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A New Look for the IJP

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Mariahilfer Srtraße 1d/e, Stock/Tür 13, A-1060 Vienna, Austria
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INTERNATIONAL JOURNAL OF
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International Journal of
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The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally. It is properly (double-blind) peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students. The Journal is published by the European Association for Psychotherapy (EAP), three times per annum. It has been published for 23 years.

It is currently working towards obtaining a listing on several different Citation Indices and thus gaining an Impact Factor from each of these.

The Focus of the Journal includes:

* Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research
* Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings
* Matters related to the work of European professional psychotherapists in public, private and voluntary settings
* Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast expanding field
* Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings
* Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world
* Current research and practice developments - ensuring that new information is brought to the attention of professionals in an informed and clear way
* Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession
* Connections, communications, relationships and association between the related professions of psychotherapy, psychology, psychiatry, counselling and health care
* Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession
* Reviews of new publications: highlighting and reviewing books & films of particular importance in this field
* Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession
* A dedication to publishing in European ‘mother-tongue’ languages, as well as in English

This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide.

We have recently developed several new 'Editorial Policies' that are available on the IJP website, via the 'Ethos' page: **www.ijp.org.uk**

International Journal of
PSYCHOTHERAPY

The IJP Website: www.ijp.org.uk

The IJP website is very comprehensive with many different pages.
It is fairly easy to negotiate via the tabs across the top of the website.

You are able to subscribe to the Journal through the website – and we have several different 'categories' of subscriptions
You can purchase single articles and whole issues as directly downloaded PDF files by using the Catalogue on the IJP website. Payment is by PayPal.
We also have printed copies of most of the Back Issues available for sale.

Furthermore, we believe that 'Book Reviews' form an essential component to the 'web of science'. We currently have about 60 books available to be reviewed: please consult the relevant pages of the IJP website and ask for the books that you would enjoy reviewing: the reviewer also gets to keep the book.
All previously published Book Reviews are available as free PDF files.

We also have a number of articles that are currently freely available on-line (top left-hand corner of the website). There are a couple of articles available from the forthcoming issue in advance of publication.

We also have an on-going, online 'Special Issue' on **"Psychotherapy vs. Spirituality"**. This 'Special Issue' is being published in several parts and the various parts are available freely on-line after publication.

In addition, we have a couple of briefing papers: one on 'What can Psychotherapy do for Refugees and Migrants in Europe?'; and one on 'Mapping the ECP into ECTS to gain EQF-7: A Briefing Paper for a new 'forward strategy for the EAP'.

INTERNATIONAL JOURNAL OF PSYCHOTHERAPY

Volume 23 – Number 2 – July 2019

EDITORIAL: "A New Look for the IJP"

Dear Readers of – and Subscribers to – the IJP,

Whilst we have continued to produce 300-500 printed issues, 3 times per annum, for the last 22 years, all of a reasonably high quality and all reasonably on time, we are also looking at how to "keep up with these 'digital' times", as well as the more old-fashioned "keeping within budgets". We have also – in my time of involvement – made available all the previously published articles and issues – through our "Catalogue" at ridiculously low prices.

At the start of this year, we were looking moving much more towards publishing **both** an e-journal **and** a printed journal, but with less printed copies. We want to keep the option open of having a printed issue to all our subscribers, as well as catering to the increasing usage of – and even desire for – purely digital media, besides cashing in on the economic benefits.

The primary reasons for these – quite radical – changes are: **(1)** the steadily increasing international postage costs, on top of the basic printing costs; and **(2)** the various current constraints – in terms of: **(a)** the number of pages per issue; **(b)** the time & costs involved in printing, packaging, transporting and distribution; as well as **(c)** labour, storage space, resources, time, etc.; in addition to **(3)** any other ecological, environmental and economic reasons – in terms of money, lower transport costs, lower postage costs, less labour, etc.; and, finally, **(4)** the shift of available (but limited) "editorial" & "administrative" resources – especially in terms of time and energy – more towards the quality of production and editorial work, rather than (perhaps) more timely and costly distribution logistics.

We had therefore decided to re-organise our whole printing and distribution system over the next 12 months, which had been currently quite over-complicated – involving 'proprietors' in Vienna; an (English) Editor in Scotland; a (Polish) Assistant Editor currently in Oxford; an Executive Editor in Poland; our printers in the Ukraine; and then deliveries needed to be made from Lviv to Budapest; so that, eventually, the individual printed copies could be posted out from Hungary to all of our readers and subscribers.

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However, as always, one can make fantastic future plans and then 'Someone-Up-There' laughs, tweaks our reality a little, and so then everything changes!

In this particular case, due to various mistaken policies and procedures, all of our outline plans for next year have had to be implemented somewhat immediately during this financial year, starting with this issue; and thus we have had to do a lot more with a lot less: it has actually been very, very difficult and somewhat depressing.

Since we were going to be going more digital, we also felt it appropriate to give all our published articles a DOI: this is a long string of numbers and letters that helps to identify 'digital objects' across the internet: it's supposed to be a good thing. It is also quite complicated to set up.

Anyway, we hope that you will approve – in due course – of these (somewhat) 'paradigm' shifts into a 'new look' for the IJP, even though you may not see any great external differences at first, but … if this is not the case … please **let us know your views and opinions** and we will print them in our 'Letters to the Editor'.

* * * * *

A New Look for the IJP

And so, now, in this particular issue of the International Journal of Psychotherapy, we offer you, first of all – besides this editorial – a very interesting article.

The topic of trauma in psychotherapy seems to be a very popular topic of interest at the moment, and this article brings a fresh and interestingly developmental perspective: **'From repeated impingement to cumulative trauma: A psychodynamic approach to the development of obsessional thinking – in some cases'**. This article is by a new author to the IJP, **John O'Connor**, an eminent professor at Trinity College, Dublin and it is also a very interesting research article.

There are many different aspects to trauma and many of us are more than familiar with Post-Traumatic Stress Disorder (PTSD) and how to treat it. Some of us are also aware of certain aspects of what is called 'trans-generational trauma', whereby trauma experienced in one generation is – to an extent – transmitted down to the next generation.

Now, we have an interesting exponent of what O'Connor describes as 'cumulative trauma'. This is something that most psychological clinicians may be aware of in their clients: in a somewhat simplistic example, the client has experienced 'this' trauma, and then has experienced 'that' trauma (often before the effects of the first trauma have been resolved). The effects of these different, and often quite widely spaced-out traumas therefore tend to accumulate. This is an example of 'cumulative trauma'.

Next, we come to another article, **Dependent Personality Disorder (DPD) & Treatment Response to Psychodynamic Therapy versus Cognitive Behavioural Therapy: A Case Study.** This article is from **Rami Abukamil**, who is a doctor at the Wayne State University, School of Medicine, Department of Psychiatry and Behavioural Neurosciences in Detroit, Michigan and **Shibany P. Toarmina,** a Ph.D., based at the Wayne State University, Schools of Medicine Department of Psychiatry and Behavioural Neurosciences in Detroit, Michigan and the Children's Hospital, Detroit, Michigan. They raise some very interesting points.

Our next article is, **Gestalt Therapy for Love Addiction**, a short, though very interesting, article on a rarely acknowledged theme, coming from one of our regular Italian contributors, **Rosalba Raffagnino**, and also from one of the former Presidents of the EAP, **Riccardo Zerbetto.**

The next article is another short article, **'Thinking Outside of the Box': An unconventional intervention**, from a student of one of our fairly regular Israeli contributors, **Avromi Deutch** with **Seymour Hoffman**. The unconventional intervention – in this case – is the use of arm-wrestling within the therapy situation.

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We then have three more articles that form part of the on-going series of articles about **'Psychotherapy vs. Spirituality'**. The first two of these articles take us further towards the somewhat contentious issue of Transpersonal Psychology: first, there is **'Transpersonal Psychology as a Science'**, by Pier Luigi Lattuada, who emphasises the specificities of transpersonal psychology, as well as its weaknesses, which its opponents often use to deny its validity: currently Transpersonal Psychotherapy is not recognised by the EAP as a scientifically-valid modality.

The next is a major article by **Mario Schlegel**, entitled: **'Criteria for Science-based Psychotherapy and the Emancipatory Aspects of its Secular Spirituality'.** Whilst this does not specifically support Transpersonal Psychology, it makes the case for C.G. Jung's Analytical Psychology being considered as sa scientifically-valid psychotherapy, though a European organisation representing Analytical Psychology or Jungian psychotherapy has not yet applied to the EAP for such recognition.

Again, this lack of accreditation may be due to the field of "psychoanalysis" seeing itself as something different from "psychotherapy"; and also "psychology" being defined as a different 'profession' from psychotherapy - and so any Jungian-based 'psychotherapy' organisation would tend to fall in between two or three different stools: none of which says anything about the excellence of the psychotherapy itself.

There is then a dialectic type of article about **'What is a Spiritual Psychotherapist?**' that was a presentation that I made at a UKCP Conference in 2000. I think you will find that the points that I made then are still quite valid.

We then have four very interesting and diverse Book Reviews, which we see as an essential component of the 'web of science' – and this completes this particular and very full issue.

Finally, in addition to all of the above: *please remember* that there are also several articles that are currently published 'on-line' & 'free' (here)[1]: ***'Read Current Online Articles Here'*** [top-left corner of the IJP website] – **in advance of their print publication**, which are , in due course, superseded by several articles published in advance of the next issue.

Also available, in this ***'Current Online Articles'*** section of the IJP website, are: **[1]** a number of articles that form part of the on-going 'On-line' Special Issue on "**Psychotherapy vs. Spirituality"**, which will be joined by the two articles above; as well as **[2]** a couple of EAP 'briefing papers' that have not been 'published' elsewhere: – **(i)** one on **"What can Psychotherapy do for Refugees and Migrants in Europe"**; and – **(ii)** a brand new one on **"Mapping the ECP into ECTS to gain EQF-7: A Briefing Paper for a new 'forward strategy' for the EAP"**.

This last briefing paper was produced in advance of the EAP meetings in Vienna in February 2019 and was designed to be especially informative for the second round of meetings with all the (now more than 90) European Accredited Psychotherapy Training Institutes (EAPTI). It tries to explain all the various different and quite complicated elements that go towards making up a realistic 'forward strategy' for the EAP into the 2020's.

We will continue to publish other articles and points of interest. We hope you will continue to be interested by our issues and our articles.

Courtenay Young
IJP Editor

[1] http://www.ijp.org.uk/index.php?ident=97705a95fdc2a4886f9b24061803f0f5c60270cb

From repeated impingement to cumulative trauma: A psychodynamic approach to the development of obsessional thinking – in some cases.

JOHN O' CONNOR

Abstract

Obsessional thoughts, both overt and covert in nature, form the central part of the profile of symptoms of Obsessive-Compulsive Disorder (OCD). In the one hundred years and more of theory relating to the origins of obsessional thinking from Freud to Salkovskis, a discussion has developed around the possible role that life events play in precipitating or in other ways contributing to its development - through predisposing to, maintaining or exacerbating the condition. The paper urges a closer examination of the cumulative interpersonal traumas that appear to lie in the background for many of these clients. The post-traumatic patina of obsessional thinking lends itself to a suggestion that an intimate link exists between sustained traumatic interpersonal environments and the development of rituals and ruminations. This paper proposes a way of understanding the link between intrusive obsessional thoughts, multiple impingements into the private space (that is, into those zones where the entry of others is neither welcome nor bearable) and the relative absence in the early interpersonal world of spaces in which to deal with these impingements. Three case vignettes are briefly discussed in order to provide support for the suggestions made here. Some implications of this conceptualisation for therapeutic work are outlined.

Key terms: Obsessive-Compulsive Disorder; Obsessional thought; Cumulative trauma; Impingement.

Introduction: A Post-Traumatic Patina

I have elsewhere considered the issue of the uncertainty of the protective 'screen' as a dynamic in the development of obsessional thoughts (O'Connor, 2007). Here, I am keen to examine what it is that happens when such a screen is not in position and when, in its absence or in its precarious presence, the developing ego and internal world is exposed to multiple and repeated impingements or encroachments.

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The concept of cumulative trauma seems to sum up such repeated exposures entails and it is this concept that lies at the centre of this paper.

The subject of trauma is one that extends through a great body of work and it should be stressed that the term is used here to describe the internal impact of internal and external events (used in the broad sense), rather than to refer actual events in themselves as is sometimes the case. Trauma can arise in a subtle, almost invisible, way. The normal processes that we have for detecting such experiences fail in these instances because such trauma really takes place under the strain of multiple small external events. We are more equipped in our role as observers to acknowledge the traumatic reality of those great life and death events, where one's life is at imminent threat or the life of another is threatened or taken.

In earlier papers, and with a number of colleagues, I have considered other aspects of the dynamics of OCD that are related to what is discussed here. I have been concerned with the kinds of issues that are now not registered frequently in the mainstream literature on OCD, particularly perhaps because of the kind of consensus position that has developed between a biological and a cognitive model.

As I have suggested elsewhere, the environment may play a decisive role in shielding the child from, and modulating the nature of, potentially noxious external realities; underexposure, as overexposure, may similarly contribute to the development of a sense of the world as dangerous (O'Connor, 2007). I have argued that OCD can be understood partly, and certainly not in its totality and in its every appearance, in relation to the dynamics of early protection and exposure provided by the environment against and in relation to various emotional impingements and insults. Then, my emphasis was focussed on the processes of shielding as well as failures in this capacity, with only passing reference to the nature and content of such impingements. Here, it is the issue of such impingements and, in particular, the idea that multiple micro-impingements can lead to a level of cumulative trauma that leads in turn to the appearance (in some instances) of obsessive thoughts and compulsive rituals.

For anyone unfamiliar with the lives of people diagnosed with OCD, its most significant aspect is perhaps the extended repetitive nature of its central features: i.e. that the ruminations and rituals are repeated over and over. The obsessive person's life becomes tied in with the realities of these repetitions, running in a direction very different to any ideals that we might have around human development (i.e., with the development of new experiences; a passing on from and away from ways of being; and ultimately a flourishing). There is, in OCD, a feeling of both a highly primitive core (in the wildness of the obsessional thought) and something that is more refined (the person's conscious efforts that, running alongside the more obvious ritualistic compulsive actions, involve a

high level of developed and sophisticated rationalisation).

I think that, in the current context, it is useful to conceptualise a shared kind of a tension that exists within us as humans between early and later versions, or between naïve and more mature versions, of the self and the world. This is ultimately the tension between the raw and the processed; between the wild and the tamed; often, what we think and what we would like to think.

In time and with some therapeutic help (i.e., a complex thinking mind, able to give us space and to do a part of the work) and when things are turned over and worked through, as opposed to remaining unprocessed, in their original or only vaguely-developed form, there is potential for development in thinking and for a relatively flexible and open approach to oneself and one's world. In their unprocessed form, things are terrifying and there is an ongoing battle between good and bad, variously embodied and shared between the self and other.

While an enormous body of work has been published in this area, in our thinking on obsessions and compulsions, and in the diagnosis of obsessive-compulsive disorder (OCD), these have arguably developed little since Freud's case account of his famous patient, the 'Rat Man', and the theoretical ideas that he presented around this presentation (Freud, 1909). Significantly (though less widely acknowledged in relation to OCD), Klein has made some suggestions which can help us forward here somewhat. Indeed, her theory itself – particularly around the transition from paranoid-schizoid to depressive position, might sound like a description of the emergence of a general obsessive process with experiences of guilt related to destructiveness leading, among other things, to efforts after atonement and reparation. Of course, at the same time and in developing his ideas on this area, another of his most detailed clinical studies, of the so-called 'Wolf Man', contained also elements of obsessional thinking.

There is still a great level of mystery around this subject and, for many professionals, a sense of inadequacy (bordering on impotence) in responding to people who present with these kinds of states – with the power of conviction and compulsion to act which comes here – in spite of confident messages around the effectiveness of a variety of approaches here. One of the reasons for this is perhaps the extent to which obsessional thoughts and compulsive rituals are entangled for patients with wider aspects of their lives, both in the present and stretching into the part. Here, the question of trauma emerges as a niggling, complicating one and often leaves clinicians feeling frustrated and ill-equipped. We do not seem to know quite where to place it, particularly within a relatively a-theoretical approach.

As well as a recognition of a basic failure at the level of containment, and thus of an ability to think-through, attention to a developmental

dimension, in the manner described by Bion – one in fact that overlaps with and works with the basic failure - is important here. I think that we might see in OCD a rather basic, though complicating, response to a kind of traumatic experience or of traumatic experiencing (with a stronger focus on the experiencing than on the nature of the traumatic event); the basic response however attains a rather complicated, certainly a demanding, form.

In a sense, the approach is one of battening down the hatches, of spotting and stopping, albeit tragically temporarily, the kind of uncomfortable reverie of one's own destructiveness. It is arguable that trauma always brings together a reality that includes an external component alongside an internal process of response; it is never simply a recorded event, though the formation of a record is a part of trauma.

Traumatic experiences can be characterised as involving a threat to the integrity of inner experience, with the experience of the vulnerable parts of the self, subject to internal or external aggression. By defining the traumatic experience in this way, we are moving away from the narrow sense of trauma (as something to be present only for those who have experienced physical or sexual abuse or who have experienced a life-threatening event or witnessed the injury or death of another or of others). It is important to broaden our definition as, to keep it narrow means that we can regularly miss a traumatic origin of difficulties and miss the overall interaction between experiences and the features of our psychological lives.

Does such a form of cumulative trauma reflect multiple traumatic moments essentially bonded or stuck to one another, so to speak, or something different? My sense in working in this area is that very many people, who present with obsessional thoughts, have experienced environments where there is a relatively high level of unmodulated anxiety. There may also be a heightened sense of phobia and panic and uncertainty, which was not really addressed in a way that sufficiently softened its edges, but continued in the environment over the span of childhood (or significant parts of it).

There was often a great cautiousness and a sense that things had to be closely monitored and managed. It has appeared to me that these men and women are liable to experience their environments consistently as hostile in nature, with a sense of paranoia or a phobic sense of things. While anxiety is inevitable in our everyday experience, and arises even when there is little obvious to arouse this, this being a part of our very nature, it is certainly coloured and influenced quantitatively by the level of anxiety in the environment, particularly when this is sustained and unmodified. It can seem that the unmodified anxiety of one generation is left for later generations to handle and modify.

Cumulative Trauma: An Introduction

The idea of cumulative trauma is particularly well developed by Khan (1963), in a sense drawing together in this concept something which has a wide observation and perhaps even an implicit tenet of many psychoanalytic accounts. It is also an idea that develops out of the clinical insights of Winnicott, most obviously, where the potential, achieved and not achieved in varying measures, of a facilitating environment, where there is a potential for impingements of different kinds, including what arises from the anxieties of the parents. When he wrote of 'impingements', Winnicott was understandably more concerned with reactions to these events, rather than the events in themselves; the reaction is, at least in part, a protective, self-protective one (e.g. Winnicott, 1955, 1956, 1960). Winnicott (1956) defines 'impingement' as "something that interrupts the continuity of being, that very thing which, if not broken up, would have formed itself into the ego of the differentiating human being" (p. 387).

In his classic paper, 'The concept of cumulative trauma', Khan drew out a distinction between: **(a)** a trauma resulting from some such a great event that interfered in some absolute manner in the person's life (leading toward, in some instances, what we encounter as post-traumatic stress disorder); and **(b)** a trauma that results from the experience of a whole series of events that were not themselves at such a level experienced as traumatic.

Taken together, these events, along with their aftermaths, add up to something much greater than any single one of these events would in itself. For the person, such events can seem very great indeed, perhaps not ever lodged or categorised or otherwise codified as a trauma, or as something that means something similar. Therefore, this event exists as a silent, yet salient and pressing, contribution to something much greater. The idea of cumulative trauma also helps us to understand the traumatised sense that we can sometimes have of people whose lives do not appear clearly to have contained any traumatic experiences of the type that we normally consider traumatic – witnessing something that threatened their own life, or the life of another, for instance.

The concept of cumulative trauma today still proves useful in accounting for those situations in which great difficulty – often of the kind we see following substantial obvious trauma – appears in a person, who had an apparently trauma-free childhood, or a difficult childhood that, at the same time, showed no major headline events that seem to meet our usual criteria for trauma. The concept of cumulative trauma continues to be of use, indeed necessary, today in thinking about what we meet in general therapeutic work and how we might respond to this (e.g. Sugarman, 2008; Lenoff, 2014). It is also a concept that proves useful in thinking about our wider cultural experience (e.g. Young-Bruehl, 2012).

There is even room still for a consideration of a kind of background cumulative trauma, comprising, for instance, "a child's experience of chronic lack of attunement to her developmental needs" (Lenoff, 2014, p. 63). The concept of cumulative trauma has also been drawn on so to think about those shared traumas that have influenced our overall group psychologies, including the development of international relations, alliances, etc. (e.g. Young-Bruehl, 2012).

It should be underlined from the outset that there is no uniform agreement among experts and professionals (in this field of OCD) regarding the impact of events, traumatic or otherwise, on the development of the condition (e.g. de Silva & Marks, 1999, 2001; Dinn, Harris & Raynard, 1999). There is certainly no body of research that points to the universal influence of such events, or to any kinds of events in particular that are predictive of the development of this disorder.

It is even more outside the current range of thinking about OCD to suggest that an accumulation of experiences (such as has been described) in the concept of 'cumulative trauma' has a clear impact on the development of OCD. In some senses, this paper presents a speculative reading of what might take place in OCD, based on clinical material that does not present altogether clear and conclusive evidence. However, we believe that the suggestions made here are worthy of presentation, because they provide what may be a useful avenue into our understanding of the connection between difficult life experiences and the details of obsessional thoughts. In working with people with OCD, we often see what appears to be a meaningfulness in the kinds of obsessional thoughts that appear. Far from being incidental, they often link into the life of the patient in a very clear manner.

These thoughts do not appear incidental or alien to the central concerns of the person. It is this observation that provides the very basis for looking further into the biographical basis of OCD. In turn, the focus of this paper is on the connection between cumulative traumatic experience, on the one hand, and obsessional thinking and compulsive actions, on the other.

With this connection, we are attempting here to examine some of the issues that are implicit in thinking around the treatment of people with OCD that are significant, if we are to going to develop a fuller understanding of the place of traumatic (often cumulative) experiences in the lives of people with this OC disorder.

Accumulation and Rumination

For the purposes of this paper, I am inclined to think of this process of cumulative trauma as a kind of 'embrittling', brought about by waves of negative experience against a relatively undefended ego. This is similar to the kind of experience of 'freeze-thaw' action, whereby what are relatively small events, in their backward and forward quality, occasion a change at the level of the integrity of experience. As well as existing at a number of different levels, the consequences of trauma are multiple, as are the kinds of events that are implicated as possible causes and stimulators of trauma; yet, there is also often a kind of brittleness that is shared here, as well as a wariness/warding-off of things that might be threatening.

One of the details that has impressed me most in working with people with obsessions and compulsions – usually with a diagnosis of obsessive-compulsive disorder (OCD) – is the presence of what I have come to think of as a 'post-traumatic patina' here, often without the presence of anything that we would ordinarily codify as a trauma. It is as if there is a kind of a colour and tone to what presents that appears like what we see when a person has actually experienced something of a traumatic nature at an interpersonal level, or something that has weakened their relationship with the world, and has eroded their confidence in their own safety. Certainly, our initial interactions contain no references to these, and although some people may have experienced significant gross traumas, such as physical or sexual abuse, and it is only some time later that we come to recognise a kind of body of experience, gathered and imposed over a long period of time, which seems to comprise an accumulated level of trauma of a kind. There may even be more than one route to what we can describe as psychological trauma and that comes to play a part in the development of various disturbed states of mind. There are those types of traumatic experiences, possibly related to those near-death or life-threatening events that nearly all can recognise as potentially shattering to our narcissistic assumption of personal immortality.

This is the kind of traumatic experience that we have in some way institutionalised within the diagnosis of post-traumatic stress disorder (PTSD): – the experience of coming oneself face-to-face with the horrors of war; the immediate threat to one's own life in accidents and attacks; from the relatively ordinary to the extraordinary; etc. There are also numerous experiences of other kinds that do not involve such clearly threatening material but which, nonetheless, leave a strong mark on the person of a kind that is similar to, though not identical to, what we see in these more obvious traumatic cases. A part of this post-traumatic patina may result from

either/both of: the absence of a protective 'psychic' shield, sufficiently robust to stand up against what is coming at the child; and the presence of a range of events, small enough in themselves in an objective sense, which certainly amount to something much greater (subjectively).

What may be most problematic for the child is that – alongside the cumulative trauma – is another kind of experience, being the absence of any kind of closeness in the parental/familial relationships that might help to offset these impingements, ~~. In fact, it is due to the absence of something that can~~ or protect the child against such impingements. We might consider that what normally takes place for the child (and adult) is that such difficult experiences are slowly metabolised. What we might see, in the early stages of OCD, is the presence of something that is accumulatively toxic, in the absence of anything detoxifying. There is, at large, an unprocessed something that retains a continuously ~~scourging~~ abrasive quality. There is a presence within him that he cannot work through and get out it of his system. He or she is like the patient who, in the absence of a surgical solution to their pain, is left to deal with it through pain killers alone. This defensive or obfuscating reaction is necessitated when a more healthy process of working through is not available.

It seems important to specify the context in which such a cumulative trauma may develop from the impingements described above. This may be found within the sphere of interpersonal experience, defined here in relation to the experience of close relationships, where the need for contact, warmth, acceptance and love is met by an environment that is unable to provide this to various extents. Such an impingement is generally not a deliberate mindful act where a parent or other person damages the child knowingly; it is an act that takes place within the interpersonal context of the particular child and parent, for instance. It is important to maintain quite a broad view of what is described as interpersonal relatedness because great variations exist here. Not all families, where there is a high level of disturbance, are unable to respond to the needs of their children. Equally, not all people are similarly in need of this sort of protective and soothing interpersonal contact: some people require a great deal; others not require very much; while most lie somewhere in-between, just needing to find a good deal of support within their interpersonal lives, in order to experience relative safety and to be able to tolerate some level of absence and emptiness. What we might see here as an 'emptiness' is then really a function of a gap between what is needed and what is available. Some situations create a hunger can never be satisfied; some people are so resilient that the merest crumb will suffice.

It is often the anxiety of the parent and the acts that he/she performs in order to dispel, mentalise, or otherwise quell

this anxiety that is the most significant impingement for the child. The parent's anxious attempts to spare the child the toxins of the world leads them to closely guard their child and be over-protective. But, it can also be so, in the absence of such safeguards, that leads to a too-great onslaught on unbuffered material that is significant here (e.g. O' Connor, 2007).

Case Material

It may be useful to describe some instances of cumulative trauma in order to illustrate how it arises and how it may influence the emergence of obsessional thoughts, as it is understood here. This certain patina of cumulative trauma is apparent in these short clinical vignettes.

Case A: Robert

Robert is a forty year-old man whose life has been brought to a virtual stand-still by a variety of obsessional thoughts and by similarly dramatic and demanding rituals appearing in his early adolescence – something that might be said of most people with OCD. When we look to his life for traumatic events, we find few that would individually appear to amount to something normally considered as traumatic. There are no early losses through death; he has had no major accidents; he has not witnessed nor been a victim of physical violence; he describes no other specific events that are of a similar magnitude. However, he is caught up in a way of experiencing the world as dangerous that, on closer examination, seems to emerge from what are on the surface small, though quite consistent, lapses in his care as a child. Such lapses, as his parents lost sight of him as they became embroiled in their torrid relationship, left Robert feeling highly vulnerable, with the additional traumatic fear that his parents would split up and, in so doing, abandon him.

In meeting him, I felt myself wary of my own mishaps, oversights and particularly aware of anything else that might impinge on him. His parents did not split up though, for years, this threat hung over the family; nor did any major events take place in the family that drew the attention of the courts, or the social services. However, it is clear that Robert experienced this environment as dangerous, though he cannot think of any specific danger that lay within it. The events that themselves seem relatively small (and sub-traumatic) in themselves added up to something much larger for him – a foundation that was fundamentally unsafe and a risk of the most terrible events occurring – something that would equate with the complete loss of a personal foundation.

In the attentive context of therapy, where detail is given significance and its value gradually amplified, Robert began to remember relatively small events that carried layers of emotion

that he began to take on in this therapeutic and restorative work. These experiences are dominant in his recollections and, in his free associations, his ruminations and rituals are discussed side by side and are interwoven with these memories.

Case B: Dermot

Dermot is a fifty- year-old man, whose obsessional thoughts emerged in an early form somewhere in his mid-childhood. Dermot's thoughts are highly distressing to him. With a (psychiatrist-imparted) diagnosis of depression, plus generalised anxiety disorder, with still-present queries around some sort of personality disturbance, he leads a life that is highly constrained – emotionally, interpersonally and socially.

He has all but abandoned any hope of finding a comfortable place in the world of work, or in the world of interpersonal relationships. His obsessional thoughts centre on violent sexual acts towards women, and he engaged in a range of complex and repetitious rituals in order to atone for these and to ensure that they would not be acted on.

When Dermot described his childhood after some months of psychotherapy, having been fearful of speaking about it initially, he does so with great drama, although with little show of sadness. It is as if he is convulsed with all the emotion that he holds very tightly and expresses only through a raised voice and a sharp aggressive tone. He calls it 'endless hell' and stresses how no one who had not gone through it could possibly have any appreciation of it. He concedes that there was no direct physical violence directed towards him, but an overall atmosphere of continuous hostility, sometimes verbal and sometimes through means of lengthy, heavy silences. He describes the emptiness between himself and his parents, and – because they were so engaged in their struggles with one another – that there was no space for considering him at all. There was an 'on-and-on', endlessly continuing, quality to the emptiness he experienced. His obsessional thoughts seem to reflect a desire, both to break through to contact with others through a thick layer of defences, and a sense of himself as the impinged-upon child. There was (seemingly) no explicit connection between the emotional neglect and the abusive sexual fantasies.

Case C: Lucy

Lucy, a woman with multiple ruminations and a concurrent diagnosis of borderline personality, finds it difficult to deal with separations from the people in her life, as she does with separations from things that she has (including from recently cut hair and nail clippings). She obsessively hoards things apparently as a way of avoiding feelings of loss. If she likes someone, she asks them if she could keep something to do with them – a pen, a slip of paper – as she also holds onto appointment letters, and any other items that she associates with people,

who have been felt as reaching out to her. Her parents had both been highly involved with their own difficulties (her mother had been diagnosed with bipolar disorder; her father had experienced recurrent episodes of morbid depression), apparently with little room to entertain Lucy's feelings and needs, or perhaps even to provide her with any position within the family. Her feeling – that her care is actually a kind of stalking itself – signals a formative repulsion toward her needs, mirroring a sense that she had developed from her parents, that she is not worthy of attention. Her hoarding was underlain by the feeling that she can only rely on the mementoes, and not on the person; the person is then abandoned, and the more reliable memento is put in its place. It is perhaps not surprising, from the vantage point of the approach taken here, that Lucy had grown up in an environment where little was certain; where her parents' attentions were drawn in many different directions (by way of the particular focus on alcohol abuse and the urgent demands of depressive rumination); and where her parents' unpredictable behaviour often involved acts that left her feeling very uneasy about what might follow.

With Lucy, there was a sense of a cumulative abandonment, with each small lateness on the part of her parents, each unplanned absence, adding up to an overall feeling of being forgotten and thus forgettable, of not being in other people's minds, of being excluded.

Case D: Alistair

Alistair was brought up in a family where there was a lot of talk of violence. Violence (or the threat of it) in fact, appears to have been seen as a way of bringing about change at a political level. While, in his home, he did not witness any actual violence (his parents being quite protective of their children in this sense), he was exposed to much talk of it; it was in the background chatter when people visited his home; and he heard it at meal times when talk of incidents from the day's news were discussed. He recalls conversations between his parents where violence had been condoned and where there was a celebration of it, in many instances. Now, Alistair struggles with highly violent thoughts, many of which, in their content, show strong links to the images that he struggled with as a child. It is as if such thoughts now exist within his mind as unwelcome guests, thoughts that once intrigued him, perhaps scared and excited him in differing proportions: they are now transmitted into obsessions.

Cumulative Trauma and the Changing Nature of OCD

However, the concept of cumulative trauma discussed here also needs to be considered in relation to the counterbalancing effects of 'positive' events, and experiences that can have the effect of protecting the person from the threat of the emergence of obsessional thinking. A developing

sense of a 'good object' can allow a dimming or dulling of what might otherwise accumulate in the manner described here. The counterbalance of positive experience is important in providing an assurance against such destructiveness or adversity; and this is perhaps what protects people who have much adversity in childhood from developing such thoughts.

Cumulative trauma can remain hidden due to certain defensive reactions that hide any sense of its presence. It may, for instance, be hidden behind the development of obsessive practices. In some instances, particularly where a high level of control has been exercised within a family, the child may respond to this by identifying with the controlling figure, and him/herself using this sort of control as a means of dealing with their anxiety. The identification with the aggressor (described by Sandor Ferenczi and Anna Freud, among others) leads to the attempt to cover up and conceal the real nature of the traumatic experience. Control is therefore gained in fantasy through being the figure (or being in alliance) with the offender.

The very depth of conviction in the obsessional thought seems to imply a strongly developed sense of danger that itself further suggests a feeling that the world can impinge – that the ramparts of personal defence are not sufficient to hold these at bay.

If, indeed, there is a meaningful link between cumulative trauma and OCD, there is good reason to approach the treatment of the condition through different means than are currently used by mainstream clinicians. If we are to accept a concept of cumulative trauma, and if we believe that this relates to a reality of people's experiences, these have great implications for how we go about working with people with OCD.

It implies that we need to be much more vigilant about the underlying experience of the person and the protective guards that they place between us.

Conclusion

In conclusion, I would like to underline that the concept of cumulative trauma (as explored here) provides one possible route for the development of obsessional thoughts. This account presents a broad way into thinking about how the impingement of experience may impact on the development of ruminations and rituals in OCD. It seems important to stress that this may be true, at one level of analysis, but requires further examination in order to provide a more comprehensive conceptualisation of this link. We have tended to conclude from the above that the actual family situation of the person has generally played a role in colouring the individual's obsessional thoughts, if not always in providing the foundation for their development in the first place. It may be said that such cumulative

trauma is the (often hidden) rationale for obsessional thoughts that are both: **(a)** ways of representing such accumulated experience; and **(b)** a way of defending against it. That is, the obsessional pattern of thought represents a part of experience; the manner in which this is represented (that hides the biographical piece) then serves as a defence against the anxiety associated with that experience. Sophie's obsessional thoughts of hating her son, for instance, seemed to correspond to a feeling that she herself had that her mother wished her dead – a kind of interpretation that had arisen in the context of her emotional absence from childhood and into her adulthood.

In conclusion, I am aware that the concept of 'cumulative trauma' carries with it a certain vagueness and that, indeed, within an inclusive framework, it may be used to describe the experiences of people in general. However, this vagueness may be preferable to a hardening account of trauma that leaves out several important facets of such experiences. With this, it is important to emphasise that we should avoid the kind of 'concretisation' of necessarily abstract concepts. We have (arguably) already done this, especially in relation to the meaning of trauma in the definition of PTSD, imposing on it the kind of 'concreteness' that is a part of legal and other culturally-developed discourses.

The assimilation of disappointments and ruptures (perhaps} leads to what might be loosely described as 'cumulative trauma' for everyone. However, I believe that this concept can add a great deal to the understanding of some of the dynamics of obsessional thinking; and is thus worthy of consideration.

I should emphasise that the accounts presented here should be considered quite loosely, rather than applied to the understanding of OCD. I think that it is very important to consider what it is that impinges; how this develops; and how it is dealt with at an internal level in obsessional thinking.

It should be understood that the experience of cumulative trauma does not always lead, ultimately, to the development of OCD. Rather, it serves to develop a kind of psychological reality that can stimulate the processes that themselves lead to obsessional thoughts, as it can set in train processes that lead to other kinds of symptoms, as well as processes that lead to a growing health.

It seems that we would be well advised to think about the traumatic dimension within OCD, from the kind of a 'wide-take' on trauma, suggested in the concept of cumulative trauma; and, with this, we can maintain a view of what is taking place internally, rather than becoming stuck at the level of external events, as well as the more objective dimensions of impact that are more generally the object of scrutiny in the mainstream literature in this field.

Author

John O'Connor, D.Clin.Psych., Assistant Professor of Clinical Psychology and Course Director, M.Phil. in Psychoanalytic Studies, School of Psychology, Trinity College, University of Dublin, Ireland; Clinical Psychologist and he works as a Psychotherapist in private practice, Dublin.
E-mail: joconno8@tcd.ie

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Dependent Personality Disorder (DPD) & Treatment Response to Psychodynamic Therapy vs. Cognitive Behavioural Therapy: A Case Study

RAMI ABUKAMIL & SHIBANY P. TAORMINA

Abstract

Dependent Personality Disorder (DPD) is a condition in which a person exhibits clingy behaviour, has difficulty making decisions, and needs the reassurance of others. Certain characterological traits of individuals with DPD, such as poor self-esteem, resulting in poor interpersonal relationships and self-doubt, often become obstacles to treatment. This paper aims to highlight the challenges inherent in the treatment of DPD, while demonstrating a differential treatment response of one case to two treatment modalities. After several years of limited response to psychotherapy, the patient (Ms. S) demonstrated positive gain following the introduction of cognitive behavioural therapy (CBT) techniques. CBT allowed for a positive utilization of the patient's strengths, while introducing tools to help address her areas of weakness, thereby allowing her to effectively pursue her goals.

Keywords: Dependent Personality Disorder, Psychodynamic Psychotherapy, Cognitive Behavioural Therapy

Introduction

Although dependency is a natural human trait that helps us survive, for some individuals such traits can take on more extreme forms to the point where they become maladaptive. Factors linked to the development of dependent personality disorder (DPD) include family environment, social learning, childhood illnesses, and biological predisposition with a resultant attachment style described as fearful, insecure, lacking assertiveness, and exhibiting high levels of social anxiety (Disney, 2013).

Individuals with DPD tend to be passive and may try to pass the responsibility for their life decisions to the therapist (Manilow, 1981; Millon, 1981). Such patients may use somatic complaints in themselves or their dependents to seek out medical attention (Andrews, 1985). Clinicians

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must strike a delicate balance between recognizing and validate the patient's fears and awareness of the clinician's role in either fostering or limiting a dependent lifestyle in their patients (Manilow, 1981; Millon, 1981).

Cognitive behavioural therapy (CBT) and psychodynamic therapy have been found to be equally effective in the treatment of personality pathology and for improvement of social functioning in individuals with personality disorders (also known as "Cluster C disorders") including dependent personality disorder (Verhuel & Herbrink, 2007; Simon 2009). However, studies have suggested treatment response is slower among Cluster C disorders than conditions like Major Depressive Disorder (Shea, *et al.*, 1990; Hardy, *et al.*, 1995), although treatment gains do tend to maintain for 1 to 2 years following termination (Simon, 2009). A similar lack of differentiation of treatment gains between modalities was found in a study of 138 subjects in Norway, comparing CBT to interpersonal therapy, although patients with DPD showed more improvement with cognitive therapy than those with avoidant personality disorder (Borge, *et al.*, 2010): similar results were found in a study by Hardy, *et al.* (1995).

Of the personality disorders, dependent personality disorder has been studied the least (Simon, 2009), with no large case series or controlled treatment trials published to date (Sperry, 2016). The following case highlights both the slow treatment progress described in the literature, as well as challenges associated with the treatment of an individual with DPD. Although studies have found similar treatment gains between CBT and dynamic therapies for personality disorders (Verhuel & Herbrink, 2007; Simon, 2009; Borge, *et al.*, 2010), the following case represents a departure from this, showing a greater response with CBT, following several years of psychodynamic therapy with little demonstrated improvement.

Case Presentation

Ms. S., a 47-year-old Caucasian female, has received treatment (psychiatry and psychotherapy) for depression, anxiety and dependent personality disorder for over eight years in a clinic, staffed by psychiatry residents, who carry therapy cases for one year before transferring them to a junior resident. Never married and with no children, she reported an unstable income and a history of long-term unemployment, despite holding a bachelor's degree. She reported financial difficulties and poor social support, which deteriorated upon her mother's passing. On-going mood symptoms included: a lack of motivation, feeling depressed, crying spells, anxiety and worry. Her medical history was positive for

hypothyroidism and early ovarian failure. She reported a history of substance use/abuse but she denied any current use. Ms. S. described social difficulties and depression in childhood and also reported that she was sexually assaulted at age 16 (fondled by a stranger). She also acknowledged a history of abusive romantic relationships and she lived alone.

Ms. S. was currently overwhelmed with the responsibility of managing her mother's estate after her mother's death and she expressed a lot of self-doubt. Although she succeeded in selling her mother's house and belongings, she proceeded to ruminate for several months over whether she had made poor choices, or whether she had accepted insufficient compensation from the sales. This tendency to experience self-doubt, followed by second-guessing herself long after making decisions, permeated all aspects of her life (e.g. whether to adopt a dog; what type of job to apply for, etc.), and these themes often took over the therapy sessions. Ms. S. had been prescribed various selective serotonin reuptake inhibitors (SSRIs), currently Buspirone, and also Clonazepam, an anti-convulsant or anti-epileptic, over the years. Most recently, she had reported the current combination of Clomipramine (a tricyclic antidepressant), Armodafanil (a stimulant against daytime fatigue and/or narcolepsy), and Clonazepam had kept her on 'an even keel.' Ms. S. had also received psychodynamic psychotherapy for the first five years of treatment, before (upon review of her lack of progress in symptom improvement) a change in the treatment 'modality' to CBT was recommended.

She found the transition from psychodynamic therapy to CBT quite difficult, due to her long experience with the psychodynamic treatment process and a fear of failure, due to her low esteem. Additionally, her co-morbid dependent personality disorder impeded her treatment progress. However, within a year, she had begun to respond favourably, as evidenced by an improvement in her symptoms of depression and anxiety and she also experienced increased comfort when around others.

Ms. S. again required time to adjust to the next clinician at the end of that particular resident's academic year, but, within a few months, she was able to continue with her previously defined treatment goals, including a job search, pursuing volunteer opportunities in fields that she enjoys (e.g. working with children and animals) and engaging more socially. Ms. S. became more aware of her cognitive distortions and her dependence on others, which manifested both through her history of unstable relationships and her tendency to turn to the therapist for instruction. She began to display more self-reliance and independent thought, actively pursued volunteer work in various organizations (e.g. as a tutor for children), and (with encouragement) used cognitive techniques to manage her feelings of low self-worth and failure. Despite yet another therapist transition, she was able to maintain her previous gains, and, for the first time in eight years, successfully secured

regular employment. Ms. S. also identified a skill gap in computers and had (self-initiated) enrolled herself in computer classes. She also extended her social circle and means of social support.

Ms. S. had also entered into an unfulfilling (but non-abusive) romantic relationship during this time. However, she was able to acknowledge that she chose to be with him for help and support, despite finding him unattractive. As her self-confidence and levels of independence and self-reliance increased however, his demands on her time encroached on her newfound lifestyle (steady employment, educational and volunteer goals) and Ms. S. decided to end this (quasi)-romantic relationship. Her current medications have not changed since June 2015. She has now maintained her full-time employment with the same organization for over a year; she consistently reports positive mood; and notes – for the first time in eight years – that she is accomplishing her goals.

Discussion

Individuals with Cluster C personality tend to be emotionally inhibited and averse to interpersonal conflicts (Bender, 2005). A challenge in building a therapeutic alliance with patients who have DPD is their lack of initiative and submissiveness, which may instead lead to a pseudo-alliance (Ms. S faced a constant need for reassurance). It was also difficult for her to take concrete steps towards gaining independence, prior to initiating CBT. Ms. S. experienced challenges (similar to those depicted by Livesley and colleagues, 2008), noting that she was unsatisfied with her romantic relationship. She remained in this unfulfilling relationship for an extended period of time, explaining that this provided her with the help and support that she needed. However, as her self-confidence and levels of independence and self-reliance increased, Ms. S. had ended this romantic relationship.

Patients with DPD have been found more likely to stay in treatment (Bender, 2005), as did Ms. S., who rarely missed or rescheduled an appointment over the course of her treatment. Ms. S.'s achievements were due – in part, perhaps – to an improved therapist-patient alliance and an increased motivation to engage in specific activities, such as volunteer work and assignments as a result of behavioural activation strategies.

Establishing a solid working alliance, and redirecting the patient when she began to steer towards negative thoughts, or when she turned to the therapist for advice, were pivotal in improving her outcomes. The treatment of Ms. S. followed a course similar to treatments described by Simon (2009). As noted, most

therapies, including brief, supportive, psychodynamic therapy, and CBT, have demonstrated some benefit to Cluster C patients (Simon, 2009). However, in the case of Ms. S., non-CBT focused therapy in the past, appeared to encourage a dependence on the therapist, and led to a largely stagnant symptom picture over the course of several years, while the structured nature of CBT seemed to serve to provide her with tools to alter her course in a more positive direction. Using problem-solving techniques, Ms. S. had learned to break her goals into smaller tasks and to create hierarchies (from most to least important and most easily or difficultly achieved). Indeed, studies have suggested that patients with personality disorders respond better to CBT, possibly due to the structured nature of cognitive and behavioral treatments (Hardy, *et al.*, 1995; Shea, *et al.*, 2002).

Conclusion

Ms S., a patient with dependent personality disorder, received 5 years of treatment (psychodynamic therapy and medication management) with little documented improvement, prior to beginning treatment via CBT. Although progress was very slow (compared to average CBT treatment time-frames) over the course of 3 years, Ms. S. accomplished her goals and developed the self-confidence and self-reliance that she had previously been unable to achieve. This case also illustrates the effects of co-morbid conditions and prior therapy experiences on the rate of response to CBT techniques, while demonstrating how flexibility and perseverance on the part of the therapist and the patient, despite slow progress, resulted in positive outcomes.

Key Points:

- Ms. S. experienced stagnant treatment progress for 5 years while receiving psychodynamic therapy.
- Ms. S. demonstrated significant improvement in her symptoms following the initiation of cognitive behavioural therapy.
- Patients with cluster C personality disorders have been found to respond equally well to different treatment modalities.
- Treatment responses among Cluster C individuals tend to be slower than for other psychiatric conditions.
- Individuals with dependent personality disorder have been demonstrated to respond better to cognitive behavioural therapy.
- Better response to cognitive behavioural therapy may be related to directly addressing deficits in independence and self-confidence through structure and skills building.

Authors

Rami Abukamil is an MD at the Wayne State University, School of Medicine, Department of Psychiatry and Behavioural Neurosciences in Detroit, Michigan.
E-mail: rabukamil@gmail.com

Shibany P. Toarmina, Ph.D., is based at the Wayne State University, Schools of Medicine Department of Psychiatry and Behavioural Neurosciences in Detroit, Michigan and the Children's Hospital, Detroit, Michigan.

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Gestalt Therapy for Love Addiction

ROSALBA RAFFAGNINO & RICCARDO ZERBETTO

Abstract

The increasing scientific interest about dependency has created a need to have clinical and therapeutic responses to this problem. A particular dependency type is love addiction (LA). While various clinical models can take care of people with an affective addiction, we know a little about this disorder in Gestalt therapy (GT), especially if the person's LA contains many points of comparison to some of the key concepts of this clinical model.

This article focuses on the use of GT in the treatment of LA, with the intent to form a theoretical and clinical connection between the two fields. We identify the match among some key aspects of LA with three GT's concepts: as the self and its relation with environmental; the figure –ground dynamic; and the concept of contact. Besides, we explain some ways that a therapist can use GT's methodological principles to help clients with LA in order to stabilize their mood; to achieve a realistic and integrated sense of their own worth; and a more functional relationship with the other.

Keywords: Gestalt Therapy, Love Addiction, Clinical Assessment

Introduction

Included among the "New Addiction", the so-called behavioural or non-substance addiction (as internet addiction, sex addiction, sports addiction, pathological gambling, excessive shopping and working), love addiction (LA) has been considered a psychological disorder referring to the tendency of the person to live pathological affective relationships. Many scholars pointed out its various features, some of them overlapping other dependence and affective disorders, such as the obsessive search of the other, also at the expense of own individuality (Reynaud, Karila, Blecha & Benyamina, 2010). It is different from some diseases of the spectrum of affective addiction. For instance, sex addiction focused on an activity (sexual intercourse) and the partner is interchangeable, while the LA implies an emotional relationship with particular partner (Reynaud *et al.*,

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2010); the co-dependency is expressed by a familial member who lives alongside a person who manifests some form of addiction (like alcohol) (Gayol, 2004).

Though many researches treated the LA as a relational pathology, others observed its similarity with natural situations of human beings. An example is the similarity with love passion (LP), a general and necessary condition of the human beings that involves an important motivation toward the others (Reynaund *et al.*, 2010). Within a normality's parameter, an interesting deepening of the analysis of the LA regards its association with attachment theory (Bowlby, 1969). This model affirm that human beings have innate needs to proximity to and to comfort from significant others and any threat to an attachment bond can create intense distress in the person (Bowlby, 1969; 1973). The research observed that the attachment system is not limited to childhood, but it remains active throughout the human life course, permitting the built of the adult attachment relationships (Hazan & Shaver, 1987). In these relationships, the persons with insecure attachment seem expressed some aspects of the LA as fear of to be abandonment and the idealization of the partner (Guerreschi, 2011).

In the empirical literature, some scholars proposed also a dimensional distinction between healthy and pathological LA. For instance, Bornstein and colleagues (Bornstein & Languirand, 2004; Bornstein, Porcerelli, Huprich & Markovat, 2009) observed the affiliative spectrum as a continuum between two opposite ends: overdependence and detachment, and, at the centre of the continuum, a healthy level of mutual dependency.

Working with people with overdependence, or featuring maladaptive relationships, involves working with their need to establish and maintain close ties to their caregivers, with their perception of themselves being weak and helpless, with a strong fear of abandonment by 'others'. The opposite pole of the continuum is detachment, characterized by the need to maintain a distance from others and a fear of being hurt or overwhelmed by emotional intimacy or closeness. The more healthy level of dependency is closely related to interdependence and features a flexible and adaptive dependency that involves seeking an appropriate level of help and support from others.

Fisher (2014) distinguished romantic love between those with positive addiction as being: *"when one's love is reciprocated, non-toxic and appropriate; and a negative addiction when one's feelings of romantic love are inappropriate, toxic, not reciprocated, and/or formally rejected"* (p. 238). Feeney (2007) defined the dependency paradox that implies a human being can be autonomous when he/she is able to depend on others only during situations with appropriate need's. For Mikulincer & Shaver (2007), a secure dependency allows a healthy autonomy and good self-esteem.

However, despite the many studies about Love Addiction, the confusion about its clear definition and the necessity of an adequate diagnosis and of an efficient intervention are objects of discussion among researchers and clinicians. Some scholars observed there is little knowledge about these themes, and hope for an increase in both further scientific research and clinical studies to improve the understanding and the treatment of this relational condition (Reynaud *et al.*, 2010).

Besides that, in empirical literature we found a paucity of studies about the use of different clinical models and their efficacy for the treatment of LA. In recent research, Ghaemi, Etemadi, Bahrami & Fatehizade (2018) observed the efficacy of an integrative clinical approach, formed by 'imago' therapy[1] and 'schema' therapy[2]. Some therapeutic indications about other diseases of the spectrum of affective addiction, such as co-dependency and dependent personality disorder (DPD), are also present in the literature. For instance, for working with co-dependency, in their systematic review, Abadi, Vand & Aghaee (2015) observe the main use is of group therapy, family therapy and cognitive therapy. For people with dependencies, Simon (2009) outlined the efficacy of cognitive therapy and psychodynamic treatment.

Considering the paucity of empirical evidence about the use and the efficacy of the various clinical models for the treatment of LA and that, in the clinical context, it is easier meet clients with difficulties associated with the spectrum of affective addiction, other than LA. It is important to consider not only the efficacious treatment for this disturbance, but also to analyse what criteria for its diagnosis meet the theory, method and techniques of the psychotherapeutic models. In fact, to maximize the effectiveness of a treatment, it might useful to match the core features of this disorder to the specific treatment techniques. So, each clinical model could be useful for some aspects of LA, but not necessarily for others. Besides that, the therapist should be familiar with the key features of LA, and also be able to propose an appropriate clinical pathway given the client's resources and vulnerabilities.

In this paper, we connect two fields, the studies about LA and those about the Gestalt Therapy (GT) approach: trying to match this clinical model with specific core features of LA. Proposing a comparison between the features of people with relational disturbances and difficulties and the theoretical knowledge and the key concepts/therapeutic components of GT, we are interested in how this clinical model may contribute both to the theoretical understanding and the treatment of LA, thus providing a map for other clinician's interventions.

The assessment of LA according to the principles of Gestalt Therapy

The difficulty of a clear definition of Love Addiction – the characteristics of which overlap with those, both of other clinical disorders and different natural situations – appears to sustain the necessity to get over a categorical assessment for directing the attention toward functionality evaluations, such as the dimensional paradigm which permits the analysis of LA as continuum between the distinct poles of health and pathology. Similarly, GT is a clinical model that is functionally oriented (Delisle, 1991). It focuses on the importance of the adaptation of a human being towards a changing environment and it express its faith in the person's ability to adapt to the various life situations in a fluid and healthly way for creating new ways of being in response to new situations (creative adjustments). According to this principle, the symptom is considered not as a perturbing element to be eliminated, but as a structural, also even if dysfunctional, way for the persons to adapting to their environment. Besides, the individual's growth is associated with the person's abilities to self-regulate in response to their environmental conditions (Perls, Hefferline & Goodman, 1951).

From this point of view, LA may be defined as a dysfunctional way of structuring the organism's environment field, as this relational disorder is regarded as an interrelate system of various and different features, which are not in themselves pathological, but they might become that, if they create a dysfunctional interaction between person and his or her environment. Therefore, the first observation is that – not all the persons with LA should be a candidate for psychotherapy. That is only necessary when a (so called) love state creates harm, where it has an important impact on a persons' life and their well-being (Earp *et al.*, 2017).

Gestalt Therapy describes ways to organize the relationship between organism and environment, in terms of figure and ground, at first illustrated by Gestalt psychologists (Koffka, 1935). In a healthy process, the 'figure' will emerge with clarity from their 'background' and will form a good 'figure'. The GT approach allows one to express an assessment of LA in terms of recurrent patterns of 'figure'/'ground' formation. In this relational condition, it is possible to identify an unhealthy process, as the persons involved are poorly differentiated from their ground and, for them, it is difficult to assimilate and integrate any new experiences. In fact, they express an inflexible and repetitive organization of their interpersonal field and their experience therefore becomes a rigid way of being. The flow between 'figure' and 'ground' experience can be inhibited by 'blocks' as anxiety attacks or obsessive traits that dominate the thoughts of these persons (Reynaund *et al.*, 2010); and resulting in an inability to form figures in the here-and-now. Besides all this, the person with LA has a low perception of their own self and a high perception of others (Guerreschi,

2011). They tend to make the 'figure' only with those cues that confirm to low perception of themselves and their need of the other. Here is a case vignette (taken from the authors' clinical experience):

In twenty years of marriage, Rosy had always allowed her husband to meet his needs to be a 'Peter Pan'. The man amused himself with his friends, forgetting his family commitments and responsibilities; and he also had frequent sexual relations with other women. She justified her husband's behaviour with the 'excuse' that the needs of a man were more important than hers; and that these behaviours expressed a way of 'being' for her husband. The same sort of psychotherapy is undertaken, with the aim of helping the husband, who is now experiencing a moment of existential unease. Rosy had always denied this reality and she has lived in an illusion of (perfect) 'union' with the other. She idealized her partner, purifying him of all the negative aspects of his behaviour. This had allowed her to live a life 'for' him and not for herself, because she considered herself 'unworthy' to be loved. All this can be explained by a history of abandonment, rejection and privation throughout her childhood.

Rosy only expressed her low self-esteem and she also tended to identify herself in a rigid and unilateral way with the passive and dependent part of her Self and thus she does not want to see any part of her active and autonomous Self.

In the Gestalt Therapy model, a key concept is 'the Self', that is considered a complex and integrate structure, which involves many parts that are also in opposition, one with another (Zerbetto, 1994). Each of the personal, interpersonal, relational, social and cultural aspects and features have its own shadow. The healthy person recognizes his or her Self, which is usually formed by different (and also opposite) aspects and he/she therefore can accept the possibility of being contradictory, as well.

In contrast, the pathological person views him/herself in a one-sided way, focusing stiffly on a single polarity of their Self (Spagnuolo Lobb, 2001). By creating a polarity, the split in the personality is at the origin of person's discomfort, in-as-much-as not allowing her/him Self to have a complete and holistic experience. Those persons with LA will act to keep this polarized self, illusively experienced as an integrity of Self, mainly living in affective relationships that do not allow them to change toward any sort of holistic self-integration. In these relationships, often, the two polarities of the Self, dependence and autonomous, are represented within the two partners. Each of them is so attracted to, and thus needs the 'Other' in order to fill the missing part of his/her Self and that may create a confluent relationship (Zerbetto, 1994).

Here is a case vignette (taken from the authors' clinical experience):

With her difficulty to live in social relationships, with a fear of being abandoned by others, Mary is attracted by Mario's ability to relate easily towards

friends. With other partners, this woman has created an intimate though dependent relationship. This dependence allows Mario to feel confident in his 'affective' relationship and so he can go out into their social world without any fear of losing the safety of his family. But, over time, it was precisely these characteristics that become the cause of their dissatisfaction and thus any relational conflicts. Mary disputed Mario's autonomy, and defined it as a lack of interest in her and their family life; whereas Mario considered that Mary's dependency was heavy and suffocating. She was afraid of Mario's autonomy and, when he behaved autonomously, she became angry.

The Self only happens in interaction with others (this is a form of 'co-creation') (Jacobs, 2007). In the Gestalt approach, this interaction is expressed through the concept of 'contact', a psychological process in which it is possible to meet – themselves, Others and their environment (Perls *et al.*, 1951). This does not mean that the Self and environment are joined, but implies an awareness of the differences and distinction between these.

According to Polster & Polster (2001), any real contact involves that the 'I' would experience the 'not me' in relationship, and, in this way, 'I' could build an intersubjective relationship that depends on the interplay between their separateness from, and union with, the 'Other' (Raffagnino, 2010).

The individuals involved need to structure different styles of contact between their individual and environmental interactions; some of these may need to be functional, creative and adaptive contact styles (Wheeler, 1991); and others are dysfunctional.

These last (dysfunctional styles) are regarded by Fritz Perls and his colleagues (1951) as "neurotic mechanisms" or "neurotic disturbances" at the frontiers of contact, or with a "loss of the function of the ego".

Observing these dysfunctional contacts as being a difficulty towards growth, Wheeler (1991) identified a continuum of contact styles, such as: confluence vs. differentiation; projection vs. retention; introjection vs. 'chewing'; retroflection vs. exchange; egoism vs. encounter; desensitization vs. merging; and deflection vs. focusing.

With respect to these, the person with LA can be observed as using dysfunctional contacts and, according to Wheeler (1991), regarded by some as coming from different continuum poles. For instance, persons with LA often express an excess of confluence and a difficulty with separation from a symbiotic relationship (confluence). They also convey a crystallized belief about the possibility to be loved by the 'Other' (a negative introjection), implying a degree of self-devaluation. They also tend to be retro-reflective towards his or her Self's own needs, resulting in self-inhibiting behaviours that hinder a healthier osmosis between the individual's needs and the possibility of contact with any environmental resources (Zerbetto, 1994). Here is another case vignette (taken from the

authors' clinical experience):

Instead of focussing on her 'Other's needs, Ana expresses her anger toward herself for not being a good wife, because her husband maintains that she is too 'sticky with' (attached to, dependent on) him. She feels humiliated, with feelings of guilt and shame that doesn't allow her to express herself fully; she uses a form of 'retroflection' in order to punish herself.

These sorts of aspects about the concept of 'contact' appear particularly meaningful, because Love Addiction is a relational and pathological condition, explored mainly within the system of 'couple's therapy' as a dysfunction aspect of their intimacy, assessed as a dynamic balance between closeness and distance between partners (Raffagnino, 2010; Raffagnino, Penzo & Bertocci, 2012). When this balance fails, the couple's intimacy becomes either too intrusive and invasive, or too distancing between the two partners. When there is an invasion into the personal space of the 'Other', the boundary between the 'I' and 'You' are missing; and then the partners tend to consider each other for their certainty and security and who transmits these. In this case, we can find aspects of dys-regulation, even in a healthy dependency (Raffagnino & Puddu, in press).

Here is another case vignette (taken from the authors' clinical experience):

A couple came into therapy because of the continuous and destructive conflicts between the two partners. At a certain point in their clinical (therapeutic) process, what emerged was their difficulty in regulating the contact between them. The wife asked for more closeness and the husband felt that this was an invasion into his space.

Drawing the 'line of intimacy', she placed herself within the space of her husband and he placed himself in his own space, away from wife (Raffagnino & Occhini, 2000; Raffagnino & Penzo, 2015)[ii].

At the end of this work, it very clearly emerged how much the 'good' aspects of the implied intimacy between them as being, not so much a search for a fixed point of contact as a possibility of moving between closeness and distance, especially in relation to the different situations of the couple's life.

Gestalt Therapy's 'treatment' of people with LA

Regarding the particular features of the LA, clinicians with a Gestalt orientation can have three aims that match the diagnostic aspects that we have identified (above). So, we believe that the clinician should be concerned: **(1)** towards restoring the client's sense of self-regulation and the boundaries of their Self, because clients with LA express a poor sense of personal worth;

(2) towards building their capacity for acceptance of themselves, as they have lost their natural ability for self-regulation when in rapport with others; and **(3)** towards building more balanced relationships, because those persons with LA practice dysfunctional relationships, trying to create a confluence with the 'Other'. Also, as these persons are not able to view the own state of need, it is important to focus on their present experience.

These aims can be achieved in a clinical context, in which the relationship between the therapist and the client is a key element of the therapeutic process, as it is considered in the Gestalt approach. Focusing on the importance of the relationship between the individual and environment, Gestalt Therapy considers a relational approach, and – for that – it puts particular emphasis on relational aspects in the 'treatment', working with dialogical interventions to strengthen the clients' ability for contact and for restoring a functional balance between the individual and their environment (Zerbetto, 2014).

This clinical relationship involves the ability of the clinician to be 'present' and to accept the clients' experience in a genuine way (Zinker, 2002). Therefore, we think it is important that the therapist must have the ability: **(a)** to support their clients, so that they feel confidence to express their emotions and thoughts; **(b)** to encourage them to accept thoughts, feelings, and actions, as parts of their Selves, and to accept their limitations; and **(c)** to permit them to reframe the narratives of their individual and relational experience in a search for new meanings.

Whereas the client with LA is not able to live in a reciprocal relationship, the clinical experience should to allow him or her to live somewhat differently from his/her usual way to create any sort of rapport with others.

In order to create an inter-subjective and meaningful relationship, the clinician should offer the client an affectively and emotionality experience, that we may be associated with any secure attachment relationship (Mikulincer, Shaver & Berant, 2013). Creating new ways of contact with the Other, she/he can help the client to contact the possibility of a relational change. So, ideally, the therapist should not push him/her for any particular change in his/her dependency behaviour as that could clash with any difficulty in changing his/her relational situation, from the fear of abandonment.

The aim is not necessarily to reduce the dependency behaviour, but it works because the present (therapeutic relational) experience of the clients becomes increasingly evident in their awareness, allowing ever-clearer 'figures' emerge from the ground. That involves – as is affirmed by Fogarty, Bhar, Theiler & O'Shea (2016): *"exploring experience as physical and emotional beings making sense of our world and our relationship to others and the environment"* (p. 35). So, the clinician should concentrate on **what**

and **how** the clients perceive, behave, feel, or think about their situation now, rather than on **why** their situation has turned out in this way. Those persons with LA do not need to explain or to interpret why they are acting in this way. Instead, they need to recognize their present experience, and to contact this in order to learn more fluid, evolutionary and experiential attitudes and behaviours when relating to others.

Through the various Gestalt techniques, which are nothing more than experiments, defined as "a behavioural approach for moving to a new operating" (Zinker, 2002, p. 31), the therapist assists the client towards a transformation from "talking about" into "talking to", as Perls (1969) affirmed. That implies recognizing the importance of any direct impact, deriving from responding and "acting" to situations in the present. So, in GT, the dramatized approach of the conflictual content is favoured in respect to the traditional conversational approach (Zerbetto, 2015). Acting "as if", the 'experiment' allows the client to explore parts of their self, expanding the vision of him/her self, and his/her awareness horizon, also bypassing the many resistances that these persons often express.

Various Gestalt experiments permit the client to put their feelings or their thoughts into action, where such an enactment consists of encouraging the client to: "say it (your feelings) directly to the other person" or "give it (your feelings) a voice". A special form of enactment uses exaggeration: a person is asked to exaggerate their feelings, thoughts, movements, etc., in order to feel them more intensely. Here is a case vignette (taken from the authors' clinical experience):

Denise is living in a dependency relationship with her partner. During the psychotherapy, she talks about her feeling to be like a baby who needs to be embraced, to be held tight in the arms of her husband. The therapist asks her: "Can you try to be this little baby, to act like a child". The therapist tries to exaggerate her one self-polarity.

Besides that, we believe that the therapist can use the client's imagination to help them to move towards a new way to be in relationship with the other. Here is another case vignette:

Since Miriam feels that she is not a lovable person for others, the therapist tries to help her to experience the reality as **not** being a lovable person:

"Imagine your reality as a non-lovable person. How do you see this reality? What you do feel as an unlovable person?" Then, the therapist helps her to contact the opposite part of herself, looking at the feelings of being lovable to another: "How is it for you to be feeling loved?"

Allowing the other part of the Self to emerge, will mean that the (previously) dominant part – the addicted part – will become less dominant. Zinker (2002) affirms: *"When an extreme of the polarity extends, it is almost automatic*

that - even on the other side - something extends. I define it as the "world tour" phenomenon: if you always go toward the north, you'll find yourself going toward south." (p. 181). Here is another case vignette:

Greta contacted the fear of being abandoned by her present partner. The therapist asks her: "Where do you feel the fear now?" She answers: "Here, in my hands which are tangled. I'm afraid of losing Alfred". The therapist affirms: "It seems to me that you keep your hands clasped as if I was afraid of losing them". So, he invites Greta to make an experiment: "You could try to lose your hands, letting them go free to move around the area". Greta makes some free movements with her hands, then she begins to move other parts of her body. After the experiment, she asserts: "I feel better; I'm more relaxed than before. I feel as if I'm no longer afraid of losing him. I feel lighter". Then the therapist asks her to communicate with her partner using these free hands: to start a dialogue with her partner while she makes free movements with her hands. She seems to succeed with this and feels happy about it.

Whilst Gestalt Therapy considers the human experience as being lived in the present, it does not forget the past, which is still very present in the actual life of the person with all their unfinished gestalts. That is a dysfunctional situation, as the person needs to complete these uncompleted gestalts, especially as Perls (1969) affirmed, our life is an infinite number of "unfinished situations". As the person with LA expresses a fear of abandonment, and his /her relationships are ruled by this emotion, in our clinical experience it has been easier to listen to a history of abandonment and insecurities when (not) receiving affection and love by their caregivers.

So, we believe that the Gestalt therapist should to try to identify unfinished gestalts about this person's history that may persist in their (present-day) 'actual' relationship with the client, such as: forces blocking the expression of any authentic affects and needs; stopping his/her growing and thus preventing any further development. Instead of filtering the client's story through his/her interpretations, the therapist should perceive, more accurately, the meanings emerging from a client's narrative history. He/she should try to facilitate an awareness of these meanings, as well as their implications for the actual relational problems, and also, he /she should to help client to express the emotions associated with his/her memories, as these emotions might be a part of an unfinished business.

A useful exercise that the therapist can implement for this narrative work is *"chairwork"*, which permits the expression of any resentments or difficult emotions and appreciations for what is represented through the chair. Greenberg and Malcolm (2002) observed that the use of the 'empty-chair' technique permitted emotional arousal that is an important factor in the

successful outcome of resolving unfinished emotional business. Here is yet another case vignette:

Mary's narrative history permits her to identify the mother as a passive figure, who had an insecure attachment bond with her. Mary has introjected this passive mode in her way to live with affective relationships and she also recognizes that, in the past, she had not accepted the passive attitude of her mother: "I was angry with her". So, the therapist asks Mary to talk with her mother, expressing all her anger. Also, the therapist helps Mary in this dialogue, allowing her to express her need of autonomy, and the way in which she prevented herself satisfying this need by becoming like her mother. Mary works with an inner conflict between the need for an autonomous self and the fearful part of herself, interjected by her mother. The therapist helps the dialogue between these two opposite self-parts through the 'chair-work'.

The empty-chair technique can also be used in couples' psychotherapy, taking into account some key characteristic of the couple's dependency relationship, such as the 'closeness and distance' dynamic between the partners. In this case, the chair-work may be used for putting the 'distance polarity' on one chair and the 'closeness polarity' on the other chair – and then the partners can experience each of their two opposite polarities and can help to contact a denied part of their self. This work may create an integrated synthesis for expanding their own selves (Raffagnino & Zerbetto, 2016).

Conclusions

We would like to conclude with some reflections on potential directions for future process of the research about the efficacy of Gestalt Therapy (GT) for interventions in cases of Love Addiction (LA), in a continuing effort to improve its efficacy and applicability to this 'relational' pathology. In fact, both Gestalt's theoretical and methodological orientations and their research findings about LA can guide clinicians in their own interventions and in each step of these. Data from empirical literature about LA offers insights to any clinicians as they treat persons with this particular pathology. To maximize the effectiveness of any treatment, it might be useful to match the core features of this disorder to the specific treatment techniques: GT can match specific core features of the LA. In our paper, we have proposed some reflections about how GT may contribute, both to the theoretical understanding, and to the treatment of LA. We believe that GT is particularly relevant for working with people and couples in which one or both partners express problems with LA. In fact, this particular clinical approach offers some interesting features for the assessment and treatment of LA, especially

regarding its focus on dysfunctional organisms – environmental adaptation, self-impotence and dysfunctional contacts in their intimate relationships. Moreover, since GT is a humanistic-existential approach, it allows us to consider that – for the main part – the conscious growth of the individual goes through the vicissitudes of love relationships. The possibility of a match between some of the key characteristics of LA and some principles of the GT approach should direct the therapist towards the consideration of the usefulness of a positive and functional assessment of the client's difficulties and discomforts. For instance, it will become necessary to distinguishing between "Pathos", associated with "Eros", and the relational pathology associated with "addictive personalities". Besides, the therapist should plan an evolutionary path for a client with LA, also providing a brief residential program focused on the "critical areas" of people with LA, followed by a long-term intervention in individual or group therapy (Zerbetto, 2014).

Authors

Rosalba Raffagnino is a psychologist and psychotherapist, trained in relationship therapy and Gestalt therapy, a sexuology counselor, and didactic supervisor at the Study Center of Gestalt Therapy (CSTG/ Siena). She is a Clinical Psychology researcher at the University of Florence, Department of Health Science and she is an assistant professor in the school of psychology.
E-mail: rosalba.raffagnino@unifi.it

Riccardo Zerbetto is a psychiatrist and psychotherapist, director of the Study Centre of Gestalt Terapy (Milan, Siena), past-president of the Italian Schools and Institutes Federation of Gestalt, and past-president of the European Association for Psychotherapy.
E-mail: r.zerbetto@cstg.it

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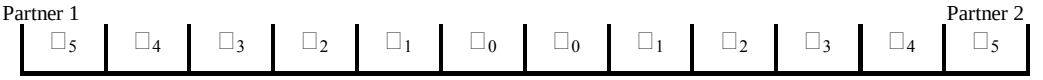
Endnotes:

[1] **'Schema therapy'** was developed by Jeffrey E. Young for use in treatment of personality disorders and chronic DSM Axis I disorders – such as when patients fail to respond or relapse after having been through other therapies (for example, traditional cognitive behavioural therapy). Schema therapy is an integrative psychotherapy combining theory and techniques from previously existing therapies, including cognitive behavioural therapy, psychoanalytic object relations theory, attachment theory and Gestalt therapy.

[2] **'Imago therapy':** Imago relationship therapy is a form of couples counselling and coaching that helps those in committed relationships work out their misunderstandings, reduce conflict, and rediscover ways to bond, communicate, and find common ground. Much of the work in Imago workshops and private therapy involves learning to recognize how early childhood relationship experiences affect how we communicate, behave, and respond to others in adult relationships.

[3] This is the 'line of intimacy', an item in the Couple's Affective Scale (CAS) (Raffagnino & Penzo, 2015).



Effectiveness of Cognitive Behavioral Therapy (CBT) for Perceived Stress, Burden and Coping, among Caregivers of Individuals with Thalassaemia

IRAM MAHMOOD & DR. UROOJ SADIQ

Abstract:

Objective: The current study investigated the Effectiveness of Cognitive Behavioural Therapy (CBT) for Perceived Stress, Burden and Coping among Caregivers of individuals with Thalassaemia. **Method:** Sample of the present study was comprised of 40 caregivers who were parents of individuals with beta-thalassaemia. These subjects were divided into a control and an experimental group with 20 people in each group. Both groups were matched demographically for example, age of children and caregivers, education and living style. The control group was given no intervention after administering questionnaires and experimental group was given treatment of CBT. Perceived Stress Scale (Cohen, 1988), Burden Assessment Scale (BAS; Sadiq & Suhail, 2013) and Coping Assessment Scale (CSS; Zaman, 2015) were used to measure the stress, burden and coping among caregivers of thalassaemia. Descriptive statistics, paired sample t-test and MANCOVA were used. **Results:** Result indicated that level of perceived stress, burden and coping is significantly different before and after intervention. It also shows that emotional-focused coping was reduced and problem focused coping was increased before and after intervention which was also significant. Results also showed that both groups; experimental and control group are likely to have significant difference before and after intervention and likely to have significant multivariate effect on the studied variables after intervention. **Conclusion:** This study can enhance coping among parents to deal with stressful events and is also helpful in increasing community awareness of parents' experiences and the way they cope in dealing with their children.

Keywords: Thalassemia, Cognitive Behavioural Therapy, Perceived Stress, Burden, Coping.

Introduction

The current study included the caregivers of individuals with thalassemia because children with continual diseases, such as Beta thalassemia, and their caregivers can face numerous problems, which includes a life frightening disease and long-term treatments. Beta thalassemia

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has a noteworthy impact on the caregivers *"psychological status causing different emotional burdens, such as the feeling of hopelessness and stress"* (Mazzone *et al.*, 2009).

Therefore, the current study focuses to identify psychological factors enhance the communication skills and reduce the psychological distress of caregivers of individuals with beta thalassaemia, as well as help to introduce positive coping strategies to the caregivers with the help of cognitive behaviour therapy.

A review of the Pakistani literature discovered that there are few studies carried out on psychological treatment on thalassemic children and their caregivers and only pays attention on assessing knowledge, thoughts and financial effects of beta thalassemia therefore; the current study will contribute to the literature.

Furthermore, this study could assist health care professionals to have better understanding of parents' emotional and psychological status, to develop new perspectives towards parents of children with Beta thalassemia and could therefore assist them to deliver quality care to the patients with Beta Thalassemia and their families.

Thalassemia is viewed as one of the challenging haematological disorder without an everlasting treatment (Aziz, Mohammed & Aburaghif, 2015). It refers to a group of genetic disorder, characterized by insufficient and defective production of haemoglobin and immoderate destruction of red blood cells (Eccleston *et al.,* 2010). This defect causes an irregular growth of red blood cells and ultimately anaemia, which is the most important attribute symptom of the thalassemia (Pruthi & Singh, 2010).

Thalassemia is manageable in Pakistan, however unlikely, it is a chronic health issue seen in the majority areas of the country (Lodhi, 2003); about five to six million kids are affected by this sickness (Ishfaq, Ali & Hashmi, 2015). According to WHO, (2008) fifty thousand to ninety thousand children expire of thalassemia in underdeveloped states in every year whereas concerning seven percent of the world's inhabitants may be a carrier of a hemoprotein disorder. These numbers are increasing as a result of lack of awareness, too little academic campaigns; as reported by Rehman, Batool & Qadir, (2002) that the majority of thalassemic traits mothers never come to understand that may be carrying the thalassemic genes and can spread the disease.

Many people with chronic illnesses like thalassemia expertise physiological, behavioural, psychological issues and these individuals need care by caregivers for prolonged durations which disturb their bodily and mental fitness (Carek*et al.*, 2010). A latest evaluation by Stenberg Ruland and Miaskowski (2010), stated that the maximum common physiological issues recounted through caregivers included sleep problems, tiredness, affliction, lack of energy, loss of urge for food, inflicting stress and weight reduction. Anie and Massaglia, (2001) argued that

psychological treatment options may be appropriate to get better effects and endorsed adherence to the medical treatments as psychological therapy allowed lessen their strain, and endorsed a tremendous temper. Psychological therapies can consist of behavioural therapy, psychodynamic and cognitive therapy (Al-Bashtawy, Al-Awamreh & Hamadneh, 2016).

To enhance the communication process, become aware of mental issues, and decrease the arousing struggling of thalassemic children, Cognitive Behavioural Therapy for family (CBFT) is one of the strong interventions. It also assists constructive coping plans to the sufferers and their caregivers (Eccleston *et al.,* 2014). Friedberg and McClure, (2002) argued that a cognitive-behavioural approach that emphasizes the improvement of coping abilities, presenting them in a comprehensible manner, and inviting people to use their abilities in an emotionally significant manner and effective remedy for people with continual illness.

Parenting a child with threatening lifestyles could be very tough and may have numerous terrible effects on parent's life. Caregivers often have complexity balancing worrying for his or her toddler with different duties which includes different jobs, social lifestyles, finances and other domestic obligations. Due to these difficulties they may expertise more strain, worries, unhappy emotions, circle of relatives' arguments and troubling child individual behaviours. Caregivers even have a greater effect on their child's adjustment and play an essential role in how their children adjust to livelihood with an ailment.

Thalassemia is such a persistent illness that could cause severe psychological struggling for the protection of different ailments. The observation recommends that thalassaemia patients and their parents required lifelong mental aid for prevention of mental fitness issues (Caocci *et al*., 2012). Psychological treatment can be appropriately suitable for them to cope with burden and stress of this threatening lifestyle situation (Anie & Massaglia, 2001).

Therefore, the present study focuses on effectiveness of Cognitive Behavioural Therapy for Perceived Stress Burden and Coping among Caregivers of individual with Thalassemia.

Method

Sample

The sample of the present study was comprised of 40 caregivers who were parents of individuals with beta-thalassaemia (BTM). These 40 caregivers were divided into control and experimental group with 20 caregivers in each group. Both groups were matched on the basis of their demographics for example, age of

children and caregivers, education and living style. Both mothers and fathers with minimum age range of 30-40 years and minimum education of matriculation were included. The children with the age range of 6-12 years were included, who were diagnosed as having BTM for at least one year and undergoing treatment of blood transfusion for at least 6 months. Patients should be living with both parents. Care-givers and parents of children diagnosed with any other physical illness or co-morbid condition other than thalassemia were excluded. Individuals undergoing treatment of phlebotomy (blood exchange) were excluded.

Assessment Measures

The following instruments were used to study and measure the variables.

Demographic Information Form

A self-prepared demographic form was used to get information about the child and the parents. The information regarding child include age, gender, education, no. of siblings, birth order, age of onset of illness, duration of diagnosis and treatment. The information regarding parents include age, type of relationship with child, education, occupation, marital status, family structure, residential area, monthly income, history related to physical illness and family history of Thalassemia or blood-related disease.

Perceived Stress Scale *(Cohen, 1988)*

The Perceived Stress Scale (PSS) was developed by Cohen, (1988) to measure the degree to which situations in one's life are appraised as stressful. It consists of 10 items and has 5 point-Likert scale. PSS scores are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1 & 4 = 0) to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items (Cohen, 1988). Cronbach's alpha for this scale was >.70 which was considered as a minimum measure of internal consistency. Test-retest reliability was evaluated using a correlation coefficient, such as Pearson's, Spearman's, or the intraclass correlation coefficient (ICC); coefficient values >.70 were usually recommended (Lee, 2012). In current study, the cronbach alpha of the scale is .933.

Burden Assessment Scale *(BAS; Sadiq &Suhail, 2013)*

This scale was developed by Reinhard *et al.* (1994) to measure caregiver burden**.** The translated burden assessment scale (BAS) will be used to evaluate the caregiver's burden. The 19 items of the scale predict factors of burden. Ten items measure Objective Burden among the caregivers due to responsibilities, while, 9 items assess Subjective Burden. The response categories on each type of burden range from not at all to a lot and have 4- point Likert scale. The score on each subscale will be calculated by summing the scores of items on separate subscales. Overall high score on burden assessment scales will indicates level of caregiver burden. Cronbach alpha for this scale was .78. In current study, the Cronbach alpha of the scale is .962.

Coping Assessment Scale *(CAS; Zaman & Ali, 2015)*

Coping assessment scale consists of 22 items and has 5 point-Likert scale. The questionnaire will evaluate two types of coping namely problem focused coping style and emotional focused coping styles. Problem focused coping style incorporate making direct move to change the circumstances itself to reduce the amount of stress. In emotional focused coping styles include attempts that are directed at changing emotional reaction to stressors. Cronbach alpha on Problem focused coping style is .879 and an emotional focused coping style is .890.

Procedure

The proposal of the research was approved by Graduate Research Committee, University of Central Punjab. After the approval of the study, permission letters from the department of psychology, University of Central Punjab explaining the nature of the research were taken to hospital of Lahore for permission of conducting the research. After permission from higher authority in hospital, 40 caregivers of patients with thalassemia were approached and divided into experimental and control group with 20 caregivers in each group. Both groups were matched on the basis of their demographics for example, age of children and caregivers, education and living style. After approaching the caregivers, the purpose of the research was explained to them and rapport was established for the betterment of the results. Participants were then informed about the nature of the research and their written consent was taken before giving them the questionnaires. The research comprised of pre and post test. The questionnaires including Demographic information form, Perceived Stress scale (Cohen, 1988), Burden Assessment Scale and Coping Assessment Scale were given to both groups as pre-test. Later, the control group was given no intervention after administering questionnaires and was assured about getting therapy after the completion of research work by the referral source. The participants in experimental group were given treatment of Cognitive Behaviour Therapy (CBT) in 10-12 sessions by the researcher. The researcher who was trained psychologist provided cognitive behaviour therapy to the participants of experimental group under the guidelines given by supervisor. Cognitive Behavioural Therapy (CBT) was conducted by following the proper schedule of treatment and variable focused strategies. 9-11 sessions were conducted on each caregiver in three stages. The CBT involved a careful assessment of the "thoughts, actions, and circumstances" that affect the amount of stress of caregivers.

There were three stages. In stage 1, decreasing the signs related to stress (anxiety, depression, losing control, insomnia, vulnerability etc.) using a holistic program for relaxation training and recovery.

In stage 2, standard CBT was used to identify "negative thoughts, beliefs and

images", and clients learned to recognize the theme which can cause faulty thinking. Cognitive-behavioural therapy helped clients in restructuring their negative thoughts by rewriting them in an alternative and more balanced way. Coping techniques were introduced which included "breathing techniques, progressive muscle relaxation, problem solving skills and stress management.'' In stage 3, CBT treatment included work on the deeper core beliefs/schemas that have been developed during their early life. These deeply held beliefs function like absolutes or biases and form a template for how we see ourselves, other people, and the world around us. Clients learned to change these beliefs which can help in prevention of relapse.

Based on the assessment, the therapist helped the patient to develop a strategic plan to help better manage his/her stress. Such a plan involved approaches to modify stress-producing thoughts and improve coping capabilities. After completion of therapy, the participants in experimental group were given questionnaires as post – test. The participants in control group were also given questionnaires after the same duration as that of experimental group. The questionnaires were taken back and participants were allowed to ask any query that aroused in their minds and the participants were thanked for their cooperation and their precious time.

Setting and Scoring

The participants were approached in hospitals; questionnaires were administered and cognitive behaviour therapy was executed in individual setting as that would reduce the social desirability bias in individuals. Homogenous setting was tried to maintain for every individual.

The instructions of the questionnaires were given according to manual and there was no time limit for questionnaires so participants were allowed to take their time to fill the questionnaires. The scoring of the items in questionnaires was done by using scoring procedure given in scale manuals.

Statistical Analysis

The collected data was given the scores according to the respective scales and the data was analyzed by SPSS software (Statistical Package for Social Sciences). Descriptive statistics were calculated in the form of percentage, mean (M) and standard deviation (SD). To determine the difference between stress, burden and coping, before and after therapy, independent sample t-test was applied.

To find out the difference between experimental and control group on study variables, multi-variate analysis of covariance (MANCOVA) was used.

RESULTS

Table 1: *Summary of Demographic Characteristics of Experimental Group (N=20)*

Characteristics		*M*	*SD*	*F*	*%*
Age		8.65	2.11		
Gender	Male			9	45.0
	Female			11	55.0
No. of sibling		2.95	1.05		
Child's birth order		2.15	.93		
Age of diagnosis	1 month-11 months			12	60.0
	1 year- 2 year			8	40.0
Duration of diagnosis	1 years-6 years			12	60.0
	7 years-12 years			8	40.0
Duration of treatment	1 years-6 years			11	55.0
	7 years-12 years			9	45.0
Caregiver's age		35.00	2.00		
Relationship with child	Mother			11	55.0
	Father			9	45
Caregiver's education	Matriculation			8	40.0
	Intermediate			4	20.0
	Graduation &above			8	40.0
Caregiver's occupation	Working			14	70.0
	Non-working/house			6	30.0
Caregiver's marital status	Living together			20	100
	Divorced/Separated			00	00
	Widow			00	00
Family system	Nuclear			7	35.0
	Joint			13	65.0
Family monthly income	10,000-30,000			14	70.0
	31,000-50,000			4	20.0
	51,000 & above			2	10.0
Residential Area	Rural			5	25
	Urban			15	75
Blood related disease of family	Yes			20	100
	No			00	00

F=frequency, %=percentage, M=Mean, SD= Standard Deviation

Table 2: *Summary of Demographic Characteristics of Control Group (N=20)*

Characteristics		*M*	*SD*	*F*	*%*
Age		9.15	2.13		
Gender	Male			13	65.0
	Female			7	35.0
No. of siblings		2.60	.88		
Child's birth order		1.85	.93		
Age of diagnosis	1 month-11 months			16	80.0
	1 year- 2 year			4	20.0
Duration of diagnosis	1 years-6 years			15	75.0
	7 years-12 years			5	25.0
Duration of treatment	1 years-6 years			14	70
	7 years-12 years			6	30
Caregiver's age		34.20	2.02		
Relationship with child	Mother			12	60.0
	Father			8	40.0
Caregiver's education	Matriculation			5	25.0
	Intermediate			7	35.0
	Graduation & above			8	40.0
Caregiver's occupation	Working			9	28.4
	Non-working/house			11	45.0
Caregiver's marital status	Living together			20	100
				00	00
	Divorced/Separated				
	Widow			00	00
Family system	Nuclear			14	70.0
	Joint			6	30.0
Family monthly income	10,000-30,000			8	40.0
	31,000-50,000			7	35.0
	51,000 & above			5	25.0
Residential Area	Rural			3	15.0
	Urban			17	85.0
Blood related disease of family	Yes			40	100
	No			00	00

F=frequency, %=percentage, M=Mean, SD= Standard Deviation

Table 3: *Psychometric Properties of Major Constructs of the Study (N=40)*

Scales	***No. of Items***	**α**	***M***	***SD***	***Range***		***Skewness***	***Kurtosis***
					Min	***Max***		
PSS	10	.933	22.6	57.7	1.62	2.77	2.10	1.11
BAS	19	.962	45.8	12.44	1.90	3.350	-1.19	.73
CAS	22	.50	58.2	5.95	1.47	3.52	-.38	.63

Note. α= Cronbach Alpha, M= Mean, SD=Standard Deviation, Min= Minimum, Max=Maximum, PSS= Perceived Stress Scale, BAS= Burden Assessment Scale, CAS= Coping Assessment Scale.

The result of paired sample t test indicated that there is a significant difference in the level of perceived stress before and after intervention (p<.01). Result shows significant decrease in stress after cognitive behaviour therapy. (see Table 4)

Table 4: *Paired sample t test indicate the difference between perceived stress before and after intervention (N=20)*

	Before (n=20)		After (n=20)				95% CI		
Variables	*M*	*SD*	*M*	*SD*	*t(19)*	*P*	*LL*	*UL*	*Cohen's d*
Perceived stress	28.35	1.84	21.30	1.45	11.18	.000	5.73	8.36	4.25

Note. p<.01; M=Mean; SD=Standard Deviation; CI= Confidence Interval; LL=Lower Limit; UL=Upper Limit

The result of paired sample t test indicated that there is a significant difference in the level of burden before and after intervention (p<.01). Result shows significant decrease in burden after cognitive behaviour therapy. (see Table 5)

Table 5: *Paired sample t test indicates the difference between burden before and after intervention (N=20)*

	Before (n=20)		After (n=20)				95% CI		
Variables	*M*	*SD*	*M*	*SD*	*t(19)*	*p*	*LL*	*UL*	*Cohen's d*
Burden	59.15	4.00	34.75	2.98	33.73	.000	22.88	25.91	6.91

Note. p<.01; M=Mean; SD=Standard Deviation; CI= Confidence Interval; LL=Lower Limit; UL=Upper Limit

The result of paired sample t-test indicated that there is a significant difference in the level of emotional-focused coping before and after intervention (p<.01). Emotional-focused coping got reduced after intervention. (see Table 6)

Table 6: *Paired sample t test indicate the difference between emotional focused coping before and after intervention (N=20)*

	Before (n=20)		After (n=20)				95% CI		
Variables	*M*	*SD*	*M*	*SD*	*t(19)*	*P*	*LL*	*UL*	*Cohen's d*
Emotional-focused coping	36.95	2.83	3.00	1.68	7.95	.000	2.21	3.78	14.58

Note. p<.01; M=Mean; SD=Standard Deviation; CI= Confidence Interval; LL=Lower Limit; UL=Upper Limit

The result of paired sample t test indicated that there is a significant difference in the level of problem-focused coping before and after intervention (p<.01). Problem-focused coping got increased after the intervention. (see Table 7)

Table 7: *Paired sample t test indicate the difference between problem focused coping before and after intervention (N=20)*

	Before (n=20)		After (n=20)				95% CI		
Variables	*M*	*SD*	*M*	*SD*	*t(19)*	*P*	*LL*	*UL*	*Cohen's d*
Problem-focused coping	20.30	3.16	27.15	2.39	-8.53	.000	-8.52	-5.17	2.44

Note. p<.01; M=Mean; SD=Standard Deviation; CI= Confidence Interval; LL=Lower Limit; UL=Upper Limit

Table 8: *MANCOVA Showing the effect of Covariates and Group on overall variables after intervention (N=40)*

Source	Wilks' lambda	F (4,31)	P	Eta Square
Pre-Perceived Stress	.97	.20	.934	.026
Pre-Burden	.15	44.13	.000	.851
Pre-Emotion focused coping	.30	17.57	.000	.694
Pre-Problem focus coping	.60	4.98	.003	.391
Groups	.02	307.89	.000	.975

These results revealed that the assumption of equality of co-variance was checked from Box's Test. No violation of this assumption was observed. This investigation indicated that Pre- Burden, Pre Emotional Focused Coping and Pre- Problem Focused Coping before intervention had significant multivariate effect on the studied variables after intervention. Both groups that are experimental and control group are likely to have significant multivariate effect on the studied variables after intervention. (see Table 9)

Table 9: *MANCOVA showing the effect of Covariates and Group on each variable after intervention (N=40)*

Source	Dependent Variables	SS	Df	MS	F	P	Eta Square
Covariate							
Pre-Perceived Stress	Post-Perceived Stress	.004	1	.004	.000	.984	.000
	Post-Burden Assessment	.042	1	.042	.009	.924	.000

Source	Dependent Variables	SS	Df	MS	F	P	Eta Square
	Post-Emotional Focus Coping	.619	1	.619	.362	.551	.011
	Post-Problem Focus Coping	1.50	1	1.50	.287	.596	.008
Pre-Burden	Post-Perceived Stress	227.26	1	227.26	24.19	.000	.416
	Post-Burden Assessment	821.14	1	821.14	177.81	.000	.839
	Post-Emotional Focus Coping	.002	1	.002	.001	.973	.000
	Post-Problem Focus Coping	5.25	1	5.25	1.003	.324	.029
Pre- Problem Focused Coping	Post-Perceived Stress	11.44	1	11.44	1.21	.27	.03
	Post-Burden Assessment	27.13	1	17.13	5.87	.021	.147
	Post-Emotional Focus Coping	.323	1	.323	.189	.667	.006
	Post-Problem Focus Coping	62.90	1	62.90	12.01	.001	.261
Pre- Emotional Focused Coping	Post-Perceived Stress	5.93	1	5.93	.632	.432	.018
	Post-Burden Assessment	13.71	1	13.71	2.97	.09	.08
	Post-Emotional Focus Coping	124.07	1	124.07	72.58	.000	.681
	Post-Problem Focus Coping	.206	1	.206	.039	.844	.001
Independent Variables							
Groups	Post-Perceived Stress	1688.14	1	1688.14	179.72	.000	.841
	Post-Burden Assessment	5041.33	1	5041.33	1091.69	.000	.970
	Post-Emotional Focus Coping	4.78	1	4.78	2.79	.104	.076
	Post-Problem Focus Coping	451.27	1	451.27	86.20	.000	.717
Error	Post-Perceived Stress	319.36	34	9.393			
	Post-Burden Assessment	157.00	34	4.618			
	Post-Emotional Focus Coping	58.12	34	1.70			
	Post-Problem Focus Coping	177.97	34	5.235			
Total	Post-Perceived Stress	22727.00	40				
	Post-Burden Assessment	89948.00	40				
	Post-Emotional Focus Coping	46233.00	40				
	Post-Problem Focus Coping	23046.00	40				

Results showed that pre-burden and pre-coping had univariate effect on the scores of post-treatment burden and post-coping assessment. Groups had significant effect on Post-Perceived Stress Post, Burden and Post Problem Focused Coping. It means that after treatment caregiver's scores on Post-Perceived Stress, Post Burden and Post Problem Focused Coping significantly decreased.

Discussion

This study was conducted in order to investigate the effectiveness of Cognitive Behavioural Therapy (CBT) for Perceived Stress, Burden and Coping among Caregivers of individuals with thalassaemia. Result of paired sample t test indicated that there is a significant difference in the perceived stress before and after intervention ($p<.05$, table 4) which means that CBT is effective for individuals for reducing the symptoms of stress. The results of the current research regarding interventions are consistent with previous studies: Davis, (2010), Walker & Colosimo (2011), Ellis (2000), Lim and Zeback (2004), who showed that Cognitive Behaviour Therapy is effective in reducing stress. Based on previous literature, different techniques of Cognitive Behaviour Therapy were used in current research. In current study, techniques of cognitive behaviour therapy such as breathing techniques, progressive muscle relaxation, problem solving skills, stress management, give feedback, doing homework household, changed attitudes and thinking were used to reduce undesirable psychological consequences of stress and prevent harmful symptoms and increase awareness, adjusted traditional habits, increase patience and tolerance, improves acquisition of coping skills and quality of life which ultimately reduce stress. Most caregivers reported that they were able to change their perspectives with the help of therapy regarding stressful events and view them in alternative ways which made these events less stressful. They were able to deal with life issues by considering the disease of their children as the wish of Almighty Allah and manage the stressful situations by using alternative solutions which they haven't practiced previously.

It was also indicated that there is a significant difference in the level of burden before and after intervention ($p<.05$) which shows that cognitive behaviour therapy is effective in reducing perceived burden and increasing physical and mental health among caregivers of patients with thalassemia in Pakistani culture. Findings about the therapy being effective in relieving burden among the caregivers are consistent with the other studies that showed significant alleviation of burden and improvement in mental health of the care-givers other severe illnesses (Brodaty & Donkin, 2009; Smits *et al.,* 2007; Spijker *et al.,* 2009; Thompson *et al.,* 2007).

Caregivers reported in sessions of current research that they feel burdened

due to many causes like treatment, expenses and complication of illness of their children. These burdensome thoughts upset them as they began to get affected by such factors psychologically and emotionally. With the help of Cognitive Behaviour Therapy, they were able to get an understanding that these burdening thoughts and acts are not helping their children and lives because they were ignoring other pleasures and responsibilities of life for children as well by focusing only on treatment as also seen in previous literature (Nahalla & Futzgerald, 2003; Pruth & Singh, 2010). Caregivers were able to manage their burdensome thoughts and activities with the help of techniques of therapy such as problem solving skills and daily activity scheduling.

Result shows that significant difference was found in coping among caregivers after cognitive behaviour therapy. Result of Paired sample t-test determined that emotion focused coping significantly decreases after CBT (Table 6) whereas problem focused coping significantly increases after CBT (Table 7). Caregivers in current research also showed the similar results as seen in previous literature (Pratt, Schmall, Wright & Cleland, 1985; Lund, Pett & Caserta, 1987). For example caregivers of present study mostly used emotions based coping strategies like distraction from the stresses, avoiding responsibilities, praying excessively and keeping their thoughts to themselves without sharing. They were using these coping strategies might be due to their self-pity thoughts like they are the only one facing difficulties of life and considering them responsible for the disease of children due to genetic factors. Caregivers were able to adapt the different coping strategies of Cognitive behaviour therapy like Addressing problem orientation, clearly defining problems, Brainstorming and evaluating solutions and Taking Action. In the current research, these strategies help the parents to reduce their distorted thoughts such as self-pity and self-blaming etc as stated by other researches as well (Lofti *et al.,* 2009). These results are also congruent with previous reports which also showed that predominantly problem-focused coping styles, with less emotion-focused coping styles, lead to a decrease of psychological distress. The use of emotion-focused coping strategies serves to avoid actually confronting the problem, and has been reported to show a positive association with depression and negative association with satisfactory outcome (Gass & Chag, 1989).

Result of the MANCOVA indicated that both groups; experimental and control group are likely to have significant multivariate effect on the studied variables after intervention (Table 8-9). It can be inferred that Cognitive Behavioural Therapy (CBT) has a meaningful effect on increasing mental health of caregivers of Thalassemia in comparison with members of Control Group. The results of this study indicate that the approach of cognitive behaviour therapy is effective for Perceived Stress, Burden and Coping

among Caregivers of individuals with thalassaemia. Caregivers were suffering from these problems due to their thinking patterns based on cognitive errors and this caused them to undergo a high level of stress but they were able to manage these distresses using different techniques of CBT. These results are consistent with the previous findings (Ahmadian, Tavassoli & Amiri, 2011) in which significant difference was found between the two groups in terms of stress and coping as a result of therapeutic intervention. The techniques of CBT helped the caregivers in replacing the negative thoughts with more constructive and rationale thoughts in experimental group whereas caregivers of control group were not able to identify and resolve their distorted thoughts because they were not given the strategies using CBT intervention plan to compare and view alternatives. The current research is congruent with the study of Bakhshian, Mohajer and Delaware (2013), who reported that Cognitive Behavioural Therapy (CBT) is effective for psychological and physical symptoms (Emotional Arousal). They used Cognitive Behavioural Therapy (CBT) for physical pains and symptoms, whose findings showed symptoms and signs of pains and other physical anxiety symptoms has been significantly decreased in those participating in Cognitive Behavioural Therapy (CBT). Therefore, it can be said that cognitive therapy was effective in reducing stress and increasing coping in experimental group as compare to control group.

Conclusion

The study was conducted in order to investigate the effectiveness of Cognitive Behavioural Therapy (CBT) for Perceived Stress, Burden and Coping among Caregivers of individuals with thalassaemia. Result indicated that Cognitive Behaviour Therapy is effective for individuals for improving the symptoms of stress and burden after the intervention. It was also indicated that cognitive behaviour therapy is effective in reducing perceived burden and increasing physical and mental health among caregivers of patients with thalassemia.

The findings also show that emotional-focused coping was significantly reduced and problem focused coping was increased after intervention. Depending on caregivers' perception of the level of control they have over stressors, different coping strategies could be effective. In the case of elevated perceived control of the stressor, caregivers were encouraged to apply problem-solving strategies and active coping. The program offers caregivers with a range of efficient coping techniques and proficiencies for dealing with daily challenges related with the care circumstances. The observed improvements in health are probably directly related to increases in coping.

This investigation indicated that perceived stress before intervention had

significant multivariate effect on the studied variables after intervention. Both groups; experimental and control group are likely to have significant difference before and after intervention. Groups had significant effect on Post Perceived Stress, Post-Problem Focus Coping and Post Burden. It means that after treatment caregiver's scores on Post Perceived Stress, Post-Problem Focus Coping and Post Burden significantly decrease. It was found that caregivers who receive cognitive behaviour therapy had greater decreases in stressful responses to the symptoms of their children as compared with caregivers in control condition. They identify their distorted thoughts with the help of different techniques of CBT and managed them by getting alternative perspectives regarding the problems of life which they majorly suffer due to the illness of their children.

Limitations and Recommendations

In the current research, the sample size was small to generalize the findings. Therefore, further researches should involve the participants in a wide range. It is also suggested that effects of therapy in other psychological factors of caregivers in other cities or areas be assessed imposing cultural differences in comparison with the various areas and also compare the effects of CBT in mental health of Thalassemia caregivers with other psychotherapy approaches. Cognitive Behaviour Therapy was the only method used in the current study.

Furthermore, this therapeutic approach could be used along with combination of other therapies. Combined parent and child interventions targeting caregiver's agony and child pain coping skills should be included, as these would enhance the child as well as parent's coping to various stressors involving the disease.

In current research, only parents were involved as caregivers as they are the source of major support for children but other individuals of the family at home can also be affected by children's disease. Therefore, further studies are needed to discover the effect of beta thalassemia on other households and relatives. The health providers were seen exhausted with their daily routines, severity of issues and family behaviours of the children with thalassemia. Further researches should involve giving help to the health care providers and their experiences.

Authors

Ms. Iram Mahmood has done a Masters (in Clinical Psychology) from the University of Central Punjab. She has also done BS (Hons.) from the College of Home Economics, Lahore. She now works at the Department of Psychology, Faculty of Arts and Social Sciences, University of Central Punjab, Lahore, Pakistan.
E-mail: Iram.mehmood94@gmail.com

Dr. Urooj Sadiq completed her doctoral degree in the field of clinical psychology from Institute of Clinical Psychology, University of Karachi in 2009. She is currently Assistant Professor, in the Department of Psychology, Faculty of Arts and Social Sciences, University of Central Punjab, Lahore, Pakistan.
E-mail: urooj.sadiq@ucp.edu.pk

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“Thinking Outside of the Box”: An unconventional intervention.

AVROMI DEUTCH & SEYMOUR HOFFMAN

One of the basic tenets of prescriptive eclecticism in psychotherapy (Dimond *et al.*, 1978) is that the psychotherapist must be able to draw upon a vast array of theories and techniques in treating people, and not be bound by a single orientation or approach to therapy. A ‘competent’ psychotherapist therefore uses his clinical judgment to decide what theory, technique and/or approach is best, given the specific patient, therapist, presenting problem and other situational variables.

The flexibility and creativity of the therapist are (therefore) an essential aspect of successful psychotherapy. The therapist *“par-excellence”* that demonstrated these traits in the treatment room was possibly Milton Erickson, the “Einstein of Treatment” (Haley, 1986). Erickson believed that:

“Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual’s needs, rather than tailoring the person to fit the Procrustean[*] bed of a hypothetical theory of human behavior”. (Zeig & Lankton, 1988)

As Maslow (1966) cautioned, *“If the only tool you have is a hammer, you will treat everything as if it was a nail”.* Therefore, flexibility in perceiving and evaluating things and situations is a *sine qua non* for creative thinking. To be a ‘creative’ therapist requires some originality and a degree of unconventionality in one’s thinking and one’s actions and also the willingness to take (calculated) risks. Quaytman, (1974) concluded, *“…what makes a creative psychotherapist is the extent to which she can risk chance, utilize diverse approaches to therapy, avoid dogma (which denies a person’s uniqueness), and expand her own life experience.”* (Hoffman, 2015)

What is therefore presented below is a one-time highly unconventional intervention executed by the therapist that enabled him to extricate himself from a possible therapeutic impasse.

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Case Example

'Eyal' (not his real name), a 22-year-old single Israeli male, was referred to an out-patient mental health clinic, after being discharged from a day-hospital ward. He had been coping (for over seven years) with severe obsessive-compulsive symptoms, specifically stuttering and social anxiety – due, in his view, to the 'social abuse' (bullying) that he had experienced in his youth. The patient had undergone intensive out-patient cognitive behavioural treatment (CBT) in the past, which had produced little significant improvement in his symptoms and functioning.

In the first few treatment sessions, 'Eyal' described – with considerable stuttering – an account of his past traumatic experiences – and his past and present difficulties – in a coherent, hesitant, apologetic (and somewhat stilted) manner. He also demonstrated a limited understanding of his 'illness', minimal self-confidence, and a seeming need to ingratiate himself with the therapist.

After a number of meetings, I (the therapist, A.D.) developed a picture of a fragile and insecure patient on the one hand, and a rigid introspective thinker on the other. I wondered how useful it would be to continue any discourse on the history and the development of his 'illness', which might only increase his introspective and rigid thinking. I felt that there was a need to reflect (somehow) on the weakness and inadequacy that this patient was displaying, but he (the patient) obviously experienced some difficulty in acknowledging and discussing this.

In supervision (with S.H.), it was discussed that – possibly – a somewhat unconventional intervention was indicated – in order to 'bypass' the patient's habitual resistance and his seemingly rigid and intellectual defences. So, in the next session, I suggested that we "arm wrestle".[3]

Eyal surprisingly acquiesced but, during the first few rounds, he exerted only a minimal effort in order to succeed in the competition and I easily managed to lower his hand. I pointed this out to him and asked him to invest more effort in the arm-wrestling competition. At this point, I noticed that – for the first time – there was some excitement on Eyal's part, as his breathing had accelerated and thus he appeared much more alive. In the next round, he exerted significantly more force, to the extent that I was unable to win and to lower his hand. It was a 'stand-off (draw).

His breathing accelerated further and then he placed his hand on his chest in order to calm himself down. After several more rounds of competition, whereby I was unsuccessful in lowering his hand, we decided to terminate this particular type of competition.

Eyal mentioned that he was surprised that I had used any force in the competition, and he then expressed some concern that – since I had acted forcefully – I did not understand how

weak he was, and therefore … how was it possible that I could help him?

This then led him to talk about his (now acknowledged) tendency to appear weak and ineffective, in order to prevent other people from abusing and taking advantage of him. I pointed out to him that I did not see him see him as a weak person and, when I insisted on seeing his strength, he actually managed to show it.

Later in the session, and in subsequent sessions, we talked about his tendency to present himself as weak and insignificant in social situations and the 'cost' (to him) of this behaviour, since it invites and encourages negative reactions on the part of others (e.g. humiliation, exploitation, etc.) and these reactions then discourage 'them' from developing potentially friendly and warm relationships with him.

My impression was that – if I had continued to take a traditional psychological treatment approach – it would have been difficult to reach this kind, or level, of discourse; and – also – that it was precisely the unconventional 'arm-wrestling' intervention that had opened up the possibility of further therapeutic progress.

We would be interested in hearing other examples of "Thinking Outside of the Box" or other people's perspectives on such – hopefully successful – "unconventional intervention.

Authors

Avromi Deutch, M.A. is a clinical psychology intern, working with:

Seymour Hoffman, Ph.D. is a supervising psychologist at the Mayanei Hayeshua Medical Center, Mental Health Center in Bnei Brak, Israel.
Emails: avrmichedvi@gmail.com; seymour.hoffman276@gmail.com

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Endnotes:

Note: Procrustes (also called Polypemon, Damastes or Procoptas) was a mythological robber bandit in Attica, Greece, who "accommodated" his captives to the size of his bed, by either stretching them to fit, or chopping their legs down if they were too big. He was eventually slain by the 'hero', Theseus. The "Procrustean bed" has thus become proverbial for arbitrarily (or ruthlessly) forcing someone or something into an unnatural scheme or pattern.

[1] **Arm-wrestling** is a 'sporting contest' involving two participants. Each person places one arm on a hard surface with their elbows bent and touching the surface, and they then grip each other's hand. The goal is to 'wrestle' - with pure arm strength - and one eventually pins the other person's hand and arm down onto the surface: the winner's hand and arm is thus 'over and above'

Transpersonal Psychology as a Science

PIER LUIGI LATTUADA

Abstract

Transpersonal psychology represents the newest movement within the psychological field. It was born at the end of the sixties as a natural evolution of humanistic psychology, in the wake of trends that favoured the development of human potential, with the aim to expand the area of interest and jurisdiction of psychology in order to include spiritual inner experiences, the whole spectrum of states of consciousness and the full realization of the Self.

In this article, I will emphasize the specificities of transpersonal psychology, but I will also mention the causes of its weaknesses, which will expose it to attacks by its opponents who are often not willing to recognize its validity. I will examine the criticism and reasons that aim to demonstrate the groundlessness of transpersonal psychology by reporting some ontological, epistemological and methodological aspects of the transpersonal approach, which can guarantee its validity as a science.

Key Words: Exposure, awareness, dis-identification, participatory dialogue, second attention.

Critiques

Before entering into the debate on the scientific basis (or scientificity) of transpersonal psychology, I will try to respond to the 'ostracism' declared by such science, which can be summarized in the following justification:

"Transpersonal psychology operates on metaphysical bases that cannot be verified or falsified through a procedure of measurement, objectively observable, and replicable; therefore, it places itself outside the field of psychological science."

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Comparing Ontologies

We will start by comparing the so-called "metaphysical bases" of transpersonal psychology to the "scientific bases" on which classical psychology is founded.

Pierre Weil (1992, p. 21), one of the founders of transpersonal psychology, outlines four assumptions that characterize transpersonal ontology:

* Consciousness is an unending and boundless flow. Limits only exist in the human mind.
* Memory goes beyond phylogeny and can be tracked back through the evolution of the living being up to the very source of the vital energy.
* Human evolution does not end in intellect but moves towards higher qualities such as wisdom, love, humbleness, sympathy, awareness, etc.
* Death is just a passage, an opportunity to reach new dimensions of being.

The "scientific" bases of classical psychology are grounded on the premises of materialistic reductionism.

Where the scientific study of the mind is concerned, consciousness and its special features are of rather minor importance. It is quite possible, indeed desirable, to give an account of language, cognition and mental states in general without taking into account consciousness and subjectivity.

Science is objective because reality itself is objective.

The objectivity of science requires that the phenomena studied are completely objective, and in the case of cognitive science this means that it must study objectively observable *behaviour*.

From the fact that reality is ultimately physical and the fact that it is completely objective, it is natural to assume that everything in reality is knowable by us. There is no place or at least very little place-for consciousness in this overall picture. (Searle, 1994, p. 28)

Going into detail on the above-mentioned visions goes beyond the aim of this paperwork; therefore, I will limit myself to emphasizing the evidence that stating that everything is matter, the mind can be studied objectively through behaviour, consciousness does not exist or is only an expression of brain activity, has no scientific value.

When it comes to metaphysics, Reductionist Materialism is just as metaphysical as the assumptions on which the transpersonal vision is based. "Ultimate reality is material", "consciousness does not include matter" and "the psyche coincides with the mind" are non-observable, measurable nor replicable statements.

The issue of the premises could be easily settled by embracing the invitation of Husserl's *epoché* (Husserl, 2006) to base the premises on a phenomenological approach that places one's own beliefs and judgments in brackets.

The demarcation line in order to consider any approach as valid should be moved from going into detail on its system of creation to the "way" it treats

it. Any discipline should emphasize its ontological assumptions and provide epistemological guarantees regarding how it achieved its knowledge and the use it makes of it.
In so doing, the focus would shift from the discipline to the people and from beliefs to the world. The fake boundary between scientific and transpersonal psychologies would be crossed and the focus would be placed on the people and their statements. The limits, tasks and jurisdictions would become clear and based on a mutual recognition of a difference in the intent, object of investigation and ontological and epistemological bases. However, these bases should not be considered as exclusive or absolutely true, but rather as starting points for the premises to be verified and the relative visions of the world to be approached with an "as if" kind of attitude.

Comparing Epistemologies

As a result, it would become possible to understand that the epistemological approach of transpersonal psychology provides tools and methods that do not invade the territory of behavioural sciences, but rather increase the validity provided by psychological science.

By simplifying the transpersonal practice and relying on a phenomenological approach that suggests leaving behind one's own beliefs and judgments, transpersonal psychology introduces in the scientific method three elements: exposure, awareness and dis-identification.

Exposure suggests declaring the ontological premises or beliefs, placing them between brackets and behaving "as if", this way overcoming the well-known problem that is reflexivity[4] (Thomas, 1923; Anderson, 2017), which is the tendency of the researcher to influence the investigation in order to confirm his own assumptions, more or less consciously.

Awareness comes from the consideration that it is possible to observe thinking, offering a further tool that adds supra-rational guarantees, provided by aware thought, to the rational guarantees of critical thought, based on meta-cognition.

Dis-identification allows detachment from the objective and therefore from the results of the research, non-attachment to one's own beliefs and it reinforces the comprehension that it is possible to act "as if". "As if" – I weren't the content of my perception, my feelings, emotions, needs, desires, thoughts, judgments, beliefs, etc.

Classical epistemology is based on reason and critical thought. Transpersonal epistemology transcends and includes without denying meta-cognition and we could say it is based on exposure, awareness and dis-identification.

Thanks to the three mentioned pillars, the researcher, or more generally the professional, can

guarantee that he knows what he is doing and, once declared his contents, *concept* and *percept*, he is able to leave them behind and not be guided by them.

Transpersonal psychology offers an epistemological map that defines an I, place of *concept* and *percept*, and a Self, place of dis-identified and aware observation, able to operate "as if" and therefore transcend the cognitive dimension of reason within the aware dimension of insight, which is that new order of comprehension mentioned by Bohm (Krishnamurti & Bohm, 1986). Rudolph Steiner says:

"Only when we have made the world content into our thought content do we rediscover the connection from which we have sundered ourselves. This goal is reached only when the tasks of scientific research are understood much more profoundly than often occurs." (Steiner, 1995, p. 33).

And continues:

"But for everyone who has the capacity to observe thinking—and, with good will, every normally constituted human being has this capacity—the observation of thinking is the most important observation that can be made."

In so doing, anyone can understand that thinking:

"Is a kind of activity that is neither subjective nor objective; it goes beyond both these concepts."
And understand that the appearances of reductionist materialism, which he calls "naïve realism", are overcome through the knowledge of thinking true essence. (Steiner, R., 1995 p. 37 & 53).

Comparing Cognitive Maps

The cognitive map of materialistic science is dual, linear and exclusive and it includes both rational and irrational levels. What is knowledgeable and can be investigated according to a rational method is considered to be scientific, whereas what goes beyond is irrational and therefore anti-scientific.

The cognitive map of the transpersonal approach is ternary, circular and inclusive. Knowledge can be acquired through pre-rational, pre-personal, instinctive, rational, personal, transpersonal and supra-rational modalities.

Exposure, awareness and dis-identification represent the main cognitive tools for the evolutionary journey – which takes place through transcendence and inclusion, differentiation and integration – of consciousness from instinct to intuition through reason.

Access to the dimensions of awareness, intuitive consciousness, supra-rational and transpersonal instances of the Self – which transcends and includes without denying, but rather by "purifying" the instinctive and rational dimensions through exposure, awareness and dis-

identification – provide validity guarantees that are testable and verifiable by anyone who knows the right set of instructions and is willing to follow them.

In summary:

In order to solve the problems of the fallacy of subjectivity, ineffability of consciousness and evanescence of the soul, psychological science has restricted its area of investigation to behaviour and has chosen the reductionist materialistic approach of natural sciences:

- Everything is matter
- Consciousness is a ghost to be left out of the area of scientific investigation
- The psyche coincides with the mind and resides in the brain
- Reason is the tool
- Measurement and replicability are the method

In so doing, it had the chance to develop effective methods for the study and treatment of psychopathology and behaviour. The object of study of the transpersonal approach is the participatory, unitary and interconnected dialogue between subject and object. The transpersonal approach suggests that:

- Human experience is a participatory dialogue between objectivity and subjectivity and there are various levels of consciousness through which it can be investigated.
- Consciousness has its own independent existence that can be studied by expanding the investigation methods
- The psyche does not coincide with the mind nor reside in the brain
- Awareness and insight are cognitive tools that transcend and include reason as well as offering guarantees for the study of the true nature of the psyche
- The unity of science is not guaranteed "by a utopic reduction of all science to physics and chemistry, but rather by a structural uniformity (regularity of dynamic models) of the various levels of reality" [5] (in Wilber, 2011, p. 19).

In so doing, it suggests tools and methods for the study and mastery of inner experience, states of consciousness and the development of the highest spiritual potentialities and qualities. Considering work such as Spiritual Emergency (Grof & Grof, 1993), or the works of Walsh and Vaughan (Vaughan, 1989; Walsh, Vaughan & Walsh, 1999), among others, would be enough to comprehend that the transpersonal approach is able of operate with competence and deal with psychological problems created by the vast world of spiritual research, providing guarantees of validity.

Transpersonal psychology represents an efficient answer to the overflow of moral-less spiritual practices, as it offers psychological guidelines, maps and methods that allow studying and mastering the ineffable dimensions of consciousness with due care.

Once again, the problem lies not in metaphysical beliefs but in what a person makes of them, that is to say the cognitive system used to deal and elaborate them. It is possible to approach a spiritual experience with a dogmatic, confessional and fundamentalist attitude or a laic, dis-identified and aware one.

Transpersonal psychology provides tools for the second kind of approach.

Circular Reasoning

Proceeding with the analysis of the criticism, we now must deal with the article by Peter Schulthess – Chairperson of the Swiss Charta for Psychotherapy and of the Science and Research Committee of EAP – in a recent issue of the International Journal of Psychotherapy (Vol. 21, No. 1, March 2017). Within a debate on psychology and spirituality, Peter Schulthess states:

*"Transpersonal Psychology's mysticism, deceive the people who hardly tolerate the existential philosophical view that the creation of life starts from a zero point and that death marks an end-point where everything is over: beginning and end. Full Stop!" (*Schulthess, 2017, p. 14)

Emphasizing the scientific inconsistency and epistemological fallacy of such statement might seem superfluous, if not for the significant position held by Schulthess within European Psychotherapy. Schulthess employs the classic circular reasoning typical of wishful thinking, since life begins with birth and ends with death, then Transpersonal Psychology's mysticism deceives the people by stating the contrary.

Besides being wrong from an epistemological point of view, the statement also represents a generalization without any foundation. Where are these deceived people and when does Transpersonal Psychology act that way? Besides ideological beliefs, the scientific thought cannot get around the basic evidence that everything always happens within a certain space and time. So, Doctor Schutlhess, here are a couple of questions: "When and where does Transpersonal Psychology's mysticism deceive the people?" "What do you mean exactly by Transpersonal Psychology's mysticism?"

Perhaps you refer to the shared awareness that apprehension of knowledge, inaccessible to the intellect, may be attained through contemplation and self-surrender, as a brief analysis of the history of human thought could easily demonstrate?

Perhaps a superficial reading doesn't

allow understanding that transpersonal psychology offers maps and models, tools and methods to guide, without dogmas nor beliefs, anyone who is looking for apprehension of knowledge and takes care of anyone willing to do that and who is lucky enough to lose themselves during the journey, by providing reliable guidance and precise reference points. The research and data on how to develop spiritual competencies in the psychological field are countless (Lukoff, 2016).

A greater knowledge of the scientific documentation and comprehension of the transpersonal approach based on the ternary cognitive map: exposure, dis-identification and awareness, might suggest greater care and willingness to engage in dialogue. It would become possible to engage in a true debate based on the aforementioned epistemological differences and agree, as Tart suggests (Tart, 2009), on the fact that there are principles and methods to investigate reality, as if life begins with birth and ends with death, this way obtaining measurable and replicable results within the fields of physio (matter) and bios (life), as well as principles and methods to investigate the *Psyché* (nous) as if it were an unlimited, synergic and interconnected flow…

As a partial justification for those who are confused, it must be remembered that transpersonal phenomenology, in absence of a map consistent with the territory, might ***seem*** to coincide with magical, superstitious and mythological contents, typical of uncritical and pre-rational fusional experiences. However, the transpersonal approach offers a non-judgmental kind of listening, maps and tools, words to name things, in order to face the arduous psychological journey into territories at the doorstep of mystery, as well as competencies for a leap of consciousness that makes it possible to face the ineffable experience of the *Psyché,* beyond a literal reading, towards a further mode, symbolic, dynamic, interconnected, synergic and archetypical.

The ternary cognitive map together with the "as if" epistemology, the tools of awareness and dis-identification, the widening of the cartography of the psyche, and pre-birth and transpersonal experiences, allows operating with the aforementioned vast phenomenology, integrating it in the field of psychology. Access to super-conscious, transpersonal and transcultural states of consciousness makes it possible to access profound and archetypical structures of consciousness.

As a consequence, the competencies obtained preserve the subjects of experience form the risk of using them in an uncritical, manipulative and dogmatic way, enriching psychology with tools, areas of intervention and research.

Psychologists state:

"Shamanic intuition and/or the eternal mystical traditions of the high religious cultures ("philosophia perennis") alienates us from our present culture and also from our profession, as the argument

is hardly rational and not externally verifiable." (Schulthess, 2017, p. 16)

Since the only science is materialistic reductionism, everything that is hardly rational and not externally verifiable is left out of psychology. Once again, the use of circular reasoning is using the premises to justify the conclusions.

Even if we overlook the ethnocentrism of an attitude that excludes what doesn't belong to Western culture for the mere reason of not belonging to it, it is very difficult to find a justification for an argument willing to support the danger of alienation in welcoming the inheritance of the past in our current culture.

Plato was aware that we are standing on the shoulders of giants. It wouldn't take much to see the historical evidence that the majority of the current psychotherapeutic practices already existed in ancient shamanic cultures.

Without the technical and cultural heritage of the past psychotherapy would not exist. If anything, the problem lies in the thinking that uses it, which depends on one's state of consciousness, which in turn, depends on one's cultural beliefs and emotional experience.

The need to differ from the past indicates an unresolved bond with it, which is a legitimate phase during development, but it must be transcended and included within integration once the conflict is resolved.

It is legitimate to feel overpowered by a heavy unresolved past and therefore act to overcome its shadows, for instance, thanks to the development of reason and the scientific thought that have freed us from the slavery to the superstitious, magical and mythological thought. On the contrary, it is certainly limiting to leave behind the inheritance of the knowledge and tools that those who came before us conquered and it is even more disconcerting to exclude from the community those who are not willing to do that.

Once again, the maps of transpersonal psychology, that take into consideration various states of consciousness and evolutionary stages of thought, provide psychology with tools capable of distinguishing and protecting from an inappropriate use of powerful traditional healing technologies.

The transpersonal psychologist's knowledge of states and stages of consciousness is the necessary resource to face those risks that the psychological community sees as a threat to its own identity.

By expanding its jurisdiction and methods through the contributions of the transpersonal epistemology and methodology, future psychological science could become a reference point capable of protecting the most authentic spiritual areas of human experience.

These areas will become increasingly attractive and it would be deleterious to leave them in the hands of New Age, confessional dogmatism of Religion or even worse the dark objectives of fundamentalism and esotericism.

The "as if" type of ontology,

epistemological maps and methodology of awareness allow traditional tools to cooperate with supra-rational modalities, purifying the process by providing guarantees of ethical and methodological validity.

In so doing, as Boadella warns, it might become possible to prevent "throwing the baby out with the bath water", giving back to the *Psyché* its original meaning and to psychology its function for the future.

Psychology or Spirituality

Another singular accusation is that transpersonal psychology contributes to spiritual visions rather than the psychology of spirituality. Such a statement is only possible if you don't properly understand Transpersonal Psychology.

There are many established clinical methodologies, namely psychotherapeutic transpersonal approaches. Having a 'vision' means supporting the practice with a theoretical model that is both ontological and epistemological. Transpersonal ontology and epistemology inevitably share many statements with perennial philosophy but, as explained before, differ from it in the interpretation and application in therapeutic practice.

The distinction between pre-personal and transpersonal contents, the laic, non-confessional, non-doctrinal and non-dogmatic approach favoured by the supra-rational and transcultural "as if" reading, the definition of maps and models that indicate the phases of the transpersonal evolutionary process, and the use of a clinical methodology that teaches how to reach, master and verify certain transpersonal stages and states, trace a clear boundary with spiritual and esoteric traditions for anyone who is willing to see the distinction.

There are many different psychodynamic, cognitive and humanistic approaches. Similarly, there are various transpersonal psychologies that present transpersonal psychotherapeutic models attributable to common matrices that respect the entire spectrum of human experience and deal both with historically important issues of Western psychology and specific matters of the transpersonal approach (Tart, 1992).

From Evidence-based to Attention-oriented Methodologies

The evidence-based method starts thanks to the life and work of Florence Nightingale (1820–1910). Nightingale used the collection, analysis, and graphical display of healthcare data from the Crimean War to prove that conditions at the time in military hospitals were not beneficent, but in fact harmful to the lives of the soldiers being treated (Small, 1998).

The transpersonal approach's suggestion to the scientific community

is based on accurate reflections, such as the consideration that evidence-based methods were born within the medical field to study the effectiveness of cures for diseases in a context. where it is clear that the disease is objectifiable and there is a method that can be a protocol for external intervention.

As it occurred for the reductionist scientific method – which, after its huge success within the study of matter, was implemented for the study of the living being and the psyche, which was in the meantime reduced to the mind and placed in the brain – the evidence-based method was also implemented for the study of behaviour, given its usefulness for the evaluation of medical treatment.

Transpersonal ontology and epistemology suggest a wider view that is not reducible only to objective data, the cure of symptoms and study of behaviour. The object of investigation of the transpersonal approach is the participatory dialogue subject/object, where the "object symptom" and the "object behaviour" are not separable from the "subject inner experience", where the "object body" and the "object mind" are not separable from the "subject consciousness", unitary experience of the psyche, dynamic and interconnected.

Moreover, it recognizes in its subject/object of investigation a self-organizing and self-transcending complexity (CAS), as well as a multiplicity of stages and states for which mere objective evidence is limiting. If the psyche is considered an expression of a body-mind unity, stratified in unconscious, conscious and supra-conscious dimensions, pre-rational, rational and supra-rational stages, evidence is interpreted as appearance. Therefore, a deeper and integral investigation is needed; an investigation that respects and recognizes the complexity and mystery and that timidly, humbly and consciously explores the ineffable territories of consciousness and the transpersonal dimension searching for classifiable regularities. These regularities might not coincide tout court with the measurable evidence demanded by behavioural science, but they may be compared within a view of reciprocal respect and synergic collaboration.

Ultimately, the transpersonal approach agrees with the necessity of the experiential guarantees demanded by the reductionist scientific method if limited to the study of behaviour.

At the same time, for the study of inner experience, the transpersonal approach claims the most elevated qualities of the human being, the realization of the Self and states of consciousness as well as other methods and forms of guarantee, as for instance the epistemological and experiential ones.

Proof that the transpersonal vision does not deny, but rather transcends and includes evidence-based methods, lies in the fact that the methods of treatment and results of transpersonal psychology do not avoid evaluation through specific tools of measurement and diagnosis of the related constructs in the

field, as the DSM-VTR classifications or psychometric tools such as the MMPI or the scales of Beck and Hamilton.

There are specific methods of measurement for the transpersonal field, precisely twenty-six different tools that are used for research (MacDonald, Friedman & Kuentzel, 1999, p. 137-154), such as: 'The Assessment Schedule for Altered States of Consciousness'; 'The Ego-Grasping Orientation'; 'The Expressions of Spirituality Inventory'; 'The Hindu Religious Coping Scale'; 'The Measures of Hindu Pathways'; 'The Self-Expansiveness Scale'; and 'The Vedic Personality Inventory'.

As it isn't limited to the study of behaviour and it deals with issues such as inner experience, the participatory object/subject dialogue and the evolutionary journey of realization of the Self, the transpersonal approach suggests the necessary transcendence and inclusion of measures and falsifications within qualities, the overcoming of correct data through the identification of regularity, as well as investigation and description through attention and awareness. A lot of research within the transpersonal field present and use innovative epistemological and research approaches, as described by Anderson and Braud (2011).

We refer, among others, to: 'The Intuitive Inquiry' by Anderson; 'The Integral Inquiry' by Braud (Anderson & Braud, 2011); 'The Organic Inquiry' by Clements; 'The Essential Science' by Tart (2009); 'The First-Person Science' by Varela (1999); 'The Integral Science' by Wilber (2011); and 'The Second Attention Epistemology' by Lattuada (2010, 2011, 2012).

Experience Based Guarantees

Scientific research excludes from its area of investigation any subjective data, emphasizes objective data and by choice disregards the subject of experience, if not in order to submit it to a strict experimental protocol.

When dealing with Physio, Bios and behaviour receiving credit is relatively easy. What happens when dealing with inner experience of a spiritual kind or non-ordinary states of consciousness? In this case, academic qualifications are not enough to have credit in the study of the *Psyché* in its integral conception; it is necessary to explain one's experience and clinical history and from there deduce the knowledge that one has gained through hands-on experience. I don't mean that we should give credit to someone only because of his experience and consequently that this person is allowed to obviate the hard task of validation of his statements, but rather that anyone who is willing to embrace a discipline and make statements about it should declare in detail his experience in the matter, so that his history, coherence of method

and subjective data can contribute to give value to his statements.

A first-hand science encourages complete transparency about our beliefs, values, motivations and experience related to the subject of research, as well as the exposition of our experience during the investigation.

This way, as Rosemarie Anderson (2017) suggests, the use of reflexivity might help the researcher rather than represent a problem to dismiss. Moreover, if it's true that looks are deceiving and reality is not as it appears, it is necessary to use an experience-based method that teaches going beyond appearances, beyond the mind understood as rational thinking, and consequently the researcher will have to explain how he intends to obviate the issue of appearance and the tools he will use to do that. Experiential investigation uses millenary technologies implemented for centuries by spiritual researchers from all around the world and it is implemented this way:

Through the laboratory of personal, inner and integral experience, according to declared and validated methods, insights are reached and they are explained to anyone who wants to verify them through the same experiential procedure and therefore recognize the veracity or falseness of the conclusions.

As Wilber says: "they show that there are higher domains of awareness that include love, identity, reality, Self and truth (Wilber, 2011, p. 369).

These statements are not dogmatic; they are not believed because stated by an authority, but rather because they are based on hundreds of years of experimental introspections and shared tests.

False statements are rejected on the basis of consensual evidence; successive evidence is used to correct and tune experimental conclusions.

In other words, these spiritual dimensions are literally purely scientific and the systematic presentations of these dimensions follow exactly the ones of any *reconstructive science"*.

Following are a few more words about the method, that is to say the type of thinking through which these statements are reached.

The highest states of consciousness that operate according to modalities of supra-rational thinking, such as casual and non-dual, can be explained rationally by those who have experienced them in first hand but cannot be experienced through rational thinking (first attention). They can be reached following a trans-rational and contemplative modality (second attention) (Lattuada, 2010, 2011, 2012).

We can understand the accusations of elitism and non-scientificity, but we cannot agree with them. The scientific community should simply accept that there are states of consciousness and stages of thought whose access demands precise procedures and whose acquisitions can be described and understood with the use of a supra

and trans-rational language.

Hereafter, we will report how Wilber describes a process of access to the psychic, subtle, causal and non-dual worlds, providing validity guarantees (Wilber, 2011 p. 381)

Injunction: "If you want to know this, do this".

Insight: as mentioned before, insight should be considered as the adequate tool to reach the true nature of knowledge; it is a direct vision that shows things the way they really are, a flash that we have all experienced once, that unveils the veil and reveals the data hidden beyond appearances.

Shared confirmation or denial: sharing one's conclusions with a community of equals.

Conclusions

We have tried to emphasize the specificity of the transpersonal approach, characterized by its object of investigation, the participatory dialogue between an individual and the world marked by an evolutionary journey of gradual realization of the Self towards the comprehension of the dimensions of inner experience of a spiritual kind. We have explored the guarantees of transpersonal psychology, offering a brief overview of the benchmark ontological premises, epistemological maps and models that are based on aware observation and the historical roots that support it. We have traced the outlines of an experience-based methodology that can be subject to validation and capable of engaging in debate and integrating with the methods of behavioural science.

Author:

Pier Luigi Lattuada, M.D., Psy.D., Ph.D, of the Integral Transpersonal Institute, Milan, Italy, and Sofia University CA and Ubiquity University CA; the founder of 'Biotransenergetics'. Pier Luigi is also the Director of the Transpersonal Psychotherapy School in Milan, which has been fully recognized by the Ministry of Education University and Research since 2002.

E-mail: djirendra@gmail.com

Translator

Timothy Moore Perazzoli

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What is a Spiritual Psychotherapist?

COURTENAY YOUNG

Abstract

This is an extended and revised version of a plenary presentation: *"The Place of Spirituality in Psychotherapy"* given at the UKCP 6th Professional Conference: **"What is Psychotherapy? - Exploring the Boundaries"**: Warwick University, England, in September 2000. It was first published in the UKCP Conference Proceedings, edited by Jenny Corrigall. It has been upgraded and revised a little since.

This article attempts to use a somewhat Socratic method to answer the question, "What is a Spiritual Psychotherapist?" Hopefully, I have avoided any particular critiques or criticisms of anyone's particular practice or spirituality.

Preamble:

I would like to start by first setting a direction and then declaring some personal assumptions. The direction of this article is to look at what constitutes a "Spiritual Psychotherapist". This is because I think that this is the most efficient way of exploring the overlap of the areas of psychotherapy and spirituality, especially to an audience of psychotherapists, many of whom may already be very spiritual or practicing in a spiritual manner.

I hope that you will agree with this direction and maybe find some resonance within yourselves. Just to reassure you, I really and truly hope that I am not going to presume to tell you what your spirituality should be: that really is your personal business. But in this arena where we are considering the place of spirituality in psychotherapy, it is also our professional business, and it is also deeply concerned with the client's business. And these agendas may, or may not, overlap. So I would like to explore this question from this perspective. A "Spiritual" Psychotherapist can mean either a psychotherapist who is spiritual in themselves, and/or a psychotherapist who practices a form of psychotherapy that is spiritually orientated: i.e. that might attract a client who is searching for something spiritual; rather than relationship-oriented; body-oriented; or behaviourally-oriented.

As a form of definition, I am clear that I make a couple of assumptions here. We happen to have a problem of

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language in this field: not all our definitions are the same, so I will try and clarify mine. The initial assumption is this:

1) The client's search for their own sense of spirituality is as much a legitimate topic for psychotherapy: as exploring their grief at the loss of a loved one; as working through the somatised reactions of an unresolved trauma; as trying to minimise the effects of a phobia; or as trying to establish a sense of self from exploring one's personal & psychic history.

The legitimacy of the client's search for their own sense of spirituality is - for me - an essential preliminary assumption. The psychotherapist who ignores (or glosses over, or is scared to support) the client's often tentative explorations and the various verbal (and non-verbal) cues coming from the client about their belief systems, or metaphysical constructs, or loss of faith … is not, according to my definition, a spiritual psychotherapist, nor even a very good non-spiritual psychotherapist.

The belief systems within which one operates are, for me, an essential component of working with a client; and I would want to know as much (or more) about these as I would want to know about their medical or psychiatric history or their early childhood. A client's inner world is often the most important thing – to them. And the richness of their life is often measurable when their inner world and their outer world begin to have a certain similarity, harmony, and/or con-jointed-ness. Behaviourism apart, some people would even argue that the eventual 'cure' for any client coming to therapy is when their connections with spirit, or their own spiritual path, are sufficiently and satisfactorily re-established.

Statistically it has been found that recovery from alcoholism, or other addictions, is much better (about 65% effective, I recall) when a 'belief' system like the 'Alcoholics Anonymous' 12-Step programme is involved, rather than when it is not.

This is not only a form of a spiritual path; but it is also a very effective therapeutic programme (especially, when undertaken residentially): consider the Second, Third and Fourth 'Steps':

2. *We came to believe that only with the aid of a Power greater than ourselves could we restore ourselves to sanity.*
3. *We made a decision to turn our will and our lives over to the care of that Power, God, as we understand him.*
4. *We made a searching and fearless moral inventory of ourselves.*

(AA Big Book Online: p. 59)

The second assumption(s), and I hope that I am not going to offend any believers in the One True Faith (whatever that is), is that:

(2a) There are many, many paths up this particular mountain that we are calling spirituality and all of them totally legitimate, some are perhaps more effective than others for different people: at least one of them is what is right for that person at this moment in time. Some belief systems seem to

claim to have a fast escalator all the way to the top, but I am assuming - I'll be open about it - that this is as much hype as the claim that using a certain soap-powder will transform your life.

(2b) The view from the top of the mountain is the same, whichever way up you went.

(2c) I am also assuming that the spiritual path, or spiritual growth, doesn't have an obvious end, so perhaps the mountain top isn't the best analogy: the Celestial City of John Bunyan's *A Pilgrim's Progress* is just a metaphor, but it is still very powerful after all these years.

I now prefer the much more Eastern pr Buddhist philosophical perspective, which is that – the only goal is to "travel well".

And if these assumptions have any truth, it means that, for me, the journey itself becomes the really rewarding factor. Is this not close to a similar commitment to the psychic process of therapy, growth and change?

This assumption clearly takes us quite a long way away from notions of a particular belief causing redemption of sin; or of eternal salvation for those who believe in 'Whomsoever'; or even about the superiority of CBT over psychodynamic processes or other psychotherapeutic modalities, because it is 'evidence-based': the new 'Holy Cow'.

Anyway, here are my last set of assumptions, and then I will try to develop these a little more fully by several 'Questions' later in the article:

(3a) That the society and culture, that we currently live in, in the West, actively predicates against spirituality: so much so that we do not have a proper language for much of this material. Our concepts are conditioned by a many centuries old tyranny of various forms of religion; and that we may not know what 'spirituality' really is when we come across it, being so conditioned by religious precepts;

(3b) That religion may, can – and for many does – touch an ordinary person's spirituality, but this is not necessarily so for all, and many times, and for many people, religion is remarkably insufficient in itself. It is a form, rather than an essence – it can contain and help people towards their feelings of spirituality, but it can also lead people to hate and kill; and … enough said.

(3c) That there are many people who are increasingly realising that these sorts of points have a validity and thus are searching for something better and more satisfying in their lives: their own spirituality.

Eventually Maslow's "hierarchy of needs" kicks in at some point, and we start looking for something much more satisfying and much more longer-lasting that food, water, shelter, work, etc.; something that touches our spirit; our truth; our essence; our soul.

This search for spirituality can often be diverted (into the wrong sort of 'spirit') and even take the form of various other addictions; "retail therapy" shopping; chasing "success";

having affairs; getting involved with a 'sect' or fundamentalist belief system that promises instant enlightenment, or whatever; and this search can also be assuaged by what I call "the smörgasbord approach to therapy" (shopping around, tasting a little bit of everything) which is equally unsatisfying ultimately.

So, what I would like to do now is to use a slightly Socratic method and pose a number of questions, centred around the main question, *"What is a spiritual psychotherapist?"* And I have to say that I do not have an answer, or The Answer, to this one; what I want to do is share with you some of my explorations around this theme.

Given all that, and it is a lot, and maybe some people will want to challenge some of these assumptions later, and I hope that there will be a suitable opportunity, I come back to the key question that I started with:

What is a Spiritual Psychotherapist?

As I have already said, I don't have any specific answers: but I do have a number of (hopefully) pertinent questions, so I will try to use these in a sort of dialectic and didactic method, and see if we get somewhere:

- **Question:** If a client is presenting themselves in a fairly chronic depressed state, with no seemingly relevant exogenous causes, or series of life-traumas, and without an effective response to medication, can a "spiritual" psychotherapist legitimately ask them about their belief systems - could a possible diagnosis be some sort of "loss of faith".

Incidentally this category now appears in DSM-IV (**N.B.:** DSM-V is a much traduced disaster), so maybe a non-spiritual psychiatrist might even ask it as well.

- **Question:** If a client starts talking about their explorations into (say): Anthroposophy; different belief systems; Zen Buddhism; Alternative Therapies; and (heaven defend!) even New Age communities:; … is a legitimate topic or question for a "spiritual" psychotherapist: "What are you really looking for?"; or do we see this as some form of pathology or avoidance of reality or are we scared that some regulation might provide an edict against this?

- **Question:** If the client is expressing that they are having cosiderable difficulties with having been brought up in an established church or religion, can one, as a "spiritual" psychotherapist, question with them legitimately the relevance of that particular set of beliefs for them now in their life, if one is also a member of that same church or religion?

I am trying to present some of the questions that come up for me when I am working in a particular area of therapy with a client, an area that is loosely called 'spirituality,' and for which there was/is very little training or preparation in my psychotherapeutic training of origin.

Indeed, in society at large, there is a prevailing presumption *against* questioning someone about their belief

systemss. This quite rightly stems from numerous periods of religious intolerance and historical persecution; but please remember, it is the client who is often coming with the sequestions. So, do we just refer them back to the minister, the priest, the rabbi, the imam, or the shaman?

Or do we dare to tackle this subject as a "spiritual" psychotherapist? I don't know whether you the readers have a different set of experiences: maybe we can have a Linked-In discussion group, about who has had specific training in their 'training of origin' working with some of this material?[2]

Let us also approach this area from another direction. One of the principles of any exploration; psychic, scientific or geographic; is to discover where the ‘edges’ are, where the limits are, and that helps us to define the size and position and extent of the area we are investigating, before plunging straight into the middle, and maybe getting a little lost. That is what I am trying to work with here. It is not easy, and I am fumbling a little bit, it is not really through lack of confidence, mainly through lack of effective tools, or even proper words.

The next set of questions comes from where there is a potential (not conflict, but say) difference, between our own set of beliefs and the client's.

Maybe you are Catholic, they are Protestant, which might not be too problematic working in England, but in Northern Ireland or around Glasgow, it may be. Or (say) the client firmly believes in reincarnation, and you don't.

Maybe this doesn't arise in the therapy for a while, but then the client discovers that they have a potentially terminal illness and this is then a relevant and immediate topic. Or, what happens if it is the other way round? You believe in reincarnation, and they don’t: and they have the illness.

- **Question:** As an assumed "spiritual" psychotherapist, how do you work with this difference of belief systems? How conscious are you of your own belief systems? How careful are you not to impose these, even by assumption, or by absence of question, onto the client? If you have the same (broadly similar) belief systems, how collusive are you in this? Maybe the client is looking for, or needing, something else? How convinced are you that, if only the client could see or understand *this* or *that* (your belief), then they would feel better?

- **Question:** When one works as a "spiritual" psychotherapist, do you lead, or do you follow? How directive are you? Do you dare to suggest a particular text: (say) *The Road Less Travelled* (by M. Scott Peck) – an excellent psychological or psycho-therapeutic book on ‘Love and Spirituality’?; or *Peace is Every Step* (by Thich Nhat Hahn), rather than *The Mindfulness Breakthrough* (by Jon Kabat-Zinn)? Maybe, that is O.K.: but what about the teachings or writings of Krishnamurti, or Bhagwan Shree Rajneesh, or Carlos Casteneda, or C.J. Jung, or Shirley MacLaine, or Ron Hubbard? Or – maybe – just maybe all

of them are valid?

But the client is needing or asking you – their therapist – for some form of help or guidance.

- **Question:** When the client is struggling with something within their own belief system, something that you may not hold to: let us say the sense of shame around indulging in pre-marital sex. Maybe they are Catholic or Muslim, and this is a biggie for them, especially if the client is female: maybe you are male, and were around in the Hippie culture of the late 60's and early 70's. Anyway, you have different mores; different belief systems. Do you tell them, "That's nonsense: everything is fine. If you want to, go ahead. It's your life"? But, what about someone who is struggling with their conscience about "whistle-blowing" - betraying their friends and colleagues; or about "environmental activism" - anti-social and possibly illegal actions: both taken up because of their own (radically different) belief-systems: maybe these are very different from yours, or maybe different to the rest of society's.

The actual angst of pre-decision-making may be a familiar topic within therapy, but what about the long-term consequences? I think that these may be more relevant, within a "spiritual" belief system, than just a systemic, cognitive or psychodynamic one. But, hey – who am I to say?

At this point, I would like to tell a little story: - a sort of a case history. For those of you who don't know, for about 17 years, I had been living within an international spiritual community in north-east Scotland, called the Findhorn Foundation.

For quite a while, I was the 'resident' (only) psychotherapist. About 2 years after I got there (in 1986), a man, in his late 20's came to me for a session. He said he was just passing through; he had a rucksack and a guitar case and shoulder-length dreadlocks. He said that he really wanted some help. His story was that he had studied Tibetan Buddhism a lot and he had actually managed to get into Tibet, to one or two of the monasteries still remaining there. (This would have been in the 1970s, when Tibet was pretty closed off). He said that he had been 'told' that, in a previous lifetime, he had been a Tibetan monk who had done something really dreadful - really horrible - perhaps killed somebody - maybe another monk. (I don't think that he actually told me what it was that he was supposed to have done, possibly as he was too ashamed.)

Apparently, his 'punishment' then was to be locked up (or walled up) in a cell and starve to death. Anyway, he was now, as a further punishment, comdemned to be on the "wheel of suffering". He said – in all seriousness – that he had now been excluded from all monasteries for several lifetimes and (even now) was still 'barred' from all contact with Tibetan monks: this was his story.

His immediate problem now was that he now could not actually (and physically) be in the same city as any

Rinpoche (senior Tibetan monk).

He said he had very severe psychosomatic symptoms whenever this happened. He felt almost cursed. There was, for him, a sort of exclusion zone around these senior Tibetan monks. And it was getting worse, as he now could not come within about 200 miles of any Rinpoche.

Well, there was and is a large Tibetan Buddhist community (with many Rinpoches) in the Scottish Borders, about 250 miles south of Findhorn, and there was not much else beyond us to the north, except the Highlands, and then Iceland.

He felt very cut-off from his spiritual source and he was also quite desperate. He was also planning on leaving the community tomorrow to go further north. Could I help him in any way?

Well ... I said that I had heard his story and that I would have to think about it and possibly consult with someone, and could he come back at such a time tomorrow, which was just before he was due to leave. He agreed to do this.

I did not know what else to do, except to talk with a fellow community member who was familiar with the whole Tibetan Buddhist scene, and who had lived at Samye Ling for quite a while. He confirmed that - within the tenets of Tibetan Buddhism - his story was indeed possible – even credible, if you were a Tibetan Buddhist monk.

However, this guy might also be totally paranoid, and deluded, etc. So we both meditated a bit about this guy's story and his problem, and we both came up with a similar sort of 'insight'.

So, when this man came for the session, I told him this almost exactly: *"I don't know if any of this can be of any help to you at all, but when this friend of mine (who is familiar with Tibetan Buddhism) and I both considered (meditated on) your situation deeply, we both separately got this insight.*

If, as you say, you are "banned" from Tibetan Buddhism for several lifetimes, and, as you seem to have "chosen" to be born into the Western world - for this lifetime, at least: in order not to interrupt your spiritual growth, why not concentrate more on the Western ways of spirituality for a while, (instead of trying to keep to the Tibetan Buddhist way) and see what you get out of that?

Apart from the variety of established Christian churches, and the whole Gnostic tradition, there is the whole field, for example, of the Celtic mystery tradition that is a very long-established spiritual path.

There is also the North American shamanistic tradition, and several other variations, etc. Some of these have many similarities with some of Tibetan Buddhism, and they are also very different. Maybe, just maybe, this can become a significant beneficial part of your karma, and that you can still grow spiritually, as a result, even though it may feel like a punishment initially, and maybe, just maybe, you have been ignoring these areas in favour of your old spiritual path."

I expanded on this theme a little and also suggested a few books that he could read, or even purchase in the community's bookshop, which was an excellent one. That was the end of the session, and he then left the community shortly after.

I never heard from him again, which may or may not be significant. But I still feel reasonably content with the 'intervention' or advice, and the way that I obtained it. Within the framework of his belief system, which I would have no possibility of altering, even if I wanted to, there was little other positive suggestions or advice or direction that I could give.

He had expressed a strong resistance towards any form of psychiatric or medical intervention - even if that might have seemed suitable (to some): I judged not as he was pretty self-sufficient, though somewhat 'lost'. He was very rational (even in his story) and seemed to be no danger to anyone else. So, back to the questions:

- **Question:** What **is** a spiritual psychotherapist? How does such a person help somebody with his or her spiritual path? Is this actually possible?

In John Bunyan's. *A Pilgrim's Progress,* the Angel offers the prospect of only one choice, other than 'destruction': it is to leave home, wife, children, etc. and get to the 'Celestial City'. No other goal (or salvation) is offered, except there are numbers 'tests' or various forms of failure on the way.

The 'hero', called 'Christian', falls into the Slough of Despond; has to climb the Hill of Difficulty; get through the Narrow Gate; meet the daemon Appollyon in the Valley of the Shadow; get destracted by Vanity Fair, etc. So the pilgrim, Christian, really got stitched up somehow by the times and the paradigm he was in.

Within Christianity, there is still the concept of only 'One Way', and of a 'Guide' or 'Spiritual Director', a person who 'directs' your spiritual path.

Nowadays, I prefer the wider choice of the 'image' of being a mentor, or a maybe a guide (leading from behind): or maybe even having a midwife (facilitator) approach to someone's emerging process.

- **Question:** As a Spiritual Psychotherapist, how does one actually help, assist or guide someone along *their* spiritual path without getting in the way, without directing it, "guiding from behind"? Reflection rather than direction, seems more relevant, perhaps: giving the person an open choice, but I'm beginning to answer my own questions and I didn't want to do that.

- **Question:** As a Spiritual Psychotherapist, how can we relate with integrity to where someone is really 'at' conceptually, unless we have had similar experiences ourselves? Does this begin to define a necessary quality or competency of a Spiritual Psychotherapist? And working with clients exploring different areas of spirituality, how eclectic does one have to be?

- **Question:** As a Spiritual Psychotherapist, what tools do we need

in our tool-bag? Do we need experience of Art Therapy and Dream Therapy, as many people explore these realms whilst on their spiritual path? Do we need awareness of Esoteric Healing - as for many, the body is intimately involved in many subtle ways (or affected by many subtle energies)? What about (legal) techniques that help to "blow your mind" or take you to different 'spiritual'/ 'esoteric' spaces; (LSD is now not a legitimate therapeutic technique, though it was when I was first sent to a psychiatrist at the tender age of 15.) Re-birthing, Holotropic Breathwork, Hypnosis, NLP, etc. are somewhat more acceptable nowadays.

There is another area, with which I have become quite familiar, but which often still takes me by surprise, and that is the arena called, "Spiritual Emergence" processes and "Spiritual Emergencies" or "Spiritual Crises".

These are phrases originally coined by Stanislav & Christina Grof. Grof was a Czech psychiatrist, who was part of the early research into, and psychological experimentations with, LSD (when it was still legitimate). He devised a number of theories about the benefits of this form of drug-induced therapy, as did many others at the time (viz: Timothy Leary, Bill Wilson, R.D. Laing, etc.).

Grof subsequently discovered certain deep breathing techniques (hyper- and hypo-ventilation that are definitively non-drug-based but that have seemingly similar beneficial results to LSD. He was then working in the community at Esalen, in Big Sur, California, for a while and had a number of cases that started to fall into certain groups or categories; so he developed this concept of Spiritual Emergencies, which I have found very useful. I hasten to add that I do not use, nor indeed totally approve of, his actual methods of working therapeutically, which is called 'Holotropic Breathwork', though – as mentioned – some of his concepts are quite useful.

The concept of a Spiritual Emergence process suggests that there is a latent spirituality within everyone that usually emerges at a certain point in one's life, sometimes in one's mid-life, but sometimes much earlier, or later.

The hypothesis is that this is a natural part of human psychic development: just as, somewhere between the years of 12 and 16, adolescence and puberty is a natural physical emergent phase, prior to full adult sexuality.

This spiritual emergence process is a form of emotional maturation, usually happening (in the West) sometime between about age 30 and 50. Many cultures actually and practically recognise this, the symptoms are known and respected, and the various aspects of a spiritual emergence process are built into the culture, and even ritualised.

However, in our culture, that of the Euro-American materialistic Western world, this doesn't happen quite so easily. Christianity and materialism

have effectively killed it.

So, at this point, I may be speaking about quite foreign concepts to you.

The symptoms of this emergence process are often seen as something of a deviance, or an aberration, or even as 'pathological' by our Western materialistic and heavily medicalised culture.

Please imagine, for a moment, a culture or society where adolescence and puberty is socially and psychologically denied: a society firmly fixed in the pre-pubertal stage. In such a culture, the growth of breasts becomes a deformity needing surgery; facial and pubic hair are seen as an aberration, not to be spoken of, and thus depilation becomes a social requirement. The relatively normal symptoms of adolescence; dizzy spells, puppy fat, facial spots, etc. are all abnormalities – needing different forms of 'treatment'.

My hypothesis is that our present society treats the symptoms of spirituality, or an emerging spiritual development process, quite similarly and quite pathologically.

Therefore, if you hear voices in your head, you are schizophrenic. If you start to emulate the behaviour of a wolf you are psychotic. If you think that you can predict certain events, you are deranged. If you think you can eal people by the laying on of hands, your are deluded.

Physiological processes that wrack your body; that might make you seem pregnant without so being; or are a reaction to chronic stress, like chronic fatigue, are also (usually) deemed to be psychosomatic, rather than forms of Kundalini.

The actual physical manifestations that often accompany changes in spirituality are almost totally denied or wrongly ascribed; and sudden changes of job, or partners, or lifestyles, etc. are seen as (just) a 'mid-life crisis' and often denigrated.

Now, in a society and culture that ignores much of spirituality, or dismisses it as a New Age phenomenon, we will inevitably find certain 'aberrations' built into that society.

The mystics and people of undefined spirituality are often persecuted, or burnt as witches. Someone who has visions is not elevated to the priesthood, or made a shamanic 'medicine man'; instead they are given psychiatric tests. Even if their visions are eventually confirmed, the Catholic Church (a state institution) might beatify or sanctify them, but usually only long after they are dead.

Unless you have been effectively "shunned" by business partners, family, friends and society around you, you cannot imagine sometimes how hard it is to experience any of the many manifestations of such a form of spirituality, or a spiritual process, as well as the attendant social disapproval, isolation, rejection, etc.

The spiritual emergence process is hard enough anyway, as many have told: let alone to be subjected to the antagonistic or disbelieving reactions from those (loved ones) around one.

Here's another little story: A good friend of mine was responsible for the Spiritual Emergency Network, a phone-line reference network for spiritual psychotherapists dealing with Spiritual Emergencies in the USA.

She got rang up one day by a little old lady from somewhere in Texas. This person said; *"Can you help me? God came and sat in my head last Christmas."* My friend asked her what were the effects (or manifestations) of this; what did she actually mean by 'God sitting in her head'.

The lady replied, *"Oh. I know what people are thinking when they come towards me."* (Pause) *"But my Minister thinks I am of the Devil; my women's group think I am a witch; and my husband doesn't want to know."*

So, the question I have for you is, *"In this story, who has the problem?"* For the lady, it was obviously a spiritual and psychic experience as "God" came and sat in her head at Christmas time. She didn't seem to have much of a problem with that: she didn't say, *"I am going crazy."* But, for everyone else around her, it seemed to be an aberration.

Many people think that they are going crazy, or there is something wrong with them, when these 'symptoms' of the spiritual emergence process happen to them, as we do not have an acceptance of these symptoms and we do not recognise the process. So, I have a few more questions for you:

- **Question:** If one is a Spiritual Psychotherapist, what training might one need to recognise the many different manifestations of these Spiritual Emergence processes? What professional competencies are needed? How feasible is it to introduce such modules into present-day psychotherapy training programmes? If we continue to ignore these phenomena, how many more people will continue to end up being wrongly diagnosed? Is an actual experience of shamanism, mysticism, channelling (or a semi-psychotic episode), a necessary 'qualification' for a Spiritual Psychotherapist?

- **Question:** As a Spiritual Psychotherapist, how easy or difficult is it to 'buck the trends' of society that requires that everything gets put back into the box (so to speak), and instead to relish and encourage these phenomenological changes to come out in your client, even at the risk that they may be judged (by the rest of society) as psychotic, mystical. New Age, aberrations, or whatever? How brave are we, as Spiritual Psychotherapists, to support the individual growth of their spirituality against the mores of the surrounding society? If you had been Martin Luther King's, or Nelson Mandela's, Spiritual Psychotherapist long before they became who they are now, how would you have fared? Could you have stood up to your more conservative supervisor?

Now, the last point that I want to make, is about actual spiritual experiences themselves. Grof, in his book, *The Stormy Search for Self*, categorises

them into about ten different types, and I don't want to go down that list particularly for the moment, but there are some startling similar characteristics that are often found in spiritual experiences from other people. Joan Borysenko, in her book, *Fire in the Soul*, describes one character, Fritz, who had a spiritual experience – whilst in hospital, intravenously receiving a high-calorie feeding solution. His perspective suddenly expanded and *"…he knew at the deepest level of his being that everything was perfect. Everything that was happening was perfect."* Please think about that for a minute.

Have you ever had a realization that the whole beautiful terrible crazy drama of life was perfect? What might that do to your 'world view'? He also had a realization of his own inner purity. Please think about that!

How-might it feel to know that - despite all the times that you have felt foolish, unworthy, bad or just plain 'not good enough,' you suddenly saw that your 'core self', your soul, was perfect, pure, without blemish and filled with light.

This is possibly the experience of seeing or realizing one's "Higher Self", the true nature of who we really are. It is far removed from just improving one's self-esteem. T

hese sorts of things just happen in this type of process. And they happen to a lot of very 'ordinary' people. You do not often hear about them, because, when the person reports these experiences to others, close friends, family, etc., they usually experience some very strange reactions. So, eventually they shut up, and they may even deny these experiences, or forget about them, and carry on "as normal".

However, there is some evidence that nearly all people who can be described as 'extraordinary' people have all of them had some sort of a spiritual 'awakening: Pierro Ferrucci wrote about this in his 1991 book, *Inevitable Grace.*

- **Question:** (and this is the final one from me). If we want this sort of experience for our clients, (and possibly for ourselves) how can we best support these processes? What do we need to do to help and maybe even encourage ourselves and/or our clients in this direction? Do we teach them mediation? Do we require them (or cajole them) so that they have expanded times of self-reflection and introspection outside of the therapy room, as a form of regular practice? Do we suggest to them that they read certain books; or go on certain courses; or do certain things? Are we, as Spiritual Psychotherapists, proactive and supportive when we hear of these phenomena. happening to our clients?

I believe that we should – when it seems appropriate. I believe that we need to help people to change, and we should not – by our actions or inactions, or our limited thinking or belief systems, or following restrictive (quasi-legal) practices – proscribe or limit the direction of that change. The UKCP UK Council for Psychotherapy) was

founded as a reaction against the sect or cult of Scientology in the mid- to late-70's. The many people attracted to such sects were, and still are, definitely looking for something more than society currently provides.

We should, maybe even must, be starting to provide understanding, acceptance, help or guidance towards this end and with this phenomenon. But how? How do we provide a much needed impetus towards spirituality, rather than towards a sect, and without avoiding it through many years of psychotherapy, religion or the materialistic thinking that pervades our culture? So, I make a plea for more direct action from the profession of psychotherapy, now.

Psychotherapy is, along with other forces like the feminist/anti-sexist movement, the ecology movement, and other grassroots, a people-powered movement (as are the recent petrol blockades, anti-war marches, pro- and anti-hunt parties, the animal rights movement, and so forth, as well as mass movements against oppression like the Arab Spring of 2010-11). Society desperately needs this type of change. The individual members of society desperately want this kind of change, diversity of choice, and enrichment, and are prepared to inconvenience themselves considerably. I don't need to quote you the statistics, they are ever present in the newspapers. The planet also desperately needs this type of change from us humans, to stop eradicating species, polluting the earth and using up all the resources; and we, as individuals on it all need to recognise this and ourselves become the agents of change, in our own ways. We cannot just objectively support these things, as and when they happen in our clients: they are not aberrations or pathologies. If we are truly Spiritual Psychotherapists we will respect them, even though we may differ, and support them, even though we may disagree.

I believe that, as a profession, we must move away from complacency and apathy, towards a higher level of conscious awareness and compassionate action – towards our selves, towards others (people and sother species) and towards the fragile planet that we live on.

I believe that spirituality is the source and the pathway for many of these movements and that without it an active and alive form of spirituality, psychotherapy will also become dry and dead and going nowhere.

Thank you!

Author

Courtenay Young is a UKCP registered psychotherapist, an EABP registered Body Psychotherapist, EABP Honorary Member, BPS member, ECP holder, EAP Individual Member, and Editor of the International Journal of Psychotherapy. He was the resident psychotherapist at the Findhorn Foundation for 17 years and

trained with various ‘transpersonal’ psychotherapist, like Stanislav Grof, Arnold Mindell, Diana Whitmore, etc. He is the author, editor and co-editor of several published books and many published articles.
E-mail: courtenay@courtenay-young.com

Note of Acknowledgement
There is an interesting article on this topic that I found helpful in the shaping of my ideas for this talk: DISHINGTON, L.F. (1996). Spirituality and Psychotherapy: In: *Progress: Family Systems Research and Therapy, Vol. 5,* pp. 99-110. Encino, CA: Phillips Graduate Institute. There are also all the other articles in the parts of these on-going Online Special Issues on Psychotheapy vs. Spirituality, which obviously came much later.

Endnotes:

1 AA Big Book On-line: hwww.aa.org/bigbookonline/en_bigbook_chapt5.pdf

2 In the 2000 conference presentation, about 25% indicated by a show of hands.

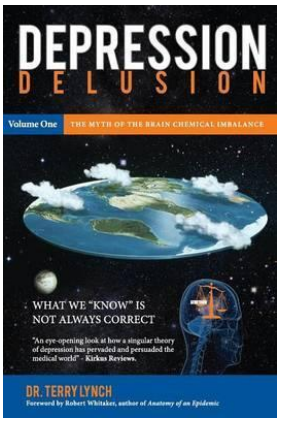
3 Kagyu Samye Ling Monastery and Tibetan Buddhist Centre, in Eskdalemuir, Dumfriessshire, DG13 0QL

4 For more information on psychedelic therapy: en.wikipedia.org/wiki/Psychedelic_therapy

5 In the month that this talk was originally given (Sept 2000), the Dalai Lama was not invited to a major international conference on world religion on the political and economic grounds that it might offend the Chinese government.

6 Ferrucci, P. (1991). *Inevitable Grace: Breakthroughs in the lives of great men and women: Guides to your self realization.* New York: Tarcher.

Book Review 1:



Depression Delusion: Vol. One: The myth of the brain chemical imbalance.

by Dr. Terry Lynch

Limerick, Ireland; Mental Health Publishing, 2015
ISBN: 978-1-908561-01-5
Paperback: 371 pp.
Indexed

RRP: £12.95; €12.39; US $19.95

Before beginning to read this book, I reflected upon an article entitled, *"This article won't change your mind"*, published in *The Atlantic* in 2017.[6] The subtitle was: *"The facts on why facts alone can't fight false beliefs."*

Although there is much evidence to support this contention, Dr. Terry Lynch, a board-certified M.D., as well as a psychotherapist, who has worked for the Irish Dept. of Mental Health and is the author of two prior books (*Beyond Prozac* being his first), tries hard to present a plethora of facts to change minds. He does not just stick to the facts; though, if any reader should have doubts about the facticity of the medical model and their concepts regarding depression, this book will clearly inform a reader that the facts do not – really – support the current (or predominant) 'brain chemical imbalance' theory.

Lynch underpins his claim, repeated sufficiently so that one cannot doubt the intent of this work, that: *"[T]he prevailing view for over half a century is that depression is caused primarily by biological brain abnormalities."* (p. 2)

He asserts, provides much research, and quotes extensively from others who support this view, that this 'myth' is: scientifically unfounded; untenable; logically incorrect; and even dangerous, even though it has been supported by an unofficial 'cabal' of psychiatrists, media, pharmaceutical companies, and even well-intentioned doctors, psychotherapists, psychologists, and other mental health workers, web-sites and literature … all of whom seem to accept it.

Lynch asserts vociferously that this 'myth' – not only has no scientific foundation – but it has been maintained by intentionally ignoring scientific research, practice and theory and

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therefore costs individuals and societies untold damage – financially, physically and psychologically. This has been done (he asserts) to provide a veneer of legitimacy to the profession of psychiatry and a "rationale" (illogical as it may be) to the medicalization of depression: *"The brain chemical imbalance delusion has become a tidy was of sanitizing such situations [fear and resistance to public expressions of distress] about which many of us feel uncomfortable."* (p. 237)

To claim that depression is a disease, like diabetes, implies that medication can correct the problem and that the person, the family, social group, or society, is not implicated – at all – in its etiology (despite very significant evidence to the contrary). Since a (so-called) 'medical' view of depression isn't as a psycho-social reality, medication becomes a potential panacea that demands no additional therapeutic work to remedy. Unfortunately, Lynch alleges, this perspective is not only false, but it is also dangerous.

The book is composed of 16 chapters of various lengths, each with ample footnotes and references so that readers can investigate the facts. The chapters are laid out clearly, logically and coherently. He refers many times to a number of logical fallacies – notably: 'Begging the Question'; 'Red Herring'; 'Weak Analogy'; 'False Cause'; and 'Appeal to Authority' that he asserts all go towards asserting erroneous claims about this medical 'myth'. Most of these chapters provide citation after citation, as well as Lynch's commentaries on, and repetitive critical analysis of, many of the quotes that support this 'myth'. There are sufficient quotes and resources furnished to buttress his attack (sustained over 14 years) against these 'errors' of logic and the betrayal of scientific methodologies and public trust that it now seems clear: anyone who pursues this matter objectively will need to adjust their understanding of depression and set aside the medical/psychiatric model of chemical imbalance.

This is where a return to the *Atlantic* article, and others of its ilk, become vital: are you willing to change your mind, if you happen to hold the notion that there are chemical imbalances that cause, or at the heart of, or occur in depression? This book thrusts onto the reader such an avalanche of facts that one is almost impelled to ignore them; to live with the cognitive dissonance; and to keep believing in this 'myth', or to concur with him and contemplate the implications and thus change one's view. In fact, an *avalanche* is an apt metaphor: Lynch inundates the reader with quotes and sustained academic debate, in sufficient quantity in an attempt to 'bury' this chemical imbalance 'myth'. Time will reveal if this happens, or if the 'vested interests' and the 'Big Pharma' organizations that have much to gain by maintaining it, or simply continuing to undermine opposition to it with marketing; continuing to ignore Lynch and many others who challenge this viewpoint.

His appeal to logic is well-founded, if one holds such a 'myth' and if one is open to discerning what science and years of research can demonstrate and to following the scientific method to its conclusion: such delusions need to be set aside when evidence is propounded forcefully and overwhelmingly. Lynch provides a few definitions of "delusion", one being from the *DSM-5*: "Fixed beliefs that are not amenable to change in light of conflicting evidence." (p. 289) Thus, this book, *Depression Delusion* is the first in a series of three books that seek to undermine this fixed belief about depression.

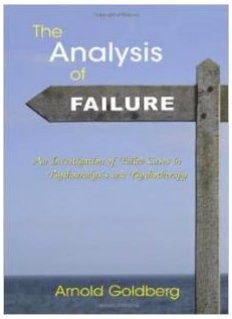
When I was reading this book, I wondered if Lynch falls victim to the fallacy known as 'Argument from Authority", but I think he does not. He definitely defers to authority and when citing particular authorities, (e.g. Robert Whitaker, Daniel Carlat, Elliot Valenstein, or Irving Kirsch), he mentions their books, position of authority, and professional titles so many times that I wondered how many pages shorter this book might be had he trusted the reader to recall what book each had written or was smart enough to refer back to the initial, or second mention of the individual. This seems to have been done to bury any potential criticism of him being a lone voice challenging this delusion.

Reviewed by Theo A. Cope,
Psychologist & Psychotherapist

Endnotes

[1] Retrieved 9-15-2018: https://www.theatlantic.com/science/archive/2017/03/this-article-wont-change-your-mind/519093/

Book Review 2:



The Analysis of Failure: An investigation of failed cases in psychoanalysis and psychotherapy

by Arnold Goldberg

New York: Routledge, 2012
Paperback: pp: x, 238
ISBN: 978-0-415-89303-9

Since there is no particular agreement on the definition of what constitutes success or failure in psychoanalysis or psychotherapy, it is therefore quite difficult to assess whether any particular intervention, or outcome as a result of a series of sessions, is disappointing and enervating, or whether it somehow meets the client's expectations and is invigorating: and then, what about the therapist's expectation (or expectations)?

So, we are already facing something of a dilemma. The author tries to address these issues in the first chapter, *Introducing Failure*, and fairly quickly presents the inherent dynamic imbalances in therapy: between the analyst and analysand; with imbalances of power and determination; as an ally or antagonist; a healer or a patient; and the implicit "promise" of therapy providing a (sort of) cure. The author does not help his argument by continuing to explore the binary polarities inherent in the cultural discriminations between apparent "success" and "failure": *"... and so what constitutes success and what makes for failure are never exact issues in reality, but rather are decisions reached by the existing community of like minded language users"* (p. 6); the different usages of these words, and the different overtones given to any normative concerns, be they moral, legal, medical or ethical: often evaluations or directives: sometimes … *"the right thing to do has its own normative scale, and this does not always coincide with the best thing to do"* (p. 8). And then his bias towards the more formal way of working in analysis begins to show – *"There is no denying that we, for the most part, are engaged in an activity that consists of following a certain set of rules established by a certain authority or a system of behaviour that is rooted in a set of principles"* (p. 8) – and unfortunately, this pervades the rest of the book making this somewhat brave

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attempt less meaningful for the more systemic, cognitive-behavioural, humanistic, process-oriented and relational psychotherapies. Perhaps this is the book's main failure.

However, this book does try – and largely succeeds – to get well below the superficial (New Age / self-help) concept that failure – however defined – is simply a form of incompletion or an impasse: a "failure" (he states) is intrinsically more final than that, and is actually quite complicated, multi-dimensional and probably itself is in need of analysis. Failure is not just based on a series of causes (mainly from mistakes by the therapist): incomplete knowledge; a lack of or an inability to sustain an empathic connection; a failure of the analysis of the transference (or counter-transference); or a failure to consider other approaches that might be more suitable to the client's needs. Neither can we, nor should we, consider any of the client's deficits in respect of a possible cause of failure: multiple diagnoses; their lack of resilience; a personality disorder; nor the concept of untreatability; nor an inability to continuing paying, coming, engaging, etc. Failure cannot also be simply rectified (he suggests) just by supplying the missing component.

As we are guided through and beyond these initial polarities, some of the benefits of this book become more apparent: Goldberg, a colleague of Kohut, does not just look at the simplistic concept of any particular failure from the perspective of blame, i.e. "What went wrong here?" nor even (thankfully) "What is wrong with the patient?", but more, from the proper analytical style of, "What didn't work, or what was missing here, or even what might have made a difference?"

This more empathic way "learning" from our "mistakes" (or missed opportunities) echoes something of Patrick Casement's works, *On Learning from the Patient,* etc. (1985, 1990, 2002) – who, surprisingly, the author doesn't reference (but then the book is very USA-oriented). However, he does consider the insularity and limitations of different schools and methods – and how these can limit us.

One aspect of identifying "failures" that he brings out quite well is that – for the most part – it is the psychotherapist / psychoanalyst (he does not seem to differentiate) who has to "come clean" about their "failures": unfortunately, this does not happen very often and he rightly endorses supervision and study groups that make a point of sharing peoples' "failures", rather than their successes.

The predominant psychoanalytic perspective is that "the unearthing of the unconscious would essentially eliminate the core component of the symptoms" – but, given that psychoanalysis is not very successful within itself, as it "… regularly promises more and regularly disappoints" because it "… is so open-ended and unlimited in its efforts that it is often doomed to falling short" (p. 37). It is acknowledged that nearly:

"… every physician, psychiatrist, psychotherapist and psychoanalyst tries to do his or her best and begins

every treatment with the hope of success" (however that may be defined), but *"... our focus on success routinely tends to blind us to failure [as we] are unable to really look failure in the face, and thus it is only scrutinised as a lack of success"* (p. 39).

We don't often look at failure in its own right, and many of us don't seem to want to, even though doing so can often be beneficial – but how else can we learn as a professional? It is rare to admit to a lack of knowledge, poor training, and – much more common – to admit to a 'failure' to fully understand aspects of the patient / client relationship; sometimes, there are problems with communication between professionals (patients in therapy are often in "dual treatment", i.e. also on medication or using alternative treatments) with many (professional) barriers of power, responsibility, parochialism and thus (lack of) understanding.

When the author tries to "deconstruct" failure (Cpt. 5), especially the ultimate failure of a patient /client who suicides, it is all to easy to label this as a "inevitable" or – worse – as "treatment resistant", but, by so doing, we again learn nothing and are therefore often left with our feelings of sometimes anger, and often despair and hopelessness, (interestingly paralleling the suicide's similar feelings). However, Goldberg – rather surprisingly – seems to miss this opportunity and, instead, examines the 'failure' of therapy (Which? all therapies, or 'conversion therapy') to work successfully with homosexuality, which was later converted into a success by redefining the successful outcome from 'heterosexuality' to 'becoming comfortable with one's homosexuality'. He then jumps to his somewhat trite analysis of a definition of failure as being:

1. A person who is either poorly or well trained, who …
2. Employs a method competently or poorly, with …
3. A patient who is likely or unlike to be affected by this method, at …
4. A moment in time that is likely to be propitious, *or not,* and that may result in …
5. An endpoint that is desired by the participants and conforms to a community standard that is acceptable at the time – *or isn't, and doesn't.*[vii]

However, perhaps what really constitutes a 'failure' is to 'fail' to take the opportunity to examine so-called failures, and thus miss out on a potential learning opportunity for the future: but, unfortunately, Goldberg doesn't emphasise this enough: *"Failure is not a single event but is a manifestation of a multitude of decisions that go awry"* (p. 63).

Instead, he advocates: **(a)** either regular group presentations within a modality or training school of (suitably disguised) cases – similar to hospitals' "mortality and morbidity" case conferences; or **(b)** presentations of the patient's history and needs to a multi-

disciplinary group of therapists, after assessment and *before* treatment.

Shortly, after trying (unsuccessfully) to 'deconstruct' what we might mean by 'failure', Goldberg develops a taxonomy of failure – as seen over time – the progress or process of therapy being implicit in the concept of failure. In this taxonomy, he considers: (1) cases that 'fail' to "get off the ground" or never start properly; (2) cases that are interrupted or unfinished, because of external influences or unforeseen events, or because of someone (analyst or patient, or patient's close family member) feeling psychologically threatened and insists upon stopping; (3) cases that "go bad" and there is a (sometimes suddenly or upsetting) cessation; (4) cases that go on and on and on – without any visible improvement; and (5) cases that just disappoint.

In addition, he considers (briefly), cases taken at the wrong 'pace'. Then he progresses to "untreatable" cases, quoting a case example of a high-class prostitute coming to therapy for impulsive behaviour and "hypomania", involving an abortion, the sale of her rings, and sleeping with an ex-boyfriend. One question examined by the 'group' on her treatability was whether this person ever properly 'engaged' as a patient.

I find this argument very weak: she had apparently attended 34 sessions, but had (possibly / probably) not fitted into the analytic criteria of "patient-hood" and so maybe it was the analyst who 'failed' her, rather than her actually being 'untreatable'. The therapy can obviously fail the patient; but can the patient 'fail' the therapy?

Is anyone untreatable? Or do we (blindly) just continue to try to do our best, and (in so doing) try to learn from our mistakes: back to Patrick Casement!

Whilst there were some good points in this book, and I admired the author's attempt to look critically into a very difficult topic, I generally felt quite disappointed by this book: Did it therefore 'fail' me, or did I fail it? .

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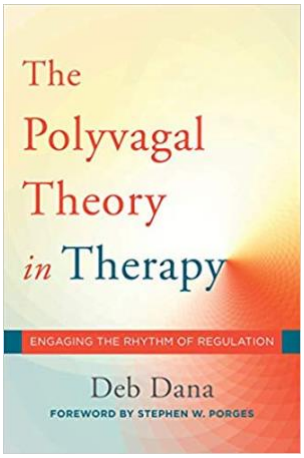
Book Review 3:



The Polyvagal Theory in Therapy – Engaging the Rhythm of Regulation

By Deb A. Dana

W.W. Norton & Co., 2018
320 pages
ISBN-13: 978-0393712377

RRP: $23.54; £19.18; €24.00

"Once upon a time there was an autonomic response..."

'The Polyvagal Theory' was originally developed by Stephen Porges in 1994 and describes – in more detail than be dealt with here – how the Autonomic Nervous System responds to the cues of safety and danger, largely coming from the environment, and thus how these cues (usually) unconsciously influence our emotions and behaviour throughout the course of our everyday life.

Getting to know how the Autonomic Nervous System works, how it reacts, what its triggers are, and how the autonomic responses can be consciously reshaped, are very powerful tools, which can be integrated into almost any psychotherapy, as well as into everyday life.

Especially, when working with people with trauma, the Polyvagal Theory brings a number of new concepts and insights for therapists, who can then help their patients to reframe their reactions to the traumatic events that trigger and thus become able to re-pattern their Autonomic Nervous System.

This book, *"The Polyvagal Theory in Therapy"* by Deb Dana, is aimed at all psychotherapists, especially those working with trauma patients, as well as for everybody interested in the Autonomic Nervous System. The author was one of the first therapists to integrate the Polyvagal Theory into clinical practice and has developed a clinical model for the practical application of the Polyvagal Theory in trauma therapy.

In this book, Deb Dana, shares her developed methodology, as much as her profound knowledge as from years of clinical work with patients.

In Section I of her book, the author explains the essential concepts of the Polyvagal Theory and gives an

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introduction into the terms and language used, in order to provide a solid foundation of knowledge.

In Section II, Deb Dana introduces the first step of her developed clinical model, which focused on learning how to recognize the daily states of sympathetic / parasympathetic and any movements on the "autonomic ladder" and thus enables one (as a therapist) to recognize the client's patterns of response. With respect to this aim, she has designed three different mapping-worksheets and explains, in detail, their application in therapy.

After the patients are able to identify their autonomic states, the author explains the next step of the therapy process in Section III, the befriending of the Autonomic Nervous System. Deb Dana shows various ways: how to observe and attend different autonomic states, as well as how clients can learn to track their response patterns, recognize their triggers and also regulate their abilities.

With the foundations set in Section II and III, Deb Dana– in Section IV – introduces methods that can enable clients actively to regulate and reshape their autonomic nervous system: e.g. through relationship-repair interactions between the client and the therapist; toning the nervous system with breath and sound; regulation through movement and touch; 'soothing' the patient's brain and mind; and experiments with play, intimacy and feelings of awe and elevation.

In the final chapters, the author presents case studies of her work with the Polyvagal Theory in trauma therapy.

"The Polyvagal Theory" – as presented by Deb Dana – represents a milestone for the clinical application of the Polyvagal Theory.

She manages to describe the complex Polyvagal Theory in an easy, understandable way and has created a wonderful, practical tool-set for its applications in therapy, as well as in life.

This book is highly recommended – not only for trauma therapists and body-oriented psychotherapists – but also for everybody / anybody interested in the function and mechanisms of our Autonomic Nervous System and how it influences us deeply on a day-to-day, moment-to-moment basis.

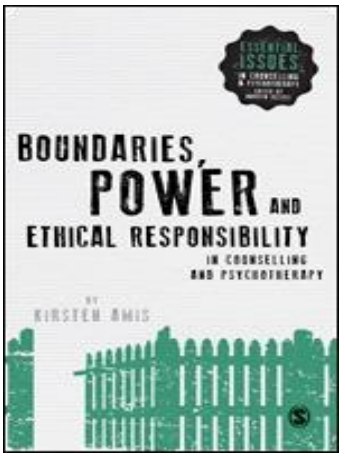
Deb Dana is a clinician and consultant specializing in working with complex trauma and is the Coordinator of the Kinsey Institute Traumatic Stress Research Consortium. She developed the Rhythm of Regulation Clinical Training Series and lectures internationally on ways in which Polyvagal Theory informs work with trauma survivors.

She is also married to Steven Porges, the proponent of the Polyvagal Theory: a theory that links the evolution of the mammalian autonomic nervous system to social behavior and emphasizes the importance of physiological state in the expression of behavioral problems and psychiatric disorders.

I can only agree with Deb Dana as she states: *"... using the Polyvagal Theory in therapy will increase the effectiveness of clinical work with trauma survivors. In this process, not only will your therapy practice change, but also your way of seeing and being in the world will change."*

Reviewed by ***Ingrid Pirker-Binder***
EAP- registered Austrian Psychotherapist and a member of the IJP Editorial Board.

Book Review 4:



Boundaries, Power and Ethical Responsibility in Counselling and Psychotherapy

by Kirsten Amis

Sage, 2017.
ISBN: 9781446296660
184 pages

RRP: £23.99; €26.99; $29.99

This book is a part of Sage Publishing's "Essential Issues in Counselling and Psychotherapy" series. In common with other books in this series, it is designed to fit neatly into the reading list of a wide range of counselling training courses. A short book (with only 162 pages, plus references & index), it covers the essentials of this topic in a style that is likely to complement any lectures or group discussions in this very important area of the profession. Trainers, across a wide range of modalities, are likely to find that it is a useful resource to assist them in creating basic content for a training group.

The way that the book is structured will be familiar to many counselling trainees, with a topic introduction, an initial exploration, a listing of influencing factors, and then some examples, followed by questions to the reader, and then a summing-up. This structure has both strengths and weaknesses, as the approach is eminently accessible, but it also feels somewhat unchallenging. Though appearing to be a textbook, there is a feeling of a workbook about it, something that trainers may find particularly helpful.

The book is aimed squarely at UK-based counselling trainees and training establishments. Despite the author being Scottish-based, it only occasionally mentions the increasing divergence of legal frameworks and social policy guidance within the UK. It feels a little bit churlish to raise this point, as it is often ignored in similar books and in counsellor trainings, however this divergence is important when looking at boundaries and ethical responsibilities, particularly as more

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counsellors include on-line working as a significant part of their practice.

Likewise, for an author who practices in Scotland, the addressing of boundary and ethical issues around working in small communities, be these defined by culture, religion, geography or language, are only briefly mentioned. This left me wanting more as this is a frequent issue that arises for those working outside of the major conurbations and will also be of relevance to those working with minorities and marginalised communities.

This is particularly unfortunate as illuminating and challenging examples of boundary questions and ethical conundrums are much more common at the edges of conventional practice: for example, a Scottish counsellor working on-line with an English client in a foreign country with (say) an adoption-related issue (where the laws and regulations are very different), or practicing in a rural community, where dual relationships are the norm, not the exception.

Although the book's title emphasises the word "Power", this area is only explored quite thinly. Understanding both the conscious and subconscious power dynamics within the therapeutic relationship is crucial to any form of boundary maintenance and ethical sensitivity, and this has also been a source of controversy since the beginning of psychotherapy. Those familiar with the work of people like Rufus May, Steve Silberman and Robert Whitaker – who work with some of the fringe elements of the profession – will be aware of professionally entrenched power processes that have led to the "Othering" of clients, with sometimes devastating consequences.

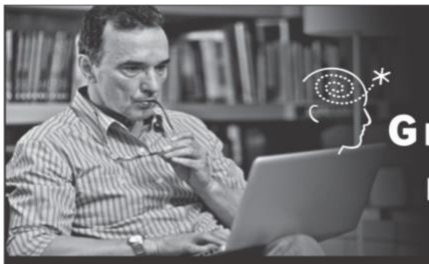
This indicates some of the book's limitations. For those looking for depth and challenge in these fundamental areas of practice, it may well leave the reader disappointed. Sometimes, it feels like a simplistic listing of factors that can affect ethical decisions and boundary maintenance, but with little context or linking to the historical and philosophical underpinnings of European psychotherapy. Though it contains many situational examples, these often feel curiously flat. There is no proper discussion of how we got to the processes described in the book, or examples of other ways of doing things in different cultures or countries, something that could have really illuminated the process of ethical development and boundary maintenance, helping the new practitioner develop their own robustness and resilience in these areas.

As with many books aimed at counsellors beginning their career, "talk to your supervisor" is mentioned frequently, however this begs the question of how to practice safely and ethically when working on the boundary of both the practitioner and their supervisor. That being said, the book does mention the 'all too common' scenario of such a 'beginning' counsellor being expected to work in a placement or in an

organisation where ethical boundaries are not very well held: in reality, a situation that is all too common, unfortunately. A useful addition to the text would have been a more robust exploration of the issues, particularly around power, when the practitioner senses that they may have a difference of ethical opinion or approach to boundary management to their line manager or supervisor. In addition, the process around how to navigate confidentiality, boundaries and ethical responsibilities in an increasingly on-line world is almost completely ignored.

There is a sense that this book avoids challenging the reader, sticking simply to basic scenarios and thus ignoring the impact of multi-cultural communities, or technology on boundaries and ethical responsibilities. In summary, this book covers its subject adequately for its target market of trainees and beginning practitioners, particularly those working in agencies, often with codified practice frameworks.

Reviewed by **Bob Hunter**: a Transactional Analysis counsellor, specialising in Neuro-diversity. Based in Edinburgh, he has previously worked in Northern Ireland and in remote communities in the West of Scotland.
E-mail: bobhunter@sealgair.co.uk



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- **Book Reviews:** short (600-800 words) not peer-reviewed, or longer (800-1200) reviewed;
- **News Items** can be 100-500 words (not peer-reviewed).

In exceptional circumstances, longer articles (or variations on these guidelines) may be considered by the editors, however authors will need a specific approval from the Editors in advance of their submission. (We usually allow a 10%+/- margin of error on word counts.)

References: The author **must** list references alphabetically at the end of the article, or on a separate sheet(s), using a basic Harvard-APA Style. The list of references should refer only to those references that appear in the text e.g. (Fairbairn, 1941) or (Grostein, 1981; Ryle & Cowmeadow, 1992): literature reviews and wider bibliographies are not accepted. Details of the common Harvard-APA style can be sent to you on request or are available on various websites.
In essence, the following format is used, with exact capitalisation, italics and punctuation.
Here are three basic examples:

(1) **For journal / periodical articles** (titles of journals should not be abbreviated):
FAIRBAIRN, W.R.D. (1941). A revised psychopathology of the psychoses and neuro-psychoses. *International Journal of Psychoanalysis, Vol. 22, pp. 250-279.*

(2) **For books:**
GROSTEIN, J. (1981). *Splitting and projective identification.* New Jersey: Jason Aronson.

(3) **For chapters within multi-authored books:**
RYLE, A. & COWMEADOW, P. (1992). Cognitive-analytic Therapy (CAT). In: W. DRYDEN (Ed.), *Integrative and Eclectic Therapy: A handbook,* (pp. 75-89). Philadelphia: Open University Press.

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