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- My First Known Blood Relative - An Exploration of Female Adoptees who give Birth to Biological Children
- Can Relationships Survive Infidelity?
- Spirituality in the Recovery Process of Addiction
- Is there an Impact on the Therapist?
- Contextual-Conceptual Therapy (CCT)
- A New Approach to Suicide Therapy

Rethinking Relationships

The logo for the Irish Association for Counselling and Psychotherapy (iacp). It features a stylized yellow and blue circular icon to the left of the lowercase letters 'iacp' in a bold, sans-serif font.

Irish Association for Counselling and Psychotherapy

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Our Title

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

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From the Editor:

Content



Dear Colleagues,

Welcome to the Spring edition of the *Irish Journal of Counselling and Psychotherapy (IJCP)*. The theme for this issue is 'Rethinking Relationships'. The very nature of our work as counsellors and psychotherapists exposes us to relationships, not only in the therapeutic sense, but those personal relationships that our clients share with us - relationships they suffer and struggle with and, equally, those in which they are strengthened and enriched. The term 'relationship counselling' is generally reserved for therapy between romantic partners. However, for most people our significant relationships extend well beyond this construct to include family members, friends, work colleagues - indeed, anyone we share a connection and emotional bond with. Equally, let us not forget possibly our most important relationship of all - that with the self. Our interpretation and experience of relationships is personal and unique to each of us and I am delighted to dedicate this edition to the complexities and diversity of what constitutes a 'relationship' and its presentations within the therapeutic space.

Our first article by Lynsey O'Kelly and Dr Siobáin O'Donnell explores the subject of female adoptees who give birth to biological children. Lynsey and Siobáin examine early attachment, the adoptees' sense of belonging and why there is often a strong desire for adoptees to have their own known blood relative. They also detail how the birth of a biological child can help affirm identity and change the relationship with the adopted mother and how they view their birth mother.

Our second offering is 'Can Relationships Survive Infidelity?' by Brendan O'Shaughnessy. Brendan has 27 years experience working with couples and reveals that although infidelity is a painful and difficult betrayal to work through, couples can successfully navigate the hurt and loss of trust that results when a partner is unfaithful. Brendan's extensive experience and research reveals that instead of trying to revive or recapture the old (pre-affair) relationship, couples committed to working on their relationship often find accepting the old relationship is dead an easier proposition to grasp. Doing this, he found, honours the betrayal and can enable couples to move forward towards a new, more rewarding and fulfilling relationship.

Our third article by Daniel Cleary is on spirituality in the recovery process of addiction and the possible impact of spirituality on the counsellor. Daniel's article explores addiction, recovery and the role of spirituality in

addiction recovery. He outlines the benefits spiritual understanding, knowledge and competence can have on individuals struggling with addiction or moving into recovery, and how embracing spirituality can benefit the addiction counsellor on two fronts - by enhancing the therapeutic relationship and enriching their personal lives.

Our final article by Gitti Maas is on Contextual-Conceptual Therapy (CCT), which is a new approach to suicide therapy. Based in Kenmare, Co Kerry, Gitti is one of three CCT associates practising in Europe. CCT is an innovative approach to suicide therapy that uses metaphors, maps and models to guide the suicidal person to the root of their suicidal thinking. At its core, CCT accepts that suicidal ideation is not an illness, but an identity crisis occurring because the suicidal individual is trapped in a self-defence mechanism that was designed, usually in childhood, to keep the true self safe from emotional pain. Working through a false self, the individual loses track of their true self, which over time becomes trapped and out of reach. In the CCT model, the therapist works with the client to rediscover themselves by embracing this new relationship with their true self.

On behalf of the *IJCP* editorial board I would like to sincerely thank all contributors to this edition, and to our readers wish you and yours a happy, healthy and prosperous 2019. Happy reading!

Kaylene Petersen MIACP

Correction

In the Winter Edition of the *IJCP* 2018, Pat Comerford was erroneously indicated as a female author in my editorial. I would like to apologise to Pat for this error. Further, I acknowledge the sequencing of articles in the issue was discordant with my editorial, apologies to our contributors. **Mike Hackett, Editor, Winter Edition, 2018**

Academic Article

My First Known Blood Relative - An Exploration of Female Adoptees who give Birth to Biological Children

By Lynsey O'Kelly & Dr. Siobáin O'Donnell



Research on adoption tends to focus on the adoption triad - adopted children, adoptive mothers and birth mothers. The female adoptees' experience of having their own biological children is a complex and far less studied one. For some adoptees, having their own biological child is the first time they recognise something of themselves in someone else and can help solidify their identity

Introduction

Considerable research on adoption exists from the viewpoint of the adoptees' earlier years, mothers who give their babies up for adoption and parents who adopt them. However, adoptees

seem to be overlooked in research, especially when they move on to have their own families (Day et al., 2015). Often when an adoptee gives birth, the child becomes their first known blood relative (Collishaw, Maughan & Pickles, 1998; Greco,

Rosnati, & Ferrari, 2015). Price (2016), in a study of adoptees who adopted children, suggests that they come to a fuller understanding of their own adoption and build a deeper connection with their adoptive mothers, but consideration needs to be given to adoptees who give birth to biological children.

Adoption is a life-altering event, affecting all members of the adoptive triad (Silverstein & Kaplan, 1982). When a child is given up for adoption, the bond and attachment with the birth mother appears to be broken and new bonds and attachments form within the adoptive family. This article explores early attachment, the adoptees' sense of belonging and desire for a blood connection, the adoptees' relationship with their birth and adoptive mothers and what occurs when female adoptees become mothers, including the fear of the loss of the child.

Attachment

Bowlby (2005) states that secure early attachment does not have to be experienced with the biological mother, but with a primary caregiver. In the case of adoption, the primary caregiver, often being the adoptive mother, is a secure enough base for the child to form an attachment. However, concerns and challenges do arise. Winnicott (1992) believes that attachment with baby and the mother begins during pregnancy where the baby

forms an attachment with the mother in the womb that continues after the baby is born. When a baby is adopted, this bond is broken and a new bond is formed with the caregiver. However, Dublin (2013) and Phillips (2011) propose that even though the attachment or bond with the birth mother appears to be broken on separation, the tie with the birth mother still exists with some adoptees. Although Bowlby (2005) asserts that secure early attachment can be formed with a primary caregiver that is not the biological parent, Sharpe (2012) questions how 'good enough' parenting can be given to a child who has arrived through some type of caring capacity, where the adoptive parents know nothing about the child and have not experienced it in the womb. Feeney, Passmore and Peterson (2007) suggest that there is a small risk factor for adult adoptees in relation to attachment security. Greco et al. (2015) highlights that very little is known about the long-term implications of adoption for psychosocial adjustment in adult life, how adoptees are in forming intimate relationships and their transition into parenthood. Jones (1997) theorises that disruption in early attachments can cause problems in intimate relationships later in life and adoptees may find it difficult to free themselves from feelings of rejection by their birth mother.

Adoptees are often told by their adoptive parents that they are special and were chosen. Jones (1997) purports that this story is an attempt by the adoptive parents to emanate their happiness and to negate the loss of the birth mother. Verrier (2009) claims that this story often puts pressure on the adoptee to live up to parents' expectations. In contrast, Kranstuber and Kellas (2011) argue that being told that

adoptees were chosen helps to solidify their sense of self and to value and trust themselves.

In her work with all members of the adoption triad, Verrier (2009) describes the "primal wound" as a wound of the adoptee that is physical, emotional, psychological and spiritual. She explains that this wound is caused by the child's separation from their biological mother and that acting out is the child's attempt to connect with the adoptive mother. She cites the results of research conducted by the Parenting Resources of Santa Ana, California, that 30-40% of the 2-3% of children who are adopted were found in residential treatment, juvenile halls and specialist schools, showing that adoptees had more difficulty in school, socially and had a higher rate of youth offending, sexual promiscuity and running away from home.

A Sense of Belonging and the Blood Connection

Adoptees often search for a place to belong, stating that they do not quite fit with their adopted family (Philips, 2011; Dublin, 2013). One adoptee interviewed by Verrier (2009) describes this sense of not belonging to her adopted family, despite being unaware that she was adopted. In a case study undertaken by Lord (1991), 'Bob' sensed that he did not fit in, although he was part of a close-knit family, which contradicted his experience of also feeling fortunate.

Jones (1997) proposes that adoptees' need for a biological link is something that contributes to their sense of identity. Day et al. (2015) suggests that the theme of longing for a blood relative to connect the mother to her heritage is similar across the racial divide. Haley (2016) reflects on the loss and lack of sense of belonging that some adoptees experience:

"In all of us there is a hunger, marrow-deep, to know our heritage - to know who we are and where we have come from. Without this enriching knowledge, there is a hollow yearning. No matter what our attainments in life, there is still a vacuum, an emptiness, and the most disquieting loneliness."

When Adopted Women Become Mothers

Congress (2012) notes that adoption research focuses mainly on the experience of adoptees in childhood and adolescence. This prompted the conduction of a study of 34 couples where one of the couple was adopted. The aim was to explore the couples' transition to parenthood. Congress found that the adoptees' definition of their identity is revisited at each stage of life events. Having biological children can bring about significant changes to new parents' lives, and when these parents are adopted these changes may take on a more complex meaning. A new baby is a link to the biological mother's heritage and issues surrounding this may surface for the first time for the adopted mother (Congress, 2012). An unpublished article by Humphries (2003), researching seven adopted mothers, suggested that having their own biological child helped them to solidify their own identity that they had lost through the experience of adoption (cited in Day et al., 2015).

Hampton (1997) conducted research on 20 adopted women, focusing on their transition to motherhood, their experiences of labour and their relationships. The desire to have a blood connection is a common theme in literature published on female adoptees as parents. In Hampton's (1997) study, one of the participants stated that "this baby is going to be the first person I've ever set eyes on in

this world that came from my own blood” (p.100). Another participant described her baby as “a blood relative of my very own... he’s my family now” (p.100). The adopted mothers declared that having their own biological children helped them recapture the connectedness that they stated was lost through their own adoption.

Hampton (1997) found that when an adoptee becomes a mother, the relationship with her two mothers, that is the adoptive mother and the birth mother, comes into focus. The adoptees’ pregnancy and subsequent birth sometimes prompts the search for their birth mothers. Congress (2012) highlights that when the adoptee gives birth, it introduces natural birth into the adoptive family history that may not have previously existed. The child’s birth was perceived by some adoptees as a gift to their adoptive family, although in some cases it emerged that the adoptive parents were not able to reconcile their fertility difficulties. Some adoptive mothers were envious of the adoptee’s ability to bear natural children (Hampton, 1997; Scabini and Rossi, 2012, cited in Congress, 2012).

In studying the effects of adoption on women in terms of relationships and parenting, Collishaw et al. (1998) states that all participants experienced a strain in the relationship with their adoptive mothers during their pregnancy, but having them present at the birth strengthened their relationship. Adopted daughters still retained a connection with their birth mothers, even though they were separated, and some birth mothers expressed a desire to see the children being born, suggesting that this was almost like experiencing their own birth (Dublin, 2013; Hampton, 1997; Phillips, 2011).

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Fear of Repeated Loss

Phillips (2011) examined how becoming a mother connected with suppressed feelings about her adoption. She expressed that when she gave birth to her first child, she had given birth to her “whole self” (p.121). She feared that she would lose her baby during her pregnancy and when he was born she could not leave him as she was afraid that he might go away. Phillips (2011) equates this with how she was separated from her own mother and her constant search for her on street corners when she was younger. The fear in pregnancy or post-birth that the baby will be taken away is a common thread in literature on female adoptees who become mothers. This need to keep their babies close was reported by several participants in Hampton’s (1997) research.

Similar to the experience of Phillip’s (2011) and Hampton’s (1997) participants, Congress (2012) ascertains that the anxiety that their baby might be lost or taken away was experienced by most of the adoptees. In contrast, some adoptees expressed that they believed their child was lucky to have their love and protection rather than being given away or abandoned as they were. In giving birth to their own child, the adoptee must also face up to the issues of why they were given away and may realise that they were not a mistake (Phillips, 2011).

Methodology

A qualitative, semi-structured interview approach to research was taken in this study. Six questions were used as guidelines to collect data from three participants. The sample was made up of three female adoptees who have given birth to at least one biological child. Participants were given pseudonyms: Daphne (three children); Kim (three children); and Peggy (four children).

Data were analysed using Interpretative Phenomenological Analysis (IPA). IPA is usually carried out for small samples of participants and therefore was a suitable method for this study. IPA examines the personal, lived experience, the meaning of it and how the participants make sense of that experience and connections with the emerging themes that were formed. Ethical principles were upheld throughout in accordance with the Belmont Principles (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978).

Findings and Discussion

This present research explored issues surrounding the incidence of female adoptees having their own biological children. It explored the adoptees’ early experience of their own adoption to gain insight into their early attachments and the relationship with their adoptive mothers. It further explored whether the birth of the adoptees’ biological children evoked thoughts of their own birth mothers and sparked any desire to reconnect with them, if this had not already occurred. Any changes in relationships with the participants’ adoptive mothers coinciding with the births were also explored and how the adoptees attached with their biological children.

The following themes were identified:

- Being chosen, early attachment; and feeling different;
- Relationship with adoptive mother;
- Reconnection with and empathy for birth mother; and
- Meeting their first blood relative and attachment with them.

Being Chosen, Early Attachment and Feeling Different

On exploration of early adoption it was reported by all participants that they were told they were chosen by their families, concurring with the findings of Kranstuber and Kellas (2011) and Verrier (2009). All participants fondly recalled feeling special on being told this and reported having a good enough early attachment in the early years with their adoptive mothers and feeling loved. Daphne asserted that this story of being chosen appealed to her as a young child, while Kim reported: “You were specially chosen and that every other mammy and daddy had to take what was given to them... but my mammy and daddy went down and picked me especially.”

In contradiction with Verrier (2009) that adoptees interpret being special as having to live up to their adoptive parents’ standards for them, this issue was not reported by any of the participants. In keeping with Jones’ (1997) theory that this was the parents’ attempt to cover up the pain, the chosen story for the participants appeared to solidify their attachment with their adoptive mothers. They knew that they were adopted, but stated that they had always been quite stable within their families.

Verrier (2009) describes the “primal wound” as a wound of the adoptee caused by the child’s

separation from their biological mother and that acting out is the child’s attempt to connect with the adoptive mother. Daphne described herself in later years as being rebellious, but did acknowledge that she always knew her mother loved her. Kim, whose relationship became strained with her mother in later years, emphasised that good early attachment had existed. Verrier (2009) explains this strain as an attempt on behalf the adoptee to connect with the adoptive mother.

On further investigation of the adoptees’ early experiences, two of the participants reported feeling different growing up, similar to the findings of Verrier (2009), Phillips (2011) and Dublin (2013). However, Peggy reported she had not felt different and emphasised that she was always included with her extended family, yet she still did not feel complete. These perceptions were echoed by Kim who described how: “They never made any differentiation, but I always felt different growing up... you’re never complete.”

Haley (2016) likened this sense of difference to loneliness and lack of belonging.

Relationship with Adoptive Mother

All three participants reported having good early relationships with their adoptive mothers, which supports Bowlby’s (2005) theory of secure attachment with the primary caregiver who is not a biological parent. Congress (2012) found in rare cases that the relationship with the adoptive mother becomes strained on the birth of the adoptees’ biological children. Whereas Collishaw et al., (1998) reported that there is no change in the relationship. Peggy described having a good relationship with her adoptive mother throughout her life, with no change in the relationship when she had her

baby. However, she recalled that her adoptive mother was thinking about her birth mother. When her baby was born, Peggy reported that her adoptive mother asked if Peggy had mentioned her birth mother during the birth and that she cried, showing how emotional she still was regarding the adoption.

Kim’s adoptive mother had died before she started a family, which she stated left her “freer to get on with her own life”. She explained that the relationship had become strained, but this was totally unrelated to her pregnancy. Daphne recollected her adoptive mother’s happiness on the birth of her grandchild and how her adoption did not really feature; her adoptive mother was just happy to have another grandchild.

Reconnection with and Empathy for Birth Mother

While the birth of their children did not change the relationship with their adoptive mothers, the births elicited diverse feelings towards their birth mothers. Two participants reported anger and annoyance, and all three reported feelings of empathy.

Before becoming pregnant with their first children, all participants had attempted to reconnect with their birth mothers. In each case the birth mothers did not indicate any desire to reconnect. Even though the reconnection had already been sought, each adoptee’s pregnancy aroused different feelings for each participant towards their birth mother.

Daphne described feeling “fiercely angry”, wondering why her birth mother “wouldn’t take the opportunity to make it right”. Daphne considered that her birth mother’s desire to meet her grandchild would somehow counteract the difficult decision to give her up. She found it challenging

to reconcile what she considered the second rejection by her birth mother, although she did feel empathy towards the “difficult decision to give the child away”.

For Kim, the birth of each of her children evoked the urge to try to reconnect with her birth mother, even though her first attempt had been rebuffed. Kim made several attempts to reconnect and believed that this was a rejection of not only her, but also her children.

All three participants experienced empathy for their birth mother, reflecting on what they must have endured in giving their babies away. Kim stated: “There is a part of me that feels very sorry for her.” Peggy, in agreement with Phillips’ (2009) research, acknowledged how hard it must have been for her birth mother to give her away and challenged the assumption that all adoptees harbour antipathy for their birth mothers: “I think most adopted children don’t feel bitter or resentful... feeling sadness for her... feeling empathy for her... feeling how bloody hard it must have been for her.”

Meeting the First-Blood Relative and Attachment with them

The meeting with their baby as their first-blood relative was a strong theme for all participants in this study. This was especially the case with Kim, who was cognisant that this baby was “my first blood relative... I wasn’t a blood relative, so here was the first baby that was mine - my flesh and blood”, which parallels Hampton’s (1997) findings. Kim described the overwhelming feelings she had for her baby and the joy of recognising parts of herself in him.

Similarly, Daphne was proud that for the first time she could see something of herself in another. She described how it was difficult to be around people who bore no resemblance to her, especially

when others made the presumption that she was biologically related to her adoptive family. Kim also reported that she searched for resemblances and wondered who the baby resembled. This was a new experience for both Kim and Daphne, which links to the findings of Jones (1997), Day et al., (2015) and Dublin (2013) regarding the adoptee’s desire to solidify their sense of identity. Peggy, while not obviously making the blood relative link, found that her first baby was something that was truly hers, alluding to the fact that she had been missing something of herself.

In exploring how the adoptees attached with their biological children, two out of three participants stated that their friends remarked on how they are overprotective of their children, which was not an issue that was conscious for them. This overprotection can be linked to the findings of Congress (2012), Phillips (2011) and Hampton (1997) wherein adoptees maintained that they feared that they would lose their babies and experienced the strong desire to keep them safe. Daphne was unsure if her overprotectiveness was due to her adoption, but acknowledged that the early rejection that she had suffered by her birth mother might have led to her overcompensation. She explained that she showed a lot of love to her children, in particular giving hugs, which was something that was not forthcoming with her adoptive mother. She stated: “If you have feelings of rejection very deep down in you, then you obviously don’t want your own children to feel that, so you might overcompensate.”

Kim related this overprotection to her insecure background, stating that she had been secure in her early years, but circumstances changed later. She acknowledged that she always wanted a big

family and this prompted her to keep her immediate family close. She explained: “I feel sometimes that I overcompensate... [which] could be because of my own background, because it was an insecure background. I wanted to make the world perfect for them... my children were going to have the best world possible... a very secure family... because I never had a family. I have a family now and... I’m going to hold on to them.”

Conclusion

In the exploration of the adoptees’ early attachment, all participants reported having a good early attachment. What was especially poignant was their recollection of being ‘chosen’. The stories told to them by their adoptive parents were recalled fondly, which helped solidify their early attachments. However, the feeling of not belonging, which seems to be common among adoptees, was echoed by two of the participants.

The meeting of a first-blood relative was strongly recognised in two out of the participants. It was the first time for them to recognise something of themselves in another and solidified their sense of identity.

While the birth of their babies did not prompt reconnection with their birth mothers, reactions were evoked relating to all members of the adoptive triad on behalf of the adoptees. Empathy towards their birth mothers was experienced and the assumption that adoptees resent their birth mothers was challenged by one participant. What was also discovered was anger towards their birth mothers on the rejection of the adoptee’s children. Regarding the relationships with their adoptive mothers, all participants reported no change in their relationships.

Recommendations for Further Research

This research suggests that the

following are worthy of further consideration:

- Conflicting reactions of anger and further rejection together with empathy towards the birth mothers was demonstrated by the participants. Further research in this area may facilitate better understanding of contradictory emotions on behalf of the adoptees.
- Further exploration of how adoptees attach to their own biological children would give insight regarding the overprotection and fear of repeated loss experienced by the participants. Further research would be welcome to shed light on the relationship between these and the effect of their own adoption. ☾

Lynsey O'Kelly

Lynsey O'Kelly holds a BA (Hons) Counselling and Psychotherapy from Dublin Business School and is a pre-accredited member of the IACP. Working from an integrative perspective grounded in person-centered therapy, she believes every person can heal and grow in a supportive non-judgmental environment. Lynsey works with a range of issues including adoption, anxiety, depression, eating disorders, stress, low self-esteem, LGBTQI+ and work-related issues. She has a special interest in working with all members of the adoption triad, specifically around loss, rejection and sense of identity. Lynsey works privately from centres in Dublin 1 and Dublin 4 and can be contacted at lynsey.okelly@gmail.com

Dr. Siobáin O'Donnell

After successfully completing a BA at TCD, Dr. Siobáin O'Donnell graduated from the MA in Addiction Studies programme at DBS School of Arts in 2000. Siobáin has worked as a Research Officer on social research projects, for example, Dept. of Psychology in the Royal College of Surgeons on the SAVI Project and with the Granada Institute on 'An Evaluation of Treatment Efficacy with Types of Men who Sexually Abuse Children'. Siobáin has been lecturing in DBS for the past 19 years in the Departments of Psychotherapy and Social Sciences and successfully completed her PhD in TCD in 2015.

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Practitioner Perspective

Can Relationships Survive Infidelity?

By Brendan O'Shaughnessy



The hurt caused by infidelity is often deep and long-lasting and the decision to work through the betrayal a fraught and emotional one. Instead of trying to return to the pre-affair relationship, accepting the pre-affair relationship as dead and committing to a new, more rewarding relationship can lead to a better understanding of individual needs and expectations

Introduction

As a therapist working with couples for 27 years, I have noticed an increase in the number of couples presenting with the issue of infidelity over the past few years. This is probably not surprising when we consider a national survey of 1,000 people conducted by Millward Brown Lansdowne (2012) found

that 40 per cent of respondents admitted to having been unfaithful in a relationship. At the same time, I have become aware of different reactions to affairs than I had previously seen, which challenged me to examine my own thoughts and feelings around the possibility of relationships recovering from infidelity.

In this article I will detail how I have altered the way I work through infidelity with clients in the following steps: Review of my initial process view; a detailed explanation of each step; and how my process was revised based on new learning.

The *Cambridge Dictionary* defines infidelity as: “[an act of] having sex with someone who is not your husband, wife, or regular sexual partner”. Although this definition has broadened to include emotional infidelity, especially in the context of online interactions, all couples I have personally worked with fell into the former definition.

For the purposes of this article, we will follow the story of a fictional couple, Chris and Pat, who have been in a committed relationship for five years and married for two. In the last year, Chris felt that Pat was taking their relationship for granted. Chris confided in a sympathetic work colleague and an affair began. When Pat found out about the affair, Chris and Pat presented for counselling.

Process View

In my experience, the general pattern I have seen with couples is outlined in Figure 1. At each stage, clients assess whether they want to continue to the next stage or come to the point where they want to end the relationship. From a process point of view, each stage needs to be worked through at some point, and it was useful for me to have a concept with which to work. Of course, each couple is unique, and their experiences did not always result in the linear flow shown in the diagram. However, each stage was usually touched on at some point throughout the counselling process (Figure 1).

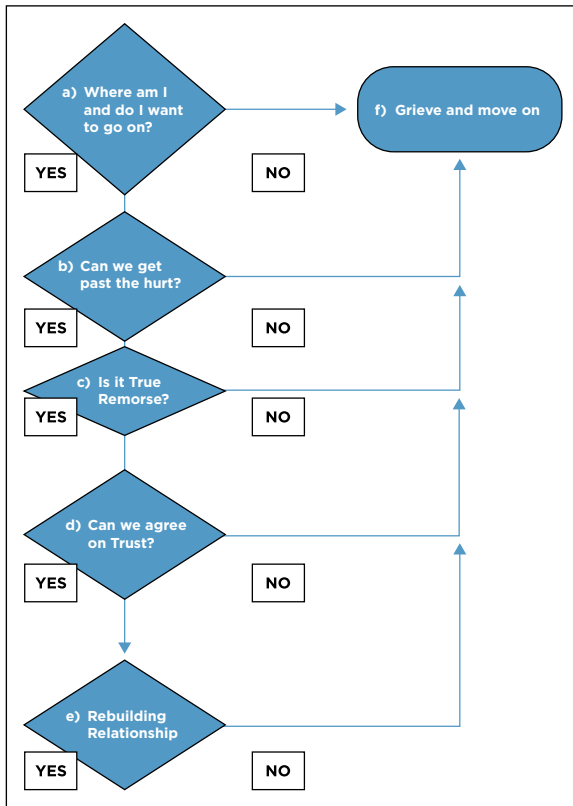


Figure 1: Process View

a) Assessment phase

The purpose of the assessment phase is to clarify where each person is now and what they want from counselling. During the initial assessment, I ask couples to individually fill out a questionnaire asking them to rate where they are in their relationship, see Table 1.

In my experience with couples, both parties tend to score low in questions 1 and 2. In our example, Chris rated low in the third question and Pat in higher numbers. Two typical responses in the case of Chris and Pat can be seen in the scenarios shown in Table 2.

This visual representation can be used to open a discussion around the future of the relationship and the purpose of counselling.

In scenario one, while it is a difficult situation for them now, both Chris and Pat can see a reasonable chance of working

towards a different future and are interested in doing so. In scenario two, Pat appears to have given up hope and/or has been so badly hurt by the betrayal that it may be necessary to name and work on ending the relationship as painlessly as possible.

b) Addressing the Hurt

When couples present with infidelity, I encourage them to name and experience the hurt and devastation of the betrayal. Failure to do so and focusing on the past (pre-affair) or the future can be viewed as minimising or disregarding the impact of the deception. I sometimes use the analogy of a car crash, where Chris is guilty of dangerous driving.

Discussing how and when they got into the car and how they intend to replace

the damaged vehicle is not relevant while Pat is lying hurt on the road.

The path to recovery begins with first aid for Pat, where the quality of care and remorse from Chris can be viewed as a starting point for regaining trust. First aid consists of recognising the hurt and facing into the storm of emotions that encompasses it. It is important to stress that this takes time. Rushing to solutions can cause more anguish as it minimises the impact of the betrayal and can be seen as an escape from responsibility by Chris. For Pat, the recognition of the damage being experienced is vital in the early stages towards recovery.

c) True Remorse

At times, clients have expressed that while

Table 1: Questionnaire asking couples to rate where they are in their relationship.

1. Where am I now in this relationship?	0	1	2	3	4	5	6	7	8	9	10
	Can't get any worse				So, so		OK		As good as it gets		
2. Where do I think I can reasonably get to?	0	1	2	3	4	5	6	7	8	9	10
	Can't get any worse				So, so		OK		As good as it gets		
3. How committed am I?	0	1	2	3	4	5	6	7	8	9	10
	Not committed			So, so		I will try		I will do anything			

Table 2: Example of typical scores from the Relationship Rating Questionnaire.

	Scenario one		Scenario two	
	Pat	Chris	Pat	Chris
Question 1	2	4	1	3
Question 2	5	8	3	6
Question 3	6	9	3	6

there may not be full remorse for having the affair, there is deep guilt for the hurt caused. Clients have stated they felt their relationship was in a rut, they were being taken for granted, or their life was going nowhere and the attention of another person brought excitement and was a welcomed distraction. Chris was candid about not fully regretting what happened, but was intensely ashamed of the hurt caused to Pat. Honest admissions like this are much more likely to be heard than an unconvincing “sorry” expressed in an attempt to bury the issue in the past.

The most important measure of remorse is not the statement of repentance, but the actions that follow. I have listened to people relate how sorry they are, but then not want to hear the true impact or fail to change the behaviours that remind their partner about the affair, for example, returning to the same place where the affair began, or continuing to work in the same company or department with the person they had the affair with. Remedial actions are the true measure of remorse.

d) Regaining Trust

In our second session, Chris asked Pat to trust again, with a view to putting the past behind them and working on restoring their relationship. One of my questions to Chris was “what percentage of trust are you targeting to earn?” Chris explained that it would take time but thought they could get back to 90% at some point in the future. Pat was adamant 90% would never be possible. We drew a graph of this to visualise the gap that exists between them in relation to trust expectations and limits (Figure 2). The challenge is to see if they can live with this gap or not. One of the purposes of

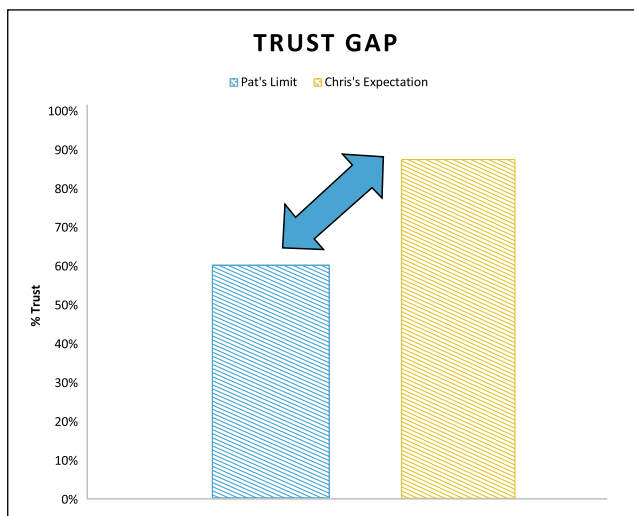


Figure 2: Trust gap showing limit and expectation

this discussion was to move the expectation/work from Pat being *required* to trust Chris, to Chris working to *earn* that trust, within Pat's limit.

e) Rebuilding the Relationship

Assuming Chris and Pat worked through the first three stages, they then began to work on rebuilding the relationship. In their case this was during their fourth session. Part of the work involved one session devoted to Pat being able to ask, and Chris committing to answer, any questions about the details of the affair. The purpose of this exercise was to allow Chris the opportunity to regain trust and to allow Pat to ask questions that needed answering. Invariably, issues in the relationship prior to the affair came into focus and these were then worked on to see what each of them could commit to change and see if this was a basis for moving forward.

f) Grieve and Move On

If the preference of either person is not to rebuild the relationship, then the grieving needs to be well under way before making practical decisions. The often quoted ‘Resentment is like taking poison

and waiting for the other person to die’ is relevant here.

Revision of Approach

Throughout the course of my work, numerous couples challenged my approach. One couple were not interested in ‘staying with the hurt’ phase and were

more focussed on the future. They quickly assessed where they were, recognised that their relationship before the affair was not nourishing for either of them and wanted to develop a new one. Two additional couples followed with similar approaches.

After a few months of work, all clients revealed that while the hurt and betrayal remained, they were experiencing deeper and more meaningful conversations than they had in previous years. Some also commented that their relationship was more interesting and intense. This feedback encouraged me to find out more about not only the possibility of a relationship recovering from an affair, but the possibility that it could improve the relationship in the long term. This led me to an interesting Ted Talk by Belgian psychotherapist Esther Perel, entitled *Rethinking Infidelity: A talk for anyone who has ever loved*.

This talk, in addition to my own discussion with clients, revealed two main points:

1. The old relationship is dead, and the question to be asked is do the clients want to start a new one or not; and

- It is possible to start a new and more rewarding relationship.

The importance of these two points led me to abandon Step e (Rebuilding Relationship) in the Process View and replace it with steps e1 and g1 as outlined in Figure 3.

e 1) Decision on a New Relationship

I have found that a recognition that the old relationship is dead because of the affair to be a much easier proposition for clients to grasp than trying to revive or recover the old relationship. It honours the impact of the betrayal and clarifies that there is no going back to where they once were. It also allows for grieving the loss of the relationship and the dreams they held for it.

f 1) Grieve and Move On

A recognition that the former relationship is dead because of the affair honours the impact of the betrayal. It also allows for grieving the loss of the relationship and the dreams both parties had for it. If the preference of either person is to not start a new relationship,

then the grieving needs to be underway before making practical decisions. Some of this grieving, for example for lost dreams for the relationship, can be done in the therapeutic space and rituals of letting go can be a great help.

g 1) Defining and Creating a New Relationship

Starting a new relationship gives each person the choice of negotiating new ground rules, now based on experience. While addressing the hurt is still an important element of the process and the remorse for the hurt caused, it appears that the assessment that the relationship is ‘dead’ validates the impact of the affair and the often deep betrayal it caused.

Unlike the way I worked in the past, where there was always a degree of looking back to what went wrong and trying to repair the old relationship, the naming of the death of this old relationship creates a freedom to explore what needs to be different in the future. All couples I worked with reported that this was more positive and led to a better understanding of their individual needs and expectations within the relationship.

Vilhauer (2016): “Working through a ruptured relationship offers you the opportunity to grow as a person and perhaps find a deeper meaning in the relationship itself” (para. 9).

I have also noted how increasingly couples appear to be able to get past an affair and wonder if this is a change in society and/or change in my perspective of the possibility to choose to start a new relationship, rather than hold on to the old. In any case, I feel more energised working with couples presenting with infidelity than I had previously and see the benefit in allowing my clients to choose the future rather than be bound by the past.

Brendan O’Shaughnessy

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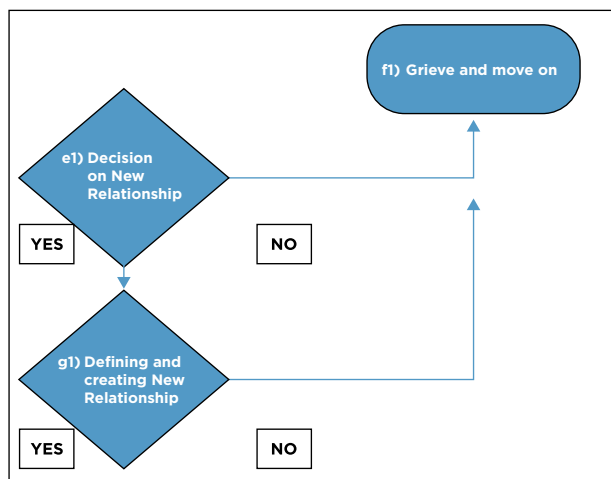


Figure 3 : Revised final two steps of Process View

Conclusion

My experience of working through infidelity with couples has proved both challenging and refreshing. My views were challenged and subsequently changed because of new experiences with my clients and has impacted on the way I now work with them. In the words of

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Practitioner Perspective

Spirituality in the Recovery Process of Addiction - Is there an Impact on the Counsellor?

By Daniel Cleary



For therapists working in the addiction treatment field, the use of spiritual concepts in the treatment of alcohol and drug addiction is viewed by some as the clearest demonstration of the value of spirituality and this construct may be seen as the central curative factor in recovery

Introduction

There may be an impact on the addiction counsellor when spirituality is incorporated into the recovery process (Treloar, Dubreuil & Miranda, 2014; Duchon & Plowman, 2005) and this poses important implications for training and supervision of therapists in

addiction work. There needs to be an openness and awareness around spirituality, irrespective of whether the counsellor personally believes in spirituality or not. When spirituality is part of the recovery process, it can enable the counsellor to deal with and manage an array of issues that arise with

the client, as well as enhancing the work and life of the therapist.

If the addiction worker has the ability to allow an open, non-judgmental and compassionate environment when working in the area of addiction treatment, spiritual understanding, knowledge and competence may increase the ability of the addiction worker to help the addicted person “to discover or rediscover their own purpose and core values, explore the negative consequences of the addictive behaviour on these values, and to develop behaviours that support the identified core values” (Treloar, Dubreuil & Miranda, 2014, p. 38). These negative consequences can include burnout, stress, empathy fatigue, vicarious trauma, sadness, transference and/or countertransference. Perhaps most striking, however, is the opportunity spirituality presents to the counsellor for personal and professional growth in their work and spiritual life. This article will explore addiction, recovery, the role of spirituality and addiction recovery and working in addiction recovery.

What is Addiction?

There has been a great deal of research into what constitutes addiction, with extensive literature published on the subject and its varied understandings and descriptions. Although the World Health Organisation’s (1992) *ICD-10 Classification of Mental and Behavioural Disorders* outlines

clinical descriptions and diagnostic guidelines for addiction, and the American Psychiatric Association lists addiction in its *Diagnostic and Statistical Manual of Mental Disorders V* (2013), defining addiction still proves difficult because it encompasses numerous fields, namely medicine, psychology, science and biology.

Addiction can take many forms. Indeed, there is further difficulty in defining who can become addicted, what an individual can be addicted to, and what the real health effects of these addictions are. There is also confusion around the motivation to use or be involved in what an individual might be addicted to (Armstrong & Piccard, 2015). Further, addiction can be viewed as multi-faceted, including both appetitive and compulsive aspects (Chassina, Pressona, Roseb & Shermanc, 2007).

The American Society of Addiction Medicine (ASAM) (2010) states that addiction can be described as a “primary, chronic disease of brain reward, motivation, memory and related circuitry” (p. 1). Dysfunction in brain reward, motivation, memory and related circuitry leads to characteristic signs of biological, psychological, social and spiritual happenings. This can be seen in an individual pathologically pursuing reward and/or relief by substance use and/or other behaviours.

Addiction encompasses the inability to consistently abstain from “impairment in behavioural control and craving, diminished recognition of significant problems with one’s behaviours and interpersonal relationships, and a dysfunctional emotional response” (ASAM, 2010, p. 1). Like other chronic diseases, addiction can involve repeated episodes of relapse and remission. Without intervention, treatment or some type of recovery, addiction is progressive and can result in long-

If recovery is going to be achieved and maintained, the person with the addiction must develop the capacity to form healthy and emotionally-regulatory relationships (Roth, 2016)

term illness, injury, or condition, or possible premature death.

What is Recovery?

Recovery, like addiction, has proved difficult to define in spite of extensive research into the process. To date, there is no consensus on a definition, even among those in recovery (Laudet, 2007; Laudet, Morgen & White, 2006). A number of researchers define recovery in terms of substance use (Cisler, Kowalchuk, Saunders, Zweben & Trinh, 2005), while others refer to recovery as total abstinence from the substance (Flynn et al., 2003; Scott et al., 2005). Either way, recovery can be viewed as a complex and dynamic process incorporating all the positive effects and advantages of the physical, mental and social health that can happen when people with an addiction receive the help they need (National Council on Alcoholism and Drug Dependence 2015).

If recovery is going to be achieved and maintained, the person with the addiction must develop the capacity to form healthy and emotionally-regulatory relationships (Roth, 2016).

The Substance Abuse and Mental Health Services Administration (2011) describes recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (para. 2). They continue that although abstinence remains the safest approach for those with substance use disorders, it emphasises that “recovery occurs

via many pathways” (para. 2).

The role of Spirituality and Religion in Addiction Recovery

People in recovery from alcoholism or other addictions through 12-step programmes like Alcoholics Anonymous (2013) often hear phrases such as ‘this is a spiritual programme’ or ‘you need to discover your spirituality or higher power’. Twelve-step programmes clearly separate themselves from religion, yet equally claim to be spiritual programmes. Likewise, some residential programmes attach themselves to a particular religion and also state that they offer a clear spiritual programme.

Religion is defined as “an organized system of beliefs and rituals associated with an institutional structure” (Rusinova & Cash, 2007, p. 252). While it is difficult to define the term and meaning of spirituality (Egan & Swedersky, 2003; West, 2000), it is not to be equated to a doctrinal or religious faith. According to the New Hope Recovery Centre (2014), spirituality does not need to be defined through the lens of religion. “Spirituality is recognizing a power greater than ourselves which is grounded in love and compassion. It is a power that gives us perspective, meaning and a purpose to our lives. It is a desire to connect with more than ourselves, to connect with everything” (para. 3).

Booth (2012) informs us that spirituality is about recognising that people have the power to change what it is in their lives that brings them pain. Whether it

As therapy is very often not the first port of call for people seeking help, it can be assumed that clients have spent some time coping with their difficulties in other ways

is an individual in need of greater positivity, or a person whose life has been destroyed by addiction, every one of us has the ability to initiate the healing process. Not surprisingly then, spirituality has become and continues to be an important topic in today's world.

Ciarrochi and Brelsford (2009) suggest that poor self-control, crime and substance abuse may be the result of a lack of religious or spiritual belief/connection. They propose that a person with a connection to a religious or spiritual institution has a higher likelihood of possessing psychological maturity and emotional well-being (Zinnbauer, Pargament & Scott, 1999, as cited in Ciarrochi & Brelsford, 2009).

For therapists working in the addiction treatment field, the use of spiritual concepts in the treatment of alcohol and drug addiction is viewed by some as the clearest demonstration of the value of spirituality and this construct may be seen as the central curative factor in recovery (Borman & Dixon 1998; Green, Fullilove & Fullilove 1998; Warfield & Goldstein 1996). And it appears to be a growing phenomenon: "Get used to it. Spirituality is creeping into the offices... And companies are turning inward in search of a 'soul' as a way to foster creativity and to motivate leaders" (Galen, 1995, para 2).

Workplace spirituality, according to Duchon and Plowman (2005), is defined as a workplace that recognizes that employees have an inner life that nourishes and is nourished by meaningful work

that takes place in the context of community. Other authors have explored spirituality in the workplace (Bell & Taylor, 2004; Carroll, 2013; Duchon & Plowman, 2005; Fry & Kriger, 2009; Lips-Wiersma & Mills, 2002). These authors, among others (Ashmos & Duchon, 2000; Dehler & Welsh, 2003; Gibbons, 2001; Kinjerski & Skrypnik, 2006; Mitroff & Denton, 1999), show spirituality at work as being comprised of three components: the inner life, which refers to human self-concept; meaningful work, which refers to work content; and community, which concerns the working context.

In their study on 'Nurturing the spirit at work: Impact on work unit performance', Duchon and Plowman (2005) note that work-unit leaders likely have an impact on the degree to which work units acknowledge and encourage issues of spirituality. Workers want to be involved in work that gives meaning to their lives (Ashmos & Duchon, 2000). Significantly, work becomes more meaningful when there is a connection between the worker's roles/job and their values.

Working in Addiction Recovery

Alcohol and drug counsellors are responsible for providing confidential addiction counselling, education and support to the individuals presenting with addiction(s) or addictive behaviour and may also be required to provide support to the family and the wider community (Alcohol and Drug Counsellor, 2005).

The type of work that a person chooses is significant for several

reasons; work is good for our health and well-being and contributes to our happiness, confidence and self-esteem. It is an integral part of our existence and identity and thus cannot be easily separated from the rest of one's life. According to Gini (1998), the business of work is not simply about producing goods, "but also to help produce people" (p. 708). Gini states that people need work and, in turn, develop their identity and are identified by the work they do. He concludes by stating that people need to be careful about what they choose to do for a living; for what we do is what we will become. Choosing well generally means deciding on a line of work that will lead to happiness because happiness leads to and fuels success. When a person is positive, their brain is more motivated, engaged, creative, energetic, resilient and productive (Action for Happiness, 2016).

What is it that could provide meaning or purpose or add to a person finding meaning or purpose in their role as an addiction therapist? Victor Frankl (2006) a psychiatrist and Holocaust survivor believes that the search for meaning is the most important aspect of a person's life; it is not the destination that matters, rather, it is the journey that is important. Highlighting this, students from the Johns Hopkins University in Baltimore, Maryland, US, were asked what they considered to be central in their lives. Some 78 per cent answered that finding a purpose and meaning in life was most important to them (Bulka, 1997).

Howden (1993) informs us that purpose is the process of searching for or discovering events or relationships that give a sense of worth, or reason, for our existence. The treatment centre or the therapist's workplace is,

like other workplaces, a place that provides connectedness to others or the self (Conger & Elder, 1994). This connection could be viewed for some as replacing what used to be experienced in churches, with extended families and local social groups that may no longer exist.

Pratt and Ashforth (2003) suggest that meaning is a subjective sense that people make of their work. According to Baumeister and Vohs (2002), meaning is a tool used by individuals for imposing stability in their life - something lacking in the life of an addicted person. Baumeister (1991) suggests that as people's work lives evolve, they strive to fulfil needs for purpose, values, efficacy and self-worth. Thus, people look for a purpose and often a deeper purpose in their work.

Some addiction therapists garner meaning at work from the impact of Eastern philosophy (Brandt, 1996). Where mindfulness is offered as a way of living and working, it provides an opportunity to reflect on values and what it is that brings meaning to one's life. Mindfulness and values-based approaches can contribute to a therapist finding psychological support in differential troublesome situations (Hayes, Follette & Linehan, 2004).

A possible struggle for the addiction therapist finding meaning in their work is the financial value put on the therapist and this can lead to a feeling of demoralisation (Brandt, 1996; Hamal & Prahalad, 1994; McWilliams, 2014; Osborn, 2004).

Some addiction therapists accept that spirituality is not religion and the two should be regarded as separate entities and can be treated and used differently (West, 2000). Irrespective of faith and/or beliefs, practices and or spirituality of the therapist, or indeed if the therapist does not identify with any of the above, it is important to be

Where mindfulness is offered as a way of living and working, it provides an opportunity to reflect on values and what it is that brings meaning to one's life

aware of the influence of Church, faith practices or spirituality in his/her life (Rusinova & Cash, 2007). Spirituality for some therapists can be more far-reaching and broader than religion. Counsellors have the knowledge and experience to know that people struggling with addiction can change and recover because spirituality offers healing and is essentially about recovery (Booth, 2012) or can have improved treatment outcomes (Carter, 1998).

The change or recovery occurs when spirituality impacts on the therapist's life due to a turning point or because of the protection and support from a higher power. The change can also occur because the counsellor is grateful to be of help to those seeking recovery (Arnold, et al., 2002).

Spirituality for some therapists can include a 'higher power' that encompasses love and compassion of the self and others (New Hope Recovery Centre, 2014). Some addiction therapists believe incorporating spirituality into the recovery process offers themselves and the client social support, optimism, and the ability to manage and deal with stress, anger and sadness and also help with conflict resolution - all of which contribute to a positive result (Corrington, 1989 & Pardini, et al., 2000). There are addiction therapists who, in a variety of ways, show their ability to be fruitful and rich in their therapeutic work, as well as having positive results being creative, generative, and compassionate, connected to people as well as being supported and enriched by different experiences that they have had.

Self-care is often referred to as a necessary and beneficial part of working in counselling and some therapists find nature and mindfulness soothing. Likewise, benefit can also be found in 'supervision', which is a place where counsellors are psychologically supported (Hayes, et al, 2004).

Some counsellors maintain that spirituality significantly influences both the addict and themselves in their ability to live responsibly (Dilorenzo, Johnson and Bussey, 2001). When this is experienced, some therapists believe they should talk about and promote spirituality as a way of getting into recovery (Newport, 2011 & Dossey, 2000).

Workplace spirituality (not religion) can, according to some therapists, nourish them and their work because they view their work as 'meaningful' (Duchon & Plowman, 2005). Likewise, some addiction counsellors may find they are impacted by the support that is often present in group and community settings where people are on similar journeys. These therapists also suggest that their own spirituality and life is impacted by what they experience in their work (Bell & Taylor, 2004; Fry & Kriger, 2009; Dehler & Welsh, 2003, and Kinjerski & Skrypnec, 2006).

Similarly, some addiction therapists note they are aware they are impacted by spirituality through discovering or rediscovering "their own purpose and core values, [and by exploring] the negative consequences of the addictive behaviour on these values" (Treloar, Dubreuil & Miranda, 2014, p.38), or by developing behaviours "that

support the identified core values” (Treloar, Dubreuil & Miranda, 2014, p.38), whether it is the addicted person seeking recovery, or the therapist, working through issues/difficulties in the recovery process of addiction. The impact also includes being productive and constructive. Some counsellors find that because of the impact of spirituality they are able to work in the challenging area of addiction therapy and their work is significantly enhanced by it.

Conclusion

Addiction therapists are generally happy in their roles and their work (Howden, 1993; Pratt & Ashforth, 2003), which in turn provides them with meaning and purpose in their life (Frankl, 2015). Work is not just about the business of therapy, but about people and helping people (Gini, 1998). Addiction therapists have a purpose in life that gives them a sense of worth that is impacted on and helped by spirituality (Howden, 1993). Therapists are connected to other people and their workplace provides this connectedness (Cogner and Elder, 1994). Being connected to other people gives therapists meaning and this meaning is enhanced by the spirituality that they experience in their workplace and in their work. While this is subjective (Pratt & Ashforth, 2003), this spirituality appears to give therapists stability to be able to work in the field of addiction and to want to continue to work in the field.

Spiritual understanding, knowledge and competence among addiction therapists enhances their effectiveness when working with individuals struggling with addictions or who are moving into recovery (Treloar, Dubreuil & Miranda 2014). When the therapist has the ability to provide an open,

non-judgmental and compassionate environment when working in the area of addiction treatment, spiritual understanding, knowledge and competence seems to increase the ability of the addiction worker to help the addicted person.

According to Treloar, Dubreuil & Miranda (2014): “When working in the area of addiction treatment, spiritual competence may increase the ability of the provider to help the client to discover or rediscover their own purpose and core values, explore the negative consequences of the addictive behaviour on these values, and to develop behaviours that support the identified core values” (p. 38). This would seem to suggest that if the addiction therapist has not considered their own spiritual understanding, knowledge and competence, or if they believe that spirituality is not of importance, when the client does, the therapist may not be able to fully address their client’s needs and may not be aware of the impact on themselves as a worker and as a person. ☺

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Practitioner Perspective

Contextual-Conceptual Therapy – A New Approach to Suicide Therapy¹

By Gitti Maas



Suicide continues to be a complex and major health problem worldwide. Contextual-Conceptual Therapy is a new and innovative approach to suicide therapy that examines the ‘language of suicide’, focusing on rediscovering the true self to uncover the roots of suicidal thinking

Introduction

According to the Irish Health Service Executive (HSE), suicide is “a global public health problem and its prevention continues to provide a major challenge to health and social services” (2018). On a worldwide scale, the World Health Organization (WHO), claim

800,000 people die by suicide every year – that is one person every 40 seconds. Further, there is evidence that for each death by suicide, more than 20 other people attempt suicide (Suicide Data, 2018). The implications of this data indicate that it is vital to have the right support in place for people

with suicidal ideation. Through my personal experience and training, I believe that Contextual-Conceptual Therapy (CCT) can offer this support.

CCT is rooted in the suicidal person’s own language; it recognises that feeling suicidal is an expression of an identity crisis and uses maps, models and metaphors to guide the suicidal person to the root of their suicidal thinking and to a life-embracing, intimate self-knowledge. CCT aims to be the starting point to a life free of suicidal ideation.

CCT is not in competition with other theories, but functions more as a forerunner and is complementary with other counselling models in a hierarchical manner. CCT supports the suicidal client to perceive the true context they are in, which needs to happen before any cognitive and behavioural therapeutic work can begin.

In the following article I shall introduce the CCT model, which recognises that “suicide cannot be prevented until it is properly conceptualised” (Maris, 1981, p.339) and illustrate how this can be done.

What is Contextual-Conceptual Therapy?

CCT is a new approach to suicide therapy, developed by Seattle-based Suicidologist Fredric Matteson, and is the only therapy model

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I am aware of that is tailored specifically for suicide. Of course other counselling models work with suicidal people, but these models have usually been created for a broader spectrum of concerns a client might present with. In contrast, CCT has been established exclusively through working with and for suicidal clients.

I first heard about CCT at the 2014 World Suicide Prevention Day Conference in Dublin, where Matteson was the keynote speaker. For me – a counsellor and survivor of two suicide attempts many years ago – Matteson stood out from the rest of the presenters that day. He was the first professional in the field I met who was able to speak from the perspective of a suicidal person, expressing a true understanding of the suffering they endure, and his words touched me deeply.

I felt suicidal for years following my suicide attempts - this was despite attending therapy, taking medication and having the support of friends. I did everything I was told to do and worked hard to “get better”. Eventually, it dawned on me that there was nothing *wrong* with me; I just did not know how to fill the void I felt within - one that I had hoped others would fill. The reality, I came to realise, was I did not know who I was.

Matteson developed CCT over the course of 25 years working with more than 16,000 suicidal patients in St. Francis Hospital, Seattle, Washington. He set about trying to understand the core experience of what it means to feel suicidal by exploring the language of his clients in the midst of their suicidal crises. Exploring the suicidal person's language, Matteson discovered that the most common metaphors used by suicidal people are ‘lost’, ‘trapped’ and ‘stuck’. His unique approach combines expressive art

techniques, education and therapy.

Through his work, Matteson found that feeling suicidal is a symptom of an underlying context-bound problem. That is, it is not an illness, but rather, an identity crisis. He uses the image of a person stuck inside an invisible ice cube to illustrate this, showing how they are unable to reach out and are unable to let anyone reach them (Figure 1).

In my own work I use a poster-size print of the ‘Invisible Ice Cube’. Every suicidal client I have met in my work has been able to identify with this image, which helps deepen our connection as the client feels seen and understood. With CCT, the client has to fully conceptualise the true context they are in. If they do not do this, they will come to the wrong conclusion that suicide is the only way to solve what they perceive their problem to be. From their perception, suicide makes logical

sense and they are caught in a self-perpetuating feedback loop.

As it is the suicidal person's ‘best and most logical thinking’ that brings them to this place, any attempt to change their thinking by reasoning will only reinforce their way of thinking as it is logical within their context; within their frame of reference. Crucially, logic cannot change context – logic works within context.

Matteson argues that although reasoning, traditional approaches and medications may help the suicidal person in the short term, these approaches cannot reach them deeply enough to end their suffering as it fails to get to the root of their suicidal thinking. The reason for this is most traditional suicide-related therapy focuses on the person not taking their life and recovery.

CCT's ‘Metaphorical Hierarchy’ (Figure 2) shows that the base of therapy determines its outcome.



Figure 1: The Invisible Ice Cube (Matteson, CCT©)

It is here we have to change the metaphor - if our efforts as therapists are rooted in a model of mental illness, aiming for the client's 'Recovery' (the metaphor at the base of the pyramid), then the outcome of our work (top of the pyramid) has to be fundamentally different to the CCT concept, which focuses on 'Discovery'; (base of the pyramid).

In the CCT model the therapist works with the suicidal person and supports their own efforts to discover themselves. In my experience, this resonates deeply with the client as it gives them permission to follow their unexpressed and often unconscious yearning. This needs to happen before the cognitive and behavioural work can start if the long-term outcome for the client is to be positive and life-embracing.

If we look at suicide as an identity crisis as opposed to a sign of mental illness, we may ask:

- What if suicide is not about what is *wrong* with the suicidal person, but about what is right with them?
- What new questions do we, as therapists, need to ask?
- What new questions does the client need to ask?

Matteson developed an understanding (based on the works of Winnicott, Kohutt and others) that the suicidal person is trapped in a self-defence mechanism that at some earlier stage (usually childhood) was designed to keep the true self safe from feeling intolerable emotional pain and being hurt.

As their self-defence mechanism works through the unconscious creation of a 'false self', the suicidal person is not aware of the existence of their true self anymore, which becomes 'lost',

'trapped' or 'stuck' somewhere out of reach. The suicidal person employs this highly sophisticated defence mechanism that becomes normalised, then internalised and, as a result, can no longer be detected. As this often happens early in life, the person lives their life split off from their true self for many years before they start feeling suicidal. Over time, this false story of who they are leads to a struggle with their perception of themselves to have to be either/or: the person they are trying to be (as in the 'bad' person they think they are); or the person they are trying to be (the 'perfect' or good person).

Matteson recognised that neither option represents the suicidal person's true self, which is hidden to them. The important and remarkable discovery Matteson made is that the suicidal person is caught in a bifurcated state (Figure 3) between these two false self-images – or, more simply, an identity crisis. He states that "suicidal individuals universally communicate about an existence in a bifurcated state where who they are to us is not who they are to themselves" (<http://suicidetherapy.com/cct-theoretical-overview/>). This bifurcation leads to a rigid mindset of 'black-and-white' thinking. This rigidity, in Matteson's revolutionary view, must be 'destabilised' to renew contact with the true self (Figure 3).

As seen in the Bifurcation Model, at the base we have the true self; a person completely in touch with who they are. Through an event – often in childhood – of intense uncomforted pain, the person develops a false self in order to protect the true self. CCT sees that this false self, which is no longer aware of the true self, experiences a lack of 'something' they cannot name. In an effort to find this 'something', they try not to be the bad person they think they are,



Figure 2: Metaphorical Hierarchy (Matteson, CCT©)

but they feel the need to become this perfect person they think they should be. As they are still not in touch with who they truly are, this effort, this black-and-white thinking, will eventually lead to a crisis point and, possibly, suicide.

When suicidal clients talk of feeling ‘lost’, ‘trapped’ or ‘stuck’, they actually experience the truth of their true self being lost to them, but they are unaware of the context in which they are operating. The suicidal person, caught inside this context-bound state, can feel what they are in, but cannot name it. Being unable to identify their ‘problem’ of being disconnected from their true self, they remain repeatedly stuck at the level of their symptoms. Therefore, they cannot see where their pain is coming from and thus cannot stop it. Here, suicide is seen as the only solution or ‘the only way out’.

The Importance of Context

The suicidal person needs to understand the context in which they are operating before they can understand the actual problem, as suicide is their solution to an unknown problem.

Neither the suicidal person, nor traditional therapy, addresses the actual *root* of feeling suicidal. Instead, the ways the suicidal person expresses this pain are being addressed (Figure 4). Attempting to cope and attending to emotions like self-doubt, tension and fear, is the equivalent of fighting smoke instead of fire. As a result, the person spirals further into anxiety, shame, guilt, hate, to eventually acting out and finally to suicide.

To illustrate this point, imagine a person falling ill on the lower deck of the *Titanic*. If our solution to the problem as we perceive it is to try and ‘stabilise’ the person by bringing them to the upper

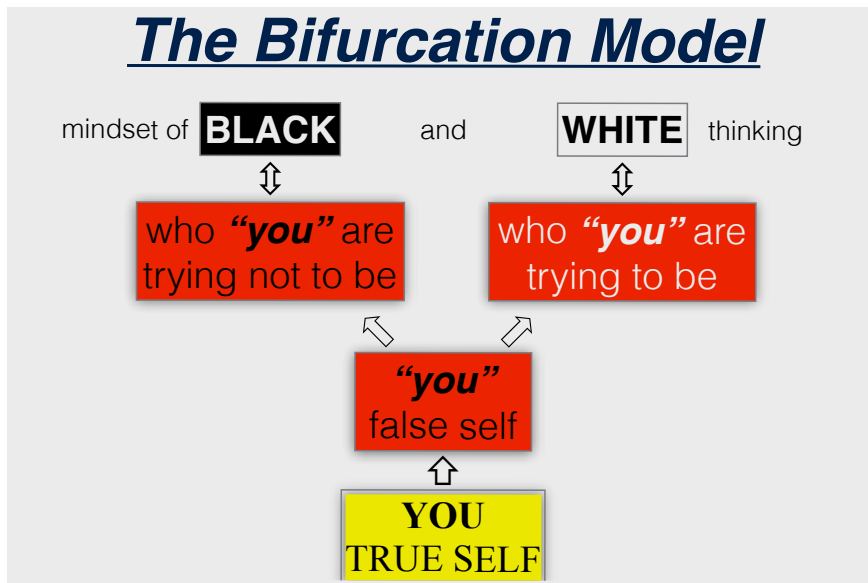


Figure 3: The Bifurcation Model (Matteson, CCT©)

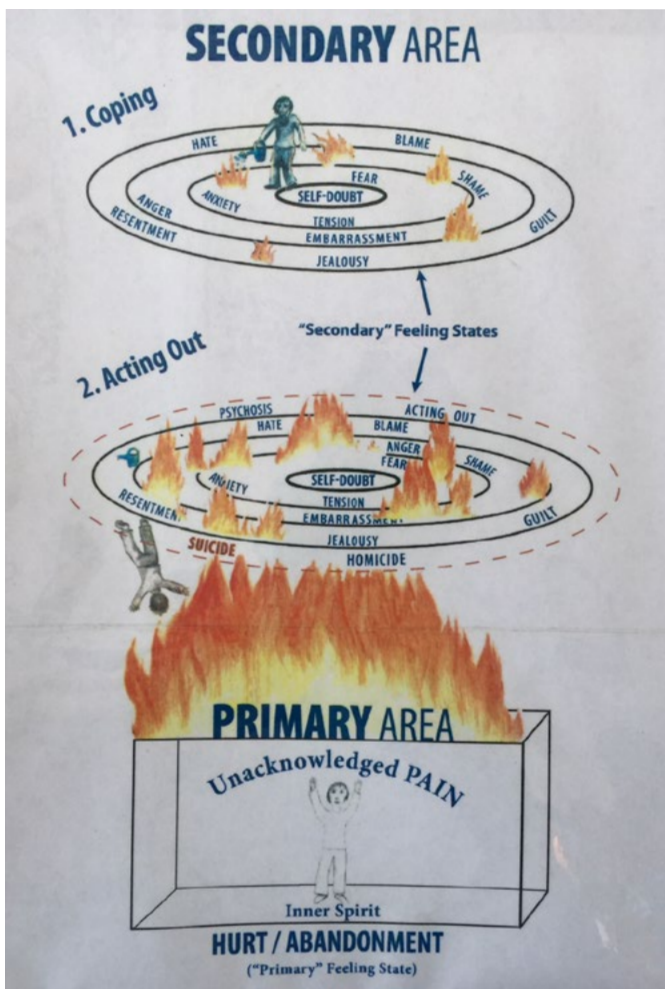


Figure 4: Fighting Smoke Instead of Fire (Matteson, CCT©)

deck for some fresh air, we might succeed in helping the person feel better temporarily. However, we are missing the true context that the *Titanic* is about to sink and that we are still on it.

Similarly, traditional therapy attempts to bring the suicidal person back to the place from where they came, i.e. back to the 'false self'. In contrast, CCT does not try to stabilise the suicidal person in their unstable place, but attempts to 'destabilise' their thinking; the CCT therapist momentarily 'shakes' the client's frame of reference, to then skilfully re-orientate the client so that they can begin to see the false context in which they are operating. This needs to be done with competence and in-depth knowledge of the CCT model to ensure the client's safety.

An indirect form of communication is employed to bypass the client's intellect and their often-strong resistance. This form of communication accesses the suicidal person's right half of the brain, opening up more and more room for curiosity. CCT listens closely to the client's own language and builds upon the client's strength and passion.

With the help of specifically designed maps, metaphors and creativity inside the CCT facilitating environment, the CCT therapist challenges the client's false self and supports the client to see themselves and their relationships in a new context.

According to Maris (1981) "Suicide cannot be prevented until it is properly conceptualised (p.339)." In this way, a new and true context, a new frame of reference, gives the client an opportunity to rediscover their true self and to conceptualise the root of their suicidal thinking.

CCT also teaches the suicidal person about their psychological

Matteson developed an understanding... that the suicidal person is trapped in a self-defence mechanism that at some earlier stage (usually childhood) was designed to keep the true self safe from feeling intolerable emotional pain

defence mechanisms and provides unique, personalised tools for ongoing self-care. CCT subscribes to Carl Jung's idea that if you try and get rid of the pain before you understand its question, you get rid of the self (Jung cited in Rohr, 2008). In this sense, CCT supports the client into their pain to discover the root of their suicidal thinking as well as their true self. It gives the client new meaning from where to engage in self-exploration and other forms of therapy. Creating true context first is essential though, as anything cognitive cannot truly succeed without context.

Throughout the therapeutic process, the relationship between the therapist and the client is crucial. It has to be one of trust, so that the therapist's challenges (within true context) are not experienced as being shameful by the client who might otherwise (without context) take what is being said as literal. The CCT therapist does not try to steer the suicidal person away from their pain, but enters into the darkness and confusion with them – both challenging and welcoming them. In this process, the false self 'dies' and the true self is 'reborn'.

My Experience at the CCT Centre in Seattle

I work closely with Fredric Matteson and have been to Seattle twice to learn about CCT. Currently, I am one

of three CCT associates working in Europe. Walking into the CCT room, it is apparent that CCT is purposefully designed to capture the client's mind in a new and innovative way. The environment is engaging with maps, images and metaphors on the walls and hanging from the ceiling - literally, a playground for the mind.

I have been able to accompany Matteson into client sessions and have met some of his current and former clients. The words of one remarkable young man, 'J', (a former client of Matteson) may help to illustrate the lived experience of the client in this approach. 'J' made several suicide attempts and had been in therapy for many years until he worked with Matteson and the CCT approach. Today he is a vibrant, open young man, full of fun and loving life. What follows are some of his words from a piece he wrote entitled '*Paradox and Pool Parties: Life after Suicide*': "Years of traditional therapy and hospitalisations ultimately lead me back to suicidal crisis... Simply learning how to change my cognition in order to 'better' my thinking, acting, and feeling was not lasting... Inside, my spirit was silently screaming. Lost in the dark... I began my work with Fredric Matteson and his unique therapeutic approach to suicidality... This work has relieved me from entrapment in a personal hell and led me to a place of synchronicity and connectivity to myself, people, and the world around me... Curiosity played a vital tool in exploring raw, dark, and unknown things. All with the target of understanding the context from which my behaviour manifests... CCT forced me to improvise. Breaking away from logic... A mixture of art, metaphor, mythology, creativity, philosophy and language moved me into a place of vulnerability. Like a child, I was

learning. But in a different sense than that of therapies previous. I was entering a transition – an ‘in-between’ place – where I was learning who I truly was. A process that took me deep into myself, building from the ground up... Soon realising that I had never stopped being me, had just lost touch... For the first time I felt that I wasn’t being ‘treated’ for what was wrong with me – but instead, ‘educated’ about what was right with me. And finding the hidden truth: that I had the answers to my suffering all along but had just lost access to them.”

Conclusion

Contextual-Conceptual Therapy (CCT) is a new and innovative approach to suicide therapy, developed by Seattle-based Suicidologist Fredric Matteson. CCT identifies that feeling suicidal is not an illness, but an expression of an identity crisis and creatively uses the suicidal person’s own language, as well as specially developed maps, models and metaphors. These aids support the suicidal person to understand the root of their suicidal thinking. Through close examination of his clients’ language, Matteson realised that feeling suicidal is a symptom of an underlying, context-bound problem. CCT highlights the importance of the suicidal person having to fully conceptualise the true context they are in as, from their perspective, caught in a self-perpetuating feedback loop, suicide makes logical sense to them.

Matteson understands that the suicidal person is trapped in a highly sophisticated defence mechanism that at some earlier stage in their life was designed to keep their true self safe from being hurt. According to Matteson, this often leads to the suicidal person being stuck in a bifurcated state and a rigidity in their thinking, which

The CCT therapist momentarily ‘shakes’ the client’s frame of reference, to then skilfully re-orientate the client so that they can begin to see the false context in which they are operating

CCT attempts to destabilise in order to renew the client’s contact with their true self.

In this process, which employs a combination of metaphor, creativity, and language, the therapist does not try to steer the suicidal person away from their pain, but goes into the darkness and confusion with them - both challenging and welcoming them. Through this work, the false self dies and the true self is reborn. Once fully in touch with their true self again, the client often realises – as one of Matteson’s former clients ‘J’ puts it in *Paradox and Pool Parties: Life after Suicide* – that they “had the answers to [their] suffering all along but had just lost access to them”.

CCT is a therapy model that asks the therapist to undergo additional training and realises it is not a ‘one-size-fit-all’ approach to therapy. I am convinced that CCT is the missing link in our efforts to reduce suicide statistics in Ireland and support suicidal clients in their struggle to overcome their despair. With CCT, the suicidal person’s moment of crisis can become their moment of transformation. ☺

Gitti Maas

Gitti Maas (MIACP, M.Ed) trained in Humanistic Integrative Counselling in Cork, and works in private practice in Kenmare. She is member of the *Coiscéim* Counselling Panel, volunteers

for ARC Cancer Support West Cork as a counsellor and is a safeTALK trainer. A close working relationship between Gitti and Fredric Matteson (CCT founder) was formed when Matteson was the Keynote Speaker at the 2014 World Suicide Prevention Day Conference in Dublin. Gitti has been to Seattle twice to receive CCT training from Matteson and his team, and is now a CCT associate in Ireland. Gitti can be contacted through her website: www.gittimaascounselling.com

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Book Review

Title: *Understanding and Healing the Hurts of Childhood*
 Author: *Jim O'Shea*
 Published: 2018
 Reviewed by: *Hugh Morley MIACP*

The stated intention of the author is to prevent and alleviate distress in adulthood by understanding the consequences of insecure childhood attachment. The book's main thesis is that childhood largely dictates adulthood. It explores all types of emergent distress and offers suggestions on healing approaches. The author, Jim O'Shea, brings both client and personal experience to his writing, as well as his professional experience as a counsellor, EMDR therapist and former secondary school principal.

The book is hugely ambitious for its 300 pages. It is a whistle-stop tour of human fear and an anthology of what Jim calls "The False Self". Fears of abandonment, failure and death, as well as social phobias, anger and toxic jealousy are attributed to insecure emotional bonds within the early caregiving relationship. The author suggests an eclectic menu of therapeutic approaches to healing the wounds. It is therefore a useful book for anybody who suspects early causes to current problems either in self or in a client.

In reading the book over Christmas (a family time), I found the writing sensitive and insightful, affecting me emotionally at times as I came in contact with my own wounds through Jim's clear naming of early angers, jealousies and fears. By sharing his own experience generously and creatively, I felt very much accompanied by the author as I read the book. In particular, his poem on personal experiences of shame was eloquent, painfully well distilled and potent. "*How I loathe you, hate your taste on my Being, detest your fiery kiss, abhor the foulness of your breath, thief of my youth, destroyer of my trust, murderer of my passion, killer of my young love*". Equally endearing to feeling accompanied were the references to Irish culture, so absent in the books from abroad (many of which are exhaustively referenced). References to the terrors and joys of Peig Sayers, the Catechism, job opportunities

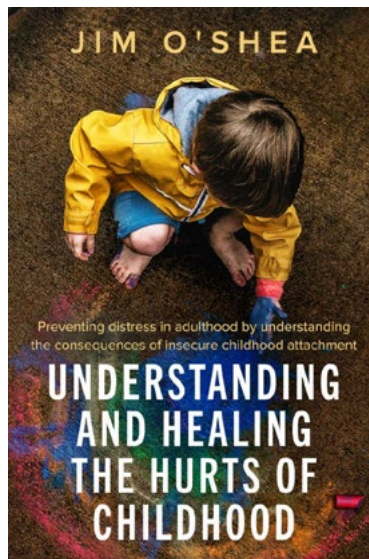
in Tipperary and hotel lobbies in Galway kept the work nicely grounded, in my view.

There are times when the writing is outstanding. Jim's short summary of the grieving process is as clear, real and integrated a description of the topic as you'll get anywhere. He writes succinctly on what he sees as the real meaning of forgiveness and on the benefits of inner child work. It is clear from his writing that he has experienced and integrated these in his own life as part of his training and work as an integrative humanistic therapist.

There are times when the writing meanders a little and would have benefited from stronger third party editing and tighter (rather than voluminous) referencing. For example, when referencing fear of death, I could not see a link between preferences for cremation or burial and childhood attachment! Jim acknowledges in the preface that he struggled with the vastness of his topic at times. Unfortunately, this reader struggled occasionally also. There was often a touch of absolutism in the thesis that so many human fears and psychological suffering (as per Jim's appendix) are "dictated" by attachment - often a singular diagnosis - and need to be "eradicated". Words like "strongly influenced" and "addressed" respectively, might sit better with the reader. At the same time, there was something brave and engaging about the strength of the author's conviction.

In summary, this book is a generous piece of work, aimed at educating, sharing, consoling and advising counsellors or clients. The teacher is very much present, as well as the counsellor and both are welcome. The book is a worthy introduction to the topic of early attachment and is a useful springboard to further reading, with copious recommendations and signposts. The whistle-stop tour was comprehensive, educational and for the most part engaging. The book is a welcome addition to Irish counselling literature and is available online at www.amazon.co.uk. Go browse!

Hugh Morley is Head of Business with Cork Counselling Services and a qualified integrative counsellor at the same organisation. He can be contacted at hugh@corkcounsellingservices.ie



Book Review

Title: *Becoming a Mother: Reflections on Adoptive Parenthood*
 Author: Mari Gallagher
 Published: 2018
 ISBN: ISBN: 978-1-786050588
 Reviewed by: Gráinne Clancy

Mari Gallagher gives a unique, personal Irish insight into the ethics, practicalities and emotional rollercoaster that begins and does not end when someone becomes an adoptive parent. This information is revealed in the stories of influential writers and adoptees, as well as the author's personal and painful journey to becoming a mother. Adoption is not a straightforward process, and the book begins with a discussion of the types, legalities and ethical considerations that have resulted in Inter-country Adoption (IA).

Adoption within Ireland has been a fraught and hidden subject, not talked about due to feelings of shame, as well as historical influences, and the author tackles the integrity of adoption sensitively and protectively - it is not just a time of joy; it is also one of grief and loss. Mari Gallagher, a counsellor and psychotherapist based in Newbridge, Co Kildare, explains how this is not only part of the process for the adoptive mother, but the child and even the biological family. Using poignant extracts from adoptees' stories, the author weaves a narrative about the nurturing family as well as the loss of heritage, due to international adoption.

For those of us who grew up with our biological parents, we likely have a greater understanding of our intergenerational history due to stories that have been passed down. Adoption very often takes this knowledge away. However, with modern technology making the world a smaller place, connections previously not possible are now a reality. Here, again, the heedful conflicts that can result are highlighted in a sensitive and protected way.

Becoming a Mother: Reflections on Adoptive Parenthood also provides insight into loss,

counselling and the practicalities of how to foster the relationship from talking about what to say to family members, protecting the child's personal information and using a development framework to explain what it is like to grow up in a different multicultural family.

The author sensitively tackles the impact of an adoptee becoming a parent for the first time and the emotions and feelings that can occur as a result when looking at their flesh and blood, perhaps for the first time. It is noted that family history can prove a difficulty because there may be a lack of awareness of hereditary medical conditions.

This book illustrates the importance of why honesty and access to child-appropriate information is an essential part of being a parent in Ireland today. As counsellors/psychotherapists, we can never honestly know the type of client who will walk through our door. Each one of us has different cultural backgrounds and empathy is essential. This book gives a unique insight and various conscientious considerations to becoming an adoptive parent in Ireland today and an awareness of our incredible diversity. Of note, 50 per cent of royalties from sales will be donated to Barnardos Post Adoption Services.

From a personal perspective, I enjoyed reviewing this book as it increased my knowledge about this very private journey towards becoming a mother.

Gráinne Clancy is a pre-accredited counsellor/psychotherapist working in LifeChange, Dublin 2. She can be contacted at info@hereforyou.ie



We are looking for reviewers

If you are interested in becoming an IJCP book reviewer please contact the editorial team:

iacpjournal@iacp.ie

Letters to the Editor

Dear Editor,

Thank you for publishing a review of my book *Depression and the Erosion of the Self in Late Modernity (IJCP, Autumn 2018)*, but may I correct some misapprehensions about it for the sake of readers tempted to buy it. The quote at the beginning of the review has been taken out of context. It is part of an explanation of my motives for writing the book. My problem lies with the hegemony of the medical view of depression – defective genes/imbalance of brain chemicals – when the alarming increase in the incidence of depression cannot be genetic and must be explained by the nature of our social environment. For this reason, drug treatment is like an analgesic hiding the pain and thus enabling the damage to continue. My point here was societal, not individual. I too believe that medication is at times a necessary intervention, and this need not necessarily – though it can – create drug dependence. I am not anti-medication in all circumstances. But I *am* against treatments that focus *entirely* on alleviation of symptoms which ignore what depression is telling the individual, i.e. what they can learn from it about their psychosocial needs not being met.

Secondly, can I say that I have not done research on memory, whether implicit or explicit, nor does the book deal with this subject.

I really appreciate the good intentions of the reviewer - particularly his last sentence obviously.

Yours

Barbara Dowds

Dear Barbara,

Thank you for your letter to the *IJCP* in relation to my subjective view of your book on the topic of depression. I never intended to imply that I thought your stance was wholly anti-medication; I was merely stating that the quote you referred to, was what intrigued me to continue reading. To be honest, I feel the main body of your letter reflects the message I tried my best to convey, that societal factors have a major influence on our susceptibility to depression. Additionally, I did mention your genetic understanding.

Anecdotally, we hear that we cannot do the 'work' with clients that are receiving psychotropic treatment. Similarly, in the field, there appears to be opposing views of working with clients who are on a methadone treatment and clients who are prescribed anti-depressants. It seems more socially accepted to work with the latter, yet I believe both would benefit from the work. In relation to implicit/explicit memory, due to my initial review going over the word count, my intended message may have been lost. Moreover, the correct word to use might have been 'interest' as opposed to 'research'; although, you stated at your book launch that you initially considered writing on this topic. I really hope that the journal readership is encouraged to make their voices heard in all areas that affect our professional practice and our profession. Furthermore, I hope that it will create a much-needed debate on depression, diagnosis and treatment of it.

Yours Sincerely,

Alan Kavanagh,
Student member of IACP

Dear Editor,

Thank you very much for the excellent *IJCP*, Winter 2018 edition. The inclusion of the article 'The Possible Person: Playfulness, Expression, Trust-Building, & Meaning-Making with At-Risk Youth in Psychotherapy' by Blake Griffin Edwards, was excellent reading and very informative. It is great having access to good research, especially when it is evidenced based, firmly supported by excellent references and resources from great analytical writers in the therapy field.

Articles like these are very refreshing, stimulating to read and enjoyable, and especially helps to refresh our thinking and skills even if we have already covered some of the material in our training.

I would encourage the *IJCP* to include more articles like this in the future and especially resourcing more international research and writings. Maybe a possibility, if you haven't already done so, could be to communicate with the editorial boards of other countries especially with the likes of BACP and ACA to share resources and articles collaboratively, if that's possible.

I felt strongly prompted to write this letter as this was an excellent edition. I have been disappointed with some of the previous journals, which I shared in the recent members survey, therefore my positive feedback is also important to be shared. I know it is a lot of work and many hours of your voluntary time, so well done and looking forward to more.

Kind regards

Jimmy Browne,
Killarney, Co Kerry