A New Look For The IJP

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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 24 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**

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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 IJP website – and we have several different 'categories' of subscriptions: for individuals and for institutions; and whether you are in an 'Eastern' or 'Western' country. We also differentiate between EAP members and non-EAP members.

You can purchase single articles – and whole issues – that are downloaded directly as PDF files by using the CATALOGUE on the IJP website (left hand side-bar). Payment is only by PayPal. We still have some printed copies of most of the Back Issues available for sale.

Additionally, we believe that 'Book Reviews' form an essential component to the 'web of science'. We currently have about 60 relatively newly published books available to be reviewed: please consult the relevant pages of the IJP website and ask for the books that you would enjoy reviewing: they will be posted to you. Having written the review, you get to keep the book. All previously published Book Reviews are available as free PDF files.

We are also proud to present some current publications that are freely available on-line (see: top left-hand corner of the website). **First:** there are some free e-books and articles that we think you may enjoy. **Secondly**, there are a couple of articles available from the forthcoming issue. There is then an on-going, online 'Special Issue' on **"Psychotherapy vs. Spirituality"**. This 'Special Issue' is being built up from a number of already published articles and these are available free-of-charge, on-line, soon after publication.

In addition, on the website, there are several topical "Briefing Papers": one on *"What Can Psychotherapy Do for Refugees and Migrants in Europe?"*; and one on an important new direction: *"Mapping the ECP into ECTS to Gain EQF-7: A Briefing Paper for a New 'Forward Strategy for the EAP"*. Because of a particular interest that we have in what is called "Intellectual Property", we have included the most recent briefing paper in this issue: *"Can Psychotherapeutic Methods, Procedures and Techniques" Be Patented, and/or Copyrighted, and/or Trademarked? – A Position Paper."*

Please Watch This Space!

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear Readers of – and Subscribers to – the IJP,

We find ourselves – at this moment in time – entering into an extraordinary phase in human history – for the first time ever in (most of) our times – we are faced with a world-wide pandemic (but this is not the first time in human history that we – as a species – have been threatened by such a pandemic) ... but, at this time, with an almost world-wide method of (internet) communication, we are all intrinsically 'bound' together in a somewhat more extraordinary way – as human 'animals' – in an attack on us, as a species, by something over which we have very little control: an almost invisible virus. We are being faced with something that is actually beyond our control: though almost nobody is really admitting to this on a personal level.

Our supposed methods of 'control' of this virus are – actually – relatively minimal and are also relatively ineffective: until **(a)** we develop a form of anti-virus protection [vaccine / inoculation], which may – or may not – be reasonably effective: – or **(b)** the 'social distancing' methods of avoidance (1 meter, or 1 meter +, or 2 meter); – or **(c)** various levels of masks to be used in various places with various restrictions; – or **(d)** the attempts to keep the nation's health service as (just) coping with the pandemic; – or **(e)** the effective 'shut-down' of international travel to avoid any further dissemination of the 'plague'; – or **(f)** the various attempts to ease the "lock-down" in various world-wide locations (primarily for economic or touristic reasons); – or **(g)** various different measures to dispose of the deceased victims safely; – or **(h)** the different financial 'sops' that are given to those who are unable to work; – or **(i)** the various forms of help "handed out" to those who generate income; and there are also – **(j)** various attempts to test several potential percentages of the population for CoVid-19; and there are also – **(k)** attempts to provide essential workers with necessary personal protective equipment (PPE), especially with respect to care homes; and – there is also **(l)** a general increase in political (state) power and social control – with the pre-eminent justification of *"This is 'necessary' and this is also 'good' for us"*.

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These serious (and necessary) measures can – oh, so easily – become the slippery slope towards increased state regulation and infringements of individual liberties; as well as attempts to limit the virus. Yet, there are also increasing threats of a "second spike" at some point in the future. We have all witnessed – and ignored – (or swallowed) – the justifications for increased social control (which are many). There are also lots of very valid reasons for more social control: terrorism; pandemics; an influx of illegal refugees; etc. It is also significant than most (if not all) of the "special powers" granted to the 'state' are usually and ultimately never revoked. However, these do not have to concern us.

On a more detailed level, the difficulties that we have been having with the new productional pipe-line of the Journal have also changed considerably with this crisis. We have been unable – effectively – to print, post and deliver copies of the Journal for about a year: so – we are moving even further towards having an on-line journal, with printed copies only for those who want them, or who have paid for them. We are also moving towards providing the e-Journal free of charge to all European Accredited Psychotherapy Training Institutes (EAPTI) trainees – so that they will have something to benefit from – especially during this "lock-down" crisis and hopefully see this as 'their' Journal in later life.

In these moments of crisis, what can we – as professional psychotherapists – do? Many of us have started to work differently – either on-line or by telephone, skype, zoom, etc. One of our colleagues, **Adrian Rhodes** (a past-President of EAP), who is the current Chairperson of the "Association for Counselling and Therapy Online" (ACTO), has put together some provisional guidelines for conducting psychotherapy sessions online. These guidelines are included in this issue – and we thank him greatly. Please disseminate these guidelines to any other professional psychotherapists that you know.

It is perhaps advisable to connect directly with your **National** (NUO/NAO) or **European-Wide** (EWO/EWAO) professional associations, or your **EAPTIs**, and discover what their guidelines are. We live in very interesting times.

Our normal offering of double-blind, peer-reviewed articles includes: *"Eye Movement Desensitization and Reprocessing (EMDR) with Body-Oriented Interventions within the Field of Adoption: Translating Neuroscience into a Clinical Case Study"* by **Katrien Vanfraussen, Edward Campforts & Lindita Imeraj**; and next *"How to Be a More Reflective Researcher-Practitioner"* by **Courtenay Young**; and another "supervision" article: *"The Problem of Parallel Process: Wild Analysis in Psychotherapy Supervision?"* by **Clifton Edward Watkins, Jr.** And, we have a short article from one of our regular contributors, **Seymour Hoffman**, *"Notes on Empathy vs Confrontation in Psychological Treatment".*

We also have a new "Position Paper" on Intellectual Property. The reason for this arose because there was (recently) a potential ('political') motion within the EAP to try to 'control' whether a psychotherapeutic modality could 'patent' its name, or 'copyright' its procedures. The short answer is "Yes" and the details are in this article.

The third additional article is an obituary of a notable Spanish psychiatrist and Vicente López-Ibor Camós. This was sent to us and – even though he was not associated with the EAP – he was obviously a very notable addition to the mental health profession: we therefore celebrate his life and send our condolences about his passing to family and colleagues. We have a couple of interesting book reviews.

And Now, for Something Completely Different – and New!

However, we also have an additional "amazing" resource for all our IJP readers is that a number of e-books and articles about psychotherapy – in general – have recently been made available through the **Academia.edu** website: and so – because we think these may be of interest to you, our readers – we have put links to these articles on the IJP website: please click on the box: *'Read Current Online Articles Here'* (in the top left-hand side-bar). These are listed below, as well. We will also put up links to other books and articles as they become available.

All these books and articles are available as free downloads from the IJP website: www.ijp.org.uk

Click on the box: *"Read Current Online Articles Here"* (in the top left-hand side-bar)

Books:

- ***"Theory and Practice of Counseling and Psychotherapy"*** *(8th Ed.)*, by Gerald Corey.
- ***"Refinding the Object and Reclaiming the Self"***, by David E. Scharff.
- ***"Handbook for Theory, Research, and Practice in Gestalt Therapy"***, edited by Philip Brownell.
- ***"Theories of Psychotherapy and Counselling: Concepts and Cases"***, by Richard S. Sharaf.
- ***"The Psychotherapy Guidebook: Easy to Understand Descriptions of 255 Different Therapies"*** *(2nd Ed.)*, edited by Richie Herink & Paul R. Herink.
- ***"Gestalt Therapy: 100 Key Points & Techniques"***, by Dave Mann.
- ***"How Does Psychotherapy Work?"***, by Martha Stark.

Articles:

HOLMQVIST, R., PHILIPS, B. & BARKHAM, M. (2013). Developing Practiced-Based Evidence: Benefits, Challenges, and Tensions. *Psychotherapy Research*, 25(1), pp. 20-31.

DUNCAN, B. L. & REESE, R. J. (2013). Empirically Supported Treatments, Evidence-Based Treatments, and Evidence-Based Practice. In: G. Stricker, T. A. Widiger & I. B. Weiner (Eds.), *Handbook of Psychology: Clinical Psychology*, (pp. 489-513). New York: John Wiley & Son.

MILLER, S. D., HUBBLE, D. L., CHOW, D. L. & SEIDEL, J. A. (2013). The Outcome of Psychotherapy: Yesterday, Today, and Tomorrow. *Psychotherapy*, Vol. 50(1), pp. 88-97.

REED, G. M., KIHLSTROM, J. F. & MESSER, S. B. (2006). What Qualifies as Evidence of Effective Practice? In: J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions*, (pp. 13-55). American Psychological Association. doi.org/10.1037/11265-001

BUCHANAN, R. D. & HASLAM, N. (2019). The Development of Psychotherapy in the Modern Era. *Article submitted for review.*

SUNDERANI, S. (2016). Therapist Self-Disclosure with Clients from Diverse Backgrounds. *Thesis submitted for MA degree, Ontario Institute for Studies in Education, University of Toronto.*

CASTONGUAY, L. G. & BOSWELL, J. CONSTANTINO, M. J., GOLDFRIED, M. R. & HILL, C. E. (2010). Training Implications of Harmful Effects of Psychological Treatments. *American Psychologist*, 65(1), pp. 34-39.

NISSEN-LIE, H. A., HAVIK, O. E., HØGLEND, P. A., MONSEN, J. T. & RØNNESTAD, M. H. (2013). The Contribution of the Quality of Therapists' Personal Lives to the Development of the Working Alliance. *Journal of Counselling Psychology*, 60(4), pp. 483-495.

STILES, W. B., SHAPIRO, D. A. & ELLIOT, R. (1986). Are All Psychotherapies Equivalent? *American Psychologist*, Vol. 41(2), pp. 165-180.

HENTON, I. (2012). Practice-Based Research and Counselling Psychology: A Critical Review and Proposal. *Counselling Psychology Review*, Vol. 27(3), pp. 11-28.

LARRIVEE, D. & ECHARTE, L. (2017). Contemplative Meditation and Neuroscience: Prospects for Mental Health. *Journal of Religious Health*, 57(6), pp. 960-978.

European Association for Psychotherapy: Interim Advice for Conducting Psychotherapy Online

Adrian M. Rhodes

March, 2020

In response to the Covid-19 pandemic, many therapists will be considering working online with their clients – to maintain their therapeutic contact, but also to minimise the risk to both client and therapist.

"Online therapy" usually refers to four formats: phone; video-conferencing; structured email therapy; and Instant Messaging (I.M. or 'text-chat'). There is robust evidence that online psychotherapy is effective – but it is not for everyone – client or therapist. And whilst online therapy shares theoretic concepts and many practices with face-to-face therapy (F2F), there are also some significant differences – just as there are differences between, say, individual therapy and couples' therapy.

This document is provided to indicate some of the issues that you will have to consider, if you are not familiar with working online, or if you have not received any specific training. It is meant as an **interim measure** and should not be considered the same as a proper training. It has been drafted by Adrian Rhodes, former President of EAP and currently Chair of ACTO – the "Association for Counselling and Therapy Online" (U.K.). This is **not** a comprehensive document; further revisions will be brought to the Board of EAP for consideration and ratification.

There will probably be advice or guidelines similar to this, provided by your professional associations: National & Modality-based (if not, ask, 'Why not?'). For an example from the UKCP see here: https://www.psychotherapy.org.uk/wp-content/uploads/2020/03/Psychotherapeutic-practice-and-working-in-isolation.pdf.

Assessment

Assessment is difficult and needs careful attention. Those unfamiliar with online working or without any training will need to be more cautious when accepting any new clients for online therapy.

In particular, you will have to pay attention to:

Risk – How to Assess, Monitor and Respond to:

- Risk of suicide and self-harm;

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- Risk of potential harm to others;
- Risk to the client from someone else;
- The presence of personal support;
- And the need to gather local information to respond to any potential risk.

You will also need to think carefully about what contact details you might need to have – including health-care or social-care professionals local to the patient.

The Psychological Profile of the Client

- Ego strength;
- Use of drugs and alcohol;
- Depression;
- Personality disorders, etc.

Confidentiality and Security

Other than purely telephonic contact – including FaceTime, there are several different communication "platforms":

- "Skype" is not considered to be a secure way of contacting patients. See the 'Good Guidance Note on Skype' at: acto-org.uk/faq;
- Many online therapists use "**Zoom**" (zoom.us) as it is possibly more secure: it meets the very high standards of "HIPAA" – the USA legal system for online security (www.hhs.gov/hipaa/for-professionals/index.html);
- Zoom also has a free service, which allows one-to-one meetings; *clients do not need to install Zoom on their computers.*

You will have to remind your clients to:

- Find a private, secure place for their sessions (not in a bar or a taxi!);
- Ensure that others in your home or office cannot overhear sound or see the screen;
- Beware of speaking too loudly, if wearing headphones;
- After a therapy session, clients might wish to clear their browser history, emails, or texts – to avoid others breaching their privacy;
- Discuss with your client whether they or you can/cannot record the session;
- If you agree that they can keep a direct record of sessions, they must keep the recording in a secure, protected file;
- You will also need to keep any recordings, computerised notes, contact details etc. in secure protected files – as you would keep physical notes in a locked filing cabinet;
- You may wish to use a secure email system specifically for psychotherapy work – such as Hushmail (www.hushmail.com) or ProtonMail (protonmail.com).

Contracting

You may wish to re-write your contract between you and the client so as to cover online work:

- For your client to give consent to work online – and what form of therapy;
- To specify that the work is covered by the legal system of your own country;
- And that the work is covered by your professional body for ethics and complaints (and give a link);
- You should state that you are not able to provide close 'emergency' care and confirm that they know how to access that locally;
- You will need to pay attention to having details of a 'safety contact';
- You should cover how payment will be made:
  - Payment is advance is suggested;
  - Some therapists offer different rates or a 'block booking' for working online;

  - Clients may have a right to cancel an online 'service' within a certain time.
- You may wish to put in the contract, that you retain ownership of any 'recording' of the session (video, emails, texts).

"Governance" Issues

- You will need to ensure that your insurance (or that of an employer) covers online work – particularly if working internationally;
- Check that your professional body or legal system does not have specific standards/laws governing online work;
- If working internationally, you will need to check if there are any laws in that country restricting your practice of psychotherapy with clients in that country;
- You will need to update (or create!!!) 'Privacy/GDPR' and 'Social Media' policies which cover online work. [for examples see mine: adrianrhodes.net/social-media-policy and adrianrhodes.net/privacy-policy. Please note: these are copyrighted!]

Technical Issues

- You (and the client) will need (depending on the media you use):
  - Computer, tablet, smartphone (not recommended) with:
    - camera, microphone;
    - possibly headphones.
  - Sufficient internet 'broadband width' or 4G signal for the medium you use.
- Ensure you are able to use the technology; practice beforehand.
- Have a 'back-up plan' of the technology fails:
  - Either another device or an email or phone number they can use.
- Pay attention to the privacy and security of the session at your end.
- If working internationally, check out the security of the internet in the client's country. Good information is available at: en.wikipedia.org/wiki/Internet_censorship_and_surveillance_by_country - and for Human rights, you can check: en.wikipedia.org/wiki/List_of_human_rights_articles_by_country.

Written On-line Issues

- Structured email therapy is '*asynchronous*': i.e. it isn't a 'simultaneous' exchange of emails. Typically, a patient will spend a 'session' (e.g. 50 minutes) writing an email and sending it to the therapist on, say Tuesday. The therapist may read it then – and/or, at a later time (say, Thursday) will read it (again) and respond in an email written in 50 minutes;
- Instant Messaging (IM – text-chat) is '*synchronous*': i.e. the therapist and client text each other for the agreed session time (say, 50 minutes);
- IM, if done directly on a smart-phone, computer or tablet, may mean that the client has a copy of the session; you may need to think about whether you want that;
- If IM is done on a secure platform (such as Zoom), you are more able to control any recording;
- More than any other type of therapy, this requires a skilled use of countertransference.

Clinical Issues

People act differently when online; you may have to adapt your theoretical perspective or clinical techniques to respond. You may also – if videoing – want to check any mannerisms or facial expressions. In particular:

- 'Digital Natives' who have grown up with

the online world, are much more familiar with it than most older psychotherapists who are 'digital immigrants' and have had to learn later in life.

- You will probably lose a degree of 'presence' with some clients – yet others will flourish and the relationship can seem more intimate online – especially in phone or I.M. work.
- The "online disinhibition" effect means that some people open up very quickly and more intensely online. This can be quite startling at first. As a result, defences and resistances can be much reduced: (www.researchgate.net/publication/8451443_The_Online_Disinhibition_Effect)
- The 'power differential' is also changed to a much more equal relationship:
  - You will not 'own' the therapy as much;
  - Clients are often more 'natural' than in a normal face-to-face (F2F) setting;
  - They act more like 'customers' than 'patients'.
- Similarly, 'free association' should be seen as different online:
  - clients will be 'meeting' in their own space;
  - they can show you photos; artefacts, etc.;
  - they can 'arrive' seated in different rooms at home – or even in the garden.
- Clients can also use pets, cushions, food, etc as defences or as comfort issues.

However, all this is 'material' that needs to be considered and incorporated into the therapeutic dynamic – and not to be criticised or judged in any way.

Therapist Self-Care

- Working with structured email, phone or I.M. ('text') can be very intense, if done properly (and the 'counter-transference' is particularly important). However, if care is not taken, the therapist may easily be distracted &/or lose concentration.
- Working through a different medium (especially video), can cause additional strain on the eyes, but also on the brain – and the back. Make sure that you take proper breaks.
- Therapists from different modalities – can – must – should – adjust their techniques and methodologies appropriately – e.g. art psychotherapy; body-oriented psychotherapists; cognitive analytic therapy; hypno-psychotherapy – even psychoanalytic therapists.
- You will need to pay particular attention to sound, to lighting and to the background – if using video; practice this with the eye of the client before starting to work online.

Therapists can get overly concerned about things happening differently in online therapy: i.e. there are very different dynamics. However, there are often parallels in face-to-face (F2F) therapy.

- Patients sometimes arrive late and keep us waiting <=> perhaps less so online;
- They may leave abruptly – walking out <=> shutting the laptop lid, breaking contact;
- The signal drops out <=> someone knocks at the door;
- They can leave us with anxiety about their safety at the end of sessions – both F2F and online – and the therapist is unable to 'act';
- There are different payment issues: the therapist doesn't have to pay room rent; the client doesn't have to travel to the session; payment cannot be done in person;
- You may also have to give particular attention to the ending of therapy – and how the client will be supported – especially if they

are in self-isolation, or in a lock-down situation during this CoVid-19 pandemic.

Supervision and Training

As online work is, in most ways, very similar to F2F therapy, it is easy to become complacent. Consider finding a supervisor who is experienced in online therapy work. Even better, consider a good supplementary training in online therapy [ACTO recommends a post-qualification Diploma of 80 hours of training]. Finally, ACTO is formulating 'Competences' for online therapy. A first draft is available at: acto-org.uk/acto-recommended-competences-for-counsellingand-psychotherapy-online/

As a last comment, to a psychotherapist who is coming to work online quite suddenly – and perhaps reluctantly – it can seem alien, complex, unsatisfactory. Yes – it can be! It is not for everyone. But, online psychotherapy can also be extremely stimulating – and it challenges F2F therapists to rethink their understanding of the psychotherapeutic encounter. Let's explore!

Authors

ADRIAN RHODES was President of the EAP from 2011-2013 and Vice-President for 2 years either side of that. He is currently President of the "European Confederation of Psychoanalytic Psychotherapies" (ECPP) – the EAP's European Wide Organisational body for the psychoanalysis and psychodynamic psychotherapy modality. He is also Chair of ACTO – the "Association for Counselling and Therapy Online" – in the UK.

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Eye Movement Desensitization and Reprocessing with Body-Oriented Interventions within the Field of Adoption: Translating Neuroscience into a Clinical Case Study

Katrien Vanfraussen, Edward Campforts & Lindita Imeraj

Abstract: This article describes the positive effects of a trauma-based approach with an adopted adolescent girl, diagnosed with Somatic Symptom Disorder (SSD). Although symptoms seemed at first sight trauma-unrelated, exploration of her pre- and post-adoption history revealed that re-activated early life adversities (ELA) probably played a crucial role in the development of her condition. In this case study, we describe in depth the content of the trauma-focused sessions, using different forms of Eye Movement Desensitization and Reprocessing (EMDR) and body-oriented exercises, as well as the theoretical rationale behind the clinical interventions.

This case study aims to support clinicians in the treatment of children who must deal with the sequelae of early traumatic events, by illustrating how the current neuroscientific knowledge on brain development and trauma can be used during the diagnostic and therapeutic process.

Key Words: Eye Movement Desensitization and Reprocessing (EMDR), storytelling, psychological trauma, adoption, yoga, neurobiology

In a child psychiatric setting, we often meet children who have experienced (single or complex) stressful events. However, these children / youngsters often do not meet the criteria of a Post-Traumatic Stress Disorder (PTSD) – as described in the Diagnostic and

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Statistical Manual of Mental Disorders (DSM-5: American Psychiatric Association, 2013: 5th ed.). This is not surprising since the validity of the criteria for children (older than 6 years) and adolescents has not yet been properly established. Except for the inclusion of a PTSD pre-school sub-type (younger than 6 years) no developmental adaptations of the symptom criteria have been made. Furthermore, this diagnosis seems to relate to the impact of acute single case trauma and to a much lesser extent to the sequelae of chronic (interpersonal) trauma. It has been well-established that the manifestation of traumatic stress in children and youngsters is influenced by developmental, as well as environmental elements. Hence, children's symptoms do not simply parallel those of adults (Adler-Tapia & Settle, 2009; Beer & de Roos, 2017). The trauma response at younger ages is often multi-faceted and masked by other clinical presentations, especially in case of chronic (long-term) traumatic exposure. Due to this diagnostic reality, the link between children's mental health problems and past traumatic experiences often goes unnoticed, resulting in a treatment that is not trauma-focused (Cloitre *et al.*, 2009; Cook *et al.*, 2005; Spinazzola *et al.*, 2011).

In this article, we look at a specific group of children often with a history of chronic traumatic exposure: adopted children. Some of these children's self-regulatory capacities are extremely impaired, which is considered a core characteristic of childhood adversity (Cook *et al.*, 2005; van der Kolk, 2005; D'Andrea *et al.*, 2012). The negative impact of chronic interpersonal traumatization – in general, as well as specifically in the context of institutionalization – on brain development and later mental health has been well established (Perry, 2009; Sheridan *et al.*, 2012; Zeanah *et al.*, 2003). However, there is also a group, who have less severe or clear-cut problems (e.g. somatic complaints, sleeping problems, alexithymia, etc.). Could it be possible that these children's current symptoms are associated with their pre-adoption experiences?

The goal of this article is to demonstrate that it is worthwhile to explore whether (adoptive) children's broad range of symptoms might positively be influenced by a treatment that focuses on potential pre-adoption traumatic experiences. This idea is based on the hypothesis that the separation from the biological mother and any early residential group care, even if of a good (enough) quality and for a relatively short period of time, are significantly stressful events that can leave a neurobiological imprint, especially when these occur early on in life.

We present the case of an adopted girl. Firstly, her symptoms and history are described. To explain the potential benefits of trauma-based interventions, even in the absence of a trauma-related diagnosis, we link the reported and observed symptoms to these early life experiences. Secondly, and most importantly, we describe in detail the therapeutic process, using various interventions. The primary focus is on Eye Movement Desensitization and Reprocessing (EMDR), next to body-oriented exercises. By describing the sessions in detail, we hope to contribute to the therapeutic knowledge about the use of EMDR with children and youngsters in general, as well as specifically with adopted children.

Case Description: Somatic Complaints in a Girl with an Adoption History

Presentation

Yin-Lee (whose name and identifying information have been changed to protect her anonymity), is a 15-year-old, adopted girl, who was referred to the first author with medically unexplained somatic problems. Prior to the referral to our outpatient unit, she had been

hospitalized for one month, undergoing psychological, as well as medical tests. The symptoms that she presented with – during her hospitalization (as well as at the time of her referral) – were the following: fatigue/tiredness (sleeping during the day and going to bed early); lack of energy; walking very slowly; delayed thinking and responding; soft speech; minor memory problems; lapses in concentration; headaches and abdominal pain. This symptomatology started in January of the year following the summer that Yin-Lee and her adoptive family had visited her country of origin. Her parents had reported some allergies and respiratory problems during childhood, as well as recurrent gastro-intestinal problems. Before the visit, Yin-Lee had been very adventurous and active. She had excellent academic grades and was a socially competent youngster. However, due to her current state, she was unable to attend school full-time and she had to give up her hobbies (swimming, cycling, surfing). She also became more socially isolated.

Based on the findings from the hospitalization, she was diagnosed with a Somatic Symptom Disorder (SSD). This disorder is characterized by somatic symptoms that are either very distressing or result in significant disruption of functioning (Criterion A), as well as excessive and disproportionate thoughts, feelings and behaviours regarding those symptoms (Criterion B). To be diagnosed with SSD, the individual must be persistently symptomatic (Criterion C) (typically at least for 6 months) (APA, 2013).

Client History

About one and a half months after her birth, Yin-Lee's biological mother abandoned her. After that, she spent the first year(s) of her life in a small orphanage with relatively good care (enough food, good hygiene, small groups, fixed caregivers, etc.). The caretakers of the orphanage described Yin-Lee as being an intelligent and obedient toddler.

Yin-Lee was adopted at the age of 22 months. When she was handed over to her adoptive parents, she first cried and then clung to her (new) mother. For the following eight months, Yin-Lee stayed at home with her mother. After this period, she had to go to day-care. She became very upset each time that she was dropped off. This was also the case whenever her mother had to go out. For the first six months after arriving in her adoptive family, she had sleeping problems. Except for the toilet training (mainly at night), Yin-Lee showed no other developmental problems. Going to kindergarten (after day-care) went well, only Yin-Lee seemed bored. An intelligence test showed she is cognitively very talented.

Yin-Lee's parents described her as an easy-going child and youngster. However, they were often 'in the dark' about how she really felt. At the age of four years, Yin-Lees parents adopted a younger sister, with whom she has no biological tie.

Linking the Body and Developmental Tasks to Early Life Experiences

In the following paragraphs, we will discuss why we considered Yin-Lee's symptoms as trauma-related, and why we chose to use trauma-oriented interventions. The goal was not to question the diagnosis, but to analyze the symptoms from a different angle.

We hypothesized that the visit to Yin-Lee's country of origin, especially to the place where her biological mother had left her to be found, had triggered Yin-Lee back into her early (pre-adoption) life experiences. The lethargic state (hypo-arousal) in which she was at the time of the psychiatric consultation, probably reflected the physiological response (freeze-state) that she experienced during the pre-adoption period. Research has shown that

young children are more likely to use a dissociative response when confronted with threat (i.e. freeze and surrender) (Perry *et al.*, 1995). Given the limited skills (e.g. verbal, motor) at this very early age, fight or flight responses are not a realistic option, and so the child finally becomes immobile, utilising the freeze response (Levine & Kline, 2007).

While talking with Yin-Lee, we noticed that she had the strong tendency to think logically and linearly, and be less intuitive and emotional. Her ability to connect to her internal states, feelings, wishes and needs seemed reduced. On a neurobiological level, it seemed that the left hemisphere dominated the right one, which exchanges information with the lower or subcortical regions of the brain (brainstem, limbic regions) and the body (Siegel, 2012; Siegel & Bryson, 2012). This lack of integration between the self and the body is often observed in victims of traumatic experiences (West *et al.*, 2017). Since trauma is held in the body, somatic symptoms like Yin-Lee's are frequently found among traumatized individuals (Lamers-Winkelman *et al.*, 2012; van der Kolk, 2014; West *et al.*, 2017).

Yin-Lee's adoptive parents also reported that their daughter still depended strongly on them, especially on the mother (e.g. choosing her clothes), and sometimes showed age-inappropriate behaviour (e.g. climbing on her father's lap during the consultation, aged 15). She barely showed any teenager specific behaviour (e.g. orientation towards peers). From a developmental perspective, moving towards independence is a central theme in adolescence. We hypothesized that this developmental task had been compromised by earlier unresolved or traumatic separation processes: in Yin-Lee's case, the separation from her biological mother and a second separation from the foster home. As described in the section *client history*, separation from her adoptive mother had often evoked anxiety in the past.

Trauma-Based Treatment

Based on the hypothesis that Yin-Lee's symptoms were trauma-related, we concluded that her treatment should be trauma-focused. We followed the Expert Consensus Guidelines for Complex PTSD (in Adults) of the International Society for Traumatic Stress Studies (ISTSS), in which a three-stage model is recommended (Cloitre *et al.*, 2011, 2012). Central to the first phase is the development of arousal, emotion regulation and social skills. The goal of the second phase is to integrate the traumatic material. Traumatic memories are not merely reactivated, but a reappraisal of the meaning of the experiences also takes place, transforming them (hopefully) into a much more positive and coherent conscious narrative, which then becomes part of the client's personal history. In the third phase, patients learn how to deal with stress in the future and are encouraged to experiment with new behaviours in everyday life, as well as to apply skills to strengthen safe and supportive relationships with others (Cloitre, 2012; Gelinas, 2003).

In the following part, we will describe in detail what the different treatment phases in our case study looked like. A total of seventeen individual sessions (45-60 minutes), including two follow-up sessions (three and six months later), and three additional sessions with the parents, all took place at the outpatient child psychiatric unit of the hospital.

First Phase: *Yoga & Interoceptive Awareness*

Keeping Yin-Lee's symptoms in mind, we introduced body-oriented exercises to increase her ability to feel the activity of the interior self, i.e. interoceptive awareness, as well as her energy level (i.e. changing her current physiological state of hypo-arousal) (Emerson, 2015).

According to the phase-based treatment model, the modulation of the arousal level is cen-

tral to trauma treatment and should proceed memory processing (Cloitre *et al.*, 2011).

Processing is only possible within a range of optimal arousal states, during which one can both think and feel, also known as the 'window of tolerance' (Ogden, Minton & Pain, 2006; Siegel, 2012). The ability to connect to the body is also relevant for the second phase since the client is then asked to identify the location of body sensations in relation to the traumatic memory (EMDR assessment phase). Heightened somatic awareness also enhances mind-body integration during processing.

To increase Yin-Lee's interoceptive capacity and energy level at the same time, we encouraged her to perform yoga postures that help to convey a sense of strength, counterbalancing her lethargic state (e.g. Mountain Pose, Warrior Pose II) and invited her to notice the impact of the different postures on her body by asking the following open question: "*What sensations do you notice in your body?*". As Emerson describes in his (2015) book on Trauma Sensitive Yoga, *notice* (or awareness) is the most important interoceptive word. The focus is on physical sensations, the language of the primitive reptilian brain, which plays an important role in trauma. By performing the postures with the therapist, feelings of interpersonal connection are positively influenced (Macy, Jones, Graham & Roach, 2018).

To further counteract the observed level of immobilization, we introduced Yin-Lee to Hatha Yoga Sun Salutations. A Sun Salutation encompasses 12 purposeful movements that help the person becoming more centred in the present. The repetitive character of the Sun Salutations can help to restore the rhythmicity of biological functions that often become disrupted in case of trauma (Brown & Gerbarg, 2009; van der Kolk, 2014). Furthermore, research has shown that yoga can reduce somatic symptoms, in general, and gastrointestinal problems in adolescents specifically (Kuttner *et al.*, 2006; Woodyard, 2011).

Since trauma is characterized by an imbalance of the stress-response system, we also introduced yoga breathing, called 'pranayama'. The breath is the only autonomic function that can be manipulated through conscious effort. Voluntarily regulated yoga breathing serves as the gateway through which the stress-response system (autonomic nervous system), metabolism, higher brain functions and mental state can be influenced (Brown & Gerbarg, 2009; Telles & Singh, 2013). Practiced by both client and therapist, these practices enhance present-moment-awareness in both participants, which improves the reciprocal attunement (Geller & Porges, 2014). We also practiced alternate nostril breathing, since this type of cyclical breathing supposedly synchronizes different areas of the brain and improves interhemispheric communication (Brown & Gerbarg, 2009).

A second element of this first phase was the implementation of a specific EMDR protocol: Resource Development and Installation (RDI) developed by Korn & Leeds (2002). This procedure, which is part of the Preparation Phase of the EMDR-protocol, is used to strengthen connections to positive memories, images and symbols and to enhance emotional resilience and coping skills (Adler-Tapia & Seattle, 2009). From a list of positive memories, Yin-Lee picked out (memories of) special moments with her friends, as well as with her family, when she felt strongly connected to them. These 'Relational Resources' represented safe places that counterbalanced the sense of abandonment that Yin-Lee must probably have felt as a baby and that corresponded to the primary relationships of the two developmental stages that would be addressed: early childhood (parental attachment figures) and adolescence (peers). In Table 1, an overview is given of all the necessary elements.

Table 1: Identification of Relational Resources and accompanying elements

Relational Resources	Image	Cognition	Emotions	Sensations
Sport camp with friends	Kayak on the river with friends – a friend falls in the water	I am loved	Powerful Happy / Cheerful	Strength in legs Flow in upper body
Parents reading a bedtime story	Together with mother in her bed reading a bedtime story	I am loved	Happy	Relaxed body

Second Phase: *Eye Movement Desensitization and Reprocessing (EMDR)*

There are different ways to integrate traumatic memories. In this case, EMDR, an evidence-based psychotherapeutic approach, was used. This integrative methodology was originally designed to treat post-traumatic stress but over the years the therapeutic scope has grown and a broad range of clinical issues are now effectively addressed by EMDR therapy. Central to the treatment is the processing of distressing memories of past experiences. These are considered to lie at the root of the client's difficulties (Hase *et al.*, 2017). This assumption is the core of the Adaptive Information Processing model (AIP), that guides EMDR practice (Shapiro & Laliotis, 2011). According to this unique theoretical model, everyone has a natural information processing system that assimilates new information by linking current perceptions to relevant stored information. When confronted with stressful experiences, it generally progresses towards adaptive resolution (integration). However, when the level of arousal is overwhelming, the event becomes stored in a maladaptive (raw/state-specific/unprocessed) form and no connection is made with other memory networks that hold adaptive information (i.e. isolated form) (Adler-tapia & Settle, 2009; Hase *et al.*, 2017; Solomon & Shapiro, 2008). By means of standardized procedures and protocols within EMDR, the dysfunctionally-stored traumatic memory can become linked to more adaptive information in other memory networks. Hence, information-(re)processing becomes facilitated.

The EMDR-protocol consists of eight phases. In the first two phases, the therapist evaluates whether the client is ready for treatment (by giving psycho-education, identifying targets, developing skills to deal with the intensity of the treatment), which corresponds with the first phase of trauma treatment. In the third phase, all traumatic memories (called 'targets') are identified and mapped out in a structured way (the most distressing part/image, irrational and desired beliefs/cognitions, emotions, sensations). While all these aspects of the person's memory are accessed, the client simultaneously focuses on a form of dual attention stimulation, such as bilateral eye movements, tones, or hand taps. After each set of bilateral stimulations, the client is invited to "***notice*** *what happens next*", to elicit further information.

The actual internal memory-processing occurs in phases four to six, when the therapist asks the client to focus on the different components and the bilateral stimulation starts. In phase seven, the therapist makes sure the client can leave the session in a relatively relaxed state and, in phase eight, he/she evaluates whether the positive results of the previous session have been preserved. In the following paragraphs, we will focus on the content of the third phase, which is the most important one.

To identify all relevant targets, we used the timeline that Yin-Lee had drawn up previously (which included positive, as well as negative memories). Three different targets connected to her adoption history were selected. The order of processing was determined by the degree of distress, when thinking about these traumatic experiences. The most recent experience presented itself as the one which was affecting Yin-Lee the most, in the sense that she could connect with it the best (as a mind-body unit, and not just in a rational way). We implemented the 'Inverted Standard Protocol' (Hofmann, 2009) and we worked our way through her life story, starting with the most recent experience, which then worked as a lever to access the pre-verbal targets that seemed to be buried deep inside.

The following "hot spots" were considered consecutively: (a) visiting the location where she was left behind as a baby. We then moved on to: (b) a photograph that was taken of her as a toddler in the orphanage. This trauma-related visual stimulus had an intense emotional charge for Yin-Lee, since it reflected how sad she had felt at the time: (c) finally, we used the story-telling method to create a structured life narrative. 'EMDR-storytelling' is a method developed by Lovett (1999) to process pre-verbal traumatic memories. This approach enabled Yin-Lee to process what she experienced during the first years of her (pre-adoption) life. We also hypothesized that the story-telling would improve Yin-Lee's sense of self across time (memory integration) – since she described the absence of a connection between her (early) past and present – as well as the collaboration between both hemispheres: a narrative implies the left hemisphere for the linear telling, and the right hemisphere to make sense of (autobiographical) experiences (Siegel, 2012). A description of the actual narrative will be given in the following paragraphs.

For the processing of the first two targets (a) and (b), we used the standard protocol: In Table 2, a description is given of all the imperative ingredients. As a child, Yin-Lee had a lot of respiratory difficulties, which might explain the focus on these body parts during the assessment and processing.

The starting point for the narrative (c), was the autobiography that Yin-Lee had written as a school assignment, which provided a chronological structure. To create a more detailed story, which included not only facts, but also emotions, we discussed each paragraph with the intention of exploring Yin-Lee's feelings and sensations. Since she only remembered her early childhood partially, we used her adoptive parents as therapeutic 'partners' and asked them to write down Yin-Lee's life-story, based on the (medical and adoption) documents that they had received and on their own observations (information regarding their daughter's pre-adoption life, her first reaction upon meeting them, and other significant behaviours later in life).

Table 2: Identification of targets and accompanying elements

Target	Image	Cognition	Emotions	Sensations
Visit to home country	Looking behind a gate to the stairway where she was left by her biological mother	NC: I am alone PC: I am part of a nice family	Sadness / relief	Cold / chest / throat
Orphanage	Photograph of her with sad face taken in orphanage	NC: I am alone and can't escape PC: I am rescued and connected	Sadness	Something hard in chest

Written feedback was given by the first author. Both documents were integrated and infused with all the structural EMDR-elements. The story, written in the third person, started with a positive introduction in which Yin-Lee could recognize herself. In the middle section, a description was given of the traumatic events with a strong emphasis on the sensorimotor perceptions, i.e. those between birth and through age 2 (Piaget, 1936), since this type of input defines a child's experience at a pre-verbal age. The final part included positive cognitions in the present and towards the future (Beer & de Roos, 2017).

Although the parents had written the story, we somehow doubted whether they should be present during the actual processing sessions, since we also needed to consider Yin-Lee's separation process and autonomy. However, we concluded that this developmental goal could only be reached if Yin-Lee could fully trust, on a visceral level, that a permanent connection (attachment) had been established between her and her adoptive parents. Their physical presence counterbalanced the parental absence and the sense of abandonment that she probably experienced during the first years of life. Before reading the story, we planned an individual session with the parents so as to explore whether there were any questions left, but also to make sure they would not get overwhelmed while reading the story.

Third Phase: *Focusing on an Autonomous Self*

Since this phase focuses on the future, we were worried about Yin-Lee's ability to become more independent. The storytelling method made it possible to integrate elements of this developmental task at the end of the story in which the main character is oriented towards the future. Developmentally congruent behaviour and age-appropriate relationships were described and linked to her new self (Herman, 1997). Furthermore, plans were made regarding school, hobbies and social activities.

Summary of Treatment Plan

Trauma treatment: Three-stage model

First Stage: Development of arousal, emotion regulation and social skills
- Yoga postures of strength
- Sun salutations
- Pranayama / breathing exercises
- Resource Development and Installation (RDI) (see Table 1)

Second Stage: Integration of the traumatic material
- EMDR-protocol (8 phases):
  - Phase 1 & 2: psychoeducation and client readiness (= first stage trauma treatment)
  - Phase 3: assessment phase = structured identification of traumatic memories or targets (see Table 2)
    - Inverted Standard Protocol
    - Storytelling
  - Phase 4 – 6 (memory-processing): desensitization, installation, body scan
  - Phase 7: closure (end of session)
  - Phase 8: reevaluation (next session)

Third Stage: Dealing with stress and practicing social and relational skills in the future
- EMDR-storytelling (last part)
- Future plans regarding school, hobbies and social activities

Post-Treatment Results

After treatment, the criteria of Somatic Symptom Disorder (APA, 2013) did no longer apply to Yin-Lee. All of the somatic complaints reported by her and her parents were resolved. Yin-Lee gradually became more active. Both the therapist and Yin-Lee's parents observed an increase in her facial expressions, which made it much easier to attune to her and to understand how she felt.

At a follow-up session three months later, Yin-Lee walked at a normal pace and moved in a dynamic and vigorous way, which had never happened before during her therapy. She fully attended school, without any adjustments to her program. She did not take any naps during the day. She even took the train to her new school and was visibly excited about the change. She was clearly heading towards autonomy. She had also decided to pick up sports again. Her parents said that their original family life had been restored (walking, cycling, going to restaurants in the evening, etc.). They described their daughter as being much more vibrant. They also said that she expressed feelings of anger and irritation towards them, as well as towards her sister, which had been difficult in the past. The (previously implicit) cognition, that she might lose the love of her parents if she would disagree, had clearly disappeared and she had moved on to a new developmental stage. We jointly decided to end treatment, since the therapeutic goals had been reached. This positive evolution also continued up to six months after the last session.

Discussion

This case study describes the positive effects of EMDR and body-oriented interventions in an adolescent girl, presenting with somatic complaints and a history of adoption. It illustrates how the theoretical knowledge on brain/mind-body development and trauma can be translated and applied to a clinical situation.

This article demonstrates how important it is to consider the impact of negative experiences during childhood even when the symptoms of the client seem (at first sight) trauma-unrelated. Detecting trauma-related symptoms in children/youngsters – and treating them properly – is highly important in terms of public health. Childhood trauma has a high co-morbidity rate, especially in case of chronic trauma, and is considered a risk factor for psychopathology later in life (Jonkman *et al.*, 2013; Meiser-Stedman, 2002; Perry, 2008; van der Kolk, 2014). Treating trauma at an age where the brain is still growing therefore can have a positive influence on adult psychopathology (Cloitre *et al.*, 2009).

To date, three meta-analyses explored the existing empirical evidence for EMDR as an efficient way to treat trauma-associated symptoms in children and adolescents (Brown *et al.*, 2017; Moreno-Alcázar *et al.*, 2017; Rodenburg *et al.*, 2009). Although the results are not yet conclusive, they point in a positive direction and practice-based guidelines do mention EMDR as a potential treatment (Potgieter-Marks, Struik & Sabau, 2017).

In this case study, different EMDR-protocols were combined. This shows that not only the standard protocol, but also developmentally-appropriate approaches like storytelling, might be promising. Although this protocol is used for children between zero and four years old, it can also be implemented with older children who are pre-verbally traumatized (de Roos & Beer, 2017). This specific format has the advantage of integrating past, present and future at the same time, which is especially useful for adopted and/or foster children/youngsters since it creates the possibility of reconstructing their life history, which enhances self-understanding (Siegel & Bryson, 2012).

As we already know, treating the effects of trauma on the body has a positive effect on

emotional and cognitive processing (Ogden *et al.*, 2006; Ogden & Fisher, 2015; van der Kolk, 2006), this case-study shows how somatic interventions can be integrated with other methodologies. In case of extreme dysregulation, we assume that an even more extensive, as well as intensive body-oriented phase than the one described in this case-study, needs to precede the EMDR-part of the 'treatment'. The better that one can self-regulate, the better one's ability is to engage in an effective way in well-established trauma-treatments (Corrigan, Fisher & Nutt, 2011). Regarding the yoga interventions (pranayama, as well as the asanas) used here, we want to emphasize that a regular practice, integrated into daily life, will enhance the favourable effects.

Finally, we paid particular attention to a specific population: adopted children & youngsters. Although a lot has been written about how these children function after they have been adopted, literature on how to treat them is less voluminous. We certainly do not want to become overly confident, but we are convinced that it is worthwhile to implement the treatment procedure that we described with other adopted or foster children. However, we should consider the diversity in this population: some of these children suffer from severe attachment issues. In case of attachment trauma, a specific EMDR-protocol has been developed (by Wesselmann *et al.*, 2012) to influence positively attachment status in children. However, it is beyond the scope of this article to discuss this approach in depth, or to consider the pros and cons of both adaptations. In summation, it seems that EMDR, possibly combined with other approaches (e.g. body work, family therapy, etc.), offers many possibilities to enhance these children's (and their family's) well-being. Findings from further clinical practice and further research will hopefully reveal which children/youngsters might benefit most from the various EMDR-protocols.

Although case studies are sometimes considered as having limited scientific value, they often add considerable value to clinical practice. The positive practice-based results, obtained in this single-case study, can be an impetus towards further evidence-based research on the potential benefits of this approach (using larger samples and multi-method pre- and post-measurements, including neuro-imaging) to reveal the impacts of trauma on the functioning of the brain.

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References

AMERICAN PSYCHIATRIC ASSOCIATION (APA). (2013). *DMS-5: Diagnostic and Statistical Manual of Mental Disorders (5th ed.).* Arlington, VA: American Psychiatric Association.

ADLER-TAPIA, R. & SETTLE, C. (2008). *EMDR and the Art of Psychotherapy with Children.* New York: Springer Publishing Company.

ADLER-TAPIA, R. & SETTLE, C. (2009). Evidence of the Efficacy of EMDR with Children and Adolescents in Individual Psychotherapy: A Review of the Research Published in Peer-Reviewed Journals. *Journal of EMDR Practice and Research*, 3 (4), pp. 232-247.

BEER, R. & DE ROOS, C. (2017). *Handboek EMDR Kinderen & Jongeren [Handbook of EMDR for Children & Youth].* Tielt: Uitgeverij Lannoo.

BROWN, R. C., WITT, A., FEGERT, J. M., KELLER, F., RASSENHOFER, M. & PLENER, P. L. (2017). Psychosocial Interventions for Children and Adolescents after Man-Made and Natural Disasters: A Meta-Analysis and Systematic Review. *Psychological Medicine*, 47 (11), pp. 1893-1905.

BROWN, R. P. & GERBARG, P. L. (2009). Yoga Breathing, Meditation, and Longevity. *Annals of the New York Academy of Sciences*, 1172, pp. 54-62.

CLOITRE, M., COURTOIS, C. A., CHARUVASTRA, A., CARAPEZZA, R., STOLBACH, B. C. & GREEN, B. L. (2011). Treatment of Complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress*, 24 (6), pp. 615-627.

CLOITRE, M., COURTOIS, C. A., FORD, J., GREEN, B., ALEXANDER, P., BRIERE, J., HERMAN, J. L., LANIUS, R., PEARLMAN, L. A., STOLBACH, B., SPINAZZOLA, J., van der KOLK, B. & van der HART, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults. Retrieved from: http://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

CLOITRE, M., STOLBACH, B. C., HERMAN, J. L., PYNOOS, R., WANG, J. & PETKOVA, E. (2009). A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity. *Journal of Traumatic Stress*, 22 (5), pp. 399-408.

COOK, A., SPINAZZOLA, J, FORD, J., BLAUSTEIN, M., CLOITRE, M., DEROSA, R., HUBBARD, R., KAGAN, R., LIAUTAUD, J., MALLAH, K., OLAFSON, E. & van der KOLK, B. (2005). Complex Trauma in Children and Adolescents. *Psychiatric Annals*, 35 (5), pp. 390-398.

CORRIGAN, F. M., FISHER, J. J. & NUTT, D. J. (2011). Autonomic Dysregulation and the Window of Tolerance Model of the Effects of Complex Emotional Trauma. *Journal of Psychopharmacology*, 25 (1), pp. 17-25.

D'ANDREA, W., FORD, J., STOLBACH, B., SPINAZZOLA, J. & van der KOLK, B. A. (2012). Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis. *American Journal of Orthopsychiatry*, 82 (2), pp. 187-200.

EMERSON, D. (2015). *Trauma-Sensitive Yoga in Therapy. Bringing the Body into Treatment.* New York/London: W.W. Norton & Co.

GELINAS, D. J. (2003). Integrating EMDR into Phase-Oriented Treatment for Trauma. *Journal of Trauma & Dissociation*, 4 (3), pp. 91-135.

GELLER, S. M. & PORGES, S. W. (2014). Therapeutic Presence: Neurophysiological Mechanisms Mediating Feeling Safe in Therapeutic Relationships. *Journal of Psychotherapy Integration*, 24 (3), pp. 178-192.

HASE, M., BALMACEDA, U. M., OSTACOLI, L., LIEBERMANN, P. & HOFMANN, A. (2017). The AIP Model of EMDR Therapy and Pothogenic Memories. *Frontiers in Psychology*, 8: 1578.

HERMAN, J. L. (1997). *Trauma and Recovery.* New York: BasicBooks.

HOFMANN, A. (2009). The Inverted EMDR Standard Protocol for Unstable Complex Post-Traumatic Stress Disorder. In: M. Luber (Ed.), *Eye Movement Desensitization (EMDR) Scripted Protocols: Special Populations,* (pp. 313-328). New York: Springer Publishing Company.

JONKMAN, C. S., VERLINDEN, E., BOLLE, E. A., BOER, F. & LINDAUER, R. J. L. (2013). Traumatic Stress Symptomatology after Child Maltreatment and Single Traumatic Events: Different Profiles. *Journal of Traumatic Stress*, 26 (2), pp. 225-232.

KORN, L. D. & LEEDS, A. M. (2002). Preliminary Evidence of Efficacy for EMDR Resource Development and Installation in the Stabilization Phase of Treatment of Complex Posttraumatic Stress Disorder. *Journal of Clinical Psychology*, 58 (12), pp. 1465-1487.

KUTTNER, L., CHAMBERS, C. T., HARDIAL, J., ISRAEL, D. M., JACOBSON, K. & EVANS, K. (2006). A Randomized Trial of Yoga for Adolescents with Irritable Bowel Syndrome. *Pain Research and Management*, 11 (4), pp. 217-223.

LAMERS-WINKELMAN, F., DE SCHIPPER, J. C. & OOSTERMAN, M. (2012). Children's Physical Health Complaints after Exposure to Intimate Partner Violence. *British Journal of Health Psychology*, 17 (4), pp. 771-784.

LEVINE, P. & KLINE, M. (2007). *Trauma Through a Child's Eyes. Awakening the Ordinary Miracle of Healing.* Berkeley: North Atlantic Books.

LOVETT, J. (1999). *Small Wonders: Healing childhood trauma with EMDR.* New York: The Free Press.

MACY, R. J., JONES, E., GRAHAM, L. M. & ROACH, L. (2018). Yoga for Trauma and Related Mental Health Problems: A Meta-Review with Clinical and Service Recommendations. *Trauma, Violence and Abuse*, 19 (1), pp. 35-57.

MEISER-STEDMAN, R. (2002). Towards a Cognitive-Behavioral Model of PTSD in Children and Adolescents. *Clinical Child and Family Psychology Review*, 5 (4), pp. 217-232.

MORENO-ALCÁZAR, A., TREEN, D., VALIENTE-GÓMEZ, A., SIO-EROLES, A., PÉREZ, V., AMANN, B. L. & RADUA, J. (2017). Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescents with Post-Traumatic Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychology*, 8, Article 1750.

OGDEN, P., MINTON, K. & PAIN, C. (2006). *Trauma and the body. A sensorimotor approach to psychotherapy*. New York & London: W.W. Norton & Co.

OGDEN, P. & FISHER, J. (2015). *Sensorimotor Therapy. Interventions for Trauma and Attachment.* New York & London: W.W. Norton & Co.

PERRY, B. D., POLLARD, R. A., BLAKLEY, T. L. & VIGILANTE, D. (1995). Childhood Trauma, the Neurobiology of Adaptation, and "Use-Dependent" Development of the Brain: How "States" Become "Traits". *Infant Mental Health Journal*, 16 (4), pp. 271-291.

PERRY, B. D. (2008). Child Maltreatment: A Neurodevelopmental Perspective on the Role of Trauma and Neglect in Psychpathology. In: T.P. Beauchaine & S.P. Hinshaw (Eds.), *Child and Adolescent Psychopathology*, (pp. 93–128). New Jersey: John Wiley & Sons.

PERRY, B. D. (2009). Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. *Journal of Loss and Trauma*, 14 (4), pp. 240-255.

PIAGET, J. (1936). *Origins of Intelligence in the Child.* London: Routledge & Kegan Paul.

POTGIETER-MARKS, R., STRUIK, A. & SABAU, A. (2017). Guidelines for the Assessment and Treatment of Children and Adolescents with Dossociative Symptoms and Dissociative Disorders. Retrieved from: www.estd.org/sites/default/files/files/estd_guidelines_child_and_adolescents_first_update_july_2.pdf

RODENBURG, R., BENJAMIN, A., DE ROOS, C. DE, MARIE, A. & JAN, G. (2009). Efficacy of EMDR in Children: A Meta-Analysis. *Clinical Psychology Review*, 29, pp. 599-606.

SHAPIRO, F. & LALIOTIS, D. (2011). EMDR and the Adaptive Information Processing Model: Integrative Treatment and Case Conceptualization. *Clinical Social Work Journal*, 33 (2), pp. 191-200.

SHERIDAN, M. A., FOX, N. A., ZEANAH, C. H., MCLAUGHLIN, K. A. & NELSON, C. A. (2012). Variation in Neural Development as a Result of Exposure to Institutionalization Early in Childhood. *Proceedings of the National Academy of Sciences*, 109 (32), pp. 12927-12932.

SIEGEL, D. J. (2012). *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are (2nd ed.).* New York: Guilford Press.

SIEGEL, D. J. & BRYSON, T. P. (2012). *The Whole-Brain Child: 12 Revolutionary Strategies to Nurture Your Child's Developing Mind.* New York: Bantam Books.

SOLOMON, R. & SHAPIRO, F. (2008). EMDR and the Adaptive Information Processing Model: Potential Mechanisms of Change. *Journal of EMDR Practice and Research*, 2 (4), pp. 315-325.

SPINAZZOLA, J., RHODES, A. M., EMERSON, D., EARLE, E. & MONROE, K. (2011). Application of Yoga in Residential Treatment of Traumatized Youth. *Journal of the American Psychiatric Nurses Association*, 17 (6), pp. 431-444.

TELLES, S. & SINGH, N. (2013). Science of the Mind. Ancient Yoga Texts and Modern Studies. *Psychiatric Clinics of North America*, 36 (1), pp. 93-108.

van der KOLK, B. A. (2005). Developmental Trauma Disorder: Toward a Rational Diagnosis for Children with Complex Trauma Histories. *Psychiatric Annals*, 35(5), pp. 401-408.

van der KOLK, B. A. (2006). Clinical Implications of Neuroscience Research in PTSD. *Annals of the New York Academy of Sciences*, 1071, pp. 277-29.

van der KOLK, B. A. (2014). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York: Viking.

WESSELMANN, D., DAVIDSON, M., ARMSTRONG, S., SCHWEITZER, C., BRUCKNER, D. & POTTER, A. E. (2012). EMDR as a Treatment for Improving Attachment Status in Adults and Children. *European Review of Applied Psychology*, 62, pp. 223-230.

WEST, J., LIANG, B. & SPINAZZOLA, J. (2017). Trauma Sensitive Yoga as a Complementary Treatment for Posttraumatic Stress Disorder: A Qualitative Descriptive Analysis. *International Journal of Stress Management*, 24 (2), pp. 173-195.

WOODYARD, C. (2011). Exploring the Therapeutic Effects of Yoga and its Ability to Increase Quality of Life. *International Journal of Yoga*, 4 (2), pp. 49-54.

ZEANAH, C. H., NELSON, C. A., FOX, N. A., SMYKE, A. T., MARSHALL, P., PARKER, S. W. & KOGA, S. (2003). Designing Research to Study the Effects of Institutionalization on Brain and Behavioral Development: The Bucharest Early Intervention Project. *Development and Psychopathology*, 15 (4), pp. 885-907.

How to Become a More Reflective Practitioner / Researcher

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Abstract: This article is an attempt to glean, from various published writings how to become something more of a reflective psychotherapy practitioner / researcher. This article looks at the use of, and different kinds of, reflectivity in professional psychotherapy practice. It is hoped that such an exploration might encourage others in the profession of psychotherapy to adopt this well-tried tool, that albeit originally came (in part) from social studies, education and anthropology.

Key Words: Reflective Practice, Psychotherapy Research, Practitioner.

Introduction

Like many of us in our original trainings in psychotherapy, much greater attention was paid about the trainee getting the method (or modality) of psychotherapy correct (albeit for the different needs of different clients), and little or less attention was paid to any form psychotherapy research, or to useful methods of feed-back. There was (perhaps) an underlying assumption that, if you did the right thing in the right way and the client got better – that was fine; but if you did the same thing in the same way and the client didn't respond – then it was the client's problem, or even their 'fault'. Reflectivity about one's practice is an attempt to over-ride such assumptions.

A major research resource – for all psychotherapists – is their own clinical data: which is any data that is produced from within the clinical setting, comprising of the behaviour, including verbal behaviour, of the client, but which also includes their affect, any manifestations of occurrent thoughts, feelings, and free associations; reports of dreams, memories, fantasies, and physical symptoms; as well as responses to the therapist's questions and interpretations. In addition to the words spoken, the manner and tone of speech, pauses, corrections, moments of forgetting or going blank, facial expressions, body language, and so on, are all part of this sort of clinical (and possibly also transferential) data. Many psychotherapists also include, as a further part of their clinical data, their own emotional responses, thoughts and feelings in response to the verbal and non-verbal behaviour of their patient (the counter-transference). [1] How all

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this data is recorded, stored, and then used, is – of course – largely up to the individual therapist, but which also depends on their training. Reflecting on these aspects can become an important – and significant – research tool.

Reflectivity: Meaning & Definition:

There have been a lot of fancy words written about being a more "reflective practitioner" or a "reflective researcher" or a "reflective therapist": – essentially, what this term means, is the capacity to operate 'reflectively' in one's professional practice; and, what is meant by this, is focussing more on the combination of two interacting elements: *prospective* and *retrospective* reflectivity.

... Becoming more of a reflective practitioner (or a reflective practitioner-researcher) is helping to maintain, or even increase, the qualitative level of research by making a significant attempt to eliminate the individual therapist's or researcher's impact on the actual on-going research process. This is because qualitative research methods are much less structured than quantitative methods and thus qualitative researchers interact more closely and personally with their clients (or research participants) thus potentially bringing their own biases to the research. David Schön's (1983) book, *The Reflective Practitioner*, introduced such concepts as '*reflection-on-action*' and '*reflection-in-action*', which explain how professionals meet the challenges of their work with a kind of improvised methodology that improves with practice. [2]

Firstly, '*reflectivity*' is a research concept that comes originally from anthropology, or qualitative social research, but is actually very applicable to all kinds of professional practice, especially in education and – of course – psychotherapy. It is the process of reflecting on a number of different aspects of yourself and your work: i.e. – what you actually said or did (depending on notes, recordings, etc.); as well as what you were feeling before, during and after the session; and - how you think you did; and whether your work was effective – especially if there has been any positive or negative feedback; and whatever assumptions or impressions you might have had were affirmed or contradicted. As a professional therapist (or researcher), all this reflective information is necessary in order to provide a more effective and impartial analysis of what was really happening in the psychotherapy session.

Types of Reflectivity

Secondly, simply put, ***prospective*** reflectivity concerns itself with all the possible effects that the person of the researcher might have on the research. What is called 'prospective reflectivity' has been more frequently accounted for in the professional literature; for example, in relation to considering how to handle: the researcher's status; insider/outsider-ness; gender or ethnicity; and also the effects of the researcher themselves (as in the case where a civilised, educated research might have considerable impacts if they were living in (say) a primitive tribal village).

Rather than seeing such influences as potential contamination of the data and thus to be avoided or allowed for, it is possible – by learning how to achieve competence and lessen potential (prospective) dissonance in any appropriate methodological procedure – to utilise this 'prospective reflectivity' in order to help researchers grow in their capacity to understand the significance of their own knowledge, feelings and values – that they themselves have brought into the field of research, and that therefore might have affected the research questions that they came to formulate. This type of reflectivity is seeking to sharpen the analytical lenses that the researchers choose to employ; and thus increase the accuracy of their findings.

Retrospective reflectivity concerns itself with the effect of the research on the researcher, and/or on the research subject: hopefully both will benefit, but sometimes disasters happen. [3] Both these types of reflectivity are attempts to find out whether there are any ways out of the essential dilemma that exists in qualitative research: on the one hand – between the hope of arriving at a non-contaminated, valid and reliable set of research knowledge; and – on the other hand – the threat of collecting trivial data, or producing (unintentionally) very personal accounts, or contaminating the research by personal or cultural prejudices that might be prominent.

These are two different ways to look at – more principally – the relevance of subjectivity and reflectivity, both in and to the process of adding to scientific knowledge; to qualitatively research, which is one of the ways in which psychotherapeutic practitioners can become involved. There are a number of different ways of doing this:

> *"... by offering possible theoretical frameworks; by examining the research process, using own empirical examples to show in which way cultural, social, professional, biographical, and personal characteristics influence what is perceived, interpreted and published; and by providing tools that can be used to highlight subjectivity in the research process in order to achieve new levels of understanding through reflectivity."* [4]

Relevance of Subjectivity and Reflectivity

With regard to the actual pragmatics of qualitative research into this (psychotherapeutic) research approach, and considering all our different methods and techniques, what we can see – as being quite central – is the essential capacity that is needed for the researcher in order to operate reflectively: which is the ability to create a significant differentiation from the researcher's subjectivity. It is probably quite likely that, as a therapist, you are already doing something of this, possibly without realising it consciously: but, what is this 'reflectivity'; why is it important; how can it be separated from pure subjectivity; and how can we use this reflectivity – not only to improve any research, but also – most importantly – to get more out of our professional practice?

> *On the one hand, there are many demands from philosophy of science and there are numerous methods that aim at eliminating researchers' impact on the research process except in controlled treatments. On the other hand, the insight spread that researchers, in continuously interacting with those being researched, inevitably influence and structure research processes and their outcomes – through their personal and professional characteristics, by leaning on theories and methods available at a special time and place in their (sub-) cultures, disciplines and nations. This is especially (but not exclusively) true for qualitative research, because qualitative methods are less structured than quantitative methods, and qualitative researchers interact for most part very closely with research participants in their respective research fields.* [5][6]

As researchers, we need to be cognizant of our own contributions to the construction of meanings and of lived experiences throughout the research process. We need to acknowledge that indeed it is (almost) impossible to remain "outside of" one's study topic, whilst conducting research. Perhaps this is the differentiation that is needed between subjectivity and reflectivity. [7]

The Importance of These Concepts

Firstly – as both psychotherapists and researchers – we absolutely have to acknowl-

edge that all our perceptions, our concepts and preconceptions, and our understanding of the world are based on – our own (subjective) individual patterns of thought and behaviour. These are our personal values; our political, culture, ethnic, religious and age and gender-based leanings; and these are also based within the structures of the profession that we were trained in and that we now follow (and these can also change significantly over our working lifetime). Almost any critical examination, or greater awareness, of these can help to improve our professional practice. By subjecting our 'subjectivity' to reflective practice, we are acknowledging – and allowing for – our individual biases.

Therefore, if – as professionals – we wish to engage in any form of qualitative research into our professional practice, this increased level of 'awareness' necessarily involves a process of consciously examining and acknowledging all our (subjective) assumptions and preconceptions: the views that we might bring into our practice, and thus that might also affect our research. All these aspects can shape or invalidate any research outcome.

None of us can ever be totally detached: there is – in actuality – no such thing as a totally objective observer or researcher. We are all human beings, who hold opinions, impressions and pre-formulated ideas, based on how we were brought up, our education, and also what experiences that we have been exposed to in our lives. The huge dilemma of not only being in the process, but also being a part of the process, while at the same time having to reflect upon what is going on is complicated. As a therapist (or as your own supervisor), your very personality, your entire person is inevitably involved. A colleague writes:

> *"I have come to the conclusion that, after more than 50 years of being in the business, that 'le veritable moi' is a very significant part of psychotherapy; and should [thus] be regarded as one of the main variables. 'The way you look tonight', the way you speak, the entirety of you, [your] body-language, are all included, and [all] affect the patient deeply and should do so; [so, there is] no way you can – or even should – be 'impersonal' (i.e. => be genuinely there). But, but – not private! … The discovery of the Mirror Neuron System (Gallese, Rizzolatti et al.) leaves no possibilities of [you] not disclosing yourself. Instead, you should strive for a deep understanding of your [own form of] "radiation", i.e. "Know Yourself"!!!"* [8]

It is therefore clear that – in to obtain such a level of self-knowledge – a significant level of 'deep enough' personal psychotherapy should be mandatory. When, practicing as a therapist, we (obviously) try to be understanding and empathetic – our focus of attention is, quite naturally, almost totally on the client, and it is therefore quite easy to forget about our own personal influences or unconscious assumptions, both about the therapeutic process and therefore also about any possible research findings.

Therefore, the attitudes and experiences – that we all carry with us, all of the time, almost inherently and inevitably – need to be acknowledged that these can influence any perspectives that we might have – either about the client, or for the process of the therapy, or for any form of 'reflective research'. For instance, the selection and wording of any questions and interventions – before, during and after the therapy session – can (almost inevitably) influence our conclusions and so, these aspects and influences can (almost inevitably) become reflected in our notes, reports or findings: i.e. our "research" conclusions.

However – and this is where reflectivity kicks in – by thinking "reflectively" throughout the entire therapeutic process – by reflecting on ourselves and on our perceptions – and by clearly owning these, and incorporating all these into our awareness – and, by making this reflective process itself, a point of the research analysis –

we can reduce the risk of being misled by any of our own experiences and interpretations – and thus we are able to come to a more accurate and objective "research" perspective.

We are (obviously) professionally aware, as a psychotherapist, that we, the therapists, can possibly – and all too easily – project our own experiences, feelings and interpretations into the therapy session – i.e. how we might have felt if (or when) we had the same or similar experiences, or when we were in a similar situation. Because we have been professionally trained, we should be able to hear the client's narrative and issues – without 'too much' bias; and we should also to be able to hear and respond to all the complex aspects of their narratives and issues – without 'too much' distortion or overlay from our own experiences.

However, our experiences and relationships in such a situation are completely unique to us, and will therefore be quite different to the client's experiences and relationships – and, indeed, different from any other therapist. As professionals, and as researchers, we need to be able to differentiate between our perspectives and experiences and the client's perspectives and experiences; and also to be able to differentiate between their perspectives and perceptions as being different from ours. This 'separation' or 'differentiation' is very important – and almost necessary – for reflectivity, as both a therapist and as a researcher.

A client's reaction to the therapist's questions and interventions and/or the therapist's reaction to the client's answers, can profoundly influence ***what*** questions or interventions that the therapist chooses to ask next, and also on ***how*** the therapist might ask these. These aspects can therefore influence the answers or reactions that the client then gives. Identifying and becoming aware of these dynamics is – in part – what is meant by 'reflective practice'.

In order to make these interactions become a part of 'reflective' practice – capable of contributing to any form of research – these dynamics need to be held – significantly – in the therapist's mind – both during the therapeutic sessions and processes, and especially when the therapist is subsequently 'writing up' the session – as for any research purposes: especially as the therapist's thoughts and reactions can significantly influence what they report, or emphasise, in their case report or in their research findings: e.g. guilt, regrets, prejudice or resentment:

> *"The workings of reflectivity are accessed via observation and reflection, and through interaction with colleagues. We observe in action; we step back to reflect; and we step up again to action. That, at least, is the simple model that we find useful to hold on to. Beyond that, the actual complexities of thinking, feeling, and acting spread out before us."* [2]

If the therapist / researcher then reflects on these points, they should be able to recognise some or most of these biases or personal aspects – and therefore seek to eliminate these. They can then try to ensure that they try to mitigate any of their own impressions or influences because of the effect that these might have had on conducting any following sessions, interactions, case reports, or, indeed, any significant effects of the therapist as a researcher. As is quoted:

> *"[This] is necessary because without such reflection the outcomes of the research process are regarded as "characteristics of objects," as "existing realities," despite their constructed nature that originates in the various choices and decisions researchers undertake during the process of researching."* [9]

How Can We – as Therapists – Become More Reflective?

There are several ways that can help a psychotherapist become more of a reflective practitioner, and thus more of a clinical researcher:

1. **Reliability:** If there is a need for a degree of research reliability and/or a degree of accurate interviewing, then there could (possibly) be more than one interviewer, therapist, observer, or researcher (or using a video- or audio-recording). Alternatively, the client could review the therapist's notes – for accuracy; or possibly, the therapist could allow enough of a gap between the sessions, for more of an objective reflection; or for allowing more time to consider different aspects and so as to either accept or reject these: *"Second thoughts should be the rule!"* [7]

2. **Surprises:** This can be when there is an obvious discrepancy between what the client and therapist (or observer) remember; or when there are inappropriate assumptions, or preconceptions that are brought to awareness. It is both appropriate – and/or necessary – to examine and reflect on these 'dissonances'. It may be necessary to take some time out to examine these: it may be that there are expectations from either client or therapist that need some time to be brought out and looked at.

3. **Recordings:** One way of determining what actually happened, or examining the processes that went 'wrong', or as a way of looking at what was 'going on', one can keep a diary, use an audio-tape, or even a video (given ethical permissions). An 'emotional' diary can help determine how the therapist was feeling on that particular occasion. These 'recordings' can be particularly useful to provide an objective perspective.

4. **Reflections:** Consider how – when the research report, or case study, or synopsis – is being written up, how one's experiences or presumptions may have influenced the report. This is particularly important where the client comes from a significantly different culture, class, race, ethnic background (or similar).

5. **Observation:** As a learning exercise, watch (or listen to) with a colleague or a supervisor, a recording of a session that you have given. If possible, choose a recording where you can see your whole body – so as to be able to see one's non-verbal language, facial expressions, etc. – as well as what is being actually said. There may be discrepancies and dissonances between what was said and how it might have been experienced (by the client). Try to use these observations non-judgementally, as a further learning experience.

All this reflective work is: **(a)** good for you anyway as it can help you to become a better practitioner; and **(b)** so that these internal observations can form part of some 'research' into the therapeutic process, or into your professional practice. Don't worry too much about the form of the research; that comes later. Practice the method of reflective practice first: probably for at least three months. Take notes, re-run any recordings; compare first (early) reflections with later ones and note any differences; discuss these with a colleague or a supervisor; make this a preparation project first – just as one does a literature review before some academic research; and read up about reflective practice. All this will inevitably have a fairly profound process of improvement on your practice. If not, you are either exceptional already (i.e. no room for improvement), which is unlikely, or you are just not 'getting it'.

How Can We – as Psychotherapists – Become More of a Clinical Researcher?

All these terms – 'clinical researcher' – 'reflective practitioner' – etc., put slightly different emphases on different aspects. Another term – Local Clinical Scientist – has been presented as a slightly different bridge between

science and practice. [10] This model is more of a mind-set and a process, than it is of carefully crafted interventions and consists of an informed sequence of hypothesis formation, testing, and revision on the part of the therapist. Any initial impressions (which may or may not be justified) now need to be 'tested out', with the idea of improving their accuracy, so the therapist might start to ask 'critical questions' – so designed that the response will indicate whether the hypothesis is reasonably correct or inadequate. [11]

> *"[Conclusion] Every clinician engages in evidence-based practice. Indeed, it would be both foolish and professionally irresponsible to knowingly ignore any available evidence. The key lies both in what evidence is available to each clinician, and how that evidence is weighed. In weighing evidence, it is critical to consider both internal and external validity. To speak in the vernacular, clinicians who rely exclusively on internal validity know more and more about less and less. Clinicians who rely exclusively on external validity know less and less about more and more. Clinicians who rely exclusively on internal validity are absolutely certain of something that may not apply to the patient in front of them. Clinicians who rely exclusively on external validity are absolutely certain about something that probably does apply to the patient, but it may not be true. Of course, these are caricatures, and there is much room between absolute reliance on one type or another of validity. The LCS occupies this ground, seeks out relevant evidence, weighs it in a balanced, critical, and skeptical manner, and applies it as best as can be done. The LCS then systematically records this new experience so that it can be consulted the next time it may become relevant, not as a guiding principle but as one more piece of relevant evidence. By doing this, the LCS is functioning as a scientist-practitioner."* [10]

From a more cognitive approach, Beck calls this 'collaborative empiricism'. [12] However, in this instance, the balance is put more towards the 'scientist-practitioner' getting it 'right', than towards a clinical researcher improving their work, in that the client is being questioned in order to 'prove' or 'disprove' the therapist's assumptions.

It is clear that reflective practice can help any individual develop both personally and professionally, as it allows all sorts of professionals to update their skills and knowledge continually and to consider new ways to interact with their patients, clients and colleagues. David Somerville and June Keeling suggested eight simple ways that professionals can practice more reflectively: [13]

1. Seek feedback: Ask "Can you give me some feedback on what I did?"
2. Ask yourself "What have I learnt today?" and ask others "What have you learnt today?"
3. Value personal strengths: Identify positive accomplishments and areas for growth
4. View experiences objectively: Imagine the situation is on stage and you are in the audience
5. Empathize: Say out loud what you imagine the other person is experiencing
6. Keep a journal: Record your thoughts, feelings and future plans; look for emerging patterns
7. Plan for the future: plan changes in behaviour based on the patterns you have identified
8. Create your own future: Combine the virtues of the dreamer, the realist, and the critic.

However, there are three more criteria or concepts that are also very significant, especially for psychotherapists: these are: (A) Trust; (B) Co-operation, and (C) Collaboration:

A) Trust: Building and maintaining a high level of trust between therapist-researcher and

client-subject is necessary not only for the therapy, but is also necessary (possibly even mandatory) for the research, in order to generate open and accurate data. This degree of trust strengthens the validity of the qualitative research and facilitates generating sound, reliable theories from it – to be tested out later.

Within this aura of trust, including some other significant concepts, is the whole issue of re-building the client's drive towards better attachment.

> *"Attachment theory is deceptively simple on the surface: it posits that the real relationships of the earliest stages of life indelibly shape our survival functions in basic ways, and that – for the rest of the life span – attachment processes lie at the center of the human experience."* [14]

The client's attachment process can be followed and developed during therapy, but it can often take several years in order to grow into some kind of maturity – depending on the background of the client. Clients with particularly disorganized attachment, or who are very insecure, will need a much longer time; and they also have quite a hard time realizing that there is such a thing as (or even a possibility of) a secure base (hopefully, via the work with the therapist) until they can feel more secure within themselves.

Depending on the therapist's way of working, it is fundamental that the (mostly unconscious) attachment dynamics are explored through similar channels to the interactive psycho-biological regulation that shaped the client's original level of attachment. In the interplay of verbal, but mostly non-verbal, interactions between the client and therapist, it is very difficult for the therapist to stay fully aware of all the subtle interplays that exist, all of the time, at many different levels. Modern developments in neuroscience make it clear that:

> *"Many features of social interaction are non-verbal, consisting of subtle variations of facial expression that set the tone for the content of the interaction. Body postures and movement patterns of the therapist…also may reflect emotions such as disapproval, support, humor, and fear. Tone and volume of voice, patterns and speed of verbal communication, and eye contact also contain elements of subliminal communication and contribute to the unconscious establishment of a safe, healing environment."* [15]

There is, therefore, a need for a considerable period of reflectivity after a session to work out more exactly what was happening in the session at any particular moment. As mentioned, exactly how one uses any notes, recordings, etc., depends on the individual practitioner-researcher.

Sometimes, the therapeutic relationship will break down completely – and then much can be understood by reflecting on why this sudden breakdown of understanding happened, or what it was that was part of the irreconcilable differences between the client and therapist's inner worlds. But, as there cannot be any further sharing of mutual experiences: so, reflectivity – at this point – is also necessary, if not essential.

B) Cooperation: Close collaboration – or co-operation – between researchers and their subjects (therapists and their clients) is also necessary – not also for strengthening the 'therapeutic alliance' (the most productive component of good therapy) – but also in order to facilitate the gathering of good data. Relationships in the research field are very important and can also be quite challenging:

> *"… it was necessary to have ongoing negotiation between the researchers, the research participants, and other stakeholders during the research process."* [16]

In some cases, appropriate methodology means making formal arrangements and getting signed permissions about making audio or video recordings, and also about destroying

these at the end of the research project. This – in itself – will have a small, but possibly significant, effect on the therapeutic relationship. The client (subject) can feel more empowered or important; they are being asked something or contributing something more to the therapy. It can also help with any feelings of respect.

C) Collaboration: Thirdly, in research, data – to be credible – often needs corroboration and, for this, collaboration with others may well be necessary, as we might need access to alternative sources of information. For example, as a psychotherapist working in the UK National Health Service, I may be able to gain relatively easy access to a client's (or patient's) medical record or mental health history. As an independent practitioner, I would definitely need the client's clear and written permission in order to access any such corroborative material. There are other forms of collaboration that may be needed.

All these components will inevitably 'change' the therapeutic relationship – in some way or another. It is possible that psychotherapists are somewhat reluctant to consider 'practitioner research' because they fear such changes. They may also feel that they are imposing, or injecting, something into the relationship from their side that might be counter-transferential or even counter-productive, rather than seeing the longer-term benefits. All these points must be considered carefully and must be "woven" into the fabric of the therapy – always to the benefit of the client first, instead of for the benefit of the therapist-researcher, or for the benefit of professional knowledge. Furthermore, there may well be ethical considerations here that should also be considered. [17]

However, once one is more practiced in reflective practice, one can then start to move towards becoming a reflective researcher:

> *"We [also] note the relevance to the reflective process of distinction between reflection-in-action and reflection-on-action without exploring, on this occasion, whether that counts for our purposes as a distinction of category or scale. A decision whether or not to record a conversation, for example, may have to be taken on the spot, while the decision to amend a research question will call for careful consideration of what has been learned. In both cases, we shape and are shaped."* [2]

Reflective researchers have to open themselves up to being a significant element of the phenomena that are to be investigated: they are thus embedded in, and also emerge from their contexts. Moreover, such researchers also need to utilise a developmental learning approach to their research methodology, as well as an educational approach to becoming a researcher: they need to be ready to change.

This is an issue that should be looked at through the magnifying lens of supervision: how much is the reflective practitioner-researcher ready to examine themselves critically and also ready to change their approach, as the result of such an examination. If supervision is to be significant here, as it should be, then the supervisor needs to have experience of, and familiarity with, reflective practice and research: one additional aspect – the use of "grounded theory" – can be particularly useful here. [18]

All, these approaches need to be equally open to the possibility of shifting insights, emergent goals, and evolving methods, in the pursuit of findings that might have become more significant than the initial research questions. However, this process of continual self-examination can be quite an exhaustive process.

A Personal Learning Journal

One of the methods suggested for reflective practice is to keep some sort of a 'learning' journal (on paper or on a computer), in which one documents one's own feelings, thoughts,

observations and (even) visions – as soon as possible after a session. Keeping a reflective journal can help to: focus thoughts and develop ideas; develop your own 'voice' and gain confidence; experiment with ideas and ask questions; organise your thinking through exploring and mapping complex issues; developing one's conceptual and analytical skills; reflecting on and making sense of experiences and the processes that lie behind them; expressing one's own feelings and emotional responses; becoming aware of one's actions, strategies and any results; developing one's own writing style and skills, and exploring different styles; developing a conversation with others. It is also suggested that: you write for yourself; ideally every day; that you be informal, using language that you are comfortable with; write by hand, or one the computer, whichever you prefer; write in your own language; be relaxed and comfortable; try sitting in different places and positions; use diagrams and drawings, if that helps; record – not just the events – but also reflections on the process; ask questions and challenge assumptions; connect up personal and professional experiences with concepts and theories. [19]

Reflective researchers need to be able to raise the level of awareness of their own internal processes with the aims, both of enriching their lived experience, and then of being able to add their new awareness to a deepening understanding of the field. With regards to experiential enrichment, the value of reflectivity is perceived to lie in the individual researcher's ability to construct an overall sense of congruence in their research practice. It is suggested that the effects of reflective practice are considerably enhanced by being in a supportive supervisory environment. [20]

Reflective Groups

Alternatively, or additionally, working in a peer-group, who meet on a regular basis and reflect together can also be a powerful supporting element of an individual's reflective practice. 'Co-operative Inquiry' is a reflective practice method for groups, initially developed by John Heron. [21]

This usually involves groups working through a structured four-stage cycle of action and reflection, through which group members move towards developing new ways of being. However, this group structure can also be very useful and supportive for the individual practitioner-researcher, using reflective practice, to share this with other similar psychotherapists, also using such.

David Kolb identified four main stages of the experiential learning process, as a continuous loop, in the order of: Concrete Experience; Reflective Observation; Abstract Conceptualisation (concluding / learning); and then Active Experimentation (planning and trying out what has been learnt); then leading back to Experience. These 'Learning Styles' have now become accepted as part of a classical model. [22]

Conclusion

In conclusion, psychotherapists of whatever modality who are working clinically are encouraged to adopt some of these reflective measures, not only to benefit their own practice, but also to take a significant step on their way towards becoming more of a (reflective) practitioner-researcher. This sort of qualitative research is becoming increasingly important, as it is one of the more relevant and appropriate methods of research for psychotherapy.

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Endnotes

1 **LACEWING, M.** (2018). The Science of Psychoanalysis. *Philosophy, Psychiatry, Psychology*, 25 (2), pp. 95-111.

2 **SCHÖN, D.** (1983). *The Reflective Practitioner: How Professionals Think in Action.* New York: Basic Books.

3 There are possibly cases of early anthropological researchers, who may have infected the tribe that they are researching with viruses, bacteria, ideas, etc., so that the tribe becomes radically changed – thus invalidating the research findings. In the same way that (hypothetically) a therapist-researcher might affect changes in the quality of the therapy (therapeutic alliance) because too much emphasis was put on the process of the research, rather than the process of the therapy.

4 **ATTIA, M. & EDGE, J.** (2017). Be(com)ing a Reflective Researcher: A Developmental Approach to Research Methodology. *Open Review of Educational Research*, 4 (1), pp. 33-45. doi: 10.1080/23265507.2017.1300068.

5 **MRUCK, K. & BREUER, F.** (2003). Subjectivity and Reflectivity in Qualitative Research – The FQS Issues. *Forum: Qualitative Social Research*, 4 (2), Art. 23.

6 **BREUER, F.** (2003). Subjectivity and Reflectivity in the Social Sciences: Epistemic Windows and Methodical Consequences. *Forum: Qualitative Social Research*, 4 (2).

7 **PALAGANAS, E. C., SANCHEZ, M. C., MOLINTAS, M. V. P. & CARICATIVO, R. D.** (2017). Reflectivity in Qualitative Research: A Journey of Learning. *The Qualitative Report*, 22 (2), pp. 426-438.

8 Personal communication: 1-May, 2020.

9 **MRUCK, K.** (1999). *„Stets ist es die Wahrheit, die über alles gebietet, doch ihre Bedeutung wandelt sich." Zur Konzeptualisierung von Forschungsobjekt, Forschungssubjekt und Forschungsprozeß in der Geschichte der Wissenschaften ["It is always the truth that commands everything, but its meaning changes." For the conceptualization of research object, research subject and research process in the history of science.]*. Münster: Lit.

10 **STRICKER, G.** (2007). The Local Clinical Scientist. In: S. G. Hofmann & J. Weinberger (Eds.), *The Art and Science of Psychotherapy* (pp. 85-102). London & New York: Routledge.

11 **SULLIVAN, H. S.** (1954). *The Psychiatric Interview.* New York: W.W. Norton & Co.

12 **BECK, A. T., RUSH, A. J., SHAW, B. F., & EMERY, G.** (1979). *Cognitive Therapy of Depression.* New York: Guilford.

13 **SOMERVILLE, D. & KEELING, J.** (2004). A Practical Approach to Promote Reflective Practice within Nursing. *Nursing Times*, 100 (12), pp. 42-45.

14 **SCHORE, J. R. & SHORE, A. N.** (2008). Modern Attachment Theory: The Central Role of Affect Regulation in Development and Treatment. *Clinical Social Work Journal*, 36, pp. 9-20.

15 **SCAER, R.** (2005). *The Trauma Spectrum: Hidden Wounds and Human Resiliency* (pp. 167-168). New York: W.W. Norton & Co.

16 **MRUCK, M. & BREUER, F.** (2003). Subjectivity and Reflectivity in Qualitative Research – The FQS Issues. *Forum: Qualitative Social Research*, Vol. 4, No. 2, Art. 23.

17 **MUNHALL, P. L.** (1988). Ethical Considerations in Qualitative Research. *Western Journal of Nursing Research*, 10(2), pp. 150-162.

18 **DOUGLAS, D.** (2003). Reflections on Research Supervision: A Grounded Theory Case of Reflective Practice. *Research in Post-Compulsory Education*, Vol. 8, No. 2, pp. 213-229.

19 **MOON, J.** (2004). *A Handbook of Reflective and Experiential Learning: Theory & Practice.* London & New York: RoutledgeFalmer.

20 **WOOD, J.** (2007). *Methods of Reflective Practice.* Unpublished Doctoral thesis, City University London.

21 **HERON, J.** (1996). *Co-Operative Inquiry: Research into the Human Condition* (pp. 9-10). London: Sage.

22 **KOLB, D. A.** (1984). *Experiential Learning: Experience as the Source of Learning and Development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall.

Notes on Empathy vs Confrontation in Psychological Treatment

Seymour Hoffman

Abstract: What prompted me to write this brief piece was my delight in reading Professor Omer's bold, unique insight and I wished to publicize his unconventional intervention, which – to my view – slaughters the sacred cow of traditional therapy and challenged Rogers and Kohut's views that empathy is the essential, 14-karat-gold, tool of the psychotherapist. As Erickson (1980) put it: *"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 hypothetical theory of human behavior."* I end with an equally apt quote, as King Solomon, the wisest of men, wrote in Ecclesiastes.

Key Words: Psychotherapy, empathy, Rogers, Kohut, confrontation

There are many so-called "sacred cows", or sacrosanct ideas that are held to be above criticism, in every school of thought – and psychotherapy, of course, is no exception. Therapist empathy has had a long history as a hypothesized key factor in the change process in psychotherapy, however, the level of empathy has been shown to be only a medium-sized predictor of client outcome, albeit robust across different theoretical orientations, treatment formats and clients' problems. There are also necessary considerations concerning diversity, different therapeutic practices and different types of empathy (Elliot *et al.*, 2018). One of these behemoths is the notion that a therapist should be empathic – nearly all of the time. Certainly – for some clients – empathy is necessary. However, therapists can also burn out, if they are over-empathic (Hendriksen, 2018).

Person Centered Therapy

Carl Rogers (1951) maintained that therapists 'must have' three attributes to create a growth-promoting climate in which individuals can move forward and become capable of becoming their true self. These are: (1) congruence (genuineness or realness); (2) unconditional positive regard (acceptance and caring); and (3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person). I would like to examine these capabilities a little more fully and to challenge that this applies for every client.

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1: Congruence (Genuineness)

Congruence refers to the therapist being real, authentic, and genuine with their clients. It's called *congruence* because their inner experience and outward expression match. In being authentic, the therapist shows they are trustworthy, which helps in building a good therapeutic relationship with the client. It also serves as a model for clients, encouraging them to be their true selves, expressing their thoughts and feelings, without any sort of false front.

2: Unconditional Positive Regard & Acceptance

Unconditional positive regard means the therapist genuinely cares for their clients and does not evaluate or judge their thoughts, feelings, or behaviours as good or bad. Each client is accepted and valued for who they are, as they are, without stipulation. Clients need not fear judgment or rejection from their therapist.

3: Accurate Empathic Understanding

Accurate empathic understanding means that the therapist understands their client's experience and feelings in an accurate and compassionate way. The therapist recognizes that each client's experience is subjective and therefore strives to see things from the client's unique perspective. An important part of accurate empathic understanding is for the therapist to convey that they "get it" by reflecting the client's experience back to them. This is supposed to encourage the clients to become more reflective with themselves, which then allows for greater understanding of themselves. The importance of the empathic connection is generally accepted as something to be strived towards. However, the automatic assumption that empathy is good, can be simplistic and flawed. There are some legitimate questions:

> *"... is it possible that instead of the client welcoming this level of closeness and understanding, he or she might regard the counsellor's ability to "see the whole person" as an intrusion? Instead of wishing to be fully known by the counsellor, might the client regard empathic understanding as a penetration into protected areas of the self, stimulating feelings of exposure, anxiety and shame? Therapeutic empathy creates a paradox. The client wishes to be seen, understood and validated but does not necessarily want be completely known, even to himself or herself, because such deep empathy evokes the client's deepest wounds. In such cases, empathy hurts!"* (Cowan *et al.*, 2013)

Another example of the use of therapeutic empathy can be found in Kohut's Self-Psychology, though in a somewhat more limited sense:

> *"Through empathy, he suggested, the therapist can be used (as an object) to gratify the early developmental needs relating to 'narcissism' (in Kohut's theory, this is a healthy stage in child development). In other words, empathy permits the natural occurrence of different narcissistic transferences from the client."* (Finlay, 2015).

Kohut Self Psychology

According to Kohut's (1971) self-psychology model:

> *"... narcissistic psychopathology is the result of parental lack of empathy during one's early development. Consequently, the individual does not develop proper capacity to regulate their self-esteem. The narcissistic adult, according to Kohut's concepts, vacillates between an irrational overestimation of the self and irrational feelings of inferiority, and thus relies on (or needs) the acclaim from others in order to regulate his self-esteem and give him a sense of value. In treatment, Kohut recommends helping the patient develop these missing functions. He proposes that the therapist should empathically experience the*

> *world from the patient's point of view ('temporary indwelling') so that the patient feels understood. Interpretations are often used when these can help the patient understand his (sometimes) intense feelings about the possibility of any empathic failure on the part of the therapist, and understand why he (the patient) needs to restore solidity and comfort after being injured by any failed empathic (self-object) ties. As insight develops, the patient begins to understand why he might experience these apparently small empathic failures so deeply"* (McLean, 2007: p. 1).

However, there are some serious critiques of this relevance of using this model, not least that people with Narcissistic Personality Disorder, either rarely come into therapy, or have great difficulty accepting any suggestion that their 'world view', can – in any way - be wrong.

In contrast to most other models of pathology that adopt more pluralistic models, Kohut proposed *"a radically abbreviated interpretive approach based on the single subjective method of empathy" (Rubovits Seitz, 1988). It has also been suggested that – whilst these can have some uses – Kohut's theories of borderline patients "are incomplete and require other theoretical models in order to understand the patient optimally"* (Adler, 1989).

Pride, Shame and Guilt

Tangey, in recent research (1995), makes the interesting and significant point that pride, shame and guilt are all related and makes an important distinction between "Authentic Pride" and "Hubristic Pride":

Authentic Pride is the sense of self confidence and efficacy one gets from a realistic appreciation of one's achievements and behaviour, humility, and ability to appreciate constructive criticism. On the other hand, negative pride is defined as **Hubristic Pride**, or what we commonly call Narcissism.

The basis for this pride is an unrealistic sense of self, which constantly needs validation from others. It is characterized by people who are constantly looking to prove themselves in the eyes of others, who are hyper-sensitive to criticism, and who also have a tendency to perceive relationships in a competitive manner, and basically be dependent on others to verify their inflated self-worth.

Helping someone overcome their unrealistic sense of self and other dependencies is easier when they are in a place of pain, but when they are benefiting of their arrogance – or abuse and use of others and are not in pain or looking for change, then it becomes very difficult, if not impossible. One possible – empathic – way forward is therefore to create a "holding environment" to help the patient:

> *"to restore and enhance the observing, anxiety-containing, and investigative capacity of the ego. This holding environment rests on only on the stability of the therapeutic setting, including the reliability and acceptance of the therapist, but on helping the patient acknowledge and process the precipitants of the emotional crisis"* (Richard-Jodoin, 1989).

A Particular Use of Confrontation in Psychotherapy

As a form of contrast, confrontation is a technique that is also used in therapy, often to help the patient recognize their shortcomings, and even some possible consequences. It is a counselling skill that attempts to gently bring about awareness in the client – something that the client may have overlooked, or avoided, or has even been blind to.

I was struck by the similarities to, and differences of, the above and the unique and unconventional psycho-therapeutic intervention recommended on one occasion by Professor

Haim Omer to one of his supervisees, who was attempting to treat a woman, preoccupied with her (low) self-worth, which had caused her much mental misery and so, she had sought some psychological help. The following excerpt is taken from Omer's excellent (1994) book, '*Critical Interventions in Psychotherapy*'.

Dora, was a 35-year-old successful lawyer, worried constantly about the impressions that she made and about her lack of self-worth. She had undergone 3 years of psychoanalytic therapy in which her lack of self-esteem had been traced back to her family of origin and – in particular – to the fact that her elder brother(?), now a successful physicist, had received all the accolades of the family and, in contrast, in the opinion of her parents, *"a woman could never really make it"*. However, the psychoanalytic treatment failed to improve her preoccupation with her own worth. Dora then asked for a short, practical treatment, feeling that she had enough of trying to understand herself.

After 7 sessions, the second therapist had also felt stalemated by Dora's disqualifying tendencies and discussed the case, in a supervision / consultation with her professor, Omer. Below (pp. 18-19), is an excerpt of the type of intervention that was recommended – by Omer – to the therapist:

> *"Maybe – what I am going to tell you – will not look like therapy at all. I believe you really have a flaw, a spiritual flaw. Your flaw is the sin of pride. This might seem strange to you, as you don't feel proud of yourself at all. The sin of pride, however, is a deeper thing. It consists in worrying oneself constantly about one's stature, as compared to that of others, in disparaging the low and their opinions, or in being so overawed by the great that nothing counts so much as being admired by them. You are obsessed with pride. You look upon life vertically, as a gradient of worth, and cannot accept the fact that you don't see yourself at the top. ... The sin of pride carries its own punishment, dooming you to go round and round with never a hope for satiation or [for] fulfilment.*
>
> *In all cultures, there has been one antidote to the sin of pride: self-abasement. If you want change, you will have to learn to mortify your overblown self, to starve your appetite for admiration, to fight your arrogance. ... If you [just] want to improve your self-esteem, there is nothing I can do. Your true enemy, however, is pride. It contaminates everything in your life: your relationship with your husband, your daughter, your friends, your peers. You were right in feeling that sympathetic support is not what you need in therapy. Neither do you need further examination of what you underwent as a child. You knew you wanted stronger [psychological] medication, and this is the line that I think we should follow:*
>
> ***Ecclesiastes, 3.1:** "To everything there is a season, and a time to every purpose under the heaven. ... **(3.5):** A time to break down [to confront], and a time to build [empathy]; a time to embrace, and a time to refrain from embracing".*

I rest my case!

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References

ADLER, G. (1989). (see https://www.ncbi.nlm.nih.gov/pubmed/2584601).

COWAN, E. W., PRESBURY, J. & ECHTERLING, L. G. (2013). The Paradox of Empathy: When Empathy Hurts. *Counseling Today*, 55(8), pp. 57-61.

ELLIOTT, R., BOHART, A. C., WATSON, J.C. & MURPHY, D. (2018). Therapist Empathy and Client Outcome: An Updated Meta-Analysis. *Psychotherapy*, 55(4), pp. 399-410.

ERIKSON, M. (1980). *Syllabus for 1st International Congress on Eriksonian Approaches to Hypnosis & Psychotherapy in Dec. 1980.*

FINLAY, L. (2015). *Relational Integrative Psychotherapy: Process and Theory in Practice.* Chichester, UK: Wiley.

HENDRIKSEN, E. (2018). A Therapist on Learning to Empathize Without Burning Out. *The Cut, New York.* Accessed: https://www.thecut.com/2018/01/a-therapist-on-learning-to-empathize-without-burning-out.html.

KOHUT, H. (1971). *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders*. New York: International Universities Press.

MCLEAN, J. (2007). (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2860525/).

OMER, H. (1994). *Critical Interventions in Psychotherapy.* New York: W.W. Norton & Co.

RICHARD-JODOIN, R. M. (1989). (see https://www.ncbi.nlm.nih.gov/pubmed/2768025)

ROGERS, C. (1951). *Client-Centered Therapy: Its Current Practice, Implications and Theory*. London: Constable.

RUBOVITS-SEITZ, P. (1988). (see https://www.ncbi.nlm.nih.gov/pubmed/3069888)

TANGNEY, J. P. & FISCHER, K. W. (Eds.). (1995). *Self-Conscious Emotions: The Psychology of Shame, Guilt, Embarrassment, and Pride.* New York: Guilford Press.

The Problem of Parallel Process: Wild Analysis in Psychotherapy Supervision?

C. Edward Watkins, Jr.

Abstract: Could it be that parallel process is more a product of 'wild analysis' than reasoned reflection? I consider that question subsequently, selectively reviewing parallel process case examples and anecdotes across the last six decades. Extending an earlier parallel process examination (Watkins, 2017), I look further into a host of published case anecdotes, subject those anecdotes to a rival hypothesis/alternate explanation perspective (Huck & Sandler, 1979), and raise questions about those anecdotes reflecting any sort of 'truth' about the parallel process at all. Although it is a much-hallowed concept, even regarded as supervision's signature phenomenon (Bernard & Goodyear, 2019), parallel process in my view merits such sceptical scrutiny. It can be valuable to challenge our most revered constructs and parallel process is no exception, and so I take up that challenge in what follows. I again revisit this concern: since our primary 'evidence' for parallel process remains the clinical anecdote (Perlman, 1996), how much real 'evidence' do such anecdotes provide?

Key Words: parallel process, supervision, reflection, clinical, psychotherapy

> *"...parallel process is an umbrella that shades many sins..."*
> (Power, 2014, p. 161)

For my purposes here, 'parallel process' will be defined as follows:

> *"...a multidirectional representational system in which major psychic events, including complex behavioral patterns, affects, and conflicts, occurring in one dyadic situation ... are repeated in ...* [a similar dyadic situation]" (Wolkenfeld, 1990, p. 96).

This involves some sort of *inter-dyadic transfer* where, as a result of unconscious processes or unawareness, that which begins in one dyad (i.e. behavioural patterns, affects and conflicts) becomes replicated in another dyad. In what follows, I specifically give focus to that inter-dyadic transfer as it purportedly occurs in the patient/therapist → supervisee/super-

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visor dyads, and vice versa. Although parallel process can be defined far more broadly, whereby any parallel between the therapy and supervision processes is regarded to be a parallel process (e.g. teaching in the supervision dyad paves the way for teaching in the therapy dyad), I will confine my considerations to the inter-dyadic definition in which the carry-over of unconscious or 'unaware' dynamics are implicated. That inter-dyadic conceptualization, though most often associated with psychoanalytic / psychodynamic supervision, can be found readily reflected across a host of supervisory theoretic visions (e.g. Guffrida, 2015; Holloway, 2016; Ladany, Friedlander, & Nelson, 2016; Mazzetti, 2013; Norcross & Popple, 2017; Pickvance, 2017; Yontef, 1997); it also appears to be an internationally endorsed way of apprehending parallel process (e.g. Arnaud, 2017 [Canada]; Binder & Strupp, 1997 [United States]; Dixon, 2017 [Australia]; Eagle & Long, 2014 [South Africa]; Ellis, 2017 [United Kingdom]; Gök, 2015 [Turkey]; Gundle, 2015 [Myanmar]; Jacobsen, 2007 [Denmark]; Popescu, 2012 [Romania]; Schmolke & Hoffmann, 2014 [Germany]).

I have examined parallel process in an earlier paper (Watkins, 2017), where I raised these three points for review: **(a)** many of our parallel process examples, anecdotal in nature, are highly suspect and may not even reflect any sort of parallel process at all; **(b)** parallel process may not be nearly as ubiquitous as is often proposed in the supervision literature (e.g., Ehrlich, *et al.*, 2017; Heuer, 2009); and **(c)** a much more circumspect and critical view about parallel process in supervision would seem prudent (see also Watkins, 2016a, 2016b). So, I wish to explore further those three points subsequently and complement the earlier paper by taking a deeper dive into the parallel process literature and providing additional 'data' to support those earlier contentions.

Parallel process admittedly generally continues to be seen in supervision as a much revered, widely accepted phenomenon (e.g. Bernard & Goodyear, 2019). But sometimes, questioning that which is much revered and widely accepted can be valuable, ideally providing a check or alternate perspective that is potentially additive. So, I hope to do that in what follows: Let us question parallel process. I therefore ask the reader to wander with me through a host of published parallel process examples and, in the process, to wonder with me about the truth and validity of the purported parallel process in these examples.

I will also take the rival hypothesis or the alternate explanation perspective: after Huck & Sandler (1979), *"rival hypothesis implies some alternative interpretation, different from the interpretation made by the researcher, for why the data turned out as they did"* (p. xv). This perspective is nicely communicated by the following 'hearing flea' example (from Helmstadter, 1970, p. 94):

> *After carefully conditioning a flea to jump out of a box on an appropriate auditory signal, the "experimenter" removed the first pair of legs to see what effect this had. Observing that the flea was still able to perform his task, the second pair of legs were removed. Once again, noting no difference in performance, the researcher removed the final pair of legs and found that the jumping behaviour no longer occurred. Thus, the investigator wrote in his notebook, "When all the legs of a flea have been removed, it will no longer be able to hear the signal."*

Could it be that all too many of our parallel process examples are products of similar (mis) reasoning? Could it be that "*...the continued use of the parallel process concept in supervisory work contributes more to ... mystification than ... elucidation...*" (Miller & Twomey, 1999, p. 578)? Those at least seem to be potentially instructive questions to entertain. Thus, I consider

alternate interpretations to those made by the original supervisor or interpreter of parallel process in the subsequent supervision examples.

To best set the stage for that presentation of examples, I will first provide a short summary about parallel process and its role in psychotherapy supervision.

Parallel Process: Historical Development and Current Status

Bottom Up, Top Down, and All Around

Referred to as supervision's: *"dominant idea"* (Rosbrow, 1997); *"most influential conception"* (Binder & Strupp, 1997), and *"signature phenomenon"* (Bernard & Goodyear, 2019), parallel process has long been regarded as a seminal discovery. It is now widely viewed as: **(a)** a way of understanding how the treatment and supervision processes intersect and influence each other; and **(b)** how that understanding can accordingly be used to inform intervention across processes (Eagle & Long, 2014; Sarnat, 2019). Though originally of psychoanalytic provenance, parallel process even now appears to be viewed in some form as applicable across all supervision perspectives, perhaps even rising to the level of a supervision common factor (Watkins, 2012, 2015a; Raichelson *et al.*, 1997).

Bottom up: But when parallel process was first explicated by Searles (1955) as the 'reflection process' over six decades ago, parallel process (so dubbed by Ekstein & Wallerstein [1958] three years later) began primarily as a one-way experience: When 'something' in the patient/therapist dyad gets transferred into the supervisee/supervisor dyad and then gets re-enacted there. Thus, the event chain unfolded as follows:

Patient → Therapist / Supervisee → Supervisor.

The therapist/supervisee served as the conduit, unconsciously transferring the unresolved patient/therapist's conflict (e.g. issues with authority, interpersonal distrust, etc.) into the process of supervision (Brenner, 1963; Ekstein & Wallerstein, 1958; Hora, 1957; Searles, 1955, 1962). 'Parallel process' was a therapeutic description of a form of unconscious communication in supervision. If that communication was properly understood, then the supervisor could then suitably intervene, taking a more responsive action to the delivered unconscious communication. The supervisor ideally used understanding of parallel process in order to affect positively the relational dynamics occurring in the "supervisor-supervisee" interaction, that effect then being carried forward and used by the supervisee to affect positively the similarly occurring relational dynamics in the therapist-patient interaction.

A bottom-up parallel process appears to involve a complex chain of converging dyadic and triadic events, where intersecting and interlocking psychodynamics become mobilized and are enacted. The complete sequence, if realized, proceeds as follows (Watkins, 2017, p. 507):

> *"... **(a)** the patient experiences some conflict, which, though unconscious, gets enacted in the treatment dyad; **(b)** the unconscious enacted conflict meshes in some way with the therapist's own conflicts; **(c)** by means of listening and empathic attunement, the therapist identifies with and becomes unknowingly "hooked" by the patient's conflict and consequently has her/his own conflicts activated; **(d)** the therapist then carries that identification with the patient and experience of being conflict "hooked" into his/her supervision; **(e)** in recounting the difficulties of the therapist-patient relationship in supervision, the therapist again experiences identification with the patient and has her/his coun-*

> *tertransference activated; **(f)** the therapist (now supervisee) regressively re-enacts the therapist-patient problem or conflictual pattern with their supervisor; **(g)** the supervisor realizes this and listens and empathizes and, if unable to detect the patient re-enactment taking place, can respond counter-transferentially and/or accordingly acts out the therapist's role in the supervision, thus treating the supervisee as if she/he were the patient…"*

Such a dizzying concatenation of intrapersonal and interpersonal events seemingly becomes possible because of identification, *"…the essential mechanism of parallelism…"* (Gediman & Wolkenfeld, 1980, p. 250). Thus, some sort of shared identification (e.g. a similar conflict) can be invoked across all triad parties and actuates the parallel process (Frawley-O'Dea & Sarnat, 2001; Gediman & Wolkenfeld, 1980; Grey & Fiscalini, 1987; McCue & Lane, 1995). The unremembered re-occurs through a form of repeating through enactment (Freud, 1958/1914; Issacharoff, 1984).

Top-down: Although Searles (1955) also acknowledged the possibility of a top-down reflection process (i.e. where 'something' in the supervisee/supervisor dyad gets transferred into the therapist/patient dyad and then gets reenacted there), it was not until Doehrman's (1976) dissertation research nearly 20 years later that top-down action (Supervisor→Supervisee / Therapist→Patient) got rightly recognized for its own importance. At that time, Mayman (1976) — in introducing Doehrman's study — memorialized the presumptive universality of parallel process with these words:

> *"…parallel processing…is a universal phenomenon…and…failure to observe its presence in supervision may signal only a natural resistance on the part of the supervisor and/or therapist…"* (p. 4).

Doehrman's (1976) research — published as an entire issue of the *Bulletin of the Menninger Clinic* — has since been recognized as a 'watershed' contribution (McKinney, 2000; Mothersole, 1999), deepening our understanding about parallel process by emphasizing its bi-directional nature (see Bernard & Goodyear's [2014] 'Web of Science' results).

A top-down parallel process also appears to involve a complex chain of converging dyadic and triadic events, where intersecting and interlocking psychodynamics become mobilized and are enacted. The complete sequence, if realized, proceeds as follows (Watkins, 2017, p. 507):

> *"…**(a)** the supervisor experiences some conflict, which, though unconscious, gets enacted in the supervision dyad (e.g., having a highly negative reaction to a certain patient and responding punitively in supervision); **(b)** the unconscious enacted conflict meshes in some way with the therapist's own conflicts (e.g., to dominate and control, to be prized by the supervisor); **(c)** by means of listening and empathic attunement, the therapist identifies with and becomes unknowingly "hooked" by the supervisor's conflict and consequently has her/his own conflicts activated; **(d)** the therapist carries that identification with the supervisor and experience of being conflict "hooked" into treatment; **(e)** in interaction with the patient, the therapist's identification with the supervisor is revived and her/his countertransference is accordingly activated; **(f)** the supervisee regressively acts out the supervisor-supervisee problem or conflictual pattern with the patient (e.g. treating the patient punitively); and **(g)** the patient listens, likely experiencing confusion and hurt, which may well lead to treatment deterioration and premature termination."*

Again, where such a dizzying array of intrapersonal and interpersonal events converge, the mechanism of identification *and* the repeating of the unremembered through enactment are both considered to be prominently in play

(Doehrman, 1976; Frawley-O'Dea & Sarnat, 2001; Freud, 1958/1914; Gediman & Wolkenfeld, 1980; Issacharoff, 1984).

And all around: From the middle out, too. Four years later, Gediman and Wolkenfeld (1980) — in their now classic supervision paper (see Bernard & Goodyear's [2014] 'Web of Science' results) — went on to accentuate the multi-directional nature of parallel process action: it could originate with any party in the supervision triad, bottom, top, or middle. The event chain of action again shifted so as to reflect that multi-directionality: Patient ↔ Therapist / Supervisee ↔ Supervisor. That parallel process can be multi-directional has since seemingly become an accepted reality (Caligor, 1981; Frawley-O'Dea & Sarnat, 2001; Gediman, 2001; Sarnat, 2016). The dynamics and mechanism of the process remain the same, as does the approximate sequence of events. But, the therapist/supervisee is now recognized as also being a point of origin.

On Celebrating Parallel Process but … A 60-Year Celebration, Reflecting on Then-and-Now

In honour of Searles and his reflection (parallel) process discovery, the journal, *Psychiatry: Interpersonal and Biological Processes* (where Searles' original 1955 article appeared), brought together 60 years later a group of accomplished scholars to comment upon the parallel process construct and its enduring legacy. As Kay (2015) succinctly stated,

> *"The outstanding contribution of this classic [1955] paper is the elucidation of the richness of the parallel process between supervisor and supervisee that is reflected in the treatment of the patient and his or her clinician"* (p. 233).

That entire special section was a celebration, with the power of parallel process in explicating therapy/supervision dynamics being roundly recognized and reinforced (see Frederickson, 2015; Fritsch, 2015; Kay, 2015; Michels, 2015; Silberman, 2015; Stadter, 2015; Waugaman, 2015; Winer, 2015). That special section also appears to nicely capture how parallel process is generally viewed now across much of psychotherapy supervision (Sarnat, 2019).

But… The tenure of parallel process, while generally enjoying the hearty embrace of the supervision community, has not been without criticism. Such descriptors as illusory (Lesser, 1983), imprecise (Baudry, 1993), and misused (Miehls, 2010; Schimel, 1984; Stimmel, 1995) have been applied. Others concerns or cautions have included: **(a)** parallel process being used as a "gotcha" supervision tool (Fritsch, 2015) that can subordinate supervisees and make them appear more like feckless pawns than otherwise (Grey & Fiscalini, 1987; Miller & Twomey, 1999; Rosbrow, 1997); **(b)** force fitting data to correspond with a foreordained parallel process explanation (Watkins, 2012; Baudry, 1993); and **(c)** therapy/supervision parallels, occurring coincidentally, or because of dyadic structural similarities, being mistakenly interpreted as parallel process (Frawley-O'Dea & Sarnat, 2001; Gordan, 1996).

Furthermore, with but two notable exceptions (Tracey, Bludworth & Glidden-Tracey, 2012; Zetzer et al., 2020), parallel process remains largely unexplored quantitatively or qualitatively, being notoriously difficult to investigate. The research has been criticized on a number of grounds, including small sample sizes, no formalized data analysis, using self-report measures, lack of comparison cases, possible observer and confirmation bias, lack of independent raters, overreliance on graduate student participants, and failure to specify critical sociodemographic variables (Watkins, 2015b). Our understanding of parallel process, instead, has come from interpret-

ed case material or anecdotes: what Perlman (1996) refers to as our "extensive database . . . of anecdotal material" (p. 491).

It is indeed the case that, down through the decades, we have relied on those very anecdotes for our understanding of what parallel process is, how it works, and how it can be used to good effect. But therein lies the problem, or at least the potential problem, in my view. How reliable are those anecdotal interpretations? Through being vetted by means of peer review and making their way into publication, these anecdotes have been granted professional sanction and licensed as reflective of parallel process. *"Once published, case reports or anecdotes gain a measure of credibility; with the passage of time, their credibility can be further enhanced, becoming eventually lodged in our psyche as 'proof'"* (Watkins, 2017, p. 509). I do wonder about that being the case for parallel process — where case examples and anecdotes have been accepted as "evidence" and passed on from one generation to the next. Just how truly parallel process reflective is our extensive anecdotal database? Could it be that: *"The more we examine the [case anecdote] details ..., the more we realize, not how much it tells us..., but how little it informs us ..."* (Miller & Twomey, 1999, p. 575)

Parallel Process: A Different Perspective Pursued

Much like these above cited critics and criticisms, I too have come to increasingly question and wonder about parallel process as a supervision reality. Whereas I 'accepted' parallel process as a 'given' in my supervisory practice for decades, that has changed in the past 10 years or so. I admittedly have always found parallel process to be a mystery, if not totally confusing, though I have not wanted to say that out loud. My reason for that 'acceptance' and for not admitting my confusion, perhaps comes down to this: if parallel process is indeed supervision's signature phenomenon, most influential conception, and dominant idea, who am I to question any of that? Why am I not getting it? Whereas I found some parallel process examples to be relatively simple and straightforward, others seemed highly convoluted and incomprehensible. Whereas some examples were captured in just a few sentences and a single interaction, others stretched on for pages and involved multiple interactions that transpired over weeks or months. Again, I wondered. How do I make sense of all that? How am I ever going to unravel meaningfully what appears to be the unending strands of interpretive possibility that reside in so many of the parallel process examples?

About 10 years ago, I began reading or re-reading the parallel process literature, so as to begin answering those long-lingering, gnawing yet unanswered questions. I wanted to solve for myself the mystery of parallel process; I wanted to have a more solid basis for my own 'acceptance' of parallel process. Perhaps part of the problem for me was due to my not really having read that much of the original parallel process literature, instead relying on secondary sources for my understanding. So, I decided to look more closely at those original sources, making efforts to start at the very beginning with Searles' (1955) ground-breaking article about the 'reflection process', and then work my way forward, decade by decade, from there. I conducted my own literature searches to find parallel process articles over the past 60 plus years, using search engines such as Google Scholar and PsycINFO; combing through reference sections from those identified articles for any missed parallel process works; and reviewing a host of chapters and books for any other parallel process source material (e.g. the 2015 special section in *Psychiatry*).

If we have an *"extensive database ... of [parallel process] anecdotal material"* (Perlman, 1996,

p. 491), and if it is through those case anecdotes that we have come to know and understand parallel process across these last 60 plus years, then I wanted to understand that anecdotal database much better, and – in so doing – I hoped to better understand parallel process. But, as I perused case anecdote after case anecdote, what began to emerge increasingly for me was this: – the suspicion that parallel process may be far more fiction than reality. Looking at parallel process anecdotes through a 'rival hypotheses and alternate explanations perspective' (Huck & Sandler, 1979), my growing suspicions about the fictional nature of parallel process — detailed in an earlier paper (Watkins, 2017) — turned more so to conviction.

I would now like to follow up and complement that earlier paper here, applying the rival hypothesis/alternate explanation perspective further to a host of new parallel process anecdotes. I now believe that the *"extensive database…of [parallel process] anecdotal material"* (Perlman, 1996) – rather than providing any sort of confirmatory evidence – provides instead extensive opportunities for database debunking. I wish to show how I see that as being so. I believe that it may indeed be the case that parallel process is psychotherapy supervision's equivalent of 'wild' analysis (cf. Freud, 1957/1910; Watkins, 2016a, 2016b).

Since the beginning of my study, I have kept a running record of parallel process contributions, and parallel process anecdotal material, that appeared in journals of psychiatry, psychoanalysis, psychology, social work, and counselling. I have: **(a)** drawn on a host of such publications for this review (1950s, three publications; 1960s, two publications; 1970s, three publications; 1980s, 12 publications; 1990s, 13 publications; 2000s, six publications; 2010s, 14 publications; see References; [a full list is available from the author upon request]; and **(b)** subjected selected examples from each of the six decades of parallel process to a rival hypothesis/alternate explanation viewpoint.

So what follows is a product of my continued study and examination, my efforts to make more sense of the parallel process conundrum. But what follows, it also seems important to caution, is purely a product of my lens being applied. Other concepts and perspectives (e.g., mirror neurons; Palmquist, 2017) may offer a contrary vision or explanation to what I propose here.

Because of the anecdotal nature of the review material, the subsequent presentation does not conform to a standard review: for example, where a research study is critiqued based on methodology, sample size, and assessment measures. Instead, what you will find are some of those very case anecdotes looked at through a critical and questioning lens.

Although you may not agree with my interpretations, I ask you to take a closer look at these parallel process anecdotes and wonder with me about their validity. Do we clearly see a parallel process here? Or do we see something else altogether? Although the selected examples admittedly allow me to easily show the perspectives of my rival hypothesis, I again contend that any parallel process example — provided sufficient description and interpretation are presented — can be readily called into question: therefore, the concept of inter-dyadic transfer in supervision becomes an increasingly difficult proposition to maintain.

Parallel Process Case Examples & Anecdotes: Across the Decades

The Foundational Publications

Let me begin at a most heretical place — giving a focus to those three most defining and enduring seminal parallel process publica-

tions: Searles (1955), Doehrman (1976), and Gediman & Wolkenfeld (1980). Because these particular papers provide the foundation for our 'bottom-up' (Searles, 1955), 'top-down' (Doehrman, 1976), and 'multi-directional' (Gediman & Wolkenfeld, 1980) understanding of parallel process, they are especially important, continue to be *the* recognized 'classics' in the field, and although from 40 to 60 years old, remain frequently referenced sources today (e.g. Bernard & Goodyear, 2014).

Searles (1955). Searles' (1955) case examples reflect a mixture of parallels, some of which, in my view, may not be reflection or parallel process at all. Let us take Example 1, pp. 137-138, as a case in point. Searles (1955) describes his work with a supervisee, who he *"had known and respected for a relatively long time ..." (p.* 137), and who was seeing a patient with a severe obsessive-compulsive disorder. As the case unfolds, Searles perceives parallels between: (a) the supervisee's presentation of his patient in supervision, where the supervisee expects (according to Searles) *adverse supervisory criticism*; and (b) the patient's own presentation of perverse sexual material in therapy, where the patient expects *adverse therapist criticism.* Searles relates that, in the first supervision hour, the supervisee *"looked at me searchingly, as if expecting adverse criticism"* (p. 137) and then connects that to the therapist's own reported experience of having his patient *"look searchingly"* at him.

Complicating this supposed picture of parallel process, however, are Searles' own words about his supervisee from the very outset. He seems to have had a strongly negative reaction to his supervisee's use of role play in treatment:

> *"In the first supervisory hour, I was surprised to hear him describe ... a recent incident in which he had engaged in some conscious role-playing with the patient ... I knew him to be a much more competent therapist than this occurrence would seem to indicate."* (p. 137)

In that same meeting, Searles goes on to say that *"I felt most critical of him [the therapist]"*; and that *"...I was open in expressing my criticism"*. During the second supervisory hour, Searles reported *"feeling a strong sense of condemnation toward the therapist"* and spoke about *"such growing resentment ... [in supervision] serving to hamper, rather than facilitate, the therapy"* (p. 137).

Based on Searles' own statements, the supervisee's expectation of adverse criticism does not seem baseless: Could it be that that expectation was instead solidly grounded in reality, with the supervisee's 'searching look' perhaps being a look of anxiety? The impact that such *"a strong sense of condemnation" w*ould have on the supervisee's behaviour would seem a stark contaminant to any sort of parallel process explanation. Rather than therapy being reflected in supervision, this example may be more a reflection of Searles' own avowedly negative feelings toward his supervisee's treatment behaviour, the highly vulnerable, powerfully disproportionate role in which the supervisee finds himself, and the supervisee's seeming response to that recognition. The example concludes this way:

> *"Following this second supervisory hour, he [therapist/supervisee] no longer manifested such an approach to me in the supervisory hours."* (p. 138)

In reviewing the entirety of these presented reflection (parallel) process examples (Searles, 1955), what we find is this: This particular example is in no way unusual. Other examples similarly raise high various signposts of caution, easily opening up potential issues that call any sort of parallelism into question. For instance, in Example 4, pp. 139-140, Searles — who first mentions being confused by statements made by his supervisee's schizophrenic patient — then follows that by reporting upon

experiencing his own in-supervision fantasy about his supervisee: *"Suddenly, as the therapist was talking, I fantasied his asking me for a declaration of love"* (p. 139). Searles' sudden supervisee fantasy is then followed by his sudden 'hearing' of a similar parallel fantasy in the patient/therapist dyad: *"I was therefore startled a few minutes later to hear him [supervisee] quote the patient as saying something that sounded to me like a disguised expression of romantic love for her therapist"* (p. 139). Again, is this parallel process, a product of the patient's own love feelings/fantasy about the therapist rippling up into the supervisory dyad and provoking Searles to have his own love fantasy about the supervisee (or vice versa)? Or might this have simply been an example of the supervisor's countertransference that, for the sake of self-protection, gets defensively re-interpreted as parallel process?

It is indeed possible that the primary process thought of this highly regressed patient accordingly stimulated primary process thought in the supervisor. But this chain of events — confusion over patient remarks → fantasied declaration of love request from supervisee → perceiving disguised expression of romantic love for therapist — leaves much open to question. I contend that that is much the case across most if not all of Searles' reflection (parallel) process examples. If this (Searles, 1955; cf. Frederickson, 2015; Fritsch, 2015; Kay, 2015; Michels, 2015; Silberman, 2015; Stadter, 2015; Waugaman, 2015; Winer, 2015) be our basis for bottom-up conceptualization, how sound is that basis?

Doehrman, 1976. Let us next take a case from Doehrman's (1976) treatise, again regarded as a watershed moment in parallel process understanding (e.g., Mothersole, 1999). The following material is taken from the Davis/Gorman case (pp. 29-40):

> *"Mrs. Davis [the supervisor] was impressed with Mrs. Gorman [the supervisee] from the start. She found her 'good to work with, non-defensive, and open'... The initial rapport between therapist and supervisor... took a 'dramatic turn for the worse in the third week' of the study when Mrs. Gorman 'pulled a blooper' with a non-research patient, Mr. Cochran. He asked for some coffee before their first hour and she allowed him to get some from the staff coffee room where patients do not generally go. Where she had worked previously patients were free to have coffee before and during therapy hours, but at the Clinic this procedure was an unspoken taboo. What disturbed Mrs. Davis...was that Mrs. Gorman had not mentioned this [letting the patient get coffee] ... she learned about it from another senior staff member. Mrs. Davis was nonplussed and called Mrs. Gorman to task, telling her that already this patient was 'running the show."* (pp. 29-30, italics added)

Mrs. Gorman, the supervisee, was seemingly taken to task for allowing something to happen that she did not even know was unallowable. We see this supervision relationship start off in conflict and continue in conflict for a number of subsequent sessions. The conflict left unaddressed for weeks, the supervisee's ill feelings festered, with the supervisor coming to view the supervisee as 'counter-dependent'. Although parallels can be found between the Davis/Gorman/patient therapy and supervision situations, which extended over a period of months, could it be that what we may most glaringly see in the supervisor-supervisee dyad is unrepaired rupture at the outset and its festering consequences taking hold?

Doehrman (1976) provides a detailed accounting about three other supervision pairings, all of which in my view are quite unusual because of their high degree of seeming dysfunctionality and conflict (Watkins, 2017). For instance, such statements and descriptors as the following are used across those three cases: **(a)** the supervisor "attacked" the supervisee in

the second supervision session (Walters/Farley case; p. 42), "a major disruptive, combative emotional climate developed" (p. 43), and the supervisee came to regard the "supervisory relationship as the worst he had ever experienced" (p. 43); **(b)** the supervisee felt "stupid, incompetent, bumbling, and inarticulate" (Walters/Simpson case; p. 55), because her "intense idealized oedipal transference [to her supervisor became] entangled with a highly critical superego" (p. 55), and she suffered depressive paralysis as a result that went unresolved for 17 weeks; and **(c)** the supervisee experienced a state of "fully justified dependence" (Davis/Johnson case; p. 58) on his supervisor, the supervisor responded with "overprotectiveness" (p. 58), and the supervisee openly rebelled and eventually left the training program. Are these common cases?

As we reflect on the nature of these supervision case anecdotes, how much 'validity' can be placed in any interpretations of parallelism where such highly dysfunctional relationships that extend over weeks and months are the norm? If dysfunctional parallels are observed, what do they really mean? That dysfunction may not be a product of unconscious inter-dyadic transfer at all. Instead, it may simply be a product of dually-enacted relational dysfunction: Dysfunction begets dysfunction, conflict begets conflict. When closely reviewing the details of the four Doehrman (1976) cases, that rival hypothesis, I contend, is far more defensible than an inference of parallelism. If this (Doehrman, 1976) be our basis for top-down conceptualization, how sound is that basis?

Gediman & Wolkenfeld, 1980. And as our last foundational article, let us take a case from Gediman & Wolkenfeld's (1980) still frequently referenced paper (see Bernard & Goodyear, 2014). That example follows (p. 241-242):

> *"An engagingly attractive supervisee so disarmed her supervisor with her fluent and entertaining reports of therapy sessions with a "charming patient" that the bewitching syntax of her reporting style delayed…the supervisor's … detection that the charming patient was highly psychopathic. This account should not be construed as an injunction against introducing charm into the supervisory relationship. It should be noted that once the supervisor pointed out to the supervisee the patient's psychopathy and once he ceased to show obvious delight at the supervisee's entertaining style of reportage, much in the therapeutic and supervisory alliance was risked. The supervisee became more anxious and less engaging, the therapy moved well, although with new struggles…in the supervisor-supervisee interaction. The "smooth stalemate" was resolved, and the work proceeded."*

The 'charm' of supervisee and patient is considered to be a paralleling problem, a ruse of sorts, in both the treatment and supervisory situations. Although it is stated that this "account should not be construed as an injunction against introducing charm into the supervisory relationship" (Gediman & Wolkenfeld, 1980, p. 242), charm does not fare favourably in this example. The supervisee's charm identified as a culprit, the supervisor seemingly radically shifted his supervisory style (or at least some aspects of it), ceasing *"to show obvious delight at the supervisee's entertaining style of reportage"* (p. 242), with much being risked in the supervisory alliance, and the supervisee becoming more anxious and less engaging as a result (which is viewed as progress?). What exactly did the supervisee do wrong? And what exactly was the parallel process here?

Could it be that the supervisor was quite bothered by not earlier detecting this patient's quite severe psychopathy and, instead of recognizing and admitting to such an understandable misstep, blamed the 'charming' supervisee and acted accordingly in supervision? *"The 'smooth stalemate' was resolved, and the*

work proceeded" (p. 242). Or might the supervisor have been so engaged by (attracted to?) this supervisee, seen as 'engagingly attractive' and 'bewitching', that he temporarily lost relational objectivity and, upon eventually recognizing that reality, placed the fault upon the 'charming' supervisee? Those questions, in my view, propose far more plausible alternatives than the purported 'smooth' and 'charm' parallelism explanation that is provided.

Gediman and Wolkenfeld (1980) present three other case examples, all of which are quite open to question once closely examined, that involve the following: **(a)** a supervision going too well due to both patient and supervisee being gifted, able to enter into an effective alliance, demonstrating optimal capacity for self-exploration, and having good reflective awareness; **(b)** a patient producing minimal content in treatment, the beginning supervisee consequently having little beyond that 'minimal content' to present in supervision about the patient, and both patient and supervisee then being judged by the supervisor as resistively withholding (parallelism); and **(c)** a supervisee discussing with two different supervisors the very same case (an adolescent concerned about loyalty conflicts toward her estranged parents) and having her own concerns about hurting the feelings of one of her supervisors, a compromising supervisory situation *"which she partially brought about"* (Gediman & Wolkenfeld, 1980, p. 244). Let us again ask how much 'validity' can be placed in these interpretations of parallelism? How is it that being gifted, being able to form an effective alliance, and displaying high reflectivity become reasons to believe that something is wrong? Is it resistive of a beginning supervisee to note that his patient produced little in session and to say the same in supervision? Where any individual is caught between two people in any affectively charged situation where a power differential is clearly in play, might that situation easily lend itself to concerns about potentially provoking relational tension or discord? Where each case is examined through a rival hypothesis/alternative explanation lens, none strongly stands, I contend, as an unimpeachable example of parallel process. If this (Gediman & Wolkenfeld, 1980) be our basis for multidirectional conceptualization, how sound is that basis?

In summary: If this be our foundation... I contend that, if these seminal, foundational publications are re-examined with a rival hypothesis/alternative explanation perspective in mind, that very foundation crumbles before our eyes. Stated most strongly, if these anecdotal case examples are the raison d'être for parallel process, then there is no raison d'être for parallel process. Stated more conservatively, if these anecdotal case examples provide 'evidence' of parallel process, then the strength of that evidence is surely open to question. Because these seminal publications have set the stage for our parallel process understanding, and have continued to shape all that has since followed (e.g., *Psychiatry* 2015 special section), their enduring influence should not be underestimated: the reach and scope of that influence merits serious re-consideration in my view.

I see these as being reasons for concern: **(a)** these case examples (or at least some of them) may well reflect a "tail wagging the dog" effect, where efforts are made to 'prove a concept' rather than critically and dispassionately reviewing the data at hand; **(b)** those 'prove a concept' efforts consequently result in what may be more data force fitting than otherwise (where the interpreter begins with parallel process as a given and works backward from there); and **(c)** such data force fitting can lead to compromises in the facilitation of supervisee development and patient care (because the situation under review is not clearly seen for what it is). To marshal support for

my argument, we need only look as far as the 18 case examples provided in Searles (1955), Doehrman (1976), and Gediman & Wolkenfeld (1980). Those examples, I maintain, **(a)** provide an abundance of reasons to wonder about the tail wagging the dog, proving a concept, and data force fits and **(b)** give us all the more reason to seriously question, even indubitably doubt, the very foundation upon which parallel process is based. What may be most in evidence across examples, as opposed to any sort of parallel process, are consequences of relationship ruptures that oftentimes go unrepaired, poor supervision, supervisee and/or supervisor dysfunction, or supervisor countertransference that masquerades as supervisee-mediated parallel process (what I have elsewhere referred to as an iatrogenic pseudo-parallel process event, where supervisors induce a relationship problem that they then interpret as an enacted therapist/patient parallelism bubbling up into the supervision relationship; Watkins, 2017).

Other Parallel Process Publications

These issues of tail wagging the dog, concept proving, and force fitting, however, do not stop with the seminal papers of Searles (1955), Doehrman (1976), and Gediman & Wolkenfeld (1980): They have continued to rear their heads in a host of other parallel process publications down through the decades. I have selected four examples, drawn from psychoanalytic, social work, and psychology publications, to illustrate my contention.

Pedder (1986). Pedder (1986), invoking the seminal contributions of Michael Balint (e.g. Balint, 1957), provides three examples of parallel process, one being the following:

> *"A female supervisor presented the problem of supervising a male therapist who had chosen to present a male patient with premature ejaculation. The problem the female supervisor was experiencing was that the therapist all the time insisted on being in control of the situation, making all his own decisions about therapy, including arranging to see the wife of his patient without even consulting the supervisor to see if that was appropriate. We felt in the seminar that the therapist was repeating his patient's problem of rushing to conclusions, i.e. premature ejaculation, and not letting his female supervisor get any satisfaction from a proper exchange and relationship with him."* (p. 9)

That there are issues of control at play with this supervisee seems clear. But can we conclude that those control issues are a product of the supervisee being *overcome* by his patient's premature ejaculation so much so that he then enacts it in supervision, thus depriving his supervisor of her supervisory satisfaction? Any such parallel process interpretation again seems like a vast overreach, a force fit. Could it be that this supervisee is instead highly threatened by his lack of therapy knowledge and experience, feels painfully insecure about that perceived lack in both treatment and supervision, and compensates (mal-adaptively so) by taking charge and striving to appear competent? Might this male supervisee be threatened by/have problems receiving supervision from a female supervisor? That there is a supervision problem here that requires redress is evident, but that that problem is a parallel process manifestation is not evident. Does not a rival hypothesis offer a more reasoned and reasonable explanation?

Williams, 1997. Williams (1997) provides two parallel process examples. Her **patient / therapist → supervisee / supervisor** example follows:

> *"Scott, the supervisee, said…his client, Millie…keeps complaining about her job and how hopeless she feels about changing it.… The supervisor asked Scott what he was feeling while he was with Millie, and Scott replied he was feeling more and more helpless and irritated.*

> *The supervisor then suggested perhaps they are playing out something transferentially … She had hardly spoken these words, when Scott abruptly agreed and replied he had already considered the possibility of transference.… At this moment, the supervisor's tone of voice took on an impatient quality as she asked Scott to "tell her exactly" what went on during the last session. In reaction to this impatient tone, Scott fidgeted and attempted to explain.… The supervisor's tone grew more 'official',… Scott became passive [and eventually] … the communication got so blocked… both Scott and the supervisor withdrew from the task of exploration."* (pp. 432-433)

As Williams (1997) indicated, there was a parallel of helplessness and irritation across the therapy/supervision dyads, with both the therapist and supervisor responding in kind. Did, as is seemingly purported, the dynamics of the therapy dyad indeed ripple up into the supervisory dyad, induce identical affects and effects there, and spell eventual doom for the supervisor-supervisee relationship? Perhaps what happened here had nothing to do with parallel process at all. Could it instead be that: **(a)** the supervisee became defensive about the supervisor's transference remark ("She had hardly spoken these words, when Scott abruptly agreed and replied he had already considered the possibility of transference, but nothing had changed as a result."); and **(b)** the supervisor, bothered by Scott's abruptness and dismissal of her transference comment, responded with an impatient, demanding tone and 'official' behaviour? Williams (1997) goes on to say that "*If the supervisor is knowledgeable of parallel process, she will consider the possibility that her own growing feelings of helplessness and irritation are exactly what Scott felt with his client*" (p. 433). What might have been even more helpful would be supervisor sensitivity to the *current interpersonal process* taking place between herself and her supervisee and responding accordingly.

Morrisey & Tribe (2001). Morrisey & Tribe's (2001) case example follows:

> *"Louise [a trainee] … was working with Mark a 40-year-old successful lawyer. Listening to a tape of Louise's session with Mark, her supervisor … commented to Louise that her voice sounded 'hesitant' with Mark. A week later, Louise's supervisor pointed out that she was discussing Mark in supervision in the same 'hesitant' manner … Initially, Louise appeared uncomfortable with her supervisor's challenge but … concluded that her hesitancy in supervision was motivated by her fear of 'saying something wrong' and being perceived as 'incompetent' … Louise's supervisor suggested that … she also feared being perceived as incompetent in her work with Mark … The ensuing discussion revealed that Louise perceived herself as 'academically threatened' because of Mark's professional status and prior experience of therapy."* (p. 109)

Much of what we observe here could actually be developmentally normative supervisee behavior (cf. Rønnestad *et al.*, 2019; Rønnestad & Skovholt, 2013) — where the supervisee experiences self-doubts, questions her ability, and wonders if she is up to the task, all of which can be magnified by having an established, successful professional as a client. I have found that nothing quite ratchets up a beginning trainee's feelings of anxiety and incompetence more so than being paired with an older, established client, and that dynamic appears to have been operative in this situation (with the client being a successful lawyer). That this trainee may experience painful self-doubt and be 'hesitant' in both the treatment and supervision situations seems understandable, but a parallel across processes does not necessarily make for parallel process (unconscious inter-dyadic transfer).

Mendelsohn (2012). Mendelsohn (2012) pro-

vides three case examples, all of which accentuate the proposed power of projective identification in parallel processes. One of those examples follows:

> *"In my supervisory work with therapist Sara, I found myself frequently lecturing and moralizing. This therapist / presenter is … a creative, highly capable individual. Therefore, I began to ask myself why I was having powerfully negative reactions to her work … It became clear that the patient was struggling with…issues regarding a seductive and undermining mother. Sara, as her therapist, was characterologically vulnerable to the pull of these enactments, as she tends to triangulate her relationships … Like an adolescent who forms intense but stereotypical and repetitive relationships, Sara tends to become intensely involved, often in an exclusionary way, with her patients. Thus, the patient and Sara began to represent an oedipal couple to me. These dynamics combined with my own (historical) struggles with feeling the unwanted third-man out. Understood this way, it makes perfect sense why, in supervising this case, I became jealous of the therapist and patient's relationship."* (p. 305)

This does not make perfect sense to me. Many leaps of faith are made in this interpretation in my view, and even if we accept all those leaps as being reality, I again ask: Where is the parallel process? How does having a pre-interpretation, diagnostic view of Sarah as being 'characterologically triangulating' then influence the parallel process interpretation that results? If we read this example closely, although mention is made of this supervisee's characterological vulnerability, tendency to triangulate relationships, hysterical style, and intense, exclusionary involvement with her patients, the jealous, third-man-out feelings of the supervisor could just as easily reflect the evocation of his issues alone — stirred up by the treatment/supervision situations but not necessarily involving any parallel process at all (i.e., did anything really travel up or down the line?). Perhaps this is purely and simply a case of supervisor countertransference recognized, analysed, and managed — and nothing more. Might that instead be a more plausible scenario?

In Summary: Building on a Questionable Foundation?

If our parallel process foundation can be doubted, called into question, even crumbles before our eyes when scrutinized (as I contend), what happens when we subsequently build our edifice, our so-called signature phenomenon, upon that very foundation? We get more of the same, as these case anecdotes show — more questionable supervisor interpretations that then form the basis for questionable supervisor actions. Again, the "tail wagging the dog", efforts to 'prove a concept', and data force fitting all appear to be in play. A conceptualization built upon a shaky foundation increasingly makes for problematic process and outcome. As Mothersole (1999) has indicated, it all comes down to this question: *"So what does thinking in this [parallel process] way do to help the client move forward and/or the supervisee to develop?"* (p. 118). Based on my examination of the parallel process literature, I see no evidence that thinking in this way has any supervision benefit for anyone.

What Does It All Mean? Practical Implications and Complications

My simple practical recommendations from this examination are these: **(a)** be forever wary of inter-dyadic, unconscious parallel process explanations and examples, never accept them as a given; and, instead; **(b)** always take a questioning stance with regard to any such

explanations and subject any corresponding anecdotes to a vigorous questioning. Those practice recommendations are based on these two most fundamental, highly concerning foundational conclusions: **(a)** our parallel process foundation may not even be any sort of foundation at all; and **(b)** all that has since developed from that very foundation may well be fruit of the poisoned tree. Could our decades of parallel process guided supervision practice be decades of misguided supervision practice? Again, I realize that readers may take issue with my conclusions, but I believe that this counter perspective at least merits consideration. By no means a panacea, a rival hypothesis/alternate explanation perspective begins in parsimony, asking, *"What is the simplest, most straightforward explanation that could be proposed about this situation*?"; *"What else might be going on?"* It provides a simple critical, check and balance thought process that can be applied to critique of parallel process phenomena. I strongly recommend its use for that purpose.

As many of these anecdotal examples have also shown, parallel process can indeed be used as *"an umbrella that shades many sins"* (Power, 2014, p. 161), conceivably providing conceptual cover for supervisor mistakes and relational fractures, even potentially harmful actions and abuses. We know from data collected over the past approximate decade that all too many supervisees are harmed by supervisor behaviour (Ellis, 2017; Ellis, *et al.*, 2014; Ellis, Creaner, Hutman & Timulak, 2015). Perhaps the umbrella of parallel process has been an easily applied shade for far too long. And that needs to change. A particularly troubling example of such 'supervisory shade' is where supervisors seemingly instigate the very conflict that they then interpret as a bottom-up (Patient→Therapist→Supervisor) parallel process manifestation (e.g., refer back to examples from Searles [1955], Gediman & Wolkenfeld [1980] & Williams [1997]) (Watkins, 2017). In that regard, may we as supervisors beware and be forever aware. To whatever extent parallel process remains supervision's dominant idea, most influential conception, and signature phenomenon, I suggest its demotion. We may be far better served in always first asking: "What might have recently or just now occurred in my current relationship with my supervisee that has led to the behaviour of concern?" (e.g., sudden changes in the supervisory relationship).

Conclusion

My hope is that these ideas, admittedly a counter perspective, will be useful in more critically thinking about parallel process and its anecdotal database. That "extensive database…of anecdotal material" (Perlman, 1996, p. 491), when viewed through a rival hypothesis/alternate explanation lens, may not so extensive after all: The mystery of parallel process may not be so mysterious, its 'spookiness' (Heuer, 2009, 2014) not so spooky, its 'other-worldliness' (Leader, 2015) quite worldly and oh so ordinary. Some of the most common signs of parallel process — atypical supervisee behaviour, sudden changes or distortions in the supervisory relationship, and inexplicable impasses (Deering, 1994) — may purely and simply be a product of the current supervisory relationship gone wrong. Case anecdotes of inter-dyadic, unconscious parallel process, I contend, have led us down a crooked path of false logic that **(a)** often appears to be more about 'concept proving' than otherwise, **(b)** increasingly opens the door for and makes more likely interpretive supervisory misuse, even abuse, and **(c)** gives license to look elsewhere for supervisor-induced supervisory relational problems. If this be parallel process, then maybe there should be no parallel process at all.

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References

ARLOW, J. A. (1963). The Supervisory Situation. *Journal of the American Psychoanalytic Association*, Vol. 11, pp. 576-594.

ARNAUD, K. O. S. (2017). Encountering the Wounded Healer: Parallel Process and Supervision. *Canadian Journal of Counselling & Psychotherapy [Revue Canadienne de Counseling et de Psychothérapie]*, Vol. 51, pp. 131-144.

BALINT, M. (1957). *The Doctor, His Patient and the Illness.* London: Pitman Medical.

BAUDRY, F. D. (1993). The Personal Dimension and Management of Tthe Supervisory Situation with a Special Note on the Parallel Process. *The Psychoanalytic Quarterly*, Vol. 62, pp. 588-614.

BERNARD, J. M. & GOODYEAR, R. K. (2014). *Fundamentals of Clinical Supervision* (5th ed.). Upper Saddle River, NJ: Pearson.

BERNARD, J. M. & GOODYEAR, R. K. (2019). *Fundamentals of Clinical Supervision* (6th ed.). Upper Saddle River, NJ: Pearson.

BINDER, J. L. & STRUPP H. H. (1997). Supervision of Psychodynamic Therapies. In: C. E. WATKINS, JR. (Ed.), *Handbook of Psychotherapy Supervision*, (pp. 44-62). New York: Wiley.

CALIGOR, L. (1981). Parallel and Reciprocal Processes in Psychoanalytic Supervision. *Contemporary Psychoanalysis*, Vol. 17, pp. 1-27.

DEERING, C. G. (1994). Parallel Process in the Supervision of Child Psychotherapy. *American Journal of Psychotherapy*, Vol. 48, pp. 102-110.

DIXON, J. (2017). The Supervisory Relationship. In: N. Pelling & P. Armstrong (Eds.), *The Practice of Counselling and Clinical Supervision* (2nd ed.), (pp. 223-235). Samford Valley, Australia: Australian Academic Press.

DOEHRMAN, M. (1976). Parallel Processes in Supervision and Psychotherapy. *Bulletin of the Menninger Clinic*, Vol. 40, pp. 3-104.

EAGLE, G. & LONG, C. (2014). Supervision of Psychoanalytic/Psychodynamic Psychotherapy. In: C. E. Watkins, Jr. & D. L. Milne (Eds.), *Wiley International Handbook of Clinical Supervision,* (pp. 471-492). Oxford, United Kingdom: Wiley.

EHRLICH, L. T., KULISH, N. M., FITZPATRICK HANLY, M. A., ROBINSON, M. & ROTHSTEIN, A. (2017). Supervisory Counter-Transferences and Impingements in Evaluating Readiness for Graduation: Always Present, Routinely Under-Recognized. *International Journal of Psychoanalysis*, Vol. 98, pp. 491-516.

EKSTEIN, R. & WALLERSTEIN, R. S. (1958). *The Teaching and Learning of Psychotherapy*. New York: Basic Books.

ELLIS, M. V. (2017). Narratives of Harmful Clinical Supervision. *The Clinical Supervisor*, Vol. 36, pp. 20-87.

ELLIS, M. V., BERGER, L., HANUS, A. E., SWORDS, B. A. & SIEMBOR, M. (2014). Inadequate and Harmful Clinical Supervision: Testing a Revised Framework and Assessing Occurrence. *The Counselling Psychologist*, Vol. 42, pp. 434-472.

ELLIS, M. V., CREANER, M., HUTMAN, H. & TIMULAK, L. (2015). A Comparative Study of Clinical Supervision in the Republic of Ireland and the United States. *Journal of Counseling Psychology*, Vol. 62, pp. 621-631.

ELLIS, S. (2017). Apprehending the Translucent in the Art of Supervision. *British Journal of Psychotherapy*, Vol. 33, pp. 297-311.

FRAWLEY-O'DEA, M. G. & SARNAT, J. E. (2001). *The Supervisory Relationship: A Contemporary Psychodynamic Approach.* New York, NY: Guilford Press.

FREDERICKSON, J. (2015). Countertransference in Supervision. *Psychiatry*, Vol. 78, pp. 217-224.

FREUD, S. (1957). 'Wild' Psycho-Analysis. In: J. STRACHEY (Ed. and Trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 11, pp. 219-228). London: Hogarth Press. (Original work published 1910)

FREUD, S. (1958). Remembering, Repeating and Working-Through (Further Recommendations in the Technique of Psycho-Analysis II). In: J. STRACHEY (Ed. & Trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud: The Case of Schreber, Papers on Technique and Other Works* (Vol., 12, pp. 145-156). London, United Kingdom: Hogarth Press. (Original work published 1914.)

FRITSCH, R. C. (2015). Subjectivity, Sensitivity, and the Supervision Process. *Psychiatry*, Vol. 78, pp. 212-216.

GEDIMAN, H. K. (2001). The Supervisory Process: Triadic System and Beyond. *Journal of the American Psychoanalytic Association*, Vol. 49, pp. 733-737.

GEDIMAN, H. K. & WOLKENFELD, F. (1980). The Parallelism Phenomenon in Psychoanalysis and Supervision: Its Reconsideration as a Triadic System. *The Psychoanalytic Quarterly*, Vol. 49, pp. 234-255.

GOK, A. C. (2015). Psikoterapi süpervizyonunda paralel süreç: Bir vaka calışması [Parallel Process in Psychotherapy Supervision: A Case Study]. *AYNA Klinik Psikoloji Dergisi*, Vol. 2(2), pp. 39-50.

GORDAN, K. (1996). *Psychotherapy Supervision in Education, Clinical Practice, and Institutions.* Northvale, NJ: Aronson.

GREY, A. G. & FISCALINI, J. (1987). Parallel Process as Transference-Countertransference Interaction. *Psychoanalytic Psychology*, Vol. 4, pp. 131-144.

GUIFFRIDA, D. (2015). A Constructive Approach to Counseling and Psychotherapy Supervision. *Journal of Constructivist Psychology*, Vol. 28, pp. 40-52.

GUNDLE, S. (2015). Parallel Process as a Learning Tool in Clinical Supervision within a Traumatized Community: Case Examples from the Burma Border. In: K. ALLDEN & N. MURAKAMI (Eds.), *Trauma and Recovery on War's Border: A Guide for Global Health Workers* (pp. 242- 260). Hanover, NH: Dartmouth College Press.

HELMSTADTER, G. M. (1970). *Research Concepts in Human Behavior: Education, Psychology, Sociology*. Englewood Cliffs, NJ: Prentice-Hall.

HEUER, G. (2009). 'Spooky Actions at a Distance': Parallel Processes in Jungian Analysis and Supervision. In: D. Mathers (Ed.), *Vision and Supervision: Jungian and Post-Jungian Perspectives*, (pp. 164-182). London, United Kingdom: Routledge.

HEUER, G. M. (2014). Spooky Actions at a Distance: Parallel Processes in Analysis/Therapy and Supervision. *Supervision Review: The Journal of the British Association for Psychoanalytic & Psychodynamic Supervision*, Vol. 12, pp. 2-19.

HOLLOWAY, E. L. (2016). *Supervision Essentials for a Systems Approach to Supervision*. Washington, DC: American Psychological Association.

HORA, T. (1957). Contribution to the Phenomenology of the Supervisory *Process. American Journal of Psychotherapy*, Vol. 11, pp. 769-773.

HUCK, S. W. & SANDLER, H. M. (1979). *Rival Hypotheses: Alternative Interpretations of Data Based Conclusions*. New York, NY: Harper & Row.

ISSACHAROFF, A. (1984). Countertransference in Supervision: Therapeutic Consequences for the Supervisee. In: L. Caligor, P. M. Bromberg & J. D. Meltzer (Eds.), *Clinical Perspectives on the Supervision of Psychoanalysis and Psychotherapy* (pp. 89-105). New York, NY: Plenum.

JACOBSEN, C. H. (2007). A Qualitative Single Case Study of Parallel Process. *Counselling and Psychotherapy Research*, Vol. 7, pp. 26-33.

KAY, J. (2015). Without Parallel in Human Relations: The Mirror between Treatment and Supervision. *Psychiatry*, Vol. 78, pp. 231-235.

LADANY, N., FRIEDLANDER, M. L. & NELSON, M. L. (2016). *Supervision Essentials for the Critical Events in Psychotherapy Supervision Model*. Washington, DC: American Psychological Association.

LEADER, C. (2015). Supervising the Uncanny: The Play within the Play. *Journal of Analytical Psychology*, Vol. 60, pp. 657-678.

LESSER, R. (1984). Supervision: Illusions, Anxieties, and Questions. In: L. Caligor, P. M. Bromberg & J. D. Meltzer (Eds.), *Clinical Perspectives on the Supervision of Psychoanalysis and Psychotherapy*, (pp. 143-152). New York, NY: Plenum.

MAYMAN, M. (1976). Foreword. *Bulletin of the Menninger Clinic*, Vol. 40, pp. 3-8.

MAZZATTI, M. (2013). Being There: Plunging into Relationship in Transactional Analysis Supervision (on receiving the Eric Berne memorial award). *Transactional Analysis Journal*, Vol. 43, pp. 95-102.

MCCUE, R. B. & LANE, R. C. (1995). Parallel Process and Perspective: Understanding, Detecting, and Intervening. *Psychotherapy in Private Practice*, Vol. 14(3), pp. 13-32.

MCKINNEY, M. (2000). Relational Perspectives and the Supervisory Triad. *Psychoanalytic Psychology*, Vol. 17, pp. 565-584.

MENDELSOHN, R. (2012). Parallel Process and Projective Identification in Psychoanalytic Supervision. *The Psychoanalytic Review*, Vol. 99, pp. 297-314.

MICHELS, R. (2015). Supervisors' Countertransference Revisited. *Psychiatry*, Vol. 78, pp. 242-244.

MIEHLS, D. (2010). Contemporary Trends in Supervision Theory: A Shift from Parallel Process to Relational and Trauma Theory. *Clinical Social Work Journal*, Vol. 38, pp. 370-378.

MILLER, L. & TWOMEY, J. E. (1999). A Parallel without a Process: A Relational View of a Supervisory Experience. *Contemporary Psychoanalysis*, Vol. 35, pp. 557-580.

MORRISSEY, J. & TRIBE, R. (2001). Parallel Process in Supervision. *Counselling Psychology Quarterly*, Vol. 14, pp. 103-110.

MOTHERSOLE, G. (1999). Parallel Process: A Review. *The Clinical Supervisor*, Vol. 18, pp. 107-122.

NORCROSS, J. C. & POPPLE, L. M. (2017). *Supervision Essentials for Integrative Psychotherapy.* Washington, DC: American Psychological Association.

PALMQUIST, D. A. (2017). Mirror, Mirror on the Wall: Please Tell Me, Do I Feel at All. *International Journal of Psychotherapy*, Vol. 21(1), pp. 5-20.

PEDDER, J. (1986). Reflections on the Theory and Practice of Supervision. *Psychoanalytic Psychotherapy*, Vol. 2, pp. 1-12.

PERLMAN, S. D. (1996). The Implications of Transference and Parallel Process for the Frame of Supervision: A Historical Perspective. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, Vol. 24, pp. 485-497.

POPESCU, O. M. (2012). The Utilization Principle and Parallel Processes in Supervision. A Case Study. *Journal of Integrative Research, Counselling and Psychotherapy*, Vol. 1, pp. 24-35.

PICKVANCE, D. (2017). CAT Supervision: A Relational Model. In: D. Pickvance (Ed.), *Cognitive Analytic Supervision,* (pp. 3-18). New York: Routledge.

POWER, A. (2014). Impasse in Supervision – Looking Back and Thinking Again. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, Vol. 8, pp. 154-171.

RAICHELSON, S. H., HERRON, W. G., PRIMEVERA, L. H. & RAMIREZ, S. M. (1997). Incidence and Effects of Parallel Process in Psychotherapy Supervision. *The Clinical Supervisor*, Vol. 15(2), pp. 37-48.

RONNESTAD, M. H., ORLINSKY D. E., SCHRODER, T. A., SKOVHOLT, T. M. & WILLUTZKI, U. (2019). The Professional Development of Counsellors and Psychotherapists: Implications of Empirical Studies for Supervision, Training and Practice. *Counselling and Psychotherapy Research*, Vol. 19, pp. 214-230.

RONNESTAD, M. H. & SKOVHOLT, T. M. (2013). *The Developing Practitioner: Growth and Stagnation of Therapists and Counselors*. New York, NY: Routledge.

ROSBROW, T. (1997). From Parallel Process to Developmental Process: A Developmental/Plan For-

mulation Approach to Supervision. In: M. H. ROCK (Ed.), *Psychodynamic Supervision* (pp. 213–238). Northvale, NJ: Aronson.

SARNAT, J. E. (2016). *Supervision Essentials for Psychodynamic Psychotherapies*. Washington, DC: American Psychological Association.

SARNAT, J. E. (2019). What's New in Parallel Process? The Evolution of Supervision's Signature Phenomenon. *American Journal of Psychoanalysis*, Vol. 79, pp. 304-328.

SCHIMEL, J. L. (1984). In Pursuit of the Truth: An Essay on an Epistemological Approach to Psychoanalytic Supervision. In: L. CALIGOR, P. BROMBERG, & J. METZLER (Eds.), *Clinical Perspectives on the Supervision of Psychoanalysis and Psychotherapy* (pp. 231–241). New York, NY: Plenum.

SEARLES, H. F. (1955). The Informational Value of Supervisor's Emotional Experience. *Psychiatry*, Vol. 18, pp. 135-146.

SEARLES, H. F. (1962). Problems of Psychoanalytic Supervision. In: J. H. MASSERMAN (Ed.), *Psychoanalytic Education* (pp. 197-215). New York, NY: Grune & Stratton.

SILBERMAN, E. K. (2015). Parallel Process and the Evolving View of the Therapeutic Situation. *Psychiatry*, Vol. 78, pp. 239-241.

SCHMOLKE, M. & HOFFMANN, N. (2014). Mirror Processes in the Protected Space of Psychoanalytic Supervision. *Archives of Psychiatry and Psychotherapy*, Vol. 3, pp. 59-63.

STADTER, M. (2015). Through a Mirror Experientially: Self-Reflection and the Reflection Process. *Psychiatry*, Vol. 78, pp. 236-238.

STIMMEL, B. (1995). Resistance to Awareness of the Supervisor's Transferences with Special Reference to the Parallel Process. *International Journal of Psychoanalysis*, Vol. 76, pp. 609-618.

THORBECK, J. (1992). The Development of the Psychodynamic Psychotherapist in Supervision. *Academic Psychiatry*, Vol. 16, pp. 72-82.

TRACEY, T. J. G., BLUDWORTH, J. & GLIDDEN-TRACEY, C. E. (2012). Are There Parallel Processes in Psychotherapy Supervision? An Empirical Examination. *Psychotherapy*, Vol. 49, pp. 330-343.

WATKINS, C. E., JR. (2012). Some Thoughts about Parallel Process and Psychotherapy Supervision: When Is a Parallel just a Parallel? *Psychotherapy*, Vol. 49, pp. 344-346.

WATKINS, C. E., JR. (2015a). Extrapolating Gelso's Tripartite Model of the Psychotherapy Relationship to the Psychotherapy Supervision Relationship: A Potential Common Factors Perspective. *Journal of Psychotherapy Integration*, Vol. 25, pp. 143-157.

WATKINS, C. E., JR. (2015b). Toward a Research-Informed, Evidence-Based Psychoanalytic Supervision. *Psychoanalytic Psychotherapy*, Vol. 29, pp. 5-19.

WATKINS, C. E., JR. (2016a). *Parallel Process as a Fascinating Supervision Fiction: On Spooky, Uncanny, and Otherworldly Action Reconsidered.* Presentation given at the International Interdisciplinary Conference on Clinical Supervision, Garden City, New York.

WATKINS, C. E., JR. (2016b). Patient-izing, Force Fits, and Wild Analysis in Parallel Process. Paper presented as part of Zetzer, H. (Chair), *The Enigma of Parallel Process: Unraveling Supervision's "Signature Phenomenon"*, at the annual meeting of the American Psychological Association, Denver, CO.

WATKINS, C. E., JR. (2017). Reconsidering Parallel Process in Psychotherapy Supervision: On Parsimo-

ny, Rival Hypotheses, and Alternate Explanations. *Psychoanalytic Psychology*, Vol. 34, pp. 506-515.

WAUGAMAN, R. M. (2015). Searles' Discovery of the Parallel Process in Supervision. *Psychiatry*, Vol. 78, pp. 225-230.

WILLIAMS, A. B. (1997). On Parallel Process in Social Work Supervision. *Clinical Social Work Journal*, Vol. 25, pp. 425-435.

WINER, R. (2015). My Searles. *Psychiatry*, Vol. 78, pp. 245-250.

WOLKENFELD, F. (1990). The Parallel Process Phenomenon Revisited: Some Additional Thoughts about the Supervisory Process. In: R. C. LANE (Ed.), *Psychoanalytic Approaches to Supervision,* (pp. 95-109). New York, NY: Brunner/Mazel.

YONTEF, G. (1997). Supervision from a Gestalt Therapy Perspective. In: C. E. WATKINS, JR. (Ed.), *Handbook of Psychotherapy Supervision,* (pp. 147-163). New York, NY: Wiley.

ZETZER, H. A., HILL, C. E., HOPSICKER, R. J., KRASNO, A. M., MONTOJO, P. C., PLUMB, E. I. W., ... & DONAHUE, M. T. (2020). Parallel Process in Psychodynamic Supervision: The Supervisor's Perspective. *Psychotherapy*. (advance online publication).

Initiating Practice-Related Research

Report on an EAP Conference, 23-Feb. 2020, Sigmund Freud Private University, Vienna

After the usual EAP Meetings in Vienna, the EAP's Science and Research Committee (SARC) organized a 1-day conference on the topic of "Initiating Practice-Related Research". As the title indicates, the aim was to initiate new Research projects with a design that fits in with psychotherapy practice. SARC invited two keynote speakers.

Mattias Desmet is professor at the Ghent University in Belgium. He made a plea (also published recently in *Psychotherapy Research*, the Society for Psychotherapy Research (SPR) journal[1]) for another, alternative research-design in psychotherapy. He criticized the predominance of RCT designs in psychotherapy research and the low meaning of single-case studies in the world of research. Therefore, he has built up a single-case study archive, where all relevant journals published single case studies are listed.[2] Currently, there are about 3100 studies. The more studies that become listed, the better they can become a statistical basis for empirical studies in the sense of a 'Single-Case Experimental Design'.

Gunther Schiepek (German & Austria) from the Paracelsus Medical University, Salzburg, is interested in Synergetics and (non-linear) Dynamic Systems in Psychology, Management and Neuroscience. He has specialized in Process-Outcome-Studies in Psychotherapy, including daily routine factors. He also criticized the predominance of RCT-designs and favours computer-supported single-case studies. He has developed an 'app' with which patients can report daily on how they are feeling today. With this, he can discover the dynamics of change process that are much more differentiated than when a study just measures symptoms at a larger time-interval. This can generate completely different results of process and outcome.[3] He demonstrated this very convincingly with some examples of single-case processes.

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After the two presentations, there were discussions in smaller groups, in order to generate questions for the presenters. In the second phase, there was an engaged and vivid discussion with the presenters and the audience, moderated by the Chair of SARC. The conference was very inspiring and seemed to encourage all the 60 participants present – from various countries and modalities – to engage more in practice-related research.

The organizers received back – after the conference, but also subsequently – a lot of positive feedback, not only from the participants, but also from the two presenters. People were impressed by the quality of the presentations and the discussion, as well by the outcome of this 1-day conference, and hope to get along soon with the next steps.

There are 4 outcomes that are arising from this conference:

- **A Project Group** (including the two presenters, members of the SARC Board and some participants) will draft a paper to give a basic understanding of practice-related psychotherapy research, that will be shared with the members of this conference. The draft will go to the participants for their feedback. After this, a revised draft will go as a proposal for a scientific position paper of EAP, for voting by the General Board at its next meeting. This scientific position paper will also be published in the *International Journal of Psychotherapy*.
- **A Working Group:** In order to make it possible for more single-case studies – that have been published in other than leading journals – to be included in the database of the Single-Case Archive, some criteria will need to be established, as a minimal 'quality standard', which are also flexible enough to be accepted by the many different psychotherapeutic modalities. A working group will be established to develop a draft of such criteria. This draft will also be sent out to all the conference participants for feedback. The aim will be: (a) to facilitate publishing single-case studies in different journals; but also (b) to install a kind of peer-review process to include these sorts of articles into the archive.
- **Training:** The EAP's SARC will organize – with Gunter Schiepek – a workshop / seminar / course (with two or three parts) to introduce and train therapists in the use of the Time Series, based on the methodology that he has developed. By using this Time Series analysis, any psychotherapists from any country or modality can join in on the ongoing research project of his centre, and get evaluations of process and outcome, based on the data from all the single case-studies included in the data-base.
- **Co-operation:** The two researchers are willing to cooperate with those interested in EAP to build up a new multi-modal and trans-national study for single-cases using the Single Case Experimental Design. Together, we will have to look for funding, which is often easier to get if universities are involved.

The two presentations are available (as pdf files) on the website of the EAP (www.europsyche.org) in the Research section. We have also prepared – in agreement with the presenters – a video / audio recording of the presentations, which can be listened to on YouTube.[4]

You are welcome to browse all the Single Case Studies that are hosted in the Single Case Archive (singlecasearchive.com) – and you can also register and add to it.

More about the Time Series will be presented in end of July 27-29, 2020 to the Human Change Summer School conference, at Seeon, Germany.

Of course, the seminar / course to be established with Gunther Schiepek (and hopefully also resulting new single-case studies) will be open for all other interested psychotherapists, and not only to the participants of the EAP- SARC 2020 conference or other EAP members.

Peter Schulthess,
Chair of SARC
May 11, 2020

Note: Details of other EAP-SARC seminars and conferences (2014, 2016, 2018) are available on the EAP website (www.europsyche.org/about-eap/research).

Endnotes

1 ***Psychotherapy Research***: Feb. 2020: DOI: 10.1080/10503307.2020.1722329

2 **Single Case Archive:** www.researchgate.net/project/Single-Case-Archive

3 **Gunter Schiepek** *et al.*, (2020). DOI: 10.1002/capr.12300

4 **YouTube**: youtu.be/hvLFgVP-Ssc

International Journal of PSYCHOTHERAPY
IJP Celebrating 20 YEARS 1996-2016

Can "Psychotherapeutic Methods, Procedures and Techniques" Be Patented, and/or Copyrighted, and/or Trademarked?

A Position Paper

Background Information about Intellectual Property

Intellectual Property (IP) is that which covers anything that a person may have created – using their mind and/or intellect, for example: any literary and artistic work; a particular invention; or symbols, names and images that are used in commerce; the names of their products or brands or methods; their inventions; the design or look of their products; the things they write, make or produce.

'Intellectual Property' (like any other property) can be protected in several different ways, mainly by: either a Copyright; or a Patent; or a Trade Mark.

- **Copyright** is the exclusive and assignable legal right, given to the author for a fixed number of years, to print, publish, perform, film, or record any literary, dramatic, artistic or musical material.
- **A Patent** is the right, registered with the state, for a set period, to prevent anyone from making, using or selling someone else's invention.
- **A Trade Mark** is words, or a symbol, that is used in trade or business to identify one's product, or that customers might recognise. It distinguishes a person's work from any of their competitors. A trade mark is protected only when it is clearly defined and registered.

Information collated by Courtenay Young, Editor IJP, March, 2020.
Checked by Justin Brunskell, Senior Lecturer in Intellectual Property Law, University of Greenwich.

It is totally the owner's responsibility to defend their own **Intellectual Property** (**IP**) and to act – especially if it comes to their attention that someone has used or is using their IP without their specific agreement or permission – which is called an 'infringement'. Examples of **IP** infringements include when someone:

- uses, sells or imports a patented product or process without the owner's knowledge, – and/or
- uses all or some of one's work under copyright without their permission, – and/or
- makes, offers or sells a registered design for commercial gain, – and/or
- uses a trade mark that's identical or similar to the registered one, – and/or
- is 'passing off' (which is a 'civil wrong' connected to **IP**), which is when one person has been misrepresenting the goods or services that they are selling as being those of another person.

The owner of the **IP** can then take the following steps: either:

1. Get the other party to stop using their **IP**; or come to an agreement with them, for example one can 'license' one's **IP** to the other party under a number of conditions.
2. Use mediation or another type of dispute resolution. If someone else is using a person's **IP** without their permission: **(a)** the owner should first contact the 'infringer' and ask them to stop; or **(b)** seek legal advice before contacting the other party.
3. Take legal action, if the dispute cannot be resolved by any other means.

'Intellectual Property Rights' as Applied to Various 'Psychotherapies'

There are a great number of different types or methods of psychotherapy, for example: Adlerian therapy; Body psychotherapy; Brief therapy; Cognitive-Behavioural therapy; Couples therapy; Dance movement psychotherapy; Existential psychotherapy; Family therapy; Gestalt therapy; Jungian Psychoanalysis; Neuro-Linguistic Psychotherapy; Objective Relations therapy; Person-Centred psychotherapy; Phenomenological therapy; Psychoanalysis; Psychodynamic psychotherapy; Relational psychotherapy; Solution-focused brief therapy; Systemic therapies; Transpersonal psychotherapy; etc.

Since these are mostly 'generic' terms, there is usually no copyright, or trademark protection, or patent possible, in using these methods, as purely descriptive terms are usually not protectable and a minimum level of originality is needed. In general, therapists should not utilise any other methods (whether these are 'trademarks', or 'copyrighted' material, or 'patented' names) in ways that would imply any connection, or affiliation, that does not exist, or in ways that might cause any confusion.

Intellectual Property Laws: The various laws about **patents** try to guarantee the ability of creators, inventors and innovators to profit from their original work. There are also laws that restrict the type of material that can be **copyrighted**. However, there is also a range of international **trademark** laws and systems that facilitate the protection of trademarks in more than one jurisdiction (viz: European Union Trademark legislation).[1] [2]

Copyright: A 'therapist' who develops an original technique may enjoy a degree of protection if she (or he) is careful to put his/her ideas and techniques into a copyrightable form. There may need to be a substantive body of written (or visual) material in support of this copyright.

Trade Marks: A number of different psychotherapies (modalities, methods and techniques) have already registered the 'specific name' of their particular modality, method or technique as a Trade Mark. Examples of such 'registered' and 'trademarked' (psycho)therapies, both in Europe and in the USA include: Hakomi; Transactional Analysis therapy; Eye-movement desensitisation and reprocessing (EMDR); Bodynamic psychotherapy; Biosynthesis psychotherapy; Psychotherapy Excellence (PESI); etc. In America, there are many more such trademark registrations within the field of psychotherapy. Many 'physical therapies' – and their logos – have also had their methods trademarked.

Once trademark rights have been established within a particular jurisdiction, these rights are generally only enforceable in that jurisdiction, a quality which is sometimes known as "territoriality". However, there is also a range of international trademark laws and systems that facilitate the protection of trademarks in more than one jurisdiction (i.e. European Union Trade Mark system).[3]

Patents: National patent laws vary considerably and usually state something like: *"An invention of a method of treatment of human beings by surgery or by (medical) therapy is **not** a patentable invention"*; or *"An invention of a method of medical diagnosis practised on human beings is **not** a patentable invention".*

The inclusion of the word *"medical"* in these types of therapy should be noted and therefore "non-medical" methods of treatment can be patented. The European Patent Office provides a useful definition of a (non-medical) 'therapy', being *"... any treatment which is designed to cure, alleviate, remove or lessen the symptoms of, or prevent or reduce the possibility of contracting any disorder or malfunction of the animal body".*[4]

When Is a Psychotherapeutic Method Considered as a "Therapeutic Treatment"?

One of the main indicators that a method is a "treatment by therapy" – within the terms of patent law – is whether the method or treatment would normally be carried out by a medical professional. One of the justifications for such a regulation is to avoid the possibility that medical professionals (or anyone else)

could be restrained or prevented from using their professional skills because of a fear of infringing a patent. Societal health is deemed more important than patent protection.

If the nature of a method of treatment is such that it can **only** be performed by, or under the supervision of, a medical professional, it is probably within the definition of a (**medical**) "therapeutic treatment" and is therefore **not** patentable. This might apply to some mental health treatments: e.g. lobotomy; ECT; or some psychiatric interventions; etc., but it will probably (almost certainly) **not** apply to 'normal' psychological or psychotherapeutic treatments. Therefore, it may indeed be possible to 'patent' a psychotherapeutic method: though it would have to be properly registered with the appropriate patent office.

Fallacies: Thus, there has arisen a common fallacy – that it is impossible to 'protect' any form of (psychological) treatment or a (psycho)therapy by a patent (or by a trademark). This is clearly **not** the case, because it all depends on the definition of "treatment by therapy" – if it is 'medical', then it is not patentable – according to the law: if it is **not** 'medical' (as described above), then it may be patentable.

Trademark protection is therefore seen as essential for many 'physical' (i.e. non-medical) therapists and their therapeutic practices. If the desired trademark is merely descriptive of some services (e.g. John Brown's Bodywork Treatment), one may **not** be able to use those words because others might also want to describe their product or services similarly (e.g. Mary Smith's Bodywork Services). Such a trademark might have to have a very distinct logo attached to the words (e.g. Apple computers), in order to create a proper trademark – and it would, of course, need to be properly registered.

A (Psycho)therapeutic Technique May Also Be Copyright-able.[5]

Copyright law is not affected by its usage. However, a therapeutic technique is **not** properly copyrightable in the form of ... just being an idea; or being something that a therapist simply "knows" or "does"; or just being something that someone has been trained in. There needs to be some definite tangible "product" – or something that can be shown that works in a realistic way; or something that has been properly documented.

However, once this technique or method is fixed into a tangible medium — for example (as being) recorded in a video, or written down on paper (like in a Handbook, or a Training Manual) — copyright protection would therefore be available to the creator of that particular therapeutic technique, but only for the actual written, visual or tangible material. Copyright law only protects written descriptions or instructions of treatment: it does not protect ideas, nor the actual methods of treatment.

Endnotes

1 European Union Intellectual Property Office: euipo.europa.eu/knowledge/login/index_euipo.php.

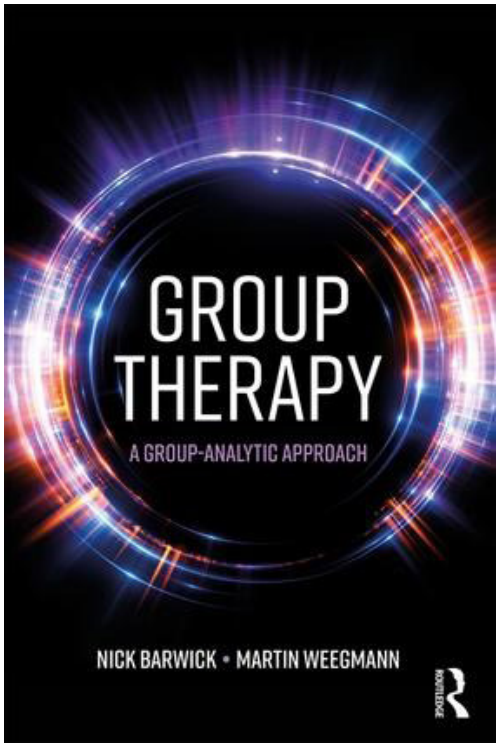
2 **FRERES, M. & FINKELMAN, J.** (2014). How to Protect the Intellectual Property of I-O and Consulting Psychology Interventions and Gain a Competitive Advantage: Secrecy, Copyright, and Patent Eligibility through Empirical Components. *Consulting Psychology Journal: Practice & Research*, 66(2): 138. DOI: 10.1037/cpb0000006.

3 European Union Trade Mark system is held within the European Union Intellectual Property Office (EUIPO): euipo.europa.eu/ohimportal/en/trade-marks. A European Union trademark is valid in all European Union member states.

4 T24/91 THOMPSON/Cornea OJEPO 1995, 512 and T 58/87 SALMINEN/Pigs III [1989] EPOR 125 58/87.

5 **JONAS, T.** "Can Therapeutic Techniques Be Copyrighted?": info.legalzoom.com/can-therapeutic-techniques-copyrighted-25441.html.

BOOK REVIEW



Group Therapy: A Group-Analytic Approach

Nick Barwick
& Martin Weegmann

Routledge, 2017
244 pages
ISBN: 978-1-138-88971-2
RRP: Hardcover: £110.00; $108.22; €140.50
Paperback: £25.99; $23.67; €33.79
Kindle: £18.40; $22.49; €19.18

The authors illustrate with enviable clarity that Group Analysis (GA) is a worthwhile theory, practice and philosophy of life. Core concepts and ways of working within the group are outlined. Novices will no longer be left in confusion about the group-analytic approach. But even experienced analysts and clinicians, without prior knowledge of Group Analysis, will find this book valuable. Whilst several chapters have been previously published, these have been extended, elaborated and updated. In their thoughtful Prologue, the authors make connections between the rising nationalism, EU referendum, Brexit, Trump and Group Analysis.

"There are no psychological islands", Barwick states. Interconnectedness is also fundamental to the group-analytic approach. Neuroscientific research confirms that we are hard-wired to connect. But it is our 'groupishness' that helps us to develop, prosper and thrive. It is indeed and the authors demonstrate this well.

They describe the interdisciplinary intercourse of Group Analysis and its development. The founder of GA, S.H. Foulkes, viewed the individual and group as two sides of the same coin. Fusing neurological and social notions, he suggested that we are formed and exist within communicational networks (matrices). For him, a group-analytic group is the preferred medium for therapy, because neurosis arises from problems which concern everybody.

We find good explanations of group specific factors (resonance, mirroring, condensation, amplification), as well as functions of the

group conductor and his/her ways of working. As dynamic administrator, s/he manages both the analytic and organisational settings. Interventions, such as, facilitation of communication, working with resistance, and (dream)interpretation are all part of the group analytic method. The authors also discuss (in a dialogue) essential qualities of effective group analysts. Their reflections of scenarios in therapy enable readers to understand the dynamics of a group in action and to address some of the common problems.

Frustrations and satisfaction of conductors are made apparent. Barwick's account of his training in a NHS psychotherapy department is refreshingly honest. Working with borderline and narcissistic patients requires social and psychic robustness. Compared to an initiation by fire (which also has some creative uses), this 'fire' together with supervisory support, theory and his own therapy, helped to forge his group-analytic skin. The influence of the conductor's personality and approach becomes clear in his narrative. Information on how to manage destructive group processes (anti-group) is also invaluable.

Weegmann's further reflections on creating a group culture that feeds growth, so that group members can develop sufficient confidence to reach out to and help each other, makes novices aware that 'one needs the orchestra (group) to practice with'. Knowing when to be more or less active as a conductor obviously comes with time. However, therapists will find solace in the authors' encouraging descriptions.

Their distinctive backgrounds, philosophical knowledge, clinical expertise and wisdom all give this book an artistic and literary flair. Weegmann cites Erasmus: '*In the beginning was the conversation'.* This expresses an important group-analytic standpoint. He also draws on Shakespeare and Gadamer and compares the group to a 'horizon' within which distance is gained and understanding formulated.

Theory is not just a model of thinking, but also an internal self-object, helping the analyst to develop and function well. Overall, concepts from Kohut, Bollas, and other group analysts, were skilfully woven into the descriptions and inspire curiosity. Barwick's musical understanding and analogy, '*There is no such thing as a wrong note'*, highlights that many 'notes' are found in the communication of the group.

Different psychotherapeutic approaches are also compared: Bions' Thanatos-driven group cultivates a primitive group mentality that manifests itself in basic "assumptions" (shared unconscious beliefs about a group's function). Through interpretations of the group-as-a-whole, the group leader makes these unconscious forces conscious. This more authoritarian, hierarchical paradigm, whereby power resides with the therapist, contrasts with Foulkes' 'Eros-driven' group and his democratic equalising vision of the conductor. Of course, such descriptions are oversimplifications, Barwick reminds us, but they serve to highlight fundamental differences between various models of the group.

The authors also outline further developments: in GA, for example, Hopper's 'Incohesion: aggregation/massification'.

The 'anti-group' is also framed within a dialectical perspective. Dalal's post-Foulkesian contribution to the social unconscious is mentioned. Stacey's 'complexity theory', which recasts unconscious psychoanalytic concepts as forms of 'complex responsive processes', is briefly described.

Citing Eliot, '*To make an end is a beginning*', the last chapter 'Endings' evokes considerable hope. It highlights that we may be able to reach a Kleinian depressive position in response to endings. By exploring ourselves in relationship with one another and to others, we can achieve the completeness that we strive for. But contemporary Group Analysis also aspires to en-

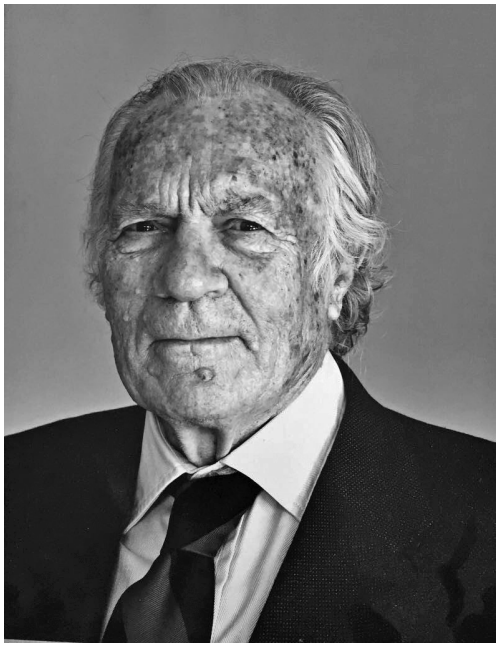
gage people in a complex psycho-social-educational experience and political discourse. Awareness of social power relations, which profoundly influence our thinking, experiences and how we relate to each other, can be achieved and explored in some depth within a group analytic group.

It is a remarkable book, brief but comprehensive, instructive but not authoritarian, analytic but not overly so. Clinicians from all backgrounds should be able to understand the essence of Group Analysis and apply some of its principles.

Reviewed by: **Dr. Susanne Vosmer,**
Clinical Psychologist & Group Analyst
Hull, UK

OBITUARY

Vicente López-Ibor Camós



The pre-eminent psychiatrist Vicente López-Ibor Camós, one of Spanish Psychiatry's most important figures, died this week, on April 6th 2020. Vicente López-Ibor Camós was a humanist and pioneer in the field of Adolescent Psychiatry.

Camós was internationally recognised for his psychiatric accomplishments, winning countless national and international recognitions. He was also appointed Honorary President of the Spanish Society for Child and Adolescent Psychiatry and in 2015, was awarded the Order of Civil Merit of Health for his tireless work to advance the discipline of psychiatry.

With Valencian roots, López-Ibor Camós was a neurologist and psychiatrist and Honorary President of the Spanish Society for Child and Adolescent Psychiatry. In addition, he had countless national and international recognitions in his profession, which he practiced for more than sixty years. This 'life-work' was recognized, among other distinctions and merits, with the Order of Civil Merit of Health.

In addition, and with over sixty years of professional practice, López-Ibor Camós made wide-ranging clinical scientific contributions to advance psychiatric exploration across a range of challenging topics. Vicente López-Ibor Camós was the brother-in-law of former Director General of UNESCO Federico Mayor and father of Spain's former National Energy Commissioner, Vicente Lopez Ibor Mayor, now president of Ampere Energy, a Valencian multinational provider of solutions, products and services for managing the transition of energy. He leaves several children and many grandchildren.

PROFESSIONAL ISSUES & ADVERTS

Information and Guidelines for Authors

This is only an indication – a small extract:
Full and up-to-date "Information and Guidelines for Authors" are on the IJP website:
www.ijp.org.uk

The **International Journal of Psychotherapy** welcomes original contributions from all parts of the world, on the basic understanding that their contents have not been published previously. (Previously published articles need a special permission from the IJP editors, and a clear reference and any appropriate permission from the previous publication). Articles should not have been submitted elsewhere for publication at the same time as submission to the IJP.

Review Process: All manuscript submissions – except for short book reviews – will be anonymised and sent to at least 2 independent referees for 'blind' peer-reviews. Their reviews (also anonymised) will then be submitted back to the author.

Manuscripts (or submissions) should be in the form of: either

- **Long articles**, which should not exceed 5000 words; or
- **Medium articles** (2000-3000 words); or
- **Short reports & reflections** or rapid publication (1000-1500 words); and
- **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.

Further Information and contact details are available on the IJP website:
www.ijp.org.uk – see the "Authors" tab.

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