014). *The Psychodynamics of social networking: Connected-up instantaneous culture and the self (Psychoanalysis and popuxlar culture).* London: Karmac.

British Association for Counselling and Psychotherapy (2009). *Guidelines for Online Counselling and Psychotherapy*, 3rd Ed. London: BACP.

Bengtsson, J., Nordin, S., & Carlbring, P. (2015). Therapists' Experiences of Conducting Cognitive Behavioural Therapy Online vis-à-vis Face-to-Face. *Cognitive Behaviour Therapy*, 44 (6), 470-479.

Button, K., Wiles, N., Lewis, G., Peters, T., & Kessler, D. (2012). Factors associated with differential response to online cognitive behavioural therapy. *Social Psychiatry & Psychiatric Epidemiology*, 47 (5), 827-833.

Clark, J. (Ed.). (2005). *Freelance Counselling and Psychotherapy. Competition and collaboration*. New York: Taylor & Frances.

Corey, G., (2013). *Theory and Practice of Counselling and Psychotherapy*, (9th Ed). Canada: Brooks/Cole, Cengage Learning

Data Protection Commission (2018). General Data Protection Regulation. Retrieved from: www.dataprotection.ie

Evans, J. (2009). *Online Counselling and Guidance Skills: A Practical Resource for Trainees and Practitioners*. London: Sage Publications.

Fay, J. (2014). So you're starting a therapy or counselling practice? *Éisteach, 14* (1).

Finn, J., & Barak, A. (2010). A descriptive study of e-counsellor attitudes, ethics, and practice. *Counselling & Psychotherapy Research, 10* (4), 268-277.

Fletcher-Tomenius, L. J., & Vossler, A. (2009). Trust in online therapeutic relationships: The therapist's experience. *Counselling Psychology Review, 24* (2), 24-33.

Gamble, N., Boyle, C., & Morris, Z. A. (2015). Ethical Practice in Telepsychology. *Australian Psychologist, 50* (4), 292-298.

Griffiths, M., & Cooper, G. (2003). Online therapy: Implications for problem gamblers and clinicians. *British Journal of Guidance & Counselling, 31* (1), 113.

Hadjistavropoulos, H; D., Pugh, N.E., Hesser, H., & Andersson G. (2017). Therapeutic alliance in Internet-delivered cognitive behaviour therapy for depression for generalized anxiety. *Clinical Psychology & Psychotherapy, 24* (2), 451-461.

Harrington, J. A. (2013). Contemporary issues in private practice: Spotlight on the self-employed mental health counsellor. *Journal of Mental Health Counselling, 35* (3), 189-197.

Hedges, L. (2013). *The relationship in psychotherapy and supervision*. USA: International Psychotherapy Institute E-Books.

Irish Association of Counsellors & Psychotherapy (2017). Recommended approach for online counselling and psychotherapy. Dublin: IACP.

Jackson, C. (2013). E-therapy, equality and access. *Therapy Today, 24* (1), 10-13.

Kingsley, A., & Henning, J. A. (2015). Online and phone therapy: Challenges and opportunities. *Journal of Individual Psychology, 71* (2), 185-194.

Lambert, M. & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp.139–194). New York: John Wiley & Sons.

McMahon, G. (1994). *Setting up your own Private Practice in Counselling and Psychotherapy*. Cambridge: National Extension College in Hunt P. (1995) Book reviews. *British Journal of Guidance & Counselling*, *23* (2), 292.

Monk, D. (2018). Direct email response received from Counselling Online.

Oravec, J. A. (2000). Online counselling and the Internet: Perspectives for mental healthcare supervision and education. *Journal of Mental Health, 9* (2), 121-135.

Prescott, J., Hanley, T., & Ujhelyi, K., (2017). Peer communication in online mental health forums for young people: Directional and non-directional support. *JMIR Mental Health, 4* (3), Doi: 10.2196/mental.6921

Reeves, A., (2017). From the chair. *Therapy Today, 28* (8), 45.

Reynolds, D., Stiles, W., Bailer, A., & Hughes, M. (2013). Impact of Exchanges and Client-Therapist Alliance in Online-Text Psychotherapy. *Cyberpsychology, Behavior & Social Networking, 16* (5), 370-377.

Richards, D., & Timulak, L. (2012). Client-identified helpful and hindering events in therapist-delivered vs. self-administered online cognitive-behavioural treatments for depression in college students. *Counselling Psychology Quarterly*, *25* (3), 251-262.

Richards, D. & Vigano, N., (2013). Online Counselling: A narrative and critical review of the literature. *Journal of Clinical Psychology, 69* (9), 994-1011.

Rogers, C. (1967). *A therapist's view of psychotherapy. On becoming a person*. London: Constable.

Starr, F., & Ciclitira, K. (2014). Setting up in private practice. *Therapy Today, 25* (3), 24-27.

Thompson, R., (2016). Psychology at a distance. Examining the efficacy of online therapy. University Honors Theses, paper 285. DOI.10.15750.292. Retrieved from: https://pdxscholar.library.pdx.edu/honorstheses

Woodworth, R. J., O'Brien-Malone, A., Diamond, M. R., & Schüz, B. (2017). Web-based positive psychology interventions: A re-examination of effectiveness. *Journal Of Clinical Psychology, 73* (3), 218-232.

Wright, J. (2002). Online counselling: learning from writing therapy. *British Journal of Guidance & Counselling, 30* (3), 285-298.

Practitioner Perspective

# The Possible Person: Playfulness, Expression, Trust-Building, & Meaning-Making with At-Risk Youth in Psychotherapy

*By Blake Griffin Edwards*

## Introduction

Far too often in therapy with at-risk youth—prompted by clients, caregivers, or even sometimes therapists—terrible weeks are merely re-hashed. The client's unstable mood or erratic behavior steals the show, a caricature of the forgotten person hiding beneath the masks worn day after day, masks stubbornly affixed as a concealment and a false comfort, and that possible person underneath the monstrous mood or the harrowing history is forgotten again.

In working with at-risk youth in therapy, I have found myself periodically stuck in vicious cycles of re-hashing. Even in clinical staffing of cases, I have become stuck in these vicious cycles. Multidisciplinary consult teams commonly become stuck in what I call "case gossip," a perversion of good, constructive case staffing in which small talk, generalised curiosity, and telling-everything-you-know takes the place of careful case conceptualisation.

Sometimes therapists lose sight of what clients need most—a genuine, nonreactive, empathic presence, authentic relationship, supportive change-validation, skill-building, and goal-directed activity. Too often, mental health workers escalate clients' distress by asserting too rigid a modality and too rational a mindset for the therapy to be therapeutic.

## Experiential Therapy Versus Intellectual Nagging

Years ago, I was providing therapy at a middle school, and a boy—my client—had an explosive reaction in class and ran outside the building yelling obscenities at the teacher who was chasing him and demanding obedience. I was asked to quickly make my way outside to assist, which I did. What followed for nearly ten minutes was a scenario in which the teacher, visibly shaken, yelled back at the youth demanding compliance with orders while nearly, literally, running in circles with him. I stood very awkwardly aside, doing very little, hoping every second that the teacher would go away, yet not wanting to say or do anything that would undermine her authority. My failure to even attempt to physically catch him or echo the teacher's demands must have exacerbated the teacher's frustration, and I absorbed a few verbal blows myself…*not* from the boy.

Finally, the teacher gave up and retreated only after demanding of me a list of requirements that her student must comply with and requiring I acknowledge that he was not to return to her classroom until he was ready to comply. I have been provided with many such lists from

parents and spouses throughout the course of my career. I stood still and quiet for a few minutes while the boy ran wildly over to a football field surrounded by a track. He ran up the small bleachers, jumping off of the back. He beat his chest. He screamed obscenities. He somehow managed to find rocks in the midst of a well-groomed lawn to throw at the side of a brick building. And still I watched.

Eventually, I walked within about 50 yards of him. About that time he had found a pile of long, narrow PVC pipes, which he threw violently toward the football field. Being late winter in the Seattle area, the field was very wet and mushy, and so the ends of the PVC pipes were landing like spears inches deep, resulting in the pipes then wobbling, almost comically, swaying—now three, four, five of them—like a kinetic art installation.

By this time, I had not spoken a single word. And then, as he walked over and removed one of the pipes and began using it as a martial arts *bo staff*, I walked the remaining distance to him. Once within a couple of yards from him and as he began to prepare his weapon for defense, I grabbed a PVC pipe myself and awkwardly swung it around, like Jackie Chan. He scoffed loudly, "Haaa! You're an idiot! You don't know what the fuck you're doing!" I laughed at myself, then offered, "Nice moves. Where'd you learn how to do all that."

He immediately began to brag about his belt rank in karate, and I listened, uttering "Ah's" and "Oh's" and "Um-hm's," along with genuinely curious questions—it was, after all, quite interesting—as he explained forms and sparring. By the time he took his first pause, nearly out of breath—from not only all the angst and exercise but also in the excitement of having someone listen to him—I shared,

*Therapists must somehow coax clients to feel their difficult emotions in the face of unconditional acceptance in order to begin working through them...*

"Well, thanks, this was fun, but I'd better get back to my office. I have a lot of paperwork to do. Do you want to walk back with me?"

I noticed a glint of suspicion in his eyes, and he declined. I responded, "It's cold out here, though. Don't stay too long. You and I both have work we should be doing." And, I walked away. I did not look back. As I walked, my anxiety rose. I had no plan. I had no idea what I was doing. I couldn't leave him out there. Yet I couldn't force him, and I saw no good coming from a power struggle. Having said what I had said to him, I couldn't now stay and supervise, or I would lose his trust. I couldn't return inside the building without him, or I would be reprimanded. What if he got hurt? What if he ran away?

I was within thirty yards of the building by the time he caught up with me. I didn't hear him coming, but he had run to my side and began walking alongside me. I smiled at him and kept walking. We walked all the way to the door of his class's portable building, which I opened. I said, "Have a great afternoon." He retorted, "Have fun with all that paperwork." We both laughed, and he took his seat. The teacher silently mouthed to me gratefully, "Thank you."

Although that therapeutic encounter was not your average session, its awkwardness and spontaneity are representative of many therapeutic moments I have endured, in which I have listened to my own gut, hesitated to act too swiftly, too directly, or to comply with rigid expectations on me or on the therapy. It can feel like "winging it," but this type of therapeutic craziness, as the symbolic-experiential therapist Carl Whitaker was known to call it, requires a fullness of therapeutic vision, as well as courage, compassion, openness, and optimism.

Therapists must somehow coax clients to feel their difficult emotions in the face of unconditional acceptance in order to begin working through *them rather than merely* talking about *them. Effective therapy is always more right-brain than left.*

One of my graduate school professors, Bill Collins, told me a story about when he was a student at Notre Dame (he was proud of the fact that they won the national football championship while he was there, but *that* is another story). He recalled one day encountering a friend after a football game. His friend was a member of the team and was angry about how things were going, including the game. His friend had a stranglehold on a young kid and evidently was intent on "beating the shit out of something." Bill was at a loss for what to do, and so, quite reflexively, just began crying. All of a sudden, his friend kind of took him in and nurtured him, and in that moment, quite unexpectedly, Bill saw change happen in both parties. He had experienced a therapeutic moment.

The family therapy pioneer Lynn Hoffman, who sadly passed away this past December, gave a language of values for sitting with clients (e.g. the non-expert position, relational responsibility, generous listening, one perspective is never enough). In an email exchange, Bill told me about his own efforts to incorporate Hoffman's values into his own therapeutic work—

*Many adults perpetuate volatile cycles of emotion, thought, and behavior unintentionally by interacting with children in ways that trigger further volatility.*

"At times, I will use an expectant silence, as if waiting for something to fall into my lap. What often happens is that into this space come very unusual thoughts, leading to unusual remarks, and not necessarily by me."

My former colleague, Blanche Douglas (2015), wrote—

> There was a method in Freud's madness when he prescribed the analyst be as undefined as possible, not disclosing details about his life and sitting behind the patient out of sight, saying little. This forced the patient to make meaning out of an ambiguous situation, and the only way he could do this was by recourse to his own experiences, unfettered by the reality of the analyst as a real person. (p. 25)

Whitaker (1978) argued that therapy should be a complex emotional experience, not "intellectual nagging" (Napier & Whitaker). We are complex creatures, most effectively engaged at multiple levels of awareness and being. Moments of emotion have ignited wars. We are far from purely rational creatures. The world is not a purely rational place. Why should therapy be?

**Hear Me, Love Me**

Children who have had a more secure attachment with their parents or other early childhood caregivers are much more likely to view their school teacher nearly automatically as, in the words of John Bowlby (1980), "being available, responsive, and helpful and a complementary model of himself as a potentially lovable and valuable person" (p. 242). This child is likely to be more confident, approachable, and resilient. But children who have had adverse or negligent relationships with parents or other caregivers are likely to be self-doubting and behave in either more withdrawn or more disruptive ways. From infancy, emotional responsiveness has been shaping relational experience. Youth who, as a baby, found no mutuality—where spontaneous gestures were not recognized or engaged with and where needs were not consistently met—may not have developed trust in others or self-confidence

Additionally, either due to traumatic experiences—including abuse or extreme neglect—or developmental anomalies, some kids have intense fight, flight, or freeze responses and little ability to self-soothe. Chronic volatility in family relationships can also set this pattern into motion. Developmental neurobiologist Daniel Siegel (2003) described how the mind develops as the brain responds to ongoing experience. Problem behavior is a manifestation of well-worn neural and cognitive pathways that translate into reflexive emotional, cognitive, and behavior patterns. In the face of problem behavior, we must learn to detour kids' domino-effect reactions, which so frequently emanate from underlying fear or shame. Many adults perpetuate volatile cycles of emotion, thought, and behavior unintentionally by interacting with children in ways that trigger further volatility.

Navigating out of these ruts requires self-control, empathy, and creativity. Explosive and withdrawn behaviors are typically adaptive responses, arising out of needs to be liked, valued, and respected, needs to have some sense of predictability and control, and needs to heighten or lessen sensory stimulation. When behaviors are confronted through criticism or control, a defensive response perpetuates the vicious cycle through an emotional display on the outside of feelings being felt on the inside. Sometimes rather than emotional displays, there are lies.

Years ago, I was chatting with a foster teen—I'll call her Bria—who shared with me that her younger sister often lied to their foster parents. She told me that the foster parents regularly and swiftly called her sister out on her lies—from stories about past events or what happened earlier that day—and that this perpetuates a vicious cycle. She explained, "I always let my sister tell me all those lies, but then she also tells me true stuff, everything that she doesn't feel safe to tell [the foster parents]. She doesn't trust to open up to them."

I asked, "But why does she lie to *you*?" She responded,

> My foster parents don't understand that when my sister is telling those lies, she just isn't ready to open up yet. It's her way of making sure someone is safe before she goes and lets them into her little world. If I am there for her and listen to what she has to say, even if it's not true, she knows I'm listening and that I love her, and pretty soon she always stops with the lies and starts telling me the truth. That's when she opens up a lot to me and talks to me about things that have happened to her and tells me how she's really feeling.

I learned from the profound insight of this caring sister. Care should seek first to nurture trust and broaden understanding; only then comes the carefully directed mission of increasing personal ownership and accountability. Emotionally nurturing relationships can act as a catalyst for healing changes in a foster child's life.

Whether their biological parents ignored their most fundamental needs or acted violently to bring a false semblance of control to the chaos of their own lives, foster kids have experienced rejection. And, of course, there are even greater evils: sexual abuses and varying forms of physical and emotional torture. When these kids are placed into the warmly anticipating homes of well-meaning foster parents, often there exists a gulf between preconceived expectations for their behavior as a member of this new family and the reality of these children's ongoing emotional warfare. Children in foster care may experience profound difficulties, from learning language and gaining healthy physical mobility to using age-appropriate thinking skills and engaging in appropriate social behaviors and decision-making. Abnormalities in appetite and sleep are often lingering effects that can stop and start for years.

Children who have experienced abuse or neglect may engage in behaviors that mirror the very abuse they have endured, often behaviors that once had some adaptive purpose essential to survival. Children who have experienced complex trauma may hoard food or engage in self-harming or even self-soothing behaviors (rocking, scratching, biting, or cutting themselves)— a particular behavior may paradoxically both harm and soothe. Some who have been abused themselves may engage in acts of cruelty directed at those smaller and less powerful (younger children, animals). Acts of aggression may stem from undeveloped empathy and impulse control that may reflect an attempt to understand how others react when experiencing pain and may also reflect attempts to make sense out of harm that was done to them.

*When a child is angry or anxious, simply feeling heard or understood can be calming and helpful.*

Without a strong emotional bond with a caregiver that acts as a secure base, children may engage in indiscriminate attachment behaviors, seeking affection from individuals relatively unknown to them, perhaps in an effort to find the reassurance of safety. Therapeutic support programs for foster parents often focus on the negative effects of trauma and the defensive strategies foster parents can engage in to respond well to the most difficult behaviors and de-escalate crisis scenarios. This type of training is critical, but with so much focus on posttraumatic stress at the root of problems, we easily miss innumerable signs of posttraumatic resilience, strength, and growth.

Heather Forbes, a prominent advocate in the field of foster care and adoption, frequently tells foster and adoptive parents that the paradigm for parenting a child who has experienced trauma must completely change, that we get the wrong answers because we ask the wrong question. She said the question we ask is: "How can I change this child's behavior?" She cautioned—as long as we ask that question, we will perpetuate a vicious cycle of power struggle, distancing, and further deterioration of attachment.

Forbes said the two "right" questions are "What is driving this child's behavior?" and "What can I do to improve my relationship with this child?" When these questions are our starting point, we find ourselves better prepared to encounter and facilitate opportunities for healing of trauma and change of behavior to begin.

Daniel Siegel (1999) noted, "The care that adults provide nurtures the development of essential mental tools for survival. These attachment experiences enable children to thrive and achieve a highly flexible and adaptive capacity for balancing their emotions, thinking, and empathic connections with others" (p. 33).

When kids misbehave, those who understand children's underlying needs respond in ways that guide the development of the personality underneath the monstrous mood paralyzing it. It is important to maintain firm guidance alongside unconditional acceptance, as well as to discern that fine line between what is vital and what is negotiable. Consequently, the need to become defensive and act out may diminish over time if the child finds that it is not needed anymore to be heard or to feel loved. When a child is angry or anxious, simply feeling heard or understood can be calming and helpful. Every child wants to be heard, which is just another way of saying understood, and loved, which is just another way of saying known.

Yet therapy with at-risk youth risks devolving into cynicism, marching forward under a cloud of subconscious assumption that the pattern of pathology presented will persist. Such a mindset ever keeps true therapy at bay. Healing happens where growth happens,

and growth happens where life flows freely into an open, as-of-yet undefined, and changeable future.

**The Pace & Space of Trust-Building & Meaning-Making**

Adolescence is a time of expression and differentiation. I can remember that initially, Bria was not too happy to sit with me during our weekly sessions. Having experienced a childhood of broken trust and sexual trauma, and after having bounced around between too many foster homes over too many years, she was understandably reticent to relax into my couch and lean into our relationship.

Bria was not the first client I had encountered with such an agonizing history. I had discovered by trial and error a therapeutic path that invited expression, an imaginative leap from dreadful realities. I had devised a simple self-assessment that helped me know whether my clients had any enjoyment of particular expressive activities such as writing stories, writing poetry, writing song lyrics, sketching drawings, sculpting clay, or other art forms. If there seemed to be no interest in these activities, I would gauge interest in more passive but still meaningful activities such as listening to music, short stories, or watching movie clips.

One day, I provided Bria with my assessment, and she indicated an interest in drawing. As I maintained a collection of colored pencils and drawing paper in my office, I offered them to her, and, another common practice of mine, I showed her an array of different colored folders she could choose to keep her drawings in at my office so they would be available to her each week. As a point of clarification, she was welcome to take any of her drawings from my office, but I only asked that she allow me to make a copy of any piece she would be taking away. If she did not wish for me to have a copy, I would honor her decision.

*Sketch art did not teach fantastic new life skills. I must confess that I certainly did not teach her much of anything, if "anything"...*

Every time that she came to see me thereafter, I had art paper and colored pencils waiting for her. I never said another word about them, never provided an invitation to her to use them. I didn't need to. And I never asked her about her drawings. I just sat with her and attempted, oftentimes awkwardly, to get to know her and to work with her to help organize her emotions into reflections and her reflections into meaning. She, all the while, organized her troubles into sketch art. Occasionally, she would hand a piece over to me and expound upon its finer points, its errors, and its meaning. On one occasion, as she did so, she fell apart into tears. At one point in the midst of that, she yelled and cursed so loudly that I could hear the footsteps on creaky hallway floors of a coworker come to discreetly check on things at my door.

Bria entered therapy oscillating between expressive anger, reflective sadness, and emotional distance. These matched her foster parents' reports from home. During the first two months of therapy, I observed difficult interactions between Bria and her parents, especially highly defensive behaviors by Bria. In her first several sessions with me, she had seemed emotionally rigid. As time wore along, I began to experience Bria differently. She seemed, in the context of our conversations over her sketch art, to be appropriately vulnerable, emotionally pliable, and more deeply reflective. However, her parents' reports to me were nearly unchanged; the Bria living at home remained stuck in an alternate dimension.

The difference, in my view, between the kind of expression and interaction that Bria experienced in therapy (eventually) versus the kind frequently experienced during the rest of her weeks was a difference of control. During the week—during her life for that matter—she felt little of it. There were a number of reasons this could be said to be true. Yet during our sessions, she had a great deal of control. And she liked that.

Sketch art did not solve Bria's problems. Nothing solved Bria's problems. Sketch art did not change Bria's past. Nothing changed Bria's past. Sketch art did not teach fantastic new life skills. I must confess that I certainly did not teach her much of anything, if "anything" should be construed as insight or manners or gumption (*note: she already had gumption*). Yet something happened in the course of our time together, and something of the give-and-take between us forged a new possibility for Bria, a new way of being in the world.

Her father noticed, and in his noticing, he came to me to ask what had changed. I reflected what wonderful care she was being provided in their home, and I knew with certainty that the reality of their consistency and care was the most powerful intervention in Bria's life. He did, however, want to know more about Bria's therapy.

I rarely knew, as a young therapist, how to explain to parents my work with their kids, and this encounter was no exception. When he pressed about what kind of strategies I was using to process

her past trauma, I sputtered out a nearly undecipherable explanation of how I try not to push her and of how she had not actually opened up to me about her past trauma. Ultimately, her father reflected, "When I pick her up from her session each week, it's like the light in her has been turned brighter, and she's opening up in a new way. She actually has begun talking to me about past abuses, just matter-of-factly, really… and what's more, she's been kidding around with us a lot more lately."

As a psychotherapist, I have had opportunities to encounter those whose journeys have led to my door. Far more than problems and solutions, I have had opportunities to help clients discover something larger—hidden worth, unrealized meanings, unseen hope. Effective psychotherapists redirect from cynicism to expectancy. The task of intervention is primarily the task of collaborative, intentional, and active therapeutic leadership, not positivity but meaning-making, and not merely meaning-making but helping another become him- or herself, stirring the *person* in the human.

In L. Frank Baum's story, *The Wonderful Wizard of Oz*, the wonderful wizard places an amalgam of bran, pins, and needles in the Scarecrow's head to inspire his intellect, gives a silk heart to the Tin Woodman to inspire love, and provides a strong drink to the Cowardly Lion to inspire bravery. Similarly, I have found it helpful in therapy to accentuate strengths that counter areas of self-doubt and amplify constructive meanings introduced by my clients. Whenever possible, I do this in ways that are indirect, sometimes through Socratic questioning or motivational interviewing, but at least as often I have done this through forms of creative, symbolic communication

*It is never merely perspective or skill that holds power to change people's lives. It is an expanded capacity for creating.*

and activity. When we signify, we promote significance. Symbol is a language whose Rorschach allows space for meaning-making. The story of Oz underscores the influence of meaning conveyed. The wizard's clients, so to speak, demonstrated respect for his power in spite of discovering he wasn't powerful. Despite his confession, they wanted his help nonetheless. By the time they had gotten it in the unfolding of an awkward, confrontative session, they had in a matter of moments released themselves of prior expectations and found a help fraught with mystery but not inconsequentiality.

**All the World's a Stage**

The psychologist David Elkind (1967) wrote of how adolescents are constantly reacting to an imaginary audience. He said that, as a result, they begin to develop a kind of personal fable in which the youth begins to see herself as a unique being in the world all her own and over-differentiates her thoughts from those around her, failing to see the interrelatedness in this ecology of people living life together. The personal fable is a narrative youth are telling themselves that begins to take on mythic life. It is difficult for some youth to differentiate their own mental constructs from reality.

When there has been a history of abuse or neglect, a survivalist mentality and an emotional schema to accompany it necessarily develops and often persists. Yet, when there is no longer a need for such a mindset, it is not easy to shed the once so-helpful rigidity and reactiveness. There is a kind of play that must be learned or relearned to become creative and integrative in life, as life at its best demands. Play, like summer vacation, has mysterious ways of relaxing stress, reprocessing experience, and integrating learning, preparing us for higher levels of growth, which includes healing processes.

Donald Winnicott (1971) referred to psychotherapy as playing together in the creation of symbols, as meaning-making. In his own words—

> "Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist." (p. 44)
>
> "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self." (p. 63)

It is never merely perspective or skill that holds power to change people's lives. It is an expanded capacity for creating. It is the integration of character. It is a wellspring of courage fed of a source previously unknown. There is integrity, beauty, and in some cases, even justice, in the fluid, organic, and risky enterprise of *care*. Integration leads to the intricate and inextricable weaving of insight (brain), compassion (heart), and will (courage), much of whose mysteries have been with us in some form from the very beginning of our journeys (surely you noticed that Dorothy's three friends in Oz resembled the farmhands who worked for her aunt and uncle back in Kansas, just as the wizard himself resembled Professor

*Much of that work involves identifying the personas, or masks, that youth are wearing over the course of their days and weeks, instruments which conceal and protect.*

Marvel, the phony fortune teller who convinced Dorothy to return home when she'd ran away).

Because our clients need this sort of holistic integration, there must, therefore, be a dimension of "play" in psychotherapy, a breaking loose of rigid constructs—beliefs and behaviors—in the process of retrofitting a more constructive and contributory meaning. Play, as a literal or figurative activity, is a relationship-building catalyst, spurring development as therapeutic gains are consolidated. As we lower our guards and heighten our senses, we tend to position ourselves for greater learning and growth. Like breathing, eating, and sleeping, we all have a built-in need to be playful, to be exploratory and creative, to be more fully ourselves, to find the spaces necessary to shed persona and pretense. If a child isn't good at playful interaction, they'll end up feeling more awkward and are more likely to withdraw from social situations. Our capacities for playful expression correlate with our capacities for resilience.

Playfulness involves imaginative consciousness and meaning-making. Everything we do can be permeated with an attitude that is playful. Emotionally responsive playfulness has its own way of signalling that there is safety in the room, and it holds potential for promoting vitality. Our clients often find themselves wandering in emotional deserts, harsh internal environments devoid of the fundamental elements necessary for play. Yet Blanche Douglas (2015), asserted—

> There is never a total absence of potential space for the creation of meaning… Where trust and reliability have been internalized, there is a potential space with an infinite capacity for being filled with creative activity. It is there that unbearable contradictions become paradox, and paradox cannot only be tolerated but can be made use of in the experiencing of life. (p. 25)

I have found myself slipping in and out of different persona's myself as I have sat with youth in therapy over the years. Since I'm not great at being playful myself, this has very often taken the form of my best efforts to engage playfully, which is, in many ways, just another way of being vulnerable. There are few better ways for therapists to catalyze therapeutic alliance with emotionally resistant clients than modelling some degree of appropriate, genuine, power-sharing vulnerability.

I think of one older adolescent boy with whom I regularly ended sessions by walking outside to have him show me his latest tricks on skateboard. He would urge me to try, at which point I would become my best version of cool, which would result nearly inevitably in falling flat on my face. Let me tell you that those few minutes each week opened up a world of trust between me and that angry, rebellious, isolated boy who felt there was no adult in the world who was worth his time of day.

I remember a preteen girl whom I had seen from the time she transitioned out of juvenile detention. She was quite skilled with hurtful words. When she walked into the room, anything I said or did would initially, typically be met with a sarcastic precision that had a way of punching me in the emotional gut and stripping me of confidence. In several of those moments early on, I had doubled-down in my emotional nakedness through goofiness and a bit of strategic self-deprecation, showing her my floundering skill of juggling hacky-sacks, which required me to stand up out of my comfortable armchair, dance around as I tossed them in cascades over my head and between my legs, and always concluded in hacky-sacks flying chaotically toward opposing walls, leaving me stumbling off balance, arms and legs twisted—a clown, without face makeup.

In those moments, she would begin to laugh not only at me, but with me. Her icy cold, threatening remarks toward me would morph into playful teases that left just enough space open for me to engage in a verbal jousting match of wit and trash talk. In the irony of that space, she—and so many other at-risk youth—have come to lose that respect, borne out of fear, for my position and power, and gain a more pliable, useful respect borne out of trust. It has been in the microcosm of those spaces that the seed of meaningful therapeutic work has been reliably planted.

Much of that work involves identifying the personas, or masks, that youth are wearing over the course of their days and weeks, instruments which conceal and protect. Rather than conveying that my clients have some "truer self" underneath their masks, I try and help them see their value and praise them for their adaptive skill in managing anxiety. My goal is not to strip them of their masks but to help them decorate them and practice expanding their repertoires.

In *The Merchant of Venice*, William Shakespeare (1564-1616) had Antonio reflect—

*"All the world's a stage,*
*And all the men and women merely players;*
*They have their exits and their entrances,*
*And one man in his time plays many parts"*

Carl Rogers (1961) wrote that as a person becomes increasingly comfortable with ways of being and becoming themselves over the course of therapy, they drop "one after another of the defensive masks with which he has faced life…[and] discovers in these experiences the stranger who has been living behind these masks, the stranger who is himself" (p. 123-124). I would clarify that a key word in Rogers's assertion is "defensive;" in other words, not *all* masks. Rogers did not intend to place clients in positions of untenable fear without recourse to their own internal, creative coping skills. He intended to have clients gain the power to become flexible in the face of fear.

Additionally, did you notice that in Rogers's metaphor, the person seemed to have had many defensive masks on all at once? This is another critical key. It does no good to wear all the masks all the time. We must know which work well for which particular role or "Act" we happen to find ourselves in. The capacity for shifting personas fluidly and creatively serves us all well in the theatre of our lives, and we have responsibility to ensure our clients are equipped to perform well as they play their parts.

**The Family Emotional System and Other Second Order Considerations**

The field of psychotherapy has by and large engaged individuals in ways that ignore the complex webs in which individuals are entangled. In the course of therapy with at-risk youth, we must both remain focused and centered in our immediate psychotherapeutic work with the particular understandings and responsibilities of individual persons while also acknowledging the multilayered complexity that is the ecological web of their life. This is no small challenge, yet while to focus only on the systemic context would be to risk missing the person of the youth, to focus only on the person would be to miss that in which the individual is firmly embedded. Either error risks psychotherapy as an adventure in missing the point.

*When the positive end of one magnet is placed against the negative end of another, an invisible force pulls them together.*

When the positive end of one magnet is placed against the negative end of another, an invisible force pulls them together. When the magnet's positive end is placed against the positive end of another, they repel one another. Two pieces of uncharged metal neither attract nor repel. There is magnetism in the emotional systems of families and, to greater or lesser degrees, between every member. The force between two is skewed by a third, and so on. The challenge of therapy is of how to work therapeutically with processes that bind and unbind, generating flexibility and instilling resilience. To grow, at-risk youth must experience freedom within the pushes and pulls of powerful self-perpetuating life forces in which not only their problems—but their families—maintain themselves.

By the time children have become adolescents, they have experienced the formative role of the affections and intolerances, approval and consequences, freedoms and restrictions of their particular family. As an adolescent's life outside the family expands, so do these dilemmas. Differentiation is a kind of rebellion, becoming unraveled from a family-of-origin and unfurled into a new adventure all our own. And this is all best-case-scenario.

We cannot ignore a youth's role in their family, their functioning in the family, their support or lack of support from the family, their responsibilities to the family, and the role of the family in their dysfunction. Though it is not our only influence—our lives are so complexly woven into biological, psychological, and social systems—family relationships are ground zero for developmental processes. Thus, regardless who attends therapy sessions, the family is never emotionally far from the scene.

As we grow, we increasingly develop self-consciousness, and by the time we become adolescents, we are self-conscious for good and ill. In angst, an adolescent may avoid play or playfulness within their family out of embarrassment. Nonetheless, playful interaction can be emotionally nourishing and has the power to send the message that you mean no harm, and it has the conduction to ground emotional lightning storms and provides a channel for more genuine engagement. Make no mistake about it—along the way, families are the best possible venue for practicing playfulness, expression, trust-building, and meaning-making. Families sometimes need therapeutic help to become sufficiently relaxed and open for playful interaction and "playing with options" to occur.

Whitaker (1978) described "the battle for initiative" and "the battle for structure," contending for therapists to win the struggle against the continual drift toward entropy, to ensure the opportunity for therapy to occur in family therapy (Napier & Whitaker). I have fought many battles with at-risk youth and their families in therapy by offering what Una McCluskey (2002) called "a fork in the road"—by, for instance, letting them know when we are tempted to explain again an explanation of their prior explanations, that they could choose between carrying on explaining, remaining in the safe position of knowing what they know already, or exploring with me other paths and perspectives, an opportunity for a different kind of learning. This approach is effective in facilitating a shift between defending, criticizing, or debating facts to a space where new emotional experiencing may reshape the landscape of not only the individual internal process but that of the emotional systems in which the individual is embedded.

Gregory Bateson (1972) suggested that painting, poetry, music, dance, and other metaphoric art forms serve as a bridge between the conscious and the unconscious, a way of communicating outwardly what dwells inwardly in order to explore relationships between the meanings they express. Whitaker (1989) taught us that what is therapeutic is not necessarily the experience itself but the meaning attached to it. If the person is to change, creative and transformative experiencing must occur.

Systemic psychotherapists recognize that clients are not the sum of their parts nor their problems and understand that the intimately personal, meaning-centered encounter is the instrument of therapy's fundamental utility. We see potential linkages, and power, between the client and every other person, challenge, and opportunity in their world and lean toward them, respectfully and intentionally stirring some of their anxiety-evoking interrelationship within the flux-and-flow of the here-and-now in order for the problems out there to be brought into here, to engage the hope for meaningful, second-order, and sustainable changes to occur.

Every time that an at-risk youth becomes defensive or abrasive or despairing, we have responsibility as therapists to normalize and perhaps even validate the emotions that extend from their complex existential situation. Every time colleagues and parents become again entrenched in problem-saturated narratives and anchored to their own fears and anxieties for clients or children, we have responsibility as therapists to point them beyond their fears and anxieties to the possible person, whose courage we playfully, carefully, evoke.


## Blake Griffin Edwards

Blake Griffin Edwards is a systemic psychotherapist, behavioral health director at Columbia Valley Community Health, behavioral health integration leader for the American Academy of Pediatrics, and health care governing board member for the North Central Accountable Community of Health in Washington State. Blake wrote the chapter, "The Empathor's New Clothes: When Person-Centred Practices and Evidence-Based Claims Collide" in the book, Re-visioning Person-Centred Therapy: Theory & Practice of a Radical Paradigm, released in June 2018 by Routledge.


**REFERENCES**


Bateson, G. (1972). *Steps to an ecology of mind*. Chicago: University of Chicago Press.

Baum, L. F. (1900). *The wonderful wizard of Oz*. New York: George M. Hill.

Bowlby J (1980). Loss: Sadness & Depression. *Attachment and loss (vol. 3)*; (International psycho-analytical library no.109). London: Hogarth Press.

Douglas, B. D. (2015, August). "Therapeutic space and the creation of meaning." *Context Magazine*. Warrington, England, United Kingdom: Association for Family Therapy and Systemic Practice.

Elkind, D. (1967). "Egocentrism in adolescence". *Child Development 38* (4), 1025–1034.

McCluskey, U. (2002). The dynamics of attachment and systems-centered group psychotherapy. *Group Dynamics: Theory, Research, and Practice, 6* (2), 131-142.

Shakespeare, W. (1564-1616; 1994). *The merchant of Venice*. Harlow, Essex, England: Longman.

Siegel, D. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: The Guilford Press.

Siegel, D., and Hartzell, M. (2003). *Parenting from the inside out: How a deeper self-understanding can help you raise children who thrive*. New York, NY: Tarcher.

Napier, A. Y., & Whitaker, C. A. (1978). *The family crucible*. New York: Harper & Row.

Whitaker, C., and Ryan, M. (1989). *Midnight musings of a family therapist*. New York: Norton.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock.

Practitioner Perspective

# Exploring The Dynamics of Relational Trauma and the Organic, Energetic Process of Change: Therapeutic, Training, and Research Perspectives

*By Rosie Burrows*


*Only when we have a direct experience of a collective trauma process, can we really get a glimpse of the effects that such a denied field of experience has on us – even if created many generations ago. Before that I believe we have a mental, rational understanding – but we can't refer it back to a felt experience. That's why I see this as a pioneering field of exploration. (Hübl, T. 2018).*

## Introduction

Welcome to this exploration in writing, inspired by the overall quality of connection to the therapeutic process of exploration and change that I experienced while offering seven training and research inquiry workshops to over three hundred counsellors, therapists and supervisors throughout Ireland for the Irish Association of Counselling and Psychotherapy during 2017/2018. It is near impossible to do justice to the energy, spirit and atmosphere of experiential work in writing. It also takes us into our heads to explain too much, losing the atmosphere of embodied mindful practice. Nevertheless, I am taking the opportunity to reflect on the workshops overall for research inquiry purposes, and to support ongoing learning to benefit the counseling and psychotherapy profession. In this paper, I begin by exploring:

i. why do this work - reflecting on personal memory as imprint of transgenerational and relational trauma?
ii. how do we do and be in this practice - key relational practitioners drawn on and missing elements; description of the relational inquiry workshops and what participants wished for; organising framework, live demonstration as research, training and therapeutic inquiry.
iii. key findings and conclusions.

## Personal and Professional reflection

To begin, an intimate personal memory and reflection: my mother told me at around age three years that I pulled my neck and head away from her, stretching back as she attempted to teach me to sing a nursery rhyme. A dynamic dance of overreaching/too forced presence, pulling away and absence, as this was part of my mother's embodied trauma imprint, a relational dance that stressed and pained both her and I. We sense, before words, our bodies responding to culture and to our learned developmental movements (Frank, 2001; Clemmens, 2011). I knew instinctively from an early age the

felt need to pull back from family and community transgenerational survival dynamics. I knew, before I knew I knew. The need for nature and other forms of embodied connection to survive and thrive - that the capacity for disconnection from oppressive and distorting aspects of culture – for *individuation-separation* and *differentiation*, was as vital as our complementary need for nourishing connection, if we are to become and be free functioning human beings. An orientation to freeing head, neck and whole body to discover freer expression, autonomy, satisfaction, love, bodily, sensual pleasure, sexuality, creativity, freedom from coercive, and therefore insecure connection and social *shoulds*. The imprint of the early dance has informed and guided my life's purpose. How do we connect to our own organic, energetic felt sense and maintain this? Our own natural, wild and safe enough connection, free(r) from spoken and unspoken expectations of family, peer group, organization, culture, and larger systems when they tend towards re-enacting and reliving restriction and narrower identities than who we really are? Learning to observe, accept, transform and/or release our relational dance, embodied experience of default survival patterns that no longer serve, at different levels of system, from the individual to the collective is central to my life purpose. To experience, that above all, we are welcomed in our being and not only in our doing (Denham-Vaughan and Chidiac, 2018).

In this purpose, I draw on many renowned relational practitioners and their key works (for an illustrative summary see Table 1 below). Also, my own embodied inquiry and research over three decades of working individually and collectively in Ireland, north and south, South Africa, Sri Lanka, the Netherlands, Denmark, and Scandinavia. Finally, learning is also informed by experiences that were ineffective or/and retraumatizing. A summary of early and later influences is illustrated in Table 1.

It is my personal and professional experience, that despite the most severe and profound losses and traumatic experiences, "there is a natural impulse within all of us towards connection, aliveness" (Heller, 2015, NARM training, Netherlands). Traumatic experiences are understood here as sudden or chronic events which overwhelm, that distort our life force and development, sometimes involving shock trauma, loss, terror, horror, helplessness and/or the chronic accumulated stress and developmental/relational trauma that passes from generation to generation. These are passed on by means of dysregulation of the nervous system/physiology, psychology, politics of human relating, poetics/language of connection/disconnection, and performance of identity, who we take ourselves to be, who we are, and the many creative possibilities in the world.

**Table 1 - Key Influences, domain and contributor**

| Early Influences | Later influences |
|---|---|
| • Contact – F. Perls, R. Hefferline and P. Goodman<br>• Working with the body and abuse - J. Kepner & R. Frank<br>• Trauma – J. L. Herman, Y. Danieli | • Precise methods for working with trauma<br>• Precise developmental theory and lens<br>• Neuroscience - S. Porges, P. Levine, L. Heller, M. McConville, M. Taylor, R. Schwartz, J. Fisher and others |
| • Support - L. Perls<br>• Anti-Oppressive - P. Lichtenberg, P. Freire<br>• Theories of Change - A. Beisser | • Precise support of autonomy and connection<br>• Principles, framework, more precise developmental lens |
| • Action research, context/field, levels of system - K.Lewin, E.Nevis, Burrows and Keenan<br>• Human rights and specific conditions | • Evolving relational ethical frameworks; BACP, IACP and others<br>• Ecological ethics - P. Curry<br>• Own practice and research inquiry lens and framework |
| • Shame – R. Lee<br>• Addiction and Embodied Culture - M. Clemmens | • Gifts of Trauma practice - Burrows<br>• Self compassion and compassion - K. Neff<br>• Sexuality and Love - S. Resnick, E. Perel |
| • Creativity, play and development<br>• Spirituality and Dialogue– M. Buber | • Intentional use of touch – self and practitioner for somatic trauma healing |

**Workshop inquiry**

At the heart of the workshop inquiry was: determining our strengths/ resources and vulnerabilities/ reactions in working with clients and others. Enquire as to whether our emotions and identifications support what we might call adult consciousness/observer or stronger identification and emotions of earlier and younger trauma survival *parts* (i.e. parentified child, abandoned child, top dog - Fisher, 2017; Schwartz, 2018). Each workshop usually began with connection to particular place, landscape and people, as a vitally alive and grounded aspect of connection. The overall objectives were:

1. Exploring our own and our clients experience: the natural impulse to aliveness, and the relational dynamics of connection and disconnection.
2. Embodiment – somatic mindfulness and somatic experience, with the embodied presence of the therapist as an important focus of the workshop.
3. Awareness of the Physiology and Psychology of Trauma and Relational Trauma Healing – a summary of nervous system, brain, primary and secondary emotions, alongside a framework of organising principles and practices for sessions. (This was not and is not a menu, so much as general guiding principles to support practitioners in recognising relational dynamics and the felt sense of an organic, energetic, healing process kept on track).
4. Practical: embodied activities, live demonstration as an opportunity to observe and experience a full session using organising principles and practices that support the client and ourselves to be present; to own; understand, and contain the energy in sensations, emotions, images and gestures. Time was given for clarifying questions, work in small groups, and experiential processing.

In pairs, we explored a negotiated contract/working agreement of what each person really wished for, the heart's desire/intention from the workshop. I took responsibility for tracking my own and overall group experience, asking each participant to take ownership/ agency for tracking their own experience alongside their intention/heart's desire (Table 2).

A developmental theory was briefly introduced to support therapist awareness of client survival strategies and to allow a focus on what has been compromised in all of our lives to a lesser or greater degree: connection, attunement, trust, autonomy, and the integration of love, spirituality, sensuality and sexuality (Heller, 2012). Developmental resources are the necessary conditions for development that are strengthened and/or eroded by the conditions of childhood and adulthood living, and practice also draws on other developmental theorists including McConville (1995).

**Framework for Working with Relational Trauma**

There was recognition of a need for a framework to help organize practice with fragmented, traumatised clients who find it difficult to focus or maintain focus, and take us with them without such a framework. Practitioners wished for the space and opportunity to explore practical skills for working with trauma relationally (Table 3)

Thanks to those central to my development, I emphasise a strong focus on the social, political and

**Table 2 - Participant Needs from Training**

| What participants wished for and needed can be summarized as follows: |
|---|
| • Networking and learning |
| • Exploring abandonment issues – 'parts' work and lack of awareness in clients, and to nourish our own younger self |
| • Freer to be more fully myself |
| • To continue to be compassionately present to myself with others |
| • To feel welcome |
| • To go beyond thinking |
| • To develop capacity to contain |
| • To become more embodied and learn more on self regulation |
| • Working with suicidal and self-harming behaviours /intense dysregulation |
| • To experience the wonder of this work |
| • Confirmation |
| • To be intentional with confidence |
| • Courage to trust my own knowing |
| • Working with hyperarousal – triggers in the client and in myself |
| • Working with shock states |
| • Working with the past and developmental trauma |
| • Demystify trauma |
| • Simplify the language of new learnings in trauma in order to take in and educate clients |
| • Embodiment activities |
| • Know our own limits |

**Table 3 - Organising Framework: Burrows (2018)© adapted from Heller (2016, Training)**

| Organising Framework for Relational Trauma Sessions and Process |
|---|
| Preconditions: Clarifying the Context (human rights/ethical issues) & Embodied self-care of the Therapist and Grounded Contact |
| Clarifying the Contract |
| Inquiry and Exploratory Questions |
| Integrity as the core process of supporting conditions for Emotional Completion (orientation towards innate resources, embodiment, completing incomplete emotions) |
| Reflecting Positive Shifts and space for integration |
| Supporting Autonomy and Agency (and the Integration of Self) |
| Clear Ethical Framework and Maintaining Developmental Gains |

organizational field of the work, and the need to hold the integrity of the process ethically at different levels of system embedded in a grounded connection. Alongside briefly exploring each of these organizing principles for sessions, we engaged with embodied activities, accompanying practices and relevant theory, so that an integrating framework was available to support the practitioner when working with clients and with our own process, with triggers or transference and counter transference reactions. While I find it impossible to do justice to the experience, I have written up further descriptions of each principle for training, supervision and consultation purposes.

The live demonstrations whereby a participant from each workshop volunteered to work on a small though significant piece of their own relational trauma or to role play one of their clients offered the richest learning opportunities for the group and myself, and I am grateful to the volunteers. We worked with exploring anger and the long-term impacts of oppression, repression and abuse, integrating healthy aggression, dis-identifying from an oppressor, a suicidal, self-harming client and a client who had been recently bereaved by the suicide of her son. In the last two examples of working with transgenerational trauma and enmeshment in families where suicide is an issue, I recognize the need to be very clear about contracting. From both role played examples it was clear on reflection, that these clients were not yet ready for a contract/working agreement. When clients are so dysregulated, we need to slow down the process until a real working agreement becomes possible, and to make it clear to the client that this is a process that can take time when there is high distress and dysregulation of the nervous system, emotions and identifications.

We also worked in concrete detail with what embodied and authentic letting go can mean in the aftermath of abuse by working with the dilemma close in between integrating present centred support and resources, holding the impulse to revenge to support the integration of natural and healthy aggression/anger, choice and freedom in the present into the future. I am still deeply moved and heartened for our work in Ireland, north and south, by the courage of each person who volunteered to work with the live demonstration, as well as the overall sensitivity of each group holding of the work.

**Three key findings from participants:**

1. Confirming - the workshop was affirming of counsellors where they are. There is a felt need for validation given the rapid changes in the field of trauma work that show the need to work with the body and emotional completion.
2. Request - to write up the workshop and to offer further practical and experiential training including a focus on live situations for therapists and supervisors that tend to be most challenging with embodied activities.
3. Specific areas where practitioners wished for further exploration included - contracting and interrupting - clear contracting and using the contract for leverage in order to help the client hold themselves accountable on what they say they want and what they do/their survival patterns, as well as interrupting the story was an area of particular interest. Demystifying trauma given the pace of change in the field, how to work with freeze/shut down, how to distinguish between shock and developmental trauma, to not just be in my mind/going beyond thinking, working with story, working with 'the past', practical activities for working with hyperarousal and hypo arousal, feeling freer to be myself working with ease and trust, to be compassionate to myself and with others, to leave our own trauma behind, to process emotions, to feel safe within myself, to work with parts, to not abandon myself, working with suicidal client who is very dysregulated and enmeshed/not yet ready to make a contract/working agreement, looking after

ourselves and maintaining development, working with eros, nature, sensuality, sexuality, and spirituality.

## Conclusions

The workshops received very positive feedback overall. As therapists, we need to understand in more depth, the influence of trauma on our own lives in order to live, work, and play well with others and to create a just and sustainable world, to thrive as well as survive. I recognize the need for a clear session and overall process framework within which to contain relational trauma work at individual and wider levels and to inquire on ethical effectiveness of the process. There is also a need for a clear developmental lens to provide a map and guidance for practitioners. I am deeply grateful to all participants in the inquiry and training workshops, and to the IACP for organizing, supporting, and the welcome feedback and resulting conversation on additional possibilities as part of developing an evolving relational movement, locally and internationally.


## Rosie Burrows

Rosie Burrows, PhD. is a Relational Gestalt Psychotherapist, Supervisor, Trainer, Consultant and Researcher. Her focus has been on collective and individual practice to resource groups and individuals experiencing marginalization and trauma. Her Ph'D explored consciousness and leadership. She is offering her own synthesis of Gestalt working with resilience, trauma, creativity, eros, nature and leadership. She is External Examiner at Metanoia Institute, London, and has authored and co-authored research since 1987, contributing to paradigm shifts on how transgenerational trauma is recognized and worked with. She has been a founding member of organisations that work with trauma, resilience, communities and human rights. Her current interests: relational and ethical leadership, resilience, creativity, ecological perspectives, relational trauma healing, exploring our relationship to nature, writing, photography, spirituality and creative connection to who we really are freer from survival strategies. She is an activist engaged with the politics and spirituality of sustainability. She offers trainings and supervision in Ireland and elsewhere.

Contact details: Rosie Burrows
www.rosieburrows.com
drrosieb@gmail.com
+447717103041


## REFERENCES


Beisser, A. (1970) *The paradoxical theory of change*. USA: No Pub.

Fagan, J. and Shepherd, I. (1970). *Gestalt therapy now*. USA: The Gestalt Journal Press.

Buber, M. (1970). *I and thou*. USA: Scribner's Sons.

Burrows, R. (2018). *Gifts from the underworld*. Italy: Gestalt Therapy Book Series.

Clemmens, M. (2011). The Interactive Field: Gestalt therapy as an embodied relational dialogue. In Talia Bar-Yoseph Levine (ed.). *Gestalt Therapy: Advances in Theory and Practice*. New York: Routledge.

Curry, P. (2011). *Ecological Ethics: An Exploration*. UK: Polity.

Danieli, Y. (1998). *International Handbook of Multigenerational Legacies of Trauma*. USA: Springer.

Denham-Vaughan, S. and Chidiac, M. A. (2018). *Ethics, Dialogue and Small Acts of Great Significance*. (In Press).

Fisher, J. (2017). *Healing The Fragmented Selves of Trauma Survivors*. UK: Routledge.

Frank, R. ( 2010). *The First Year And The Rest Of Your Life*. UK: Routledge.

Freire, P. (2014). *Pedagogy of the Oppressed: 30th Anniversary Edition*. London: Bloomsbury.

Heller, L. (2012). *Healing Developmental Trauma*. USA: North Atlantic Books.

Herman, J. L. (1994). *Trauma and Recovery*. USA: Basic Books.

Hoskinson, S. (2014). *In person*. (Unpublished Work) Physiological Phases.

Hübl, T. (2018) *An essential moment: presence and collective trauma*. (Conference Paper). Heiligenfeld Congress, Kairos – Shaping Change, in Bad Kissingen, Germany.

Keenan, B. and Burrows, R. (2010). Extraordinary Skills for Extraordinary Circumstances: Supporting parents, children and caregivers in the transition from armed conflict in the North of Ireland. In J. Melnick & E. C. Nevis *Mending the world: Social Healing interventions by Gestalt practitioners worldwide*. USA: Gestalt Press.

Kepner, J. (1995). *Healing Tasks: Psychotherapy with Adult Survivors of Childhood Abuse*. USA: Gestalt Press.

Lee, R. (1996). *The Voice of Shame*. USA: Gestalt Press.

Levine, P. (2010). *In an Unspoken Voice*. California: North Atlantic Books.

Lewin, K., and Dorwin Cartwright (Ed.) (1951). *Field theory in social science*. New York: Harper.

Lichtenberg, P. (1990). *Communities and Confluence: Undoing the Clench of Oppression*. USA: Gestalt Institute of Cleveland.

McConville, M. (1995). *Adolescence and the Emergent Self*. USA: Gestalt Press.

Neff, K. (2011). *Self Compassion*. USA: Hodder and Staughton.

Nevis, E. (1987). *Organisational Consulting:A Gestalt Approach*. USA: Gestalt Institute of Cleveland.

Perel, E. (2017). *The State Of Affairs: Rethinking Infidelity*. USA: Harper Collins.

Perls, F., Hefferline, R. and Goodman, P. (1951). *Gestalt therapy*. New York: Dell.

Perls, L. (1992). *Living at the Boundary*. USA: Gestalt Journal Press.

Porges, S. (2011). *The Polyvagal Theory: Neurophysiological foundations of emotions, attachment, communication, self-regulation*. UK: Norton Series.

NEXUS (2006.) *"Don't talk to me now, I'm scanning for danger": How your nervous system sabotages your ability to relate*. Online article. Retrieved from: http://stephenporges.com/images/nexus.pdf

Resnick. S. (2018). *Body to Body Intimacy*. UK: Routledge.

Schwartz, R. (2018). *Greater Than The Sum Of Our Parts* [Audible ed.]. USA: Sounds True.

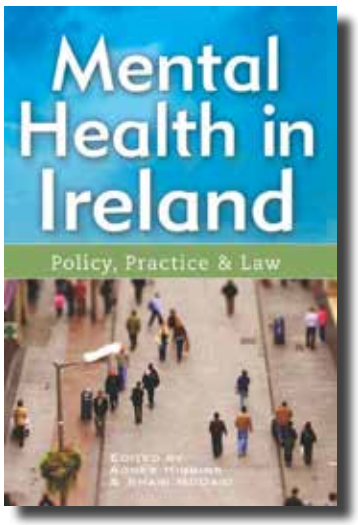
Taylor, M. (2014). *Trauma Therapy and Clinical Practice*. UK: The Open University Press

# Book Review

| | |
|---|---|
| Title: | *Mental Health in Ireland: Policy, Practice and Law.* |
| Edited by: | *Edited by Agnes Higgins and Shari McDaid* |
| Published: | *Gill & MacMillan: Dublin, 2014.* |
| ISBN: | *ISBN:-978-1-78220-590-6* |
| Reviewed by: | *Hugh Morley, Cork Counselling Services* |

Two men in a quarry are cutting stones. One is disillusioned with his limited job, the other whistles as he starts the building of a cathedral. In the same way, when a counsellor focuses on his or her discipline, it is important to have a vision for mental health nationally.

The co-editor and part-author of "Mental Health In Ireland", Dr. Shari McDaid is working hard to assemble such a vision. McDaid is Director of Mental Health Reform, a coalition of organisations (including several counselling organisations) which advocates for reform of the mental health system. She is also a member of Joint Committee on Future of Mental Health Care, chaired by Senator Joan Freeman, Presidential Candidate and founder of Pieta House who name checked McDaid several times during the campaign. This tweaked my interest in this 2014 publication which was not reviewed in these pages, yet which concerns us all.




Co-edited with Dr Agnes Higgins, Professor in Mental Health Nursing at Trinity College Dublin, the text gives an overview of developments in mental health policy, practice and law since the mid-forties. It looks at the current context for care and support and new developments in service delivery. It also addresses to vision and prognosis for mental health into the future.

I came to the book with a critical eye, being a counsellor who is sceptical of the dominance of the medical model. I came with a desire for inspiration, and a wish that "somebody up there" has a clear, motivating and budgeted plan for mental health. I leave the book, still dubious about the workable vision but well informed about the complexity, the medicalisation, the deinstitutionalisation, the hopes, the raw politics, the honest efforts, the social exclusion, the vulnerability, the confusion and the diversity associated with mental health in this country. I also learnt that my counselling responsibilities for vision and change go beyond simply waiting for it.

While the book offers critical perspectives by professors, lecturers, sociologists and psychiatrists which are both well-researched and argued, the counsellor's voice is notably absent. I am most impressed with the input of contributors like Mike Watts and Paddy McGowan who bravely acknowledge knowing the system "from the inside out" and insist (rebelliously) that recovery should be primarily in the hands of those who shape their own journey of discovery and healing through mental and emotional distress. This argument concerns partnership-based support to that self-defined recovery rather than expert-led care. Contributor Dr Lisa Brosnan traces the rise of the empowered service-user's voice, which she claims requires strong advocacy and funding, yet she bemoans the lack of implementation of this vision to date.

The book makes clear that the profession of psychiatry controls mental health, and at the same time bemoans that "psychiatry is woefully out of date, bound up in a germ theory of disease that has long outlived its relevance .. while too often there is little in the way of a trusting, therapeutic relationship with the aim of addressing the underlying causes" (Dr Ivor Brown). How depressing for a counsellor to read!

Professor David Healy challenges the dominance of the pharmaceutical industry in psychiatry.

Brendan Kennelly of NUI Galway takes a recent budgetary report to show that just 5% of health expenditure goes on mental health of which 25% goes to medications. It's a clear rejection of the theory of psychosomatic illness or the holistic approach. Kennelly advocates that the economics of mental health must include the lost contribution of those who cannot work due to mental health difficulties.

The book has hope for the integrated approach. Dr Ed Molloy, Chairman of Mental Health Reform, in his foreword, states that "for all forms of emotional or mental distress .. the single most efficacious and indispensable response is to listen with respect to the person .. creating a context in which the person feels genuinely respected as a person .. without this element, the effect of all other therapies, cognitive, chemical or other that might be applied will be blunted, neutralised or even detrimental". Counselling and psychotherapy surely have their place in mental health in Ireland, if not adequately acknowledged in this very readable book of the same title.