From the Editor:

Dear Colleagues,

Welcome to the summer edition of Eisteach.

At a time of year when our thoughts turn to holidays, time-out and relaxation it seems appropriate to take a look at some of the supports and coping strategies that therapists use to deal with the challenges in their work.

The connecting frame here is promoting care for the carers; developing resilience, awareness and restorative practices that will support us in working with all the complexity of human distress. In a world that encourages and supports 24-hour availability through technology the discipline and need to switch off is ever more urgent. How do we model this with clients? When a culture of busyness is endemic it can feel like constantly moving against the tide.

The practice of mindfulness has mushroomed over the past couple of years with a proliferation of workshops, classes and training courses now available. What is the appeal? Dr. Antony Sharkey offers us a brief history of this phenomenon which places its popularity in historical context and gives us an insight into how mindfulness has moved from the margins into the mainstream. Our second piece on mindfulness is research-based and attempts to address the question of efficacy; does it work?

There is now a considerable weight of evidence which suggests that individuals who have higher levels of mindfulness, have increased performance in attention and cognitive ability and lower levels of perceived stress. The sample size in the submission of Hazel Morgan and Chris Gibbons, was relatively large, at 521, recruited through Facebook but they caution that sampling was voluntary and likely to attract a higher percentage of people who were already pre-disposed to mindfulness. They are not measuring whether respondents have a formal mindfulness practice per se but the extent *'to which the individual shows receptive awareness and attention to the present'*. The results are interesting.

Eoin O'Shea takes a broader examination of how counsellors and psychotherapists manage anxieties and set boundaries to be effective in the work. All respondents in this research were recruited through the IACP database and the results are presented here as a thematic analysis which indicates the range and depth of strategies used by members including; the formal, such as group supervision, personal therapy and CPD and the less formal such as; peer support, walking the dog, yoga, skiing and dance. The researcher indicates that further studies employing a similar methodology but focusing in on specific self-care strategies may be useful.

Finally, Ann McDonald takes us into the arena of group supervision as an environment ideal for promoting cultural competency in the work. Ireland has moved from being essentially a monocultural nation to one that is increasingly diverse in a relatively short space of time and this brings a challenge to our own cultural bias and need for self-reflection.

May you be happy.

May you be wise.

May the summer bring you all you need and deserve.

Aine Egan MIACP

Facilitating Cultural Competency through Group Supervision

by Ann McDonald

Introduction

Group supervision is profoundly more affecting and emotional than might be expected. On paper, it can have a flatness that belies its necessity to unsettle. With its centrality of relationship, multiple tasks and functions, and its unremitting insistence on making the implicit explicit, group supervision unavoidably perturbs. In the agreed joint service of the client, and the unique development and flourishing of each supervisee, it makes demands on the supervisor and supervisees for reflexivity, reflection and critical thinking as vital to the group's ongoing learning and change. In this article, I focus on facilitating cultural competency as part of the educative/formative (Proctor,2000) component of group supervision.

What is Culture?

Culture as a social construct is complex and multifaceted. It includes but is not limited to tenets such as ethnicity, race, gender, religion, social class and sexuality (Hardy & Laszloffy, 1995). Falicov usefully talks about culture as "those sets of world views and adaptive behaviours derived from simultaneous membership in a variety of contexts…religious background, nationality and ethnicity, social class, gender-related experiences, minority status, occupation…"(1988, p. 337).

The acronym of the social GRRAACCEESS: gender, race, religion, age, ability/disability, class, culture, ethnicity, education, sexuality and spirituality (Roper-Hall, 1993) is an accessible way to generate reflection on different aspects of culture which 'become foreground or background at different times' (Burnham & Harris, 2002). Use of the frame of the social GRRAACCEESS (Burnham et al, 2008) forms a central tenet of my own training in facilitating cultural competency as an ongoing process (and not just a training event), that can be plugged into the formative layers and levels of group supervision.

Facilitating cultural competency is more about process than content (Burnham & Harris, 2002). It requires the fostering of supervisees' reflexivity i.e. a folding inward to feel their feelings, question their questions, think about their thinking, incorporating reflection, critical thinking, self-awareness and monitoring for the purpose of recalibrating their work, particularly in the therapist-client system (Burnham, 1993, 2005; Hoffman, 1992) in relation to cultural sensitivity and competency (Hardy & Laszloffy, 1995; Divac & Heaphy, 2005; McGoldrick et al, 1986). Such reflexive inquiry and consciousness (Oliver, 2005) opens the space for supervisees to connect into and affectively understand their own 'ecological niche' (Falicov, 1988; 1995) and cultural identity. Here the supervisor aims to:

- Create through the group supervisory relationship the necessary receptivity and openness for the development of the supervisees' cultural competency in relation to

themselves, each other and their clients, building, for example, what McGoldrick et al (1996) call a 'road map' for understanding their clients' ethnicity.

- Facilitate supervisees' reflexive capacities and understanding of the complexities of their own cultural self and identities over time. This includes becoming aware of themselves culturally as: located in different aspects of culture, changing in relation to aspects of culture over time, participating simultaneously in different cultural contexts, foregrounding different contexts (e.g. gender, age, race) at different times (Burnham & Harris, 2002; Divac & Heaphy, 2005.
- Give space to critically explore the values underpinning their own cultural scripts which they bring into the therapy encounter. This is integral to a reflexive stance and a systemic orientation which holds that change in one person in an emotional system can bring about change in others (Watzlawick et al, 1974).
- Recognise that all members of the same ethnic group are not the same (particularly pertinent in group supervision).
- Increase awareness of social difference and of practices of power, oppression, marginalisation, racism and injustice (Divac & Heaphy, 2005; Waldergrave, 1990) in a way that heightens supervisees' consciousness of their own power as therapists (Burnham et al, 2008). To do this with congruence, the supervisor must be upfront about the power and authority invested in his/her supervisory role (Bernard & Goodyear, 1992). For Jones, pretending otherwise is an abuse of power (1993).
- Help supervisees to keep in mind that emotions, thoughts, behaviours, and events can have different meanings in different cultures, at different times, and between different people in similar cultures (Burnham & Harris, 2002). Examples of these differences include: showing and 'doing' emotion, constructs of gender, family, the self, ageing, addiction and rituals of death, dying and bereavement (Murray-Parkes, 1997).

How does the Supervisor achieve these aims?

To reflexively facilitate contexts in which social difference might be considered, the supervisor must be able to use the group and him/herself in ways that hold both rigour and imagination (Bateson, 1972), safety and risk (Mason, 1993). There is an ethical responsibility on the supervisor to build up his/her own capacities and expertise so that s/he can generate therapists' reflexive consciousness and understanding of their cultural identity (Hardy & Laszloffy, 1995; Inman, 2006). Down (2000) believes that the supervisor must go through his/her own experiential and reflexive trajectory prior to facilitating a similar process for supervisees. Without such a commitment to his/her own continuing process of cultural reflexivity, the supervisor is blind to the effect of his/her own cultural values and beliefs on the supervision process.

The relationship of supervisor and supervisee/s is core – at the very heart of supervision (Holloway, 1995). The supervisor must take responsibility for his/her part in creating a strong working alliance (Page & Wosket, 1994, Crockett, 2002), and a safe enough place to belong (Wilson, 1993). If the emancipatory discourse and reflexive inquiry is to emerge, the supervisory relationship must be able to mirror, guide and contain it, itself freeing, developing and capable of being the object of its own enquiry (Oliver, 2005).

Processes which facilitate Cultural Competency

Along with an integrated use of the lens of the social GRRAACCEESS (Roper-Hall, 1993), ways that the supervisor can promote cultural competence as part of group supervision include:

- The group itself - its stages and dynamics, conscious and unconscious processes (Bion, 1961; Tuckman, 1965, Schultz, 1967; Proctor, 2000) - is central to enhancing cultural literacy in group supervision (Burnham & Harris, 2002). Using the here-and –now immediacy of the group to explore gender, for example, can expose the mechanics of power and privilege, projection and internalised oppression at a felt level.

Mason's (1993, 2002, 2005) ideas of safe uncertainty, authoritative doubt and relational risk taking, and his questions: 'what are we moving away from? How can we begin to talk about that?' can open the necessary space for the unsaid and the unsayable. Hawkins & Shohet

(2002) suggested statements: *'What I think we avoid talking about here is; What I hold back on saying here is…'* are similarly useful. In this context, use of the the metaphor of the fifth province provides an imaginative, containing and liberating dialogical space (Kearney et al, 1988; McCarthy & Byrne, 1995; Young, 2000).

Another useful lens here is isomorphism as parallel process i.e. mirroring and the tendency of patterns to repeat across systems (Du Laing 1991). The supervisory relationship can reflect or mirror relationship dynamics (Searles 1955; Doehrman, 1976; Mattinson,1981; Morrissey & Tribe, 2001) and patterns (Carr,2012):

- within the client system
- between the client and therapist
- within the organisation
- at a social, political, cultural level

- The cultural genogram (Hardy & Laszloffy, 1995). This allows supervisees to map and affectively engage with their own cultural stories and their meaning over time. Exploring themes of belonging, inclusion, marginalisation, pride and shame can begin a process of understanding the history of their own cultural identity which is key to cultural competency.
- The reflecting formats and reflexive practices of systemic supervision as gateways to the expansion of reflexive capabilities in the process of supervisees' ongoing development as culturally competent practitioners (McDonald, 2010). The use of diverse, multi-layered activities such as internalized other interviewing, reflecting teams, role-play and sculpting allows space for:
  - movement, meta-positioning, multiple descriptions, punctuations, meanings and perspectives (Andersen, 1991; Gorrell-Barnes et al, 2000)
  - rehearsing, inviting 'clumsiness' (Burnham et al, 2008), talking about talking, experimenting and practicing to stretch 'the performance of practice' (Wilson, 2007)
  - the unfolding of internal and external dialogue, along with the emergence of the 'not yet heard and not yet thought of ' (Andersen, 1993, p.303)
  - the expansion and deconstruction of chronological time, bridging and extending present learning into reflexive practices outside of the current episode of supervision (Burck & Campbell, 2002)
- **Stories and story-telling** as a reflexive site in the process of learning to learn cultural competency can:
  - cut across the boundaries of time (Roberts, 1994, 2002).
  - open up future reflexive learning, not least space for supervisees to reflect on the stories they carry with them into the therapy and supervision contexts (Burnham et al, 2008). In this way, there can be a loosening of binding stories (Kearney, 2002) and a creating of preferred stories (White, 2000)
  - provide more personally linked, and memorable learning (Wacker & Silverman, 2003), connecting the supervisee to themselves and each other
  - help supervisees to focus on lived experiences, particularly, in relation to developing an emotional understanding of their own ecological niche (Falicov, 1988) and cultural values (Hardy & Laszloffy, 1995 ; Laszloffy & Hardy, 2000; Divac & Heaphy, 2005)
  - be put into the centre of Kolb's (1984) cycle of experiential learning with supervisees using the process to best suit the way that they learn, and experiment with new ways of learning (Burnham et al, 2008)
  - bridge all learning styles (Kolb, 1984;Agget,2004). It allows supervisees, for example, to pick up information visually by creating images; through their hearing, and also viscerally, emotionally, cognitively, reflectively, spiritually (Wacker & Silverman, 2003)
  - invite reflection in and on (Schon, 1983,1987) their own and each other's stories, connecting the teller to themselves and to others

Conclusion

For me, group supervision is an intentionally collaborative (Hawes, 1993; Anderson & Swim, 1993) relationship where the supervisor and supervisees, in the context of the group process, co-create a reflexive site of learning, imagination, possibility and fifth province like spaciousness(McCarthy & Byrne, 1995) to jointly facilitate the responsible care (FTAI, 2005) and well-being of the client and the

unique ongoing development of each supervisee.

Facilitating cultural competency so that supervisees can reflect on their own cultural stories is integral to a reflexive, questioning stance in which the supervisor and supervisees enagage in transformative learning and remain open to change as the only constant (Hoffman, 1992; Burnham, 2005). Exploring issues of power and aspects of the cultural self including gender, race, religion, age, education, class, sexuality calls on supervisees to ask of themselves and each other: What does my practice stand for?

With regard to race, Kiberd (1995) wonders if Ireland came to function as England's unconscious, with the suppressed, unbearable parts of themselves attributed to the Irish. As supervisors, we need to face our own cultural projections and prejudices in relation to all aspects of culture, and in so doing increase our capacity to facilitate cultural competency. In a progressively multi-cultural Irish society, this is an ethical imperative (Swim et al, 2001).

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The Mindfulness Phenomenon: A Brief History

by Dr. Antony Sharkey

Introduction

In 1996 when I first started to run mindfulness courses for people who were suffering from medical problems it was a relatively unknown psychotherapeutic or medical intervention. How things have changed. Today there is a keen openness to know more and an eagerness to learn how to integrate mindfulness practice into daily lives to support resilience, awareness and all the qualities we would consider essential to the 'good life'. This article attempts a brief outline of the history of the phenomenon of mindfulness and offers a context for its appeal to the helping professions and the general public.

This is a story of the vision of some extraordinary people as well as a story of the extraordinary times that we have lived through over the last twenty years. I offer this short history from my personal perspective as a medical doctor and someone who has had a daily meditation practice of one - two hours a day for the last 30 years and as an active mindfulness teacher with a keen interest in the ongoing unfoldment of human evolution.

Why has mindfulness emerged from relative obscurity in such a short time period?

New ideas do not usually get accepted into mainstream culture and especially into professional communities that quickly. Why has mindfulness become such a popular social trend when there are many other useful and proven approaches to health and well-being? Today, mainstream psychiatric and psychology journals report evidence-based research from conventional medicine, healthcare, cognitive science and affective neuroscience demonstrating the benefits of mindfulness.

Mindfulness courses are now offered specifically for doctors in the Irish College of General Physicians. Mindfulness as an effective ingredient in the prevention of relapse in chronic depression is now fully endorsed by the National Health Service in the UK. In January 2014, 'Time' magazine featured 'The Mindfulness Revolution' on its front cover.

Where did mindfulness begin?

The story begins with some cultural cross-pollination between East and West in the mid to late-nineteenth century. Philosophies such as those contained in ancient Hindu Vedic texts like the Upanishads and Bhagavad Gita, and Buddhist texts came to the attention of many writers and philosophers in the West including Ralph Waldo Emerson and William James in America, W.B. Yeats and friends (the Golden Dawn movement) in

Ireland and the Transcendentalists in the UK and Europe.

These philosophies also came to the attention of the eminent psychologist Carl Jung who brought a more spiritualised perspective to the work of Freud. In the sciences, the great physicists of the early and mid-twentieth century including Einstein, Schopenhauer, Schrodinger and Pauli were as interested in the Eastern philosophical texts and principles as they were in physics. They highlighted the importance of the influence of human observation to scientific endeavour and their ideas set the theoretical ground work for evidence-based approaches to research

What *exactly* is mindfulness?

With the growing pervasiveness of the phenomenon, there are many different interpretations as to what mindfulness means and what it is means to practice same. In order to avoid any confusion, I want to spell out exactly what mindfulness is, from my perspective so that at least we know that we are talking about the same thing.

> Mindfulness is the same as Meditation. They are two sides of the same coin.
>
> Meditation is a set of skills you formally practice and learn on a meditation seat.
>
> Mindfulness is practicing these same skills when you are off the seat and getting on with daily life.

I think of the relationship in terms of tennis. Professional tennis players spend hours practicing with a tennis ball machine. With the machine the player can focus on one thing - hitting the ball. Other potentially distracting factors have been removed as much as possible. Practicing meditation is the same in principle. There is one thing to focus on - usually attention is given to some sensation in the body e.g. the breath. All potentially distracting factors have been removed. Similarly with mindfulness, there is still the same focus of bringing attention to a sensation in the body but now there is 'daily life' to contend with.

How to explain the mindfulness phenomenon?

To more fully understand the mindfulness phenomenon I'm going to use sociologist Malcolm Gladwell's concept of "The Tipping Point" (*'The Tipping Point: How Little Things Can Make a Big Difference'* (2000)) as a background organising model.

Gladwell defines a "Tipping Point" as "the moment of critical mass, the threshold, the boiling point". He uses the overarching metaphor of an "epidemic" as a visualisation of how social trends spread. He suggests that ideas and products and messages and behaviours spread like viruses do. Gladwell puts the spread of epidemics down to the "Three rules of epidemics" as an explanation for why tipping points happen.

Rule One: <u>The Law of the Few</u>

"The Law of the Few", or, as Gladwell states, "The success of any kind of social epidemic is heavily dependent on the involvement of people with a particular and rare set of social gifts.".

These "Few" create and perpetuate trends. When an idea comes to the attention of one or more of these special classes of people, the likelihood of the idea tipping into an epidemic increases. These people are described in the following ways:

Connectors

These are the people in a community who know large numbers of people and who are in the habit of making introductions. A connector is essentially the social equivalent of a computer network hub. They usually know people across an array of social, cultural, professional, and economic circles. They are "a handful of people with a truly extraordinary knack of making friends and acquaintances" according to Gladwell.

Mavens

A maven is a trusted expert in a particular field who seeks to pass knowledge on to others. The word maven is Hebrew, meaning "one who understands". These are "people we rely upon to connect us with new information". Mavens start "word-of-mouth epidemics" due to their knowledge, social skills, and ability to communicate.

Salesmen

These are "persuaders", charismatic people with powerful negotiation skills. They tend to have an indefinable trait that goes beyond what they say, which makes others want to agree with them. All of the individuals involved in the mindfulness phenomenon fall into one of these three classes of people.

Rule Two: <u>The Stickiness Factor</u>

The Stickiness Factor is a law about the actual informational content and packaging of a message. The "Few" can certainly help a message spread, but if the

message is not worth spreading, then it is doomed to failure. The stickiness factor says that messages must have certain characteristics which causes them to remain active in the recipients' minds. An idea is "sticky" if it is:

- Clear and easy to understand
- Concrete and practically orientated
- Credible and evidence-based
- Emotionally appealing and based on a story or narrative

All of the ideas embodied in the mindfulness phenomenon share at least one of these characteristics.

Rule Three: Cultural and environmental context

The population must be prone to these ideas. This is fairly self-explanatory yet the elements that make up a culture and environment are a little bit more difficult to pin down. I suggest these three rules go some way to explaining where we are today and I will draw on Gladwell's theory to contextualise the growth of the mindfulness phenomenon.

The Relaxation Response

In 1956, Dr. Hans Selye published 'The Stress of Life' and is credited with coining the term 'Stress Response'. He believed that;

> *'Stress in health and disease is medically, sociologically and philosophically the most meaningful subject for humanity that I can think of'* (Szabo, Tache, Somoygi, 2012)

In the 1970's, the first scientific research on the 'new' ancient meditation phenomenon was performed by Dr. Herbert Benson at Harvard University. Benson realised that meditation produced the opposite of the stress response and coined his famous term 'The Relaxation Response' in a book that sold widely and spawned an interest in the subject. However, the actual practice that Benson suggested was not meditation per se. The 'Relaxation Response' happened if you systematically went through your body and briefly contracted the main muscle groups. In contrast, in meditation you do not do attempt to do anything with your body except to keep it as non-moving as possible. Although the technique worked, it tended to be cumbersome to do and was unappealing to many.

So despite promising early clinical findings, 'meditation' in the form of the Relaxation Response didn't stick with the medical or psychotherapeutic professions at that time. It wasn't until the 1980's when a number of factors coincided that it really began to spread.

"The Cultural Creatives"

In the late 1980's there was a shift in the cultural climate and a new group of people became identified called the 'Cultural Creatives'. The term was coined by Paul H. Ray, a sociologist and Sherry Ruth Anderson, a psychologist in the 1988 publication 'The Cultural Creatives: How 50 Million People Are Changing the World'.

This social phenomenon comprised ordinary people from a variety of cultural backgrounds who identified themselves as 'spiritual' but didn't align themselves with any traditional Western religion and was estimated to include up to one-fifth of the population of the US at the time. They looked for answers to their physical and mental health concerns which didn't necessarily include standard Western medication and surgical intervention.

In parallel, several meditation retreat centres were being established in the States. The founders were either traditional Eastern monks or Americans who had spent some time practicing in the East and were inspired to return home and practice. These Americans were talented teachers, business people and incisive writers and they had "sticky" ideas. Two such writers were Jack Kornfield and Joseph Goldstein. In 1976 they opened the Insight Meditation Retreat Centre in Barre, Massachusetts and it was here that Jon Kabbat-Zinn was introduced to meditation.

The Emergence of New Clinical Approaches

In the 1970's - 1980's there emerged new psychotherapeutic approaches which promised to treat psychological suffering more quickly than traditional psychoanalysis, especially the suffering associated with depression. One such approach was Cognitive Behaviour Therapy, pioneered by Aaron T. Beck, psychiatrist at the University of Pennsylvania. Beck was one of the Few. He is described as one of the "five most influential psychotherapists of all time" by The American Psychologist in July 1989.

Becks main 'sticky' idea about depression

1. *Negative thinking processes are at the root of depressive illness*

   Prior to Beck most clinicians assumed that the negative thinking associated with

depression stemmed from unresolved inter-psychic conflict or unbalanced brain chemistry. In practice this meant that clinicians treated the underlying cause (psychotherapeutically or pharmacologically) with the hope that the associated negative thinking would get better. But for Beck, negative thinking was the primary problem to be addressed. He encouraged his patients to *practice awareness outside of the therapy sessions*, to "catch" their "automatic thoughts" and bring them in for investigation.

Beck initiated the idea of standardisation or 'measurement' (Beck Depression Inventory, Beck Hopelessness Scale, Beck Scale for Suicidal Ideation and the Beck Anxiety Inventory) of depression so that the CBT processes and outcomes could be compared against the standard existing treatment of antidepressant medication. This explicitly evidence-based approach was 'sticky' to the logic and reason of many psychotherapists and other clinicians.

Evidence-based work of Jon Kabbat-Zinn

In 1979 a course called the *'Stress Reduction and Relaxation Program'* began in the Department of Medicine in the University of Massachusetts run by Jon Kabbat-Zinn. This course eventually became known as mindfulness-Based Stress Reduction or MBSR. This was an eight week structured program teaching mindfulness practice to patients suffering from the stress of chronic physical illness.

He ran randomised controlled trials and reported his results in various standard medical journals. He also wrote the book *'Full Catastrophe Living : Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness'* (1990) which was a summary of his course material and the background philosophy. He conclusively demonstrated that mindfulness practice worked to reduce pain and suffering when nothing else available was working.

I suggest that the primary reason Jon Kabbat- Zinn's course was 'sticky' was that he taught patients a new approach to deal with their pain: 'Being with' rather than the suppression or expression cycle.

'Being with'

Kabbat-Zinn taught the traditional Buddhist approach to pain which is called the *'Being With' relationship*. It is the heart and core of mindfulness practice. Pain, or any uncomfortable experience is allowed to 'be there'. All that is required is that its presence is registered in awareness. No attempt is made to control or change anything. Paradoxically, what happens next when "Being With" is practiced is that the pain often changes character and sometimes disappears.

The 'Being with' approach to pain is a nuanced counterintuitive approach to pain and can be easily misunderstood as a passive resignation. To be effective it required focused tuition and required conscious commitment and a deliberate deployment of energy. It needed regular and consistent practice to work.

Kabbat-Zinn was masterful at communicating the nuances and the course was intensely practice oriented. Most of the course was done at home using supportive audios and participants were required to meditate for one hour every day. This meant that through their own personal practice they could find out *directly for themselves* what could happen with this new approach. It would work for them or not, and it did indeed work for many of them. What he was offering did gain ground among some in the medical profession, myself included but I don't think that his course was a tipping point. The epidemic was brewing but it was still localised.

The Tipping Point

In 1992 one of the most popular TV networks in the US, PBS broadcast a documentary series called *'Healing and the Mind'* with Bill Moyers, a high profile and respected journalist. He was one of the *'Few'*. The documentary was an in-depth look at workable alternatives to traditional medical treatments which included the MBSR course. This could have lain forgotten in the archives but with the emergence of Google (1998) and YouTube, the film was uploaded and has been viewed over 40 million times since then.

Following this, the tipping point for the mindfulness phenomenon, I would suggest, came about in 2001 when *'Mindfulness-Based Cognitive Therapy for Depression'* 2001, Segal, Williams, Teasdale was published. The books appearance unleashed an avalanche of interest, clinical practice, and research throughout the world. The authors were credible PhD professional researchers and CBT clinicians.

In 1992, Segal was funded to investigate alternatives to medicating solutions for clinical depression. He and his colleagues participated in the MBSR course. The CBT model was eventually expanded to integrate the MBSR approach, which they called Mindfulness Based Cognitive Therapy. They conclusively demonstrated that MBCT was more effective than CBT alone (Segal, 2001).

Two reasons why the book is 'Sticky'

1. *Their evidence-based research methodology had a transparency to it.*

   This is my own very personal sense and may not be shared by everybody. I usually read 'evidence-based' material cautiously. I am aware that there is often a hidden agenda, usually to convince me that the product or approach works and therefore to buy it. 'Does MBCT work?' is the chapter of the book outlining research methodology and findings. It is conversational in style and non - obscure. There seems to be no hidden agenda. I could wholeheartedly accept, agree and embrace the evidence that that they presented. To me and to other clinicians it was "sticky".

2. *The 'Way of Being' of the mindfulness teacher is vital*

   The authors repeatedly observe that the mindfulness teacher's way of being with the course participants is central to success. The teachers have to become a living embodiment of the practice and share from this place. This is not a new observation. Similar qualities are highlighted by Duncan & Millar (2004) in 'The Heroic Client' and others. However, this book is an eloquent exposition of the practice.

   Teachers are called "instructors" and teach by using enquiry, they do not "fix problems". They communicate "Loving Kindness" and "Compassion" non - verbally. Participants are known as guests to be treated with warm hospitality. In essence, the course material only "sticks" with participants if the teachers have a meditation practice of their own so that they can authentically 'Be With' the participants in the same way that the participants have to 'Be With' their own pain.

Conclusion

The mindfulness story continues to unfold and we professionals find ourselves in the middle of it, as people search for solutions to problems that are as old as time itself. While mindfulness is considered a modern phenomenon, its roots lie in philosophies and practices that are thousands of years old. I suggest these teachings survived this long because they inspired the human heart and spirit to take effective action to move beyond apparent limitation.

More recently these same philosophies and practices have been rigorously researched and have convincingly proven their worth in alleviating the pain and suffering associated with some of our most intractable of human problems. To become an active participant in the unfolding story is simple; all that is required is to graciously accept mindfulness as gift and to diligently practice so that one can be even better at "Being With" one's own and one's clients suffering.

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Mindfulness – As a Coping Strategy

by Dr. Chris Gibbons & Hazel Morgan

Introduction

Mindfulness has been described as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally." (Kabat-Zinn, 1994, p. 4). It is a technique where one focuses on the present, gradually letting go of thoughts about the past or the future. Mindfulness is becoming more popular as a technique to help people manage stress. Research suggests, for example, that individuals who have higher levels of mindfulness have increased performance in attention and cognitive flexibility (Moore & Malinowski, 2009); report higher levels of relationship satisfaction (Kozlowski, 2013), and lower levels of perceived stress (Roeser et al., 2013). As a therapeutic technique mindfulness has been shown to be effective through, for example, Mindfulness Based Cognitive Therapy and Mindfulness-Based Stress Reduction (Nevanper, 2012).

Aims of Research

The argument offered here is that mindfulness is likely to act in the same way as other types of coping i.e. that it is not a 'silver bullet' and that it is likely to be a preferred strategy used by some and not others. The aim of this research therefore is to compare the impact of mindfulness compared to other types of coping on well-being - operationalised as happiness, self-compassion and stress.

Self-compassion refers to the extent to which one is forgiving of one's failures and inadequacies and it has been found to be positively associated to mindfulness. Self-compassion has also been associated with optimism and self-efficacy (Alberts et al., 2014), and to increases in self-esteem and happiness (Umphrey & Sherblom, 2014).

What do we mean by Coping? Lazarus and Folkman (1984) defined coping as:

'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (Lazarus and Folkman, 1984, p. 141).

The research in this area has broadly focused on problem and emotion based coping. Both can be used in effective and ineffective ways but problem-based coping tends to be more goal-orientated and associated with a more positive outcome. It involves actively attempting to overcome the issue that is causing distress, such as making a tasks list, seeking support, planning and executing that plan. Those who used problem-focused coping strategies are significantly more likely to report lower emotional and behavioural difficulties compared to those who used emotion-focused coping (Folkman, 1997).

Emotion-focused coping is commonly used when a distressing problem is perceived as outside the person's control (Lazarus & Folkman, 1984). Both active and avoidant coping strategies can be used to manage one's emotional reaction to stress (Green, Choi, & Kane, 2010). Emotion-focused coping strategies can include positive reframing, the use of emotional or instrumental support, humour and acceptance. (Carver, 1997).

Avoidance-based coping refers to attempts to direct attention away from the emotional distress.

Typical strategies can include: denial, self-distraction, behavioural disengagement, venting, self-blame, and substance use and they are commonly associated with poorer psychological outcomes (Gibbons, Dempster & Moutray 2009). Avoidance-based coping is ineffective coping and even if it is used only occasionally it was been found to be a strong predictor of adverse well-being (Gibbons, 2010).

Mindfulness is one of a range of strategies that has been found to be helpful in managing stress. Other powerful coping resources include support (Gibbons, 2010 and Taylor et al., 2004), pursuing optimism (Seligman, 2002), developing a sense of 'flow' (Csikszentmihalyi, 2000) and developing a sense of control (e.g. Rotter, 1966 & Gibbons 2010, 2012). No one strategy or resource is a 'silver bullet', rather the focus should be on using a range of strategies and to identify those that match with one's preference. Gibbons, Dempster and Moutray (2010) found, for example, that support was not equally effective across samples of nursing and psychology students but effective most for those who had a preference for it and those with this preference were most distressed when expected support was not available. Control is normally construed as an effective strategy but Gibbons (2010) found that those high in control were most distressed when they faced demands where they could not draw on this preferred coping style - those high in control were more distressed than those low in control! This highlights the point that those who cope well tend not just to have a preferred style of coping but they are adaptable and able to draw on a range of coping resources.

Methodology

The sample consisted of 521 participants; 76 male (14.6%) and 419 female (80.4%) and the age range was 18 to 75. Participants were invited to fill out an online questionnaire through Facebook via a personal account. A volunteer sample was used along with snowball sampling.

A survey method and correlational design was used with the predictor variables being age, gender, mindfulness and problem- and emotion-based coping. The outcome measures were Self-compassion, happiness and general psychological well-being as measured by the General Health Questionnaire. The coping inventory measured fourteen types of coping drawn from Carver's (1997) coping scale. The mean Cronbach's alpha coefficient has been reported at .89 for this scale (Carver, 1997).

The Mindful Attention Awareness Scale is a 15-item scale that measures open or receptive awareness and attention to the present - a core characteristic of dispositional mindfulness. The Cronbach's alpha has been consistently reported to be above .80 (Brown et al., 2011). This study then is not measuring if respondents formally practice mindfulness, rather 'mindfulness' in this context refers to the extent to which the individual shows receptive awareness and attention to the present.

The Self-Compassion Scale (Neff, 2003) is a 26-item scale. It was only the Self-Kindness sub-scale that is the focus of this research. The Cronbach's alpha coefficient has been reported at .92 (Neff, 2003).

The General Health Questionnaire (Goldberg, 1972).

The 12 item version of the General Health Questionnaire was used to measure transitory distress. Each of the twelve items have a four response option and Goldberg's scoring rubric was used to measure the extent to which one was at risk of developing a stress-related illness. Cronbach's alpha coefficient has been reported at .88 (Picardi, Abeni & Pasquini, 2001).

Happiness was measured by asking respondents to rate how happy they were on a scale from 1-10, 1 being 'not at all happy' and 10 'very happy' Deiner (2000). This is a one item measure and research has shown itself to be a valid predictor of subjective well-being (Deiner, 2000).

Results

See Figure 1.

Discussion

Happiness

The first model explained 37.4% of the variance in happiness scores. Mindfulness was the strongest predictor - as it increased so did happiness. This corresponds with the earlier findings of Kozlowski (2013) and Roeser et al (2013) on the association between mindfulness and relationship satisfaction and stress management. Self-blame was negatively related to happiness - the more one used this type of coping the less happy one was. However, one has to caution against necessarily assuming self-blame is mainly or always an example of poor coping. Other research has found

Figure 1: Results

Final regression model - happiness

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	3.552	.486		7.302	.000
	Mindfulness	.187	.024	.326	7.865	.0001
	Substance use	-.095	.039	-.094	-2.437	.015
	Emotional support	.073	.033	.080	2.188	.029
	Behavioural disengagement	-.176	.051	-.147	-3.427	.001
	Self-blame	-.213	.041	-.235	-5.130	.0001

R squared .381, Adjusted R squared .374

Final regression model with Self-kindness (Self-compassion)

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	5.858	1.116		5.247	.000
	Age	.023	.011	.068	2.212	.027
	Mindfulness	.716	.052	.497	13.835	.0001
	Emotional support	.229	.073	.101	3.158	.002
	Behavioural disengagement	-.233	.106	-.076	-2.192	.029
	Acceptance	.230	.091	.084	2.526	.012
	Self-blame	-.629	.086	-.278	-7.345	.0001

R squared .601 Adjusted R squared .595

Final regression model with GHQ

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.192	1.120		1.064	.288
	Mindfulness	-.208	.059	-.158	-3.539	.0001
	Self-distraction	.274	.092	.123	2.978	.003
	Denial	.285	.121	.101	2.364	.019
	Behavioural disengagement	.590	.128	.217	4.605	.0001
	Positive reframing	-.187	.090	-.084	-2.076	.039
	Self-blame	.514	.097	.253	5.295	.0001

R squared .398, Adjusted R squared .389

that those high in self-blame are also likely to score high on diligence, to see a task through to its completion and to have a tendency to take responsibility for large areas of work. For those with this quality who work in human-service professions (e.g. teaching, nursing, retail etc.) they are more likely to be valued and rated as very competent (Gibbons, 1998, 2008), but, at the individual level, it may well add to their perception of stress. Another way of viewing this is that a perception of some level of stress is necessary to perform at the optimum. This is referred to as 'eustress' and where 'self-blame' adds to one's performance it is likely to be because it increases the perception of eustress (Gibbons, 2008).

The more one disengages from others the less happy one is. This concurs with earlier research with this type of coping broadly being equivalent to Maslach's (1996) measure of depersonalization (a component of burn-out). Essentially, the more one feels disengaged, alienated and removed from those one works with the lower are the scores on work satisfaction and happiness. This study did not limit respondents to their experience of this type of coping in a work context but to life in general. This suggests that isolation and disengagement are important indicators that one is not coping and not happy and should be seen as a signal for remedial action rather than as a tendency to continue using this strategy.

Consistent with this finding is that as emotional support increased so did happiness. While the Beta value is small, support contributed to the final model and it is important to remember that of the seventeen variables measured - fourteen types of coping, mindfulness, age and gender - it is those in the final model that are the key factors. As expected, as substance use increased happiness declined. This suggests that it is ineffective coping and it is likely to be used as a form of avoidance in the same way disengagement may be an attempt to avoid other perceived stressors.

Self-compassion

The final model explained 59.5% of the variance in scores on self-compassion. Again the variable that explained the most variance was mindfulness. As it increased so did self-compassion. Mindfulness is clearly very effective at nurturing this quality or vice versa.

The more one used self-blame the lower was the score on self-

compassion. It makes sense that the more one is critical of oneself (self-blame) the less likely one will simultaneously show self-compassion. To achieve in one's endeavours, however, one has to strike a balance between being critical of one's standards and efforts while simultaneously being willing to forgive one's own mistakes. As has been mentioned, those high in self-blame do tend to achieve to high standards but being too self-critical and taking on too much responsibility (self-blame), adversely affects well-being and, in the long-term, performance. It is a game of fine margins to strike this balance!

As support and acceptance increased so did self-compassion, and behaviour disengagement negatively related to self-compassion – that is to say that as one becomes disengaged from others one runs the risk of being less in tune with one's own emotional needs (as indicated by measures on the self-compassion scale).

General Health Questionnaire (GHQ)

The greater the scores on GHQ the greater is the risk of developing a stress-related illness. This model explained 38.9% of the variance in GHQ scores. The largest variance was explained by the self-blame coping strategy - the more one used self-blame the greater was the risk of developing a stress-related illness. Similarly, the more one coped by disengaging from others - be that work colleagues, friends or family - the greater was the risk of developing a stress-related illness. The earlier explanation offered for these variables in relation to happiness, is likely to apply here too. Earlier research and the interpretations offered here show that self-distraction and denial are ineffective ways of coping and this corresponds with the findings with GHQ – as it increased so did scores on these types of coping. The two ways of coping that had a beneficial effect were mindfulness and positive reframing with mindfulness having a far more powerful influence.

If one scores 3 or more on the GHQ one can be categorised as 'at risk' of developing a stress-related illness and T-test comparisons between those 'at risk' and 'not at risk' revealed that those 'not at risk'- the 'good-copers' effectively, were happier and scored significantly higher on mindfulness; religious beliefs; levels of acceptance and positive reframing and significantly low on denial and behaviour disengagement.

That mindfulness was reported as the largest Beta value by some margin across all the models indicates that it is the single most beneficial influence on promoting self-compassion; in managing the effects of distress (GHQ) and in happiness. The first finding is less surprising given the practice or qualities associated with mindfulness are likely to promote self-compassion but it is a testament to mindfulness that it appears to be a far stronger influence on well-being than the wide variety of coping strategies measured here, such as humour, support, positive reframing, planning, active coping and religion, all of which have a strong track record in the research literature on coping and enhancing well-being.

Conclusion

The overall variance explained by each model suggests that there were many factors not measured that also contribute to each of the outcome measures. It is rarely the case that a regression model explains more than 50% of the variance in an outcome measure and here is no exception. There were limitations to the study too - the sample size was an exceptionally good one for what had started out as a piece of undergraduate research but the sampling was voluntary and it was likely that the procedure attracted a higher proportion of individuals already predisposed to mindfulness. The sample size was sufficient to test the number of factors that were entered into each model and the findings were statistically robust. The interpretations arrived at suggested that avoidance; in the form of self-distraction, disengagement from others or substance use, had adverse effects on well-being. Self-blame was also associated with distress but also with achievement and it is important to strike the right balance between setting one's goals high but avoiding being too self-critical. Consistent with earlier research was the value of support, acceptance and positive reframing. However, a key finding was that mindfulness was the strongest influence and not just in promoting these qualities but which, in its own right, promotes well-being and effective coping.

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Methods employed in managing counselling self-efficacy anxiety.

by Eoin O'Shea & Dr. Freja Petersen

Introduction

Self-Efficacy

The concept of self-efficacy refers to "beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments" (Bandura, 1997, p.3). The above author explains:

The self-assurance with which people approach and manage difficult tasks determines whether they make good or poor use of their capabilities. Insidious self-doubts can easily overrule the best of skills. (p. 35.)

Faced with an incalculable number of potentially relevant 'variables', a counsellor/ psychotherapist must possess sound (though realistic) perceptions of their capabilities if they are to endure the ambiguity inherent in counselling work with 'real life' clients.

Counselling self-efficacy (CSE) is defined as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p. 180). CSE beliefs are seen as subjective assessments of competence in counselling; that is, individuals with strong CSE believe they are highly capable to counsel, whereas persons with low CSE do not believe they have adequate skills to perform counselling. Daniels and Larson (1998) examined 32 studies suggesting the predictive strength of CSE in its relationship to other important counsellor variables such as counsellor anxiety, counsellor performance, and the supervision environment. Barnes (2004) details some implicit assumptions of CSE theory: (a) CSE is a primary mechanism through which effective counselling occurs, (b) strong CSE beliefs result in enhanced counsellor trainee perseverance in the face of difficult tasks, and (c) counsellor trainees who experience strong CSE are better able to receive and incorporate evaluative feedback into their learning experiences than are trainees who do not possess robust CSE beliefs (Larson, 1998). Studies have found that CSE is positively related to counsellor training level and experience, counsellor self-concept (Larson et al., 1992), counsellor development (Leach, Stoltenberg, McNeill, & Eichenfield, 1997), and expectations of counselling outcomes (Sipps, Sugden, & Faiver, 1988). Furthermore, researchers have demonstrated a negative relationship between CSE and counsellor anxiety (Larson et al., 1992).

Risks to Therapists and Effects of Low Self-Efficacy:

According to Bandura (1997), a sense of efficacy can activate a broad range of biological processes that influence human health and disease. Many of

these effects arise when coping with acute or chronic stressors in our everyday lives. Stress (an emotional state generated by perceived threats and taxing demands) has been implicated as an influential contributor to many physical dysfunctions (Cohen, Evans, Stokols, & Krantz, 1986). Encountering stressors (without perceived or actual control) activates neuroendocrine, catecholamine, and opioid systems and impairs the functioning of the immune system (Shavit & Martin, 1987). The intensity and chronicity of stress is governed largely by perceived control over the demands of one's life. Both epidemiological and correlational studies have shown that lack of behavioural or perceived control over environmental demands increases our susceptibility to bacterial and viral infections, contributes to the development of physical disorders, and accelerates the rate of progression of disease (Peterson & Stunkard, 1989; Schneiderman, McCabe, & Baum, 1992; Steptoe & Appels, 1989).

The present article is the second part of a research study (O'Shea & O'Leary, 2009) which investigated the events or circumstances associated with counselling self-efficacy anxiety. The research question in that article read: "What are/have been the typical fears, anxieties, doubts regarding your perceptions of your own abilities as a counsellor since you have begun such work?" The broad inclusion of fears, anxieties, and doubts in this wording was intended to capture a wide range of relevant experiences and is also in keeping with a cognitive formulation of anxiety (Clark & Beck, 2010).

Methodology:

Participants:

Participants in this study were comprised of 70 counsellors and psychotherapists who responded to a posted questionnaire (56 female/14 male). Mean age was 54.5 years with a SD = 6.84. The oldest person was 69 with the youngest being 35. Respondents' mean number of years providing therapy was 13.8 with a SD = 5.96. Most and least experienced respondents had been providing counselling for 30 and five years respectively. There were no problematic ethical dilemmas envisioned in the study which was approved by a Research Ethics Committee at UCC.

Materials & Procedure:

The research questionnaire was posted to 300 therapists who were selected (using an online random number generator) from the Irish Association of Counselling and Psychotherapy's (IACP) members' listings of over 900 individuals. Of the 300 members, 70 completed and returned the questionnaire containing the research question, "What, if any, methods have you employed to deal with/work through fears, anxieties, or doubts regarding your abilities as a counsellor since you have begun such work? (Responses need not only include professionally-recommended methods such as supervision, etc, but can include your own personal/idiosyncratic ways of dealing with such anxiety)". Demographic items regarding age, sex, and number of years engaged in providing professional counselling/therapy were also included. These were accompanied by a stamped, self-addressed envelope for ease of response and a cover sheet detailing the purposes of the research, assurances of anonymity, etc. Following return of these questionnaires and completion of initial stages of research, a thematic analysis was conducted on the data.

Thematic Analysis:

Roulston (2001) suggested that thematic analysis is a poorly demarcated and rarely acknowledged, yet widely used qualitative analytic method within and beyond psychology. Braun and Clarke (2006) have attempted to 'fill the gap' of theory and practice relating to thematic analysis (TA) and have presented a step-by-step guide to employing TA as a data analytic method. They define TA as "a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail" (p.79). The authors go on to delineate a step-by-step process through which a thematic analysis is conducted. These steps include: (1) Familiarising yourself with the data; (2) generating initial codes, i.e. whereby the researcher groups related words, concepts, or comments together due to an apparent similarity in meaning, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. The third of these stages also marks the point at which one examines relations between themes with a view to generating 'sub-themes' where appropriate.

Thematic Report:
"What, if any, methods have you employed to deal with/work through such fears, anxieties, or doubts? (Responses need not only include professionally-recommended methods such as supervision, etc, but can include your own personal/idiosyncratic ways of dealing with such anxiety".

Supervision:
Supervision was the most common method that respondents used to deal with self-efficacy anxieties, such prevalence matched by items positing it as the most salient or effective method, e.g. "chief method of dealing with my doubts/fears/anxieties" and "supervision would be my main resource". Responses indicated the most useful instances for respondents, i.e. in cases of suicidal risk, emotional support, personal exploration of fears, consideration of errors in practice, and assurance regarding therapeutic interventions and strategies. Unsurprisingly, "experienced", "challenging", and "competent" supervisors were preferred. Individual and group supervision was indicated, the former being more common. Supervision provided a safe, accepting, and yet at times challenging space in which to "unload and thrash out what's going on" and be "vulnerable". Frequency of attendance varied, e.g. 1-1.5 hours/week or one 4-hour group session/month. Only one respondent indicated that supervision was "way over-rated as a tool for therapist support". Respondents generally felt "relaxed" and "assured" by regular individual and group supervision.

Personal Reflection, Self-Talk and Past Work:
Reflection was helpful in relation to fears, overactive "superegos", taking adequate time before and after sessions to reflect, and honesty/integrity of examining both oneself and one's work. Possible counter-transference was considered at such times along with potential vicarious traumatisation and "stuckness" with clients. Emotional awareness offered an opportunity to process needs, consider boundaries, examine vulnerabilities, and integrate insights. One could question perceived failures in considering how things could have been done differently with a view to moving on. Self-talk included "affirmations" and "[p]ositive thinking" used to "surrender and let go of fears", e.g. "You are a trained counsellor and you have the skills and attributes necessary for the work at hand". This helped respondents to "accept [their] limits" and appreciate the "privilege" that such work represented. Focusing on past work/successes, e.g. "reminding myself of work that went well", was used to alleviate anxieties regarding self-efficacy. Respondents formed a "positive attitude based on evidence", e.g. growth in one's private practice and referrals. A specific practice mentioned in facilitating self-reflection was journal-keeping.

Continuing Professional Development (CPD):
CPD included "further education and training", "ongoing professional development/training", with specific examples including "workshops", "reading" (of articles and books, mostly – but not all – related to psychology, counselling and psychotherapy), further educational qualifications (e.g. "M.A. in Further Education"), "T.V.", "the Internet", and "constant involvement with accrediting bodies regarding standards and training". A number of items paired 'professional' with 'personal' development and this seems to indicate an overlap of the two at times. Respondents reported achieving "new insights", upgrades of knowledge, and "confirmation of knowledge" from CPD involvement. As with supervision, a number of individuals saw CPD as "essential", "influenc[ing] good practice", and "believe[d] strongly" in it.

Peer/Collegial Support:
Peer/Collegial support was distinguished from the supervision theme in that it represented a less formal, often less structured, and free support. Peer support was provided by co-workers. Most items were broadly expressed without explanatory detail, e.g. "peer/colleague support", "consultation with peers", etc. Such peer contact 'normalised' the fears and anxieties experienced through sharing with others while another found that this "helps as most have the same doubts/fears". Both individual and group involvement was suggested in responses. Some items indicated such support was engaged in at work whereas other individuals had formed groups/arrangements based on work friendships

developed over years. Group size indications were scarce but ranged from 3-6 individuals. "Fun" was also mentioned in relation to such meetings; indeed, this practice was seen as "very supportive" and fits with the findings of some (e.g. Greenglass, Burke, & Fiksenbaum, 1998) that such support can protect against burnout.

Leisure and Hobbies:

One respondent indicated the grounding function of non-counselling activities. Specific forms varied but common examples included reading (e.g. "identification" with the characters of J.R.R. Tolkien's work). Music (both listening and playing) and well as singing featured as part of this. Related also were a small number of responses indicating the use of dance – movement to music was seen by one respondent as aiding in "self-regulation". Watching films/DVDs was also mentioned along with art forms such as drawing and sculpture being seen as helpful "creative work", e.g. card-making: "a favourite hobby!". Gardening and cooking featured and these were useful in keeping some therapists "grounded", e.g. maintaining a vegetable garden and contact with "soil" and "nature" was suggested as beneficial. As one person said: "[there is a benefit] by engaging in nature; sea, mountains, animals". "Regular" massage was viewed by one respondent as "vital!" and language classes received a mention, as did acupuncture, "getting physically engaged in housework", and "maintaining an interest in current affairs".

Trust in Therapeutic Relationship and Client Responsibility:

For a number of therapists, trust in the therapeutic relationship as a significant agent of change encompassed beliefs regarding client responsibility (and also capacity) to bring about positive change. "Skills and experience" were thought to be of secondary importance by one respondent when compared to "trust [in] the power of the dynamic in an authentic encounter". "Being present and available to the client" and "acknowledging what's in the room" was emphasised as part of the "the therapeutic relationship"/"the process". This was specified at times in terms of "the core conditions" and, more specifically, "unconditional positive regard". Some could "leave go of fears and inadequacy when working by being present to the client". 'Client responsibility' could be understood in terms of greater emphasis placed on the client's role in the therapeutic process. Some respondents advised against seeing therapy in terms of 'fixing'/'healing' the client, instead "remembering that [the] client has [their] own strength and healing ability". Another question posed was "who is doing the needed work – therapist or client?" Boundaries of therapists' responsibility were viewed as facilitating unconditional positive regard for themselves – vital in modelling the very same for the client.

Spirituality and Meditative Grounding:

Spirituality, while difficult to define in explicit terms, was thought to involve practices relating to, or believed to affect, the spirit or transpersonal functioning. It sometimes, though not always, involved practices considered to be 'religious' in nature. Meditative grounding, on the other hand, consisted of practices perceived as relating to a sense of 'perspective-enhancing' or attentional 'rooting in the moment'. As meditation is often practised within the context of religious, spiritual, or transpersonal thought systems, these two terms were believed to warrant inclusion under the same theme. Prayer was mentioned as an effective method of "self-regulation" and was sometimes accompanied by the lighting of a candle. Techniques designed for relaxation as well as breathing exercises were employed by a number of respondents with relaxation tapes sometimes being used. "Meditative music" was noted as helping therapists to accept their fears. The importance of "a good sense of humour" was cited; this could be a 'black' sense of humour and might alleviate stress. Three symbolic practices included wearing specific items of clothing that held personal significance for the wearer, were specific for work, or going to another room following a session to "leave behind" material before returning to the sessional room.

Personal Therapy:

Relatively little detail regarding the specific approaches involved were included – only one respondent indicated "ecotherapy". However, descriptions as "best support", "essential", and "[the] main tool" suggest its significance to

some. One respondent implied its importance "for [their] own issues which may have been triggered" – its usefulness in combating potential counter-transference is apparent here. Another indicated the belief that therapists "can't take clients where [they] haven't gone [themselves]". Explicit indications of frequency varied, e.g. "fortnightly" and "when required"/"when issues arise". This suggests that therapists not in ongoing therapy availed of it when specific challenges occurred. More than a third of respondents were either presently in/availed of therapy when needed.

Balance of Work and Social Life:

It is reasonable to assume that other themes – such as those pertaining to Leisure and Hobbies, or Exercise, also contain items that could as easily be considered part of the aforementioned 'balance'. This theme instead included responses that explicitly referred to notions of such 'balance' and which are not deemed as suitable for inclusion in the more specific categories previously mentioned. Some responses were broad, e.g. "I maintain a good balance between work and pleasure" with others more specific, e.g. "entertaining friends", "having fun by mixing with non-therapists", and "meeting friends for coffee". Respondents indicated the importance of 'leaving work at work', e.g. having a mobile phone specifically for work purposes which was turned off after work hours. The importance of achieving this balance "could not be exaggerated". Spouses, other family members, and friends were typically mentioned with a notable exception being a generous tribute paid to a therapist's dog in helping to achieve this 'work/social life balance'.

Exercise:

Physical activity was seen by respondents as important in managing their self-efficacy anxieties and references to "exercise" were numerous. The most common form was walking. Long walks, walking with the dog, and hill-walking, along with the suggested function of "grounding", were the specific details provided in relation to this. Yoga was also mentioned frequently along with one reference to Tai Chi. Also mentioned were skiing and dance. A lone response detailing "active engagement in sports" suggested relatively little participation in competitive forms of physical exercise.

Adequate Holidays:

Responses indicated the importance of regular breaks from work, including non-specific items, e.g. "Adequate rest/holidays", and more specific items, e.g. trips to the Spanish mountains for personal therapy and fun, a yearly Zen residential silent retreat, retreats at a Christian monastery four times a year. "Active", "enjoyable", and "frequent" holidays were predictably favoured. Other forms of 'holiday' encompassed time taken from work (without necessarily 'going on holiday', as such), e.g. "Having plenty of time out", "cutting back on work", and choosing to "work a very short week" were mentioned. Suggested benefits included having "time for myself" and "avoid[ing] burnout".

Counselling-Specific Strategies:

Certain practical steps that aided in allaying anxieties regarding counselling self-efficacy were indicated. A number of these related to issues of time, e.g. being very clear with clients regarding time constraints of sessions. Respondents took some time (e.g. half an hour) between sessions to compose themselves as well as write/familiarise themselves with notes. Suicide contracts were advocated and details of the client's family/next of kin were collected also. One respondent indicated being "choosy" regarding which agencies to work with and refused to work with those perceived as "unprofessional". Another found that being in communication with a client's doctor/psychiatrist relieved anxiety. Therapist safety was also mentioned, e.g. devising practical plans when working with angry clients, not having potentially dangerous objects in the counselling room, and working only when colleagues were in the building.

Feedback and Clarification:

This theme involved open communication between therapist and client regarding the process of counselling itself and how it was proceeding. Broad items included "seeking clarification and feedback", "checking out with client do they believe if something is useful for them", stressing the "voluntary nature" of counselling along with "confidentiality and terms of contract". Termination was dealt with by encouraging the client to move on and reassuring them that the therapist would

continue to be available. Feedback was "so important" in assessing what the client needed "more of/less of". A method employed involved regularly 'checking in' with clients to assure shared goals, what the client found most useful, and clarification of specific issues such as particular instructions, arrangements, etc. Personal disclosure was sometimes employed though care in how this was undertaken was indicated.

Recognition of Limits and Referral:

This theme related to awareness of one's professional boundaries and how to deal with cases where these limits were challenged by some clients. Responses included general recognitions of one's limitations, e.g. "not always having answers is ok", "reality – knowing my limits", and "realistic expectations of my abilities as a counsellor", with self-acceptance being implicated. Discussion of referral with peers was accompanied by similar discussion with clients if they were not consistently attending. "Alternative therapies" could be explored with clients and some respondents were "selective who [they] take on", only working with issues and clients they felt "comfortable with". Seeking referral from general practitioners made their service "professional; more appropriate". Limiting amounts of work was necessary so as not to "burn out".

Discussion:

The present study's investigation of therapists' typical methods used to help deal with anxieties, doubts, and fears concerning their counselling abilities broadly matched previous research. Suggestions for further reading include those studies highlighting the importance of supervision (e.g. Borders, 2006), self-talk (e.g. Morran, 1986), continuing professional development (e.g. Bor, 2006), peer support (e.g. Barlow & Phelan, 2007), leisure and hobbies (e.g. Sowa, May, & Niles, 1994), issues pertaining to the therapeutic relationship (e.g. Skovholt, 2005), spirituality and meditative grounding (e.g. Newsome, Christopher, Dahlen, & Christopher, 2006), personal therapy (e.g. Kumari, 2011), the balance of work with social life (e.g. Bryant & Constantine, 2006), exercise (e.g. Dixon, Mauzey, & Hall, 2003), adequate holidays (e.g. Dubrow-Marshall, 2011), counselling-specific strategies (Cox, 1982), feedback and clarification (McLeod & Cooper, 2011), and recognition of limits and referral (Shiles, 2009).

Limitations of the present study include the broadness of the research question, i.e. the inclusion of fears, anxieties, and doubts. This was done to include as many elements of the cognitive formulation of anxiety as possible including experiential elements of the primary threat mode, secondary elaborative processes, and various cognitive products (Clark & Beck, 2010). However, additional research might narrow the scope of anxiety features whilst maintaining the present study's qualitative inclusiveness. Further studies employing a similar methodology but focusing on specific self-care strategies in more detail may be warranted. Nevertheless, this study is posited as further exploring a sample of the sheer breadth of strategies employed by practising therapists when managing the anxieties they experience regarding counselling abilities.

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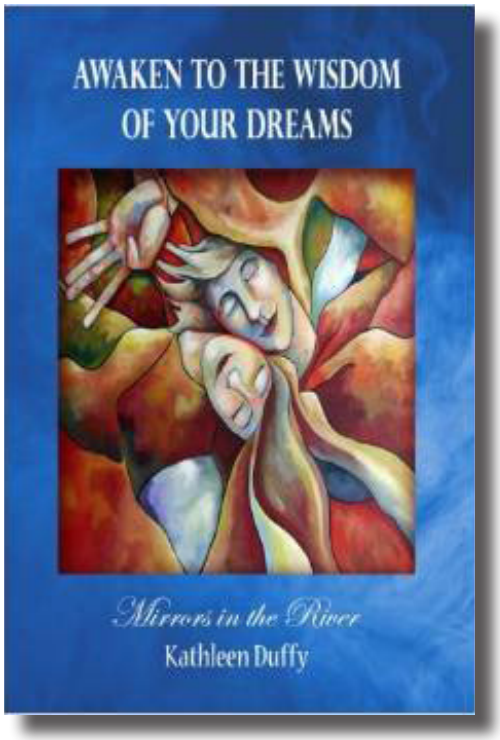
Book Review

Title:	*Awaken to the Wisdom of your Dreams*
Author:	Kathleen Duffy
Published:	December 2014
ISBN:	978-0954574093
Reviewed by:	Catherine Tierney MIACP

For those readers who don't tend to remember their dreams, this book offers the following challenge: "When we are prepared to accept that our dreams give voice to the Psyche seeking wholeness, that every soul longs to be reunited with its full potential, then doors can begin to open".

If you are prepared to take up that challenge, then this is a book worth exploring. It includes almost one hundred dreams, with detailed reflections on each. The key approach is Jungian but also draws on Fritz Perls, Freud's Free Association and Assagioli's Psychosynthesis to mention but a few.



James Hollis features also, primarily because dreams can assist us in addressing Hollis' important existential questions: "What is the world asking of me?" for the first half of life. For the second half of life – "What, now, does the soul ask of me?" This book is for anyone approaching (or in) the second half of life who is willing to engage with that question, through their dreams. For those interested in exploring a client's dream, the examples given are full of the symbolism and rich imagery of the dream world, the language of the Soul. However it may be best to practise on one's own dreams first, to build confidence.

What makes this book stand out for me – both as a psychotherapist and as a presenter of dream workshops - is the author's courage and honesty in sharing dreams which chart pivotal moments along her own journey. It is a passionate and deeply spiritual book, steeped in the landscape of the west of Ireland (the author grew up in Mayo and practices there) and full of religious symbolism from the strong Christian tradition of her childhood. In revealing so much of herself, the author calls all of us to examine where we are on our own journey.

Two precognitive dreams appear to predict the deaths of both her parents. Later dreams, after their deaths, give great comfort. She shares the disturbing dream of a client who was sexually abused as a child. The author handles this dream and her client with tender care and compassion and with great skill. If I had one wish for the book it would be for a dream index at the back. There were many dreams with wonderful titles which I wanted to re-examine for example: themes of loss, transitions, anxiety, relationships, anima/animus struggles but couldn't relocate them.

There is a lovely line in the book: "Consider the loyalty of our Soul Self in its continual effort to have us face and embrace all of who we are". One great dream of the author's encapsulates this with "a two-layered hem of black and of gold". How Jung would have loved that perfect allegory for his beloved dream work, the dark and the gold. The Shadow figure can shine a light on our unlived potential (90% gold according to Jung) but can also reveal our darkness (e.g. what is repressed or denied).

Jung spoke of numinous dreams, magical experiences, which give us a glimpse of the soul itself. Some of the author's dreams have this quality and show how far along the road she has bravely travelled. This book inspires me to keep travelling!

Workshop Review

COUNSELLING & PSYCHOTHERAPY FOR CLIENTS WITH A PSYCHIATRIC DIAGNOSIS OR WITH CO-MORBIDITY

Presenter:	Gerry Farrell	Reviewed by:	Caroline Singh, MIACP
Date:	Saturday 21st March 2015	Venue:	Tuar Ard, Moate, Co. Westmeath
Organised by:	Midlands Regional Branch IACP		

I was drawn to this workshop as I have spent nearly twenty years working as a secretary in a GP practice and trained and now work as a Counsellor/ Psychotherapist. I wanted to learn more about working effectively with diagnoses from a counselling rather than medical perspective. It proved to be a very rewarding, entertaining and informative experience.

The presenter, Gerry Farrell, has a background in psychiatric nursing in Ireland and the UK including; care of the elderly, working with addictions, adolescents, and in residential eating disorder centres. Over time his eyes were opened to the possibility of helping individuals in a non-residential setting. This helped to steer his path into the area of counselling and psychotherapy. Gerry began by inviting us to introduce ourselves and outline what we hoped to gain from the day. Borderline Personality Disorder, prescribed medication, Narcissism, Bi-Polar Disorder, Dementia and General Anxiety Disorder (GAD), were discussed during the workshop.

The facilitator kept the content informative as well as entertaining with excellent humorous observations; slipping in and out of character frequently to give us a taste of the individual personality types and punctuating the more thought-provoking and challenging parts of the day with sufficient levity to keep us interested. He allayed some fears expressed that counsellors need to be an expert to work with a specific diagnosis. What matters more are empathic relationships and creating the space for a client to tell you what their diagnosis is like for them. He also stressed the importance of rolling with any resistance encountered rather than get drawn into a 'Yes but....' dialogue often evidenced within the diagnosis of Dysthymia or longstanding, chronic Depression.

There was a diverse range of material presented here, interspersed with discussions on Schizophrenia, Bi-Polar and Narcissism. Gerry introduced Charles Handy's, 'Four Gods of Management', whereby employees of various organisations can find themselves availing of EAP (Employee Assist Programme) services, as a result of being on the receiving end of a Narcissistic Personality, particularly in a Zeus type of organisation.

The systemic dynamic of neurotransmitters was explained simply and clearly and we learnt about the roles of each of the six main neurotransmitters that pharmaceutical drugs can assist in re-balancing, inhibiting or replacing. With a concise handout to explain the major prescribed medications we looked at this technical part of the presentation with ease and a resultant new depth of knowledge.

In an exploration of Bi-Polar Disorder, Gerry demonstrated a client presentation which included a specific and very distinctive rate of speech, grandiose ideation and a high degree of perception with the question to participants – 'How would you feel about working with a client like that?' We were given a copy of a Mental State Examination assessment form and were guided through the form highlighting the presence or absence of the listed criteria.

During the afternoon the focus switched to addictions and how they impact on family systems where, the facilitator managed to balance theory and the context of human fragility and connection. When the content became more detailed Gerry maintained the knack of lightening the moment with a witty story or comment providing ample evidence of his passion for acting and performing. We also learnt about temperament types - Blue, Red, Yellow and Green as applicable to Generalised Anxiety Disorder and Borderline Personality Disorder.

All too soon, the day came to a close and I, along with several other participants were left feeling like we wanted more. I eagerly await the opportunity to attend a follow-up workshop.

Éisteach Editorial Committee – Invitation

The editorial committee would like to invite members to both consider volunteering with the committee and would like to encourage members to submit articles for potential publication. An on-going issue for the field of counselling/psychotherapy is the insufficient amount of empirical evidence demonstrating the efficacy of therapy in the eyes of some in the medical profession and among insurance underwriters. No doubt, countless potential referrals have been lost as a consequence. Accordingly, for the coming year, Éisteach will give precedence to articles which have a research element, be they quantitative or qualitative in nature.

The committee will also continue to welcome articles which reflect the diversity of modalities and views within IACP. Interestingly, some aspects of therapy seem to generate many more articles than others, most notably the themes of sexuality and spirituality in the past year. The committee would like to encourage articles from areas of counselling and psychotherapy which have been under-represented in recent issues.

Those that meet the guidelines for publication, available on the IACP website, are more likely to be published. Finally, a word to the wise: writing is a skill built-up over time through lots of practice, and not an inborn talent only possessed by a few. Give it a try! There are some books in HQ available for review and we welcome requests from members who have an interest in reading and submitting a review on any of the following; email dee@iacp.ie

Cóilín Ó Braonáin PhD – Chairperson
eisteachchair@gmail.com

Books Available for Review

The Guided Way: A Counsellor's Work with Young People. Seeking Solutions Together through Writing & Listening – Lucy McCullen

The Backwards Book: Poetry Therapy from Practice to Theory – Niall Hickey

Mastering Your Self – Mastering Your World (living by the Serenity Prayer) – John William Reich

The Forgiveness Project: Stories for a Vengeful Age – Marina Cantacuzino

What You Really Need to Know about Counselling & Psychotherapy Training – Cathy McQuaid

In Gratitude (The Story of a Gift-Filled Life) – Catherine McCann