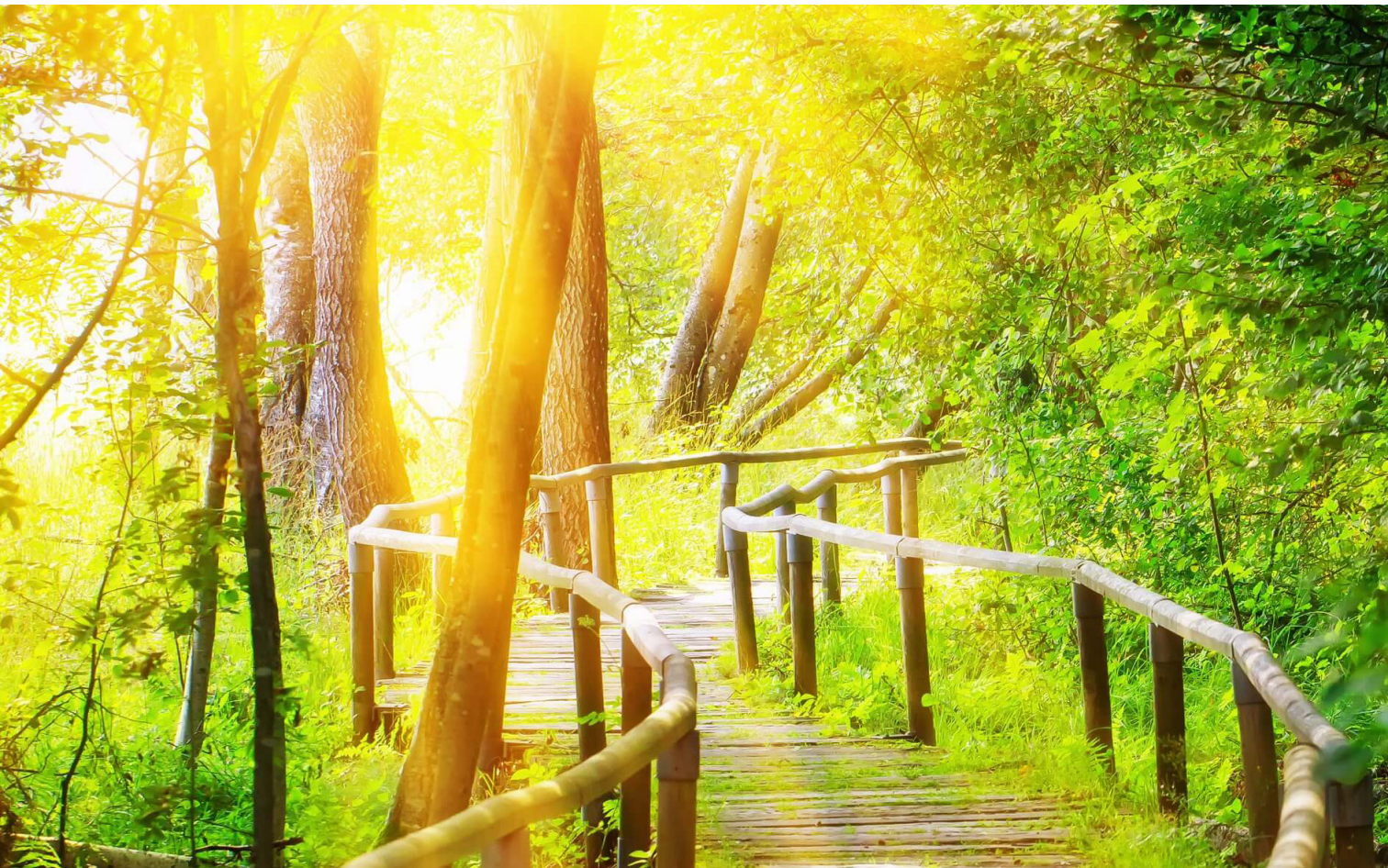


The Irish

# Journal of Counselling and Psychotherapy

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- A simulated interview with William Glasser:  
Part I – An ideology about mental health
- Is the treatment of behavioural addictions the  
same as the treatment of substance addictions?
- Breaking up is hard to do
- Planning for our death/incapacitation as  
therapists

## Road to Recovery



*Irish Association for Counselling and Psychotherapy*

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### Our Title

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

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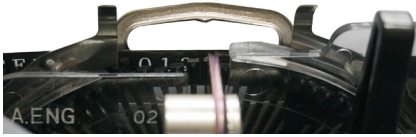
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## From the Editor:

# Content



Dear Colleagues,

A very warm welcome to the Autumn edition of the *IJCP*. As we bid farewell to the summer months and ease into the shorter days, I am conscious of the challenges this can bring for all of us - especially our clients. No matter what time of year, they face a difficult and testing journey on their 'Road to Recovery'. On it, their fear of change can feel like a mountain to climb or a leap too far, but with the support, care and indeed at times, the gentle challenging of their counsellor/therapist, they realise they have the capacity to alter their perspective on issues and discover they hold the key to navigating this journey. The articles in this edition of the *IJCP* address some of the challenges our clients encounter and detail emerging developments in their treatment.

In our first article 'A simulated interview with William Glasser: Part 1: An ideology about mental health', James Overholser illustrates Glasser's views on how clients can move forward in the therapeutic process. Through the simulated conversation he reveals Glasser's emphasis on the importance of enhanced self-control and taking responsibility for decision making. This allows clients to gain control of their lives, promotes empowerment

and helps them manage the challenges they face on their journey. We are also informed of the importance of connectivity and of Glasser's view that the most difficult problems are those involving human relationship issues and the deadly habits that can exist within them. Future editions of the *IJCP* will include Parts 2 and 3, so stay tuned for those.

Marie Healy's article asks: 'Is the treatment of behavioural addiction fundamentally the same as the treatment of substance addictions?' and looks at both the similarities and the differences between substance and behavioural addictions, specifically gambling and sex addictions. Marie examines the different types of treatment, including motivational interviewing and cognitive behavioural therapy (CBT), the use of psychoeducation and how approaches vary, depending on the addiction. Additionally, she stresses the need for counsellors working in this area to embrace changes in the treatment field, the importance of the therapeutic relationship, and emphasizes that the therapist's attention must focus on the needs of the service user.

In our next piece, 'Breaking up is hard to do', on the subject of complicated grief, Kaylene Petersen focuses on the loss of an intimate relationship and how debilitating it can be for some individuals. Kaylene notes that numerous studies have shown that attachment styles can have a bearing on one's reaction to loss and highlights how relationship

losses are often less noticed and acknowledged, only adding to the sense of isolation and heartache. Her own research outlines the importance of first identifying if a client presenting with prolonged grief is suffering with complicated grief disorder (CGD). Finally, Kaylene reveals that an emerging therapy, complicated grief therapy (CGT), which combines elements of CBT and interpersonal therapy, has been shown in several studies to be the most effective treatment for those presenting with prolonged grief.

In our final article of this edition 'Planning for our death/incapacitation as therapists', Mike Hackett delivers a stark reminder - we are mortal beings! We do not know what the future holds and so, we owe it to our clients to put a plan in place to ensure their continued care in the event of a sudden death or incapacitation. Mike highlights the devastation an unplanned termination of the therapeutic relationship can cause clients. The article outlines what is involved in the making of a professional will and explains how through its creation we are protecting the vulnerable, makes the case for a professional will as an ethical requirement and to safeguard the integrity of the profession of counselling and psychotherapy.

On behalf of the *IJCP* editorial committee may I sincerely thank everyone who contributed to this edition of the journal. Best wishes to all of our readers in their pursuits over the coming months.

**Annette Murphy MIACP**

### Committee update:

On behalf of the *IJCP* Committee, the IACP and its members, we would like to offer our sincere thanks to Dr Cólín O'Braonáin who is stepping down as the Chair of our Committee. Cólín has been instrumental in raising standards across our journal over the past several years, elevating it to a quarterly publication worthy of international recognition. The Committee would further like to announce that Mike Hackett (of the current committee) has accepted the baton from Cólín as Committee Chair. We would like to thank Mike for accepting the position and wish him well in his stewardship of the *IJCP*.

## Academic Article

# A simulated interview with William Glasser: Part 1 – An ideology about mental health

By James C. Overholser, Ph.D., ABPP



## Introduction

William Glasser developed an approach to psychotherapy called Reality Therapy, designed to enhance self-control and responsible decision-making. Glasser espoused views that promoted choice and personal responsibility aimed to satisfy basic human needs that are common to all people. Although he was a board-certified psychiatrist, throughout his career, Glasser's approach focused on psychological treatments instead of psychotropic medications. Reality Therapy aims to help clients gain control of their lives.

William Glasser was born in 1925 and raised in Cleveland Ohio. He studied at Western Reserve College where he earned a bachelor's degree in chemical engineering in 1945. After the war, he returned to Cleveland to earn his Master's Degree In Clinical Psychology In 1947, And His Medical Degree With Specialization In Psychiatry in 1953. This odd mix of fields helped to shape his pragmatic views of mental illness and patterns of change.

After completing his training, Glasser worked as Staff Psychiatrist at the Ventura School for Delinquent Girls, a residential

correctional facility. During his work there, he learned how to help these teenagers shift from adolescent rebellion to mature self-growth. Many of his ideas and strategies appear highly useful for clients of all ages.

Over his years spent conducting psychotherapy sessions, Glasser refined his views on responsibility of choice. Toward the end of his career, Glasser shifted from treatment to prevention, emphasizing the important role that schools can play in the development of rational choices and adaptive behaviours.

In 2013, Dr. Glasser died peacefully at his home in Los Angeles at the age of 88. Although his views on psychotherapy were developed more than 50 years ago, many of these concepts remain useful and relevant today. The remainder of this article will present a simulated interview with William Glasser (WG) conducted by James C. Overholser (JCO).

**JCO:** Thank you for meeting with me. I am eager to hear your views about psychotherapy.

**WG:** "I appreciate your coming here" (Glasser, 2000a, p. 223). "I want to talk with you, too" (Glasser, 2000a, p. 201).

**JCO:** Great. Let's get started. Why did you call your approach to therapy 'Reality Therapy'?

**WG:** "Patients, no matter what their psychiatric complaint, suffer from a universal defect: they are unable to fulfill their needs in a realistic way and have taken some less realistic way in their unsuccessful attempts to do so" (Glasser, 1965, p. 23). "In their unsuccessful effort to fulfill their needs, no matter what behaviour they choose, all patients

have a common characteristic: they all deny the reality of the world around them” (Glasser, 1965, p. 6).

**JCO:** So these basic needs guide our behaviour?

**WG:** “Oh, yes” (Glasser in Brandt, 1988, p. 43). “Except for those who live in deepest poverty, the psychological needs - love, power, freedom, and fun – takes precedence over the survival needs” (Glasser in Gough, 1987, p. 656). “Besides survival ... we are genetically programmed to try to satisfy four psychological needs: love and belonging, power, freedom, and fun. All our behaviour is always our best choice, at the time we make the choice, to satisfy one or more of these needs” (Glasser, 1998, p. 28). “Satisfying one or more of these needs feels very good” (Glasser, 1997b, p. 17).

**JCO:** Are some needs disturbed or pathological?

**WG:** “The needs of all people, normal or abnormal, are the same” (Glasser, 1960, p. 3). “The strength of each need is fixed at birth and does not change” (Glasser, 1998, p. 91). “What gives us our different personalities is that our five basic, or genetic, needs differ in strength” (Glasser, 1998, p. 91).

**JCO:** In modern society, why do so many clients continue to struggle?

**WG:** “While the traditional struggle for a goal – a job, a diploma, a home, a secure family – still exists, now suddenly it has been preceded by the struggle to find oneself as a human being” (Glasser, 1975, p. 2).

**JCO:** So you do not focus on a client’s academic success or career advancement?

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*“People are driven to abnormal behaviour by loneliness and by feelings of worthlessness”*

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*(Glasser in Berges, 1976, p. 10)*

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**WG:** No, not at all” (Glasser in Gough, 1987, p. 662). “The most difficult problems are human relationship problems” (Glasser, 1997a, p. 598). “What I believe is the source of almost all clients’ problems: the lack of satisfying present relationships” (Glasser, 2000a, p. xvii). “We are social creatures, we need each other” (Glasser in Onedera & Greenwalt, 2007, p. 80).

**JCO:** So the search for love and belongingness creates the central human need?

**WG:** “All long-lasting psychological problems are relationship problems” (Glasser, 1998, p. 333). “All unhappy people have the same problem: They are unable to get along well with the people they want to get along well with” (Glasser, 1998, p. 5). “All our lives, we search for ways to satisfy our needs for love, belonging, caring, sharing, and cooperation” (Glasser in Gough, 1987, p. 657). “When we fail to connect with other people ... we suffer because the need to do so is as much built into our genes as the need to survive” (Glasser, 2000a, p. 1). “Satisfying the need for love and belonging is the key to satisfying the other four needs” (Glasser, 2000a, pp. 22-23).

**JCO:** Why are relationship problems so important?

**WG:** “We are by our nature social creatures and to be healthy or

happy, we need to get along well with the people in our lives” (Glasser, 2003, p. xxi). “Our inability to get along with the important people in our lives is the only psychological problem that we all have to deal with. It causes divorce, school failure, bad parent-child relationships and bad situations at work (Glasser, 2016, p. 55). “People who kill themselves are having great difficulty satisfying one or more of their psychological needs for love, power, or freedom. But most of the evidence points to their inability to find sufficient love” (Glasser, 1993b, p. 18).

**JCO:** In your view, psychological problems are caused by bad choices?

**WG:** “That’s an important question” (Glasser, 2000a, p. 54). “We choose essentially everything we do, including the behaviours that are commonly called mental illnesses” (Glasser, 2000a, p. xv). “If we focus on the symptom, we enable the client to avoid the real problem, which is improving present relationships” (Glasser, 2000a, p. 23).

**JCO:** Do you believe that depression is due to relationship problems?

**WG:** “Right” (Glasser in Onedera & Greenwalt, 2007, p. 80). “To me, everything boils down to relationships” (Glasser, Haight, & Shaughnessy, 2003, p. 410). “I believe people are unhappy because they are not getting along as well as they would like with the important people in their lives” (Glasser, 2016, p. 31). “People are driven to abnormal behaviour by loneliness and by feelings of worthlessness” (Glasser in Berges, 1976, p. 10).

**JCO:** So how do clients “fix” this situation?

**WG:** “To gain control over our lives, we need to get along well with those close to us” (Glasser, 2013, p. 131). “I focus on four major relationships ... husband-wife, parent-child, teacher-student, and manager-worker” (Glasser, 1998, p. ix). “I don’t believe that there are hundreds of human problems, but only one and that is learning to get along better with the important people in our lives and removing all of the external control that we can from our lives” (Glasser, 2016, p. 181).

**JCO:** What do you mean by external control?

**WG:** “Let me explain” Glasser, 2000a, p. 179). “You don’t try to change people around you” (Glasser in Onedera & Greenwalt, 2007, p. 80). “The world is dominated by what I call the seven deadly habits of external control - criticizing, blaming, complaining, nagging, threatening, punishing, and bribing” (Glasser, 2000b, p. 79). “If we use external control psychology which is ‘I know what is right for you and I’m going to change you’, it will harm your relationships” (Glasser in Nelson, 2002, p. 98). “Get rid of the seven deadly habits that, given enough time, will put an end to any relationship” (Glasser, 2000a, p. 54). “In my opinion, criticizing is by far the single most destructive behaviour we use as an attempt to take charge of our lives” (Glasser, 2013, p. 136). “These are the things that husbands do to wives, that parents do to children, teachers do to children, bosses do to employees. All of these are behaviours that harm the relationship” (Glasser in Onedera & Greenwalt, 2007, p. 84).

**JCO:** So what should we do about these bad habits?

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*“The psychiatric establishment has replaced science with common sense. If you have symptoms, something must be wrong with your brain”*

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*(Glasser, 2003, p. 17).*

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**WG:** “Getting rid of the deadly habits in all your relationships is central to leading a happier life” (Glasser, 2013, p. 11). “I never use the deadly habits with anyone. I never criticize, never blame” (Glasser in Robey & Wubbolding, 2012, p. 29). “To replace the deadly habits, there are seven caring habits (Glasser & Glasser, 2007, p. 34) ... “supporting, encouraging, listening, accepting, trusting, respecting, and negotiating differences” (Glasser in Onedera & Greenwalt, 2007, p. 85).

**JCO:** Wow! These are great ideas, but I don’t know how to implement them in daily action.

**WG:** “The only behaviour we can control is our own” (Glasser, 1996a, p. 20). “In my relationship to other people, I can only control my own behaviour. Any attempt to control their behaviour will harm the relationship” (Glasser in Onedera & Greenwalt, 2007, p. 80). “We can only control our own behaviour, so you should talk solely about what you are willing to do, not what you want others to do” (Glasser, 1998, p. 98). “If you are tolerant of yourself and others, you will have a much better chance for happiness” (Glasser, 2000a, p. 81).

**JCO:** So how do I help my clients make this change in perspective?

**WG:** “People all attempt to satisfy their needs in a variety of ways.

Some of these ways are very irresponsible, debilitating, and crazy” (Glasser, 2016, p. 44).

**JCO:** This is all very helpful. If it would be okay, let me shift topics a bit. As a psychiatrist, do you see mental illness as a biological malfunction?

**WG:** “No, not at all” (Glasser in Gough, 1987, p. 662). “The basic human problem has nothing to do with the structure or physiology of our brain” (Glasser, 2003, p. xxi).

**JCO:** Has your opinion of medications changed over the years?

**WG:** “No, it hasn’t” (Glasser, 1996b, p. 176). “The psychiatric establishment has replaced science with common sense. If you have symptoms, something must be wrong with your brain” (Glasser, 2003, p. 17). “I think there’s nothing wrong with your brain” (Glasser, Haight, & Shaughnessy, 2003, p. 408). “The basic human problem has nothing to do with the structure or physiology of our brain. We are by our nature social creatures and to be mentally healthy or happy, we need to get along well with the people in our lives” (Glasser, 2003, p. xxi).

**JCO:** So mental illness is not caused by biochemical deficiencies?

**WG:** “Those who believe in mental illness assume incorrectly that something definite is wrong with the patient which causes him to be the way he is” (Glasser, 1976b, p. 95). “Most of the people we call mentally ill are choosing behaviours that they believe are most satisfying for them at the time, even though to us they are self-destructive”

(Glasser in Brandt, 1988, p. 42-43). “If we examined all ... depressed people carefully, we would find that out of the millions who suffer, there are a few whose ... depression is caused by some chemical abnormality” (Glasser, 2013, p. 113). “I have given up thinking of human unhappiness as some sort of mental illness caused by something mysterious going on in the brain” (Glasser, 2002, p. 2).

**JCO:** But so many people view mental illness as a form of illness?

**WG:** “That is a fatal flaw” (Glasser, 1993a, p. 37). “The mental health system is not a mental health system. It’s a mental illness system!” (Glasser, Haight, & Shaughnessy, 2003, p. 408). “If there is a medical illness which applies to psychiatric problems, it is not illness but weakness. While illness can be cured by removing the causative agent, weakness can be cured only by strengthening the existing body to cope with the stress of the world” (Glasser, 1976b, p. 96). “The less than mentally healthy, unhappy, symptomatic people are mentally out of shape ... they do not know what to do to become happier and get rid of their symptoms” (Glasser, 2004, p. 340). “Weakness is the cause of almost all the unfortunate choices we make” (Glasser, 1976a, p. 1). “It’s the doing, the moving toward applying yourself physically and mentally to what you want that builds your strength” (Glasser, 1976c, p. 70). “Strength comes from making a commitment to work for what you want” (Glasser, 1976c, p. 70).

**JCO:** So you don’t rely on medications for treating your patients?

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*“Huge quantities of antidepressant ... drugs are prescribed in the vain hope that they will cure a non-existent disease. Again, used in small doses as temporary relief until patients can be counselled to regain control over their lives, these drugs have benefit, but used to cure, they promise a hope that they cannot fulfill”*

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*(Glasser, 2013, p. 114).*

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**WG:** “That’s right” (Glasser in Brandt, 1988, p. 44). “I do not prescribe psychiatric drugs” (Glasser, 2000b, p. 78). “I have never used medications” (Glasser, 2016, p. 44). “The danger of psychiatric drugs is now coming out of the closet” (Glasser, 2004, p. 341). “I have been able to treat people with good success without medications and therefore never felt any need to turn to the use of these medications” (Glasser, 2016, p. 45).

**JCO:** But so many people want medications for psychological problems. These ideas seem like a drastic shift coming from a psychiatrist.

**WG:** “I don’t think any of my ideas are drastic” (Glasser in Nelson, 2002, p. 97). “We absolutely cannot depend on long-term use of drugs to do anything except get in the way” (Glasser, 2013, p. 115). “Huge quantities of antidepressant ... drugs are prescribed in the vain hope that they will cure a non-existent disease. Again, used in small doses as temporary relief until patients can be counselled

to regain control over their lives, these drugs have benefit, but used to cure, they promise a hope that they cannot fulfill” (Glasser, 2013, p. 114). “The medications are harmful ... they don’t really deal with the problem” (Glasser, Haight, & Shaughnessy, 2003, p. 408).

**JCO:** If medications are inappropriate, then psychotherapy is key?

**WG:** “I am a firm believer in the effectiveness of good psychotherapy, and I do not support the current wide use of psychiatric drugs. People with serious problems cannot be made whole by chemicals” (Glasser, 1980, p. 59). “Psychotropic medication tends to remove responsibility for behaviour” (Glasser & Zunin, 1979, p. 333). “If we believe that what we do is caused by forces outside of us, we are acting like dead machines” (Glasser, 2013, p. 5).

**JCO:** So you believe that both recreational drugs and prescription drugs are dangerous?

**WG:** “Why not? It’s the truth” (Glasser, 2003, p. 52). “In most instances drug use, legal or illegal, stands squarely in the way of effective therapy” (Glasser, 1980, p. 59). “Drugs are harmful for people with failure identities because they make the loneliness, the failure, and the self-involvement tolerable. In doing so, the drugs negate the purpose of the pain: to warn us that our companion, self-involvement, is working poorly at best. They allow us to sit on the hot stove and not feel the pain even though we know we are being burned” (Glasser, 1975, p. 50). “When the pain is anesthetized, the best motivation to become responsibly involved is removed” (Glasser, 1975, p. 51).

**JCO:** So pain provides the leverage, or motivation, for change?

**WG:** “Right” (Glasser in Brandt, 1988, p. 42). “When we suffer any pain, mental or physical,...we must try to do something to reduce the pain” (Glasser, 2000a, p. 1).

**JCO:** And then the therapist can use the pain to motivate the person to change?

**WG:** “That’s a good question” (Glasser, 2000a, p. 175). “Therapy is not primarily directed toward making him happy” (Glasser, 1973, p. 579). “Our job is not to lessen the pain of irresponsible actions but

to increase the patient’s strength so that he can bear the necessary pain of a full life as well as enjoy the rewards of a deeply responsible existence” (Glasser, 1976b, p. 101).

**JCO:** Should we take a short break?

**WG:** “I guess you are hungry” (Glasser, 1985, p. 243).

**JCO:** Sure. Let’s stop for lunch. Maybe we can talk again next week?

**WG:** “I’m sure we can” (Glasser in Chance & Bibens, 1990, p. 2). “I think we’ve had a real good get-

together” (Glasser, 2000a, p. 208). “I’ll see you next week” (Glasser, 2000a, p. 181). ☺

### Jim Overholser

Jim Overholser is a professor of psychology at Case Western Reserve University, Cleveland, Ohio and is a licensed clinical psychologist who provides outpatient psychotherapy through a local charity clinic. Dr. Overholser conducts research on depression and suicide risk through a local VA Medical Centre and the County Medical Examiner’s Office.

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## Practitioner Perspective

# Is the treatment of behavioural addictions fundamentally the same as the treatment of substance addictions?

By Marie Healy



*According to the DSM-5 there is currently insufficient evidence to group all behavioural addictive disorders into the same category as substance use disorders (Potenza, 2014). However, a comparative analysis of the two highlights significant similarities that could impact treatment options*

## Introduction

The concept of addiction has been described as being in a continued state of change and a “multicomponent complex phenomenon” (Thombs & Osborn, 2013, p. 27). Addiction is certainly not a new phenomenon with its origins dating back as far as the 19th century. The Industrial

Revolution provided a cultural context in which problematic drinking could be defined (Yates & Malloch, 2010). However, the DSM-5 has brought new ways of defining addiction, choosing to use terms such as Alcohol Use Disorder and Substance Use Disorder (APA, 2013). It has been argued that not all people dependent on

substances are in fact addicts but that addiction is more than a physiological dependence. Cravings and ego-dystonic behaviours are more important to making a diagnosis of addiction than mere dependency (Rosenberg & Curtiss Feder, 2014). Orford (1985) states that addiction has become overly identified with illicit drug use. However, print media in recent times have brought us stories of people whose lives have been adversely affected by behavioural addictions such as gambling, food and sex addictions. Articles on gaming are appearing with increasing frequency such as; Hsu, 2018, Marsh, 2018, Dodgen-Magee, 2019. An article in the *New York Times* outlines concerns that many young Chinese children need glasses due to excessive time spent on the Internet. New controls on online games were among Chinese authorities recommendations for reducing this problem of near sightedness. The same article sadly mentions a 17-year-old who died after playing a smart phone game continuously for 40 hours (Zhong, 2018).

In this article I intend to look at the similarities and differences in substance addictions and behavioural addictions. I intend to address two specific behavioural addictions, gambling and sex and how the areas of psychoeducation and working with cognitive distortions can be different from

working with substance addictions. I will explore to what extent treating behavioural addictions is different to treating substance addictions.

### Defining Behavioural Addictions

There are many people who actually dispute the concept of behavioural addiction. Dr Allen Frances, a well-known psychiatrist who chaired the American psychiatric task force which developed the *DSM-4*, is one such objector. Instead, he describes it as “normal” for people to repeatedly pursue entertaining activities which are not sensible. He expresses concern that behavioural addictions would reduce what is defined as normal and having one or more mental disorders would in fact become the new normal (Frances, 2010). There may also be a concern that in legitimizing behavioural addictions as a psychiatric disorder may excuse criminal behaviour (Rosenberg & Curtiss Feder, 2014).

Many psychologists take the opposite view and propose that their prevalence is in fact underestimated (Sussman, Lisha & Griffiths 2011). Stanton Peele first wrote about love addiction in 1975. Writing in 2007 he says,

“People can become addicted to powerful experiences such as sex, love, gambling, shopping, food and indeed any experience that can absorb their feelings and consciousness.” (Peele, 2007, p. 12).

Experts do not agree on what particular disorders qualify as behavioural addictions. Black (2013) lists behaviours such as problematic gambling, compulsive sexual behaviour, compulsive buying, compulsive Internet or Internet addiction, compulsive

## *Diagnostic criteria for behavioural addictions in general have been adapted from the principles of substance addictions*

video game playing, binge eating disorder, kleptomania and pyromania. Grant, Potenza, Weinstein and Gorelick (2010) explain that behavioural addictions are characterised by behaviours that produce short term rewards, leading to persistent behaviours despite knowledge of adverse consequences. Griffiths (2005) further elaborates on behavioural addictions, “the difference between an excessive healthy enthusiasm and an addiction is that a healthy enthusiasm adds to life, whereas addiction takes away from it” (Griffiths, 2005, p. 195).

As a counsellor working in an addiction service I have regularly encountered people who, once the therapeutic relationship was established, and the substance use under control or reduced, have expressed concerns about engagement in certain behaviours such as involvement with sex workers, spending excessive amounts of time viewing pornography or excessive amounts of time gaming. I have witnessed shame and distress in these people. With respect to Dr Allen Frances, it could be asked if such descriptions correlate more with Griffiths’ description above, rather than Dr Allen Frances’ description.

There are currently two behavioural addictions listed in the *DSM-5* as official disorders and (one listed in the appendix). Gambling disorder is listed under substance related and addictive disorders (formerly classified as an impulse control disorder) and

binge eating disorder is listed under feeding and eating disorder. Gaming disorder, although not listed as an official disorder in the *DSM-5*, has been included in the appendix and the American Psychiatric Association has requested additional research in this area (APA, 2013).

### What is Similar?

There are many similarities between substance addictions and behavioural addictions and this aids the treatment process. They both generally develop in adolescence and young adulthood (Thombs & Osborn, 2013). They both have a pattern which may be chronic and relapsing and like substance use disorder, many people recover on their own without undergoing formal treatment (Slutske, 2006) Neuroscience also supports a unified neurobiological theory of addictions regardless of the addictive substance or activities which now includes behavioural addictions (Rosenberg & Curtiss Feder, 2014).

Ambivalence can be a key feature in any addictive behaviour including both substance addictions and behavioural addictions (Arkowitz, Miller & Rollnick, 2015). Therefore Motivational Interviewing (MI) can be used as a possible intervention. Del Guidice & Kutinsky (2007) advocate the use of MI in the treatment of sexual compulsivity and addiction when incorporated alongside other approaches, which are integrated and promote empathic and active engagement. Cognitive distortions feature strongly in any addictive process (Kouimtsidis, Reynolds, Drummond et al, 2007), therefore Cognitive Behavioural Therapy (CBT) may also be used as a possible intervention.

There are 12-step programmes for both substance addictions and behavioural addictions. Examples

are; Gamblers Anonymous (GA), Overeaters Anonymous (OA), Sex and Lovers Anonymous (SLA) and Alcoholics Anonymous (AA) Diagnostic criteria for behavioural addictions in general have been adapted from the principles of substance addictions. Carnes (1991) proposed 10 diagnostic criteria for sexual addiction adapted from the criteria for chemical addiction. Co-morbidity with mental health conditions is very common in alcohol and substance addictions (Phillips, McKeown & Sandford, 2010). This can also be the case with behavioural addictions (Rosenberg & Curtiss Feder, 2014).

### What is Different?

Perhaps one of the main differences between behavioural and substance addictions is that most behavioural addictions are not listed in the *DSM-5* and as already stated, there are many who question if these behaviours are in fact addictions at all. This clearly has an impact on how people can talk about these difficulties and there are obvious difficulties in accessing treatments. This is clearly different in substance and alcohol addictions.

Definitions of abstinence are more complex in behavioural addictions (Thombs and Osborn, 2013), this is particularly relevant in the area of food and sex addiction (Carnes, 1991). Evolutionary psychology explains how the need for both is necessary for survival. Food and sex addictions are the most fundamental human addictions (Carnes, 1991).

Clearly, behavioural addictions do not carry the risk of physical withdrawal which may lead to a medical emergency. Yet, withdrawal has been noted in behavioural addictions and have been included in diagnostic criteria

## *There are specific differences in the treatment of behavioural addictions in the areas of psychoeducation and working with cognitive distortions*

(Donovan & Marlatt, 2005). It is not at all unusual for a client in the early stage of abstinence from gambling disorder to complain of insomnia, agitation, poor concentration and low mood.

### Addiction Treatment

Treatment in the addiction field has not had a straightforward path. Early services were based on the Minnesota Model which primarily treated alcoholism and the addiction counselling field has developed from the treatment of alcoholism (Butler, 2011). Addiction was recognised as a disease (Butler, 2011). The Minnesota Model appears to have treated the behavioural addiction of gambling from the early stages. A recent review of a predominantly Minnesota Model service in the Cork area reported that 22% of people attending the service in 2017 had been treated for problem gambling (Murphy, A., 2018). With the ideological demise of the disease concept other treatment options became available to people with alcohol and/or substance misuse problems. As cited in Thombs and Osborn (2013) Carroll (2012) notes what constitutes clinically meaningful outcomes remains in dispute in the substance treatment and research field. There is consistent evidence that outcomes of several different approaches vary widely (Miller, Zweben and Johnson, 2005). However, there is agreement that the quality

of the therapeutic relationship and high levels of empathy have a positive impact on outcomes (Hester & Miller, 1995). Among the evidence-based treatments recommended for the treatment of substance and alcohol use disorders are: MI, CBT, Community Reinforcement Approach and Contingency Management (Miller & Carroll, 2006). Given the various presentations of substance and alcohol use disorders, it is argued that that no single treatment model can solve all substance abuse problems and that an integrated treatment system is the most effective solution for substance abuse problems (Broekart et al., 2010). It could be contended that due to the history of alcohol and substance addiction treatment, there is no straightforward formula for the treatment of behavioural addictions. People with addictions, both substance and behavioural, can present with a wide variety of issues. It could also be asked if treatment is simply about the substance or the behaviour or is it more concerned with the person?

However there are specific differences in the treatment of behavioural addictions in the areas of psychoeducation and working with cognitive distortions. For the purpose of this article I shall focus primarily on two behavioural addictions gambling disorder and sex addictions, to illustrate these differences.

### Gambling Disorder

The assessment of any addictive disorder can be complex and gambling disorder is no different. (Marlatt & Donovan, 2005). Any assessment should include a risk assessment for suicidal ideation and psychiatric co-morbidity should be screened for as well. Psychiatric co-morbidity is the norm rather than the exception in gambling disorder (Rosenberg & Curtiss

Feder, 2014). It is essential to rule out manic or hypomanic episodes.

Research has shown that most people think irrationally when gambling and there is some evidence that problem gamblers hold more irrational beliefs than non-problem gamblers (May, Whelan, Meyer & Stenberg 2005). There are a number of irrational beliefs documented in which people with gambling disorder may frequently engage. Primarily among these are the illusion of control and the gambler's fallacy (the belief that a string of losses must predict an imminent win) (Petry, 2005). I have witnessed in addiction counselling sessions a person bargaining about abstinence, believing that the next bet would solve all his/her financial difficulties. Many individuals report intrusive thoughts and urges related to gambling which can interfere with their ability to concentrate at home or at work (Grant & Kim, 2001). Grant & Odlaug (2014) say that the primary differences between non-problem and problem gamblers seem to be in how much the problem gambler holds on to his gambling related beliefs.

Cognitive strategies used in the treatment of problem gambling usually include cognitive restructuring, psychoeducation, understanding of gambling urges and irrational cognition awareness training (Grant & Odlaug, 2014). Cowlshew et al (2012) examined 14 studies, as part of a Cochrane review. Their review concluded that there is efficacy for CBT in reducing gambling behaviour following therapy, but the duration of this gain is not known.

While acknowledging the important part which cognitive distortions play in gambling disorder, many researchers propose a broader perspective to be taken in this complex disorder.

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*There are many features of the internet which assist and even enhance the addictive tendencies in relation to sexual behaviour such as, accessibility, affordability, convenience, and disinhibition*

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May et al (2005) questioned the validity of the cognitive model as the only explanation for the cause and continuation of gambling disorder. Blazczynski & Nowers (2001) proposed a pathway model of problem and pathological gambling. They argue that problem gamblers are not a homogenous group and describe three subgroups; behaviourally conditioned, emotionally vulnerable and antisocial and impulsive. They propose that treatment approaches should be tailored in accordance with specific needs.

### **Sexual Addiction**

Rosenberg, O'Connor and Carnes (2014) deliberate that excessive sexual appetites were identified as far back as 1812. They cite that in 1886 a German psychiatrist, Dr Richard von Krafft-Ebbing argued that pathological sexual behaviour was in fact a true psychiatric illness. However, as already discussed it has not been included in the DSM-5. The difficulty in separating normal and abnormal sexual behaviours, the difficulty in determining when loss of control occurs and the difficulty in assessing the role of culture have been cited as reasons for problems with defining the dependence model of sexual

addiction (Carnes, 1991). Levine and Troiden (1998) argue that the label of sexual addiction is stigmatizing and renders a moral judgement on behaviour which diverges from the prevailing cultural standards.

“Sex addicts use their sexuality as a medication for sleep, anxiety, pain and family and life problems.” (Carnes, 1991, p23)

I believe that this statement does not deviate at all from what could be said about a person addicted to benzodiazepines, heroin or alcohol. While there are a lot of similarities between working with substance addiction and sexual addiction, there are some notable differences.

Carnes (1991) proposes that the core beliefs for sexual addicts arise out of a history of abuse, trauma and neglect. Birchard (2015) says that almost every sex addict he has worked with has a history of traumatic attachment. There are others who advocate a broader approach. Hall (2013) suggests the Opportunity, Attachment and Trauma Model (OAT). She lists opportunity as a key player in the list of variables which may lead to sexual addiction, paying particular attention to the role of the Internet and the increase in opportunity which it has brought. Samenow (2010) proposes a biopsychosocial model of hypersexual disorder/sexual addiction which allows for a more comprehensive understanding of the individual rather than focusing on a particular theory. He guards against one school of thought such as “most sexual addicts have been traumatised and have shame”.

Sexual addiction frequently co-occurs with other addictions, Birchard (2015) uses the term Addiction Interaction Disorder.

Psychiatric co-morbidity should also be screened for, as this is also common (Birchard, 2015) I have already referred to the importance of the therapeutic relationship as a predictor of satisfactory outcomes in therapy. Birchard (2015) places a very strong emphasis on the therapeutic alliance. He states that the capacity of the therapist to talk about sex and to understand sex is crucial in this. He guards against automatic reactions, evident in body language and facial expression, in response to some of the material discussed which may compound the shame of the person seeking help.

(Hart et al, 2012) argue that the treatment for sexual addiction is firstly about education. Hall (2013) proposes that among the treatment objectives include understanding the cycle of addiction, shame reduction, commitment to recovery, resolution of the underlying issues, prevention of relapse and the development of a healthy lifestyle. Undoubtedly, it could be argued that these treatment objectives are very similar to that of treating a substance addiction. However, I see the biggest difference in the area of education on the cycle of addiction and shame reduction.

Birchard (2015) says the concept of supernormal stimuli has been extremely helpful in helping people understand the place of pornography in sexual addiction. Birchard (2015) explains that the excitement about the artificially enhanced is greater than the excitement of the reality. He suggests that this may be the reason why so many people presenting for treatment have difficulty in sustaining an intimate relationship.

The Internet has clearly made the availability of supernormal stimuli much more accessible.

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*We always need to ask, is it people or substances/behaviours we are treating? The focus of our attention should always be the best treatment to meet the needs of the service user*

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There are many features of the Internet which assist and even enhance the addictive tendencies in relation to sexual behaviour such as, accessibility, affordability, convenience, and disinhibition. The Internet can also make possible activities, which would not be possible offline, such as cybersex (Griffiths, 2016). Equally, sexual addiction is not the only area where the Internet has played a significant role. It can be clearly seen in the area of gambling disorder and indeed substance use disorder. It is also not at all unusual for service users to access drugs online, particularly benzodiazepines.

### **Conclusion**

This article has looked at both the similarities and differences between substance and behavioural addictions. There are some important similarities in the treatment approaches. As discussed both types of addictions may present with impaired insight, ambivalence and distorted thinking. Therefore, MI and CBT can be considered to be appropriate treatment approaches. The role of the therapeutic relationship will always have an important impact on outcomes (O'Driscoll and Foy, 2017). Some specific areas which are different in their treatment are addressed with reference to gambling disorder

and sexual addiction. Specifically, the issue of psychoeducation was discussed with reference to sexual addiction and working with cognitive distortions in relation to gambling disorder. Even within the substance addiction field, psychoeducation can vary depending on which substance is being abused. Psychoeducation for somebody abusing opiates will be very different from psychoeducation for somebody abusing alcohol. The fact that very few behavioural addictions are recognised in the *DSM-5* is very significant with regard to how people will access help for their difficulties. Abstinence is also less clearly defined in behavioural addictions. In addition some behavioural addictions may actually be overvalued by society, for example the over pursuit of exercise is not generally met with criticism, moral judgement or negative social consequences (Ascher & Levounis, 2015). Excessive working may also be seen in the same light.

As a practitioner I expect that we shall be hearing a lot more about behavioural addictions in the addiction treatment field. Counsellors working in addiction services will need to embrace these changes, a task which should not be difficult given the variety of issues with which clients with addictions present. Undoubtedly, the number of similarities far outweighs the differences in treating both types of addiction. In the addiction treatment field, you can never say that treatments are exactly the same because of the varying needs of service users. We always need to ask, is it people or substances/behaviours we are treating? The focus of our attention should always be the best treatment to meet the needs of the service user. ○

## Marie Healy

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## Academic Article

# Breaking up is hard to do

## An exploration of attachment styles as a predisposition to complicated grief disorder following relationship loss

By Kaylene Petersen



*While the majority of people are able to navigate the loss of an intimate relationship in due course, for some, the grief that follows can involve incessant yearning, become debilitating and, in some cases, be life-threatening. Numerous studies have shown that attachment styles can be a predisposition to this complex and multifaceted reaction to loss*

### Introduction

Grief is a normal reaction to loss of anything significant from our lives. It is an ongoing process that may appear to be never-ending, however, for most people grief does subside in time. Unfortunately, for a subset of individuals, grief can become a prolonged

and permanent state of being. Pathological grief reactions, marked by functional impairment, persistent emotional pain and an increased incidence of morbidity and mortality are possible following any major loss. This reaction is known by various names, notably ‘traumatic grief’, ‘complicated grief disorder

(CGD)’, ‘prolonged grief disorder’ and, most recently, after review by the *Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition* (2013), ‘persistent complex bereavement disorder’, where it is currently placed under a chapter for further study. Failure to agree on a name is due in part to a lack of consensus on when grief becomes pathological. The term CGD is used in this article due to its prevalence in academic literature.

The end of a romantic relationship can be a highly painful event that can lead to CGD. Studies have shown that the grief response to relationship dissolution can mirror that of death, although relationship loss is generally not validated in the way death is.

At the heart of attachment theory is separation and loss, making it a clear theoretical framework for studying grief reactions. Several empirically-supported studies have found complicated grief therapy – a specific therapy for complicated grief – to be most effective in treating CGD.

### The universality of loss

Loss is an unavoidable part of life. From the moment we enter the world, loss is apparent. In fact, “we begin life with loss. We are cast from the womb without an apartment... a job or a car” (Viorst, 1986, p.9). As we grow, life by its very nature continues to serve us up loss – loss of a prized possession; a friend moves away; our youth passes us by; we change jobs; lovers come and go; our

health deteriorates; and, probably most devastating of all, a loved one dies. All of these unavoidable losses are part of the fabric of life. Sometimes subtle, sometimes painful, but irrefutably necessary for us to change and grow (Viorst, 1986).

Of all the losses an individual will experience throughout the lifespan, death of a loved one is regarded as the ultimate loss (Bozarth, 1982). However, according to Viorst, (1986): “When we think of loss we think of the loss, through death, of people we love. But loss is a far more encompassing theme in our life. For we lose not only through death, but also by leaving and being left, by changing and letting go and moving on” (p.2).

Literature, music, film and poetry are bursting with themes of romantic loss and yet the vast majority of studies on loss, grief and bereavement are examined within the context of death (Harvey, 1998). However, the reasons that individuals seek professional intervention for loss far surpass that of bereavement through death of a loved one.

In romantic relationships, we inevitably form an emotional connection with our partner. The end of a relationship can therefore represent a major loss in an individual’s life and give rise to a grief response. The dissolution of an intimate relationship is often painful – it signals the end of what once held meaning and shared hopes and dreams. Relationship loss is thus multi-layered. We are not alone losing the person we love, we are losing all that they represented and all we hoped they would come to represent in the future.

Grief can be defined as “an abiding and pervasive sense of sadness that overwhelms us when we are separated from a person, place or object important

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*For most people, the painful journey to recovery following relationship loss is relatively short-lived*

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to our emotional life” (Doyle, 1980, p.6). It is a natural reaction when someone we love leaves us and encompasses physical, behavioural, emotional, cognitive and social reactions (Prigerson & Jacobs, 2001).

The degree to which we are affected by a loss is largely dependent on the level of attachment we ascribe to the loss. How long grief lasts and the intensity to which it is felt is dependent on numerous factors. According to Zisook and Shear (2009), these can include “...the individual’s pre-existing personality, attachment style, genetic make-up and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; [and] the nature of the relationship” (p. 67).

Doka (1987) uses the term ‘disenfranchised grief’ to explain grief that is not generally acknowledged or socially sanctioned. Examples of this include miscarriage, suicide and relationship break-ups.

While relationship loss may be regarded as disenfranchised, for many it is a highly stressful event. The Holmes & Rahe Stress Scale (1967) of life events that can result in illness, places a spouse’s death as the most stressful event. This is immediately followed by divorce and then marital separation.

Significantly, grief experienced after relationship loss can mirror the grief response to death, namely, intrusive thoughts, insomnia and depression (Prigerson & Jacobs, 2001). More serious complications that have been found to coincide

with the end of a romantic relationship include immune dysfunction and stress-induced cardiomyopathy, also known as ‘broken heart syndrome’, which is a sudden and temporary weakening of the muscular part of the heart (Field, 2011).

In one study of those recently bereaved by relationship loss, it was found that the same areas of the brain were aroused when the subject was scolded on the arm with hot coffee as they were when shown a photograph of their former partner (Eisenberger, 2012). The results revealed that the brain does not differentiate between physical pain and the intense emotional pain that can follow a break-up. Further, it can be argued that for some individuals, separation from a loved one can prove far more disruptive and emotionally painful than a physical illness.

Given the ubiquitous nature of grief, key contributors in the field have long been interested in its process: Bowlby, Lindemann, Kübler-Ross, Worden and Rando are all names synonymous with grief theory. While each theorist has their own personal take on grief, they are united on two fronts: grief is a process that must be worked through in stages or cycles to reach a stage of acceptance or integration; and grief can go wrong.

### **Complicated grief**

For most people, the painful journey to recovery following relationship loss is relatively short-lived. Having traversed the rocky road of heartbreak – a process that involves confronting feelings of shock, sadness, anger, anxiety, loneliness and fatigue (Worden, 2009) – they eventually find their footing again and their lives return to a place of normalcy, although they are often irrefutably changed by the experience.

However, “it is important to



acknowledge that satisfactory reorganisation of one's life following a major loss is not guaranteed" (Neimeyer, 2000, p.14). For some individuals, the end of a romantic relationship can result in a prolonged grief process that can severely impact on their quality of life.

To this end, it is possible for an individual to become 'stuck' in their grief. When this happens, grieving can be ignored completely, the grief process can become chronic and, in some cases, grief can be so intense that it is life-threatening. This is CGD and research suggests it occurs in approximately 15% of bereaved individuals (Horowitz et al., 1997; Prigerson et al., 1995). However, it is important to note that CGD is a "greatly under-recognised public health problem across the lifespan" (Shear, Ghesquieue & Katzke, 2013, p.232) as many people with prolonged grief symptoms do not seek out clinical help (Lichtenthal et al., 2011).

There are several grief processes that fall under the umbrella term of 'complicated mourning'. These include: absent grief, where grief symptoms are not existent or minimal following a loss; delayed grief, where the grief response may not be experienced until a much later time; conflicted or exaggerated grief reactions, where an individual feels overwhelmed by grief and may resort to maladaptive behaviour such as anger and hostility as coping mechanisms; and chronic grief, where grief is prolonged and unremitting (Worden, 2009).

CGD can be defined as "the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behaviour, or remains interminably in a state of grief without progression of the mourning process towards completion" (Horowitz, Wilner, Marmar & Krupnick, 1980, p.1157). Although CGD is typically

### *Another distinguishing feature of CGD is avoidance of specific stimuli related to the loss*

associated with death, its symptoms are also experienced following relationship loss (Field et al., 2009).

Although our experience of grief is unique, a normative grief response following a romantic break-up could involve initial disbelief, followed by a combination of painful emotions such as preoccupation with the person who has left and a reluctance to process and accept the loss for a period of up to six months (Shear & Mulhare, 2008).

According to Shear et al., (2011) for a person to be diagnosed with CGD they must experience their grief symptoms following a significant loss for more than six months. They must also exhibit separation distress through one of the following symptoms on a daily basis:

- Intense emotional pain and pangs of sorrow related to the loss of the relationship
- Consistent intrusive thoughts relating to the loss of the relationship
- Intense yearning for the lost person

Further, they must experience five or more of the following:

- Confusion about one's identity
- Difficulty accepting the loss
- Avoiders of reminders of the reality of the loss
- Bitterness or anger related to the loss
- Difficulty moving on with life
- Numbness
- Feeling that life is unfulfilling, empty and meaningless
- Feeling stunned, dazed or shocked by the loss

(Shear et al., 2011)

Put succinctly, "individuals suffering from complicated grief fail to experience reprieve from pain and longing. Caught in a loop of prolonged grief symptoms and complicating psychological and/or life problems, time seems to stand still" (Shear et al., 2007, p. 453).

Although CGD is widely treated as depression, they are two distinct disorders, although symptoms may overlap. Notably, with depression there is a general feeling of sadness and a lack of interest in all areas of life. A depressed person is also likely to ruminate and dwell on past failings. With CGD, the grief is almost entirely confined to the loss, characterised by pre-occupation, yearning and the belief that reunion with the ex-partner will bring about satisfaction (Shear, 2012). Similarly, while the onset of CGD and Post-Traumatic Stress Disorder (PTSD) occur after a traumatic event, CGD symptoms of emotional numbness, identity confusion, feeling 'adrift' and that life is meaningless are not evident in PTSD (Prigerson & Jacobs, 2001).

Another distinguishing feature of CGD is avoidance of specific stimuli related to the loss. In addition, the stress from CGD can "increase the likelihood of onset or worsening of other physical or mental disorders" (Shear et al., 2011, p. 103). Other studies have noted significant levels of sleep disturbance among those with CGD (Germain, Caroff & Buysse, 2005; Hardison, Neimeyer & Lichstein, 2005) and a correlation between CGD and a heightened risk of substance abuse, cardiac disease, cancer and suicide (Szanto, Shear & Houck, 2006).

According to Zisook and Shear (2009), once CGD takes hold, it tends to be chronic and persistent. CGD can be diagnosed using the Inventory of Complicated Grief (ICG) (Prigerson, et al., 1995). The ICG is comprised of 19 statements

with response options ranging from 'never' to 'always'. An individual scoring  $\geq 30$  six months after bereavement can be clinically diagnosed with CGD.

Possibly the most extensive study into risk factors of prolonged grief was by Burke and Neimeyer (2013) who examined peer-review literature over a 30-year period. Confirmed risk factors for CGD include being the spouse of the deceased, low levels of support, high neuroticism and insecure attachment styles.

That CGD can be linked to attachment disorders is not overly surprising. When we lose someone from our life whom we loved, feelings of abandonment we may have suppressed since childhood can suddenly resurface in a highly distressing way.

### **Attachment styles and complicated grief disorder**

How we cope with the end of an intimate relationship depends on personal, social and psychological factors, such as our personality, stage of life, supports we have around us, our mental health and, crucially, our style of attachment (Wilson, 2014).

According to John Bowlby, the pioneer of attachment theory, attachment refers to the "lasting psychological connectedness between human beings" (1969, p.194) and it is this primitive instinct that forms the basis of his theory of attachment.

During periods of stress, particularly in the face of separation or fear, an individual's attachment style is usually activated to varying degrees (Schenck et al., 2015). For this reason, theorists and researchers have turned to attachment theory to examine why human beings develop close affectional bonds and, further, why when these bonds are broken, intense emotional reactions can ensue.

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As detailed by Fraley and Shaver (1999): "Whether an individual exhibits a healthy or problematic pattern of grief following separation depends on the way his or her attachment system has become organised over the course of development" (p. 740).

### **Research into attachment styles and complicated grief disorder**

CGD appears to be linked with attachment disturbance and high levels of insecurity with the self and with an individual's relationships to others (Berger, Shuster & von Roenn, 2007). Given this, it is not a stretch to hypothesise that securely-attached individuals would cope better with loss than their insecurely-attached counterparts.

According to Stroebe et al., (2007) adults with secure attachment, who had their emotional and physical needs consistently met throughout development, are generally equipped with the characteristics needed to navigate stressful situations, such as relationship loss, confidently and independently with minimal guidance from others. Thus, a secure attachment can be viewed as a protective agent against psychopathology and also against adverse reactions to situations of trauma and stress. The securely-attached adult is able to recall a former lost partner and talk about them coherently without

too much difficulty (Collins & Feeney, 2000).

By comparison, in cases where an attachment figure is not seen as a consistent and reliable source of support and security, an individual may develop an insecure style of attachment (Feeney, 1999). This may result in "a predictable sequenced response to separation" (Shear & Shair, 2005, p. 254). Adults who are insecurely attached can develop either a more anxious response to their relationships, such as uncertainty about a partner's responsiveness and availability to them, or an avoidant response, such as unease when in situations that requires relying on others (Brennan, Clark & Shaver, 1998).

Individuals categorised with insecure-anxious attachment tend to lack trust in themselves and this can be played out with intense anxiety, sorrow and yearning following the loss of a significant other. Given this, insecure-anxious individuals tend to be highly emotional, more likely to have difficulty processing and accepting loss and find it harder to move on and establish new meaning in life when confronted with it (Delespau et al., 2013). Similarly, individuals who have experienced abuse in childhood, i.e. disorganised attachment, have been found to be more susceptible to acute grief reactions and CGD (Silverman et al., 2001).

These findings were reinforced in one of the largest studies to date into emotional and behavioural reactions to break-ups. The online study of 5,000 individuals found that individuals classified as securely-attached utilised social coping strategies, such as confiding in friends and family, and used these supports as 'safe havens' to help alleviate distress (Davis et al., 2003).

Conversely, respondents who

were categorised as possessing an insecure-anxious attachment style reported a preoccupation over the loss of their partner. This encompassed heightened levels of physical and emotional distress, increased efforts to resurrect the relationship and turning to dysfunctional coping strategies, such as excessive intake of alcohol or use of recreational drugs (Davis et al., 2003).

Insecure-avoidant responders were noted to react to romantic relationship dissolution with more avoidant-style coping strategies, for example, suppressing their feelings, shying away from support from others and avoiding new relationships (Davis et al., 2003).

One study that examined attachment style and individual reaction to divorce found that adults with insecure attachment styles exhibited heightened distress and decreased well-being when compared to securely-attached participants (Birnbaum, Orr, Mikulincer, & Florian, 1997). The study found that while insecure-avoidant individuals were of the opinion they could cope, they saw divorce as a threat and, as such, utilised ineffective coping strategies that impacted negatively on their well-being. The researchers stated that while insecure-avoidant individuals may be able to control their level of distress following relationship dissolution in short-term dating relationships, they may not fare so well in the case of long-term relationships, such as divorce. Thus, for some avoidant individuals, the longer the duration of the relationship – and the higher the degree of attachment – the more heightened the level of distress and the more acute the grief experience.

Delespau et al., (2013) corroborated these findings, suggesting that avoidant-attached bereaved individuals are more

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*Students rated factors including crying, preoccupation with thoughts over the loss, being stunned and not being able to accept the end of the relationship*

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inclined to avoid emotional upset and revert to defensive reactions in an attempt to play down the significance of the loss and avoid memories of the person no longer in their life. This avoiding grief may prove beneficial in the short term but can lead to what is known as ‘prolonged absence of conscious grieving’ (Bowlby, 1980) or, more commonly, ‘absent grief’.

#### **The Break-up Distress Scale**

In a bid to differentiate between acute grief symptoms and depression following relationship loss in young adults, the Break-up Distress Scale (Field, et al., 2009) was adapted from the ICG. The scales’ authors were keen to highlight that as grief is a distinct disorder to depression, a unique mode of measurement is needed to categorise individuals with pathological grief following a break-up. They conducted a study of 192 college students who had experienced a recent traumatic break-up. Students rated factors including crying, preoccupation with thoughts over the loss, being stunned and not being able to accept the end of the relationship. Students were then separated into ‘high-distress’ and ‘low-distress’ groups. The study found females to be more susceptible to break-up distress, and non-initiators of the break-up reported higher levels of distress, as did those whose break-up was sudden and unexpected. It also found that those students in the high-distress group reported more intrusive thoughts, an inability

to control such thoughts, insomnia and anxiety, concluding that distress from a break-up may take on the form of CGD.

Thompson (1987) found the main suicide stressors in young adults included romantic break-up (26%); family disagreements (22%); and problems with the law (16%). In another study, individuals six to 12 months following a bereavement were assessed using the Yale Evaluation of Suicidality. The results found that 10.1% of those characterized as grieving normally were positive for suicidal ideation, compared to 57.1% of those in the CG category (Prigerson et al., 2009).

#### **Treatment for complicated grief disorder**

Encouraging and supporting recovery following a significant loss has long been considered a staple of psychotherapy and, consequently, clinicians have put forward various forms of treatment for bereavement and grief-related issues. Such treatments draw from a diverse range of therapeutic techniques, however, most of these interventions do not specifically target symptoms of CGD, focusing more generally on depression and/or distress (Wetherell, 2012).

Individual and group psychotherapy is the primary mode for grief work and, to date, cognitive behavioural therapy (CBT) approaches have not alone been most rigorously tested, but have also received the most validation (Mancini et al., 2012).

In general, CBT approaches focus on: elements of cognitive restructuring – noting the most problematic aspects related to the loss and re-examining and developing an understanding of them; and exposure – this may involve verbalizing the personal story of loss and then confronting areas or people associated with the loss (Mancini et al., 2012).

### Complicated grief therapy

An emerging treatment in the field is Complicated Grief Therapy (CGT) – an attachment-based psychotherapy process that incorporates elements of CBT and interpersonal therapy (IPT) (Shear, Frank, Houck & Reynolds, 2005).

CGT incorporates exposure techniques and places emphasis on personal goals and relationships. That this treatment is steeped in attachment processes lends credence to the assumption that CGD is “fundamentally an attachment disorder” (Lobb, Kristjanson, Aoun, Monterosso, Halkett & Davies, 2010, p. 690).

From an attachment perspective, acute grief follows the loss of an attachment figure resulting in disruption to one’s attachment system. When a successful mourning process occurs, individuals are able to navigate from acute grief to integrated grief, that is, the loss is acknowledged, trauma related to the loss is resolved and painful memories become more ‘bittersweet’ as life goals are recognised and readjusted.

In CGT this process is made possible through the dual process model (Stroebe & Schut, 1999) that states healing is the result of two distinct processes:

- 1) A loss-oriented approach, whereby the client is able to come to terms with the loss; and
- 2) A restoration-orientated process where the client is able to incorporate new meaning in their life without their former partner.

Generally, CBT techniques target the painful and intrusive memories that accompany the loss as well as any avoidance behaviour. IPT works to help the client reconnect with relationships and personal life goals and help them rediscover

### *Insecurely-attached individuals have been found to react in differential maladaptive ways to loss*

meaning in their life (Wetherell, 2012).

Several investigations have shown empirical support for CGT (Wetherell, 2012). In one study of 83 adult patients with CGD, the efficacy of CGT was compared with IPT (Shear, et al., 2005). Results found that 51% of participants in CGT versus 28% of participants using IPT noted a 20-point or higher reduction in scores on the ICG. Those participants in the CGT group also reported ICG score reductions faster than those in the IPT group (Shear, et al., 2005).

Another randomized clinical trial of 151 individuals with CGD who received either CGT or IPT found that those in the CGT group reported over two times the response rate (Shear, Wang, Skritskaya, Duan, Mauro, & Ghesquiere, 2014). Significantly, those in the CGT group also reported a significantly greater decline in their symptoms.

CGT is comprised of 16 sessions of 45 minutes to one hour in duration and is divided into three stages. Stage one, the introductory stage (incorporating sessions one through three); stage two, the intermediate stage (sessions four to nine); and the final stage, (sessions 10 to 16). A summary of the structure of CGT is seen in Table 1 (p21).

### Conclusion

As loss is a consistent theme throughout the lifespan, few will escape unscathed by its painful consequences. While death of a loved one is generally considered the most traumatic loss we shall

ever face, we will encounter many other losses throughout our lives that may trigger acute grief responses. Many of these disenfranchised losses can have a profound impact on an individual’s psychological functioning and can be just as painful and traumatic as loss of a loved one through death. However, grief following these losses is generally less noticed and less acknowledged.

While most individuals will recover from relationship loss in time and integrate their separation into the unique fabric of their life, for some, this integration fails to occur and they find themselves trapped in a painful, seemingly never-ending loop of acute sadness.

CGD is a largely under-recognised pathological grief disorder that has a significant adverse impact on quality of life mental health and in some cases can be so painful that, tragically, suicide is viewed as the only solution.

As has been shown, one clear risk factor for CGD is an insecure attachment style, with insecure-anxious, insecure-avoidant and disorganised styles of attachment found to be differentially linked to CGD.

Insecurely-attached individuals have been found to react in differential maladaptive ways to loss. Insecure-anxious and disorganised attached individuals are more inclined to find the end of a relationship a highly distressing event.

Insecure-avoidant individuals often feel uncomfortable expressing their feelings and as such are more inclined to minimise or ignore confronting feelings of anxiety following relationship loss. This absence of grief can have detrimental effects in the long-term, particularly if maladaptive coping mechanisms are employed.

The ICG and Break-up Distress Scale are two tools that can assess

**Table 1: Summary of the structure of CGT**

<b>SESSION 1</b>	The client is welcomed to the process of CGT. A history of interpersonal relationships and other significant losses is taken. Focus is placed on the client's story of the loss, support networks and stressors. The therapist gives a handout that explains the process of CGT and activities (that help clients move towards aspirations) to be completed between sessions. The client is also asked to record upsetting moments and triggers in a grief diary.
<b>SESSION 2</b>	Information from the grief diary is discussed. A copy of the CGT handout is given to the client to pass on to a supportive person who is invited to attend the third session.
<b>SESSION 3</b>	A supportive person joins the client and therapist in session (or via phone). This is an orchestrated move as sufferers of CGD often feel a sense of disconnectedness to the world. The supportive person is asked to describe the client since the break-up. The model of CGD is then explained to the individual. The client is seen alone for the remaining 15 minutes for analysis of the grief diary.
<b>SESSION 4</b>	The client is introduced to 'imaginal revisiting', which involves asking the client to visualise and discuss the moment they realised they were separating for approximately five minutes into a tape recorder. Imaginal revisiting allows the client to come to terms with their loss by rationalising the loss and integrating logic with the emotional processes. Debriefing with the therapist follows about what emotions are brought to the surface. The client names a reward that they could give to themselves in the following week for the difficult task of listening to the tape recording once every day. The grief diary is consulted again and restoration-oriented work continues, whereby the client works towards a personal goal not connected to the loss.
<b>SESSION 5</b>	The therapist reviews the imaginal revisiting and grief diary and introduces daily 'situational revisiting' – a process whereby the client details places and/or people they have avoided since the break-up because they trigger painful memories.
<b>SESSIONS 6 TO 9</b>	The grief diary, situational and imaginal revisiting activities are discussed. The client is asked to talk of positive and negative memories and characteristics of their ex-partner. Clients often bring photos to these sessions.
<b>SESSION 10</b>	The therapist uses the ICG questionnaire, or similar, to note 'stuck' points. Client and therapist collaborate regarding the remainder of therapy, i.e. examine previous losses, engage in more IPT-orientated work.
<b>SESSIONS 11-16</b>	These final sessions are spent analysing the grief diary and examining situational revisiting exercises. At this juncture, imaginal revisiting is generally no longer required. Clients are asked to participate in 'imaginal conversation'. Here, the client imagines the break-up has just happened and speaks for both themselves and their former partner. The client can ask questions of their former partner and this can prove a moving and eye-opening experience for them. In final sessions, clients work towards termination of the therapy.

the prevalence of CGD and, further, help produce effective clinical outcomes by attending specifically to those individuals presenting with acute grief who have insecure attachment styles.

To date, CGT has been shown to be the most effective treatment for individuals with CGD in several studies. The therapy, combining attachment processes and borrowing from CBT and IPT techniques, helps individuals integrate loss by allowing them to detach from the former partner and move towards the attainment of

new positive life goals.

Evidence supporting a definitive relationship between insecure attachment and a predisposition to CGD does appear to exist, but the minutiae of the relationship requires further research. When counsellors have a thorough understanding of CGD and the treatment options available, the emotional and physical consequences that mar the lives of those with CGD following relationship loss – and indeed any loss – may one day be significantly reduced. ☺

### Kaylene Petersen

Kaylene Petersen worked as a sub-editor in Australia, the UK and Ireland, before obtaining a BSc (Hons) in Counselling & Psychotherapy. An accredited counsellor and psychotherapist in private practice in Kilkenny city, her areas of speciality include relationship issues, prolonged grief and self-esteem.

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## Practitioner Perspective

# Planning for our death/incapacitation as therapists

By Mike Hackett



## *E*thics, client-care and posthumous attending: Preparing for therapist incapacitation or death in service, a practice based issue

### Introduction

Therapists, like their clients, die. The myth of the untroubled therapist (Adams, 2013) is shattered all too soon with the unexpected and shocking news of the death of a therapist following a short illness or due to incident or accident. These kinds of unplanned terminations have been demonstrated to result in a range of damaging effects on clients including evoking feelings of “ultimate abandonment ... [triggering] complex mourning ... rage ... betrayal of trust ... denial

... expressions of hostility ... anger ... the client became stranded ... despair ... depersonalization and somatization” (Beder, 2003, p. 28; Lord, Ritvo, & Solnit, 1978; Garcia-Lawson, Lane, & Koetting, 2000; Alexander, Kolodziejski, Sanville, & Shaw, 1989). Further, Barbanel (1989) found that therapists who “inherit” clients whose previous therapist died, often experienced negative comparisons to the deceased therapist and that therapeutic attachment was not as secure.

Likely due to the negative impact

of unexpected termination on clients, codes of ethics in Ireland and internationally mandate that provisions are made in the event of the sudden death or incapacitation of therapists/supervisors (American Counseling Association (ACA), 2014; American Psychological Association (APA), 2017; European Association for Counselling (EAC), 2015; Irish Association for Counselling and Psychotherapy (IACP), 2018). However, only the APA provides tools and resources which therapists can use to deliver on this obligation (APA, 2014).

Practical and legal matters also arise on the death of a therapist. These include the implications of intestacy (Citizens Information Board, 2016) and the demands on surviving family members to notify key individuals, as well as their obligations and duties as executor/administrator of the deceased clinician’s estate.

Autobiographically, my own lived experience of incapacitation following an accident (leading to hospitalisation and several weeks of convalescence), faced with my own mortality I was challenged to consider the broader implications had my accident resulted in my death. What would have happened to my clients and supervisees? What burden would I have placed on my family to wind-up my practice when already bereft? What are my legal, ethical and practical responsibilities? What do I need to have in place in the event of my incapacitation/death? What

does the literature offer regarding solutions to this personally and professionally challenging issue? The aim of this paper is to explore these questions with the objective of developing a practice-based solution to the issue of unexpected termination due to therapist death or incapacitation.

### **Unexpected termination: Impact on the client**

A major theme from the literature (predominantly in the psychoanalytic tradition) describes the impact on the client of therapist-initiated unexpected termination due to incapacitation or death. These range from transference dynamics (Abend, 1982); shock, disbelief, protest, despair and mourning (Alexander et al., 1989); sudden death traumatising the client (Beder, 2003); breach of trust due to failing to plan for client confidentiality post-mortem (Bradley, Hendricks, & Kabell, 2011); feeling abandoned (Bram, 1995) and; burdening clients with the dual tasks of independent functioning and assimilation of a shocking loss (Chwast, 1983). Similarly, secondary reactions of hostility toward the deceased therapist from patients family and friends are also indicated in the literature (Shwed, 1980).

In only one study, however, is the voice of the client affected by the loss of her therapist to be heard. In her first-person account of her own experience of loss, Deutsch (2011) describes how “I missed not just my analyst, but also my analysis. I had lost contact with that part of me that had come to think in certain ways, to access fleeting thoughts and feelings and share them with another” (p. 527). As a result, “the protected position of analyst and analysand alone isolates the bereaved analysand.” (p. 528), the impact of which persists for months or years.

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*Codes of ethics also emphasise the need for informed consent. Clients must consent to participation in therapy and must acknowledge that they understand the limits of confidentiality and their rights within the therapeutic relationship*

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The impact of the sudden loss of the therapeutic relationship accompanies the loss of the therapist. The client, therefore, loses twice. In the aftermath, their loss is amplified because unlike other bereavements where society prizes rituals, social interactions and various opportunities for public mourning, the client/therapist relationship is a private (often secret) one with “no socially sanctioned role for the analysand as mourner” (Galatzer-Levy, 2004, p. 1011). Recognising these various impacts on clients and despite them, the same paper found that most therapists “made no provision to notify patients of their death” (p. 1010). Perhaps the fear of death within the therapist trumps the emphasis on the therapeutic relationship and as a result, represents a counter-transference, an emergent property of the defense of death denial within the therapist (Dattner, 1989). The Galatzer-Levy study goes on to present the startling reality for most clients faced with the unexpected death of their therapist in that “Analysands learned of their analyst’s death through newspaper notices, arriving for appointments to find a note on the analyst’s door, word of mouth from colleagues, and telephone calls from clerical personnel or

members of the analyst’s family” (p. 1010).

### **The ethical imperative for preparing for therapist incapacitation/death**

Within the very earliest of care-providing relationships, that of physician and patient, the rights of the vulnerable and the obligations of the provider to uphold several ethical standards are enshrined. The Hippocratic Oath, circa 275 CE (Edelstein, 2000) constitutes the cornerstone of modern medical ethics which in turn advances foundational elements for codes of ethics in the related fields e.g. psychology and by extension, psychotherapy (Miller & Thelen, 1987). *Confidentiality* is one of these bedrock ethical doctrines and is explicitly stated as vital to the therapeutic relationship itself e.g. “Definition of Counselling & Psychotherapy” (IACP, 2018). However, confidentiality requires a basic assumption – that a living therapist is the gatekeeper of the client’s story described in their case notes, and is thus the ultimate *keeper of their secrets*. But what about post-mortem confidentiality? Though most of the literature focusses on the care of client records after their death (Berg, 2001; Bradley et al., 2011; Maixner & Morin, 2001), a small number of papers describe the various nuances of client confidentiality on the death of the therapist including; the requirement to have a plan for cessation of their practice and the appointment of a records custodian (Bradley, Hendricks, & Kabell, 2012). A second group of papers recommend the development of tools, resources and protocols, essentially, a Professional Will (Gamino & Ritter, 2010; Rutzky, 2000; Steiner, 2002a, 2002b, 2011).



Burke (1995) highlights one case in the USA where a therapist released session audio recordings to the executor of the estate of a former client, a well-known poet. The ensuing controversy led to the then head of the American Psychiatric Association, Jeremy Lazarus, declaring “A patient’s right to confidentiality survives death. Our view is that only the patient can give that release. What the family wants does not matter a whit” (Stanley, 1991 as cited in Burke, 1995, p. 278).

Codes of ethics also emphasise the need for *informed consent*. Clients must consent to participation in therapy and must acknowledge that they understand the limits of confidentiality and their rights within the therapeutic relationship. This raises several questions typically overlooked by therapists (particularly those in private practice where the support of an organisation or service is absent) including: what happens to case files, emails, text messages etc. in paper files, computer documents and on mobile devices left stranded following their death/incapacitation; who has access to this material; who will dispose of it in compliance with ethical and legal obligations and what are the implications for insurance company obligations for data retention?

A final challenge to addressing the ethical obligation of client data confidentiality is due to the limits imposed by the recent European and Irish statutes relating to data protection and extending to the rights of clients with respect to appropriate collection, storage, processing and disposal of personal data. Though the European statute declares (when referring to the principles of data protection) “This Regulation does not apply to the personal data of deceased persons.” (European

## *A final ethical consideration is that of continuity of client care*

Parliament, 2016, p. 5), the Irish Parliament has enacted its right to amend this statement and when passed in 2018, the statute now declares that “Article 32 of the Data Protection Regulation shall apply to a deceased individual’s relevant information (individual) as it applies to a living individual’s relevant information (individual).” (Government of Ireland: Office of the Attorney General, 2018, p. 175). Neither the legislation nor the practical guidance from the Irish Data Protection Commission offers input as to how to achieve this requirement for professionals in the field.

A final ethical consideration is that of *continuity of client care*. This ethical requirement is stated explicitly as a therapist obligation by the IACP and requires therapists to “make suitable arrangements for the responsible care of clients and the management of records in the event of the practitioner’s ill-health, retirement and termination of practice” (IACP, 2018, Section 2.4, Item E). It offers no advice or guidance however on how this may be accomplished and indeed begins the statement with “Where possible...” thus inviting the question When would it *not* be possible to plan for one’s own death/incapacitation? Indeed Pope & Vasquez (2016) advance the idea of the best time to prepare a professional will as being “now rather than later” (p. 123).

Thus the ethical and practical considerations highlighted by the literature provide a solid basis for the necessity for Irish therapists to focus on planning and preparing

for the unfortunate event of unexpected therapy termination. The good news is that the literature developed by US-based clinicians offers much in terms of solutions to these ethical dilemmas. In particular, the work of Dr Ann Steiner contributes significantly to this crucial element of ethical practice in her development of a suite of tools and resources culminating in *The Therapist’s Professional Will – A Backup Plan Every Clinician Needs* (Steiner, 2011).

### **The Professional Will**

Several authors espouse the ethical, practical, legal and personal need for clinicians to make a Professional Will (Becher, Ogasawara, & Harris, 2012; Bradley et al., 2012; Cooper & Ramage, 2006; Fair & Bressler, 1992; Garcia-Lawson & Lane, 1997; Pope & Vasquez, 2016; Rutzky, 2000). A Professional Will is defined variously as: “a plan for what happens if we die suddenly or become incapacitated without warning” (Pope & Vasquez, 2016, p. 123); “details your wishes for the treatment of your patients in your absence ... whether due to serious illness, retirement, or death” (Steiner, 2011, p. 35) and is described as “a document designating and instructing an individual or individuals to terminate or continue counselling services to a client in a manner that provides for the needs of a client” (Bradley et al., 2012, p. 309).

Steiner (2002a) introduces the concept of a therapist’s Emergency Response Team (ERT) as a resource when planning to address responses to unplanned death or incapacitation. Indeed, the idea of some kind of committee to oversee practice disposition had been suggested in literature from the USA since the 1980s (Shwed, 1980).

This committee, or team approach, provides for a clear identification of the various roles necessary in the execution of a Professional Will which in turn facilitates easier allocation of tasks to each role identified. By building on this idea, it is possible to clearly separate the professional and personal domains of the clinician, thereby creating clear boundaries which safeguard them, their family, executors, clients and supervisees. Building on this work, the ERT can be conceptualised for a clinician (Peter Bonnington) as shown in Figure 1.

As well as the ERT, the literature on preparing a Professional Will exposes several themes and sub-themes clinicians should consider when preparing the document(s) (Bradley et al., 2012; Cooper & Ramage, 2006; Rutzky, 2000; Steiner, 2011). These provide a reliable ethical, legal and practical basis from which to meet the requirements of codes of ethics of professional bodies for the care of clients and support the necessary planning for therapist incapacitation/death. These practical plan elements are summarised in Table 1.

**Final Reflections**

Counselling and psychotherapy are essentially relational activities involving (at least initially) a vulnerable person; the client, and a trained professional; the therapist. Both are human beings subject to the same vicissitudes of life, the whims of fate, of illness and infirmity. As the professional in the room, it is the duty of the therapist to contain the work in what is often described in the therapeutic encounter as “a safe emergency” (Perls, Hefferline, & Goodman, 1951, p. 63). Containment begins with the first contact with the client and ends during the termination phase (Schlesinger, 2014). But

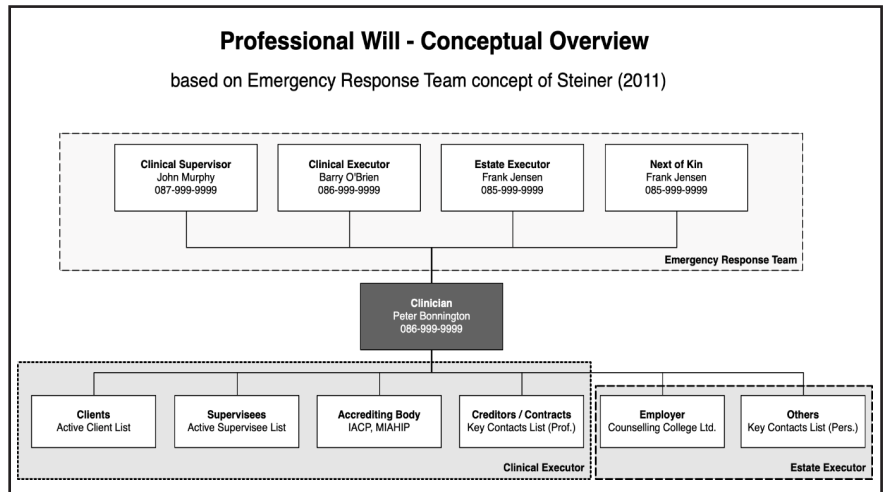


Figure 1: Professional Will - Conceptual Overview.

not all terminations are planned and when those terminations are sudden, unexpected and shocking (as in the unexpected cessation of therapy due to therapist incapacitation or death) the impact on the client, as has been seen earlier, can be significant.

In their 2011 book *The Resilient Practitioner*, Skovholt & Trotter-Mathison describe a simple, four-phase cycle of caring, mirroring the relational foundation of the work and the essence of practice as a therapist; empathic attachment; active involvement; felt separation and re-creation. They describe the therapist as “a highly skilled relationship maker who constantly attaches, is involved, separates well [emphasis added], then steps away from the professional intensity, then does it again with a new person.” (2011, p. 21). Other writers have emphasised the importance of therapeutic endings and the need to safeguard the therapeutic encounter (Davis & Younggren, 2009; Dewald, 1982; Fair & Bressler, 1992; Norcross, Zimmerman, Greenberg, & Swift, 2017). By attending to the possibility of unexpected, unplanned termination due to incapacitation/death, clinicians can confront their own mortality and make responsible preparations to safeguard the

welfare of the various clients/ supervisees under their care.

Finally, by creating a Professional Will, clinicians safeguard the integrity of the profession of counselling/psychotherapy by upholding ethical standards designed to protect the vulnerable. By attending to their limitations, recognising their own mortality and making responsible preparations for the suspension or termination of their practice due to unexpected incapacitation or death, they demonstrate a posthumous kindness and care for their families, colleagues, clients and supervisees when they themselves are no longer able to do so in life. ☺

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**Table 1 – Summary of key considerations – Making a Professional Will**

PLAN THEMES	PLAN STEPS
<b>1. Identifying and preparing an Emergency Response Team (ERT)</b>	<ol style="list-style-type: none"> <li>1.1. Identify key individuals (other professionals) who will act on your behalf in the event of incapacitation/death.</li> <li>1.2. Identify a 'Professional Executor' and name that person in a clause or codicil in your personal will (with contact details).</li> <li>1.3. Assign roles/actions to each individual e.g. contacting clients/supervisees, 1.1. disposal of records etc. consider backups.</li> <li>1.4. Contract with these individuals, explain roles and document key tasks and 1.1. assignments based on roles identified.</li> <li>1.5. Identify preferred referral sources and/or a Bridge Therapist.</li> <li>1.6. Create a master "Files, Passwords and Contacts List" (FPC List).</li> </ol>
<b>2. Organise access to premises</b>	<ol style="list-style-type: none"> <li>2.1. Make copies of keys necessary to access your practice and any locked storage containing client/supervisee information.</li> <li>2.2. Update FPC List with office address, alarm codes, file stores, passwords for computers / phone(s) / voicemail.</li> <li>2.3. Package these into a sealed envelope and ensure the location of this package is described in your personal will.</li> </ol>
<b>3. Organise client/supervisee data</b>	<ol style="list-style-type: none"> <li>3.1. Update FPC List with names and contact details of all active clients and supervisees as well as those who have left within the last year (they may wish to return having taken a break).</li> <li>3.2. Include only that information which is necessary for your ERT to affect your wishes (consider data protection legislation).</li> <li>3.3. Organise email into folders in your email client (MsOutlook, Mail etc.). Note locations and passwords on FPC List.</li> <li>3.4. Organise computer files into folders on your computer. Note locations and passwords on FPC List.</li> </ol>
<b>4. Organise business data</b>	<ol style="list-style-type: none"> <li>4.1. Update FPC List to include key business contacts who will need to be contacted; insurance company; landlord; service providers (light, heat, phone etc.).</li> <li>4.2. Identify and document any open/ongoing business transactions which need to be closed/ended.</li> <li>4.3. Identify any billing arrangements with clients/supervisees which may require some follow up (e.g. refunds to supervisees who pay monthly in advance etc.).</li> <li>4.4. Consider what should happen with your online footprint (your website, Facebook, Twitter and other social media accounts).</li> </ol>
<b>5. Legal Review</b>	<ol style="list-style-type: none"> <li>5.1. Send copy of professional will to solicitor for reviews, witnessing and signoff.</li> <li>5.2. Distribute sealed copies to Emergency Response Team members.</li> </ol>
<b>6. Prepare 'In the event of' materials</b>	<ol style="list-style-type: none"> <li>6.1. Create instructions for contacting clients/supervisees on FPC List.</li> <li>6.2. Identify location and version of current appointments book.</li> <li>6.3. Create a list of onward referrals for clients/supervisees.</li> <li>6.4. Indicate which client records are to be disposed of and how safe disposal should be affected.</li> <li>6.5. Put aside a sum of money to reimburse professional executor (to cover their expenses and their time).</li> <li>6.6. Save a copy of your professional will with your personal will as a codicil and ensure your solicitor has a copy of both.</li> <li>6.7. Provide a sealed, dated copy of your professional will to your professional executor.</li> <li>6.8. Indicate that your business mobile phone should be securely wiped of all information before disposal/reuse.</li> <li>6.9. Document your preferences for formal communication/notices e.g. death notice, cessation of practice, etc.</li> </ol>

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## Book Review

Title: *Reframe Your Thinking Around Autism: How the Polyvagal Theory and Brain Plasticity Help Us Make Sense of Autism*

Author: *Holly Bridges*

Published: 2015

ISBN: 978-1-84905-672-4

Reviewed by: *Vincent Ryan*

model, sensorimotor psychotherapy, and the work of Bessel Van Der Kolk. The gentle movements and felt sense style of working that Anat Baniel offers fits into a well-established tradition of body psychotherapy. Thus the background science and practice of these ideas will be familiar to many psychotherapists.

*Reframe Your Thinking Around Autism* is a manifesto for a new way to conceptualize and work with people on the autism spectrum and I certainly believe it deserves attention. Bridges maps out

How can we best understand autism? And how can we work more therapeutically with someone 'on the spectrum'? These are the questions that Holly Bridges addresses in her recent book, *Reframe Your Thinking Around Autism*. She proposes that Stephen Porges' polyvagal theory, along with Anat Baniel's NeuroMovement approach, may offer novel ways to answer these important questions.

How does the author 'reframe' autism? In a nutshell, she (following Porges) hypothesizes that autism is not so much a result of structural brain defects, but rather it is more as a result of a chronic nervous system dysregulation, where the person is stuck in a cycle of profound fight, flight and immobilized state that arrest neurotypical development.

Bridges does not subscribe to the 'refrigerator mother' theory of autism, nor does she want parents to feel blame for their child's difficulty. On the other hand, she (following Porges) hypothesizes that possibly some trauma trigger, during pregnancy or in infancy, might lead to chronic stress and immobilization responses that present as autism features later on in the child's development.

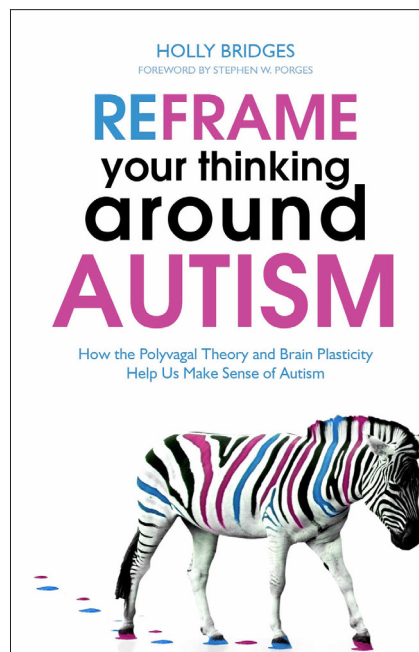
Stephen Porges has written a forward to the book and has given it his blessing. The polyvagal theory has been around for over 25 years now and is a well documented science. It has had a major impact on psychotherapy theory and practice, especially approaches that take the body more into account, notably somatic experiencing, Larry Heller's NARM

the polyvagal theory in a clear and pragmatic way and with this she does therapists of all orientations a real service. The author reports a growing base of case studies that have shown good outcomes. On the other hand, her approach is novel and there are undoubtedly processes and details that could be refined. Her approach would really benefit from some rigorous and impartial studies to better establish its' scope and limitations. Personally, I feel this would really help move it into the mainstream of treatment, establish funding for it, and build confidence in using it.

In conclusion, as a practicing psychotherapist I feel grateful to Bridges for making the polyvagal

theory and the awareness movement approach more accessible and applicable to me in my work with a broad range of clients. What she emphasizes is that everyone is 'on the spectrum' insofar as 'neurotypical' is a construct. We all share similar nervous systems that can be prone to move out of balance into fight, flight and freeze states that can be chronic and debilitating across a wide spectrum. Her book will most likely help to make the polyvagal theory more accessible to the wider public and deepen our understanding of how embodied states operate, and for these reasons I feel that her book is a valuable resource.

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