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Fresh Thinking in Psychotherapy

- **Intimate Partner Emotional Abuse and the Application of Attachment Theory**
- **Post Traumatic Growth**
- **Counselling and Homelessness**
- **VAT – Why Us? Do I Have to? and What Is It All About?**

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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.'

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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:

Dear Colleagues,

I am delighted to present this Summer edition of Éisteach. In this edition there is some fresh thinking in the areas of Intimate Partner Emotional Abuse, latest evidence based Irish research into Bullying and Posttraumatic Growth, great insights into Counselling and Homelessness and a first for Éisteach, we attempt to unravel the persistent conundrum of VAT as it applies to Counsellors and Psychotherapists. This foray into the business world is in recognition that most Counsellors and Psychotherapists are self-employed and are required to be business people, as well as therapists.

Workshop reviews take a look at the Use of Supervision as well as the broad area of Sexual Addiction and Dr. Coleen Jones adds a clear voice to the ongoing DSM controversy in the letters section.

As well as reflecting emerging trends in the field, the articles demonstrate the continued good will, academic excellence and energy of our contributors to whom we are eternally grateful.

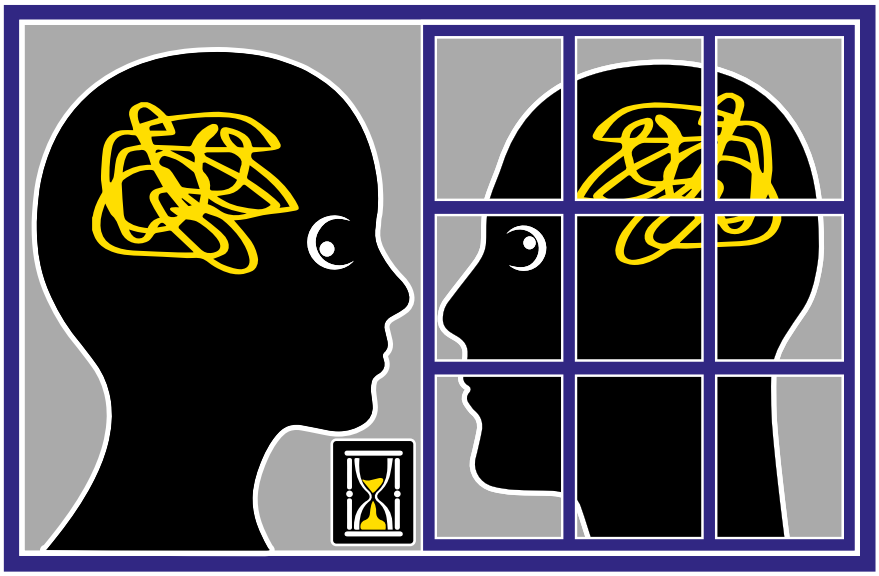
Wishing you a wonderful summer,

Antoinette Stanbridge, MIACP
Editor

Antoinette Stanbridge is in private practice in Dun Laoghaire as well as Faculty and Link Tutor with PCI College. Contact antoinettestanbridge@gmail.com

Intimate Partner Emotional Abuse and the Application of Attachment Theory

By Gavin Haugh



Introduction

Intimate Partner Emotional Abuse (IPEA) is a widespread phenomenon, with 9,912 women in Ireland contacting the Women's Aid helpline in 2012 to report incidents of being subjected to intimate partner emotional abuse. This was more than three times the number who reported physical abuse (Women's Aid, 2012). While comparable numbers for male victims of IPEA in Ireland are not available it is known that men are at least as likely to suffer emotional abuse from their intimate partners as women are (Goldstein et al., 2008).

This prevalence of IPEA is of concern for a number of reasons. Firstly, the presence of emotional abuse in intimate relationships is often an indicator of later physical or sexual abuse occurring with Henning & Klesges (2003) reporting the presence of emotional abuse prior to physical violence and sexual assault in 80% of cases. Secondly, physical and sexual abuse of an intimate partner very rarely occurs without the co-existence of emotional abuse (Sackett & Saunders, 2001), so therapists who seek to work with intimate partner violence (IPV) will need to address emotional abuse also. Thirdly, even in cases where abuse remains emotional only, it still has many severe and detrimental effects. O'Leary (2001) found that victims of IPEA reported emotional abuse as being more relentless and terrorising that physical abuse while Queen et al. (2009) reported the effects of emotional abuse, in contrast to physical abuse, as continuing long after the abuse had ended. Bancroft (2002) highlights the fact that emotional abuse is a reported factor in more than 25% of female suicide attempts.

IPEA is an issue that can affect men or women of any age regardless of the duration of the relationship, marital status, sexuality or living arrangements (Renn, 2012). As such, it is likely that therapists will encounter both perpetrators and victims of IPEA regardless of their general client base and will have a need to be familiar with the causes, characteristics and impact of IPEA, as well as have an ability to work with it in an effective manner. Whether therapists currently have this ability is questionable. Studies in 1991 and 2008 found that a large proportion of sampled therapists failed to detect physical or emotional abuse and only a negligible amount made effective interventions to prevent escalation (Hansen et al., 1991 and Dudley et al., 2008).

In order to successfully work with Intimate Partner Emotional Abuse therapists must first understand what it is and how it may be defined. In contrast to physical abuse there are not clear cut definitions for emotional abuse, nor can we as easily see the marks it leaves. Therapists will be aware that most couples argue at one point or another and often these arguments will contain elements of emotionally abusive behaviour. Determining when couple interactions change from unpleasant to abusive is no simple task and while numerous attempts have been made to categorise and quantify emotional abuse universal agreement remains elusive, possibly owing to the complex and

subjective nature of emotional abuse (Hamel, 2013).

While a number of authors have offered their own definitions or characterisations of IPEA one of the most comprehensive reviews was carried out for the US Center for Disease Control (Saltzman, 2002). That report stated that emotional abuse can include humiliation, dictating what the victim can and can't do, withholding of information, deliberately trying to make the victim feel less worthy, using the victim's money, disregarding the desires of the victim, isolating the victim, restricting access to communication or transport, getting the victim to engage in illegal activities, destroying the victim's property, damaging the victim's reputation through disclosure of information or misinformation, using the victim's children against the victim through threat of loss of access/custody or other means or withholding money or other basic resources. While these varying elements of emotional abuse provide a useful guide to therapists it is worth noting that the report conceded that in certain cases abusiveness can only be determined through how the victim perceives behaviours and acts rather than assessment of the acts themselves. McKenery et al. (2006) highlight the fact that abusive behaviours may vary but have the common goal of increasing the power and control of the abuser over their partner. Daly et al. (1982) found the reason that abusers wish to have this control over their partner is to alleviate feelings of insecurity that they will be abandoned.

While there is no set path to someone becoming emotionally abusive towards their partner certain trends have been found amongst perpetrators of IPEA, with a number of authors identifying insecure attachment styles as a significant risk factor for victimisation and perpetration (Dutton et al, 1994; Wilson et al., 2013). If insecure attachment styles are a cause of IPEA then understanding a clients' attachment history may aid the therapist in understanding their current emotionally abusive relationships.

Background to attachment theory

Attachment theory may be considered an index of emotional regulation, classifying as it does the affect employed by an individual in response to perceived loss of, or rejection from, their attachment figure (Babcock et al., 2000). This attachment figure is usually the mother in infancy but becomes the subject's intimate partner in later life (Bowlby, 1988).

Attachment theory states that depending on how people are nurtured and comforted by their attachment figure the individual will develop inner beliefs about whether their attachment figure is caring and responsive and also whether or not they themselves are worthy of care and attention. This influence on how intimate partners are viewed, as well as how the individual feels about their own right to be cared for, has implications for emotionally abusive adult relationships (Hazan and Shaver, 1987).

Classification of infant attachment styles was refined by Mary Ainsworth and her clinical study The Strange Situation (1970). This study involved observing the behaviour of infants after their attachment figure left them for a period of time. The varying affects employed by the subjects were initially classified in one of three attachment styles: Secure, Insecure-Avoidant, Insecure-Ambivalent. A fourth classification of 'Disorganised' was later introduced by Main and Soloman (1986).

Securely attached infants in Ainsworth's Strange Situation (1970) were observed to be upset at the parting of their attachment figure but not panicked, and displayed relief and happiness at their return. This behaviour of not internalising rejection corresponds with a greater ability in secure adults to maintain self-worth and defend oneself when arguing with an intimate partner (Babcock et al., 2000).

Insecure-avoidant children displayed little or no emotion at the leaving or returning of their caregiver in The Strange Situation, yet showed physiological symptoms of distress.

Insecure-avoidant children displayed little or no emotion at the leaving or returning of their caregiver in The Strange Situation, yet showed physiological symptoms of distress, such as elevated heart rate. This masking of emotion on the part of the infant is in response to emotional rejection from the attachment figure (Howe, 2011). In essence the infant has learned that expressing emotion does not create closeness or comfort with their caretaker and may in fact have the opposite effect of driving them away. The resulting suppression of emotional displays is borne of a fear of increasing emotional and physical distance with their attachment figure. In adulthood this attachment style is referred to as Avoidant-Dismissing and involves a similar affect of outward projection

of independence. Emotional and sometimes physical distance from the intimate partner is common to the avoidant-dismissing type as rather than allow themselves to become close and risk rejection they instead seek to keep partners at arm's length (Levine & Heller, 2010). In terms of IPEA this can manifest as a withdrawal of affection if the relationship becomes more intimate than the Avoidant-Dismissive is comfortable with. It is important to note that the withdrawal of affection is in itself an abusive act and has been shown to have as great a role in IPEA as overt acts of control or demeaning. (Queen et al., 2009)

The third attachment style of Ainsworth's Strange Situation (1970) is the ambivalent type. This group of infants reacted to the return of their attachment figure with a strong need for close proximity, often clinging to their caretaker. Anger and physical aggression directed at the attachment figure was also prevalent in this group (Jackson, 2007). This angry protesting has been shown to be an instinctive biological response by infants to separation from their attachment figure (Renn, 2012) and is not intended to drive the attachment figure away, but rather is an effort to increase the intensity of communication to the attachment figure in order to pull them back to a proximity in which the infant feels secure and comforted (Bowlby, 1973). For adults this attachment style is classified as Anxious-Preoccupied, a style of attachment that is more prone to abusive behaviour when the individual feels their partner is withdrawing from them (Babcock et al., 2000). The emotional abuse of an intimate partner may be an exaggerated and dysfunctional manifestation of the primal protest behaviour observed in infancy (Bartholomew, & Allison, 2006) in response to a perceived rejection or lack of availability from the intimate partner (Kesner et al., 1997).

Disorganised infants display strongly conflicting behaviour of both seeking proximity with their attachment figure whilst also avoiding contact by turning away. A significant percentage of these infants were found to be experiencing physical or emotional neglect or abuse from their attachment figure (Alexander, 2009). This abuse in childhood correlates with a higher risk of entering an intimate relationship with an abusive partner in adulthood (Follette et al., 1996). Adults with this attachment style find themselves in a situation of feeling rejection from, and fear of, their attachment figure but also being drawn towards them for comfort and protection (Shemmings & Shemmings,

2011). This is known as Fearful-Avoidant attachment and can be a factor in victims feeling unwilling to leave their abusive partner as well as being abusive themselves (Dutton et al., 1994).

Interaction of attachment styles as a risk factor for IPEA

Wilson et al. (2013) found that attachment pairings in intimate relationships have a significant correspondence to emotional abuse with relationships made up of two secure individuals least likely to involves abuse, with couples made of a secure and insecure partners more at risk and pairings of two insecure people showing the highest rates of abusive behaviour.

While securely attached adults are less likely to emotionally abuse their partner and are less at risk of staying in an abusive relationship (Holtzworth-Monroe et al., 1997) it should be remembered that attachment styles may change over time and a securely attached person may become insecurely attached to their partner in the face of emotional abuse (Weston, 2008). That this attachment is classified as insecure does not equate to a weakening of the attachment as the quality of a relationship is unrelated to strength of attachment (Renn, 2012). Victims of emotional abuse can be very strongly, though traumatically attached to their abuser (Follette et al., 1996) meaning ending the relationship may be a difficult or unwanted outcome for the victim.

Within relationships of two insecure people particular issues have been noted. Fearful-

Avoidant types often fail to recognise and understand the needs of their partner, resulting in feelings of frustration for both parties. Rather than confront these feelings and address their underlying fear of loss and rejection the Fearful-Avoidant may lash out, verbally or physically (Howe, 2011). Relationships of Anxious-Preoccupied types with Dismissive Avoidant or Fearful-Avoidant partners have been associated with higher levels of abuse, regardless of whether the Fearful-Avoidant person is male or female (Doumas et al., 2008)

Therapeutic focus: Cause or effect?

For therapists working with

This abuse in childhood correlates with a higher risk of entering an intimate relationship with an abusive partner in adulthood.

perpetrators of IPEA the question of whether causes, such as attachment style, are relevant must be considered. Review of the existing literature indicates a common approach of focusing on abusive behaviours and the taking of responsibility for those behaviours rather than addressing underlying causes. According to Bancroft (2002), "There is no way to overcome a problem with abusiveness by focusing on tangents such as self-esteem, conflict resolution, anger management or impulse control. Abusiveness is resolved by dealing with abusiveness". Bancroft is not alone in stating that abusive relationships should be approached from a perspective of focusing on the abuse itself. Evans (2010) highlights the importance of confronting denial and evasion of responsibility in abusive clients rather than exploring issues that may be later used as excuses for the emotionally abusive behaviours. Jones, as cited by Hennessy (2012), finds that the effect of therapy on an abusive partner may be to turn them from "abusive and apologetic" to "abusive and self-righteous" if the therapist approaches the problem from a perspective of causes or through exploring the emotional state of the perpetrator. Stosny (2008) agrees with this, finding that exploring causes serves only to trigger more abuse in the present, as the abuser does not have the ability to self-regulate their emotional response to the feelings brought up by therapy.

Dutton (2007) challenges the viewpoint that focusing on anything other than abusive behaviours and responsibility is detrimental and writes, "Treatment of [the underlying] issues does not, as psycho-educational groups insist, merely bring 'excuses' into play, it opens up the infrastructure of abuse to remediation". Engel (2002) considers understanding the reasons for emotional abuse and patterns of behaviour to be of the utmost importance in creating positive change, second only to the abuser admitting the existence of abuse. Supporting this stance that addressing the underlying causes of IPEA is not just worthwhile but should be a key aspect of therapy is the high rate of recidivism in cases where therapy takes a 'responsibility' approach but does not address causes. Studies by Babcock et al. (2004) and Feder & Wilson (2005) both found almost universal failure in long-term outcome studies of therapy effectiveness for abusive partners when the abuser was pressured or ordered to attend, and the focus of therapy was on confronting denial and admitting responsibility. It is possible that the confrontational nature of the standard approach to intimate partner abuse inhibits the development of a therapeutic relationship, particularly if the client has not come of their own volition or already recognised their own responsibility. Thomas (2007) supports this possibility, finding that "confrontation and breaking down denial is more likely to lead to compliance than to real change". This is likely a result of abusers feeling a desire to make changes to save their relationship but also wrestling with increased feelings of stress, self-pity and victimisation when confronted by the therapist (Dutton, 2007). While short term arrest of abusive behaviours may be made through strong conscious effort the client ultimately retreats to their dysfunctional coping mechanism of being emotionally abusive to their partner.

Employing an attachment focused approach

If therapists accept the role attachment plays in intimate partner emotional abuse they must also consider the role attachment styles will play in therapy. Reviews have found that insecurely attached clients are found to be more difficult to create therapeutic alliances with than secure individuals, owing to the fact clients perceive the therapist in much the same way as they perceive their attachment figure (Mallinckrodt et al., 2009). Anxious-Preoccupied clients expect their therapist to let them down and doubt their continuing responsiveness while Avoidant clients will defensively inflate their own self-esteem as a barrier to connecting with the therapist (Mikulincer et al., 2003). Both of these responses are borne of the same fear of rejection and abandonment that impacts their relationship with their intimate partner. This insecurity, in keeping with the findings that focusing on blame and responsibility does not lead to long term positive outcomes, reinforces the need to work patiently and empathetically with emotionally abusive clients.

Avoidant types often fail to recognise and understand the needs of their partner, resulting in feelings of frustration for both parties.

An attachment oriented approach may also be suitable owing to the fact it is a systemic model which links clients with their behaviour by focusing on habitual affects employed in response to, and preparation for, interacting with

others (Johnson, 2004). This technique of linking a person with their behaviour, rather than simply telling them that the behaviour is unacceptable and must be stopped, may be more effective owing to the creation of self-understanding and greater cognitive awareness of automatic negative reactions to emotional distress. Dutton (2007) suggests that consideration of attachment styles and behaviours is strongly compatible with a Cognitive Behavioural Therapy approach for these same reasons while Matsakis et al. (2001) also determined attachment orientation to be a beneficial approach for creating a case conception and addressing negative patterns owing to it highlighting the primary emotions associated with IPEA as well as the cognitive distortions that exist within insecure attachments. Kesner et al., (1997) suggest that addressing unresolved childhood attachment issues through individual or couples therapy might provide "appropriate interpersonal expectations, insight into their own behaviour, individual behavioural responsibility, and new behaviours associated with appropriate attachment".

Conclusion

IPEA is a complex and harmful phenomenon present within a great many intimate relationships. Occurring as it does on a continuum of severity and frequency it is far more difficult to define or identify than intimate partner violence. This complexity that surrounds IPEA may go some way to explaining the limited amount of IPEA research available, in contrast to the multitude of publications dedicated to IPV. Despite clearly involving behaviours and consequences distinct from IPV many of the papers reviewed for this essay included emotional abuse under the umbrella term of partner abuse/violence, while others made only brief reference to it as a sidebar. A significant amount of the literature on partner abuse excluded emotional or psychological abuse altogether.

This situation of emotional abuse being seen as secondary or being discounted altogether may partly be explained by the fact it is less suited to empirical research. In contrast to physical abuse there are no large databases of arrests or convictions for emotional abuse and determining whether IPEA has occurred is often a subjective experience. The fact that victims may even be unaware of the abuse only increases the difficulties of studying IPEA. Yet the lack of research into IPEA cannot simply be ascribed to the academic challenges. There appears to be a widespread view that emotional abuse within relationship is a less serious issue than physical violence. On the one hand this viewpoint is understandable, IPV can and does cause serious injury and death. This makes IPV more likely to garner headlines, cause outrage and become part of societal concern. Yet, as has been noted in this work, IPEA has serious and long lasting consequences for the victim that have been described as more terrorising than physical abuse. That IPEA may be a warning sign to later physical abuse also reinforces the need for greater focus and understanding of the issue.

Another impact of the inclusion in the literature of IPEA as just an aspect of partner violence is that the same therapeutic interventions being employed for both issues. The emphasis that is given to perpetrators admitting responsibility and making promises to stop abuse is borne of an understandable and necessary goal of ensuring the safety of the partner in cases of violence. However, this approach necessitates the therapist taking a more confrontational stance in early sessions than may normally be desired and inhibits the development of a therapeutic alliance. This in turn reduces the likelihood of abusers continuing the therapy or making a real connection with their behaviours. With research showing high rates of recidivism in cases of IPV therapy that factor confrontational methods it is reasonable to expect the same outcome for IPEA. Reducing the risk of this long term relapse should be a key goal of any methodology and may be aided by taking a more patient and exploratory tact with clients. That is not to say that emotional abuse should not be named and highlighted as a damaging an unacceptable behaviour, but that there is less requirement on the therapist to be as forceful or urgent in doing so owing to the non-immediate risk to the victim that IPEA poses. Taking a more gradual and encompassing approach that blends naming abuse with understanding the reasons for it and acknowledging responsibility with compassion for the perpetrator is more likely to lead to a long term solution rather than just short term respite, a preferable outcome for both perpetrator and victim.

Attachment styles provide a useful framework for therapists to take this encompassing view of exploring current abusive behaviours as well as underlying causes. While it is by no means the only explanation for emotional abuse, and readers are advised to consider other issues such as addiction and Antisocial Personality Disorder or Dissocial Personality Disorder, which have been attributed as the cause of abuse in 15-30% of cases (Hilton & Harris, 2005), understanding the role of attachment may aid both therapist and client, regardless of whether the work is being conducted with the perpetrator,

victim or both. Where clients are no longer in relationships but have histories of abuse recognising and exploring attachment style may lead to healthier decisions in the future and provide a real means of ending habitual behaviour that may have existed since infancy.

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Gavin Haugh (BSc Hons)

Gavin Haugh (BSc Hons) is Pre-Accredited member of IACP working in private practice at Oscailt Integrative Health Centre in Dublin 4.

This article is an abridged and edited version of the prize winning essay in the Martin Kitterick Award in 2015. This is awarded annually to a PCI College final year student marking outstanding achievement, originality and academic excellence, in memory of Martin Kitterick, former director of the college who passed away in 2012.

Contact: gavinhaugh@gmail.com

Post Traumatic Growth: Examining an Increase of Optimism Amongst Targets of Bullying in Ireland

by Jolanta Burke, Ph.D.

Abstract

Traumatic events, such as bullying, may lead to both distress and enhanced levels of well-being. In order to test this theory, a study was carried out to measure optimism in 2,441 participants aged 12-19 across 13 Irish schools, 312 of whom were bullied on a daily basis, whilst the additional 454 experienced perpetration "once a month" or "once a week". The results showed that Targets of bullying scored lower on the level of overall optimism, in comparison to those who have not been bullied. However, further analysis found that young people who experienced bullying on a daily basis reported the highest levels of optimism in negative situations. This result suggests that experiencing bullying may have helped participants develop symptoms of Posttraumatic Growth. The implications of this finding, in relation to therapists, are discussed.

Introduction

It is universally known that experiencing life adversities may lead to an increase of pathologies, such as depression, aggression (Mitchell, Tynes, Umana-Taylor & Williams, 2015), anxiety (Kendler, Hettema, Butera, Gardner, & Prescott, 2003), and suicidal ideation (Serafini et al., 2015). However, what is not often mentioned is that pathologies are not an inevitable consequence of adversities. Studies show that after facing a traumatic event such as illness diagnosis, only 5 to 35 per cent of people experience symptoms of Post-Traumatic Stress Disorder, whilst the vast majority report resilience and even a measure of psychological growth post-trauma (Cordova, 2008; Jospeh, 2011; Kangas, Henry & Bryant, 2002). Trauma is defined as an unexpected, out of the ordinary occurrence that disrupts individuals' personal narratives (Tedeschi & Calhoun, 2006), as opposed to intermittent stress, which may be both manageable and beneficial to individuals (Charney, 2004).

Moreover, research shows that those who experience moderate life adversities appear to be happier than those who have been completely protected (Seery, Holman & Silver, 2010). This may be due to the stress inoculation that occurs when people cope with life challenges, which in turn enhances their self-efficacy and preparedness to tackle subsequent life difficulties. This "positive" side to adversity is often neglected by researchers and practitioners; yet, it has slowly begun to emerge as a field of research within Positive Psychology.

Positive Psychology Perspective

Positive Psychology is a science that aims to study individuals' and groups' positive traits (Seligman & Csikszentmihalyi, 2000), the conditions that contribute to having a good life (Gable & Haidt, 2005), as well as examining the dark side of life that may induce positive

outcomes (Ivtzan, Lomas, Hefferon, & Worth, 2016). Thus, the "positive" in positive psychology does not refer to the promotion of positive thinking and disregard of all that is negative; rather, it examines all life experiences and individual qualities that may serve as a resource for creating positive outcomes. This may include, such factors as life adversities and traumas, as well as potential growth from them. There are many life events that may be considered traumatic, one of them is school bullying (McGrath & Noble, 2003).

Bullying

Bullying is a "repetitive behaviour that is intended to harm and which is characterised by an imbalance of power between a Target and Perpetrator, where it is difficult for the Target to defend himself or herself" (Burke, 2016, p. 12). The effect of bullying can be very traumatic for individuals, as Targets often re-live the disturbing memories of their perpetration (Sharp, 1995), which may lead to increases in experiencing symptoms of depression (Hawker & Boulton, 2000), as well as suicide ideation (Mills et al., 2002; Roland, 2002). However, whilst bullying is associated with increases of ill-being symptoms, such as depression, anxiety and other psychiatric disorders, experiencing ill-being does not automatically exclude the existence of well-being symptoms, such as engagement, sense of achievement, meaning in life, or optimism (Burke & Minton, in press). Therefore, the current study measured one aspect of well-being, namely optimism, amongst young people who have been Targets of school bullying.

Optimism

Optimism can be perceived either as a stable personality trait

Pathologies are not an inevitable consequence of adversities.

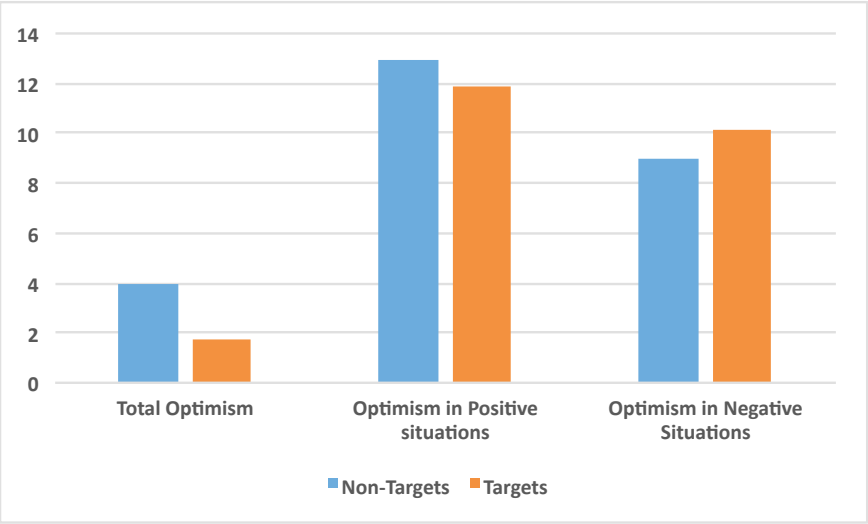
(Scheier & Carver, 1985) or a thinking style (Seligman, 2006). In the current research, optimism was viewed as a thinking style that individuals can learn over their lifespan. The way people explain the causes of both, their positive and negative life events, makes their thinking style either optimistic or pessimistic. If they explain their life events in a pessimistic way, it can result in experiencing helplessness, inertia, and potential depression. On the other hand, when individuals explain their life circumstances in an optimistic manner, they are more likely to take action to change their situation, gain increased levels of motivation, and experience more symptoms of well-being.

Current Study

The current research was carried out with 2,441 students aged 12-19 from 13 schools across Ireland. It was a part of a larger study, the aim of which was to examine positive psychological characteristics of students participating in school bullying (Burke, 2016). Bullying was measured using the Corcoran (2013) version of netTEEN questionnaire, which identified the frequency of bullying behaviours, such as verbal and physical abuse, threats, gossip, exclusion, and extortion experienced by participants over 3 months. Optimism, in the current study, was measured using the Children Attributional Style Questionnaire (CASQ: Kaslow, Tannenbaum, & Seligman, 1978).

The participants' overall optimism score was calculated by subtracting individuals' levels of optimism in negative situations from their levels of optimism in positive situations. The result of the study showed that when compared with those who have not been bullied, Targets of bullying scored the lowest in overall optimism, however, they also reported the highest scores in optimism displayed in negative situations (Graph 1).

Since the study identified correlation, rather than causation, there is a possibility that Targets of bullying had higher levels of optimism in negative situation prior to being bullied. However,



Graph 1: Optimism scores for non-Targets and Targets of bullying.

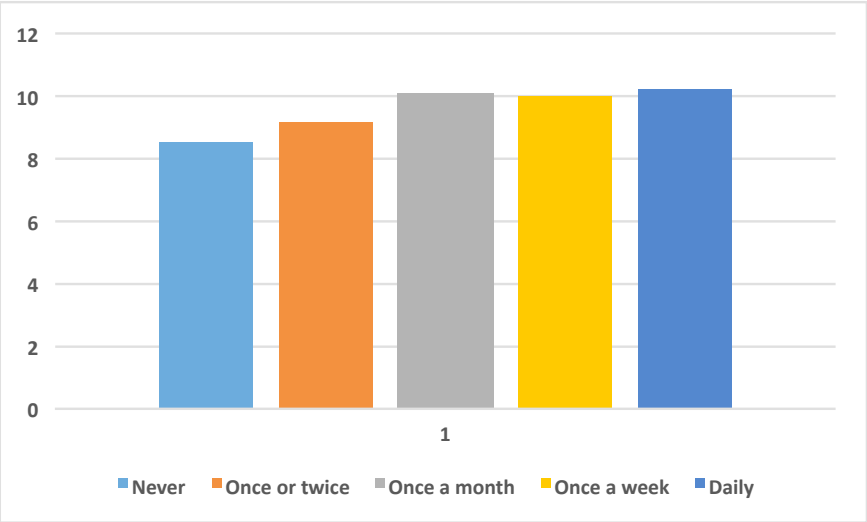
another possibility is that they may have developed optimistic thinking style, as a protective mechanism to "survive" bullying after their perpetration occurred.

In order to test this presupposition, further analysis was carried out, which showed that those who have been bullied daily reported the highest levels of optimism in negative situations compared to those who have been bullied less frequently, or not at all (Graph 2). Therefore, it may suggest that the ordeal of having to bear daily perpetration may have helped Targets advance their life skills, such as optimism, which help them survive their torment. Thus, experiencing bullying may have helped Targets develop more optimistic thinking style in difficult situations. However, further research needs to be carried out to confirm this finding.

Optimism is associated with a belief that Targets of bullying are not to be blamed for being bullied, rather the circumstances and other people, such as their Perpetrators, are responsible for this. Also, optimism is connected with thinking that the bullying situation is only temporary, thus will not last forever. Such a belief may be particularly useful for Targets of frequent bullying, as it allows them to have hope that all will be resolved, and take steps to change the situation. Finally, optimism is linked to the conviction that Targets have a life outside of being bullied, therefore, they may be haunted by their Perpetrators, yet they might still enjoy their school, engage in activities and have a support of good family and friends. Being able to see bullying as one of many aspects of one's life is an indicator of optimism.

Optimism is associated with a belief that Targets of bullying are not to be blamed for being bullied.

Nonetheless, it needs to be noted that, in the current study, some participants did not share a more optimistic view of their lives in negative situations, and scored lower in this domain than those who have not been bullied. However, on average, young people bullied "once a month", "once a week" and "daily" reported higher levels of optimism in negative situations than those who have not been bullied at all, or have been bullied "once or twice" in the last three months. Their score may be a sign of Posttraumatic Growth that developed as a result of being bullied.



Graph 2: Optimism in negative situations across frequency of bullying.

Posttraumatic Growth (PTG)

There are several models of PTG (e.g. Hobfoll et al., 2007; Joseph & Linley, 2005; Pals & McAdams, 2004). However, the most frequently applied model comes from Tedeschi and Calhoun (2006), according to which people experience "positive psychological changes as a result of the struggle with highly challenging life circumstances" (p.1). These positive changes can be obtained in the following five domains:

1. Perceived changes in self

After experiencing an adversity, people report feeling stronger, more confident, more aware of the "authentic" them; in other words, they become a better version of themselves.

2. Improved relationships

Their relationships with people becomes stronger. Some report that the trauma made them realise who their "true" friends are. They also feel a stronger affinity towards people who have gone through similarly traumatic events.

3. Changes in life philosophy

Another important change that might occur in Posttraumatic Growth is that people begin to reflect upon their mortality, as well as meaning and purpose in their lives. This allows them to make meaning from the trauma they experienced. Some talk about the benefits of their trauma and realise their vulnerability in life, as well as the shortness of time.

4. Altered priorities

Some individuals report that after traumatic events their life priorities have changed. How they want to spend their time and who they want to spend it with might have altered. As a result, they may want to go back to college, enjoy the simple life, change their jobs, spend more time with their family, or appreciate the "here and now".

5. Enhanced spiritual beliefs

Another significant change might occur in their spiritual beliefs. Post-trauma they may return to faith, and engage in spiritual practices. These changes depend on the religion and the culture of individuals undergoing adverse events in their lives.

According to Joseph (2011) approximately 70% of individuals, who have undergone a traumatic event, experience at least one of the PTG symptoms. Moreover, some people may report as many as all the five symptoms, at the same time. Therefore, it is an outcome experienced by majority of people, rather than a selected few. Sadly, researchers and therapists focus predominantly on the negative effects of trauma. This creates an imbalanced view of a person, whose deficits are highlighted, whilst their resources are ignored. Considering that therapists are facilitators for change, it is important that they offer their clients the whole picture of who they are. That said, unless therapists are familiar with the symptoms of PTG, the positive changes that occur in a client might be left unnoticed.

Furthermore, research found that when five minutes prior to the session therapists focus on clients' strengths, such as the symptoms of PTG, they report an improved relationship with a client as well as better therapy outcomes

The emerging symptoms of well-being can help clients recover faster post-trauma, as well as psychologically flourish.

(Fluckiger, Caspar, Holtforth, & Willutzki, 2009). Therefore, it is critical for therapists to consider PTG symptoms along with clients' deficits.

Also, it is important to note that experiencing Posttraumatic Growth is not exclusive of distress. Therefore, clients may experience both the presence of distress, as well symptoms of growth at the same time, which is why it is crucial that whilst therapists work with clients on reducing their symptoms of ill-being, they also attempt to enhance the symptoms of well-being (Burke & Stephens, in press). The emerging symptoms of well-being can help clients recover faster post-trauma, as well as psychologically flourish.

At the same time, PTG is a like a butterfly, the more it is chased, the more elusive it becomes. Thus, experiencing PTG should not become a therapeutic goal; rather a side effect of a therapeutic journey. Joseph (2011) developed a process that helps evoke PTG, which includes such steps as taking stock of all that has happened to them, harvesting hope, re-authoring their past, identifying change, valuing that change, and expressing their change in action. Therefore, it is important for therapists not only to notice PTG symptoms, but also take steps to improve clients' likelihood of experiencing them.

Conclusions

Taking everything into consideration, depression, anxiety, and other psychiatric conditions are not the only outcomes of traumatic life events, such as bullying. Most individuals are resilient, thus able to bounce back promptly from adversities; furthermore, some experience Posttraumatic Growth that enables them to transform their lives for the better after a traumatic event. The current study showed some preliminary evidence suggesting that such traumatic event as experiences of daily bullying may result in participants enhancing their skills of optimistic thinking in negative situations. Therapists need to be vigilant to positive changes in their clients, not only negative outcomes, as noting such changes may help clients recover from their adversity faster and allow them to subsequently flourish.

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Jolanta Burke, Ph.D.

Dr. Jolanta Burke is a psychologist specialising in Positive Psychology. She is a lecturer in Masters of Applied Positive Psychology and Coaching at the University of East London, and a visiting researcher in Trinity College Dublin. Dr. Burke is also an Irish representative of the European Network for Positive Psychology. She writes extensively and speaks regularly at conferences in Ireland and abroad. She is currently co-writing a book with Eoin Stephens, senior lecturer and past president of PCI College, about applying Positive Therapy in Ireland. For further information, please go to www.jolantaburke.com.

Counselling and Homelessness

by Andrea Koenigstorfer, MIACP, BACP

Addressing the issue of homelessness needs to go beyond the provision of immediate crisis help, and incorporate dealing with the traumatic experiences and psychological issues that are intrinsically linked with being homeless. Counsellors are uniquely able to reach out to these clients and support them in processing these issues that are so often overlooked in homelessness services. The challenge for the counsellor lies not only in being open-minded with regards to how counselling might need to be adapted in this particular setting, but also in taking appropriate measures for self-care when working with this client population.

The Dublin Simon Community Sure Steps Counselling Service was established in 2012, and has since developed into a specialised trauma-informed counselling service. Currently, about 20 pre-accredited and fully accredited counsellors are providing psychological support to an average of 70 clients per month presenting with a wide variety of issues. The range of services encompasses 1-to-1 counselling across treatment services and housing / emergency accommodation services, weekly drop-in clinics in treatment services as well as in the mobile health unit, in-reach and outreach crisis intervention, and a counsellor-led emotional wellbeing group programme.

The root causes of homelessness are multifaceted and wide-ranging. A large percentage of individuals who are homeless have been exposed to some form of previous trauma (Hopper, Bassuk & Olivet 2010). However, many people affected by homelessness also present with depression, substance use issues (Fischer & Breakey 1991; Jainchill, Hawke & Yagelka 2000), and severe mental health conditions (Fitzpatrick, Kemp & Klinker 2000; Jainchill, Hawke & Yagelka 2000). As a result, these individuals are even more vulnerable to revictimisation (Goodman, Dutton & Harris 1995) and have impaired social networks and complicated service needs (Jainchill, Hawke & Yagelka 2000). Homelessness leaves people isolated and alone and hugely stigmatised by society, who often consider these individuals responsible for their situation and unwilling to pull themselves out of homelessness (Fitzpatrick, Kemp & Klinker 2000). Society's biases against the homeless are often internalized by the people who experience homelessness, resulting in a severe lack of self-esteem and feelings of extreme guilt and shame (Shallcross 2010).

Historically, the impact of

trauma has been overlooked in providing care to individuals in homeless service settings (Hopper, Bassuk & Olivet 2010). However, recent research has shown that responding to the immediate crisis of homelessness alone is not enough; a holistic approach also needs to incorporate the longer-term healing of these individuals. When working with the homeless, counsellors therefore need to adopt a trauma-informed perspective.

Experiences that create a sense of fear, helplessness, or horror, and overwhelm a person's coping resources are referred to as trauma (Hopper, Bassuk & Olivet 2010). The impact of trauma can be long-term and devastating and interfere with a person's sense of self, sense of safety and control, ability to self-regulate, and interpersonal relationships. This often makes them hypervigilant and hyper-alert.

Homeless clients of every gender, age, race and background often have been exposed to a variety of traumas in their lives, including physical, psychological and sexual abuse, neglect and (domestic) violence (Hopper, Bassuk & Olivet 2010). This early trauma provides a subtext for the narrative of many clients' pathways into homelessness (Browne 1993). The consequences of earlier trauma are a difficulty of people affected by homelessness to cope with the numerous hurdles they have to master in order to exit homelessness (Bassuk, Perlof & Dawson 2001).

Loss is another inherent factor in homelessness (Shallcross 2010). Many people are affected by homelessness after a loved one becomes ill or dies, someone loses a job or a home burns down. It is essential to help clients process their losses, and one way of doing so is through helping them find a sense of connectedness to break through their isolation.

The experience of being homeless is traumatic in itself. Homeless clients lack a stable home and the uncertainty of whether they are going to sleep in a safe environment or get a decent meal puts them under constant stress. The lack of financial resources, life skills, and social supports makes it extremely difficult for them to change their life circumstances (Hopper, Bassuk & Olivet 2010). The physical aspect of rough sleeping is equally traumatic – partly because homeless people are vulnerable to attacks by predators, as well as harassment from the authorities (Shallcross 2010).

Because control is often taken away in traumatic situations, and because homelessness in itself is highly disempowering, counselling needs to emphasize the importance of choice for these clients.

What does this mean for the counsellor?

Trauma-informed counselling involves "understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been victimized may have in a particular setting or service" (Moses et al. 2004 P.19). Counsellors working with clients affected by homelessness need to be aware of the traumatic experiences of their clients and incorporate an understanding of this trauma into their work (Hopper, Bassuk & Olivet 2010). Given that homeless clients with a history of trauma often feel unsafe, the counselling process needs to work towards building their physical and emotional safety. Because control is often taken away in traumatic situations, and because homelessness in itself is highly disempowering, counselling needs to emphasize the importance of choice for these clients. This allows them to re-build a sense of self-efficacy and control over their lives. Last but not least, a trauma-informed counselling approach focusses on the strengths rather than the deficits of the clients. Clients affected by homelessness are often pigeonholed (or judge themselves!) in terms of negatives – substance use issues, illiteracy, severe physical or mental health issues, unemployment, forensic history etc. Counselling needs to support these clients in identifying and highlighting their own strengths and develop coping skills to further develop their own resiliency.

Given their background, for many homeless clients learning to trust their counsellor is a first step towards rebuilding trust with others (Shallcross 2010). The importance of the counsellor's work lies in recognising and accepting these clients as human beings – or in other words, simply listen to them tell their story. A lack of validation is a common theme among clients affected by homelessness. They feel judged, they feel nobody cares about them. They feel powerless, dirty and a sense of shame that is overwhelming. It is essential for the counsellor to change this paradigm, build a relationship with them and improve their experience within "the system". To be able to achieve this, the counsellor needs to listen to each individual client with an open mind, without any preconceived ideas about what a homeless person is. Contrary to what most counsellors would have learned during training, it can be useful for counsellors to allow themselves to be vulnerable and share their feelings when working with homeless clients. It is okay as a counsellor to let these clients know that you're sad or hurt or angry about what has happened to them.

One way of getting to know homeless clients is to understand what drives them to act in certain ways rather than jumping to conclusions (Shallcross 2010). Clients affected by homelessness are often emotionally and cognitively dysregulated. A client that shows a high absence rate in a class might have anxiety issues and is afraid of waiting alone at the bus stop to go to and from the class, while staff interpret his absences as a lack of motivation or disinterest. A client may have a history of rejection and therefore be extremely vulnerable to any signs of being rejected.

Working with clients affected by homelessness is very demanding. It challenges counsellors counsellors emotionally and it is easy to become discouraged and disheartened

A counsellor cancelling an appointment might be interpreted as yet another abandonment and result in a violent or angry outburst that does not fit the facts – and therefore be met with a lack of understanding on behalf of the counsellor, yet another instance of being invalidated. Rather than jumping to conclusions, it is important to sit down with the client and explore what the problem is. At the same time, we can use their story to expand their perspective and encourage change, taking away the blame, while empowering them to take charge in changing their current circumstances.

To work effectively with clients affected by homelessness means the counsellor has to meet the client where they are at and go where they need to go (Shallcross 2010). This entails being open and non-judgmental, and often to give up on the idea that counselling happens in your own office. Counsellors need to reach out to clients in a very humanizing way. Sure Steps Counsellors see clients in their current environment, whether this is in emergency accommodation, supported housing or treatment services. For clients that may not yet be ready for counselling we provide weekly drop-in clinics the Dublin Simon Community Detox and Stabilisation Units as well as in a mobile health clinic where clients who are too frightened of engaging with a counsellor inside a building can make initial contact with a counsellor in their usual environment.

The specific theoretical approach used with clients affected by homelessness is not the most important factor (Shallcross 2010). What matters most is the ability of the counsellor to relate to the client. Because homeless clients feel isolated and disconnected, building a relationship with the counsellor for them is a way of connecting and feeling empowered.

A client may have a history of rejection and therefore be extremely vulnerable to any signs of being rejected. A counsellor cancelling an appointment might be interpreted as yet another abandonment

There is no quick fix with homeless clients yet counselling offers homeless clients an opportunity to understand why they react to certain situations and teach them more pro-active coping mechanisms.

Conclusion

Addressing the issue of homelessness needs to incorporate addressing the underlying trauma that is so closely linked with the experience of homelessness. Counsellors working in homeless services have the opportunity to reach out to trauma survivors who otherwise are often disregarded. Providing immediate crisis relief in the form of food, shelter, and clothing needs to go alongside with helping individuals heal from past trauma and build healthy, supportive connections in the community.

Working with clients affected by homelessness is very demanding. It challenges counsellors emotionally and it is easy to become discouraged and disheartened in view of the apparent inability to help facilitate change. In light of this feeling of hopelessness, as well as the traumatic history some of these clients present with, there is a risk of burnout if this is not managed properly. What is important is to find the value in what we are doing and appreciating that success might not come in huge leaps and bounds. Accepting this truth is essential – we often may just be planting a seed by creating an environment and experience for the homeless person that is different. This is all we have control over. There is no quick fix with homeless clients yet counselling offers homeless clients an opportunity to understand why they react to certain situations and teach them more pro-active coping mechanisms as an alternative. Together with other interventions this does open up new prospects for the future.

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Andrea Koenigstorfer, MIACP, BACP

Andrea Koenigstorfer is an accredited psychotherapist in private practice with experience in a wide range of settings, including individual and group therapy and residential treatment programmes. She is also working as a contract counsellor with the Dublin Simon Community Sure Steps Counselling Service providing one-to- one therapy and a psychoeducational group programme. Andrea holds a BA (Hons) in Counselling and Psychotherapy from Glyndwr Universityand an MSc. in Mental Health from Trinity College Dublin.

Contact:
crossroadcounselling@gmail.com

VAT – Why Us? Do I Have to? and What Is It All About?

by Fergal Maher FCCA, CTA

Introduction

The issue of VAT is one that raises it's head on a regular basis and typically the questions asked are as follows?

- Why are Counsellors and Psychotherapists required to charge VAT whilst Psychologists don't?
- I am not earning very much as a Counsellor/Psychotherapist, do I have to charge VAT?
- When I exceed the exemption threshold do I only charge VAT on the excess income or on all my income?
- Is all of my income vatable or just my Therapy income?

As a result of these issues being brought up by members on an ongoing basis we asked tax expert, Fergal Maher of Byrne Curtin Kelly, auditors to IACP, to prepare an updated guide for IACP Members.

We hope that Fergal's comprehensive summary addresses all of your questions however if not then please don't hesitate to send your queries through to accounts@iacp.ie and we will ask Fergal to comment further.

On the greater issue of why it is necessary for Counsellors and Psychotherapists to charge VAT when their clients are predominantly attending in a personal capacity and therefore cannot reclaim VAT, we have, in the past, raised this with Revenue and with Government representatives and other political parties in the ongoing discussions around the regulation of the profession.

However, recently we have been in discussion with Tony Kelly, our client partner in BCK, and sought his advice around making a further submission to Government to incorporate a compelling business case for changing the VAT status of Counselling and Psychotherapy to that of Exempt, in line with other medical professionals.

We will keep you appraised of our progress with the submission and in relation to any response that we receive from Government or Revenue.

VAT – Implications for Counsellors and Psychotherapists

Value Added Tax

1972 was in many ways a momentous year for Ireland. London imposed direct rule on Northern Ireland, the Republic was (yet again) broke and in May of that year a massive 83% of the electorate voted in favour of Ireland entering the European Economic Community. A condition of entry into the European Community was the introduction of a system of Value Added Tax which was already operating in other EU countries. And so it was that our old Turnover and Wholesale taxes were replaced with a new system of VAT with rates of between 0% to just over 30%.

This new tax, which would quickly grow to become the second largest contributor to the Exchequer (after income tax), was unusual in many ways. The tax was based on turnover rather than profits and designed so that the cost is borne by the end-user rather than suppliers. But perhaps

most controversially, VAT was (and continues to be) applied at vastly differing rates to supplies of goods and services on what can often appear to be an arbitrary basis.

The curious nature of this tax was perhaps best summarized by Lord Justice Sedly in the 2001 UK Appeal case of Royal & Sun Alliance, when he said.. "Beyond the everyday world…lies the world of VAT, a kind of fiscal theme park in which factual and legal realities are suspended or inverted".

This fiscal theme park is supported by directives at the EU level, legislation at the national level, and a myriad of revenue precedents and court decisions in between.

VAT and Medical Services

All EU Member States are required to introduce and apply their own VAT legislation which must comply with the relevant EU Directives. Article 13A(1) of the European Communities Sixth Directive lists certain activities which countries are required to exempt from VAT and includes 'The provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned'.

Exemptions from VAT have always been interpreted very narrowly by the EU and member states. In broad terms it is accepted that the exemption for medical services applies to services provided to protect, maintain or support the health of a patient. As the exemption applies to services rather than the service provider, medical professionals may find that while the vast majority of their work is VAT exempt, certain services they provide are vatable as they do not protect, maintain or support the health of a patient (e.g. the provision of expert reports for medical negligence litigation).

Schedule 1 of our 2010 VAT Consolidation Act lists exempt services, the section relating to Medical Services includes the following:

- Professional medical care services recognised as such by the Department of Health and Children.
- Other professional medical care services that, on 1 January 2010, were recognised by the Revenue Commissioners as exempt activities.

In an information leaflet published in 2011, Revenues VAT Interpretation Section lists Medical Professionals they will treat as VAT exempt when providing qualifying medical services. The list includes.

- Persons registered under the Medical Practitioners Act 2007.
- Persons registered under the Nurses Act 1985.
- Persons designated under S4(1) of the Health and Social Care Professionals Act 2005;

Section 4(1) of the Health and Social Care Professionals Act includes health care providers such as Dieticians, Occupational Therapists and Psychologists.

Unfortunately Psychotherapists are not included on the above lists and it is currently the opinion of the Revenue Commissioners that the profession is vatable at the reduced rate of 13.5% in accordance with Schedule 3 paragraph 21 (1) of VAT Consolidation Act , which applies to "Services consisting of the care of the human body,'

What this means for the practising psychotherapist is that where their income from the provision of services exceeds, or is likely to exceed €37,500 in a 12 month period, they are required to register for VAT.

In the case of services consisting of the care of the human body (including presumably the mind), VAT should be accounted for at 13.5%. Where other services are provided (e.g. fitness certificates, lifestyle counselling, expert witness etc), VAT should be accounted for at the standard rate of 23%.

This can have a very significant effect on the cash flow of a practising Psychotherapist. Patients are typically not vat registered and therefore cannot reclaim VAT on fees, and while therapists are entitled to claim a VAT deduction for tax incurred on any practice expenses (electricity, phone, rent etc), this 'input VAT' will not usually be significant. The net effect is that for every €100 in fees a therapist earns he or she will first have to pay VAT of €11.90 (100 x 13.5% / 113.5%), leaving just €88.10 to pay other expenses such as wages, employers taxes, rent, utilities, and lastly him or herself.

In addition to being a cash flow burden, VAT can also be an administrative burden, though with appropriate systems in place the burden should not be overly cumbersome.

Registering for VAT

A practitioner is required to register for VAT as soon as it becomes apparent that annual turnover will exceed the €37,500 threshold. Where a number of practitioners are trading together via a partnership or company, the €37.5k turnover threshold applies to the partnership/ company as a whole and not the individual practitioners. Therapists (or their agents) should register for VAT via Revenues Online Services (ROS).

VAT returns are usually filed bi-monthly via ROS, with a return

for the Jan/Feb VAT period due for submission and payment by 19th March etc. Traders whose annual liability is less than €14k have the option of filing quarterly returns.

Alternatively practitioners can elect to avail of Revenues Direct Debit on Line payment system. Traders availing of this scheme will pay their VAT monthly by direct debit and submit an annual VAT return, at which point an overpayment, or additional liability might arise.

When registering for VAT the therapist will be requested to provide details of the bank account to be used for the purpose of making payments or receiving refunds.

Accounting for VAT

VAT is usually accounted for on an invoice basis, i.e. the service provider must account for VAT in the period in which an invoice is raised, regardless of when payment is actually received. Traders can avail of the cash receipts basis if sales are less than €2m per annum, or 90% or more of supplies are to unregistered entities. The majority of practitioners / practices should qualify for the cash receipts basis and when registering for VAT it is important to notify Revenue that you wish to avail of this basis.

Where services are provided to VAT registered businesses the usual practice would be to quote a net-of-vat fee and issue an invoice including the appropriate VAT which the client should then be able to reclaim. A valid VAT invoice must include all of the following information:

- the date of issue of the invoice,
- a sequential number which uniquely identifies the invoice,
- the full name, address and the registration number of the therapist (or practice),
- the full name and address of the person to whom services were provided,
- the nature of the services provided,
- the date on which the services were provided,
- the net of VAT fee and the appropriate VAT at 13.5% and / or 23%

In calculating their bi-monthly or annual VAT liability a practitioner / practice is entitled to deduct any VAT incurred on the purchase of goods and services in so far as:

- the goods / services are used for the purposes of making vatable supplies and.
- the practitioner has a valid VAT invoice in respect of the expense (see above).

A deduction may not be taken for expenditure on food, drink, entertainment or personal services. VAT on accommodation is allowable only where it relates to attending conferences, subject to certain conditions. VAT on petrol or on the purchase or hire of cars is also specifically excluded, however VAT on diesel is deductible in so far as it is used for the business purposes, other than travel to or from work.

Practitioners are required to retain VAT invoices for a period of 6 years after the relevant transaction and while it is not necessary to provide invoices when filing a VAT return, this information will be requested in the event of a routine VAT return compliance check, or a revenue audit.

Conclusion

While VAT rules and regulations seem relatively straightforward at first glance, their interpretation and application can produce some very strange results.

A 'fiscal theme park in which factual and legal realities are suspended or inverted' seems a very apt description of a world in which ballet dancing classes are VAT exempt as a cultural activity, but Irish dancing classes are vatable at 23%. Unfortunately practicing psychotherapists currently find themselves front row and centre in this fiscal theme park.

While it is to be hoped that Revenue will change their view in the not too distance future, at the moment psychotherapists are pretty much alone amongst conventional health care providers in having to charge VAT on their services. As these services are predominantly provided to unregistered individuals, the VAT cannot be reclaimed and therefore the cost invariably falls on the practitioner.

A further consequence of providing vatable services to unregistered individuals is that failure to operate the tax properly can lead to an expensive VAT demand (with interest and penalties), which cannot be invoiced on to the client.

Because VAT is a tax on turnover rather than profit, it can frequently be overlooked by therapists who might mistakenly believe they are not making enough to be within the charge. However, it is for this very same reason that failure to operate the tax properly can prove very costly and therefore VAT is a tax that should not be overlooked by practising psychotherapists.

Fergal Maher FCCA, CTA

Fergal is Taxation Director with BCK Accountants Ltd and has over 20 years' experience providing taxation compliance and consultancy services to a wide variety of Irish based SME's and individuals.

Letter to the Editor

Suite 2
South Terrace Medical Centre
Cork

9 March 2016.

To the Editor of Eisteach,

In response to the Spring 2016 Eisteach article "Lets make Friends with the DSM, I wish to bring an additional perspective to the aspect of Diagnostics. I am struck by the author's choice of a mechanistic model of likening clients in the therapeutic encounter to cars, which can be "fixed without be-labouring further" and the suggestion that the DSM is "needed to diagnose accurately". What the author does not present is the fact that, historically, the DSM classified homosexuality as a mental illness and now regards mourning as a "grief disorder". She suggests further that by befriending the DSM this "is an invitation to become an expert.

Counsellors and psychotherapists are most comfortable and relational when they regard the client as a "self-actualising, self-regulating and self-transcendent being" (IAHIP Ethics), where clients are supported and empowered to plumb the depths of their own souls, invited to discover their own truths and encouraged to find their passions, eros and integrity. In working with a client the therapist eschews the nouns, "experts" and "knowledge". Instead, the therapeutic pair, the client and therapist befriend and embrace the idea of "getting to know", "not knowing", and "knowing" in the present-continuous form of the verb, which inhabits the NOW in keeping with Mindfulness (Kabbat-Zinn, Tolle). The therapeutic encounter then becomes a sacred and creative process held within the "potential space" of therapy as espoused by Donald Winnicott.

Carl Jung, alternatively, suggests that we might consider the client's problematic and distressing behaviours as aggregating around a nodal point in the form of a "complex". The concept of a Complex serves to describe a repertoire of behaviours. But it avoids classifying, labelling or diagnosing the client in a specific and fixed way. This approach brings hope as it allows the client to investigate and find a way to think differently (CBT) and hence choose alternative behaviours (Reality & Choice Theory) in the hope that they might bring more eros (Jung) and ease where there has been an absence of ease (dys-ease or dis-ease).There is value in this approach which is a normalising alternative to the exclusive reliance on a pathologising disease model.

Kind regards
Dr Coleen Jones

[Dr Coleen Jones is a psychotherapist and counsellor in private practice in Cork. She worked as a Core-Trainer on the Masters in Integrative Psychotherapy at UCC for 15 years, served on the Board of the Irish Council for Psychotherapy (ICP) and the European Association of Psychotherapy (EAP)]

Workshop Review

THE USE OF SUPERVISION – FOR THE SUPERVISOR AND THE SUPERVISEE

Presenter:	Dr. Bobby Moore	Reviewed by:	Liz Sugar, MIACP
Date:	26th September 2015	Venue:	Tuar Ard, Moate, Co Westmeath
Organised by:	Midlands Regional Committee		

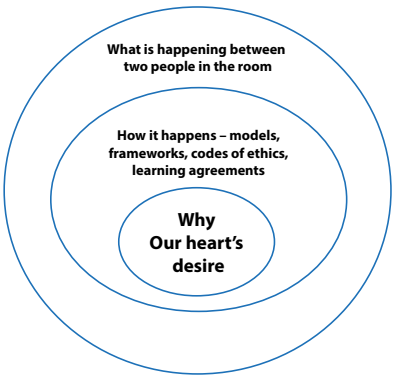
The topic for this workshop led to a high level of interest and on the day there were 30 participants. Personally, I felt it was a rare opportunity for practitioners to come together and look at both sides of supervision. In reality, we are all both supervisors (perhaps it's our internal supervisor, if we are not 'trained/qualified' supervisors) and supervisees.

Bobby Moore, the facilitator, has a rich and diverse background in psychotherapy, supervision, leadership and mediation.

His engaging style and looking at the workshop as 'pro-creating a conversation' within the room was both compelling and experiential and afforded each of us the opportunity to move into a reflective space.

'As supervisees desire the attributes of commitment, self awareness, groundedness, knowledge, confidence, competence, safety, equality, to name but a few and yet supervisors cannot give that and therefore cannot be accountable for whether a person has them or not - what supervisors are accountable for is engaging in a relationship that offers the best chance of the other 'getting it'... Yet as therapists, supervisees and supervisors we need to hold the awareness that when our desire to give exceeds the other's capacity to receive, it becomes even more painful for the other.

As professionals the word we use for this relationship



is 'supervision' and visually this can be seen as:

In the evolving conversation of this workshop, we were introduced to the notion of listening being an art. Listening can be broken down as:

- **Listening to interrupt** – the listener focuses their own narrative
- **Listening to understand** – whilst this can be a gateway, the listener is limited by their capacity to understand
- **Listening to ignite** – this type of listening generates something new that neither listener or speaker could create individually – and this connects into the 'WHY' of the supervisory relationship where the quality of presence facilitates rather than intrudes. This, of course, also holds true in the therapeutic relationship and any relationship so it is a life skill.

It was interesting that in our personal lives, in general we felt we moved between listening to interrupt and listening to understand and professionally we moved between listening to understand and listening to ignite.

As human beings we can only learn what we do not know, otherwise it is remembering. The challenge for us is to become comfortable in that place of 'not knowing'.

Continuing our conversation, we looked closer at the work of Nancy Kline who proposes nine components in a thinking environment:

- Attention
- Equality
- Ease inside yourself
- Encouragement
- Information
- Feelings
- Diversity
- Incisive questions
- The place

If we are able to focus on these components, we increase our chance of creating a space that facilitates a learning environment.

The time had flown by and before finishing we all reflected on what we were taking away from the day.

From the perspective of writing this review, it is extremely difficult to convey the energy and interest that stayed in the room for the whole workshop – it was experiential and Bobby's skill drew us all into a space that facilitated growth and reflection whether we were a supervisee or supervisor professionally.

References: *Components of a Thinking Environment, from Kline, N. (199) More Time to Think.*

Workshop Review

SEXUAL ADDICTION AND PORNOGRAPHY

Presenter:	Kevin McCann	Reviewed by:	Joe Heffernan
Date:	19th September 2015	Venue:	Vienna Woods Hotel, Cork
Organised by:	Southern Regional Committee		

This was a very well presented workshop. A vast array of material was presented by Kevin and handouts were plentiful, informative and very up-to-date.

Kevin is part of the faculty at the Gestalt Associates Training, Los Angeles, with Bob and Rita Resnick.

Kevin spoke about addiction to the arousal system. He explained that the etymology of the word, "pornography" was the Greek word πορνογραφια (pr. *Pornographia*) which literally means, "writing about prostitutes".

He discussed the fact that in the modern world sexual addiction can be indulged in anonymously, cheaply and is readily available. Therefore it is an addiction which will present itself in counselling rooms much more often in the current environment.

A central point of Kevin's presentation was, "*paying attention to the dialogic/relational aspect of the therapeutic process when working with clients who present with sexual addiction issues*".

Kevin spoke very eloquently of the lack of any point of intimate contact in the sexual context of e.g. online porn and online contact in the context of "*pseudo-relationships*", where the "*person*" is absent from, irrelevant to the "*relationship*" and where only the sexual "*act*" matters.

The aforementioned handouts contained information regarding topics such as, "Signs of Sexual Addiction", "Levels of Sexual Addiction" "Fears over Smartphone Usage by Children", *"Characteristics of Love and Sex Addiction"*. These topics were discussed and explained by Kevin. For example, he discussed the levels of sexual addiction as (1) Solitary activities such as fantasy, pornography and masturbation, (2) Activities involving another person such as repeated affairs, telephone sex; (3) Minor criminal activities such as exhibitionism, voyeurism and prostitution and (4) Major criminal activities such as child molestation/ pornography, incest, rape etc.

Very importantly there was a lively interaction with the 31 participants and presenter throughout.

Also very importantly there was a comprehensive list of resources for both clients and professionals working in this area given by Kevin. These included, SLAA (Augustine Fellowship); Ritona Fellowship for those affected by another's sexual addiction; The Irish Centre for Sexual Addiction (Eoin Stephens) are some examples and he also mentioned two movies, "*Shame*" and "*Diary of a Sex Addict*".

Kevin came across as very knowledgeable about his subject and enthusiastic and powerful in his presentation. The very serious subject matter was lightened by humour and Kevin held our attention to the extent that the day flew.

The venue was very good location-wise and food-wise All in all an excellent workshop.