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Occlusions, omissions, and lacunae

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From the Editor:

Dear Colleagues,

Here we are once again finding ourselves having moved around full circle, entering into the wonderfully beautiful, bittersweet season that is autumn. This season brings with it shorter and chillier days. It is a season that reminds us all of the natural course of our world. It is fair to say that the season of autumn serves to remind us that everything we know will run its natural course eventually. However, upon reflection, I find myself becoming aware that autumn also carries with it a promise of renewal. And indeed, this reminds us to always be aware of that which we ourselves need to renew, re-energise, and revitalise in our own lives, so that we can always live our best life, and always be the best version of ourselves that we can possibly be. Perhaps the season of autumn reminds us that there is always room for improvement in our lives.

In this issue of the *IJCP*, we begin with an article by Dr. Coleen Jones called, *Occlusions, omissions, and lacunae - how gaps contribute to adverse childhood experiences and the impact in later life*. In this article Dr. Coleen writes of how when information is withheld, deliberately or by a simple "act of omission" from the growing child, the impact in later life on the adult leaves occlusions that are interpersonally confusing. She gives examples of how adverse childhood experiences (ACE) can negatively affect the fragile architecture of a child's developing brain and can lead to future attachment difficulties in relationships.

Our second article is by our editor in chief, Eve Menezes Cunningham called *Multiskilled Therapy, Coaching and Supervision - working ethically, effectively and creatively while integrating multiple skills*. In this practitioner perspective article, Eve writes of the challenge of bringing together a wide range of skills in order to best assist clients and shares her exciting and often challenging journey of integration.

Our third choice of article is, *Let's talk about (problematic) sex - the cycle of sexual addiction, potential causes and treatment approaches* by Kaylene Petersen. Kaylene begins by describing how society and its views on sexuality have changed a great deal in the last half century, and how we do not need to look too far to see depictions of sex, and how it is used in advertising to sell everything from hamburgers to cars. Kaylene also looks at sexual addition, its definition, its causes, and its clinical classification. In this comprehensive article Kaylene insightfully argues that whilst there is no definitive cause of sexual addiction, researchers have noted links with childhood exposure to trauma, neglect and early-onset sexualisation.

Our fourth choice of article is *Child-centred attachment therapy (CcAT) - when personal and professional quests for healing intersect* by Alexandra Maeja Raicar. In this interesting article, Alexandra speaks of developing and offering the CcAT Program and how this was integral to her own personal and professional healing.

Our fifth and final choice of article is *"Death and types of grief - a guide to the intricate and universal path of grief*, by Hamza Mahoney. Here we are guided through the intricate and universal path of grief. Hamza provides us with an excellent, informative insight into various theoretical frameworks of grief, including the Dual Process Theory and the Biopsychosocial Model (Two-Track Model) of Grief. Hamza demonstrates the importance of understanding grief, with some interesting insights into the different types of grief, including acute, integrated, and complicated grief.

This is my first time to sit in the quarterly Editor's chair. I would like to thank our contributors who provided us with some excellent articles to consider. I would also like to thank my colleagues on the *IJCP* editorial committee for their confident encouragement, support, guidance, and advice. In particular Eve Menezes Cunningham, Hugh Morley, Kaylene Petersen, Jayne Leonard, and Hamza Mahoney. I also cannot leave you without a word of gratitude to Jim Hutton on the Equality, Diversity and Inclusion Committee who was invaluable with his support. Everyone mentioned had a part to play in bringing this *IJCP* issue to you, our IACP members.

I leave you to enjoy this issue.

Ciaran Whyte MIACP, Editor
Hugh Morley MIACP, Assistant Editor
Autumn 2024.

We encourage you to consider writing for the IJCP – email iacpjournal@iacp.ie for author guidelines. We look forward to hearing from you in the future.

Practitioner Perspective

Occlusions, omissions, and lacunae

How gaps contribute to adverse childhood experiences and impact in later life

By Dr. Coleen Jones

This paper explores the impact in adult life when information is withheld from the growing child, whether deliberately or by a simple "act of omission." The impact can include occlusions that are interpersonally confusing. This paper gives examples of how adverse childhood experiences (ACE) negatively affect the fragile architecture of the child's developing brain, often leading to future attachment difficulties in relationships.

Introduction

Gestalt therapy rests primarily on the premise of explicating the "field" which is made up of what is "figural" - that which is existentially significant and urgent, whilst other information recedes into the back-"ground" and is regarded as insignificant, unborn, unknown and unconscious and possibly less urgent. It may be represented by an equation: "field = figure + ground." In the same way we are familiar with "synthesis = thesis + antithesis."

It was Freud who initially drew people's attention to the fact that there were unknown beliefs, emotions and attitudes hidden in the background in what he called the unconscious. These attitudes, values and behaviours, since they are unconscious, are unknown to the individual. We might ask, how do we get to know what we don't know? Usually, these factors will emerge in symptoms, dreams or "Freudian slips." There is an additional complexity when some of the unknown factors and issues are transgenerational, passing down from parent to child. This means that they bypass the scrutiny of the mind, the body and the emotions.

In jurisprudence, we have the legal statutes that classify crimes into acts of commission together with acts of omission. The former includes theft, rape and assault while an "act of omission" describes an action that should have been performed under the requirement of the law, which failed to happen – the action is omitted. Examples are tax evasion or child protection issues where children have not received adequate care and protection. Our interest in this paper is in relation to what is hidden from the individual that impacts on them in childhood and may continue to affect them into adulthood. Therapists are usually concerned with what traumatic incidents may have happened to the patient in childhood (acts of commission) but may not fully take account of what should have taken place, but never happened or what should have been known but remained occluded as acts of omission.

Clinical considerations

Under "acts of commission," we can list a vast range of "bad"

things perpetrated against clients which present in therapy. In certain instances, because of the seriousness of the injury, the trauma may be repressed, and the client temporarily dissociated from the experience. It is clear from the work of neuroscientists and trauma experts such as Babette Rothschild, and Bessel van der Kolk, that clients initially need support to establish a secure therapeutic base from which to explore details of the injury or trauma. We know that with safety, a secure base, a good working alliance with the therapist, and sufficient "slow" time, that the client may begin to explore what happened and begin to understand what might have been repressed. Bringing the client into the "presentness" of time is efficacious. This might be referred to as "present remembering" which facilitates healing and may hopefully bring clarity and ease in relation to past traumatic experiences.

Under "acts of omission," clients falling into this category are referred to therapy for non-specific symptoms. They may present with difficulties in interpersonal relationships, an inability to sustain relationships, often with a history of going from therapist to therapist in an attempt to try different approaches. I use the term "therapist" to include a wide range of mental health practitioners. These clients are frustrated because of not getting to the nub of the issue, confused because they do not seem to know what is wrong with them and puzzled because their siblings may all be doing well, with parents who may be elderly and kind. They cannot seem to remember anything really "bad" or traumatic happening to them as children. They often worry reactively that they may have been sexually abused or have experienced some other trauma when they were young, without having any clear recall in the present. The workplace and their intimate relationships seem to be the areas where their difficulties play out and where they experience a great deal of turbulence. These clients may go from job to job, relationship to relationship and therapist to therapist, still unable to manage the demands of relationships.

They may resort to medication which might add another "fuzzy" layer to the depth of the confusion

They often feel disgruntled with therapists and may be referred to as "borderline." This leads them to question "What is wrong with me?" They consequently believe that they are "defective" or "lacking" in some undefinable way. This undermines their confidence. They lose faith in themselves and others, especially therapists. It causes them great distress and fear. They may feel misunderstood and in turn respond aggressively. They are left wondering and perplexed, why other people are so disagreeable when "they," the clients, are after all, so "pleasant and considerate."

It may lead them to the question "what is wrong with others"? Either way there is a confusing conundrum facing the client, who is suffering, is fearful, is feeling alienated from others and is despairing. The client is mystified and left feeling frustrated. There is a negative progression of their symptoms and experiences, as they feel worse and worse mostly disgruntled and disappointed with family members and a swathe of health professionals who they believe are incapable of pinpointing the problem. They may resort to medication which might add another "fuzzy" layer to the depth of the confusion. As one woman said in therapy "I am not anxious nor am I depressed, either way medication is not going to help." She feels confused and anxious realising "she does not know what she does not know" but knows that something is amiss. Health professionals, psychiatrists, counsellors along with psychologists and psychotherapists might pause to question themselves – "how do we get to know what we do not know?" In the book *The Little Prince*, de Saint-Exupery suggests that to "know yourself" is to be known by another and that living is about being born...slowly! This process of discovery relies on a level of intuition on the part of the therapist who is willing to explore the client's history intuitively and carefully using inductive reasoning appended to what I call "whispers" that the client might bring in the form of dream images, associations, mistakes, parapraxes (Freud) and projections. These usually point to some or other omission or occlusion where something has been left out of awareness.

Vignette 1

The author, drawing from her own clinical experiences presents a melee of vignettes creatively woven together in order to maintain client confidentiality which illustrate some of the gaps that might cause confusion and distress. Mary, a new client, begins her first session by telling the therapist that she had a dream about her, the therapist, the previous night. Mary laughs as she shares her dream in which she recounts seeing the therapist in her car which had a registration plate numbering 1984. The therapist waits judiciously before asking Mary what had happened that was significant to her in the year 1984. Mary is surprised, becomes tearful in the session, and then relates how in 1984 she had found herself struggling to cope when her eldest sister, who was put out for adoption as an infant - and who was never mentioned or spoken about - contacted her mother and asked to connect with Mary and her brother.

If we think of therapy in relation

to "acts of omission," we find that some or other significant fact, event, experience or person has been omitted from the client's awareness. In the case cited above, Mary was not aware of having an older sister. She was not able to understand why her mother was always detached and distant from her during her childhood. As a child, she assumed that it must be her, Mary, who was unlovable or deficient in some or other way. In time, the full picture unfolded to reveal that, during Mary's childhood, her mother was grieving the loss of her first-born daughter and hiding her shame at conceiving out of wedlock. Consequently, Mary grew up with the belief that *she, Mary* was deficient and unable to draw or hold love to her. When someone is left out of conscious awareness, it affects the entire family system. The system needs to RE-MEMBER - needs to bring into consciousness the missing person, the family member or missing facts. It needs to bring what has been omitted back into conscious awareness in order to fully understand the emotional turmoil, influences and misunderstandings which over the years have caused such confusion. Good secure attachment is never established in the mystery and fog of omissions. The client, initially as a child, then as an adult, is puzzled, feels abandoned and believes themselves to be unlovable and to be the problem. This psychically shaky ground sets the whole corrosive and erosive process in motion.

> *"The patient says that he feels there is a fault within him, a fault that must be put right. And it is felt to be a fault, not a complex, not a conflict, not a situation…. There is a feeling that the cause of this fault is that someone has either failed the patient or defaulted on him; and…a great anxiety invariably surrounds the area, usually expressed as a desperate demand that this time the analyst should not – in fact must not – fail him."* (Balint, 1968, p21).

Vignette 2

Jane came to therapy because of interpersonal difficulties with her sister. She felt defective, fragile and weak. Gentle work led her to explore her childhood, not as a confused frightened child looking into the chaos, but as a smart woman wondering why her father, a very esteemed medic, seemed to be absent for such long periods of time from the family home, and living abroad. Why was it that her mother collapsed and was taken away, leaving a huddle of frightened children clinging to one another for comfort and acting out sometimes inappropriately? As she explored and remembered how she used to move furniture around her bedroom, to reconstitute reality, she came to realise that there were huge gaps in her narrative. These "holes" were absences, lacunae and spaces that led her to feel insubstantial and unreal. The over-arching and obscuring issue that papered over the holes was the idealisation of the father, the father that she knew others adored. She experienced, on the other hand, day to day as a child, his raw frustration and violence with the children, one could say, "like a house devil and a street angel." Jane was living in a family that colluded in hiding the truth yet prided itself on being devoted to the wellbeing of the five children. As an adult in therapy the obscuration cleared sufficiently for her to realise that her father was living a dual life having a lovechild abroad, unbeknown to her and the family. It explained why her unconscious kept driving her to move the furniture around in her bedroom in order to complete the gestalt, to seek some coherence to her implicit knowing and to finally bring clarity, ease and explicit knowing. According to Christopher Bollas (1987, in Daniel Stern, 2004, p116),

> *"Implicit knowledge is transposable into words… [he] has coined the term 'the unthought known' as a major clinical reality."*

Attachment

From a neurological perspective, we know that the basic architecture of the brain is laid down in utero. Later development of the infant may be hampered by what does not happen; what is omitted in the early months. As a result of Adverse Childhood Experiences (ACE) the dyadic interactions between mother and baby may not be secure. Consequently, there is an absence of soothing and attunement, which would normally lay down the neural circuitry for secure attachment. Templates for contactful relationships are thus left out of the equation, they are not imprinted in the early months. The baby is unable by inference to adequately embody empathy, unable to attune or connect bodily processes with felt affective turbulence. When this baby becomes a mother, these omissions and deficits may surface in the form of post-natal depression. John Bowlby's work on Attachment Theory in the 1950s is a psychological, evolutionary and ethological theory that provides a descriptive and explanatory framework for understanding interpersonal relationships between human beings. It shows that maternal disturbances negatively influence the attachment behaviour trajectory of a child's life. The new mother's lack of her own secure attachment and imprinting as a child may be a major factor in her incapacity to nurture her own infant. Fathers and partners may be similarly affected. The maturation of the infant's brain is experience dependent, and these experiences are embedded in the attachment relationship (Schore, 1994, 2001).

> *"Research carried out with Romanian orphans has shown that those poor children who were*

deprived of loving and responsive contact, left in their cots all day, suffered not only mentally but also physiologically, having a "virtual black hole" where their orbitofrontal cortex should be." (Gerhardt 2004, p38 quoted in Watson 2008, p25).

Vignette 3

Michael and his wife Liz came to couple's therapy because Michael had suddenly begun over-indulging in gay porn soon after the birth of their first child. This fact alarmed both of them. Over time in therapy, he remembered as a little boy running around naked when the family had visitors. In therapy he considered and then said that if he had been the parent in that situation, he would have taken that little boy and comforted him and held him lovingly. This encouraged Michael to talk to his elderly father and enquire as to his behaviour as a youngster. His father revealed that before Michael was born, his sister, just older than him, had tripped over a stone garden fence (placed there by himself, the father) and had died of serious head injuries. Both parents in their horrific grief never mentioned the sister. Mother immediately became pregnant with Michael as a way of avoiding her sorrow. This meant that he was born into a dark, grieving family. In this grief-stricken family constellation, he was unconsciously drawn to replace the sister who had been lost. This fact, which he was later to mourn, was not known to Michael until he came to therapy. A tragic act of omission contributed to massive confusion.

Some clients just give up because they never find true understanding. This results in them being dispatched to a category usually with a diagnosis of a non-specific personality disorder. Healing requires that the therapist stay close to his/her intuitive wisdom, being almost "sleuth-like" knowing that there must be something; searching for some fact that has not been brought fully into the light of consciousness. Reparative work requires that the therapist first establish a good working alliance, then adopt a stance and proceed to work with "clinical precision and creative indifference" (Bion, 1970, p42). It behoves the therapist to stay like a stylus in the groove of a vinyl record. This in time plays out and reveals the full story. It brings coherence such that the client can then establish "narrative competency" and begin emotionally relating to their own story. This brings fluidity, it fills in the occlusions, it brings coherence and hence a clearer understanding. The client's life story previously had gaps, unbeknownst to him/her. There was an absence of connection relating to relationships. What should have been switched on, love and tenderness did not happen in their early years. Prior to therapy Michael was not fully awake or born as a beloved son.

Some clients just give up because they never find true understanding.

"Memories that are not so much about something terrible happening but, in D.W. Winnicott's words, about 'nothing happening when something might profitably have happened.'" (Epstein, 1995, p 165).

Vignette 4

Ciara a mother in her forties came to therapy worried and heartbroken about her eldest son being distant from her and preferring her husband. In therapy, she revealed that after her son, the eldest child, was born, that she had experienced five miscarriages, the first at full term which was dreadfully traumatic. She had needed time to recover - away from the home, away from her toddler who was just fifteen months old at the time. This meant that her young son was predominantly and carefully cared for by his father. This eldest boy was totally unaware of the reasons for his mother's absence. Like Ciara he had no awareness of her emotional distance and the depths of grief. Ciara was grief stricken during her son's early years - as she lost baby after baby, a total of five before finally conceiving and producing a healthy daughter. As she became more aware and started healing, she was able to mourn, bring to mind the need for memorials for her babies and begin to fill in what had been omitted from consciousness. Her newly discovered understanding and compassion allowed her to talk to her eldest son, fill in the gaps and explain what was missing from his early years thereby drawing closer to him as they mourned and remembered.

According to Christopher Bollas (1987, in Daniel Stern, 2004, p116), "implicit knowledge is transposable into words… [he] has coined the term 'the unthought known' as a major clinical reality." When a client experiences some or other omission such as not knowing consciously about another sibling, or about a prior termination, or where a step-sibling is excluded from the second family, where cultural or religious divides exclude family members, clients are unconsciously affected by what they don't know. It interrupts the normal attachment process of belonging. Children who are deprived of their right to love, protection and respect (as in the case of a child being neglected by a stepparent after the death of their mother) may believe that they are unworthy. There might be misattributed paternity, or the ignorance of a parent being sent to prison. The omission is usually invisible to the child. But what is omitted often leads to insecure attachment, a psychical disorganisation which plays out in later years and affects most relationships. In the case of children who grow up with gaps, such as

being left in hospital for treatment for tuberculosis without visits from their parents that being the practice in the early part of the twentieth century – or left for months in a nursery awaiting adoptive parents, there is a mis-belief formed in the mind of that child, the client saying either, "I am defective," or "I am unworthy," or "I am unlovable" or "everyone else is at fault." This is problematic when attempting to form close, adult, enduring relationships. The therapeutic relationship is often quite challenging. It requires careful and steady holding by the therapist. Children who were raised by very demanding or critical parents are similarly deprived of compassion and softness. This omission leads them to drive either themselves or others in their remit or care to despair.

Omissions are usually invisible to the individual who although may be capable, well-educated and wealthy may at the same time be incapable of sustaining relationships and may be blind to what is missing, confusing and troubling. There are cases where a death occurs and the body is never found due to a drowning, a mishap at sea or political unrest and violence. All these gaps and omissions cause a great deal of pain as something essential is left out of the equation.

Conclusion

The work in therapy is relational and restorative. It works to develop a coherent narrative and to connect the dots. This allows clients to incorporate what is absent so that they can understand their younger selves and adjust their thinking around the information, in order to attain psychical cohesion. In time, they may establish a secure attachment to the therapist, ultimately to the self, and thereby facilitate intra-psychic repair. The transferential and reparative relationship with the therapist is what is facilitative.

This approach allows the client in the "present moment," to address the trauma from a wiser, safer perspective instead of struggling with past events, feeling like a vulnerable child, a naïve teenager, or a helpless victim at the mercy of discombobulating flashbacks and dreams. There is time enough in therapy, to deal with what has occurred or been omitted – overwriting the past in the present – filling in the occlusions. The adage "hasten slowly" is an appropriate imperative. In order to achieve "narrative competency" there are three steps:

- Firstly, the client relating the story about a past event.
- Secondly, the client becoming aware of the story being witnessed by another in the present.
- Thirdly, the client witnessing themself telling the story in the present moment.

"The present can change the past…it is changed functionally and experientially, and that is where we live." (Stern, 2004. p201).

Coleen Jones

Dr. Coleen Jones is a psychotherapist and supervisor in practice in Cork, Ireland. She has worked in the field since 1976 in Johannesburg and since 1990 in Ireland. She worked at University College Cork in Applied Psychology for fifteen years and subsequently was on the board of ICP (Irish Council for Psychotherapy) and represented Ireland on the board of the ECP (European Council for Psychotherapy) as well as time spent on the accreditation committee and governing body of IAHIP (Irish Association for Humanistic and Integrative Psychotherapy) and supervision committee of IACP (Irish Association of Counselling and Psychotherapy).

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REFERENCES

Balint, M. (1968). *The Basic Fault; Therapeutic Aspects of Regression*. Tavistock.

Bion, W.R. (1970). *Attention and Interpretation*. Basic Books.

Epstein, M. (1995). *Thoughts without a Thinker*. Basic Books.

Stern, D. (2004). *The Present Moment; In Psychotherapy and Everyday Life*. Norton &Co.

Watson, G. (2008). *Beyond Happiness*. Karnac.

BIBLIOGRAPHY

Barrett, L.F., (2020). *Seven and a Half Lessons About the Brain*. Picador.

Blauner, A. (Ed.). (2024) *On the Couch*. Princeton University Press.

Bollas, C. (1987). *Cracking Up*. Routledge.

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. Routledge.

de Saint-Exupéry, A. (1986). The Little Prince. Klett

Gerhardt, S. (2004). *Why Love Matters*. Brunner/Routledge.

Jones, C. (1997). *Psychotherapists and their health; a qualitative analysis of awareness as expressed by a random group of psychotherapists*. University College Cork.

Jones, C. (2020). Love, Hate & Health Professionals. *Irish Journal of Counselling and Psychotherapy, Vol 20, Issue 3*.Jones, C. (2022). Omissions, Lacunae and Occlusions. *Counselling Australia Journal*. Spring 2022, Vol. 23;3, pp 44-51.

Jung C.J. (1944). The Psychology of the Transference. *The Practice of Psychotherapy*: Collected Works, 16

McGilchrist, I., (2009). *The Master and his Emissary*. Yale University Press.

McGilchrist, I. (2022). *The Matter with Things*. Perspectiva Press.

Schore, A. N. (1994). *Affect Regulation and the origin of the Self*. Hillsdale.

Schore A.N. (2001a). The Effects of a Secure Attachment Relationship on Right Brain Development. *Infant Mental Health Journal* 22:7-60

Shonkoff J., Richter L., Van der Gaag J., & Bhutto Z.A. (2012). *Paediatrics*: 10.1542/peds 2011- 0366

Van der Horst, F.C.P. (2011). *John Bowlby – From Psychoanalysis to Ethology*. Wiley-Blackwell.

Van der Kolk B. (2005). Developmental Trauma Disorder: Toward a Rational Diagnosis For Children with Complex Trauma Histories: *Psychiatric Annals*, 36, no 5: 401-408

Winnicott, D. (1947). *Through Paediatrics to Psychoanalysis*. Collected Papers. Hogarth 1975: Reprinted by Karnac 1992

Winnicott, D. (1971). *Playing and Reality*. Routledge

Winnicott, D. (1990). *Home is where we start from*. Penguin.

Practitioner Perspective

Multiskilled Therapy, Coaching and Supervision

Working ethically, effectively and creatively while integrating multiple skills

By Eve Menezes Cunningham

The author reflects on her personal and professional journey from trauma survivor to complementary therapist, coach, trauma therapist and supervisor of multiskilled therapists and coaches. She explores the importance of ethics, training, supervision and professional bodies as well as the joy of bringing your whole self to serve your whole client.

Introduction

While increasing numbers of counsellors and psychotherapists are integrating coaching or offering coaching as well as therapy, it wasn't always that way. In this article, I reflect on the not so distant past when it felt like we were doing something very different and new.

I share some of my personal journey as well as my experience with different trainings and professional bodies. My hope is that readers will feel more secure as well as curious about their own existing or potential multiskilled and integrative practices. I also hope that they'll gain some ideas for ensuring their own practice is as ethical as possible as well as effective and creative.

Working ethically

When I first joined the British Association for Counselling and Psychotherapy (BACP) Coaching and the Association of Integrative Coach Therapy Professionals (AICTP), I wasn't thinking, "I want to integrate the different therapies and coaching I'm qualified in ethically, effectively and creatively."

As a student member then full member of BACP Coaching it was simply a delight to meet people integrating different things at network meetings. I was also very involved with the AICTP.

Gill Fennings, then Chair of BACP Coaching coined the term "multiskilled practitioner" (Fennings-Monkman). Gill asked me to join BACP's Coaching Executive as a Specialist for Communications and when she stepped down as Chair a few years later, I stepped up.

My years on the BACP Coaching Executive meant I became immersed in sharing the excitement and home I felt like I'd found with the wider membership. We lost the network meetings that had meant so much to me but organised conferences and CPD days with the support of BACP's Events team. My time with the Executive was a gift in terms of learning from such a wide range of people as well as building my own confidence in my varied

offerings. It helped me feel safe for myself and for my clients as I developed my private practice.

Our ongoing focus was getting the Coaching Competencies developed and released. I lost count of the number of Letters from the Chair I wrote (Menezes Cunningham, 2017) promising the Executive Committee and wider BACP Coaching membership that the competencies were on their way. It took a while, but BACP members can now see where they're already competent to coach and where they need additional training.

My journey and natural love of integration

Writing this in 2024, I understand how my heritage (Indian Irish, London born, UK and partly US raised, now living in Ireland) and neurodivergence (awaiting assessment for ADHD at time of writing) made me multiskilled.

I'd never intended to train in so many modalities but for the first ten years, I was prioritising my own trauma recovery. My seeming addiction to training was partially my curious nature but also, especially in that first decade of my practice, my ongoing quest to save my own life.

I couldn't have articulated it back then, but the interpersonal element of the traumas had meant I was not ready to put my trust in any one therapist. Training in various therapies that felt personally helpful meant I could learn to regulate myself to feel better every day. It was several more years before I was ready to benefit from the essential healing benefits of co-regulation.

I'd been coaching myself and practicing yoga (as pain relief for endometriosis, not yet understanding the mental health benefits) for years at this stage. I had begun to feel that I was doing so much better when actively working on myself. This was long before I started using the term self care (let alone Self care – for connecting with and taking better care of the Self, that highest, wisest, truest, wildest, most joyful, brilliant and miraculous part of yourself) it was enormous progress. Still, as soon I stopped this active self care, I was back in the old default self-loathing and despair I'd lived in for so long.

At the start of my psychosynthesis training, spotting a couple of crystals in the Psychosynthesis and Education Trust at London Bridge meant I felt instantly welcome

The idea of compulsory counselling (as well as the expense) had put me off training as a counsellor for many years. By 2008, I was ready to bridge the gulf between the new feelings of happiness and the background, incessant self-loathing. I was ready to delve deep into my past and hopefully heal, though I still wasn't convinced that I would.

Even though I only brought the tip of the iceberg over the several years I saw my delightful therapist (continuing long after the mandatory hours had been completed), it was the beginning of my co-regulatory healing.

At the start of my psychosynthesis training, spotting a couple of crystals in the Psychosynthesis and Education Trust at London Bridge meant I felt instantly welcome. But throughout my training, I felt ashamed of constantly trying to understand how ALL my offerings fitted together. The experiential exercises were so beneficial, I knew it was worth it. These simple but powerful practices gave me hope that my own trauma recovery was possible. Even now, I sometimes recognise things I first became aware of during these practises. I remind myself to drop into my breath and ground myself in order to let my nervous system settle and rest.

It all fits together so well

As well as being influenced by Freud (with whom he'd worked) psychosynthesis' creator, Roberto Assagioli, was heavily influenced by Eastern philosophies including yoga. The time he'd lived in meant that he felt he had to minimise the enormous influence of ancient healing practices and traditions in order not to be written off by the medical community. I still feel uncomfortable about what sometimes feels to me like cultural appropriation, while also understanding that it was a different time.

I'd already trained as a life coach, and I developed what I called Crystal Coaching as my final project back in 2003. I didn't know the term 'integrative' back then but I wanted more for my crystal therapy clients than for them to simply lie back and depend on me or any complementary therapist. Long before I started using the term self care, I wanted clients to know how to use the crystals to support themselves in working towards their goals in between sessions. Whether they believed in the crystals' energies or not, they could still be used as visual and kinaesthetic anchors to remind each client of their focus, intention or goal.

I'd begun the three-year training because the crystals offered me some pain relief. It introduced me to meditation. One early meditation had me fearing that I was having a heart attack as I clutched the rose quartz I'd been guided to hold. I didn't want to disturb the

other trainees so sat quietly until mentioning it afterwards, when I was feeling fine again. "Nothing to worry about," I was told, "just your heart chakra opening." It amplified my appreciation of how powerful and scary these stones' energies could be.

I'd started practicing yoga, again for pain relief and, after endometriosis surgery in 2001, I quit smoking and drinking. I loved the almost medicinal benefits of yoga but the psychospiritual aspect both terrified and appealed to me until I learned how to ground myself more effectively and to regulate my own nervous system.

Years later, I was able to offer some training in simple trauma sensitive yoga tools with yoga teachers in the UK before I moved to Ireland. It's so easy to integrate basic grounding and resourcing for yoga students and therapy clients as appropriate.

The Emotional Freedom Technique (EFT) training I undertook was a revelation. I had been coaching for a few years by that stage. Working hard to reframe everything and to be as positive as possible, the idea of voicing all the negative self-talk to release energy blocks felt horrifying Yet without voicing them and releasing them, those thoughts and beliefs were having a big impact.

The Neuro Linguistic Programming (NLP) training helped me to feel like I was creating a little bit of a manual for staying alive. I hadn't felt actively suicidal for a few years by that stage. Something as simple as learning to set a well-formed outcome (figuring out what I wanted in any given situation), using sensory acuity (letting all my senses feedback to me as to whether my approach was working or not) and flexibility (to adapt my approach as needed) revolutionised my everything.

Being Indian Irish growing up in London, Essex and, for a year, America, I hadn't understood that the water in which I was swimming was multicultural

By the time I completed the Master Practitioner level training in NLP, I felt I was done with training. I had just been diagnosed with post traumatic stress disorder (PTSD) after a house fire and I finally had language to express for how I'd always felt with what I later learned was complex developmental trauma). Nevertheless, it was at this point that the psychosynthesis training called me.

After nearly four years of experiential earthquakes and academic challenges, this training left me feeling like I'd survived an emotional washing machine. Then a taster day for yoga therapy for the mind took up nearly two years. Wearing my freelance journalist hat, I'd gone to the event thinking I'd write a feature about it, but it led to my enrolling on a 350 hour trauma-informed yoga therapy for mental health training.

Heather Mason, founder of the Minded Institute in London, had integrated psychotherapy, mindfulness, yoga and neuroscience. Our cohort was fortunate to have as guest lecturers Dr Dan Siegel, who created and popularised the 'window of tolerance' model and Dr Patricia Gerbarg, with her amazing work around Coherent Breathing and work with enormous groups of trauma survivors.

Nervous system regulation has been an enormous part of my work ever since.

Deepening the somatic, embodied approach through trauma informed yoga was incredible for my own trauma recovery – body work you do yourself. After all, 80% of the body's signals go up, via the vagus nerve, to the brain. It's MUCH faster and more effective to use our bodies through movement and breath than telling ourselves (especially if further alarming the amygdala by yelling at ourselves) to be more relaxed or confident etc.

Learning how to integrate ethically

Working with the thoughts, feelings, body and the transpersonal (energy work and spirit) gave me the confidence to work more deeply with clients and groups, knowing that while not all of my offerings were appropriate for all of them, they could guide me.

There's a sweet coaching story about a young fish not understanding what water was because she was so immersed in it. Being Indian Irish growing up in London, Essex and, for a year, America, I hadn't understood that the water in which I was swimming was multicultural. Similarly, having been integrating therapies and coaching before I knew what that meant made the pioneering new book, *Personal Consultancy: A model for integrating counselling and coaching* (Popovic, N. & Jinks, D. 2014) an incredible read for me. I'd been asked to read and review it for the BACP journals, *Therapy Today* and *Coaching Today*.

I loved the *Personal Consultancy* book and model so much that I signed up for the then brand new integrative counselling and coaching course by the authors (the first post-graduate training of its kind in the UK) at the University of East London (UEL).

The psychosynthesis training had integrated elements from Gestalt and Person-Centred Therapy as well as Psychodynamic. Assagioli's interest in human potential as well as wounding meant that he pursued a different path from Freud. I was

learning all of it at the same time. It had been integrated for us. I didn't yet know how the different parts had come together or how to integrate ethically.

Around this time, I met Liz Hall, author of *Mindful Coaching* (Hall, L. 2013) through one of the BACP Coaching networking meetings. I interviewed her for a couple of features and she inspired me to begin thinking more deeply about the possibilities of integrating the elements of my practice that weren't just coaching.

The collaborative approach – with clients' selves

Nash Popovic spent a lot of time with us exploring the differences between integration and working eclectically. I learned about collaborating, simply naming the options so the clients (and later supervisees) could choose which of the different ways of working they would like.

Popovic's perspective was that it was unethical to send a client away to begin their story all over if the issue was something the same practitioner could support them with. It was all about contracting and recontracting.

I'd already been collaborating with clients' highest, wisest, truest most miraculous parts but, as a student and newly qualified counsellor, hadn't had the confidence to name as much to make the work truly collaborative with their conscious selves, too.

The transpersonal energy of psychosynthesis – the beyond the person elements – helped me to feel supported enough to hold the space for my clients while knowing that there is something bigger than both of us helping them connect with and honour that innate inner wisdom and knowing.

I ask new clients if they have any spiritual or religious beliefs. No matter what religion or spiritual practice, using appropriate terminology for their own beliefs helps them connect with that highest, wisest, truest, wildest, most joyful, brilliant and miraculous part of themselves.

> *That Loving Kindness wish for them to be happy and healthy, peaceful and at ease*

I start each morning with a Metta, a Buddhist Loving Kindness meditation. As well as including all the usual elements of Metta meditation, I send Metta to all my clients, supervisees, readers and groups, past, present and future. Especially those I'm working with that day.

With my trauma informed practice, anytime a client crosses my mind, I stop myself ruminating by sending them Metta. That Loving Kindness wish for them to be happy and healthy, peaceful and at ease. To be able to take care of themselves joyfully, with the courage, wisdom, patience and determination to manage life's challenges.

This immediately soothes my own nervous system, helps me potentially make a note suggesting a specific offering for our next session and enables me to let go. It helps me work with the heart's electromagnetic field while staying grounded and resourced. It also helps me enormously when reading or watching the news or talking to anyone who's suffering. It helps me remember that my suffering doesn't help anyone.

Diana Whitmore (who'd set up the Psychosynthesis and Education Trust with another student of Assagioli's, Piero Ferrucci) spoke about a conversation she had with Assagioli about filling the therapeutic space with Good Will. She said a part of her had scoffed at the idea but he had said to experiment with it. She started doing so and when she forgot one day, she reported that she felt as if she'd been slapped by the client. I use a simple tool from Energetic NLP to energetically clear the space of anywhere I'm working whether it's with clients or presenting or even as a participant. I do this before sessions and often during sessions.

Support from professional bodies and supervision

I've already mentioned BACP Coaching and AICTP. Other professional bodies I joined and got accredited with along the way include being an Experienced Yoga Teacher with Yoga Alliance Professionals UK, the Association for NLP (neuro linguistic programming) ANLP and being an Advanced Practitioner and Mentor for EFT International.

As soon as I started planning my move to Ireland in 2018, I took advantage of the reciprocal accreditation scheme between BACP and IACP and joined IACP. I became Senior Accredited with BACP as a supervisor of individuals to meet IACP's criteria for supervising IACP members while my supervision accreditation was going through their process.

After presenting at the international therapy conference during Covid lockdowns, I was delighted to be asked to design and deliver a 3-hour training for IACP's CPD hub. It's still available and shows therapists how to use EFT to support themselves through a range of issues that might come up. We made it very clear that it didn't qualify them to use it with anyone other than themselves. I also did a live EFT demonstration when I presented at the IACP conference in 2023, shared some psychoeducation around burnout and the nervous system, a yoga

nidra (guided relaxation) and more. In the UK, I presented a few times at BACP conferences and other events, sharing mind body practices, psychoeducation and other elements from my practice. One time, a keynote speaker got ill so I had the unexpected pleasure/challenge of covering the straight after lunch spot. People are often quite sluggish then so I taught some chair yoga while dressed in a maxi-dress.

When integrating the crystals, yoga, NLP and EFT in this multiskilled way I feel like I have to be more vigilant about best possible practice than if I was simply working in the one way in which I'd been trained.

I've worked with different supervisors over the years and my main supervisor, while not trained in all the modalities in which I work, knows enough to be able to support me. I get additional supervision and mentoring in the other elements of my practice as needed by myself or required by professional bodies. I also advertise clearly so that people know what to expect. I have also written a book about self care and this helped me to own all aspects of my multiskilled integrative practice.

Complementary not alternative

An important ethical consideration for me is to ensure that clients know that there are many potential ways to work with their issues and that if a particular modality or tool doesn't work for them, that's no problem at all.

It feels especially important, when integrating counselling with coaching and complementary therapies, to be incredibly grounded and avoid any kind of potentially misleading claims or anything that might leave a client feeling like there was something wrong with them if the tools didn't help. I remember an early piece I wrote about NLP and allergies in ANLP's magazine. One of my experts said that my anaphylaxis allergy to peppers was just a 'limiting belief' and that he could cure me. I adore NLP and the way it's helped me and others in so many ways, but it worries me when people talk about any one thing (including modern medicine) as THE panacea.

I make it very clear when talking about crystal coaching that crystals are not a cure for anything

I make it very clear when talking about crystal coaching that crystals are not a cure for anything. They helped me enormously with pain relief over 20 years ago and I continue to use them daily in a variety of ways (from supporting sleep to anchoring different goals I'm working towards).

That being said, we know that up to 90% of GP visits are due to conditions which have been exacerbated by stress (Benson, H. 1975) and that relaxing can support the body's natural healing capabilities as we move into restorative rest/digest parasympathetic activation of the nervous system.

Whether I'm integrating crystals, yoga therapy, breathwork, imagery, mindfulness or anything else, I encourage clients to seek appropriate medical advice.

While the Personal Consultancy model begins with deep listening, because I integrate other modalities, I reverted to beginning work with each new client with the in-depth assessment form I've developed over several years. This includes elements from all my ways of working as well as finding out what supports (medical and social) clients have between sessions.

Conclusion

Whether you're already integrating coaching and other therapies or are considering upskilling, I hope you've found this article helpful and that you'll access some of the resources (especially the aforementioned book, *Personal Consultancy*) that helped me learn to integrate more consciously and collaboratively. Supervision is also key, and an increasing number of supervisors are open to supporting wider practice. Let your whole self serve your clients' whole selves.

Eve Menezes Cunningham

Based in Westport, Co Mayo, Eve works mostly online with clients across Ireland and the UK. As well as her trauma informed therapies, coaching and supervision, she's a writer (journalist and author of *365 Ways to Feel Better: Self-care Ideas for Embodied Wellbeing*), host and producer of The Feel Better Every Day Podcast. Eve also facilitates the Embodied with Evei online community and runs a free Facebook group for Multiskilled Therapists and Coaches. You can find out more and get in touch via selfcarecoaching.net

REFERENCES

Benson, H. (1975) *The Relaxation Response*. William Morrow.

Fennings-Monkman, G as part of her MA thesis. *https://www.coaching-at-work.com/2017/01/04/profile-gill-fennings-monkman-working-for-joy/*

Menezes Cunningham, E (2017, 2018) *https://selfcarecoaching.net/media/coach-therapy-features-and-columns/*

https://www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/coaching/

Popovic, N. & Jinks, D. (2014), *Personal Consultancy: A Model for Integrating Counselling and Coaching*. Routledge.

Hall, L. (2014), *Mindful Coaching: How Mindfulness Can Transform Coaching Practice*. Kogan Page.

Menezes Cunningham, E. (2017) *365 Ways to Feel Better: Self-care Ideas for Embodied Wellbeing*. Pen & Sword.

Academic/Research Article

Let's talk about (problematic) sex

The cycle of sexual addiction, potential causes and treatment approaches

By Kaylene Petersen

The World Health Organisation recently added Compulsive Sexual Behaviour Disorder as a new diagnosis in its International Classification of Diseases (11th Edition) (ICD-11). This groundbreaking move has focused attention on a subject that has long been at the centre of intense debate and, in our digital age, increasingly presenting in the therapeutic space

Introduction

Society and its views on sexuality have changed a great deal in the last half century. We do not need to look too far to see depictions of sex – it is used in advertising to sell everything from hamburgers to cars; the media jumps on celebrity sex scandals to bolster sales of newspapers and magazines; attending strip clubs is a legal source of entertainment; and pornography that was once kept high on top shelves, presumably out of "harm's way," is now available with the click of a few buttons. These cultural changes have not only made sex far more accessible that it ever was before, they have also made sexual rewards far more readily available.

Today, most Western adolescents and adults have access to smartphones and sexually stimulating images at their fingertips. In an age where sexuality and sexual diversity is more socially acceptable than ever before, issues surrounding sexuality are likely to be increasingly present in counselling and psychotherapy. The ways these issues present in the therapeutic space are numerous, including sexual abuse, sexual dysfunction, issues relating to sexual offending and sexual addiction. This article will examine the complex and controversial topic of sexual addiction, including the cycle of sexual addiction, potential causes and an exploration of several treatment approaches.

Defining sexual addiction

If one is to gain an understanding of sexual addiction – a term that is used interchangeably with hypersexuality, compulsive sexual behaviour and excessive sexual desire disorder – it is necessary to first grasp what constitutes addiction in the broader sense. The term sexual addiction will be

used throughout this article due to it being the most commonly-used lay term. The word 'addiction' has its roots in the Latin *addicere*, which literally means 'to be bound over by judicial decree,' (Birchard, 2015, p.1) and can be defined as "... a chronic condition involving a repeated powerful motivation to engage in a rewarding behaviour, acquired as a result of engaging in that behaviour, that has significant potential for unintended harm" (West & Brown, 2013, p.4).

Just as an alcoholic will crave alcohol and a drug addict their drug of choice, a sex addict will crave sexual stimulation and orgasms – and make doing so the primary focus of their life (Abel & O'Brien, 2015).

Although sexual addiction is regarded by many as a relatively recent phenomenon borne out of the creation of the internet, the characteristics of compulsive sexual behaviour were recorded by Austrian-German psychiatrist, Richard von Krafft-Ebing, as far back as 1886. In *Psychopathia Sexualis,* he wrote of subjects whose "... sexual appetite is abnormally increased to such an extent that it permeates all his thoughts and feelings" (p.70). Numerous labels including satyriasis (excessive male sexual desire), nymphomania (excessive female sexual desire), perversion and Don Juanism have historically been applied to individuals that exhibited disordered sexual behaviour (Garcia & Thibaut, 2010).

Sex as an addiction

Modern interest in the notion that sex could be addictive took hold in the 1980s with the publication Patrick Carne's *The Sexual Addiction* (1983). However, unlike alcohol and illicit drugs, there has been a distinct resistance to labelling sexual behaviour addictive (George et al., 2018).

Sexual addiction affects men and women, although it has historically been studied in men

Trivialising of the disorder, for instance, jokes that "sex addiction is the best addiction to have," or views that celebrities have labelled themselves sex addicts in the face of public scrutiny for extra-marital affairs, have likely not helped the cause. Unlike addiction to chemicals, which is more likely to result in genuine concern and understanding, mere mention of the term "sex addiction" often results in sniggers and provokes contempt. While addiction to alcohol and drugs is widely accepted, behavioural addictions, where an individual is addicted to the behaviour and/or feeling they experience when acting out the behaviour, is impacted by a significant research gap in literature (Jamieson & Dowrick, 2021).

Karila et al. (2014) state that, in the main, sexual addiction has been ignored by psychiatrists. Hall (2012) supports this, stating that some medical professionals deny the condition exists and many more are unaware how complex and serious it can become. While it is widely accepted that addictive disorders are often associated with severe consequences, most studies examining the link between addiction and suicide risk have focused primarily on substance addiction or gambling disorder (Valenciano-Mendoza et al., 2021). One 15-year study that assessed suicide risk of 4,404 participants that presented with various addiction disorders found that the highest prevalence of suicide attempts were made by those with sexual addiction (9.1%) (Valenciano-Mendoza et al., 2021).

There is no solitary behaviour that indicates sex addiction. Indeed, there are a plethora of sexual behaviours that can become intense, compulsive and, consequently, unmanageable, such as pornography, engagement with (or becoming) sex workers, multiple affairs, attending strip clubs, cybersex, masturbation and exhibitionism, among others. An individual may become addicted to any of these sexual behaviours, however, crucially, it is not necessarily the frequency that an individual engages in these behaviours that determines if they are suffering from sexual addiction, but rather the consequences that arise out of such behaviours (Padwa & Cunningham, 2010).

Indulging in sexual activity several times a day and viewing pornography does not necessarily make someone a sex addict. However, if their sexual behaviour compromises important aspects of their life, such as their health, family, financial situation, work and personal relationships and there are feelings afterwards that affect emotional well-being, such as powerlessness, shame and guilt and the individual cannot stop such destructive behaviours, they may be classified as suffering with sexual addiction (Padwa & Cunningham, 2010).

Sexual addiction affects men and women, although it has historically been studied in men. Specific to women, unplanned pregnancies, irrespective of whether the woman chooses to have the child or have an abortion, can have long-term emotional consequences, such as regret, anxiety and depression (Ferree, 2010).

Comorbidities

One behaviour that is apparent in a substantial number of sex addicts is paraphilic sex, whereby sexual excitement is derived

from fantasising about and/or participating in behaviour that is deemed unusual (de Roos, Longpre & van Dongéen, 2024). In addition to the prevalence of paraphilia, individuals characterised as sex addicts may also present with major mood disorders, for example, schizophrenia. (Sadock & Sadock, 2011). Other disorders that have been linked to sexual addiction include borderline personality disorder and antisocial personality disorder (Sadock & Sadock, 2011).

Research has found that 83% of sex addicts present with multiple addictions, including 42% with chemical addictions; 38% with eating disorders; and 28% with compulsive working (Carnes, 1991). This suggests that for some there may be a genetic predisposition to addictive behaviour, which has been supported in various twin studies (Anholt & Mackay, 2010).

Cycle of sexual addiction

Addictive behaviour, by its very nature, is cyclical and this is outlined in the cycle of addiction. Carnes (1983) developed the first cycle of sexual addiction that is comprised of four sequential stages: preoccupation (fantasy); ritualisation ("the bubble"); compulsive sexual behaviour (acting out); and despair.

In the preoccupation stage, the mind is focused on thoughts of sex. These preoccupations are the result of triggers that act as catalysts and compel an individual to act out sexually. Triggers may include emotional states (boredom, stress), an argument with a partner, a location or smell. This preoccupation often results in a trance-like state where the addict has only one mission – to seek out sexual stimulation.

The ritualisation stage is dependent on the individual's personal routine that leads them to their "acting out" sexually.

As a sex addict uses the pursuit of their high to escape emotional discomfort, when that high ends, a sex addict is propelled back into the real world and back to the initial emotion that caused them to become preoccupied with sex in the first place

This could involve turning on the computer, contacting sex workers, wearing a certain aftershave/perfume or consuming alcohol. These rituals exacerbate preoccupation and increase the level of arousal and excitement. It is this phase that provides sex addicts with their "high" and thus, sex addicts will often try and extend this stage for as long as possible.

The third stage is compulsive sexual behaviour. Crucially, the actual act can be short and unsatisfying, or it may go on for extensive periods of time to the point of causing physical damage to the tissue of the genitalia (Hasting, 1998).

The final stage in Carnes' cycle of sexual addiction is despair. As a sex addict uses the pursuit of their high to escape emotional discomfort, when that high ends, a sex addict is propelled back into the real world and back to the initial emotion that caused them to become preoccupied with sex in the first place. Only now, they not only have that initial unsettling emotion to contend with, but they have a multitude of new emotions such as self-loathing and guilt thrown into the mix because they acted out *yet again*. The level of despair can be so difficult that a sex addict returns to preoccupation with sexual fantasies to help numb the pain, thus invoking the cycle of sex addiction again.

Clinical classification of sexual addiction

Although the term sexual addiction is a universal one and has featured in literature for a significant period of time, the labelling of it as a mental disorder has proved controversial and divisive. The view that excessive sexual behaviour (in varying forms) is a type of behavioural addiction that can become problematic has continued to gain traction, however, controversy abounds regarding operationalisation of the concept (Andreassen et al., 2018). Highlighting this, sexual addiction was proposed for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* under the name "hyperousal disorder," but was excluded due to limited empirical evidence (Campbell and Stein, 2015).

Conversely, the World Health Organisation (WHO) recently elected to include "Compulsive Sexual Behaviour Disorder" (CSBD) as an impulse control disorder in the *International Statistical Classification of Diseases and Related Health Problems, Eleventh Edition* (*ICD-11*), which officially came into effect on January 1, 2022.

Compulsive Sexual Behaviour Disorder

Similar to the numerous overlapping names that preceded it, CSBD in the *ICD-11*, is "... characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour" (WHO, 2022). See Table 1 for the diagnostic criteria for CSBD.

The prevalence of CSBD is thought to be between 3% - 6% in the general population (Dickenson, et al., 2018). However, this can only be considered a rough estimate since the condition is likely significantly under-

Diagnostic criteria of Compulsive Sexual Behaviour Disorder (CSBD) in the ICD-11

A persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour, manifested in one or more of the following:

- Engaging in repetitive sexual behaviour has become a central focus of the individual's life to the point of neglecting health and personal care or other interests, activities and responsibilities.
- The individual has made numerous unsuccessful efforts to control or significantly reduce repetitive sexual behaviour.
- The individual continues to engage in repetitive sexual behaviour despite adverse consequences (e.g., marital conflict due to sexual behaviour, financial or legal consequences, negative impact on health).
- The person continues to engage in repetitive sexual behaviour even when the individual derives little or no satisfaction from it.
- The pattern of failure to control intense, repetitive sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g., six months or more).
- The pattern of failure to control intense, repetitive sexual impulses or urges and resulting repetitive sexual behaviour is not better accounted for by another mental disorder (e.g., Manic Episode) or other medical condition and is not due to the effects of a substance or medication.
- The pattern of repetitive sexual behaviour results in marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Distress that is entirely related to moral judgements and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement.

Table 1: *Diagnostic criteria of Compulsive Sexual Behaviour Disorder (CSBD) in the ICD-11 (WHO, 2022)*

reported as a result of shame and/or embarrassment and the stigma surrounding sexual behaviours (Dickenson, et al., 2018). Additionally, studies on the prevalence of compulsive behaviour within the general population remains scarce (Brikin, 2022). Of note, women are less likely to seek out support as a result of shame (Dhuffar and Griffiths, 2016).

The increasing use of digital media for sexual stimulation through consumption of porn and masturbation is also likely to significantly increase the risk of developing CSBD (Caponnetto et al., 2018).

Causes of sex addiction

As with all types of addiction, controversy abounds as to the underlying causes. Part of the problem is that no single biological cause has been found that can explain its origins (Fong, 2006). However, numerous researchers have noted that childhood trauma, including child sexual abuse and neglect, is a significant factor in adults presenting as sex addicts (Fong, 2006). Many people with sexual addiction admit their problem began before they were 16 (40%) and some under the age of 10 (6%) (www.sexaddictionhelp.com, 2014, as cited in Hall, 2015).

Early-onset sexualisation has also been linked to sex addiction (Feuerborn, 2015). This could include sexual abuse, but also exposure to pornography. Such exposure can have an impact on a child's sexual attitudes – in particular, it can lead to an increased awareness of sex and early sexual experimentation and activity (Feuerborn, 2015).

According to George et al. (2020), pathologically pursuing reward and/or relief either through a substance or behaviour suggests a dysfunction in brain reward circuitry. Sexual activity results in the release of neurotransmitters (such as dopamine and endorphins) that give rise to pleasure, and it is argued that those individuals that indulge in sexual activity to excess may end up needing higher levels of neurotransmitters in their systems (Padwa & Cunningham, 2010). As with alcohol or other chemical use, sexual arousal initially produces a state of euphoria that helps reduce stress. Sex addicts note a neurochemical high when they think about and prepare for a sexual act. However, once this euphoric feeling subsides, it can result in craving, relapse and further distress.

Other factors that may contribute to sex addiction include low serotonin levels, having a pre-existing mental health condition such as anxiety and/or depression, having an impulse control disorder or bipolar disorder, and having one or more parents addicted to sex or substances (Schreiber, Odlaug & Grant, 2011, Fong, 2006).

Therapeutic intervention for sexual addiction

Therapy for sexual addiction is a long journey. It must examine the underlying reasons that cause an individual to form their addiction in the first place (for instance, trauma) and, further, provide effective strategies that will help prevent relapse (Hall, 2012).

The main difference between treating sexual addiction and substance addiction is that total abstinence is not the ultimate long-term goal with sexual addiction. Rather, individuals work closely with their therapist to change behaviour by examining those behaviours that are troublesome and those that are not, and only abstaining from those that are problematic (Fong, 2006).

Goals of sexual addiction therapy are numerous, including: reduce and eliminate the sexual behaviour that is compulsive and shame-inducing; equipping the individual with the ability to manage cravings and urges; raising awareness of triggers and identifying behavioural strategies to address them; help the client establish a support system that includes specific contacts if relapse looks likely; and help the client reduce distorted thoughts/beliefs and address denial (Hayden, 2013).

While the therapeutic alliance is important in therapy for any presenting issue, it is especially the case with sexual addiction (Fong, 2006). Clients presenting with sexual addiction often enter therapy paralysed by shame and the need for therapists to be aware of this cannot be overstated. The therapeutic space may be the first time an individual has felt able to speak openly about the behaviour that has caused them so much emotional turmoil.

In the words of Stephen (aged 61) in Barnett (2012): "The addiction is incredibly isolating. Deep down, you feel terribly ashamed of what you're doing, your self-esteem hits the ground, and you think you're not worthy of being loved at all ... the addiction really is a very bleak place to be."

Shame and feelings of not being worthy human beings are central in sex addiction

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a highly-directive talk therapy that helps individuals change the way they think (cognitive) and what they do (behaviour). Of note, it is one of the main therapies for treating substance and behavioural addiction (Fong, 2006).

CBT for sex addiction centres on identifying a client's triggers, brainstorming how to cope when they arise, and examining and redefining cognitive distortions (Hall, 2012). Therapists can help clients manage stress better (emotion regulation) and improve their coping skills, particularly with regards to anxiety and depression, thus reducing their susceptibility to their compulsive sexual behaviour. CBT also focuses on altering the client's maladaptive core beliefs (Sadock & Sadock, 2008). These negative beliefs are central to dysfunctional patterns of living and only serve to drive the dependency on compulsive sexual behaviour. Therapists can introduce positive core beliefs that change the way an individual sees themselves, others and the world around them. Crucially, relapse prevention should be explored to help clients anticipate and manage situations that may potentially cause relapse.

Motivational interviewing

Motivational interviewing (MI) is "a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence" (Miller & Rollnick, 1995, p. 326). MI helps individuals to recognise their current problems and do something about them and has been shown to be particularly useful when clients are unsure or reluctant to change their behaviour (Miller & Rollnick, 1995).

The therapist's role in MI is not to force change on a client, rather, emphasis is placed on helping the client find their inner desire to change and to actively encourage them to make better, informed life choices based on such internal desire. The motivation comes from informing clients that they are able to control their behaviour(s) and make choices that are healthy for themselves and those around them (Miller & Rollnick, 1995).

Shame and feelings of not being worthy human beings are central in sex addiction. MI helps clients to overcome such feelings and helps promote self-efficacy. This is done through reflective listening whereby the therapist echoes statements that the client has made from a neutral perspective. Central here is the therapeutic relationship and its provision in helping clients see beyond their perceived failings and help reinforce their positive qualities.

Group therapy

Therapists have long championed group therapy as a treatment modality for sex addiction (Carnes, 1991). While this may seem an unlikely approach, given the shame-based profile of the condition, the approach is effective for this very reason. Group therapy allows individuals to hear personal accounts of others who are struggling with the same addiction. These 'others' can be seen as loving, encouraging and worthwhile, thereby dispelling the myth that sex addicts are defined by their addiction and are inherently bad or flawed (Hall, 2012). Further, group

therapy allows for the sharing of techniques to help prevent relapse. The formation of friendships, based on solidarity, compassion and understanding are another benefit of group therapy (Hall, 2012). One criticism of this therapy is that not everyone is comfortable discussing their stories as this may prove a deterrent to some.

Conclusion

Society has never been more sexualised and access to sexually stimulating material has never been more available, which is likely to see a rise in the incidence of sexual addiction in the future. Individuals presenting with an insatiable sexual appetite that can become compulsive and have serious detrimental consequences has been documented in literature throughout history under various names.

While their is no definitive cause of sexual addiction, researchers have noted links with childhood exposure to trauma, neglect and early-onset sexualisation. Growing up with a parent who is addicted to either sex or substances also has been posited.

Therapy for sexual addiction aims to reduce and eliminate those sexual behaviours that are compulsive and invoke shame, assist clients with the skills to manage cravings and make them aware of personal triggers.

Given that we live in a digital age and are constantly bombarded with sexual stimuli, developing a sex addiction has become *too* easy. The WHO's recent decision to include compulsive sexual behaviour disorder in the *IDC-11* has shone a much-needed spotlight on compulsive sexual behaviours and will hopefully lead to further investigation and research that will translate into effective and accessible treatment options.

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REFERENCES

Abel, N. & O'Brien, J. (2015). *Treating addictions with EMDR therapy and the stages of change*. Springer Publishing Company.

Anholt, R.H. & Mackay, T.F.C. (2010). *Principles of behavioral genetics*. Elsevier.

Andreassen, C.S., Pallesen, S., Griffiths, M.D., Torsheim, T., Sinha, R. (2018). The development and validation of the Bergen-Yale Sex Addiction Scale with a large national sample. *Frontiers in psychology*, 9, Article 144. http://doi: 10.3389/fpsyg.2018.00144

Barnett, L. (2012, January 10). Shame: Sex addicts reveal all. *The Guardian*. http://www.theguardian.com/lifeandstyle/2012/jan/10/sex-addicts-talk

Briken, P., Wiessner, C., Štulhofer, A., Klein, V., Fuß, J., Reed, G.M., & Dekker M. (2022). 'Who feels affected by out of control' sexual behaviour? Prevalence and correlates of indicators for ICD-11 compulsive sexual behaviour disorder in the German Health and Sexuality Survey (GeSiD). *Journal of Behavioural Addiction*, 11(3), 900-911. http://doi:10.1556/2006.2022.00060

Birchard, T. (2015). *CBT for compulsive sexual behaviour: A guide for professionals*. Routledge.

Campbell, M. M., & Stein, D.J. (2015). *Behavioural addiction: DSM 5 and beyond*. Oxford University Press. https://doi.org/10.1093/med/9780199391547.003.0005

Caponnetto, P., Maglia, M., Prezzavento, G. C., & Pirrone, C. (2022). Sexual addiction, hypersexual behaviour and relative psychological dynamics during the period of social distancing and stay-at-home policies due to COVID-19. *International Journal of Environmental Research and Public Health*, 19(5), 2704. http://doi:10.3390/ijerph19052704

Carnes, P. (1983). *The sexual addiction*. CompCare.

Carnes, P. (1991). *Don't call it love: Recovery from sexual addiction*. Bantan.

de Roos, M. S., Longpré, N., & van Dongen, J. D. M. (2024). When Kinks Come to Life: An Exploration of Paraphilic Behaviors and Underlying Predictors. *The Journal of Sex Research*, 1-13. https://doi.org/10.1080/00224499.2024.2319242

Dhuffar, M. K.; Griffiths, M.D. (2016). Barriers to female sex addiction treatment in the UK. *Journal of Behavioural Addiction*, 5(4), 562-567. http://doi:10.1556/2006.5.2016.072

Dickenson, J. A., Gleason, N., Coleman, E., & Miner, M. H. (2018). Prevalence of distress associated with difficulty controlling sexual urges, feelings, and behaviours in the United States. *JAMA network open*, 1(7). http://doi:10.1001/jamanetworkopen.2018.4468

Ferree, M.C. (2010). *Stones: women redeemed from sexual addiction* (2nd ed.) InterVarsity Press.

Feuerborn, W. (2015). Hypersexual behaviour: Helping clients through diagnosis and treatment. In E.M.P. Schott, E.L. Weiss (Eds). *Transformative social work practice*. Sage.

Fong, T.W. (2006). Understanding and Managing Compulsive Sexual Behaviours. *Psychiatry*, 3(11), 51-58.

Garcia, F.D. & Thibaut, F. (2010). Sexual addictions. *American Journal of Drug and Alcohol Abuse*, 36(5), 254-60.

George, M., Maheshwari, S., Chandran, S., Rao, S.S., Shivanand, M. J., & Sathyanarayana Rao, T.S. (2018). Psychosocial intervention for sexual addiction. *Indian Journal of Psychiatry*, 60(4), S510-S513. https://doi: 10.4103/psychiatry.IndianJPsychiatry_38_18

Hall, P. (2012). *Understanding and treating sex addiction: A comprehensive guide for people who struggle with sex addiction and those who want to help them*. Routledge.

Hall, P. (2015). *Sex addiction: The partner's perspective: A comprehensive guide to understanding and surviving addiction for partners and those who want to help them*. Routledge.

Hayden, D. (2013). *Total sex recovery – A guide to therapy*. Xlibris Corporation.

Jamieson, S., & Dowrick,C. (2021). Comparing public perceptions of substance addictions and behavioural addictions. *Drug and Alcohol Dependence*. https://doi.org/10.1016/j.drugalcdep.2020.108472

Karila, L., Wéry, A., Weinstein, A., Cottencin, O., Petit, A., Reynaud, M., Billieux, J. (2014). Sexual addiction or hypersexual disorder: Different terms for the same problem? A review of the literature. *Current Pharmaceutical Design*. 20(25), 4012-20. https://doi:10.2174/13816128113199990619

Krafft-Ebing, R.F. (1886). *Psychopathia Sexualis*, reprinted by Bloat Books, 1999.

Miller, W.R. & Rollnick, S. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23(4), 325-334.

Padwa, H. & Cunningham, J. (2010). *Addiction: A reference encyclopedia*. ABC Clio

Sadock, B. J. & Sadock, V.A. (2008). *Kaplan & Sadock's concise textbook of clinical psychiatry* (3rd ed.). Lippincott, Williams & Wilkins.

Sadock, B.J. & Sadock, V.A. (2011). *Kaplan and Sadock's synopsis of psychiatry: Behavioural sciences/clinical psychiatry* (10th ed.). Lippincott Williams & Wilkins.

Schreiber, L., Odlaug, B. L. & Grant, J. E. (2011). Impulse Control Disorders: Updated Review of Clinical Characteristics and Pharmacological Management. *Frontiers in Psychiatry*, 2,(1). http://10.3389/fpsyt.2011.00001

Valenciano-Mendoza, E., Fernández-Aranda, F., Granero, R., Gómez-Peña, M., Moragas, L., Mora-Maltas, B., Håkansson, A., Menchón, J. M., & Jiménez-Murcia, S. (2021). Prevalence of suicidal behaviour and associated clinical correlates in patients with behavioural addictions. *International Journal of Environmental Research and Public Health*. 18(21). http://doi:10.3390/ijerph182111085

West, R. & Brown, J. (2013). *Theory of addiction* (2nd ed.). Wiley-Blackwell.

World Health Organization. (2022). *ICD-11: International classification of diseases (11th revision)*. https://doi:icd.who.int/

Practitioner Perspective

Child-Centred Attachment Therapy (CcAT) Programme

When personal and professional quests for healing intersect

By Alexandra Maeja Raicar

The article describes a brief (10-session) family attachment therapy programme, CcAT, developed by the author and three adoption colleagues in Essex, England, in the mid-1990s. The framework was later used to carry out therapeutic assessments for local adoption agencies, and to support birth and step-families – latterly by Maeja in Ireland too.

Introduction

Developing and offering Child-Centred Attachment Therapy (the CcAT Programme) to families in Essex and, more recently, in Ireland became part of my own healing journey. In the past, I mistakenly assumed that my choices of work and training were adult-led. I now know they were driven by my Child Self who needed to heal relationships within my family of origin.

It seemed just chance that my job opportunities - both as a social worker and a therapist - were mainly in the field of adoption and fostering. Decades later, I realised I was unconsciously seeking throughout to compensate for my own family losses.

In the early 1990s, I felt impelled to join a pioneering course in Parent-Infant Psychotherapy at The School of Infant Mental Health in Hampstead, even though I was halfway through my training as an Adult Psychotherapist at what is now The Bowlby Centre in London. I can still recall the tutor's surprise (and mine) at the pre-clinical training interview when – in response to his standard question as to why I wished to proceed with that adult therapy course - I heard my Child Self reply: "to be a resource for mothers and babies." That could well have been the end of my adult training, but, as the good therapist he was, he reflected back my seemingly irrelevant answer. I somehow explained my reasoning, he accepted it, and I duly began the clinical work.

Shortly after qualifying as an adult therapist, I was invited in February 1995 to lead one of the many attachment-themed mini-workshops at the annual John Bowlby Memorial conference. Mine was to be on my social work specialism: adoption and fostering. This meant I had to emotionally understand and explain "attachment" as a working concept to myself first. As a Kenyan Goan in Britain, coming from a traumatised migrant family with a range of "insecure" attachment styles (Bowlby, 1969) amongst our members, I understand now much better why it took me so long to recognise at "heart" level what a "secure" attachment feels like and how it can be carefully fostered in a new family.

Both my parents came from Catholic families in Goa which had been culturally colonised by the Portuguese for generations there; they then emigrated to Kenya, an apartheid-style British colony – where my siblings and I grew up. Not surprisingly, our parents' "sense of self" was severely impacted, and they could not model secure attachments for us. However, my training therapist and supervisors happened to be white migrants from South Africa. "Homeless at heart" like me, they had escaped its harsh apartheid regime when young and then had the shared experience of being "othered" in the "mother country," England, as I was.

Through therapy and supervision support, and play in the Winnicottian sense, I gradually reconnected with my hidden "Child Self" and slowly learned about "secure" attachments - which I could then model better for the clients and families I worked with. Winnicott explored the relationship between play, creativity, self-discovery, and the ability to engage authentically with others (Winnicott, 1985).

It is no coincidence that I had by then over four years of training therapy with a wise and committed therapist who nurtured my avoidant, almost runaway Child Self

Development of the CcAT Programme (1995)

In order to prepare for my mini-workshop presentation at the Bowlby Conference, I turned to the writings of Dr. Vera Fahlberg, an American attachment therapist. She had presented her work at BAAF (British Agencies for Adoption and Fostering) training events in London, as well as in her many "how to" manuals. Although I heard Fahlberg speak in previous years, and even read her books, it was only now that her very simple "bonding cycle" diagram – which I had seen before and in different guises by other writers too on attachment – suddenly made complete emotional sense to me, as did her "Positive Interaction Cycle" (Fahlberg, 1991). It is no coincidence that I had by then over four years of training therapy with a wise and committed therapist who nurtured my avoidant, almost runaway Child Self.

This became my "aha" moment, since I finally understood at heart level both how attachment works_and ways in which it can be fostered in new families. I remember my childlike excitement as I copied and expanded on Fahlberg's diagrams one weekend at home. Later that week I took them into work to photocopy and share with any one in our always busy adoption and fostering team who might be interested. My colleagues knew of Fahlberg's work, but only three - Maggie, Margaret and Pauline - seemed to see the potential of applying her specific model to work with newly formed families.

They shared my excitement at its possibilities and discussed how we could use it systematically to support new adoptive families. It felt like synchronicity with the Universe as a series of fortuituous events occurred to offer new opportunities for exploring and clarifying our ideas in a more disciplined way.

Our then director of Social Services was already interested in Attachment Theory, and in Fahlberg's work in particular. He was looking for new initiatives that might help to maintain child placements, and so it was a good time to approach the County Adoption Manager with a formal proposal. A senior colleague and friend happened to meet with me that same week, and her questions helped to further crystallise my ideas. Within a few weeks our proposal for a six-month pilot project was accepted. A county focus group of senior adoption practitioners was set up to meet bi-monthly and reflect on our findings. Even more helpfully, a senior researcher in the county agreed to evaluate our pilot project.

Understandably, our local manager had doubts about the unit being able to afford the extra staff time we four workers would need to trial such intensive placement support. However, we negotiated working one day a week in pairs, with a family each, for specific attachment therapy over a six-month period.

The manager wisely insisted that our service be time-limited, in order to focus the work for both the parents and therapists. We agreed to a ten-session programme, incorporating assessment and review. This time boundary has proved to be very effective, both for containing the work and keeping everyone motivated over an agreed period of time.

Coincidentally, Pauline and Margaret were already doing play-work with one or more children at our unit, so it was agreed that Maggie and I would be Parent Therapists and co-work with them as Play Workers in separate pairs. Through further synchrony, one of Pauline's child clients was suddenly labelled as "attachment disordered" by his social worker. She had already asked for the family to be referred to a specialist post-adoption service in London for a week's experimental attachment therapy that was to be trialled there shortly, based partly on a controversial model in America of "holding therapy."

Not long afterwards, Pauline and I were able to accompany and observe some of the therapy interventions with the family on their first and final day of the week's trial in London. This was very useful as we had to provide follow-up support locally; we could thus be more discerning as to how we ourselves might work with the family in the future. Neither of us agreed with "holding therapy" for children, especially if they had previously been abused physically, sexually, and/ or emotionally. We agreed that we needed to be child-centred ourselves in any therapeutic interventions, and our own project was named accordingly.

It was again synchrony for us that a self-help group of adoptive parents in Britain, PPIAS (Parent to Parent Information on Adoption Services, and later known as Adoption UK) had already been disseminating among its members new information from America about various attachment therapies, including "holding therapy," to treat what were now described as attachment-disordered children, many with Reactive Attachment Disorder. The mother of Pauline's child client happened to be a member of PPIAS and so had heard, not only of American adoptive parents' experiences, but of the new attachment therapy to be trialled in London. Her family was one of only two included in the pilot project there.

The child will need sensitive Life Story Work, perhaps in gradated versions to accommodate her growing understanding of why she is not living with birth parents, who may have been idealised by her

The CcAT Pilot Project (1996) - key strands of work

1. The importance of grief work

Conceiving and co-developing the CcAT Programme in one year from theoretical framework to therapeutic practice had been facilitated by synchronistic events. Sadly, however, over a six-month period, our unit also experienced a series of devastating personal and family losses – through serious illnesses, deaths or accidents. These inevitably delayed the start of the pilot project as seven of the eleven staff were affected and needed time off for mourning. They included our manager and three of the four CcAT team members – almost aborting the project at its very inception.

Furthermore, both our pilot families also experienced a sudden parental loss so that they too were forced to do griefwork before we could even begin attachment work with them and the identified child client. Since (following Fahlberg) griefwork is one of the three main strands of CcAT attachment work with child and carers, the timing of all these losses felt like more than just coincidence. It was as if we, as CcAT therapists, had to be reminded of the incapacitating effects of loss, and the need to acknowledge and mourn it, before we could move on to work with our chosen families.

As I have written elsewhere:

> *"Loss is the bedrock on which the social and legal edifices of adoption are built. And on which they can crumble when this stark reality is not acknowledged and honoured by all those involved in their construction..."* (Raicar, 2010)

In the context of adoption, both child and carer losses need to be acknowledged and mourned before either can be expected to form new attachments. The child will need sensitive Life Story Work, perhaps in gradated versions to accommodate her growing understanding of why she is not living with birth parents, who may have been idealised by her. She may have to give up the fantasy of perfect birth parents in order to grieve, and accept the reality of her losses, while slowly beginning to attach to her new carer.

Similarly, the adopter will need to relinquish the fantasy child

she may have dreamed of having herself or adopting. She has to walk an emotional tightrope of attaching enough to the child to claim him as hers, and so protect him from harm, while remembering he has a birth family whom he may later wish to seek out and reclaim as a member. If adopters are too empathic with the birth family, they may feel guilty or not entitled to parent the child, and so may not claim her to keep her safe.

2. Matching cues and responses

For any relationship to work, both partners have to give the right "cues," so as to elicit the desired "responses." This is such a fundamental truth that even newborn babies instinctively cry in order to have their basic needs met. Their carers have to learn to correctly identify the baby's cue and need (to be fed, held, comforted, kept warm or cool, played with, etc.) in order to give the right response, so meeting the need appropriately.

As in the Basic Bonding Cycle – which is one of bodily arousal, crying to express discomfort, satisfaction of need, and relaxation – both baby and carer will need countless repetitions of such interactions in order to reassure the baby that her needs will be safely met (responded to) and appropriately. The baby's relaxed state, after the need has been met, will likely invite playful interactions with the carer who feels reassured he has met the baby's need, i.e. he is a good-enough carer. Such daily repetitions of cue, response, and playful interaction slowly build up trust in the baby, who learns: "It's okay to have and express my needs. This carer will meet them and enjoys being with me."

The carer develops confidence:

They spend less and less fun time with each other; instead, they become increasingly critical, rejecting and hostile, magnifying each other's negative traits and seeing no positive ones

"I know how to care for this baby. She trusts me. I am a good carer."

In this way, mutual attachment and trust between child and carer grow, as well as their self-esteem. They develop a sense of belonging, and claim each other – crucial for keeping the child safe.

Attachment and protection are two sides of the same coin. If the carer feels claimed by the child, s/he will feel entitled to look after and protect her. Equally, if a carer feels rejected by the child, s/he will not feel entitled to claim him as hers to keep him safe. And if a child does not feel claimed by the carer and kept safe, she may run away or put herself in danger to provoke safe care. This will likely confirm for the carer his feelings of inadequacy and may even lead to his ending a placement – so confirming to the child she is so bad and dangerous, no one cares enough to keep her safe, since she is worthless.

3. Having fun time together

This third, but equally important strand of the CcAT Programme builds on the success of the second: matching cues and responses to improve the carer/child relationship. We all know that, if we get on well with someone, we are more likely to spend fun time together. The converse is also true. When we don't get on with someone, we have no wish to spend any time with them.

This is exactly what happens when carer and child (or couples) get caught up in "Negative Interaction Cycles." They spend less and less fun time with each other; instead, they become increasingly critical, rejecting and hostile, magnifying each other's negative traits and seeing no positive ones.

Even in seemingly hopeless situations, just starting by having brief fun time together every day can help to salvage the relationship, if both are committed to making positive changes. In a carer/child situation, we suggest that the child be allowed to choose a fun activity that the carer can tolerate, if not actually enjoy, and gradually increase time spent together in fun or neutral activities.

The carer, as adult, will be expected to model positive communication, or at least desist from saying anything negative. Carers may need individual work to ensure that their hurt Child Self is heard, and not pulled out inappropriately for slanging contests with the actual child in their care.

Learning from CcAT work

We realised over the following decade that we had indeed been inspired when putting together CcAT as a brief and coherent programme of simple child and family interventions to help both child and parent grieve their losses and learn to attach or reattach. It is based on very simple attachment principles that can be easily taught to families and professionals who are committed and open. It is a cost-effective, brief family intervention (four to six months usually) that

can make a positive difference to a lot of unhappy children and parents.

We have also used the CcAT framework for therapeutic assessments of struggling families to salvage failing placements, including in long term foster homes. And to assess sibling and family attachments, and complex contact arrangements, in order to make recommendations to placing agencies and the Courts.

Since moving to Ireland in recent years, I have been able to trial CcAT in a different culture and with birth families on self-referral to a family centre, usually for help with a child. Over a period of twenty months, I received thirteen referrals, and generally positive feedback on our work together from most of the parents who engaged with my service. They were all single parents, after the father had left or been coercive towards them and/or the children, or had found another partner. These mothers were resourceful and resilient, and most were willing to learn and work on themselves in order to move on.

Bereavement was a major issue for the families, since the loss of the father had to be talked about and grieved, even if it was the mother who had asked him to leave. Protection was also a recurring issue.

The mothers chose whether to bring their children to any of the sessions or not. I saw a separated father occasionally, often because the still grieving child wanted him included in family work.

I added a new tool, EFT (Emotional Freedom Technique) tapping on specific acupressure points, while stating negative self-beliefs and gradually changing them to positive affirmations. Humorous self-statements can be included, which add a touch of lightness to what can otherwise be quite heavy sessions. I noticed that the women who were willing to use this energy therapy to work on their own issues were most likely to experience positive changes in their home situation. One or two felt able to continue work on their own after only a few sessions, mainly because of using EFT.

My original inspiration for incorporating the use of EFT in psychotherapy was Dr. Phil Mollon, a pioneering English psychoanalyst, who has written about his use of energy therapies in his work

(Mollon, 2005)

My original inspiration for incorporating the use of EFT in psychotherapy was Dr. Phil Mollon, a pioneering English psychoanalyst, who has written about his use of energy therapies in his work (Mollon, 2005).

Increasingly over the years in my work as a therapist, I have encouraged interested clients to learn to use EFT for self-care. It can be very effective in interrupting the cycle of negative self-beliefs and actions, which can otherwise feel hopeless when reinforced by constant repetition of trauma stories.

Conclusion

It has been very encouraging to find that CcAT principles and ways of working are also easily transferrable to contexts outside adoption. And that they can be adapted to couples or sibling relationships too. Hopefully, a new generation of therapists will take this work forward.

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REFERENCES

Bowlby, J. (1969). *Attachment* (Vol. 1). Hogarth.

Winnicott, D.W. (1985). *Playing and Reality.* Harmondsworth: Penguin.

Fahlberg, V. (1991). *A Child's Journey Through Placement.* BAAF.

Raicar, A.M. (2009).*Child-Centered Attachment Therapy: The CcAT Programme.* UKCP/Karnac.

Raicar, A.M. (2010). *When adopted adults are shadowed by disrupted attachments* in Adoption: transmuting losses into gains through griefwork, *The Psychotherapist*, UKCP journal, Issue 44, Spring 2010.

Mollon, P. (2005). *EMDR and The Energy Therapies: A Psychoanalytic Perspective.* Karnac.

Academic/Research Article

Death and types of grief

A guide to the intricate and universal path of grief

By Hamza Mahoney

This article gives an insight into various theoretical frameworks of grief, such as the Dual Process Theory, the Biopsychosocial Model (Two-Track Model) of Grief, Grief Attachment Theory, the Task Model of Grief, the Continuing Bonds Theory, and the Meaning Making Theory, and also demonstrates the importance of understanding grief. An interesting insight into the different types of grief, including acute, integrated, and complicated grief, and underlines the importance of signposting for counsellors and therapists.

Introduction

Grief, a profoundly painful experience, is a universal journey of loss, which encompasses physical, emotional, cognitive, behavioural, and spiritual aspects (Hall, 2014). It is a journey most individuals inevitably embark on, facing the death of a close friend or relative at various points in their lives (Bonanno & Kaltman, 2001). The circumstances of the loss, the nature of the relationship, and individual coping mechanisms can influence the manifestation of the grieving process in various ways. Ultimately, grief is the price we pay for love (Hall, 2014), a shared experience that binds us all.

According to Supiano (2018), theory is vital in grief and grief therapy as it provides a systematic framework for understanding and addressing bereavement's complex processes. It aids researchers and practitioners in making sense of grieving individuals' experiences, guiding the development of tailored interventions. Theories offer explanations and predictions about grief reactions, allowing professionals to meet bereaved individuals' specific needs. Additionally, theory underpins research by identifying mechanisms that facilitate growth in grief and dismantling intervention effects to determine what contributes to therapeutic change, for whom, and under what circumstances treatment works best.

This article delves into various theoretical frameworks, offering practical insights into how individuals cope with grief. These frameworks, including the Dual Process Theory, the Biopsychosocial Model (Two-Track Model) of Grief, the Attachment Theory, the Task Models of Grief, the Continuing Bonds Theory, and the Meaning Making Theory, are not just academic concepts. When

understood and applied, they are powerful tools that can significantly enhance the support counsellors and therapists provide to clients coping with grief and loss.

Furthermore, this article explores different types of grief, including acute, integrated, complicated and pet grief, and the role of death education. It concludes by exploring the importance of signposting for counsellors and therapists and highlighting some available supports in Ireland.

Navigating grief and loss is a deeply personal and often challenging journey that individuals face at various points in their lives. Several theoretical frameworks offer insights into how bereaved individuals could cope with these experiences.

Acute, integrated and complicated grief

Deep sorrow, distress, and disbelief characterise acute grief, the initial response to loss (Hall, 2014). This often includes a range of emotional, cognitive, and physical symptoms such as anxiety, confusion, fatigue, physical pain and sadness. The intensity and duration of these symptoms can vary depending on a variety of factors contributing to the impact of the loss and the grieving process, including the type of death, background, relationship to the deceased, individual coping styles, and social community supports (Neimeyer, 2019).

Integrated grief marks the enduring response that follows successful adaptation to loss, rekindling a sense of contentment in one's ongoing life (Shear et al., 2013). Specific individuals may not follow this trajectory and develop complicated grief, also known as prolonged grief disorder, impacting between 10% and 15% of bereaved individuals, especially those affected by unexpected, violent, suicidal or untimely deaths (Hall, 2014).

Early identification and intervention for complicated grief are not just important; they are essential, as research has shown that specially designed grief therapy supports bereaved individuals with complicated grief

(Shear et al., 2013)

The concept of complicated grief, a severe response to loss, is included in the World Health Organisation's *International Classification of Diseases, 11th Revision (ICD-11)* and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* and continues to evolve (Dodd et al., 2022). It is a disorder (Shear et al., 2013) that significantly impacts a variety of areas for the bereaved individual, including family relationships, social functioning, purposelessness and continuing to struggle with the reality of the loss for a year or more following the bereavement. The time since the loss and the ability to function are crucial components in identifying complicated grief (Bonanno, 2009). Early identification and intervention for complicated grief are not just important; they are essential, as research has shown that specially designed grief therapy supports bereaved individuals with complicated grief (Shear et al., 2013).

In complicated grief treatment, the agenda for the 16 weekly sessions is structured in four phases: getting started, core revisiting sequence, mid-course review, and closing sequence. Tools used in complicated grief treatment include a grief monitoring diary for the client to identify grief triggers and patterns and observe their daily intensity experiences with grief. The counsellor or therapist would suggest that clients invite a close friend or family member to join a session to rebuild connections. In later sessions, clients explore memories and hold an imaginal conversation with the deceased (Shear & Gribbin Bloom, 2017).

Dual Process Model

Stroebe and Schut (1999) developed the Dual Process Model of coping with bereavement, which outlines a divided approach to comprehending how individuals navigate the challenging experience of grief. This model comprises two primary dimensions: loss orientation and restoration orientation.

Loss orientation pertains to emotional engagement with grief, encompassing feelings such as yearning, sorrow, and enduring attachment to the deceased. During the initial phases, negative emotions are predominant; however, positive affect gradually emerges as time progresses. This orientation underscores the fluctuating focus between the bereavement experience and other life stressors. It highlights the necessity of oscillating between confronting the emotional pain of the loss and overcoming any resistance to change (Corr et al., 2019).

On the other hand, restoration orientation involves problem-solving, re-establishing routines, and seeking new roles and activities, contributing to a renewed sense of purpose. It addresses the practical and instrumental challenges the bereaved individual faces (Corr et al., 2019). This component emphasises balancing grief work with efforts to restore a functional and meaningful life and adapt to the new world for bereaved persons.

In later research, Stroebe and Schut (2016) addressed that these stressors can accumulate and become overwhelming for an individual journeying through grief. Overload in the context of bereavement can manifest as multiple losses, conflicting demands, financial difficulties, and work-related stressors. These accumulating stressors can overwhelm bereaved individuals, significantly impacting their ability to cope effectively.

The Dual Process Model posits that effective coping with bereavement is dynamic, requiring a balance between emotional processing and active engagement in life-rebuilding activities (Neimeyer, 2016). By integrating loss and restoration orientations, this model offers a holistic framework that captures the multifaceted nature of coping with grief. It acknowledges that bereaved individuals need to process the emotional impact of their loss while also managing the practical exigencies that arise.

The Two-Track Model

The Two-Track Model, proposed by Rubin (1999), offers a bifocal perspective on responding to interpersonal loss. This model integrates biopsychosocial functioning and the ongoing relational bond with the deceased across the life cycle. It demonstrates an understanding of how loss affects an individual's overall functioning and the nature of their relationship with the deceased.

Track one

Biopsychosocial functioning focuses on bereavement's biopsychosocial impact. It examines how the death of a significant other affects biological, behavioural, cognitive, emotional, intrapersonal, and interpersonal aspects of the bereaved individual's life. This track evaluates negative and positive functioning changes, similar to assessments for other major life stressors, including levels of anxiety and depression, the ability to invest in life, the use of social supports, and general markers of functioning. The primary aim is to support the bereaved individual function and manage the new reality without the deceased (Malkinson et al., 2006).

> *Relational bond underscores the continuing bond's significance and strongly emphasises the bereaved individual's relationship with the deceased*
>
> *(Malkinson et al., 2006)*

Track two

Relational bond underscores the continuing bond's significance and strongly emphasises the bereaved individual's relationship with the deceased (Malkinson et al., 2006). It investigates how this relationship evolves post-loss and how the bereaved maintains bonds with the deceased. This track emphasises the importance of understanding the psychological organisation of the pre-loss tie and how it changes after death.

Grief Attachment Theory

John Bowlby's (1982) model of grief is rooted in attachment theory, and these attachment bonds shape an individual's emotional grief experience with the deceased. Bowlby (1982) asserts that grief is a typical reaction to loss and separation, characterised by a variety of feelings and actions as an individual comes to terms with the deceased's absence.

The theory categorises individuals into different attachment styles, including anxious-ambivalent, avoidant, disorganised, or secure, based on their early caregiving experiences, which influence how they cope with grief later in life (Bowlby, 2005). In grief, the perceived attachment signal activates the behavioural system, resonating with the individual's attachment style. These attachment styles shape affective, behavioural, and cognitive responses and coping strategies (Neimeyer, 2016), and they contribute to understanding love and loss (Machin, 2009), similar to maintaining a continuing bond with the lost object through these internal representations.

Klass (1988) stated that while Bowlby's model addresses the initial stages of grief and the process of detachment from the deceased, it does not fully account for the ongoing relationship with the internal representation of the lost object. However, this ongoing relationship is a significant aspect of the grieving process, reassuring individuals about the continued significance of their loved ones in their lives.

Task Models of Grief

William Worden (2010) posits that mourning necessitates the completion of four essential tasks to avoid impeding further growth and development. Worden's Task Model of Grief outlines specific actions individuals must take to cope with loss successfully (Humphrey & Zimpfer, 2008). These tasks include accepting the reality of the loss, processing the pain of grief, adjusting to life without the deceased, and finding an enduring connection with the deceased while moving forward. Worden's model provides a structured yet flexible framework for counsellors and therapists to support bereaved individuals.

Task 1: Accepting the reality of the loss (Yousuf-Abramson, 2020). This task requires both intellectual and emotional acceptance of the fact that the loved one has passed away. Intellectual acceptance entails acknowledging the loss, such as attending the deceased's funeral and burial. On the other hand, emotional acceptance involves coming to terms with the emotional impact of the loss, which can be more challenging.

Task 2: Processing the pain of grief. This task involves dealing with the pain that comes with the loss of a loved one. Worden (2010) acknowledges that the levels of pain experienced can vary from person to person but emphasises that feelings of discomfort are inevitable in the grieving process.

Task 3: Adjusting to a world without the deceased (Yousuf-Abramson, 2020). This task entails accepting the practical and emotional changes and navigating through them after a loved one's departure. Adjusting to a world without the deceased can involve various challenges, such as redefining roles and responsibilities, adapting to changes in daily routines, and finding ways to cope with the emotional void left by the loss.

Task 4: Finding an enduring connection with the deceased while embarking on the journey of life (Yousuf-Abramson, 2020). This task involves finding healthy ways to remember the deceased while embarking on a new life. This task focuses on creating an enduring connection with the deceased and integrating their memory into one's ongoing life.

Continuing Bonds Theory

The Continuing Bonds Theory (Klass et al., 1996) refers to the ongoing emotional connection and relationship that individuals maintain with a deceased loved one after their passing. This theory validates bereaved individuals' desire to honour and remember their loved ones, offering a compassionate approach to grief counselling. It views continuing bonds as a natural and healthy part of the grieving process.

The quality of the bereaved individual's relationship with the deceased before their passing can influence how they engage with continuing bonds and how it affects their grieving process

Continuing bonds influence how the bereaved individual appraises the loss and finds meaning after it, potentially aiding their coping process. This theory suggests that bereaved individuals can continue to feel connected to their loved ones through tangible actions and symbolic representations, including celebrating their loved one's birthday, visiting their grave, or keeping their belongings to maintain a connection (Boelen et al., 2006).

These factors highlight the complexity of continuing bonds in grief and demonstrate the positive or negative influence towards the bereaved individual's adjustment to the loss (Root & Exline, 2013). For example, how the bereaved individual perceives the continuing bond with the deceased, whether positive or negative, can impact their coping mechanisms and adjustment to the loss. The quality of the bereaved individual's relationship with the deceased before their passing can influence how they engage with continuing bonds and how it affects their grieving process.

Bereaved individuals' beliefs about the afterlife and the continuation of existence after death can shape their experience of continuing bonds and their coping strategies. The specificity of the expressions of continuing bonds, ranging from vague feelings of connection to more concrete manifestations like seeing visions of the deceased, can impact the effectiveness of the bond in helping the bereaved individual adapt to the loss.

Meaning Reconstruction

Niemeyer's meaning reconstruction is a framework underlying the concept of continuing a bond with a loved one who has passed away. It emphasises two key themes: first, the importance of making sense of the loss by the bereaved individual; second, finding meaning and integrating the experience of loss into one's own self-narrative (Thompson & Neimeyer, 2014).

Niemeyer emphasises the importance of allowing individuals in high-safety and low-avoidance environments to tell their story, recounting the event of the death and exploring the history of the relationship with the deceased using restorative retelling, imaginal conversations, memory boxes, and life imprints (Neimeyer, 2019).

Restorative retelling involves the bereaved client unpacking and discussing details of the dying process over multiple sessions, exploring the external, internal, and reflexive narratives. Imaginal conversations with the deceased are a therapeutic technique involving imagining the deceased as a helper in therapy. The aim,

in a symbolic way, is to confirm a secure attachment to the deceased. Memory boxes and life imprints support reflecting on the deceased's ongoing impact on the individual's sense of self. Techniques include using family photos to stimulate recollections, exploring the deceased's unique qualities, stories, and strengths, and using memory boxes to hold mementoes. This storytelling process enables individuals to make sense of the loss's impact and significance by integrating it into their ongoing life story (Neimeyer, 2019). These techniques aim to help bereaved individuals process their grief, find meaning in the loss, and rework their attachment to the deceased in a way that promotes healing and adaptation.

Pets

Grieving a pet loss highlights differences and similarities in the loss experience between a person and a pet. Society often places more value on and provides more significant support for human grief than pet loss, leading to potential feelings of disenfranchised grief for pet owners (Thompson & Cox, 2017). Additionally, pet owners may experience anticipatory grief before an impending loss due to pets' shorter lifespans, knowing that they will likely outlive their animal companions, which can impact the grieving process. The decision-making process around euthanasia is a unique aspect of pet loss (Barnard-Nguyen, 2016), where owners may have to make the difficult choice to end their pet's life, a situation not typically encountered in human loss experiences. Despite these differences, the emotional impact of losing a person or a pet can evoke similarly intense feelings of grief, sadness, and loss, highlighting the depth of the emotional connection between humans and their animal companions.

Individuals may maintain a sense of connection and bond with deceased loved ones and pets through memories, rituals, and dreams, demonstrating the enduring impact of these relationships on the grieving process

Individuals may maintain a sense of connection and bond with deceased loved ones and pets through memories, rituals, and dreams, demonstrating the enduring impact of these relationships on the grieving process. Human and pet loss scenarios share similar coping mechanisms, such as seeking social support and exploring ways to remember and cherish the relationship.

Death education

Death education is an essential component of training for professionals and aims to provide knowledge and skills to understand and support individuals with death, dying, and bereavement. Normalising discussions about death helps reduce the stigma associated with it and manage emotional responses to loss and death, ultimately fostering a healthier approach to grief and loss.

Signposting

Natural support, including family, friends, and others in the community, aids against psychological morbidity (Aoun et al., 2018) and is sufficient for most bereaved individuals (Shear et al., 2013). As research has demonstrated, parents who have lost children or individuals who have been bereaved by suicide or homicide are prone towards developing complicated grief Neimeyer, (2019).

Counsellors and therapists should recognise that their expertise and capacity for work are limited, and they should take responsibility for referring clients as appropriate to ensure the best service (IACP Ethics Committee, 2018). Therefore, effective signposting regarding emotional, practical and informational support is required. Within Ireland, there are a variety of appropriate services and resources, including grief counsellors and therapists, support groups, online resources, and community organisations specialising in bereavement support.

Conclusion

Grief is an intrinsic part of the human experience, embodying loss's profound pain and complexity. Understanding and addressing grief is essential for individuals and professionals, encompassing many emotional, cognitive, physical, and spiritual responses. The theories and models discussed provide crucial frameworks for comprehending and supporting the grieving process.

Acute and prolonged grief highlights the spectrum of responses to loss, from the intense initial reactions to the potential for a long-term disruption in daily functioning. These insights emphasise the importance of tailored interventions to support those struggling with grief, acknowledging the unique circumstances and relationships that shape each individual experience.

Understanding grief helps counsellors and therapists provide emotional comfort, practical help, and information on coping

strategies. These are essential components of comprehensive support systems to assist bereaved individuals in navigating the multifaceted grief journey. Most importantly, promoting the counsellor's and therapists' self-care as working with bereaved individuals is emotionally challenging (Shear & Gribbin Bloom, 2017).

In essence, grief symbolises the profound depth of our connections and attachments, portraying it as the inevitable cost of love. By embracing a compassionate, well-informed, and multifaceted approach to grief and loss, counsellors and therapists can promote and support bereaved individuals in finding ways to move forward. This holistic understanding of grief underscores the importance of continual learning and empathy in supporting those who face the inevitable reality of loss.

The quality of the bereaved individual's relationship with the deceased before their passing can influence how they engage with continuing bonds and how it affects their grieving process

Hamza Mahoney

Hamza is pursuing a master's in MSc Loss and Bereavement and holds a first-class honours degree in BA Counselling with Addiction. Hamza is passionate about addiction rehabilitation, bereavement, and loss. He has a private practice and delivers workshops on addiction, anxiety, mindfulness, self-harm and self-care in the digital world.

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REFERENCES

Aoun, S. M., Breen, L. J., White, I., Rumbold, B., & Kellehear, A. (2018). What sources of bereavement support are perceived helpful by bereaved people and why? Empirical evidence for the Compassionate Communities Approach. Palliative Medicine, 32(8), 1378–1388. https://doi.org/10.1177/0269216318774995

Barnard-Nguyen, S., Breit, M., Anderson, K. A., & Nielsen, J. (2016). Pet loss and grief: Identifying at-risk pet owners during the euthanasia process. *Anthrozoös*, 29(3), 421-430. https://doi.org/10.1080/08927936.2016.1181362

Boelen, P. A., Stroebe, M. S., Schut, H. A., & Zijerveld, A. M. (2006). Continuing bonds and grief: A prospective analysis. *Death Studies*, 30(8), 767–776. https://doi.org/10.1080/07481180600852936

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology* Review, 21(5), 705–734. https://doi.org/10.1016/s0272-7358(00)00062-3

Bonanno, G. A. (2009). *The other side of sadness: What the new science of bereavement tells us about life after loss*. Basic Books.

Bowlby, J. (1982). *Attachment and loss. Volume 3 Loss: Sadness and depression* (2nd ed.). Basic Books.

Bowlby, J. (2005). *A secure base: Clinical applications of attachment theory* (Vol. 393). Taylor & Francis.

Corr, C. A., Corr, D. M., & Doka, K. J. (2019). *Death and dying, life and living* (8th ed.). Cengage Learning, Inc.

Corey, G. (2009). Theory and practice of counseling and psychotherapy (8th ed.). Thomson Brooks/Cole.

Dodd, A., Guerin, S., Delaney, S., & Dodd, P. (2022). How can we know what we don't know? An exploration of professionals' engagement with complicated grief. *Patient Education and Counseling*, 105(5), 1329–1337. https://doi.org/10.1016/j.pec.2021.09.014

Hall, C. (2014). Bereavement theory: Recent developments in our understanding of grief and bereavement. *Bereavement Care*, 33(1), 7-12. https://doi.org/10.1080/02682621.2014.902610

IACP Ethics Committee. (2018, January 1). IACP code of ethics and practice for counsellors/psychotherapists. The Irish Association Code of Ethics. https://www.iacp.ie/iacp-code-of-ethics

Humphrey, G. M., & Zimpfer, D. G. (2008). *Counselling for grief and bereavement* (2nd ed.). SAGE Publications Ltd.

Klass, D. (1988). John Bowlby's model of grief and the problem of identification. *OMEGA - Journal of Death and Dying*, 18(1), 13–32. https://doi.org/10.2190/63PM-GEF7-3P13-473D

Klass, D., Silverman, P. R., & Nickman, S. L. (1996). *Continuing bonds: New understandings of grief*. Taylor & Francis.

Klass, D., & Steffen, E. (2018). *Continuing bonds in bereavement: New directions for research and practice*. Routledge.

Machin, L. (2009). *Working with loss and grief: A new model for practitioners*. Sage.

Malkinson, R., Rubin, S. S., & Witztum, E. (2006). Therapeutic issues and the relationship to the deceased: Working clinically with the two-track model of bereavement. *Death Studies*, 30(9), 797–815. https://doi.org/10.1080/07481180600884723

Nagoski, E., & Nagoski, A. (2020). *Burnout: The secret to unlocking the stress cycle*. Ballantine Books.

Neimeyer, R. A. (2016). *Techniques of grief therapy: Assessment and intervention*. Routledge.

Neimeyer, R. A. (2019). Meaning reconstruction in bereavement: Development of a research program. *Death Studies*, 43(2), 79–91. https://doi.org/10.1080/07481187.2018.1456620

Root, B. L., & Exline, J. J. (2013). The role of continuing bonds in coping with grief: Overview and future directions. *Death Studies*, 38(1), 1-8. https://doi.org/10.1080/07481187.2012.712608

Rubin, S. S. (1999). The two-track model of bereavement: Overview, retrospect, and prospect. *Death Studies*, 23(8), 681–714. https://doi.org/10.1080/074811899200731

Shear, M. K., Ghesquiere, A., & Glickman, K. (2013). Bereavement and complicated grief. *Current Psychiatry Reports*, 15(11). https://doi.org/10.1007/s11920-013-0406-z

Shear, M. K., & Gribbin Bloom, C. (2017). Complicated grief treatment: An evidence-based approach to grief therapy. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 35(1), 6–25. https://doi.org/10.1007/s10942-016-0242-2

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, 23(3), 197-224. https://doi.org/10.1080/074811899201046

Stroebe, M., & Schut, H. (2016). Overload. *OMEGA - Journal of Death and Dying*, 74(1), 96–109. https://doi.org/10.1177/0030222816666540

Supiano, K. P. (2018). The role of theory in understanding grief. Death Studies, 43(2), 75–78. https://doi.org/10.1080/07481187.2018.1456678

The Irish Hospice Foundation. (2020). *Adult Bereavement Care Pyramid: A national framework*. The Irish Hospice Foundation.

Thompson, B. E., & Neimeyer, R. A. (2014). *Grief and the expressive arts: Practices for creating meaning*. Routledge.

Thompson, N., & Cox, G. R. (2017). *Handbook of the sociology of death, grief, and bereavement: A guide to theory and practice*. Routledge.

Worden, J. W. (2010). *Grief counselling and grief therapy: A handbook for the mental health practitioner*. Routledge.

Yousuf-Abramson, S. (2020). Worden's tasks of mourning through a social work lens. *Journal of Social Work Practice*, 35(4), 367–379. https://doi.org/10.1080/02650533.2020.1843146

Book Review

Title: *Navigating Family Estrangement: Helping adults understand and manage the challenges of Family Estrangement.*

Author: *Karl Melvin*

Published: *2024*

ISBN: *978-1-03242-31-04 (Hardback)*
978-1-03242-30-67 (Paperback)
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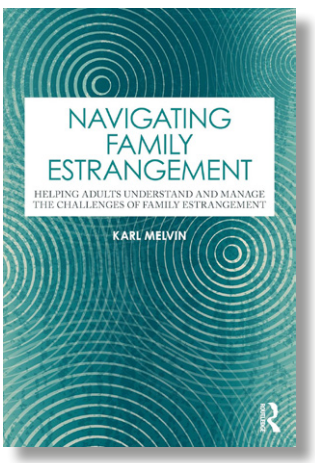
Price: *€23.79 (Paperback)*

Reviewed by: *Alan Kavanagh MIACP.*



Karl Melvin's book is an insightful, comprehensive, and empathetic exploration of a topic seldom discussed. Whether we admit it or not, we are all part of a family where conflict can arise. However, how and why does a person becomes estranged? Melvin's internationally renowned work is centred on educating professionals and supporting clients navigate Family Estrangement (FE).

Psychotherapists are often drawn to work in areas that they may have struggled with themselves. This is true for the author, as he begins the book by sharing his own lived experience of estrangement. What sets this book apart is Melvin's ability to speak directly to readers who are in the midst of estrangement, offering validation for the commonality of shame and rejection felt. In the introduction, I appreciate that the author writes a letter directly to both the professional and the estranged person and how this text might help them.

The book is divided into four parts and discusses key insights into the Estrangement Impact Triad, the Support Dilemma, and Karl Melvin's 'Estrangement Model Inquiry,' that elicits important details to each client in relation to their FE. A chapter is dedicated to five case studies that demonstrate the Estrangement Impact Triad and how to apply theory to practice. Moreover, Melvin provides practical steps and strategies to help individuals navigate their FE utilising the Estrangement Toolbox. These narratives acknowledges that FE does not have a one-size-fits-all solution, highlighting the uniqueness of each FE situation. By using multiple perspectives, readers are brought face-to-face with the pain and healing that accompanies estrangement. Melvin posits that family bonds are often romanticised in society but can also be sources of profound distress.

Each case study includes an Estrangement Map, that is the FE conceptualisation garnered from the Estrangement Inquiry Model. It takes the form of a table with seven columns for each of the seven factors and a row for each of the client's estranged parties. The factors cover the people directly or indirectly impacted, the type of estrangement (such as physical, emotional, cyclical, absent, inherited, and so on), the nature of the estrangement (i.e., voluntary or involuntary and whether mutual or not), as well as the duration, method, and reason for the FE.

The book delves into the Estrangement Impact Triad, which explores the emotional, mental, and social impacts of FE. Melvin explores these impacts in a multifaceted manner, providing a comprehensive framework for understanding the emotional labyrinth of FE. The book highlights the support dilemma, noting that friends and family may often lack understanding or even exacerbate feelings of guilt and shame, making professional help and a supportive network crucial. Through poignant anecdotes and theoretical explanations, Melvin enables readers to grasp various causes of estrangement and offers moments of hope, regardless of whether reconciliation is possible.

Virginia Satir accentuated healing the family as a means to heal the world. This concept resonated and prompted reflection on societal views and ingrained beliefs about family, such as "blood is thicker than water" and "you can choose your friends, but you can't choose your family." The harsh truth is that not all familial ties endure throughout life. There is social pressure to defend family ties, even when certain family members' actions are indefensible. This makes it essential to question the validity of maintaining damaging family relationships. And I wonder about comparisons and differences between individualistic and collectivist cultures in relation to FE.

In conclusion, Melvin advocates for widening the lens on the stigma and shame surrounding FE and to urge society to humanise a subject shrouded in silence. The author's compassionate approach to such a sensitive topic makes this a must-read for anyone dealing with or working with FE. With heartfelt prose, Melvin proposes that FE is not just an end, but sometimes a beginning and offers solace in knowing those estranged are not alone in their suffering.

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IACP Noticeboard

Cathaoirleach's Letter to Members Autumn 2024

Dear Member,

As I look back over the last seven years of my time on the Board, and write my last piece for the journal as your Cathaoirleach, I am amazed at how quickly the years have gone by, it seems like these years have passed in a flash and I wonder where they have gone.

As the saying goes:

"Time is a river that sweeps me along, but I am the river; it is a tiger that mangles me, but I am the tiger; it is a fire that consumes me, but I am the fire." - Jorge Luis Borges

We have spoken many times about the changes to our normal routines and work practices that have happened during this time including post-COVID and the advances in technology. Our membership has grown in numbers from 4,185 in 2017 with more than 6,000 today. We have such a respectful and vibrant community and I am so very proud to be part of it.

As I reflect, I'm reminded of this famous quote by Sir Isaac Newton,

"If I have seen further, it is by standing on the shoulders of giants."

The giants in the IACP are too numerous to mention, but I must acknowledge Ray Henry and Bernie Hackett. They are very special people to me that I admire and I learned so much from their leadership when they served as Chair. I was delighted to take the helm over from their very capable hands.

Our organisation continues to be successful because of you - the members, whose contributions have helped us grow on your shoulders and of course our volunteers who give of their time selflessly. We have 10 committees, five working groups, and eight regional committees, what great contributions all of you have made.

Cathaoirleach Séamus Sheedy and Ray Henry (MIACP) at The 8th Counselling and Psychotherapy Conference at TCD

The Board relies upon our Regional Committees to provide invaluable insights regarding what our members priorities are through their networking events, as well as CPD sessions. The regions with the guidance of Regional Director, Eamon Fortune provide members with a means to share positive experience/ feedback with their fellow members and provides a communication pathway.

The pursuit of research is a strategic initiative and very important to us for many years, the creation of the Research Committee, which had its first meeting in September 2019 has been a great achievement and has grown in leaps and bounds, we held our first online research event - 'Sharpening the Lens: Fresh Insights for Counselling and Psychotherapy Practice' in June 2023. It was a thought-provoking day for the more than 400 members. The IACP Member and General Public Surveys are another important research element. These surveys alternate every year and provide insightful data that has helped guide and inform our priorities as a professional body.

Cathaoirleach's Letter to Members

Cathaoirleach Séamus Sheedy, Dr Ted Remley, University of Holy Cross, Leas Cathaoirleach Jade Lawless, Dr Rebecca Michel, and CEO Lisa Molloy

I have had the pleasure of participating and representing the IACP at a number of conferences during my tenure. As you've heard me say before, conferences are an important way for us all to continue to learn and grow as therapists. One highlight of mine was the Social Justice Conference "Let the Voices Be Heard" in October 2019 that we co- hosted with the BACP and ACA. I'm particularly proud of our Annual Member Conferences and how they have grown and developed over the years offering amazing presentations from our members and other leaders in the fields of counselling and psychotherapy, and they are a wonderful opportunity for networking and sharing knowledge with my fellow members. I was delighted (and our post-survey results confirm you were too) with this year's conference 'Reclaiming Voices: Reshaping Therapeutic Dialogues Beyond Oppression', with the theme exploring colonialism in the counselling context with our wonderful international speakers and member lead discussion panels.

Over the last seven years we have engaged on your behalf with many lobbying and outreach activities, definitely too numerous to mention them all but top of my list have been; our ongoing-call for counselling supports in primary and secondary schools with the successful result of the Government funding the Counselling in Primary Schools Pilot (2023-2025), on matters such as the VAT exemption for our services, tax relief for medical expenses, and a range of health-related benefits under the PRSI system to include counselling and psychotherapy. We continue to bring our messages to Government with presentations to the Oireachtas and I have been privileged to attend.

In addition to lobbying on behalf of our profession we are continuously promoting members and the IACP nationally on radio, in the press, and through our strong social media presence and promotion of IACP members and counselling and psychotherapy. All of those efforts culminated last year with our national TV and radio campaign promoting The Find a Therapist Tool on iacp.ie. Our radio advertisements debuted in June last year on Today FM and RTÉ 2FM. The first-ever IACP TV advertisement aired on Virgin Media and RTÉ last summer and autumn which was a great success and I am very proud of. We continue to help inform the public about the benefits of therapy by creating resources such as varied content and member authored articles. One of my favourites is the Winter Blues video launched in January 2019 on iacp.ie where it is available and continues to provide assistance.

I speak of being a proud professional member of IACP, I feel so privileged to have worked alongside you our members, great volunteers, and our wonderful team in the office who make all this happen. The field of therapy

Cathaoirleach's Letter to Members

Pictured at the Oireachtas CEO Lisa Molloy, Cathaoirleach Séamus Sheedy and Leas Cathaoirleach Jade Lawless

is one which is continually evolving as you know and we were delighted to have submitted on your behalf a comprehensive submission outlining in detail our feedback, gathered from our members, on the CORU Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and for Psychotherapists.

As I come to the end of my term, we are delighted that our Volunteer Strategy Working Group was established by the Board as per our Strategic Plan Objective to Embrace the IACP Community and Nurture Member Connection. Our Equality, Diversity and Inclusion Committee supports the achievement of the IACP's core value in encouraging and embracing EDI. As you read this our inaugural EDI conference is due to take place later this month.

Another project we are thrilled to see finalised is our Collaboration with AsIAm, Thriving Autistic and Middletown Autism regarding development of the "Guidelines for Counsellors and Psychotherapists to work in a neuro affirmative way with Autistic Adult clients" and a CPD training programme to support the guidelines which launched in September.

I hope I have given a flavour of some of our achievements, the annual report in October will provide even more comprehensive information. I have enjoyed every minute of my time on the Board over the last seven years and in particular serving as Regional Director and Cathaoirleach, thank you for giving me this opportunity and for your support and confidence. It has been my pleasure and honour to be your Cathaoirleach and serving alongside the members of the Board and to lead and promote the professional standards and integrity of our profession as counsellors and therapists.

I feel humbled and honoured also to have worked with such special people, who have contributed so much to the fabric of IACP and make it the success it is, the great individuals who have been part of the Board, the members of all our wonderful committees, you the members who have contributed so much.

Last but by no means least a huge heartfelt thank you to our CEO, Lisa Molloy.

Lisa has such wisdom and professionalism and has been such a support that words cannot describe. A big thank you to the absolutely incredible team in the office, I have felt so special and supported and I will miss their great insights, dedication, leadership and friendship.

I look forward to seeing you all at the hybrid AGM in October in Dún Laoghire and online.

I'll sign off with this inspiring quote:

> *The greatest friend of truth is Time, her greatest enemy is Prejudice, and her constant companion is Humility*
>
> *- Charles Caleb Colton*

Beir bua agus beannacht.

Sincerely yours,

Séamus Sheedy.

Séamus Sheedy
Cathaoirleach, IACP

A Message from the Chief Executive Autumn 2024

Dear Member,

I'm delighted to be writing today to share with you the latest updates and news from the IACP national office for the last quarter. The summer months are ones that I cherish and look forward to because I have the opportunity to enjoy the brighter and longer evenings. I hope you all enjoyed the summer doing the things that make your heart smile.

This is also a time of planning and excitement in the office for our summer IACP activities and our busy calendar of events that the autumn season brings.

Building Partnerships

Speaking of events, in June Cathaoirleach Séamus Sheedy, Leas Cathaoirleach Jade Lawless, and members of the national office and I were delighted to represent the IACP at the 30th Annual BACP Research Conference in Birmingham, England. The conference theme was 'Enriching research, policy and practice with lived experience' and there were a wealth of stimulating research papers, workshops, and discussion panels featured on the robust agenda. The fascinating opening keynote discussion and presentations really brought home the importance of lived experience in research and policy to all those attending this enlightening conference. These international conferences provide a valuable opportunity to engage with our colleagues from around the world to share and exchange best practices in the fields of counselling and psychotherapy.

In the spirit of building partnerships, we are continuing to strengthen our strong relationships with our colleagues in the community of mental health services with meetings with our stakeholder network. During one such meeting I was delighted to welcome Stephanie Manahan, CEO and Emma Dolan, Clinical Director of Pieta to our offices in Dún Laoghaire. We had an interesting discussion around the areas of mutual interest and we explored future collaborative opportunities.

CEO Lisa Molloy with Pieta CEO Stephanie Manahan and Emma Dolan Clinical Director

Left to right: IACP staff Iwona Blasi and Ellen Kelly pictured with CEO Lisa Molloy, Leas Cathaoirleach Jade Lawless, and Cathaoirleach Séamus Sheedy at the BACP Research Conference

A message from the Chief Executive

IAC Conference

Continuing our efforts to build our professional community and promote the benefits of therapy, in July Séamus and I travelled to Naples, Italy to attend the International Association for Counselling's conference, Counselling Around the World: Promoting Well-being and Resilience in Individuals and Communities. We attended engaging conference sessions as well as meetings with our counterparts from counselling associations around the world. I'm sure you'll be interested to read Séamus' detailed account on page 45. I am honored to serve on the IAC Europe's interim leadership team and to represent the profession in Ireland at international level. At the conference I presented with my leadership team colleagues on the progress of the regulation of the counselling profession across Europe.

CEO Lisa Molloy (in white) presenting in Naples following her appointment to the IAC Europe's interim leadership team

8th Counselling and Psychotherapy Conference

Continuing in the spirit of collaboration, the 8th Counselling and Psychotherapy Conference: Advancements and Discoveries in Counselling and Psychotherapy organised by the IACP, the University of Holy Cross, New Orleans and DePaul University Chicago was held at Trinity College Dublin on 31st July. As in past years it was a sold-out and engaging event. I want to personally thank and recognise Dr Ted Remley of the University of Holy Cross on his retirement from organising this event. Ted has spent countless hours dedicated to our long running joint conference and nurturing the close ties between the United States and Ireland. For more on the conference see page 38.

Member Survey

As your professional body we are dedicated to promoting and advancing the profession of counselling and psychotherapy. One of the tactics we use to ensure we're focusing on what's important to you is to ask you. Every other year we partner with Ipsos B&A to develop a member survey. Thank you very much to all of you that took part and shared your views and opinions, there was as usual a very good response rate. We received robust data for analysis which is currently underway and will share highlights with you in the annual report.

School Counselling Event

As you know the IACP has been lobbying and advocating for counselling and psychotherapy in schools for many years. We were delighted by the announcement of a pilot programme of counselling

The IACP Team - Innovation & Development Manager Iwona Blasi, Member Care Officer Lia Wright, Executive Administrator Aidan O'Leary, Garda Vetting Officer Carla Kiely, and CEO Lisa Molloy

supports for children in primary schools and the extension of the pilot for another year.

We were pleased to collaborate with the Department of Education to host an online event for members on how to apply to be a member of the School Counselling Pilot therapist panel with Dr Pól Bond, Senior Educational Psychologist, NEPS. We were very encouraged to see your interest with 100 members signing into Mastering Your Application for the School Counselling Pilot - Information Session. This well-attended event explored everything you needed to know to apply to be a member of the School Counselling Pilot therapist panel. I was happy to facilitate the session, your questions and insights were very beneficial to the Department.

As you are aware, the pilot programme is currently in place across seven counties. We have worked closely with the Department of Education in outreach efforts to recruit therapists for the panels. In fact, I'm proud to share that the majority of counsellors and psychotherapists providing support via this pilot to schoolchildren are IACP members. We believe that early invention works and yields favorable outcomes for children.

The IACP envisions that the role of school therapist will become a new and exciting career path and opportunity for our members. Not only will counsellors and psychotherapists in schools meet the mental health needs of children and young people it will help further weave the profession into the fabric of school life and the wider community and create new jobs. The information session is now available to view in the IACP Online CPD portal.

Conversion Therapy MoU

The IACP and colleagues from the College of Psychiatrists of Ireland and the Psychological Society of Ireland, joined together in renouncing the practice of conversion therapy, which seeks to change or deny a person's sexual orientation and/or gender identity at a Memorandum of Understating signing on 12th July. LGBT Ireland was the Supporter Organisation of the MoU. I want to especially thank Cathaoirleach Séamus Sheedy for his many contributions made to the working group that developed the MoU. We are honoured to formalise our commitment to ending this harmful and unethical practice by being one of the first organisations to sign the MoU.

Leas Cathaoirleach Jade Lawless pictured with Jim Hutton MIACP, Chair of the IACP's EDIC Committee at launch of the new MoU on 12th July

Jade Lawless, Vice-Chair represented the IACP and spoke at the signing at Trinity College Dublin and said during her remarks, "The IACP stands with our colleagues, in renouncing the practice of conversion therapy, which seeks to change or deny a person's sexual orientation and/or gender identity. The IACP supports our member counsellors and psychotherapists to provide therapy using highly ethical practice standards that are appropriately informed and which seek to prize individuality and autonomy in the spirit of our caring and empathic profession. We believe that conversion therapy creates lasting psychological damage and must not be practised in Ireland or in any country." Jade was joined at the event by Jim Hutton, Chair of IACP's Equality, Diversity, and Inclusion Committee and she cited the committee's important work during her speech.

In closing, I want to sincerely thank Séamus Sheedy for his tremendous service as our Cathaoirleach for the last two years and his seven years on the Board of Directors. Séamus has been an enthusiastic and dedicated leader and advocate of IACP members across the globe and at home. I truly appreciate all of his guidance, wisdom, professionalism, good humor, and his love of the profession and our members, it is truly boundless. I will never forget the energy and all of the bualadh bos Séamus brought to every event and speech. Thank you from the bottom of my heart.

Yours sincerely,

Lisa Molloy
Chief Executive, IACP

IACP Noticeboard

Eighth Annual Counselling & Psychotherapy Conference

The Eighth Annual Counselling & Psychotherapy Conference hosted by the IACP and our American partners from DePaul and Holy Cross Universities was held on the 31st July in Trinity College Dublin. This year's theme '*Advancements and Discoveries In Counselling and Psychotherapy*' provided an interesting framework for the 15 fascinating presentations from the IACP members and our visiting colleagues from the United States. A lively networking event where discussions around the topics covered during the day-long conference was held after the closing feedback session panel.

Anita Lynch (MIACP) delivers her talk, Reclaiming Sexual Empowerment after Surviving Childhood Sexual Abuse from the Perspective of Therapists in Private Practice in Ireland

Dan Boland (MIACP) discusses The Integration of Science and Spirituality

Kevin Bailey (IACP Student Member) offers his expertise on The Internal Supervisor – Creating and Maintaining Equilibrium

Equality, Diversity and Inclusion Committee Vice Chair Ravind Jeawon and member Ejiro Ogbevoen

Jim Hutton (MIACP) presents Addiction How Reliably Informed Can We Be To Work and Walk Well With Our Clients

CEO Lisa Molloy presents Dr Pat Thomas, University of Holy Cross, with a token of IACP's appreciation for her numerous contributions over the years to the success of the annual conferences

Liz Quish, (MIACP) makes a point during her talk, An Exploration of the Benefits of Integrating Sand Tray Therapy in Clinical Practice

Ray Henry, (MIACP) and Ashley, University of Holy Cross attend the networking the networking reception

Dr Rebecca Michel, DePaul University, presents Séamus Sheedy with a certificate recognising his contributions to the conference as an IACP board member for the last seven years on the occasion of his last conference as Cathaoirleach

Dr Aaron Norton, University of South Florida; Ericka Amador, California State University; Anita Lynch, (MIACP); Sandra McQuoid, (MIACP); and Leas Cathaoirleach Jade Lawless reflect on the day during the closing panel discussion

IACP Noticeboard

Sandra McQuoid (MIACP) presents, Walking the Dark Path - The Lived Experiences of Psychotherapists Working in Crisis Intervention and Facing the Possibility of a Client with Suicidal Ideation

Cathaoirleach Séamus Sheedy presents Dr Ted Remley, University of Holy Cross, with a thank you gift for his many years of leadership and friendship in organising our annual conference held at TCD for the last eight years

IACP members catching up at the conference

Heike Felzmann (MIACP) presents her talk entitled The Chatbot Will See You Now

Professor Suzanne Whitehead (seated far right), and her students and colleagues from California State University, USA

Maureen Levy (MIACP) gives her presentation called Just Say Yes An Introduction to Applied Improvisational Comedy For Therapists and Their Clients

IACP members Anita Lynch and Sandra McQuoid

IACP members looking forward to an interesting day

Raymond Walsh (MIACP) Rationalisation Over Rumination, Using Stress in Your Favour and Combatting the Manipulation of the Mind

IACP AGM 2024

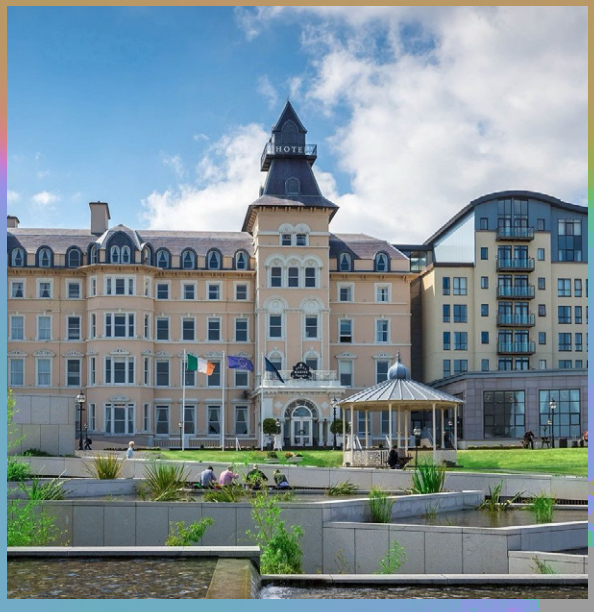
The IACP Board of Directors cordially invites you to attend the 2024 Annual General Meeting on Friday 18th October.

It will be a hybrid AGM again this year, in-person at the Royal Marine Hotel in Dún Laoghaire, Co. Dublin or online.

The AGM is free for members to attend and will be in session from 14:00 onwards.

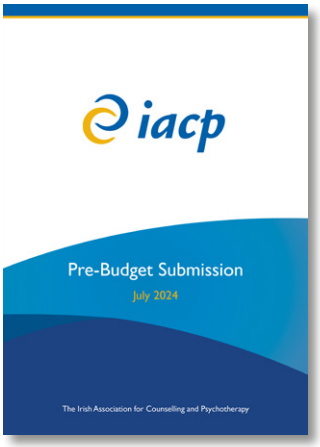
The AGM is a wonderful opportunity for members to keep up to date on current policies, standards, and upcoming activities. The AGM is also a great way to catch up and connect with fellow members, Board of Directors, and IACP staff.

Book your place on the events page at www.iacp.ie



IACP Noticeboard

IACP Pre-Budget Submission



Our lobbying and outreach initiatives are in full gear and we launched our Pre-Budget Submission 2025 in late July. In fact, we received a positive response from Minister of State for Mental Health and Older People Mary Butler noting her awareness of the inconsistencies in how VAT policy is applied to the counselling and psychotherapy professions and her willingness to discuss the matter with her colleagues in the Department of Finance.

The IACP is calling on the Government in Budget 2025 **to increase investment in counselling and psychotherapy** with the ultimate aim of **establishing universal access to mental health supports for all people**.

To support the achievement of this goal the IACP has identified three priorities for the 2025 budget.

1. **VAT Exemption for Counselling and Psychotherapy Services:** Provide equitable treatment of mental health professionals and improve access to essential mental health supports by reducing the cost of therapy.
2. **Tax Relief Fairness:** Expand tax relief for counselling and psychotherapy to be deemed an eligible expense in line with other health services.
3. **School Counselling Expansion:** Provide all primary and secondary students access to counselling services in schools.

Mental Health Reform Pre-Budget Submission

The IACP is an active member of Mental Health Reform and we join with our colleagues to call on the Government to prioritise funding for mental health in the upcoming budget.

The "**I am a Reason**" campaign highlights the many reasons why the Government should invest in mental health in Budget 2025, including the importance of timely, high-quality mental health supports and the need for sustainable and multi-annual funding for the voluntary and community sector.

Funding is essential to progress the implementation of our national mental health policy Sharing the Vision, to support early intervention and prevention, and to improve access to mental health services for communities across Ireland.

Thanks to all of our members that have engaged with our online portal and sent emails to your TDs and Senators in support of our priorities.

CEO Lisa Molloy attending the launch of the Mental Health Reform Pre-Budget Submission campaign and the "I am Reason" campaign launch.

Research Highlights

IACP Research Conference – September 25th 2024

We are delighted to announce our upcoming **Research Conference - Supporting Lives, Sustaining Ourselves: Exploring Attachment, Suicidality and Burnout which will take place online via Zoom on September 25th 2024 (10:00am – 2:00pm)**. The date coincides with National Psychotherapy Day - promoting mental well-being and awareness of the benefits of therapy.

Professor Una McCluskey

Leo Muckley

Dr Stephanie Finan

The keynote speaker is **Professor Una McCluskey** who will present **Exploring the Dynamics of Attachment in Adult Life**. In addition to this IACP pre-accredited member **Leo Muckley** will present **Pluralistic Psychotherapists' and Counsellors' Experiences of Working with Actively Suicidal Clients**, while **Dr Stephanie Finan** (MIACP) will present **What it Costs us – Exploring Psychotherapists' Experiences of Burnout**.

There will be a brief Q&A after each presentation, followed by break-out rooms for group discussions and a wider discussion with the panel at the end.

The Research Conference will be facilitated by IACP Research Committee Chair Aisling O'Connor and Vice Chair Dr Caitriona Kinsella.

To book a place (Free, CPD) please visit the Events page of iacp.ie

Research Journal Club

IACP's **Research Journal Club** is going from strength to strength. The sixth club evening took place in early summer, at which we discussed the research paper "**Older adults' experience of psychological therapy**" by Maureen McIntosh and Catherine Sykes from ***Counselling Psychology Review*** Vol. 31, No. 1, June 2016. Joining Research Committee facilitators Aisling O'Connor (Chair) and Dr Caitriona Kinsella (Vice Chair) was IACP member Agapi Kapeloni who shared insights from her research on encountering older adults in psychotherapy and from her co-authored paper published in the ***European Journal of Psychotherapy & Counselling*** in 2022. It was an excellent, highly attended event and feedback from participants on the evening shows great levels of satisfaction (97%) and enjoyment overall. A couple of comments from the feedback survey may help to describe what the RJC is like – for those who may wish to consider attending in the future:

> **Presenters were Excellent and content Superb. A most lovely atmosphere also as everyone exchanged their thoughts - a very enriching event …**
>
> **I thoroughly enjoyed the event. It was wonderful to hear the presentations and enjoy sharing and hearing from peers on this topic. I thought it was very safely facilitated and the presentations were excellent. These events make me proud of IACP! We have such wisdom and heart for our profession and our clients and we have the ability to hear from each other and learn with humility and wisdom …**

Our seventh Research Journal Club (Online, Free, CPD) will take place in the latter part of the year – following on from our main Research Conference in September. To join us for this, book a place by visiting the Events page of iacp.ie in early November.

IACP Noticeboard

Research Journey – Path to Publication Video Resource

For IACP members who have had their research published in Journals or books - what was their path to publication like? How and why did they become interested in the chosen area of research in the first place? How did they approach the publication process? What were the moments of surprise or disappointment along the way? Was perseverance important? How did they feel at the end of the process?

In a fresh initiative, we've invited members into a conversation about their research journey and path to publication. This will be available as a video resource for all IACP members to view shortly. We hope that this, along with the excellent written pieces posted in the Research Corner, will serve to increase awareness about the publication process and help to demystify it to an extent, as well as facilitating engagement with research carried out by IACP members.

If you have any questions or suggestions – or if you would like to be considered for writing a piece about your Path to Publication, please email research@iacp.ie

Member Survey 2024

Thanks to all who took the time to participate in IACP's Member Survey 2024 carried out by Ipsos B&A in the early part of the summer. We had a strong response rate of 16% offering robust insights from the data. Highlights from the survey will be shared in the IACP Annual Report 2024 in October and the full member survey report will be available to all on the website.

BACP Research Conference – May 2024

BACP's 30th Annual Research Conference took place in Birmingham in May. With a conference theme of ***Enriching research, policy and practice with lived experience*** there was a wealth of stimulating research papers, workshops and discussion sessions to attend. The excellent opening keynote discussion and keynote presentations really brought the importance of lived experience in research, policy and practice to all delegates. Autoethnography, co-production and creative methodologies were key features of many sessions, offering fresh and exciting insights.

Dr Ellen Kelly Research Lead, Karen Foran – PhD Researcher and BACP Accredited Psychotherapist and Iwona Blasi, Innovation and Development Manager at the BACP Research Conference

Left to right: CEO Lisa Molloy, Cathaoirleach Séamus Sheedy, Natalie Bailey, BACP Chair, and Leas Cathaoirleach Jade Lawless at the BACP Research Conference

A Letter from the IAC Conference – Naples, Italy

Dear Members,

From the 28th to 30th June, Lisa Molloy our CEO and I had the pleasure of representing you our members at the International Association of Counselling Conference, it was held in Naples Italy and hosted by AssoCounseling. The IACP is an active member of this important and influential organisation.

Increasing our cultural competency within the IACP continues to be part of our strategic plan and it is now more important than ever as our profession goes from strength to strength as we are delighted that our membership continues to grow.

Dr William A. Borgen, President IAC opening the Conference

About the IAC
The International Association for Counselling is the world body for the counselling profession. Established in 1966, the IAC is an International Non-Governmental Organisation with United Nations consultative status. The IAC advances the development of counselling in order to improve people's lives and well-being. The IAC and its members strive for human rights and the inclusive, sustainable development of our profession through the promotion of counselling, best practice and international cooperation.

About AssoCounseling
AssoCounseling is an Italian professional association which welcomes any counsellor professional that meets the criteria established by statute and the ethical principles of the association. The organisation was founded July 8, 2009 in Florence, Italy and represents about 3,000 counsellors.

Conference Highlights
The experience of the conference was for us invaluable. It continues to shine more light on the whole area of counselling and psychotherapy from an international perspective. I hope I can capture as much of the experience of the conference, the atmosphere that existed, and the content that was provided in this short column.

The Official Opening of the Conference was by Dr Alessandra Benedetta Caporale, President of

IACP Noticeboard

AssoCounseling and Dr William A. Borgen, President of the IAC. After the opening we had a fascinating and insightful keynote address from Roberta Metsola, President of European Parliament, elected in January 2022. She was first elected to the European Parliament in 2013, becoming one of Malta's first female Members of the European Parliament. Prior to her election as a MEP, President Metsola served within the Permanent Representation of Malta to the European Union and later as the legal advisor to the High Representative of the European Union for Foreign Affairs and Security Policy.

The next keynote speech was "Look Within and Find Your HERO!" By Dr Christine Suniti Bhat, President Elect, American Counselling Association. Dr Bhat is the elected 73rd President of the ACA and is a professor and Chair of the Department of Counseling & Higher Education at Ohio University.

My summary of this keynote: Fred Luthans (2002), who pioneered the concept of Psychological Capital [PsyCap] would agree with Mariah Carey, "Look Within and Find Your Hero" which was the title of his talk. PsyCap is a positive state that is comprised of the psychological assets of Hope (persevering toward goals and, when necessary, redirecting paths to goals in order to succeed); Efficacy (having confidence), (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; Resilience (when beset by problems and adversity), sustaining and bouncing back and even beyond to attain success; and Optimism (making a positive attribution about succeeding now and in the future); (Luthans et al., 2007, p. 3). Known by the acronym HERO, PsyCap has been validated internationally. It falls in the middle of the trait-state continuum. This makes PsyCap amenable to interventions focused on increasing it, or it can decrease when we become discouraged or beaten down by setbacks. PsyCap development is valuable for both counsellors and clients as we face the challenges in life that we inevitably encounter.

Next Keynote Speech "Supporting Communities Affected by Adversity: The Work of WHO in Developing and Implementing Scalable Psychological Interventions around the World" by Dr Kenneth Carswell, World Health Organisation. His background is in clinical psychology and he is a Mental Health Specialist

Keynote address from Roberta Metsola, President of European Parliament

with the WHO Department of Mental Health and Substance Use in Geneva. He is the departmental focal point for innovation, digital mental health and scalable psychological interventions. He has been centrally involved in the development, testing, and implementation of the WHO scalable psychological interventions for populations affected by adversity.

Summary Highlights:
Psychological interventions play a vital role in promoting mental health, well-being and resilience in communities affected by adversity. The WHO recognises the importance of these interventions in addressing various mental health challenges globally, in particular by using task- sharing approaches. This presentation provided an overview of the work in the areas of the WHO Psychological Intervention Implementation Manual and various evidence based psychological interventions that are open access, available in multiple languages and are designed for use in a range of settings including humanitarian emergencies. It will provide examples of wide scale implementation and possible future directions. The presentation was thought provoking and generated much discussion with our colleagues.

Natalie Bailey, BACP Chair; Dr Phil James, BACP Chief Executive; Séamus Sheedy, Cathaoirleach; Jodie McKenzie, CEO ACA at the IAC Roundtable

This conference also afforded us the opportunity of meeting even more new and interesting people from the counselling and psychotherapy fields and we continue to build on the wonderful links from other associations we have already developed. I must say we truly learn so much from these international occasions and organisations that these conferences bring together.

Hopefully the IACP will continue to be instrumental in playing a major role in the future of IAC and counselling through its involvement in this organisation. Both Lisa and Nicole Mac Dermott, our communications supervisor in the office already contribute to the IAC by serving on the government and advocacy working groups.

Both Lisa and I were delighted to have been part of the IAC General Assembly (for IAC members only) and the IAC Associations' Roundtable and participated in meetings over the few days with other world-wide associations to continue the wonderful collaboration that has been built up over the last 43 years within the IAC.

On Sunday, the day started off with "The Future of Counselling in Europe" with Dr Dione Mifsud, IAC.

Next up was the "IAC-Europe presentation" from the IAC-Europe Interim Leadership Committee which Lisa is a member of and she spoke about the developments happening; such as laying the foundation for a common European definition of the professional profile of the counsellor. It is also hoped that the IAC Europa will be established in Brussels, the European branch of IAC. We hope that this will open up new and interesting perspectives at a European level and will help countries like Ireland and others to strengthen the profession.

Meetings with International Associations

We met with the British Association for Counselling and Psychotherapy's Dr Phil James, Chief Executive Officer and Natalie Bailey, Chair who continue to give us invaluable support and we collaborate in many ways as you know. We then went on to meet Canadian Counselling and Psychotherapy Association representative Carrie Foster, CCPA/ACCP who we also have a great relationship with and share innovations and best practices between our two countries. We also met with Australian Counselling Association's Jodie McKenzie, CEO, these are invaluable meetings giving us opportunities to discuss many issues and challenges facing counselling and psychotherapy at both local and global levels. We share many resources which are of benefit to you our members. They are too numerous to mention but one of those that comes straight to mind as you know, we had the joy of Jodie speaking at our conference in Sligo earlier this year.

I look forward to sharing more of my learnings from this fabulous conference when I see you next.

Kind regards from Naples,

Séamus Sheedy.

Séamus Sheedy

IACP Noticeboard

IACP in the Media

22/07/2024 – The KCLR Daily with Brian Redmond featuring Clive Rooney discussing body positivity during the summer months

13/07/2024 – Conversion therapy not supported by evidence, healthcare bodies warn – Irish Examiner

13/07/2024 – Law banning conversion therapy unlikely – Irish Times

13/07/2024 – Mental heal/experts oppose conversion therapy, insisting 'there is no place for it' – Irish Independent

13/07/2024 – Irish mental heal/organisations sign memorandum renouncing 'conversion therapy – theoutmost.com

12/07/2024 – Anyone else lost their tolerance for gut-wrenching TV shows? featuring Maxine Walsh – The Herald and Irish Independent

30/06/2024 – It's Good To Talk: Stress and how to manage it featuring Tracy McKeague – inishlive.ie

21/06/2024 – LGBTQ+ people still need support despite progress here in Ireland by Michael Ryan – The Sun (ROI)

14/06/2024 – Counsellor honoured with award featuring member Patricia Wilson – Kilkenny People

06/06/2024 – Exam anxiety: Advice for parents featuring Melissa Daly – The Avondhu

05/06/2024 – Kathleen honoured with Northeast Regional Award – Drogheda Independent

03/06/2024 – Moate psychotherapist receives regional award featuring Anita Lynch – westmeathindependent.ie

03/06/2024 – Are you burning out? Here are the signs to watch out for featuring Linda Breathnach – thejournal.ie

01/06/2024 – Moate psychotherapist receives regional award featuring Anita Lynch in Westmeath Independent

31/05/2024 – Turning towards trauma by Leo Muckley – Cork People

28/05/2024 – 'Slamming doors is a regular thing in our house' featuring IACP Cathaoirleach Séamus Sheedy – Irish Times

21/05/2024 – Ardrahan woman honoured with IACP Western Regional Award featuring Michelle Caulfield – Connacht Tribune

14/05/2024 – Belonging ranks very high in list of human needs featuring Pádraig O'Moráin – Irish Times

09/05/2024 – Ennis Psychotherapist honoured for research featuring Jayne Leonard – Clare Echo

07/05/2024 – To therapy or not to therapy by Leo Muckley – West Cork People

03/05/2024 – Flanagan honoured for outstanding achievement in Counselling and Psychotherapy Field featuring Audrey Flanagan – Dublin People

28/04/2024 – How to praise children: Don't link ideas of being 'good' with being quiet and compliant, featuring Leas Cathaoirleach Jade Lawless – Irish Times

26/04/2024 – Addressing anxiety by Leo Muckley – West Cork People

thejournal.ie

THE Sun

westcorkpeople

Irish Independent

THE Clare Echo

THE IRISH TIMES

IACP CPD and Events (Full Details available at www.iacp.ie)

New Online CPD for IACP Members on IACP Online CPD Portal:

IACP Annual Conference 2024 Recordings (5 CPD) €20

This online CPD includes six recordings from the IACP Conference 2024 'Reclaiming Voices: Reshaping Therapeutic Dialogues Beyond Oppression', with the theme exploring colonialism in the counselling/psychotherapy context - four recorded Speaker Presentations and also - 2 Panel Discussions with Q&A.

Creative Approaches In Supervision: Mask Work (1CPD) FREE

Creative Approaches In Supervision Series created by IACP Accredited Member and Supervisor Mike Hackett.

Mask work is a highly experiential creative process by which supervisors can assist supervisees in understanding their professional persona in their work with clients, and the potential gap between their personal and professional selves.

Introducing Couples Therapy by Karen Murphy (2CPD) FREE

Couples can benefit from counselling at all stages of their relationship. At the early stages of the relationship it can be really beneficial to address each person's core needs and identify any areas of difference. This can ensure that you are entering a relationship openly aware of areas of potential difficulties. As the relationship progresses counselling can help you find ways to identify and constructively work on conflicts.

This CPD includes two parts:

Part 1 - Conceptualising Relationships

Part 2 - Assessment and Interventions

Schools Counselling Pilot Information Session with Dr Pól Bond (1CPD) FREE

This well-attended event explored everything you need to know about successfully applying to be a member of School Counselling Pilot therapist panel. It was facilitated by Dr Pól Bond, Senior Educational Psychologist, NEPS and Lisa Molloy, IACP's Chief Executive Officer. The presentation was recorded and it is available on the IACP Online CPD portal.

Supervision Skills Series: Reflective Practice (2CPD) FREE

Enhancing Supervisee Reflection using the Rolfe Model by IACP Accredited Member and Supervisor - Mike Hackett is a new CPD for IACP Supervisors.

The Rolfe Model is perhaps the simplest yet one of the most effective reflexive models for use in supervision. With only three questions, and only five words this session will explore practical uses in supervision and the many benefits it offers in the supervisory encounter.

CPD: PLEASE LOG IN TO THE IACP MEMBER AREA ON THE IACP WEBSITE AND CLICK ON ONLINE CPD, WHICH WILL GIVE YOU ACCESS TO THE IACP CPD PORTAL.

Free Online Events for Members in September

Mandatory Reporting Obligations - Refresher training for IACP Members (2 CPD)

As per previous notifications, on the 12th December 2023, the Court of Appeal ruled on 8th December 2023 that child protection legislation does not require Health Service Executive therapists and other mandated people to report to Tusla when an adult discloses historic child abuse, provided there is no reasonable suspicion that a child is at risk.

This decision is in relation to the High Court ruling - McGrath v. The Health Service Executive [2022] IEHC 541, which called for retrospective mandated reporting of abuse to a child to be made even without client consent or without the details of alleged perpetrator.

This important ruling follows the IACP Mandatory Reporting Training provided to members in 2023 and previous information sent to members in August 2023 in relation to the High Court case.

Based on this important ruling, we have engaged with Fieldfisher Solicitors to provide a refresher training for the IACP Members on this topic. The training will take place on September 3rd 2024, 10:00am - 12:00noon with 2 CPD hours.

Data Protection Commission Ireland - Part Two

Presenter: Data Commission Ireland Facilitator: Hannah Furey - Accreditation Department Supervisor

This event will take place online on Zoom on 6th September 2024

Event Outline:

This webinar is the second in a two-part series which focuses on FAQs IACP has received from our members relating to Data Protection and GDPR. A review of the information shared during the first part of the series is planned, as well as a step-by-step guide of what to do when there has been a data breach. There will also be an opportunity to ask questions via the chat to the DPC directly.

EVENTS CAN BE BOOKED THROUGH THE IACP WEBSITE AND CLICKING ON EVENTS.

IACP Accreditations

First Time Accreditation

Claire Ambrose	Co. Clare	Anne Fenlon	Co. Wexford	David McSweeney	Co. Kerry
Declan Balfe	Co. Dublin	Silvia Ferreira	Co. Dublin	Robert Mooney	Co. Dublin
Katherine Bree	Co. Sligo	Eimear Finnegan	Co. Galway	Peter Murphy	Co. Louth
David Brophy	Co. Kildare	Sarah Francis	Northern Ireland	Lisa O'Dornan	Co. Tipperary
Joan Byrne	Co. Kilkenny	Jessica Gallagher	Co. Dublin	Catherine O'Brien	Co. Dublin
Ann Cadogan	Co. Wexford	Maeve Geraghty	Co. Dublin	Barbara O'Connell	Co. Cork
Justin John Carroll	Co. Wexford	Maureen Gleeson	Co. Tipperary	Stephen O'Connell	Co. Cork
Veronika Ceita	Co. Louth	Ursula Graham	Co. Dublin	Aileen O'Farrell	Co. Wexford
Viviane Chambers	Co. Dublin	Arlene Gray	Co. Galway	Yasmin O'Keefe	Co. Down
Kay Coakley	Co. Dublin	Neasa Greene	Co. Dublin	Marcus O'Sullivan	Co. Cork
Michelle Cranny	Co. Kildare	Cjhelle Griffiths	Co. Wicklow	Carol Power	Co. Wicklow
Olivia Creegan	Co. Meath	Aurora Guilfoyle	Co. Louth	Gráinne Redmond	Co. Cork
Kara Cronin	Co. Cork	Pamela Halton	Co. Meath	Deirdre Reilly	Co. Meath
Mary Bridget Crowley	Co. Cork	Tony Hanrahan	Co. Dublin	Michelle Reilly	Co. Dublin
Triona Delicato	Co. Dublin	Anne Marie Hayes	Co. Tipperary	Deirdre Ronan	Co. Galway
Loreena Dowdall	Co Carlow	Helen Hill	Co. Offaly	Aisleen Sivertsen	Co. Dublin
Christine Dowling	Co. Carlow	(Thomas) Vincent Howard	Co. Cork	Orla Stafford	Co. Meath
Susan Dowling	Co. Dublin	Christina Hughes	Co. Dublin	Peter Stout	Co. Cork
John Dunlea	Co. Cork	Caroline Irwin	Co. Dublin	Ciara Tangney	Co. Kerry
Ann Marie Durkan	Co. Dublin	Alison Keenan	Co. Wicklow	Yvonne Tiernan	Co. Galway
Barbara Dutton	Co. Dublin	Mark Kennedy	Co. Kildare	Cady Walker	Co. Dublin
Caroline Earley	Co. Dublin	Bernadette King	Co. Meath	Beverley Webster	Co. Wexford
Alexandra Fagan	Co Dublin	Pamela Lannon	Co. Leitrim	Clare Williams	Co. Wexford
Adrian Fahy	Co. Tipperary	Kamila Linstedt	Co. Westmeath	Brian Williams	Co. Galway
Elisabetta Favilli Coonan	Co. Dublin	Linda Lunardi	Co. Dublin	Joanne Woodlock	Co. Tipperary
Shane Fay	Co. Dublin	Sean Maguire	Co. Meath		
Mary Feehan	Co. Cork	Helen McGeough	Co. Galway		

Newly Accredited Supervisors

Ann Cadogan	Co. Wexford	Debbie Hegarty	Co. Cork	Barbara O'Connell	Co. Cork
Greta Carroll	Co. Dublin	Amber Kavanagh	Co. Kerry	Thomas O'Connor	Co. Cavan
Deirdre Condon	Co. Kildare	Kathleen Mulhern	Co. Kildare	Mary O'Farrell	Co. Clare
Margo Foley Minihane	Co. Cork	Dympna O'Callaghan	Co. Cork	Anne Marie Toole	Co. Dublin