

Éisteach

The Irish Journal of Counselling and Psychotherapy

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Practitioner health and self-compassion

- Is a therapist's attachment style predictive of stress and burnout in a sample of Irish therapists?
- Is there a role for counselling in the treatment of addiction?
- Mindfulness for Supervisors
- My personal experience of Grief and Loss and learning to live in the NOW.



Irish Association for Counselling and Psychotherapy

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Our Title

The word Éisteach means 'attentive in listening' (Irish-English Dictionary, Irish Texts Society, 1927). Therefore, 'duine éisteach' would be 'a person who listens attentively.'

Disclaimer:

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Scripts:

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

From the Editor:

Myself and my colleagues enjoyed reading the contributions submitted for inclusion in the Spring Edition. If your article is not published in this edition don't despair, we will be in touch. The articles we have chosen are diverse and for the first time we have classified them into the categories set out overleaf. There is one academic piece, two which fall into the category of practitioner perspective, and one is a reflective piece. The academic article relates to a study undertaken by Ciaran Carr and Jonathon Egan of NUI Galway which aimed to investigate whether attachment style as measured by current levels of attachment anxiety and avoidance predicted stress and burnout in therapists. Some of the independent variables tested reached statistical significance. For example, attachment anxiety predicted emotional exhaustion in therapists, with an avoidant attachment style predicting higher

levels of depersonalisation in therapists. Even if statistics are not your forte it is well worth a fair reading.

Mick Devine in his (practitioner perspective) article asks if there is a role for counselling in the treatment of addiction? Mick who has a vast experience in the area takes as his starting point the disease model of addiction. He advocates counselling as an additional support in the treatment of addiction but it is his opinion "that counselling really comes into its own when the service user responds to the challenge of establishing a drug-free lifestyle as central to managing addiction".

Padraig O'Morain in his article (practitioner perspective) on the use of mindfulness in supervision, explains what mindfulness is and goes on to describe how some mindfulness techniques can be used by the supervisor in the supervision encounter. For example

giving "bare" attention can help us meet the supervisee "anew" thus ensuring that the current session is not coloured in a negative manner by some unhelpful hangover from the previous session. Also being in the present-moment will better allow us to recognise those inklings of countertransference and may help to restrain us from acting out of them in a destructive way.

Marian Staunton's (reflective) and poignant piece on her experience of grief and loss during the illness, and following the death, of her beloved brother, speaks for itself.

As I complete this editorial it occurs to me that there is a theme that binds the articles together and that is practitioner health and self-compassion. Please keep your contributions coming, your voice needs to be heard. Also, keep the categories of article to hand. They will help you write to your strengths.

Maureen Raymond-McKay MIACP

Correction

In the Winter '16 edition of *Éisteach*, we inadvertently omitted to indicate prior publication of the piece by Maevé Dooley and the full reference to same. We would like to apologise to the IAHIP and *Inside Out* (in which the original article appeared) and include the reference here to the original work. Dooley, M. (2015). Does Psychotherapy = Counselling? A View on Some Defining Differences. *Inside Out* (Issue 75). Retrieved from: <http://iahip.org/inside-out/issue-75-spring-2015/does-psychotherapy-counselling-a-view-on-some-defining-differences>

| Editorial Team Update



Publishing Policy

In addition to the authors' guidelines printed in our recent Winter 2016 edition of *Éisteach* (and on www.iacp.ie), the Editorial Board wishes to further simplify the publishing process. We wish to broaden access and accommodate the diversity of membership within the IACP, consequently we invite articles of four types, each with different criteria in terms of presentation and academic requirements. The aim is to enhance inclusiveness and diversity in the material published, while simultaneously maintaining high standards of publication. The four categories of article are; a) academic work, b) practitioner perspectives, c) reflective articles, and d) a student corner. Descriptions of each type of article follows.

Academic Work

An article designated as academic work will either be based on original research, or comprise a comprehensive literature review of the chosen topic. In both cases, the writing must be evidence-based

and substantive claims must be supported by the literature, or the research conducted. Qualitative, quantitative or mixed methods are welcome, however quantitative findings should be described in language that will allow readers unfamiliar with statistics to appreciate the significance of the findings. Work in this category must apply the American Psychological Association (APA) style.

Practitioner Perspectives

Articles, which address clinical issues in counselling & psychotherapy primarily from the counsellors' experience in delivering treatment to clients, may also refer (where relevant) to significant authors, but can be principally based on clinical experience and observation. Such articles are often based on a psychotherapist's work with many clients who presented with the same or similar issues. Any passing reference to actual clients must be brief and anonymised. Full case histories are not accepted (even with consent), in order to avoid any possible inadvertent

breach of client confidentiality. This category provides a voice for you the practitioner to educate, inform, contribute or encourage discussion in our field, expressing your professional basis and your passion for your subject.

Reflective Articles

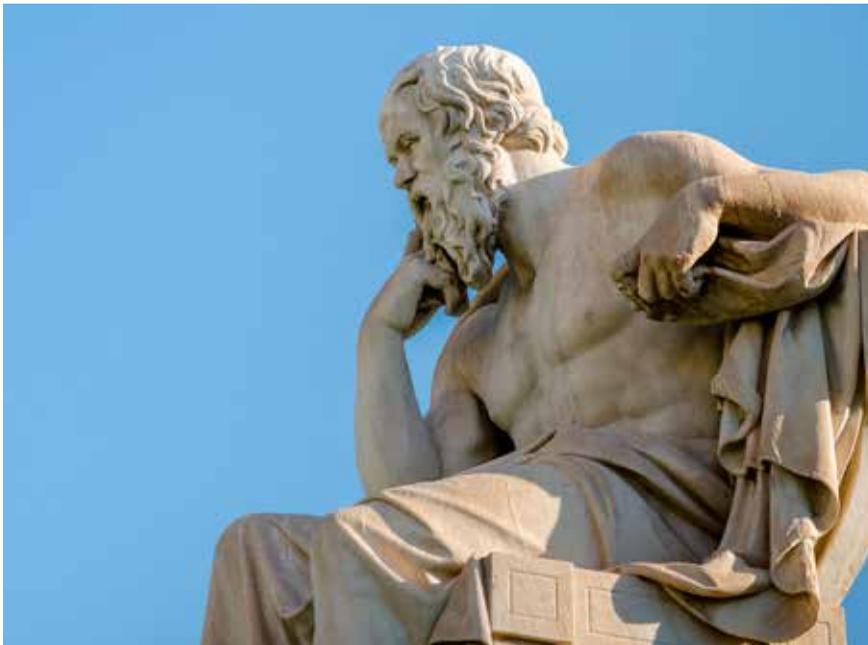
Reflective articles centre on a member's personal experience of a theme such as depression, or bereavement. These articles do not necessarily refer to specific client work, but focus on the personal development of the therapist, or supervisor and perhaps the application of that experience to client work. Reflective articles may also address specific topics in the field of counselling and psychotherapy, or reflections on the past, present or future of our profession. Reflective pieces do not require APA referencing but must be adequately well written to be considered for publication.

Student Corner

As tomorrow's professionals, we want to encourage the voice of students of counselling and psychotherapy as they encounter the many facets of modern professional practice and personal development. Student articles, therefore, may conform to any of the above descriptions. While high standards of writing are expected, student articles need not meet the same rigour that is expected of accredited members. Articles which are pertinent to the student experience of aspects of training or self-development are welcome, in addition to work relating to psychological topics.

Is a therapist's attachment style predictive of stress and burnout in a sample of Irish therapists?

Ciaran Carr and Jonathan Egan. NUI Galway



Abstract

The current study investigated whether attachment style, as measured by levels of attachment anxiety and avoidance, in a sample of (N = 137) therapists predicted stress and burnout. A series of hierarchical multiple regressions accounted for 20% of variance in stress, with insecure-anxious attachment and years working as a therapist being significant predictors, 12% in Emotional Exhaustion, with insecure-anxious attachment being significant, 17% in Depersonalization, with insecure-avoidant attachment and age being significant.

Introduction

Siegler, DeLoache and Eisenberg (2003) define attachment as 'an emotional bond developed with a specific person that is enduring across both time and space' (p. 213), with Ainsworth, Caldwell and Ricciuti (1973) proposing that attachment style is a relatively stable construct across time. She would go on to propose the existence of four separate styles of attachment, them being (A) secure, (B) insecure-avoidant, (C) insecure-anxious and (D) insecure-ambivalent (Ainsworth et al., 1973; Crittenden & Ainsworth, 1989). West (2015) determined that those working in the health services

are at risk of developing negative health outcomes as a result of their attachment style. She determined that a carer's attachment style can act as a moderator of well-being, which is often measured in terms of levels of stress, burnout and compassion fatigue. In spite of West's (2015) assertion, there have been few previous applications of Attachment Theory specifically to therapists. In her review, she observed that an insecure attachment style predicted negative psychological outcomes in healthcare professionals, with a secure attachment predicting overall vitality. There is a developing literature suggesting that secure attachment is a predictor of general well-being. Pereira et al., (2011) observed that an insecure attachment style predicted increased levels of stress in those working in palliative care. In a study conducted over a period of six months, Kim, Kashy and Evans (2007) observed that palliative care workers with an anxious attachment style, characterized by 'a strong desire for closeness' (p. 35), as well as a 'hypervigilance for cues of abandonment, and emotional upset both at separation and reunion' (p. 35) with clients, presented with significantly higher levels of stress.

Burnout was defined by Maslach (1976) as 'a syndrome of emotional exhaustion, depersonalization of others, and a feeling of reduced

personal accomplishment' (p. 16). Subsequently, the characteristics of increased emotional exhaustion, depersonalization and diminished personal accomplishment would form the foundation of her measurement criteria for burnout; Maslach's Burnout Inventory. In a review of the literature, Bria, Baban and Dumitru (2012) determined that burnout is a process which is often experienced by individuals who are exposed to 'overwhelming emotional and interpersonal interactions' (p. 21), with elevated instances of burnout being observed in nurses (Allan, Farquharson, Choudhary, Johnston, Jones, & Johnston, 2009) and hospital consultants (Taylor et al., 2005) among others. In a further review of the literature however, Danhof-Pont, van Even & Zitman (2011) observed no consistent biological predictors of burnout. Indeed, Heard, Lake and McCluskey (2011) suggested that previous exposure to trauma predisposed healthcare workers to elevated emotional exhaustion, supporting Egan, Meehan, Carr and Hevey's (2015) assertion that burnout may be the result of unconscious immature defence mechanisms such as dissociation, distortion of self by devaluing self in presence of others, or omnipotence, maintaining self-esteem by blaming the patient or other staff for their stress. The assertion that both immature emotional responding and the attachment security of the therapist-client relationships might be a fruitful area to develop research. Skovholt and Trotter-Mathison (2014) observed that secure attachment predicted lower levels of burnout in mental healthcare professionals, as well as higher levels of overall vitality and superior coping styles. Egan et al. (2015) reported that psychologists who used less mature defence styles (devaluing clients or self, or moving to omnipotence, or dominant/submissive positions

in therapy) were more likely to present with both higher emotional exhaustion and depersonalization. Zerubavel and Wright (2012) expand on this by arguing that that a therapist's own psychological trauma can carry curative power for clients, but that the therapists need to be cognisant of their wound. Tosone, Bettmann, Minami and Jaspersen (2010) observed that compassion fatigue was more prevalent in insecurely attached New York based social workers who worked with clients following September the 11th, 2001. In a subsequent study, Bauwens and Tosone (2014), noted that secure attachment predicted greater resilience in Social Workers from New Orleans following Hurricane Katrina, while insecure-avoidant and insecure-ambivalent attachment styles predicted greater compassion fatigue.

In addition to attachment style, factors such as age (Rosenberg and Pace, 2006), gender (Craig & Sprang, 2010) level of qualification (Sodeke-Gregson, Holttum, & Billings 2013), years working as a therapist (Lim, Kim, Kim, Yang, & Lee, 2010), hours of client contact per week (Cherniss, 2016), as well as perceived levels of social support (Pines, 2004) have been observed to predict psychological well-being in healthcare-professionals (as measured by way of the levels of stress, burnout and compassion fatigue).

The current study aims to investigate the relationships between therapists' attachment styles and their current levels of stress and burnout. There is a dearth of literature in relation to how attachment style and a therapist's well-being interact. Insecure attachment in therapists by definition describes their tendency to seek or not seek others in the modulation of personal upset. A tendency to withdraw from or not engage in instrumental and emotional supports

may result in a therapist slowly and imperceptibly becoming more and more physically and emotionally drained (Figley, 2002). The current lack of extant research is ironic given that stress (Cohen, 2004) and burnout (Bria et al., 2012) present more frequently in professionals who work directly with patients or service users in some capacity (Figley, 2002).

Method

Participants

A sample of 137 therapists aged between 26 and 74 years of age, average age 52 years, Standard Deviation (SD) = 9.9, were recruited for analysis. Demographics are displayed in Table 1 below. Both men and women who participated had similar ages.

Table 1.

	N	Mean Age	SD
Male	25	54	9
Female	112	52	10
Total	137	52.3	9.9

Measures

A series of questionnaires were used as part of analysis.

1. Attachment Style was measured using the Adult Attachment Questionnaire (AAQ; Simpson, Rholes & Phillips, 1996). The AAQ is a 17 item questionnaire that measures participant's levels of avoidance and anxiety.
2. Perceived Social Support was measured using the 12 item Perceived Social Support (PSS) Scale (Zimet, Dahlem, Zimet & Farley 1988; Cronbach's Alpha of .9).
3. The General Health Questionnaire-12 (GHQ-12) was used to measure general well-being (Goldberg & Williams, 1988; Cronbach's alpha of .63).

4. Burnout was measured using Maslach and Jackson's (1986) 22 item Burnout Inventory (MBI) for Human Services, with the items pertaining to Emotional Exhaustion holding a Cronbach's alpha of .9. The Depersonalization subscale had a Cronbach's alpha of .8, while the Personal Achievement subscale has a Cronbach's alpha of .9.

Survey Monkey was used as a means of collecting the data from therapists. The use of online questionnaires ensured that participants could be easily contacted, provide consent, complete the questionnaires and be provided with an extensive debriefing in an efficient manner. Additional apparatus utilised was a personal computer, which facilitated the use of SPSS and Microsoft Word. SPSS was used to perform analysis on the data collected.

Procedure

Participants were contacted via e-mail. Participants were sampled randomly. A total of 1,046 e-mails were sent, with 177 responses indicating a response rate of 17%. Of these, 40 responses were incomplete and therefore excluded, thus leaving a total of 137 complete responses. The e-mail included an introduction to the author, a description of the research being conducted and a link to the online questionnaire.

Ethics

Ethical approval was sought and received from the School of Psychology at the National University of Ireland, Galway. Given the sensitive nature of what was being measured, participants were provided with a list of contacts for in the event that they became distressed during data collection. These contacts were provided on

the consent form presented to participants prior to the study. The participants, however, were not considered to be vulnerable.

Results

A series of three hierarchical multiple regressions were employed to evaluate how age, gender, years working as a therapist, qualification, perceived social support, levels of anxious avoidant attachment predicted levels of general stress, emotional exhaustion, and depersonalization in therapists. In each regression, age, gender, years working as a therapist and qualification level were controlled for in Step 1, Perceived Social Support was entered in Step 2 and levels of avoidant and anxious attachment were entered in Step 3.

The first Hierarchical Multiple Regression was conducted to observe the predictors of Stress in Therapists, the results of which are displayed in Table 2.

With regard to therapists' stress levels, the overall model was significant ($F(8, 136) = 5.16, p < .00, R^2 = .24, Adj R^2 = .20$). Step 1 did not significantly predict any of the variance ($F(5, 131) = 1.56, p = .18, R^2 = .06, Adj R^2 = .02$), although age ($\beta = .22, p < .02$) and the number of years working as a therapist ($\beta =$

$-.19, p < .05$) were observed to be significant predictors of stress in therapists. Step 2 was observed to be significant ($F(6, 130) = 12.55, p < .01, R^2 = .14, Adj R^2 = .10$), however, Perceived Social Support ($\beta = -.10, p = .27$) was not observed to be a significant predictor of stress in therapists. Step 3 was also observed to be a significant predictor of stress in Therapists ($F(8, 128) = 8.56, p = .00, R^2 = .24, Adj R^2 = .20$, all VIF (<1) and tolerance (> 1) scores ensured against multicollinearity). An anxious attachment style ($\beta = .35, p < .00$) significantly predicted stress in therapists, whereas the avoidant attachment style did not ($\beta = .08, p = .41$).

A second Hierarchical multiple regression was conducted in order to observe the predictors of Emotional Exhaustion in therapists. The results of the analysis is displayed in Table 3.

The overall model was significant ($F_{(8, 136)} = 3.29, p < .00, R^2 = .17, Adj R^2 = .12$), accounting for 12% of the overall variance. Step 1 did not significantly predict any of the variance ($F_{(5, 131)} = 1.61, p = .16, R^2 = .06, Adj R^2 = .02$). Step 2 was observed to be significant ($F_{(1, 130)} = 3.19, p < .00, R^2 = .13, Adj R^2 = .09$), however, Perceived Social Support ($\beta = -.15, p = .14$) was not observed to be a significant predictor

Table 2. Hierarchical Multiple Regression for Predictors of Stress in Therapists (N = 137)

Variable	β	R^2	Adj R^2	F Change
Step 1		.06	.02	1.56
Age	.22*			
Gender	.10			
Qualification	-.03			
Years Working as a Therapist	-.19*			
Hours of Client Contact per week	.10			
Step 2		.14	.10	12.55**
Perceived Social Support	-.10			
Step 3		.24	.20	8.56***
Avoidance	.07			
Anxiety	.35***			

Total $R^2 = .24$, Total Adj $R^2 = .20$. Significance Level: * = $p < .05$, ** = $p < .01$, *** = $p < .00$.

Table 3. Hierarchical Multiple Regression for Predictors of Emotional Exhaustion in Therapists (N = 137)

Variable	β	R^2	Adj R^2	F Change
Step 1		.06	.02	1.61
Age	-.13			
Gender	-.02			
Qualification	-.03			
Years Working as a Therapist	.04			
Hours of Client Contact per week	.16			
Step 2		.13	.09	10.51**
Perceived Social Support	-.15			
Step 3		.17	.12	3.27*
Avoidance	.06			
Anxiety	.22*			

Total $R^2 = .17$, Total Adj $R^2 = .12$. Significance Level: * = $p < .05$, ** = $p < .01$

of Emotional Exhaustion in Therapists. Step 3 was also observed to be a significant ($F_{(2, 128)} = 3.29, p = .00, R^2 = .17, \text{Adj } R^2 = .12$), with therapists anxious attachment style ($\beta = .22, p < .05$) significantly predicting stress in Therapists (only 3% of the variance), with the avoidant style not being related to emotional exhaustion ($\beta = .06, p = .53$).

A third Hierarchical multiple regression was conducted in order to observe the predictors of depersonalization in therapists. The results of the analysis is displayed in Table 4, with the overall model being significant and accounting for 17 percent of the variance ($F_{(8, 136)} =$

4.58, $p < .00, R^2 = .22, \text{Adj } R^2 = .17$).

Step 1 was significant ($F_{(5, 131)} = 2.53, p < .05, R^2 = .09, \text{Adj } R^2 = .05$), however, age ($\beta = -.25, p < .01$) was the only variable observed to significantly predict Depersonalization in therapists. Step 2 was also observed to be significant ($F_{(1, 130)} = 3.9, p < .01, R^2 = .15, \text{Adj } R^2 = .11$), but Perceived Social Support ($\beta = -.08, p = .43$) did not predict elevated Depersonalization in Therapists. Step 3 was also observed to be significant ($F_{(2, 128)} = 4.58, p < .00, R^2 = .22, \text{Adj } R^2 = .17$), with an avoidant attachment style ($\beta = .23, p < .05$) predicting depersonalization in therapists.

Table 4. Hierarchical Multiple Regression for Predictors of Depersonalization in Therapists (N = 137)

Variable	β	R^2	Adj R^2	F Change
Step 1		.09	.05	2.53*
Age	-.25**			
Gender	-.11			
Qualification	-.06			
Years Working as a Therapist	.02			
Hours of Client Contact per week	.06			
Step 2		.15	.11	9.91**
Perceived Social Support	-.08			
Step 3		.22	.17	5.77**
Avoidance	.23*			
Anxiety	.16			

Total $R^2 = .22$, Total Adj $R^2 = .17$. Significance Level: * = $p < .05$, ** = $p < .01$

Discussion

One distinct limitation of the current research is that a cross-sectional design was employed. While cross-sectional designs enable the efficient collection of data, they do not allow for statements of causation, which is particularly important given Shanafelt et al's (2012) observation that burnout in Healthcare Professionals develops gradually, over years of therapeutic encounters.

This is the first published study investigating the effect of attachment styles on a large sample of therapists working in Ireland. Having an anxious or preoccupied attachment style resulted in having higher general levels of stress which replicates West's (2015) findings in health care professionals. Interestingly, attachment anxiety also predicted emotional exhaustion in therapists, with the avoidant attachment style predicting higher levels of detachment from clients via a depersonalization syndrome. As per Egan et al.'s (2015) call for supervisors to be trained in identifying immature defence styles in therapists, the call might also need to be expanded to helping therapists reach out for support rather than becoming pre-occupied and anxious in relation to their clients, and for therapists who use an avoidant way of coping interpersonally, to stay present and to learn to tolerate attachment anxiety and distress.

Further research needs to take place to explore whether primitive defence styles related to the attachment system, such as dissociation could be key defences related to the avoidant attachment style being activated in therapists. Finally, it would also be interesting to investigate whether some therapists somatise their distress rather than seek a carer and put the distress into words. An analysis of commonly reported somatic symptoms such as musculoskeletal pain (neck and

back), headaches (migraine and tension), gastro-intestinal upset and fatigue might be fruitful and add to the supervisor's understanding of the care-seeker. 

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Ciaran Carr

From the rural Fanad peninsula in North Donegal, Ciaran Carr is a recent graduate of the Health Psychology Masters program at the National University of Ireland, Galway. His undergraduate research dealt with the predictors of risky driving behaviour in male drivers as well as the predictors sexual hygiene and health in students. More recently, he has observed attachment style as a predictor of well-being in therapists, in term of the levels of stress, burnout and compassion fatigue they present with. He is currently employed as a Health and Social Care Support Worker where he hopes to garner vital experience that will aid his progression as a clinician in future, while also satiating his interest in research.

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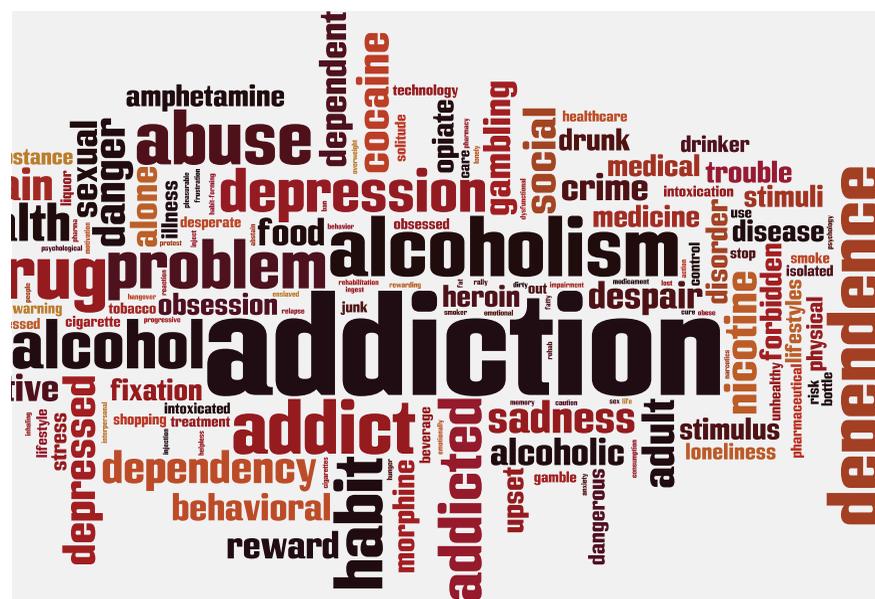
Jonathan Egan

Dr Jonathan Egan is the Deputy Director of the Doctorate in Clinical Psychology at NUI Galway. He has previously worked as the principal specialist psychologist in the Mater Hospital and prior to this was one of the founding Directors of Counselling in the HSE. He presents and has written extensively on the effects of the work of therapy on therapists. This summer he was a keynote speaker at the National Counselling Services Annual Conference in Galway talking about his recent research on the importance of attachment style and the role of defences in well-being. He is currently undertaking further training with Dr Una McCluskey (York) who trains therapists about the goal corrected nature of care-seeking.

Practitioner Perspective

Is there a role for counselling in the treatment of addiction?

Mick Devine



Introduction

This article seeks to articulate the place for counselling in the treatment of addiction. With harmful and hazardous alcohol and drug misuse, education and prevention measures are preferred with some brief solution focused interventions (Department of Health; 2012). For opiate addiction, medical interventions to stabilize and reduce harm are rightly to the fore (Health Service Executive Social Inclusion Unit, 2010). I am Clinical Director of Tabor Group, a Cork-based treatment agency guided in treating addiction by the Minnesota Model of care. This approach is based on a 'disease concept' of addiction and favours the long term goal a 'drug free lifestyle' for clients. I am often asked "what is your success rate?"

and in my experience, many who opt for 'drug free lifestyle' treatment options, relapse is common and is therefore seen as failure. To assist service users in achieving a drug-free lifestyle counselling is essential. In this article I present the case for counselling in the management of addiction at Tabor Group and this article uses the American Society of Addiction Medicine's (2011) definition of addiction to answer the question posed in the title. This definition will structure the article as I present addiction as (i) a 'chronic disease', (ii) a 'chronic brain disease' that (iii) diminishes the person's recognition of the problem. I will quote directly from this definition and also use it to reflect on my professional experience of the value

of counselling in the treatment of addiction. This will prepare the way for presenting the role of counselling in treating addiction.

Multi-agency Treatment of Addiction

On one hand there is growing acceptance of harmful and hazardous misuse of alcohol and drugs which requires education and prevention services and where treatment services are necessary they may be brief and solution focused (HSE 2012). On the other hand there is a growing awareness of the complexity of needs that often accompanies addiction (MacGabhann et al., 2004; Najavits, 2002).

From this awareness results an emphasis on the need for multiple agencies to be involved in the rehabilitation of people affected by addiction (Department of Community Rural and Gaeltacht Affairs, 2009).

General Practitioners, Pharmacists, Detoxification Services, Community Drugs Workers, Homeless Services, Social Workers, Key Workers, Case Managers, Community Enterprise Schemes, Adult Learning and Training agencies, Probation Services, Treatment Agencies of various types, 12 Step Fellowships, Family Support Services, and Parenting Programmes all have valuable roles to play in rehabilitation. From my experience of engagement in delivering treatment for 20 years in the Health Service Executive Southern Region, all of these agencies have a caring dimension and staff is equipped with

some level of listening skills and capability for empathic response.

Part of the response to the overwhelming complexity of need in many of our addicted population is to see that a realistic goal for individual care plans is to reduce the harm caused by the addiction rather than a goal of full rehabilitation including a drug-free lifestyle. With such an approach the emphasis is on maintaining a stabilisation in the individual's situation. This includes assisting the person to refrain from illicit drug use, from criminality in order to obtain illicit drugs and keep the person safe from risky behaviour by introducing them to a stable dose of prescribed methadone. As a result the key agencies of General Practitioner and Pharmacist come to the fore in the delivery of care. Allied services have an important support role.

Counselling can also be part of this important support role allowing the person explore healthy options and the motivation to pursue them. It is my experience however, that counselling really comes into its own when the service user responds to the challenge of establishing a drug-free lifestyle as central to managing addiction. This can be an extremely difficult task but not impossible. The following will hopefully portray the nature of the difficulty and also demonstrate how success is possible when counselling is fully utilised.

Disease Concept of Addiction

In her preface to National Institute of Drug Abuse 2010 publication, *Drugs Brains and Behaviour*, Nora Volkov MD, Director of National Institute of Drug Abuse recalls that when science began to study addictive behaviour in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. We now know addiction is a disease that affects

When science began to study addictive behaviour in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower.

the brain (National Institute of Drug Abuse, 2010). While the 'disease concept' of addiction seems to confirm that the lead agents in its treatment should be medical, it is this disease concept which appears to most securely establish the role of counselling in its treatment.

To elaborate the point it is useful to present a definition of addiction issued by The American Society of Addiction Medicine (short version) (ASAM, Web 2011):

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours (Home Page).

Addiction is characterised by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (Home Page).

There are many elements of this rich definition which provide food for thought when considering the question of the role of counselling in the treatment of addiction. However I will highlight three elements; (i) that addiction is a 'chronic disease',

(ii) that addiction is a 'chronic brain disease' and (iii) that addiction is characterised by a diminished recognition of significant problems of one's behaviour and interpersonal relationships and dysfunctional emotional response.

Addiction is a chronic disease

To establish the nature of a *chronic* health condition it is useful to contrast it with an *acute* health condition. White (2003) outlines that acute health conditions are of sudden onset and short duration; symptoms appear suddenly and the pain is insistent. Additionally he argues that immediate care is required and is usually clearly defined, administered by an expert using surgery or medication and brings about a cure. Examples are infection, appendicitis and a broken bone. Acute health conditions, he says, are seen to be something that happens to a person.

White (2003) contrasts this with a chronic health condition which he says is persistent and long lasting, usually more than three months. He says that the onset is gradual and the condition may be characterised by periods of remission and relapse. Furthermore, the condition may not insist on attention until well progressed. He contends that the condition is managed rather than cured and the participation of the 'patient' is central to the successful management. Insight, for White, is a crucial component of the recruitment of the patient in the management of the condition. Examples of chronic health conditions are diabetes, hypertension and heart condition. Chronic health conditions,

he concludes, are seen to be physiological defects in the person.

Considering addiction as a chronic condition and that the individual must be actively involved in the management of their addiction creates an opening for the inclusion of counselling in this process. The management of a chronic health condition such as diabetes also requires the active involvement of the person but counselling is not usually required to secure the person's engagement as the organ affected is the pancreas. Once the person has the insight that their pancreas is dysfunctional in the production of insulin and the patient needs to assist its functioning, they are generally recruited to the enterprise of managing the diabetes. In the case of addiction however it is the brain that is affected. The person's identity is centrally bound up with the brain because, while the pancreas produces insulin, the brain produces our thoughts, feelings, instinctual motivations, decision making apparatus and other functions central to all that establishes us as an individual. (Hanson & Mendius, 2009).

Addiction is a brain disease.

ASAM (2011) states that in addiction vital brain functions are impaired; (a) reward circuits, (b) motivation and memory circuits and (c) the executive function of decision making. The reader is referred to the full text of this rich definition for the following observations.

Firstly, if drugs enhance reward function then drug using is preferred to other healthy behaviours (Koob & Moai, 2001). The person is therefore more motivated for drug use than for other activities which the brain also rewards. Such activities include those which ensure safety and security, maintenance of interpersonal relationships, stable accommodation, successful

occupation or student career. As far as the brain knows the drug use satisfies these needs. Over time such altered priorities for drug use lead to a lifestyle that is unsuccessful, frustrating and characterised by agitation and negativity (Keane, 2014).

Secondly, the repeated engagement in drug use leads to neuroadaptation in the motivational circuitry which leads to further addictive drug use hence the

individual is motivated towards further drug use. In other words, the positive reinforcement of the euphoria obtained from drug using and the negative reinforcement of the relief from negative emotional states conspire to reinforce the motivation for continued drug use. Additionally, memory circuits play a role in addiction as memories of previous drug use trigger cravings to resume use in their current situation (Koob & Moai, 2001).

Finally, the frontal cortex of the brain is charged with executive functioning. Therefore, it is the centre with the power to think, solve problems and make decisions and when it becomes affected by addiction the person's decision making capacity is impaired. Examples of such impairment include powers of perception, learning and judgement being compromised as well as the ability to defer gratification as impulsivity is strong. Furthermore, the person can make many mistakes when it comes to deciding if it is a good decision to use drugs. The ability to choose to avoid using is compromised by the strength of the craving to

continue using, the strength of the reward obtained from using, and the positive memory of previous use. Therefore the situation is out of the person's control and it is not realistic to expect choices to be made according to conventional value hierarchies. Despite the negative consequences that inevitably come with impairment of executive functioning the person shows a low readiness to change (Koob & Moai, 2001).

Addiction is characterised by a diminished recognition of significant problems with one's behaviour and interpersonal relationships and a dysfunctional emotional response.

As part of the treatment programme at Tabor Lodge clients are encouraged to learn about addiction and apply the learning to their own real-life situations. The ASAM definition in its long and short versions is used. The Diagnostic and Statistical Manual of the American Psychiatric Association Edition V is also used. From many clients undergoing the treatment programme the following reflections are possible.

The addicted person cannot see the reality of their situation. The shame, guilt, failure and suicidal tendencies associated with addiction are defended against by the person. They do not recognise significant problems as such. The dysfunctional emotional response causes them to minimise the extent of their difficulties and disadvantage. They may become detached from their difficulties by being overly intellectualising. It causes them also to disregard, diminish or explain away the problems in inter-personal relationships. Alternatively, the dysfunctional emotional response may cause them to exaggerate their difficulties resulting in their anger

and aggression, blaming, resenting, or self-pitying and hopelessness.

They adapt to accommodate themselves to their diminished circumstances and to avoid being confronted by the difficulties addiction is causing. Accommodation may take the form of developing a false self which has an insistence that 'all is well'. Addicted people may become avoidant and distant and lose real contact with meaningful others.

Clients often acknowledge that changes occur both in cognitive and affective functioning. For example, the person is preoccupied with drug use, has a distorted view of the benefits of using and can attribute unwanted consequences to other causes than the drug using. Emotionally there is increase in anxiety and sensitivity to stressors. Furthermore, the client comes to see that there can also be emotional overreaction and under reaction. This may include emotional responses which are inappropriate for the situation such as an aggressive reaction to a child making a mistake and spilling milk or at another time showing no reaction to an inability to pay an important household bill.

The client can become crisis prone. Failures and set backs are inevitable. Over time the addicted person burns their bridges and their social and personal support network is weakened. It is harder for them to bounce back. If the person is the parent in a family unit the impact on all the family is devastating, particularly on children. As the situation spirals out of control the person's ability to cope with stressors is overwhelmed. The resulting sense of panic increases cravings to continue using. Drug using is the main coping strategy and so the person has nowhere to turn. Stressful situations mount and escalate. In response the person

becomes more defensive. The person is unable or unwilling to take corrective action. The person's self-deception is significant.

The Role of Counselling

My experience in the field has led me to believe that it is very difficult to separate the impact caused by the addiction from that caused by the contribution of the person themselves; it is as if there is no difference between the two. The person is an addicted person. I mentioned above how the person's reward center is affected by substance use, the person's motivation and incentive system is affected by the substance use, as is their executive functioning. It is my opinion that these functions of our brain are instinctive and unconscious; they are part and parcel of who we take ourselves to be. Hence our identity is intricately wrapped around these brain functions. Therefore, to reflect on the thinking, feeling, attitudes, beliefs, perceptual apparatus, judgement and choices that have all become affected by substance abuse is very challenging as it is almost impossible for the person to separate all that out from who they are in the first place. The education is difficult for the person because the syllabus is themselves and what their life and the lives of their loved ones has become as a result of not addressing their addiction. Additionally, the insight is illusive because the instrument of obtaining insight is the most affected. It's like the eye seeing itself.

I would argue therefore that counselling is crucial to the person in order to succeed in managing the condition. It is within a trusting therapeutic relationship that the person can undertake the necessary reflection so they can see the reality of their situation as opposed to the distorted perspective noted above.

Counselling is needed because it is uncommon for the person to be capable of such insight without assistance. The person must firmly but gently confront him/herself about situations that are beyond their ability to see for themselves. Hence, the counsellor is particularly well positioned to assist the person with this task and to provide the necessary emotional support for such confrontations. My experience has highlighted how the honesty required to allow the full picture to emerge is often not easy to come by yet the detached but trusted counsellor can provide the 'holding' to allow this to happen. I have witnessed how the greater the accuracy in developing an awareness of the extent of the impact of addiction, the more motivated the person becomes to manage the condition successfully. The counsellor skilled in the art of listening and empathic response, who has understanding of the defense mechanisms of a person feeling trapped and overwhelmed, and who has the ability to maintain the person in positive regard is crucial to the success of this enterprise. (Mate, 2012)

The insight needed for the management of a chronic condition can be gradual. The contribution of the counsellor can be an indispensable part of the treatment process. Through the expertise in the caring support of an interpersonal relationship the addicted person can achieve enough distance from the catastrophe to see it clearly and to see that that is not all there is to them. The counsellor models in their interactions that there is no stigma, no judgement, no loss of essential value and goodness. The addicted person can begin to believe that recovery is possible.

Conclusion

In this article I have tried to

In my experience, concealed within this medical definition of addiction is the securing of the place for counselling in the management of this chronic health condition.

articulate the centrality of the role for counselling in the treatment of addiction. I have used the short and long version of the definition of addiction of the American Society of Addiction Medicine. In my experience, concealed within this medical definition of addiction is the securing of the place for counselling in the management of this chronic health condition. I have demonstrated that if we don't see the chronicity of the disease we overlook the role of the addicted person in the management of the condition. The organ chiefly affected is the brain. Our brain is the organ where our drives, attitudes and beliefs are seated as well as our executive capacities such as thinking, motivations, deferring immediate gratification and decision making. As such its functioning is central to our identity.

I hope it is now clear that, in my experience, the addicted person is challenged with an intractable dilemma. Those seeking to successfully manage the condition need help. For the addicted person to succeed they need to get some distance from this identity to see its operations. When they can do so insight and objectivity are possible. Counselling is central to the addicted person achieving this distance.

This is a delicate matter particularly when there is so much shame attached to being addicted and there is so much societal stigma surrounding it. That the person can address painful issues associated with being addicted is central to good quality outcomes. To address the matter takes skill. Supportive, challenging interventions delivered

with care and empathy can play a significant role. From this support the addicted person sees the disease in action and the part they play in its dynamics. They can also see their part in neutralizing these dynamics so as to achieve full rehabilitation (TZU, 2014; Dupuy, 2013). ☺

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Mick Devine

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He was Administrator of the unit from 2000 to 2011 and, upon its amalgamation with Renewal and Fellowship House; he became clinical director of Tabor Group. He was a member of National Drug Rehabilitation Implementation Committee (NDRIC) from 2008 to 2012. He is a member of the Treatment and Rehabilitation Committee of the Southern Regional Drug and Alcohol Task Force since its inception in 2003 and was chair of this committee from 2003 to 2012. He represents Tabor Group on Addiction Treatment Centres of Ireland (ATCI) and is currently playing an active role in the consultation process of Ireland's new Substance Misuse Strategy 2016 - 2020.

He is committed to psycho-spiritual development, his own and others, and is currently engaged in a teacher training programme with Ridhwan School. He also runs a small private counselling and training practice in Cork.

Mindfulness for Supervisors

Padraig O'Moráin



and reacting to the inner and outer experiences that we are all normally, caught up in, and learn to step back from.”(p. 33)

This is what is meant by his more frequently cited statement that mindfulness involves paying attention with a non-judgmental attitude. It isn't a question of abandoning all efforts to assess and evaluate what's going on: it's more a question of not rushing to judgement and of not getting swept away by habitual reactions. Mindful awareness, for instance of our breathing, can give us the space in which to take that non-judgmental attitude.

This attitude leads into the practice of acceptance: “Acceptance as we are speaking of it simply means that you have come around to the willingness to see things as they are. This attitude sets the stage for acting appropriately in your life, no matter what is happening.” (p.39) (citation)

For instance, accepting that you have a drink problem doesn't mean that you will abandon all restraint. Accepting that you have the problem leads on, sometimes sooner, sometimes later, to a

Quite often, more attention is given to present-moment awareness than to acceptance in the public discourse on mindfulness.

This article is a reflection on the contribution that mindfulness and the attitudes surrounding it can make to the supervisory relationship and to the well-being of the supervisor himself or herself.

Little or no research has been done on mindfulness in the supervisory relationship and this article, as it is not research-based, does not aim to fill that gap.

I will begin by discussing what mindfulness is; then I will outline ways to create and maintain a mindfulness practice; and then I will reflect on the question of the contribution of mindfulness to supervision.

What mindfulness is

This is worth dwelling on because the effort to define mindfulness can be of practical help in our

mindfulness practice.

My definition of mindfulness is that it is the practice of returning deliberately to awareness of what is happening here and now and of cultivating an attitude of acceptance in our lives.

Jon Kabat-Zinn (1990) who probably did more than anybody else to bring about the current Western interest in mindfulness, writes that “Simply put, mindfulness is moment-to-moment awareness. It is cultivated by purposefully paying attention to things we ordinarily never give a moment's thought to.” (p.2)

He adds later that “Mindfulness is cultivated by assuming the stance of an impartial witness to your own experience. To do this requires that you become aware of the constant stream of judging

consideration of what you can do about it.

Christopher Germer (2005) writes that acceptance is an important aspect of therapeutic relationships. In his chapter in *Mindfulness and Psychotherapy* he says that empathy and positive regard “overlap with acceptance” (p.7). This, of course, will not come as news to the readers of *Eisteach*.

Quite often, more attention is given to present-moment awareness than to acceptance in the public discourse on mindfulness. That’s a pity. In my experience, acceptance is the other half of mindfulness and may be the better half.

In his important book “The heart of Buddhist meditation - a handbook of mental training based on the Buddhist way of mindfulness,” Nyanaponika Thera (1962) sees “bare attention” as providing the “key” (p.30) to mindfulness.

“Bare attention consists in a bare and exact registry of the object.” He notes that “this is not as easy a task as it may appear, since it is not what we normally do, except when engaged in disinterested investigation. Normally man is not concerned with disinterested knowledge of things as they truly are, but with handling and judging them from the viewpoint of his self-interest, which may be wider or narrower, noble or low.”(p.32)

“Bare attention first allows things to speak for themselves, without interruption by final verdicts pronounced too hastily.” (p. 35)

Nyanaponika Thera wrote in the Burmese Buddhist tradition which had a major influence on mindfulness as practised today in the West.

This approach could be seen as an intertwining of awareness

A supervisor may feel that he or she is not as good a therapist as the supervisee, may feel nervous about telling the supervisee something that he or she does not want to hear.

and acceptance. Both, of course, are central to the work done in the counselling space and in supervision.

Mindfulness as an approach has been most highly developed in Buddhism which traces its origins back approximately 2,500 years. Most of the people who use mindfulness in the West today are not Buddhists. Jon Kabat-Zinn’s implementation of mindfulness almost 40 years ago to help people to change their relationship to pain and to stress - through his Mindfulness Based Stress Reduction courses - was entirely secular, though the practices were Buddhist practices or derived from them. Similarly, Professor Mark Williams’ work on mindfulness and depression and Dr Marsha Linehan’s use of mindfulness as a resource for people with Borderline Personality Disorder are secularised without spiritual or religious connotations.

Ways to cultivate mindfulness

At its simplest, mindfulness means being aware of what you are doing while you are doing it. This means being aware that you are breathing, walking, driving, running making a phone call, cooking a meal and so on. When you notice you have drifted off into thoughts, you bring yourself back to awareness of what is happening in the world outside your thoughts - to what you are physically doing, for instance.

This return to awareness is done with acceptance that people drift off again and again, so it is done gently.

Quick mindfulness practices

Here are three:

- 1. Get in touch with your senses.** Notice the temperature of your skin. Notice that you are breathing in and out. Notice background sounds around you. Notice your breathing again. Every time your mind drifts as you are doing this - and it will - bring it back gently to the present moment.
- 2. Just notice your breathing.** Just notice that you are breathing in and out. Notice the in-breath and the out-breath. When thoughts come into your mind, return to your breathing. Do not get involved with them. Simply go back to noticing your breathing in and out.
- 3. Create mindfulness triggers.** Pick some everyday things that you do routinely. Decide that whenever you do them you will be mindful and will be aware that you are doing them. Examples are: brushing your teeth, going up or down stairs or steps, arranging your desk or other workspace, tidying, washing up, taking a shower.

Some slightly longer mindfulness practices are:

Awareness of breathing. Sit still. Notice that you are breathing in and out. Notice the in-breath and the out-breath. If you are breathing through your nose, notice that the air is colder when entering your nose than when leaving. When thoughts come into your mind just let them float on by. Do not get involved with them. If you like you can just label your thoughts: when you get a thought, just say to yourself “thinking”. Then go back

to noticing your breathing in and out. If you like, you can count your breaths, counting from 1 to 7 and then back to 1 again. Do this for 3 to 20 minutes, once or twice a day.

Awareness of walking. Notice the feeling of the ground against your feet as you walk. Notice your breathing. When you drift into your imagination, bring your mind back to your walking. Be aware that you are walking, of the feel of walking and of your breathing. Do this for 3 to 20 minutes once or twice a day.

All these practices are simple.

What you are doing with them is training yourself to return easily and often from mind wandering to the present moment and to do so with acceptance (in this case of the fact that your mind wanders a lot).

From the practices above choose what suits you best. Do mindfulness practice at set times during the day or as the opportunity arises. Prof Mark Williams suggests at least eight minutes a day which can be made up of shorter periods. One option is to do a brief practice between clients.

If you want to explore further mindfulness practices, you will find audios which you can download and use at no cost on my website www.padraigomorain.com under the "Audios" heading.

Mindfulness and supervision

Here are the effects, as I see them, of mindfulness practice on supervision where the supervisor has made mindfulness part of his or her life.

a) **The supervisor is fully present in the room.** In other words, the supervisor is better able to step out of preoccupations with whatever may have happened before the supervisee arrives. If you

If countertransference is a human trait than supervisors being, presumably, human share that trait.

had a fight with somebody in a call centre before the session, a short mindfulness practice can orientate you towards the supervisee and not towards your newly acquired enemy in the call centre, at least for the length of the session.

b) **Mindfulness allows you to "park" the effects of previous sessions at least temporarily.** In other words it can enable you to meet the supervisee "anew" and without having the encounter coloured from the beginning by the emotional hangover, so speak, of previous sessions with this person. Of course, patterns are significant, have a tendency to re-occur and need to be attended to. But mindfulness, by enabling you to step out of the patterns for a little while, can make more room for the arrival of new issues and material in the session.

c) **You can bring a perspective of "beginner's mind" to the session.** This Zen concept describes the capacity to look at things afresh without having your very perception clouded by what has gone before. What has gone before doesn't just include what has happened between you and the supervisee; it also includes your own experience of similar cases to that which the supervisee is bringing to you. How you handled a similar case may be useful and informative but it is probably less important than how the supervisee has handled,

is handling and will handle the case which he or she is bringing to supervision. Because in mindfulness we tend to step out of patterns of thinking and rumination, we have a far better chance of approaching these cases with "beginner's mind" when we are mindful. This doesn't mean that we only apply "beginner's mind" and leave our previous experience outside the door. It means we try on a "beginner's mind" as part of our approach to the issue and mindfulness practice makes this much easier to do.

d) **It improves the chances of spotting countertransference at work in the supervisor/supervisee relationship.** If countertransference is a human trait than supervisors being, presumably, human share that trait. Who else is sitting in front of you invisibly beside this person? An earnest/rebellious student? A respected/dodgy colleague? Uncle? Aunt? Son? Daughter?

The possibilities are, of course, endless but it is well to have some inkling of them, how they might be pushing the supervisory relationship in a particular direction, whether that is a helpful or unhelpful direction. Since countertransference appears to be largely unconscious as a dynamic, an inkling may be as good as we can hope to get. But I believe that in fostering an ability to detach from habitual thinking, countertransference

helps us to get a somewhat larger inkling than would otherwise be the case.

- e) **Makes you aware of your goals for your supervisee and for the supervisee's client.** Therapeutic relationships are fluid and hard to pin down and don't usually run along neat parallel tracks. It's fine to think that the supervisee's client really ought to leave her husband. However, expressing that without mindful restraint could derail the therapy if the supervisee takes this as the required way to approach the matter with the client. You may feel that the supervisee really ought to lay down the law with a client who habitually arrives five minutes late and runs ten minutes over. But for all you know your insistence, if too strongly put, could end up demoralising the supervisee without necessarily solving the problem of time-keeping. What a more mindful approach does is to help you to see your goals for the supervisee's work and to make a cool assessment as to the extent to which you should or should not promote them.
- f) **Helps you to be compassionate and to temper that compassion where necessary.** Supervisees can suffer the same pangs of self-doubt as anybody else. Sometimes the self-doubt points to an issue the supervisee needs to deal with but often, in my experience, it is unjustified and may occur because the client is travelling more slowly than the therapist wants him or her to travel; because the client is obstructing the therapy, in the eyes of the therapist; or because the therapist generally brings an attitude of self-doubt to his or her interactions

with the world. The mindful supervisor will recognise this and will help the supervisee to explore his or her self-doubt with compassion and in a way, that is more likely to be useful than simply denying or ignoring it. If the supervisee's self-doubt is justified, then compassion needs to be tempered with the duty to help the supervisee to correct his or her approach. Mindful detachment can enable the supervisor to navigate these tricky waters.

- g) **Cultivates self-compassion in the supervisor.** Supervisors, too, have a need for their own compassion, in other words for self-compassion. A supervisor may feel that he or she is not as good a therapist as the supervisee, may feel nervous about telling the supervisee something that he or she does not want to hear, may feel exasperated by the supervisee's habitual responses and so on. In all of these, kindness towards the self can be a form of practical self-care for the supervisor. Mindfulness promotes both compassion and self-compassion. In this way it can help the supervisor to spot unjustifiable self-criticism or to treat oneself with kindness where the criticism has a grain of truth in it. Self-compassion is not only a question of being kind to oneself - as described by Dr Kristin Neff in *Self-compassion* (2011), it also involves recognising one's common humanity. In this case, recognising common humanity involves acknowledging that other supervisors probably feel the same way from time to time. This breaks through the sense of isolation or being uniquely faulty.

Conclusion

The above are just some of the ways in which mindfulness can make an important contribution to the supervision relationship. Perhaps as importantly, mindfulness can contribute much to the well-being of the supervisor as a person. It is by adopting mindfulness practices and attitudes, such as those outlined here, that one can begin to experience those benefits. ☺

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My personal experience of Grief and Loss and learning to live in the NOW.

Marian Staunton



I thought I knew what grief and loss felt like. From past experiences of death, knowledge gained, trainings and the privilege of being with others who were grieving, to date I knew I could empathise with others as they shared their thoughts and feelings. I knew and had felt before now, the different stages according to; Elizabeth Kubler Ross; of shock/numbness, sadness, depression, anger and acceptance. I felt confident and comfortable sitting with, listening to and accompanying clients as they journeyed their paths into, in and through their grief and loss experiences.

Then I received a phone call which was to change my life and the lives of everyone in my family. My brother not yet 60 had just

received a diagnosis of a terminal illness; he had colon and advanced liver cancer. No option for surgery or chemotherapy– only a short time left. A remote possibility to participate in a trial drug and only if he were a suitable patient, *which he did*, giving him and all his family valuable time to live, grieve, accept, time together and to complete all he and we could complete before his physical life ended. Feelings of shock, numbness, fear, sadness, powerlessness, along with horror and disbelief erupted and swirled in my body and rushed to the surface, all at the same time, leaving me feeling overwhelmed.

Trying to comprehend that in a very short time my brother would no longer be in this realm was an

enormity almost too great to bear. With acute awareness I watched his life's energy ebb and flow from health to sickness over and over again until such time as the dreaded death itself became a reality. I witnessed my brother's physical strength weaken and his body deteriorate and at the same time his inner spiritual strength develop and grow. The grief and loss stages became constant unwanted companions. I watched his failing health and his huge determination to live and at all times feeling the loss of whom I had known him to be. My view of life and the after-life changed many times as I travelled my journey through this time. My past experiences of death were of little comfort now as I witnessed my brother just one year older than me die a little more each day. **I felt utterly powerless.**

Day and night brought my emotions, feelings, thoughts swirling and crashing into each other- all vying for their own space. Words like no hope, too advanced, drugs, procedures, tests, and results very quickly became the new normal in every day vocabulary. Despite all this an overall feeling of hope was ever present and cushioned a stark reality that kept us all going. Being “in the moment” took on new meaning and gave a sense of power in an otherwise overwhelming situation.

Together we began to reflect on life, and the sharing of memories

of our times together- when we played, laughed, disagreed, fought with each other, were in competition with each other, all became bitter sweet. Cramming as much of these times into each day along with visits, phone calls, texts, chats with him and other family members, when we travelled the length of the country to be with him was difficult but, I had much gratitude that I could do it.

I truly valued the times when he was capable of interaction and response and when he was not able we sat with “presence and stillness”. *Now I could be truly with me in the moment and without any effort.* A treasured and privileged space in which I was storing memories that “has” to last a life-time. Journeying the four hours home after each hospital visit was often the most painful because the reality of how he was on that particular day could now be really felt and also a glimpse of the future I did not wish to see. His deteriorating health, his struggle to stay alive, his-physical pain, weight loss, at times not able to engage left me with a harsh reminder that the inevitable was going to happen. Nevertheless, I wished I could hold onto **the now** and that time would stand still. Denial, (another of the grief and loss stages according to Kubler Ross), served me well and was most welcome and had a very valuable place in my life. During these trying times my heart felt sore and heavy. Tears of deep sadness brought some relief. I witnessed my brother living and dying consciously, choosing how he wanted to live the last few months he would be on this earth and in so far as he could choose, how he was going to die. He rarely talked about his diagnoses or dying. His response when asked “how are you?”; was always the same, “sure what can I do – I’ll do what the doctors tell me and I could have

dropped dead from a heart attack or be killed on the road”. He would then talk about life and living and remembering the past became part of all our conversations. Not sharing about how he felt and/or death definitely helped him to live and die in his own way. Kubler Ross states “that we all live, grieve and die in our own way”. Journeying and walking with “another” took on new meaning and staying present was all that was needed.

As I watched his enthusiasm in telling a story it was obvious that he enjoyed and got great satisfaction at recalling and remembering events in his life so far. Happy, funny, difficult and challenging and above all rewarding times – his view and experiences in life. I so so treasured those times together.

His dreams, projects, aspirations for the future now took precedence. He continued to plan for his family’s future, a future he knew he would not be here to experience. No time now for him to wait or have patience. This time he was in a hurry and it seemed his joy was in being able to share with them his wishes for when he would no longer be in this realm with them. Always a worker- a hunter gatherer, he planned and arranged turf for the following winter- organised the refurbishment of the range he would not see again but, it was sufficient now for the job to be completed. This was a huge change for him given that he had always been task orientated and would always see a job through to the end and then stand back and admire it. Now the planning for some-one else to do it was enough and he “was in the moment”. In this I am reminded of the stage of “chaos” according to “Kubler Ross and others” when thoughts feeling emotions are all experienced together with no acceptance of something that is very fearful. It is

a time when powerlessness is truly felt and to engage in life and doing gives some sense of order and power. Next he decided to organise a really big project the replacement of the septic tank at his home. He had already thought about this job but, had been waiting for “good weather, longer and brighter days and a few weeks off work”. Now there could be no waiting and he organised and arranged this job from his hospital bed and in between tests and procedures. The project that normally would take a number of weeks maybe even months, was completed in record time. He had a purpose at a time when I have no doubt he often wondered about life and purpose. Through the seven months from diagnosis to his death he engaged in a crash course of guidance and advice for his two boys telling them, many things about his life, how to go forward with theirs and how to look after each other and their mam. During this time I and other family members who were present felt an overwhelming and deep sadness and an acute awareness of the reality of his limited physical time on this earth. Giving life and whatever energy he had to his plans seemed to bring comfort, satisfaction and fulfilment. Grief, loss, failing health, spiritual, profound, were all together in each moment. Straightening his affairs – the making of his will also became part of completing his life’s journey and creating closure, before he travelled on. For me, each day was welcomed as a new beginning and at night I felt a grief that we had one less day as sister and brother in this lifetime.

His refusal of certain pain relief medication which would leave him sleeping more and less conscious, was his daily choice and decision. He wanted to and did live his life to the full and up until his last day.

True to who he had always been there was work to do and he was completing his journey in his own way. His power to complete and leave in his own conscious time was comforting to witness despite my sadness and I had immense gratitude that I could spend more time connecting with him, before he slipped into unconsciousness and eventually coma. During those times I saw again the man and brother who lived life to the full and to the very end. At the same time I was living my own parallel journey of feelings, emotions and thoughts all taking on their own form and expression. I was letting go and experiencing all the stages of death before it happened. Life and death were now as one, with a new and most profound awareness, “that one is the opposite side of the other just as a coin has two opposite sides”. A deep and real sense of spirituality surrounded and enveloped me and I could feel it within and without. Watching him fade away whilst, he was living life as fully as he could, brought comfort. His body dying and his soul fulfilling its purpose was sad, frightening, humbling, and a privilege to be part of. Mourning for the past, relishing in the present, longing to hold onto the now and fearing for the future we would not have together in this realm. This heightened awareness gave birth to an acceptance of “this is it” “the now” is all I and each one of us has. His grief and loss was for the death of his physical body, death of the future that up until now he thought he would have and most of all leaving his family. Mine was for my brother as I knew him. I was letting go of the healthy man and very soon I would also be letting go of the sick man, and letting go too of future family times together.

The ordinary everyday happenings and activities helped during this time. I had an acute awareness

of everything. Sounds seemed louder, smells, taste, touch, were all heightened, lights were brighter, my work as a therapist became more meaningful and real. Love and support from family and friends felt supportive, comforting and wholesome and gave profound meaning to living and being in the now. I felt at a very deep level the meaning of living in the NOW. Awareness of my own limitations and energy levels had to be considered and right alongside this was a fear for my own mortality and of course the fragility of life.

I had thought I knew, and felt deep within my psyche, what it felt like, to be in the moment but, now I have been brought to new depths in my own being. All this brought me to trust and acceptance- trust in the process, trust in my journey; my brother's journey, in all our journeys- trust in the purpose of life, trust in the length of time each of us will have in the physical realm- trust in our souls journey. Trust became my new and close friend. My brother was just one year older than me. As he was slipping away from this life, this world, we all joined hands around his bed and included him in our conversation as we chatted about life, told jokes, laughed and cried together. It was only when he did not take his next breath that I knew he was gone- a beautiful death and a really spiritual time- one moment **life** and the next moment **death**.

Two years on I am still grieving, facing the many stages of grief, now that my brother has died. It has not been an easy time. It certainly is not the same as other losses which I have experienced throughout my life. Acute awareness of my own mortality surfaces often. The loss of my sibling has left me feeling, vulnerable, sad, questioning life and life's meaning repeatedly. And in the midst of all my feelings, emotions

and thoughts is, “a deep and heart felt loss for my sibling-my brother”. I miss the ordinary things – the phone calls, the banter and healthy teasing, our times together around mine and his kitchen tables- where we drank copious amounts of tea/coffee and one meal ran into the other. The day trips to a local town where we always bought something perhaps a jacket which he liked to wear especially when it was bought in our home county – a dress or piece of jewellery for me. Precious visits, times, fun and craic that can never be repeated now. A **gift** in his death for me is “to live life to its fullest”.

Before he died my greatest fear was that our connection to each other would be severed forever but, throughout the past two years of grieving I have also experienced a parallel process of “loss and at the same time connected”, connected in a way I had not felt during his life, and his to me, is our spiritual connection. My memories remain special and will last me my lifetime. ☺

Marian Staunton

Marian Staunton works in private practice as a psychotherapist and supervisor in Castlebar Co Mayo. Having completed her training in 1998 Marian has continued to pursue various studies in her search for deeper meaning and in 2007 she completed her training in Holotropic Breathwork™ facilitation and Family Constellation facilitation in 2013. Her interest in trauma has led her to offering supervision and support to Rape Crisis Centres in Mayo and Sligo.

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Book Review

Title: *Thrive: The Power of Psychological Therapy*
 Author: Richard Layard & David Clark
 Published: 2015
 ISBN: 978-0-241-96111-7
 Reviewed by: Coilín O'Braonáin MIACP

'Thrive' is a UK publication which highlights the double standard in treating psychological disturbance compared to physical illness. Layard & Clark, one an economist and the other a psychologist, provide copious evidence that many people do not receive help with psychological problems. Society still has trouble taking mental illness seriously in spite of its prevalence. For example, the World Health Organisation (WHO) has found that 40% of all illness in rich countries is mental, while cancer, stroke, heart disease, lung disease and diabetes together account for 20% of illness.

In advocating psychotherapy, the authors favour evidence-based therapies, and in particular refer to CBT, given the large body of empirical support which exists for CBT. The average cost of treatment, per client, of CBT in the UK is about €1,200, whereas the cost of untreated patients being on sick benefit, or losing their jobs is twice that amount. Obviously, human suffering is also reduced, and 'Thrive' points out that mental pain is as real as physical suffering. Indeed, both types of pain are experienced in the same regions of the brain; the anterior cingulate cortex and the anterior insula.

A discussion of the efficacy of therapy follows and the question regarding the effectiveness of anti-depressant treatment versus psychotherapy is addressed. The National Institute for Health and Care Excellence (NICE) is quoted as finding that only severe depression is ameliorated by medications. Consequently, only psychotherapy is recommended for mild and moderate depression. Nonetheless, an astonishing 8% of European adults are taking anti-depressants when most of them are not in the severe range.

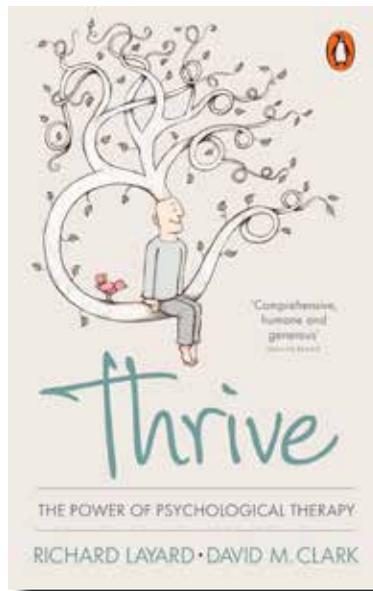
Another interesting point made concerns whether it is the therapist or the therapeutic modality which

affects successful treatment? Research has found that therapist training greatly determines the outcome, not the therapists' personal qualities, e.g., empathic ability. In one study, the difference between therapists who had varying degrees of effectiveness was eliminated when they received a 3-day intensive CBT training following by 8 months of supervision. Another interesting fact is that patient choice of modality has an effect on outcomes. That is, given a choice of two types of effective therapy, clients will do better with the therapy they find more credible, than they will with the other equally effective therapy.

Finally, 'Thrive' looks at the underpinnings of mental illness taking into account the effects of work place-stress, parenting styles, parental relationships, and consumerism on our collective levels of happiness. This foray into the realm of positive psychology is quite broad and less measurable, but nonetheless addresses the substrate of mental health. It is noted that richer countries with lower levels of cooperation and higher levels of competition for position have higher rates of psychological problems. The pressure to be financially successful in very stressful work environments is, in fact, counter-productive to well-being.

In contrast, a study of the '100 Best Places to Work' in the USA over 25 years found that share values of those companies were worth 50% more than a control sample. It seems that happy workers are even good for business! The fact that higher incomes does not necessarily increase well-being is highlighted by a UK finding, that family income per head has no effect on whether children are happy or not.

This book is a valuable tool in presenting the importance of psychotherapy and in advocating for greater availability of therapy. A strength of the book is that the material presented is itself well-grounded in research. This very readable book is a useful resource for therapists wishing to address doubts raised by clients about the efficacy of counselling, and also for students wishing to broaden their training to the socio-political realm.



Book Review

Title: *Helping Adolescents and Adults to build Self-Esteem. A Photocopiable Re-source Book*
 Author: Deborah M. Plummer
 Published: 2014
 ISBN: 978-1-907855-07-8
 Reviewed by: Izabela Morris

Deborah M. Plummer is known for her work with children and adolescents. At present she is a writer, imagework practitioner and workshop facilitator. She also has an extensive experience as a senior lecturer at De Montford University in Leicester in the area of health psychology and counselling. Formerly she worked as a lead speech and language therapist within the NHS. Her many books focus on personal development, play, imagination and mindfulness to enhance emotional well-being of children and adolescents. The books offer resources to not only professionals who work with children and adolescents but also for parents.

In this book Plummer outlines her belief that “self-esteem is a complex, multi-faceted aspect of life; a primary component in the building and maintenance of physical, emotional and spiritual well-being” (p.13). She explores “Self-esteem” and brings in diverse theories and studies. Plummer explains how to gain a healthy self-esteem and the possible consequences of neglecting low self-esteem. She cites Virginia Satir when quoting: “Since the feeling of worth has been learned, it can be unlearned, and something new can be learned in its place. The possibility for this learning lasts from birth to death, so it is never too late. At any point in a person’s life he can begin to feel better about himself” (p.18). Plummer considers eight “foundation elements” that contribute to a good self-esteem, social and emotional well-being. These are: self-knowledge, self-awareness, self-acceptance, self and others, self-reliance, self-expression, self-confidence and beyond self.

The book is divided into two parts: theoretical and practical. In the theoretical part the author looks at Self-Esteem and Well-Being. She examines what happens with well-being if a person’s self-esteem is low and how learning and the process of change could be facilitated. It also includes “neuron nuggets” that provide the reader with information about different

stages of the adolescent’s brain development. The practical part consists of activities with guidelines on how to help young people distinguish what healthy and low self-esteem is. All the eight foundational elements are introduced and explored widely. Comprehensive and abundant exercises and activities are presented such as worksheets on “Working on Avoidances”, “Desensitization”, and “How I Normally Express Emotions”, to name a few. This part provides different tools that could be used while working with young clients with a variety of issues including building self-awareness, building self-acceptance, learning assertiveness, creative problem solving, setting and achieving goals and many more. Relaxation/visualisation and breathing exercises are contained in the Appendix. Given that the author has provided appropriate guidelines or the work-sheets these could be used in one to one counselling and group work.

I found Chapter Three relating to “Working with Imagery and the Imagination” very interesting as an introduction to Image-work. Image-work is explained as “developing the receptive ability to tune into the images that guide us, and the active ability to create new images that enhance our health, happiness, and creativity” (p. 30). Plummer believes that people who are firmly grounded in reality might greatly benefit from engaging with imagery and workings

of the unconscious at the level of “make sense” without going into the depths. Personally I believe that section three called “Who am I?” was the most helpful. An additional advantage of this book is that many pages are intended for photocopying. Another aspect of the book that caught my attention were illustrations. Alice Harper pictured some of the emotions expressed on the faces of teens as well as variety of other things that are both supportive and refreshing while using the book.

Overall, for those who work with adolescents and young adults this book could be an excellent resource. For those not working in that field, reading this book could offer benefits through stimulating new ideas and perspectives or by possibly refreshing their current knowledge.

I am most grateful to the IACP allowing me to borrow this book. The review of this book has been a lengthy process but a most interesting and rewarding experience. Having read and reviewed this book I believe that the book offers practical interventions for therapeutic work and would be a great resource to store on your bookshelf.

