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IRISH ASSOCIATION OF ALCOHOL AND ADDICTION COUNSELLORS

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Editorial

Dear Members, Associate Members and All Readers,

We hope you had a great summer. Time to relax, to reflect and to enjoy our glorious sunshine. No doubt all of us feel renewed and refreshed, ready to embark into our work again what ever that maybe. The Executive Committee had the pleasant opportunity of inviting Tony Geoghegan and Mary Slattery to a 'Thank You' meal, this was to show our appreciation for all the good work they did for IAAAC. Indeed it was really nice catching up with both of them and hear their news.

Our Conference and AGM is going to be held on the first weekend in March 2007 so please put this in your diary... more details in our next issue. Again if you have an article/book review/ conference/workshop report etc to share with our members feel free to contact us and we will be delighted to put it to print. Many thanks to all our contributors in this edition.

Enjoy the Autumn.

Mairn and Hugh

Editorial Committee

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Congratulations Recently Accredited....

John Sherwin.....Co. Westmeath

John O'Keefe.....Co. Cork

Liam Hunter.....Co. Kildare

Gemma Collins.....Dublin 10

Maggie Bowen.....Dublin 7

Alan Higgins.....Co. Meath

Bernie Brady.....Co. Westmeath

Kevin Langan.....Co. Laois

Paul Holdaway.....Dublin 7

Lorraine Devoy.....Dublin 5

Angie Howell.....Co. Wicklow



Date for your Diary....

IAAAC Conference 2007

**Friday 2nd & Saturday 3rd March
2007**

Eye Movement Desensitization and Reprocessing (EMDR)

By Dr. Ian Mc Cabe

Dr. Ian Mc Cabe, Ph.D, Psy.D., is a counselling and clinical psychologist specialising in Addiction Counselling. He works part time for Addiction Response Crumlin with children of parents in Addiction using sandplay. He has a private practice and is a director of Alcohol Counselling Services and can be contacted on 01-496-5998. Also see:

www.alcoholcounselling.com

Eye Movement Desensitization and Reprocessing (EMDR) is a new and controversial psychological technique that claims to alleviate a range of emotional problems, including anxiety, depression, panic attacks, phobias and, in particular, post traumatic stress. Proponents claim that EMDR is the most revolutionary and successful technique to enter psychological treatment in the last 20 years.

EMDR was developed by American psychologist Francine Shapiro, who noted that moving her eyes rapidly seemed to decrease her anxiety about her own disturbing memories. She tested her theory on friends and students, who also found it helpful. Today, approximately 50,000 therapists have been trained in the method and over a million people have been treated effectively with EMDR.

Normally, minor disturbances, upsets or shocks are processed during Rapid Eye Movement sleep. However, overwhelming events may not be processed and instead be stored as painful memories in the unconscious. This happens because during a traumatic event, a part of the right hemisphere of the brain (the amygdala) produces such a high level of fear that it may close down the part of the left hemisphere (the hippocampus) that normally processes information into memory. Because the trauma is not effectively processed, it can return to haunt the sufferer.

EMDR combines eye movement with elements of other therapeutic approaches, such as cognitive-behavioural therapy. During an EMDR session, the client's eyes follow the left-to-right movement of the therapist's finger. The eye movement apparently has the effect of connecting and stimulating the right and left hemispheres of the brain thereby giving the brain a second chance to process a traumatic memory. This allows the client to effectively reprocess the trauma. While the memory itself is not erased, the emotions associated with it are lessened or are replaced by positive feelings. Reported results are primarily relief from anxious feelings associated with past traumas and an increase in self-esteem. Hor-

mones released by the brain during the EMDR process serve to make the changes permanent.

I was initially very skeptical of this quick-fix approach, believing that brief therapies such as this were band-aids that hid symptoms for only a short while. However, after hearing success stories from several colleagues, I trained in the EMDR technique.

While working at a New York clinic, I counselled several clients* who suffered from childhood traumas. A woman, now aged 64, could eat only food that was cut into small pieces or liquefied. This was related to her choking on a sliver of orange as a child. We used EMDR while discussing the likelihood that a similar incident would happen to her again. After four sessions she reported that she was eating food normally.

A 27-year-old man had, ten years earlier, taken Ecstasy at a party that was raided by the police. That night he suffered from heart palpitations, was ditched by his girlfriend and learned that a school friend had reputedly died of a heart attack. He began to believe that he would die of a sudden heart attack and was constantly worried that any pain meant that death was imminent. After our eighth session of EMDR, his fear left him and he began jogging.

A woman of 29 had been sexually abused by her tennis coach in her early teens and was told it was her fault. She was left with a sense of worthlessness, began abusing drugs and did not play tennis again for 16 years. As the sessions progressed, she felt less disturbed by the abuse, was able to cognitively and emotionally process the trauma and state that her sense of worthlessness was no longer valid. Once this negative concept was eradicated I asked her "on a scale of 0-7 how true is it that you are worthwhile?" This was intended to install and reinforce a positive belief that she was a worthwhile person who was not to blame for the sexual abuse.

After several sessions she reported that her level of emotional disturbance about the abuse was significantly reduced. She had resumed playing tennis and now had a sense of personal worth and was prepared to tackle her drug dependence.

EMDR appears to be particularly effective for people in addiction, many of whom have suffered physical and sexual trauma that may resurface if the alcohol or other drug is removed. By alleviating the emotional effect of the original trauma, EMDR can help the person face reality without the support of drugs.

There are lingering questions regarding the scientific validity and reliability of the method. Its runaway success has been compared to Mesmerism. This was enormously popular in the late 18th century and it claimed to heal people by using magnetic forces to rearrange the chemical imbalances in their bodies. Critics say that EMDR's apparent success may be due to a hypnotic effect, whereby the client is repeatedly encouraged to see the trauma as less frightening and may simply be trying to please the therapist. However, even if these criticisms are true, it would appear that the technique does work! It is more likely that the reason that it works is because the therapist is more actively involved with the client than in other methods. The therapist's attentive participation may well be that indefinable ingredient that inspires confidence in the client and acts as additional support to the healing process.

EMDR is one of the most thoroughly researched techniques for treating trauma available today. Both the clinical division of the American Psychological Association and the American Psychiatric Association have endorsed it. The Northern Ireland Department of Health, Social Services and Public Safety has called EMDR and cognitive-behavioural therapy the "treatments of choice" for post traumatic stress disorder.

*Clients granted permission and their identities have been disguised.

(Ian Mc Cabe, Ph.D, PsyD, Reg. Psycho!. Ps.S.L, is a director of Alcohol Consultancy Services, Dublin. ianmccabe@eircom.net).

This is the real Tony Ceoghegan



Accredited Membership Renewal 2006-2007

- **If** paid prior to September 2006 €80.00
- **If** paid between 1st October 30th November 2006 €110.00
- No renewals for 2006-2007 will be accepted post 1st December 2006

This is your final reminder



Ballymun Youth Action Project Limited

We have moved

Ballymun Youth Action Project, Urrús and Aftercare
have all now relocated to:-

Horizons Centre
Balcurris Road
Ballymun
Dublin 11

Contact details are as follows: -

Ballymun Youth Action Project (YAP)
Tel. 842-8071 (same number)
Fax 846-7901
Email: byap@iol.ie

Urrús - Ireland's Community Addiction Studies Training Centre
Tel. 846-7980
Fax 846-7981
Email: urrus@iol.ie

Aftercare
c/o Ballymun Youth Action Project
Tel. 842-8071
Fax 846-7901
Email: byap@iol.ie

Dropout and Related Factors in Therapy

By Jonathan Egan

Jonathan Egan is Director of Counselling with the National Counselling Service, HSE, Midland Area. He can be contacted by email tJonathan.Egan@mailq.hse.ie

Any review of the literature on clients who choose to access therapeutic services and then dropout must firstly state that the findings are based on information retrieved from a very small percentage of those who actually need an intervention. Epidemiological surveys suggest that only approximately 13 percent of individuals who receive a diagnosis/assessment based on structured interviews or instruments that warrant specialist intervention actually seek the therapeutic service they require (Clarkin and Levy, 2004).

In addition, even though most psychological therapies have been shown to be very effective (Hubble, Duncan & Miller, 1999; Lambert, 2004), approximately 8 percent of clients are worse off after attending at least 12 sessions of therapy. Some evidence suggests that the more training a therapist has, the lower the dropout rate of clients (Stein & Lambert, 1995). In addition more experienced therapists appear to be able to hold on to their clients better than less experienced.

Lambert, Harmon and Nielson (2005) reported that clinicians are historically poor at identifying which clients will not successfully complete therapy. They constructed a measure which correctly identified 85 percent of those likely to dropout when the measure is used over the first three sessions of client contact. They could successfully identify 100 percent of clients whose condition had deteriorated by end of therapy when using the measure.

"Patient deterioration can be reduced if therapists are alerted to the possibility early in treatment" (Lambert & Ogles, 2004, p. 779).

Dropout rates have been comprehensively addressed in a meta-analysis of 125 outpatient therapy studies which examined factors related to attrition. This meta-analysis found that on average, one should expect that approximately 47 percent of clients will dropout of therapy (Wierzbicki & Pekarik, 1993). Even in a comprehensive research study which was carried out by the National Institute of

Mental Health (NIMH) in the U.S. where 249 clients took part in the intake process, only 169 of these completed 12 sessions of therapy! This meant that one third of the initial participants had dropped out. Research has consistently found that community studies have significantly higher dropout than better funded, more standardised and high initial contact with clients NIMH studies (Lambert and Ogle, 2004).

Some clinicians are better at keeping clients engaged in therapy and they tend to have better outcomes than those who do not. Clients who present with significant and complex difficulties may benefit from being referred to these therapists who have a skill in engaging with difficult clients (Brown & Jones, 2005).

The following section will address an A-Z of factors related to a client staying in or dropping out from individual or group therapy early. Interestingly, two factors which in general were not found in the research to be related to therapeutic outcomes were a client's sex and age (Clarkin & Levy, 2004).

The A-Z of factors related to attrition and dropout:

(A) Clients with a lower SES and who are from a minority culture have higher rates of dropout (Hubble, Duncan & Miller, 1999; Lambert, 2004).

(B) Severity of symptoms at presentation predict dropout (Clarkin & Levy, 2004)

(C) Negative attitudes toward therapy is related to early dropout (Lambert, 2004). The converse is also true; clients who state at the end of first session that they think that therapy is going to be helpful will have predicted 20 percent of their outcome in that initial session (Wampold, 2001).

(D) Incongruent therapy expectations are related to early client dropout. For example, a client who is treated with prolonged exposure and relapse prevention techniques is more likely to dropout from therapy if they had expected an analytic approach

for their treatment of their obsessive-compulsive symptoms. (Hubble, Duncan & Miler, 1999; Clarkin & Levy, 2004; Wampold, 2001).

(E) Initial negative evaluation of the therapist by the client results in early termination (Bachelor & Horvath, 1999; Clarkin & Levy, 2004).

(F) Clients' expectations of therapy and more importantly, the strength of the therapeutic alliance as rated by the client predicts their level of attrition and treatment outcome (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004).

(G) Prochaska (1999) found that 93 percent of clients could be correctly classified into three groups; (a) premature terminators, (b) early but appropriate terminators and (c) continuers in therapy. This correct classification of clients was based on the stage of change that they identified themselves in. Those in the precontemplation phase of change, quickly and prematurely dropped out (40 percent). 20 percent of clients were in the in the action stage when entering therapy, these clients tended to finish quickly but appropriately. Finally, a mixed, larger group of clients, most of whom (40 percent) were in the contemplation stage continued in longer-term therapy.

(H) Clients with personality disorders, particularly narcissistic issues and young hostile clients with a diagnosis of borderline personality disorder have higher dropout rates. Clients with a dependent or histrionic personality tend to have better outcomes and stay in therapy longer than those with borderline, schizoid, narcissistic, schizotypal, paranoid and antisocial personality disorders (Clarkin & Levy, 2004; Hubble, Duncan & Miller, 1999).

(I) Clients who present with initial hostility dropout quicker than those who present as open and agreeable (Clarkin & Levy, 2004; Tallman & Bohart, 1999). Clients with high levels of resistance in the therapeutic relationship benefit more from non-directive therapy and those who have a non-defensive stance have better outcomes from a more directive therapeutic approach (Beutler et al., 2004).

(D) Clients with abnormal sleep profiles have poorer outcomes than those with normal sleep profiles (Thase et al., 1997).

(K) The mismatch between therapist and client result in early termination; this is especially true where there is an ethnic mismatch (Hubble, Duncan &

Miller, 1999; Lambert, 2004).

(L) A psychological formulation of a client's treatment by the therapist results in a higher treatment effect over a medicalised formulation of the clients problems (Hubble, Duncan & Miller, 1999; Lambert, 2004: moderate effect size difference).

(M) The 'light-bulb' analogy holds true: clients who are ready for change appear to have better outcomes and reported levels of engagement in the therapy process than those who do not report that they are ready to change (Clarkin & Levy, 2004).

(N) Psychological mindedness is more important for clients in short-term therapy but this factor is not related to outcome in medium to long-term therapy (Clarkin & Levy, 2004; Prochaska, 1999).

(O) Better ego strength in a client, their capacity to hold onto their identity despite psychic pain, distress, turmoil and conflict between opposing internal forces as well as the demands of their reality has been found to be related to better treatment outcomes (Clarkin & Levy, 2004).

(P) Introjective clients, those who are perfectionistic and self-critical have better outcomes when attending a psychoanalytic approach versus psychotherapy. Anaclitic clients, those who have fears of abandonment and concerns about loss have better outcomes when attending psychotherapy rather than psychoanalytic therapy (Blatt, Ford, Berman, Cook, Cramer, & Robins, 1994).

(Q) Object Relations: 'a person's life long pattern of relationships and their characteristic way of interpreting social information' (Clarkin & Levy, 2004, p. 208). Clients with less maturely developed object relations can only utilise therapy as a supportive adjunct to life, the more maturely integrated object relations of a client, the more the effects of the therapeutic relationship can be generalised to other relationships.

(R) Attachment Patterns: Clients with a secure attachment style fare better than those with insecure attachment styles: "They perceive themselves as competent in relationships and expect a positive response from others" (Clarkin & Levy, 2004, p. 209). There is some evidence that a therapist's attachment style interacts with that of their clients and this influences the quality of the therapeutic relationship (Bachelor & Horvath, 1999).

(S) Situation specific versus chronic, recurrent problems are more responsive to behavioural interventions (Hubble, Duncan, & Miller, 1999; Lambert, 2004).

(T) Clients with better interpersonal styles have higher outcome results in group therapy than those with poor interpersonal ability (Burlingame, MacKenzie & Strauss, 2004) (*The Irish Psychologist*).

(U) Anxiety disorders respond better to therapies that use in-vitro and in-vivo exposure techniques (Ogles, Anderson, & Lunnen, 1999).

(V) Group therapy has a higher level of attrition of clients who have started therapy than those clients who have started individual therapy (Hubble, Duncan & Miller, 1999). Dies (1993) suggested that certain clients should not be selected for group therapy because of this high level of drop-out. Dies (1993) suggested that clients who are in an acute crisis, who have a history of broken attendance in therapy, who have major problems of self-disclosure, who express difficulties with intimacy, who mistrust close relationships, who use denial excessively, who have impulsive behaviour patterns, and who have expressed that they don't want to attend group therapy should not be selected.

(W) Groups with around ten to eleven members have been found to have more attrition than groups with around eight members. In addition, clients who were invited to attend an extant group were more likely to dropout. Importantly, clients who were waiting/or more than a year on a waiting list were also found to dropout early compared to those on a waiting list for less than a year (Burlingame et al., 2004 reporting on Kordy & Senf, 1992, a German Study of 445 clients who had attended in-patient group therapy. Original article in German).

(X) Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O'Kelly, & Steinberg (1999) found that clients in interpretive individual therapy were five times more likely to dropout than those in supportive psychotherapy. They found that when the sessions previous to a client's dropout were analysed that early in the final session the client had made their feelings with regard to dropping out obvious. The clients had expressed frustration about their therapy sessions, that their expectations had not been met, and they complained of the therapist's repeated focus on painful feelings. Therapists had addressed this by focusing on the client-therapist relationship and they had tended to make transference

interpretations. The clients resisted this focus on transference by remaining silent or disagreeing with their therapist. The therapists then tended to persist with their interpretations. An argument usually had ensued which appeared similar to a power struggle: At times therapists were rated as sharp, blunt, sarcastic, insistent, impatient, or condescending. The session would then tend to end with encouragement by the therapist for the client to continue therapy (these clients then dropped out of therapy after this session).

(Y) An eclectic approach appears to meet a client's needs better than a rigid adherence to a specific model. Most experienced therapists are reflecting this finding and are now reporting that they draw on multiple training experiences to inform their clinical practice (Lambert, Bergin, & Garfield, 2004).

(Z) 40 percent of clients spontaneously remit and leave therapy prematurely, often without explaining the reason to the therapist. This is similar to the 'placebo effect' in waiting list control groups. The improvement may be due to factors outside of the therapy environment. So, on occasion the dropout from therapy might not mean that a client is doing poorly, it may be that the client has improved because of other environmental factors other than therapy; e.g., increased social support from partner, family and friends etc.

(Hubble, Duncan & Miller, 1999; Lambert, 2004) (*The Irish Psychologist* September 2005).

Conclusion and Recommendations

Factors related to a client's initial presentation can determine their length of time in therapy, their treatment outcome and the degree to which they can engage in a therapeutic relationship, as well as whether they prematurely drop out or not. The strength of the alliance between the client and therapist as rated at the beginning of therapy by the client is strongly predictive of outcome. Using a clinician's opinion to predict dropout/engagement is not a reliable method to predict clients who will complete their treatment or drop out prematurely. Rating mechanisms and models of a client's readiness to change which are better at predicting clients who are at risk of dropout have been developed. Identifying these clients who are at risk of attrition during the assessment and early treatment phases of treatment is recommended. The factors which assist in helping these clients continue attending their therapy should also be explored.

Facilitating staff in receiving multiple training experiences should theoretically assist therapists in being better able to meet a client where they are at. This should enhance a client's therapeutic engagement and reduce dropout. It may also be useful for principal and senior psychologists to identify members in their teams who demonstrate an ability to engage and keep clients who would have been rated as a high risk for dropout.

In Ireland, there is a dearth of research in relation to the current baseline rates of dropout, premature termination and the number of clients who complete their therapy contracts. Understanding the degree to which dropout occurs in the community setting and the factors which influence higher and lower levels of this attrition may help normalise this phenomenon for psychologists at the coal face and assist their line managers in service planning.

Finally, there is no doubt that the level of dropout reported in community services is equal to a significant percentage of whole time equivalent (WTE) staff in a regional psychology service. The actual percentage of WTE psychologists' time and the monetary cost of dropout, cancellations and clients who do not fully engage in treatment needs to be assessed.

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Publications on the Website

Please be advised that current and past issues of the Irish Psychologist are now available on our website, at www.psihq.ie. A range of articles and reports from the IP will now be available to download from the website. We hope to have issues of the Irish Journal of Psychology also available on the website shortly.

Working with Issues of Addiction with Sexual Abuse

By **Rachel Somers** MIAAAC, MIACP, MIAHIP.

Rachel Somers, B.Soc.Sc., Prof. Dip. Couns. and Psych., MIAHIP, MIACP, MIAAAC, formerly employed with Merchants' Quay Project and Coolmine Therapeutic Community, she has also worked with One in Four as a psychotherapist. Rachel now works in private practice as well as teaching on the Professional Diploma Course in Humanistic and Integrative Psychotherapy in Mullingar.

Introduction

As I considered writing an article on the presenting issues facing a therapist when working with an individual who has experienced sexual abuse and addiction, I became aware and was struck by the many factors which can challenge the therapist. I became interested in hearing my colleagues' and peers' opinions and their experiences regarding this subject and was struck by the array of reactions to the subject. These included fearful facial expressions; some long silences while pondering the subject, and comments such as "well, you're not working with the whole person, are you?" As I met these reactions, I wondered what is it about the subject of working with sexual abuse combined with addiction that could possibly provoke such reactions. I was also left with the question of who is it I am actually working with, if it's not the whole person.

The following article is an account of the presenting issues relating to individuals who are in therapy to process issues of sexual abuse and addiction. It explores the resistance to this type of work, and the gap such resistance can leave. I have outlined the defenses met within the individual and the awareness the therapist needs to work in this area and thus explores the overall difficulties presented when working with an individual who has experienced sexual violence and uses addiction as a coping strategy.

Resistance and Reluctance

I initially became aware of a resistance to working within this field some years ago. I discovered a reluctance within some organisations and even with individual therapists to working with the issue of addiction in conjunction with sexual abuse.

This reluctance came and presented itself in my experience as an addiction counsellor as I attempted to refer clients for therapy regarding sexual abuse. I was met with several similar responses of "the client will have to deal with the addiction before we can

see him/her", or "not until they have finished their treatment". This restriction created a waiting period for the client who needed to avail of appropriate support services when most vulnerable. Such responses not only highlighted a gap and delay in the level of support available to the client but also encouraged me to question the whys regarding this gap. Surely, an individual, if addicted whether it is to food, sex, heroin, alcohol, etc., will constantly be dealing with, or in recovery for this addiction for the rest of his/her life. Therefore, how can the individual seek adequate support and therapeutic intervention regarding experiences of sexual abuse when needed?

In my work as a psychotherapist and addiction counsellor, I have found that the issues involved in working with individuals who have had an experience of sexual abuse or violence and who use addiction as a way of coping, can be complicated. The therapist can discover varying additional issues which require a wide range of skills and education. The therapist can become challenged to work in a way which can often conflict with various schools of thought regarding psychotherapy and its process.

A Challenging Approach

Having worked within the field of addiction for 6 years I became aware of the issues which presented themselves when working with an individual. I was struck by the large proportion of clients, initially coping with addiction, but also who had used their addiction as a coping mechanism to relieve the pain of their experience of sexual abuse or/and violence as a child. The basic recovery issues facing the client in recovery for addiction involve behavioural adjustment, self awareness, self identity development, knowledge of addiction and cognitive denial, underlying factors, relapse prevention, stress management, personal goal setting, social development, understanding relationships, assertiveness training, money management and further education. When working with an individual who has experienced sexual abuse one can expect to meet post-traumatic stress, depression, panic attacks, dissociation,

obsessive compulsion, impact and distress of the trauma, flashbacks, sleep disturbance, fear, anxiety, terror, loss, relationship issues, social isolation, physical manifestations, eating disorders, suicidal ideation and self harm.

A cognitive, educative and often directive approach is required when working with the individual who is working through addiction. This teaches and encourages the client to explore the defenses and behaviours the individual uses to 'get what they want'. When observed, these defenses often become evident within sessions and in the therapeutic relationship with the therapist. This transference experience can be very useful to work with and in my opinion, must be worked with before the "whole person" may become revealed. Addiction can often be the defense strategy used to mask and avoid working through the internalized affects of sexual abuse and sexual violence. Therefore to enter into a therapeutic alliance with the client who has experience of both, means to adopt an often educative and cognitive role toward client work, as well as the humanistic and person-centred approach. This can challenge an entire core belief as to what therapy is and involves.

Mechanisms at Work

It is my belief that the ultimate aim for the individual dealing with sexual abuse and addiction in therapy is to take personal responsibility for the self and the behaviours used to cope with life before any exploration of past experience can occur.

The following is an account of what one may meet as a therapist working with such an individual. These behaviours can seek to withhold the individual from the experience, emotion and thought of sexual abuse as a child or young adult.

1. Blame

Blame is often met when working with clients dealing with addiction and sexual abuse.

A lengthy period of time might be spent in this position. While here the client can explore emotions such as frustration, irritation, anger and rage, the potential for the client to become enmeshed in this position is quite high. The client might blame others for their own behaviour, feelings and thoughts. There can be a reluctance in naming and taking responsibility for the self. The focus on "He made me feel", as opposed to "I feel", can act as a barrier at times to connection with self and the personal

experience. Therefore the therapist must be confident in sensitively challenging this behaviour once the individual begins to present this enmeshment. To not challenge this behaviour facilitates the client to remain in this position and can enable the individual not to take personal responsibility for the self and their own recovery.

2. Maximization

To maximize, is a behaviour often used by the individual dealing with addiction and sexual abuse. This behaviour can provide the space and the time for the subject of change and responsibility to become much bigger than is the reality. As long as change is too big and unreachable, then the potential for taking personal responsibility is greatly reduced for the client. The therapist must be capable of bringing this to a state of awareness for the client. By using cognitive awareness, the reality of the 'now' must be presented to counteract the client's often distorted and manipulated perception.

3. Minimisation

Minimisation is the mechanism which can be used again by the client, to alter the current reality of the client's situation. Sometimes the addiction and/or abuse can be presented as 'lesser than' the reality. As with Maximisation, the therapist needs to explore the reality of the situation with the client. In this work it can be important to explore the reality and challenge the before mentioned distorted perception of the client.

4. Justification and Rationale

These can be the strategies used by the individual to make the abuse or addiction 'ok'. If the subject is 'ok' then it does not need to be explored, expressed or worked through. Therefore change (in the eyes of the client) is not needed. The therapist might be met with remarks such as "It's not that bad" or "It's nothing major". The therapist can sometimes become confused and bewildered by a blizzard of words, ideas and false reasons which can only serve to interfere and prevent the individual from being seen. The damage experienced as a result of sexual abuse can be extensive. Sexual abuse is an intensive form of violation and can lead to the individual feeling objectified. The self can be seen and experienced as an object rather than a person deserving of care and attention. With this the person can take on the shame of their abuser and can develop irrational beliefs of 'being a bad person'.

The therapist might hear statements such as "I will never heal" or "all I'm good for is sex". These beliefs and behaviours, if facilitated and left unchallenged will only serve to restrict the level of recovery the client is fully capable of achieving.

5. Denial

Denial can be described as an ego defense mechanism that operates unconsciously to resolve emotional conflict and to allay anxiety by refusing to perceive the more unpleasant aspects of external reality. The individual believes their own deceptions and distortions and therefore observes the contrasting opinion of others as false. This suppression of reality can enable the client to avoid personal responsibility. It can be important therefore to inform and educate the client as to the differing mechanisms used to defend the self from the reality of the sexual abuse.

6. Manipulation

Manipulation can be presented in varying different patterns for the individual and is an effective method whereby the client can 'get what they want'. Instead of asserting the self in a direct fashion (because the skills may not be there to do so), the therapist might find him/herself manipulated. For e.g. to provide extra sessions, not to challenge, for sessions to be missed, and to allow the boundaries of the session and the relationship to loosen. While I worked in an addiction treatment centre I became aware of a consistent pattern of client's informing me of how wonderful I was, how good I was at my job, and how pleased they were to have me as their therapist. This extreme affirmation and massaging of my ego served to hold me back from challenging and confronting the negative behaviours aligned with their addiction. If the client is not challenged then no change will occur. Thus the therapist can only act only as a facilitator for continuing the addictive behaviour and ultimately enables the client to continue to avoid responsibility.

7. Not Too Close But Not Too Far

Individuals who have had an experience of sexual abuse will either have difficulties with intimacy or distance. This can manifest within session as the therapist must become conscious to create a balance between the two. There needs to be a positive distance from the client without appearing non-engaging as well as creating a positive alliance without breaking boundaries and being too close. It

is important for the therapist to be aware of the nature of dependency and how this may impact on the client/therapist relationship. Dependency is:

"In social and personality psychology, the reliance to a higher degree than normal of one person on another (or others) for emotional, economic, or other support." (Reber and Reber 1985)

Once the client has relieved the self from the dependency of the substance or behaviour, this dependency can also be transferred to another object, often the therapist. While in all therapeutic relationships, boundaries are important, there needs to be a heightened awareness of these when working with a client who has had an experience of sexual abuse and addiction.

This may manifest through a desire by the client to learn more about the therapist's personal life, a need for extra sessions, a desire for advice, and an overall elevation of status for the therapist in the eyes of the client. Often the therapist might feel as though they have been placed on a pedestal where their every word is hung on by the client. In my experience, this can affect the client's recovery process whereby an individual places the utmost importance on the one to one therapy process and therefore neglecting or disregarding other support services and mechanisms which have previously been put in place to avoid relapse. Whilst this devoted commitment can be positive, the therapist will undoubtedly and naturally fall from the transferential pedestal leaving the client having rejected any other potential support in danger and therefore placing the self in the path of relapse.

When working with an individual dealing with addiction and sexual abuse, the therapist can experience a situation whereby boundaries are tested. There can be an inconsistent pattern of attendance, late arrival to sessions, a difficulty in committing to the process, poor payment of fee etc... These presenting issues, when worked with and addressed, can be invaluable to the individual's process as the behaviour can often reflect the individual's attitudes and experiences outside of the therapy space. This can be a prevalent feature for the individual who has been sexually abused and who uses addiction as a way of coping. Trust is extremely difficult. To commit to any relationship is testing and rife with danger for the client who expects to be abused again. Thus to enter into a relationship with the therapist, to give their innermost thoughts, feelings and experiences is high risk.

8. *The Transient Client*

The often transient nature of the individual who is in active addiction can add to the difficulties involved in maintaining the therapeutic relationship. There may be no fixed address for the person who moves from one accommodation to another regularly which can add to difficulty in staying consistent with attendance. There may also be difficulties with money management and placing importance or value on sessions and on the relationship between client and therapist.

9. *Co Dependency*

The individual in therapy may be living with family or a partner and in a co-dependent relationship. A co-dependent relationship is a:

"Mutual dependence such as that between two individuals each of whom is emotionally dependent upon the other". (Reber and Reber 1985)

This ultimately can influence the individual's recovery and the therapeutic process. The co-dependent system for the individual is one whereby the person develops co-dependent relationships rather than interdependent ones. They can become entangled with each other and lean excessively on one another rather than standing separate. The person then cannot be autonomous and cannot conduct life according to their own needs and values. A co-dependent's behaviour can be self-defeating and self-destructive. This can prevent the person in therapy from achieving change in their own lives. The co-dependent partner can often be the one to carry and manage all the feelings within the relationship. This can result in the individual quite literally leaving his/her emotions at home.

I have found it can be very difficult to work with a co-dependent client whose family can seek to intervene in the individual's therapeutic process. While I worked with a client who had managed his childhood experiences of sexual abuse with the use of heroin, I became harshly aware of his family attempts at intervention and interruption in his process. I was met with phone calls from the family, a demand for confidentiality to be wavered for their information, and an overall attempt to sabotage their son's healing through the creation of arguments and stresses within the family system. I was later to discover that the threat of their son's behaviours changing through therapy would mean their roles as enablers and facilitators of the

addiction would be challenged. This would ultimately leave them available to explore their own dysfunctional attitudes and behaviours. It was easier and less intrusive an experience for them to observe their son as the problem as opposed to taking responsibility for their absence when he had needed them most.

10. *Relapse Prevention*

To work with such an individual brings to the fore the issue of possible relapse. When dealing with such sensitive issues of sexual abuse/violence, the therapist must be very aware of the possibility of potential relapse. Relapse prevention can depend on relationship between therapist and client focusing on issues such as assertion, warning signals to prevent relapse, interventions should relapse occur, phases of recovery and exploration of high risk situations. Positive support structures must be in place for the individual in therapy when managing issues and experiences which have long been buried. Thus the therapist must be educated in his/her knowledge of organizational support, meetings with Alcoholics/ Narcotics/ Overeaters Anonymous etc... and be conscious that the client is consistent in their attendance at such support. The therapist also needs to be mindful regarding re-triggering the abuse trauma which can re-activate the need to withdraw back behind the addiction. It is also important to focus the client on potential support required for their families as often family difficulties and a lack of familial support can play a role in potential relapse.

Conclusion

So what is it to work with the individual as a whole? To me, whole represents the physical, emotional, mental and also spiritual aspects of the individual. Yet the person who has the added experience of addiction as a method of coping with an experience of sexual abuse/violence, may be physically dealing with withdrawals, emotionally disconnected, mentally affected due to years of damage caused by chemical and physical abuse, and spiritually unaware. An individual who has had an experience of sexual abuse/violence can present as being extremely vulnerable, sensitive, insecure, fragile, fearful and isolated. This individual may also present as being capable, competent, independent, controlled and a fully functioning member of society. In my experience of working with such individuals who as a result use addiction as a strategy to cope with such traumatic memories and experiences of sexual violation, is to work with the defenses and strategies

used when the substance or behaviour of the addiction is removed. Overall, to work with this client represents the 'double whammy' of clinical issues which is not only challenging to the therapist to facilitate such work, but demanding a directive, confrontational, and educative relationship. This can confront and unnerve the therapist's skills and confidence in sitting with such a barrage of issues, emotions, thoughts and perceptions met. In my opinion it is no wonder that a reluctance exists to work with this individual. However my fear exists that to resist and reject this individual, as has been my experience with some therapists and organisations, is to continue the experience and pattern of abuse the client is very familiar with.

1. Reber and Reber (1985) The Penguin Dictionary of Psychology. 3rd Edition.
London:Penguin . Pg.188

2. Reber and Reber (1985) The Penguin Dictionary of Psychology. 3rd Edition.
London: Penguin. Pg. 127

***Below is a wonderful poem Audrey Hepburn wrote when asked to share her "beauty tips."
It was read at her funeral years later.***

For attractive lips, speak words of kindness...

For lovely eyes, seek out the good in people.

For a slim figure, share your food with the hungry.

For beautiful hair, let a child run his/her fingers through it once a day.

For poise, walk with the knowledge that you never walk alone... People, even more than things, have to be restored, renewed, revived, reclaimed, and redeemed; never throw out anyone.

Remember, if you ever need a helping hand, you will find one at the end of each of your arms. As you grow older, you will discover that you have **two hands**; one for helping yourself, and the other for helping others.

WISHFUL THINKING

CHILDREN PLAYING IN THE STREET BOUNCING BALLS
BETWEEN THEIR FEET
HAPPY FACES ALL A GLOW
NO WORRIES AT ALL
NO PLACE TO GO

LITTLE GIRLS SKIPPING FREE AND WILD
O WHAT A JOY TO BE A CHILD
SMALL BOYS CLIMBING APPLE TREES
NO BAD THOUGHTS OR MEMORIES
I WISH THAT WAS ME

L WISH I COULD GO BACK TO THAT TIME

I WOULD MAKE DIFFERENT CHOICES ALONG THE LINE

I SHOULD HAVE KNOWN BETTER THOUGHT I KNEW IT ALL

BUT I WAS REALLY HEADING

FOR SUCH A BIG FALL

I HAVE MADE BIG MISTAKES
HURT THE PEOPLE WHO CARED
BUT MY SECOND CHANCE IS HERE
AND I AM VERY AWARE

John Flood

Centre for Sexual Addictions

New website now at
www.csa-addictions.ie

For information on
client supports, professional training etc

Email: info@csa-addictions.ie

Attending to Freud: report on Freud 150

Barry O'Donnell, Ph.D.

Barry O'Donnell works as a psychoanalyst in private practice as well as working as a counsellor in the Drug Treatment Centre Board, Trinity Court, Dublin 2. He also lectures and is involved in course development in academic and clinical training programmes in the School of Psychotherapy (St. Vincent's University Hospital and UCD) and DBS School of Arts. He is currently chair of APPI.

Just over 100 years ago Sigmund Freud introduced a new clinical practice, psychoanalysis, on the basis of his insight into the unconscious processes of the human mind. This practice is a response to the questions which underpin the human condition and which determine psychopathological expression as well as the everyday experiences of discontent and unease. These fundamental questions, for the most part unavailable to our conscious thought, ask how we are in our bodies, how we face our limitations, our lack and our finitude. Addiction, which we recognise today as one of the most prevalent forms of psychopathological expression, is a way of living which successfully gathers up and provides strategies for the handling of these questions. But at a price.

Psychoanalysis allows us to see how the position of the addict may constitute a resistance to, if not refusal of, any articulation of the questions. Freud himself encountered addicts in his practice and while he did not elaborate a theory of addiction explicitly his work constitutes an extensive elaboration of what it is the addict is refusing. Recognition of the fundamental and psychologically terrifying, if not annihilating, forces at work in the human mind allows us to appreciate just how powerful addiction can be. For all the suffering it may bring, addiction may, nonetheless, be preferable to facing into an alternative form of management of the forces of the body - the drives of sexuality and aggressivity - and their problematic modes of enjoyment. In other words, Freud's work allows us to situate addiction in the context of the difficulty and anxiety of human being. In his remarkable 1930 paper *Civilisation and its Discontents* Freud includes intoxication amongst a list of "techniques for the conduct of life" necessarily adopted by each of us. (The list includes the so-called normal techniques of work, creative endeavour and caring for others as well as the supposedly more pathological forms such as isolation, neurosis and madness. Each of these techniques in their own way attempts to accommodate and seek satisfaction for the sexual, the aggressive and the narcissistic impulses which constitute each of us.) Those of us, therefore, specifically occupied with the manifestations of human suffering in forms of addic-

tion would benefit from attending to Freud. Our own experience of psychoanalysis can radically inform the treatment we dispense as well as provide a framework for consideration of our own question and our own part in the work that we do.

The Association for Psychoanalysis and Psychotherapy in Ireland (APPI) formed in the early 1990s to represent and advance in Ireland the work of Sigmund Freud and his follower, the French psychiatrist and psychoanalyst, Jacques Lacan. On 12 May 2006 APPI hosted *Freud 150*, a day of papers and discussion marking the 150th anniversary of Freud's birth in 1856. The event was held in the Education and Research Centre, St. Vincent's University Hospital, Elm Park and there was a very good turn out from workers in the fields of counselling, psychotherapy, general practice and psychiatry. Each was interested in hearing more about the contribution to their work and lives which psychoanalysis can provide. The day consisted of a series of papers presented by clinicians who have chosen, on the basis of their own experience of psychoanalysis, to let their work in various clinical settings be informed by Freud's insight. There was also very engaged participation in the form of questions and discussion from the floor.

To begin Professor Kevin Malone of the Department of Psychiatry and Mental Health Research in St. Vincent's University Hospital provided Opening Remarks in which he re-iterated his support for psychoanalytic work and the training informed by it offered by the School of Psychotherapy in St. Vincent's. He stressed its crucial contribution to mental health work in Ireland.

The first speaker of the day was Cormac Gallagher who introduced the room to the continuing relevance of Freudian-Lacanian psychoanalysis. This was most appropriate since it was Dr. Gallagher who introduced Lacanian psychoanalysis to Ireland in the 1970s, work which led to the founding of the School of Psychotherapy itself in the 1980s. A key message in Cormac Gallagher's paper was the way the Freudian discovery has been elaborated and kept alive through the work of Jacques Lacan. He pointed

out that psychoanalysis is not a set of deadened and deadening dogmata, unless we make it such. He emphasised that it is the responsibility of those working in the field to maintain a productive interrogation of their relation to psychoanalysis through their own analysis, supervision and theoretical elaboration. Returning to attend to the rich nuances of Freud and Lacan's work can be the basis of advancing our own work and its understanding. He contrasted this approach to that which adopts a hostile attitude towards psychoanalysis and everything associated with the names Freud and Lacan, an attitude which does not contribute anything productive to the clinical investigation of our human being and its inevitable subjective suffering. We should not be afraid to have confidence in the insights of great minds and allowing them to inform our practices.

The next speaker was Helen Sheehan, a Lacanian psychoanalyst working in Dublin who makes a very important contribution to psychoanalysis in Ireland. The title of the paper was 'Sigmund Freud: a time for understanding'. Through consideration of Freud's extraordinary short paper 'The Moses of Michelangelo' and Lacan's formulation of logical time Helen Sheehan brought to our attention a moment in the history of psychoanalysis when Freud took up a position which marked psychoanalytic work off from other modes of psychological work. This again was an important paper for psychoanalytic practitioners as they work to articulate their own relation to psychoanalysis. It also had a lot to say to those new to the field who can hear that psychoanalysis requires a position distinct from other forms of psychological work, a position achieved through analysis and not founded on frustration, vengeance or the whim of the mob. This was an appropriate message on a day aiming to delineate the specific contribution psychoanalysis makes. It is important for psychoanalysis to remain true to its endeavour in the face of the discomfiting truths it uncovers and in the face of less problematic, more appealing forms of intervention.

Gerry Sullivan, a Lacanian analyst and practitioner in Chinese medicine, spoke of Lacan's interest in Chinese thought. This allowed us to hear of one of the ways the fundamental questioning present in Freud's work has been elaborated by Lacan. In particular Gerry spoke of how Freud's work allows us to think of human being in a new way just as an encounter with Chinese thought can be the basis for clarifying the presuppositions about our being in the world.

After mid-morning coffee Mary Darby, consultant psychiatrist in St. Vincent's, introduced six speakers who gave brief presentations reflecting the way psychoanalysis informs their work in a variety of settings. Angela Noonan and Emer Rutledge spoke of

their work as Senior Registrar psychiatrists. Angela questioned the speed with which we medicalise difficulties and Emer proposed a psychoanalytic response to Borderline Personality Disorder. Claire Hawkes, who works as a psychotherapist in Schizophrenia Ireland, proposed combining medication with psychoanalysis in the treatment of psychosis. Malachi McCoy who works with young people in the new addiction unit in Belgard Road suggested that the actions of the self-harmer and the car thief be considered the expression of the same fundamental difficulty in different languages. He quoted the French child psychoanalyst Catherine Mathelin who has said that the child's world is one of horror, hatred and death for which a sugary response is not appropriate. Bernard Kennedy presented work in progress from his Ph.D. research on the sense of the symptom in psychoanalysis as a response to the question of subjective suffering. Mary Cullen spoke of her work in the Mount-town Community Project in South Dublin. She focussed on the place and the function of the father in society and in each individual's psychological make-up. It was generally felt that this series made a very valuable contribution to the day in so far as it represented the way psychoanalysis directs work which goes under a range of different job descriptions.

After lunch Patricia McCarthy, psychoanalyst, psychiatrist and incoming Director of the School of Psychotherapy, proposed that recent documents - one 'A Vision for Change' produced by the Government's Expert Group in Mental Health Policy, the other a mission statement from UCD - can be responded to in accordance with psychoanalytic principles. Patricia McCarthy challenged the meeting to engage with the social and with the discourses of state and university in order to let psychoanalysis inform developments in these areas.

Helena Texier provided interesting insights into the inaugural dream of psychoanalysis, the dream of Irma's injection as well as speaking about her experience with her psychotherapy practice in Dublin. Aisling Campbell of University Hospital, Cork, presented challenging questions concerning the differences between psychiatric and psychoanalytic work. As a consultant psychiatrist and psychoanalyst she has daily experience of these questions and was somewhat pessimistic about current psychiatric practice in Ireland allowing itself to be informed by Freud's work. Dr. Campbell asked how psychoanalysis could situate itself in relation to the mental health services demanded by psychotherapeutic intervention in that context. She said that psychoanalysis

alone can provide insight into the inevitable transference onto any mental health service itself and, particularly, onto the consultant psychiatrist. And it is the transference which determines every patient's relation to, and attendance at, their service, or programme whether that be mental health, addiction or, indeed, general medical. For psychoanalysis to be effective it must be let function somewhat outside of 'the system', on its margins, so to speak. My own paper which traced Freud's discovery of transference highlighted the specific aspect of human being to which psychoanalytic work responds, namely hysteria. Freud's work allows us to see that hysteria is not a medical problem as such in that medical intervention in relation to it is futile. Hysteria is, however, a problem for the medics and other health care professionals to whom it is addressed every day of the week and whom it successfully frustrates and infuriates. A psychoanalytically informed position is required to work with these everyday manifestations of transference whether in the clinic of addiction treatment or general practice.

The remaining time was given over to the floor to ask questions and make comments. Jackie Montwill, Senior Registrar psychiatrist from the Drug Treatment Centre Board raised a concern psychiatrists have regarding psychotherapy with patients diagnosed as psychotic (the dual diagnosis, as it is being called these days). Cormac Gallagher assured her that those training in psychoanalytic psychotherapy are strongly advised against working with psychosis in the first years of their training but that psychoanalytic intervention by an appropriately trained analyst could occur in conjunction with medication. Such psychotherapeutic intervention offers the patient the opportunity to speak about their life and articulate their condition. Professor Noel Walsh, who set up the School of Psychotherapy with Cormac Gallagher and Mary Darby in the 1980s and who trained in analysis, spoke of his experience working psychotherapeutically with psychotic patients along side of being their medicating psychiatrist. John Cooney, consultant liaison psychiatrist in St. James' Hospital observed that, by and large, psychiatry knows what to do regarding the pharmacological treatment of psychosis and welcomed the idea of patients with psychosis being provided with the opportunity to speak. He said, however, that psychiatry was at a loss when it came to the other forms of psychopathology which present themselves. As a liaison psychiatrist he works with hospital patients who have not been admitted with a major mental illness as such. He said that it was in relation to the other forms of psychopathology that psychiatry would very much welcome the contribution of psychoanalysis. On this note the day's discussion drew to a close. The contributions at the end strongly indi-

cate that there is a very real interest in what Freud's work can offer to clinicians in the field of mental health. It now is the task of psychoanalytic practitioners to respond to that indication.

There is an opportunity in the coming months to participate in that response. As well as regular clinical seminars APPI holds an annual Congress in November. This year the Congress will be held on 24th / 25th November in the Education and Research Centre, St. Vincent's University Hospital, Elm Park. With a number of highly regarded clinicians from home and abroad attending and speaking, the event will explore the work of Jacques Lacan as well as take further the discussion of the ways in which psychoanalysis can contribute to and productively inform clinical practice in Ireland today, including the treatment of addiction. (See www.appi.ie)

The Association for Psychoanalysis and Psychotherapy in Ireland (APPI) In the early 1990s the Association for Psychoanalysis and Psychotherapy in Ireland (APPI) formed as a learned society. It drew together graduates of the School of Psychotherapy, St. Vincent's Hospital, and others, who had trained abroad. What they had in common was a commitment to the work of Jacques Lacan. The group worked to advance Freudian and Lacanian psychoanalysis in Ireland through practice, seminars, reading groups and congresses. Members of APPI were instrumental in setting up courses in psychoanalytic studies and a clinical MA in Psychoanalysis at The Centre for Psychoanalytic Studies, LSB College, Dublin (now DBS School of Arts). Members set up *The Letter*, a Lacanian journal which has gained an international reputation. Through these activities APPI and its members supported the provision of elements of training in the field of psychoanalysis in Ireland. From incorporation in 1998 the primary object of the company has been "to advance Freudian and Lacanian psychoanalysis and psychoanalytic psychotherapy." It states that "in keeping with the Freudian principle, this advancement shall remain centred on the personal psychoanalysis as the indispensable means by which the practice of psychoanalysis and psychoanalytic psychotherapy can be transmitted, studied and understood." APPI holds a Register of Practitioner Members which allows members to have their experience and practice in the field of psychoanalysis recognised. APPI continues to work to represent the work of Freudian and Lacanian psychoanalysis, one instance of which was the Freud 150 event. The website is www.appi.ie

Rik Loose, psychoanalyst and author of *The Subject of Addiction - psychoanalysis and the administration of enjoyment*, describes addiction in terms of a strategy for the administration of the drives of the body by taking in a toxicant. This is an alternative to the never entirely successful management of the drives with other strategies such as work or relationships. Loose, R. *The Subject of Addiction - psychoanalysis and the administration of enjoyment*, Kamac, 2002.

Bottled Messages

by Rolande Anderson

How do they get away with it? Is there anyone out there who cares? These sorts of questions have been irritating me so much that I wrote this article. I am sick to the point of nausea of disingenuous bland advertisements in all forms of the media regarding alcohol. The drinks industry and its puppet organisation, 'Meas' (Mature Enjoyment of Alcohol in Society), have a proliferation of messages that are allegedly designed to help us think about our drinking and to encourage us to drink more moderately. So we have ads that go like; 'enjoy/drink such and such sensibly/ moderately/ responsibly'. 'Don't see a great night wasted' and variations. This trend is catching on too and I recently heard some other product being similarly advertised. Soon we will have, 'Enjoy beans sensibly' or 'drive cars moderately! Alcohol is 'no ordinary commodity' as the excellent book by Tom Babor et al reminds us and the industry is in a classic double bind. On the one hand they want to sell their products, maximise profits, sponsor sport and music and tv programmes etc while on the other hand they want to be seen to be behaving responsibly. They worry about retribution and state control. In particular they fear health taxes, bans on advertising and law-suits by individuals and families harmed by their products. They are concerned about future profits and the tide turning, as it did with tobacco. So they solve this dilemma by trite, meaningless, sound bite advertisements. They call it social responsibility.

Let us have a closer look at such bottled messages, 'Enjoy xxxx sensibly', just as an example. I have numerous problems with such ads. Who is the target audience? The general population?, young people and children?, pregnant women?, people drinking on their own?, people drinking in the morning?, people who are alcohol dependent?, people who are in recovery? - because they all see and hear them - and what is sensible drinking? There are no limits given, daily or weekly, no advice proffered and no exceptional circumstances.

Another problem is the actual language used. The ad contains another double bind. 'Enjoy drinking' is one instruction and 'drink sensibly' is a separate one. Psychologists tell us that we only remember the first bit of any such instructions. So the message most of us hear and see is 'enjoy drinking'.

Now look, I try to be reasonable, and I do understand that ads have to be short. I know that it is not easy to get a quick slogan to prevent alcohol

related harm. For example it would be difficult to include the following; 'Don't drink to the point that you don't know what you are doing, that you try to climb over a barbed wire fence or swim across a river or kick someone violently or get so depressed that you might contemplate suicide' or never, ever get into a car when you are drunk, not even as a passenger, because passengers who are drunk can cause fatal accidents'.

Yet we have seen excellent counter advertising. Ray D'Arcy in conjunction with an advertising agency has commissioned brilliant hard hitting radio advertisements to discourage drinking and driving that appear to be effective.

Every day of my working life I see the devastating effects of alcohol on the lives of individuals, families and communities. Heavy drinking has been normalised in our society and there are truly awful consequences for the way we live. Absenteeism, industrial accidents, domestic violence, street aggression, marital breakdown, sexually transmitted infections, unintended pregnancies, abortions, homicides, suicides, psychiatric illness, insomnia, hypertension (and loads of other physical conditions), road traffic accidents, personal misery, family disharmony, addiction, attendances at 'A and E', and hospitalisations are all dreadful prices we pay for our national problem. The causes and solutions to our drinking culture are complex. We need a Noel Browne type of politician who will lead us out of the current situation. We also require good will, government intervention, public support and ongoing commitment. Let's start with a small gesture and get rid of the pithy public messages from the industry. Public health messages are best left in the hands of the appropriate professionals and those with no profit motives. If you agree with these sentiments please do complain. Write to the newspapers and other media outlets that carry such ads, to the advertising standard authorities and to your politicians. The vested interests must not be allowed to get away with such bottled messages.

End
15.5.06

Rolande Anderson is an Alcohol Counsellor and also Director of 'Helping Patients with Alcohol Problems' with the Irish College of General Practitioners.

Dear Editor

I read with interest Arlene Vetere and Mavis Henley's stimulating article describing their pantheoretical approach within a community alcohol service by integrating systemic psychotherapy with group analytic psychotherapy.

For readers who might like to know more about Group Analytic Psychotherapy, I would like to draw your attention to the advert in this edition to the forthcoming workshop at Group Analytic Practice. The workshop could be of benefit to those who may be considering further training in Group Therapy or who are completing individual therapy with clients with a view to referring to Group or those who might just like to explore the theme of Longing and Belonging in a safe and secure workshop.

Yours Sincerely

Deirdre Foran

Group Analyst/Psychotherapist

Director Group Analytic Practice

I A A A C Training Dates for your Diary

Relapse Prevention

**Facilitator: Austin Prior
Friday 20th October 2006
All Hallows College**

Supervision Training

**With Val Wosket
Dates to be announced shortly**

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Longing and Belonging in a Stranger World

A Group Analytic Exploration

This year we have chosen as our theme 'Longing and Belonging in a Stranger World'. As society becomes more complex and embraces greater diversity and plurality we can often find ourselves in a strange and 'stranger' world. Finding a secure sense of belonging, a pre-condition for emotional well-being, may present new challenges to the individual both personally and as a member of the group.

Our workshop this year offers an opportunity to participants to explore these themes of strangers and strangeness and the longing in all of us, amidst such turbulence and feelings of isolation, for a healthy group identity.

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