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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 pages.

You are also able to subscribe to the Journal through the website – and we have several different 'categories' of subscriptions.

You can also 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 recent Back Issues available for sale.

Furthermore, we believe that **'Book Reviews'** form an essential component to the 'web of science'. We currently have about 60 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; and – as a reviewer – you would get to keep the book. All previously published Book Reviews are available as free PDF files.

We are also proud to present a whole cornucopia of material that is currently **freely available on-line** (see box in top left-hand corner of the website). **Firstly**: there are several 'Open Access' books and articles, free-of-charge for you to read – if you wish; **next** there are an increasing number of free "Open Access" articles; **then** there are usually a couple of articles available from the forthcoming issue, in advance of publication. In addition, there is 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 now available freely on-line, soon after publication.

Finally, there are a number of previously published **Briefing Papers**: there is 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 by "Intellectual Property", we have also included a recent briefing paper: *"Can Psychotherapeutic Methods, Procedures and Techniques" Be Patented, and/or Copyrighted, and/or Trademarked? – A Position Paper."* Lastly, as part of the initiative to promote psychotherapy as an independent profession in Europe, we have: *"A Position Paper on the Nature and Policy Applications of Appropriate Psychotherapy Research"*, which we have published in a recent issue.

International Journal of Psychotherapy

Editorial: ‘Is Psychotherapy Now Scientific?’

Courtenay Young

Editor, International Journal of Psychotherapy

Just over 20 years ago, I wrote my first published article (Young & Heller, 2000) with the somewhat outrageous title, *The Scientific ‘What?’ of Psychotherapy: Psychotherapy is a craft, not a science!* Back then, I was protesting about the European Association of Psychotherapy (EAP)’s ‘process’ of establishing the different methods of psychotherapy (or ‘modalities’) using the EAP’s “15 Questions on Scientific Validity”. Very shortly afterwards, becoming slightly more enlightened and reversing my position and realising the error of my ways (a little like Saul of Tarsus), I became a strong advocate of these 15 Questions, wrote them out for the mainstream of Body Psychotherapy, and also helped write the fuller description and explanation of these [1] for the EAP’s European Wide Organisations Committee (EWOC). However, I felt – and I still feel equally strongly – that this process of scientific validation is not sufficient, as it ignores the basic skill set of the clinicians, the psychotherapists and their ‘craft’ of psychotherapy.

Since then, much of my non-clinical work within the politics of the profession of psychotherapy, firstly in the early days of the United Kingdom Council for Psychotherapy (UKCP), then within the EAP in Europe, and also from within my original modality of Body Psychotherapy, has been to try to improve the quality – the skill, the craft, the (dare I say) beauty – of the professional work in these professions. So, later with a few like-minded colleagues, I initiated and became heavily involved in the EAP’s Project to Establish the Professional Competencies of a European Psychotherapist (Young *et al.*, 2013). [2] [3]

But, what inspired this particular present piece of literary output – and what brought me back to this topic for an Editorial – was Anna Scott’s editorial in the

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latest issue of the UKCP's quarterly magazine, entitled "The Outliers: Science and Psychotherapy".

> *"The idea that psychotherapy is not scientific has held strong for more than a century. From Freud's wrestling with methodologies to the dominance of behaviourism in psychology, psychotherapy has come to be seen as different – more 'art' than 'science'. As a result, quantitative, randomised controlled trials are pre-eminent in psychological research, and talking therapies awarded efficacy in this way are dominant in the NHS. Psychotherapists and psychotherapy are, to a significant extent, sidelined in public health. But qualitative research approaches that can demonstrate the efficacy of psychotherapy are just as valuable as quantitative. ... Science cannot displace or replace the 'truth' as we see in psychotherapy, but provide another level of description and reality instead, and the two disciplines can "engage in mutually respective dialogue". ... It's also a common mistake to assume psychotherapy is not 'scientific'. Neuroscience has become helpful at discovering the causal relations in psychotherapy and in the study of emotion, for example. This work allows psychotherapists to refine their techniques and demonstrate psychotherapy's huge worth as a mental health intervention."* (Scott, 2021)

The main article, by Joy Persaud, references *'Evidence-based Psychotherapy: the state of the science and psychotherapy'* (David, Lynn & Montgomery, 2017) – which is well worth reading [4] – echoes a theme in my original article, that science can and should inform psychotherapy and psychotherapy can and should inform science, thus the basic question in the title: "Is Psychotherapy Now Scientific?" can now be answered generally. It can also be answered in a number of different ways.

There is still the horrendous confusion – a seemingly unbridgeable dichotomy – about the treatment of mental illness – on the one side – and the more practical help that is needed for people experiencing mental health issues, on the other. One is a medical / psychiatric issue and is commonly dealt with through the over-use of psychopharmacology or the abuse of psycho-surgery and similar 'sledgehammer' interventions (like ECT); whereas, the other is the necessary de-medicalisation of psychotherapy and counselling and the active promotion and availability of effective interventions from skilled people in a helpful and caring way, as well as ongoing initiatives to prevent such mental health issues being created in the first place by better parenting, improved social and economic conditions, and more targeted education: none of which has anything to do with medicine. I frequently say to clients – often in the first session:

> *"There is almost certainly nothing wrong with you and, as far as I am aware, you have not done anything wrong. What **is** almost certainly 'wrong' is everything that has happened to you and around you – this, and then that, and that, and that, and then that – and all of that has inevitably and naturally affected you. How many logs can you carry? However, you still have the capacity to heal and grow stronger and that is what I can possibly help you with."*

This is not very scientific, but this sort of statement is usually responded to positively by about 95% of all client referrals! It may also be accurate. Thus, we start to build a positive therapeutic relationship – which has been demonstrated 'scientifically' to be the most effective component in psychotherapy and counselling (Norcross, 2010). It also helps to re-enforce the person's resilience – their capacity to endure hardship and cope better with difficulties in the future: another very positive 'marker' for mental health.[5]

By way of contrast, I am currently a member of a couple of Science & Research Committees, within the EAP and within EABP (European Association of Body Psychotherapy), without having had any form of 'proper' education in science or research, but having picked up bits and pieces over the last 40 years. So, I still struggle – as a relative lay-person and as a wise 'Socratic'[6] scientist-researcher – to continue to bridge some of the traditional gaps between research and clinical practice. So, now to the material in the rest of this issue.

Firstly, we have an article from **Pádraig Cotter** on Process Oriented Psychotherapy, comparing this method with several other methods: Person-Centred Psychotherapy, Cognitive Behaviour Therapy, Analytical Psychotherapy, Brief Psychodynamic Therapy, Gestalt Therapy and Milan Systemic Family Therapy.

Next, we have an article on "Building Trust: Clinical Process in Forensic Psychotherapy" by **Sanja Stojadinovic**. This gives a fascinating insight into working with criminals in Serbia, trying to re-habilitate them with group & individual therapy, and via art therapy as well.

Our third article is more of a reflective article about group analysis, about why we should embrace Positivism, by **Susanne Vosmer**. This raises some very interesting points about the type of research that may be appropriate for group analysis.

Next, we have the second part of an interesting series on supervision by **James C. Overholser**: "A Pragmatic Framework for the Supervision of Psychotherapy", entitled 'Supportive Alliance'. This looks at the supervisor / supervisee relationship in some detail.

We have to apologise that the next article was overlooked when we had a couple of Special Issues. It gives an in-depth look at the state of psychotherapy in Russia. It was compiled by **Victor Makarov**, one of our esteemed colleagues within the EAP. He identifies nearly 50 different types (mainstreams, modalities and methods) that have received professional recognition in the Russian 'League'.

Finally, we have another article in the series of "Psychotherapy vs. Spirituality". This is by **Daniel A. Helminiak** on "Treating Spiritual Issues in Secular Psychotherapy". It is a somewhat overlong and detailed exposition, but also somewhat fascinating.

Happy Reading!

Endnotes

1. **EAP's 15 Questions about Scientific Validity**: www.europsyche.org/app/uploads/2020/06/EAP_15_Questions.pdf
2. **The Professional Competencies of a European Psychotherapist**: www.europsyche.org/quality-standards/eap-standards/professional-competencies-of-a-european-psychotherapist
3. **The Professional Competencies of a European Psychotherapist website**: www.psychotherapy-competency.eu
4. **UKCP *New Psychotherapist***: www.psychotherapy.org.uk/new-psychotherapist
5. **Building your resilience**: www.apa.org/topics/resilience
6. **'Socratic' wisdom** – "ἔοικα γοῦν τούτου γε σμικρῷ τινι αὐτῷ τούτῳ σοφώτερος εἶναι, ὅτι ἃ μὴ οἶδα οὐδὲ οἴομαι εἰδέναι. "I know that I am wise because I know that I know nothing" or – more accurately – "I seem, then, in just this little thing to be wiser than this man at any rate, that what I do not know I do not think I know either."

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A Comparison of Process Oriented Psychotherapy with Person-Centred Psychotherapy, Cognitive Behaviour Therapy, Analytical Psychotherapy, Brief Psychodynamic Therapy, Gestalt Therapy and Milan Systemic Family Therapy

Pádraig Cotter

Abstract: Process Oriented Psychotherapy (POP) was developed by Arnold Mindell in the 1970's. One of the chief aims of this approach is to bring awareness to the 'process' occurring in the moment as a way of developing a greater understanding of different aspects of human condition, particularly those that are less known. This paper compares POP to Person-Centred Psychotherapy, Cognitive Behaviour Therapy, Analytical Psychotherapy, Brief Psychodynamic Therapy, Gestalt Therapy and Milan Systemic Family Therapy. Each of these modalities is compared to POP in terms of theory and practise. Key similarities and differences are delineated using a clinical vignette. The paper also considers how Mindell has integrated different aspects of each of the six modalities in developing POP.

Key Words: Process Oriented Psychotherapy, Arnold Mindell, Integrative Psychotherapy, Process, Awareness

Introduction

Process Oriented Psychotherapy (POP) or 'Process Work' was originally developed by Arnold Mindell in the 1970's (e.g. Mindell, 1982, 1985, 1988). Mindell (1984, p. 5) defined 'process' as *"the change in what we observe, the flow of signals and the messages they carry"*.

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POP originally differentiated the process in terms of 'primary' and 'secondary' processes, separated by an 'edge' (Diamond & Spark Jones, 2004). A person's (or group's) primary process refers to the experiences that are better known to them and closer to their known sense of identity, whereas secondary processes refer to experiences that are further from that known identity. The 'edge' represents the limit of the person's known identity and the beginning of their lesser known or disavowed experiences.

As POP theory developed, the terms 'consensus reality' (CR), 'non-consensus reality' (NCR) and 'marginalisation' were introduced to highlight the importance of awareness in following a process (Mindell, 2002). CR refers to those aspects of human experience that are generally agreed upon (there being a consensus) as being 'real', as they reflect how people identify and function in most people's everyday reality. NCR experiences are those aspects of people's lives that are not objectively viewed as 'real', but may be very meaningful at a subjective level. NCR can be further delineated in terms of the 'dreamland' level, and 'essence' or 'sentient' level. The former includes aspects of both night-time and daytime dreaming (e.g. emotions, thoughts, fantasies, intra-psychic roles) whereas the latter refers to the non-dualistic unity at the core of a human's being (RSPOPUK, 2019).

The person's emerging process is usually explored and amplified in six channels (Mindell & Mindell, 1992). There are four irreducible channels (auditory, visual, proprioceptive, movement) and two composite channels (relationship and world). Awareness of 'rank' within the approach is very important (Mindell, 1995). Rank is considered in terms of four overall categories (social, contextual, psychological, spiritual) – all of which intersect with each other to influence a person's life. POP aims to bring awareness to externalised oppression as it occurs within the world or within a system, as well as how that oppression becomes internalised and thus to the 'internalised oppressor' it gives rise to (Mindell, 1992).

Mindell (2017) identified four phases within therapy. Phase 1 is where the client doesn't see any real problem. Phase 2 is often characterised by tension and anger, when the problem can no longer be marginalised and impacts upon the person's consciousness: – the problem (X) is now disturbing the person's primary identity (U). In Phase 3, the client's relationship to their problem changes: they are no longer simply 'against' it or defensive of it, allowing them to 'role-switch'. In Phase 4, the client becomes further detached from 'X' and 'U', giving rise to a sense of compassion and neutrality.

'Metaskills' are the feeling attitudes, values and beliefs that inform the therapist's overarching engagement (Mindell, 1994). For a more in-depth overview of POP, the reader is referred to Diamond & Jones (2004).

This paper compares POP to other models of psychotherapy. These include: Person-Centred Psychotherapy (PCP; Rogers, 1951); Cognitive Behaviour Therapy (CBT; Rachman, 1997); Analytical Psychotherapy (AP; Jung, 1968); Brief Psychodynamic Therapy (BPT; Malan, 1995; McCullough *et al.*, 2003); Gestalt Therapy (GT; Perls, Hefferline & Goodman, 1951); and Milan Systemic Family Therapy (MSFT; Boscolo *et al.*, 1987). This is done using a clinical vignette (Box 1). An overview of working with this client using a POP approach is outlined. It is compared with each of the above approaches in terms of its theoretically informed formulation and key elements of practise. Finally, some overarching reflections – in terms of how POP comprises elements of each of these approaches – are provided.

There has been less writing about POP within the broader psychotherapy literature, relative

to other modalities. As a result, it may be less known than some of the other approaches. To the author's knowledge, and following a recent review of the literature, this is the first academic paper to consider POP, relative to other schools of psychotherapy.

POP is centralised throughout the paper. The corollary of this is that the other therapies may seem to be 'othered' (Hegel, 1910). The intention is not to downplay the value of the other modalities, but rather to outline POP relative to these other approaches and its relationship with them. The author is aware that the description of other modalities may feel oversimplified to the expert reader in that modality. The aim is not to provide a comprehensive overview of each, rather to demonstrate how POP has similarities and differences with them and how Mindell has incorporated learnings from each.

Process Oriented Psychotherapy (POP)

A process structure-based formulation for Abebi is outlined in Figure 1 (below). This appears more static in diagrammatic form than its more process-like experiential form. Abebi experienced significant external oppression. This included being sexually assaulted by her uncle; the way her family did not acknowledge this; the bullying she experienced in secondary-school; racism she experienced as a black person; and the opportunities that she has **not** had within her life because of being female. All these gave rise to significant internalised oppression. Within these situations and with respect to other aspects of her life, Abebi has been the victim of rank abuse. Contextually, being the youngest and female within her family often meant that it was hard for her

Abebi*

Abebi is 23 years old. Her parents, both originally from Nigeria, moved to London from Ibadan when she was 3 years of age. Abebi has two brothers and two sisters, who are all successful. Abebi is the youngest member of the family. She was sexually assaulted by an uncle on several occasions between ages 12 and 14. While her family no longer speak to this uncle, they have never really acknowledged what happened.

Abebi did reasonably well at primary school and did not have many difficulties making friends. However, she found post-primary school much more challenging, often finding it difficult to make and sustain friendships. Despite this, Abebi completed her GCSE's exams and later attended University. She found the transition to University difficult. She regularly failed exams before eventually dropping out. Abebi has worked in retail and catering since. Abebi has not had a romantic relationship but has concerns that she may be attracted to both women and men.

Abebi has experienced significant anxiety and low mood at regular intervals throughout the second half of her life. She sometimes thinks about death and that life may be better for everyone if she was no longer around.

* N.B. This is a fictitious client.

Box 1. *Vignette of a Client*

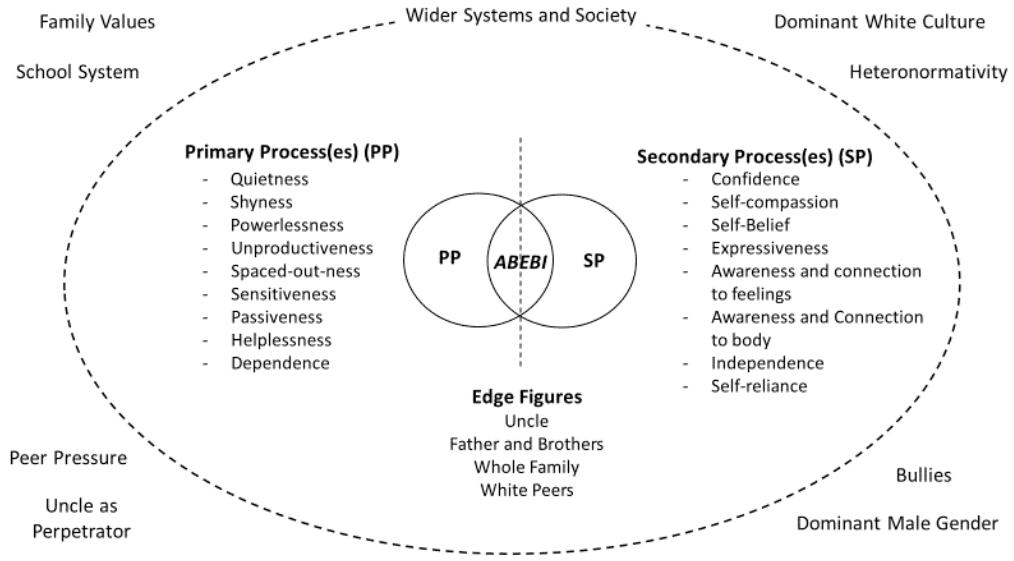

Figure 1. *ProcessWork Structure-based Formulation*

to speak up. Socially, she experienced significantly lower rank relative to her male and white peers. The impact of these pre-existing dynamics became more pronounced after she was assaulted / abused. The intersectionality of the above issues and their aggregated impact left Abebi with low psychological rank. This was further compounded by concerns about her sexuality. As a child, Abebi's mother used tell her stories about Osun, an orisha (or deity) of the Yoruba people of Southwestern Nigeria. This gave Abebi a high level of spiritual rank when she was younger, however it became frowned upon by her brothers and father, who felt the need to conform to an urban British life – an example of the wider structural and societal oppression experienced by Abebi's family.

At the outset, when Abebi was regularly in Phase 1, therapy focused on developing an awareness of Abebi's more primary processes and how these developed within her life. This focused more on consensus reality (CR). Metaskills of 'eldership' and 'beginner's mind' were key. Through following Abebi's nature, and paying attention to her various signals (both verbal and non-verbal), a greater awareness of her 'edges' and 'edge figures' emerged. This led to more work within Phase 2 and different aspects of her 'dreaming' process. Given the micro and macro traumas that Abebi had experienced, going very slowly and gently as her edge(s) were approached was important. It was more 'primary' for Abebi to stay in her auditory and visual channels, than in proprioceptive or movement channels.

Over time, through following Abebi's feedback, amplifying within the primary channels and adding the more secondary channels, role-playing was used effectively. The primary U-energy was often represented by quiet, shy qualities and the problematic X-energy by characteristics that Abebi associated with her uncle and father. It took some time before Abebi's feedback indicated that she was closer to role-switching and moving into Phase 3. Her 'critic', often comprising negative influences from different figures in her family, was

frequently a missing role (or 'ghost-role') in the field.

Phase 4 work, at the sentient level, was supported by Abebi's dreamfigure, Osun. Regularly, a number of these Phases emerged within a single session. To further support work in the relationship and world channel, Abebi joined a process-oriented group for young black women, where she became more aware of how her life had been impacted by sexual, racial and gender-related oppression and how this had impacted her at an intrapersonal, interpersonal and transpersonal level.

Person-Centred Psychotherapy (PCP)

PCP was developed by Carl Rogers (1951) in 1940's and 50's America, as part of the Humanistic movement that emerged in response (reaction) to the behaviourism of B.F. Skinner (1957).

As seen within this modality, Abebi was conditionally accepted by her father and brothers. There were clear parameters regarding what was expected of her as a female and what a successful life should be. This was buffered by her mother's and primary school teacher's unconditional positive regard. They supported her to trust her own feelings. In childhood, Abebi's growth was mostly in keeping with her self-actualising. Her real and ideal selves were reasonably congruent. Her development was largely moving in the direction of 'fully functioning' person-hood. This was disrupted significantly when she was sexually abused. It was compounded by her father's subsequent invalidation of the abuse; her mother's belief that she could not go against her husband; and other difficulties that arose (e.g. school avoidance, bullying, etc.). With time, a greater incongruence developed between her real and ideal selves and Abebi came to trust her own experiences and her sense of herself less and less.

Roger's notion of 'self-concept' was influenced by his white, male, Christian, American background and could / would / might exclude aspects of Abebi's cultural background, experience of being a woman, and same-sex attraction. POP aims to avoid this potential exclusion by working with Abebi's everchanging process, rather than with a culturally-bound, fixed concept of 'Self'. PCP ascribes to a relatively normative pathway of 'optimal development'. POP would aim to support Abebi in developing her own developmental pathway, regardless of the social expectations of 1950's America, or indeed of 21st century Britain. Roger's ideas of the 'ideal' and 'real' selves are somewhat more static concepts than Mindell's primary and secondary processes, however there are some similarities. The idea of the 'real self' could be likened to having more integrated primary and secondary processes and a greater capacity for more neutral meta-communication. Similarly, parts of Abebi's real self that were only accepted conditionally are not unlike secondary processes that were marginalised. Roger's Humanistic perspective does not explicitly make space for Abebi's spiritual experiences, unlike when working at the sentient level within POP.

The primary therapeutic intervention within PCP would be actively listening to Abebi. This involved the therapist being empathic and reflecting Abebi's feelings back to her; being genuine in sharing their own feelings; and exhibiting unconditional positive regard. Non-judgementalness and acceptance would be important. A further key part of the work would be non-directiveness with Abebi leading the therapy. Key skills used to support active listening would be summarising, reflecting, paraphrasing, and use of open questions and encouragers (e.g. 'go on').

PCP prescribes 'non-directiveness', 'non-judgement', and 'acceptance'. This may hinder the therapist from noticing that being di-

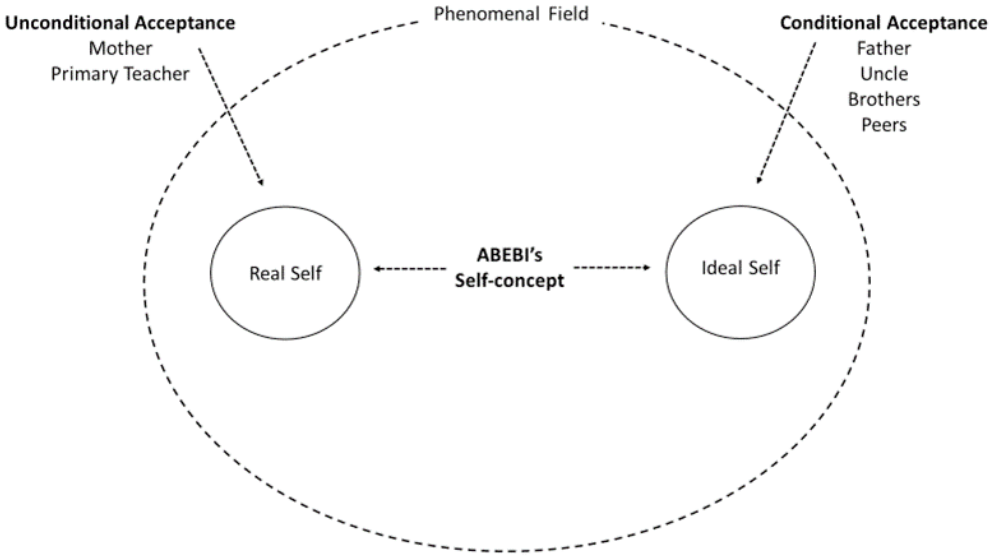

Figure 2. *Person-Centred Formulation*

rect, judgemental, or non-acceptant could be significant roles within the client's field. In contrast, the POP therapist plays a more active role in following Abebi's process whereas the PCP therapist is more 'non-directive'. PCP is more focused on the auditory channel and the primary process, whereas POP is also concerned with Abebi's more secondary sensory-grounded signals and the therapist's internal feedback. PCP does not usually address how the therapist's experiences may be part of the therapeutic process. In POP, the relationship channel is more multi-faceted as therapists use their awareness of their own process as a gateway into aspects of Abebi's process. For example, Abebi's feedback may lead the POP therapist to pick up the role of the 'directive' one, so that Abebi can interact with it. Roger's approach provides less specific direction around facilitating macro-traumas, such as Abebi's experience of abuse. POP highlights the importance of taking a lot of time around the edges of such experiences; the importance of the therapist's feedback as the ethical regulator; and working with the parts of Abebi's process that got left behind and the parts that kept going. Rogers mentions a 'phenomenal' field in his theory, but less is said about how it can be used within 'person-centred' therapy. The POP therapist may bring awareness to wider structural and systemic oppression, using the 'world' channel and potential synchronicities.

Cognitive Behaviour Therapy (CBT)

CBT comprises a range of psychotherapeutic theories and practises including cognitive therapy (Beck *et al.*, 1979) and behaviour therapy and modification (Skinner, 1957), all of which are rooted in learning theories (Rachman, 1997).

According to these theories, Abebi's 'current' presenting anxiety and depressive symptoms, as measured via relevant self-report measures, would be used to construct a CBT for-

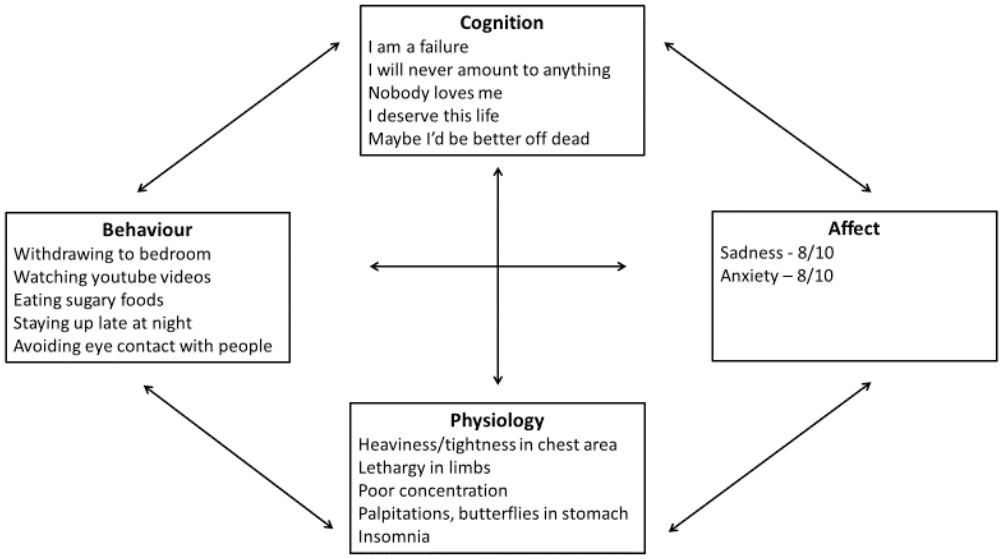

Figure 3. *CBT Formulation*

mulation (Figure 3). The therapist and Abebi would utilise a blank formulation template and write down Abebi's experiences. They would have discussed how her feelings of anxiety were affected by her thoughts, behaviours and bodily experiences, and how each affects the other. For example, when Abebi feels sad, she would withdraw to her room and eats sweets. This behaviour makes it more difficult for her to sleep, which results in her thinking about how her life has amounted to nothing.

CBT highlights the importance of generating a shared formulation, however it is much more therapist-driven than in POP, where the therapist's role focuses on supporting the client's process that is trying to emerge so that Abebi can 'formulate' her own experiences with greater awareness of primary and secondary processes. A CBT formulation focuses more on a cross-section of Abebi's experiences, with less attention given to her past and to other areas of life. In POP, these experiences are 'welcomed-in' to the ever-evolving formulation as and when Abebi's process directs this to be the case. The CBT formulation uses a more reductionistic perspective to separate Abebi's experiences into components, whereas – in POP – the formulation emerges based on Abebi's subjective experiences. The CBT formulation constellates the 'presenting difficulties' and the factors giving rise to them as residing within Abebi. Little attention is given to the impact of the wider system(s). Many important aspects of Abebi's life may get marginalised within this reductionistic formulation, whereas the real-time formulation process within POP is actively trying to avoid doing this.

CBT with Abebi might include a range of cognitive restructuring techniques and behavioural interventions. Cognitive techniques included 'Socratic' questioning, thought record sheets, exploring thought distortions, evaluating, and challenging thoughts, cost-benefit analyses of thoughts and behaviours, role-playing both sides of a thought, and downward arrowing. Behavioural techniques might include activity scheduling and use of behavioural exper-

iments (e.g. hypothesis testing, theory A/B, etc.).

CBT structure – and the therapist within it – direct proceedings more than in POP, where the emerging process guides the therapy. The CBT therapist assumes a more defined role that is somewhat akin to a teacher or coach. Each session with Abebi, would have involved 'contracting', 'goal-setting', 'agenda setting', and 'homework setting'. The POP therapist may assume this 'role' at times, but it is Abebi's process that dictates when this is to be the case, rather than it being prescribed by the modality. The CBT therapist who assumes this more 'directive' role may ignore signals and feedback from Abebi that indicate that a different role is required. CBT operates primarily in the auditory and visual channel, often using paper and pencil in a Western classroom-based manner. In POP, these channels are used occasionally, but no less than other techniques in the other channels and what is indicated by the process at any one time. CBT focuses a lot on Abebi's CR issues, relating more to her primary process perspective with less attention given to the dreamland level or the sentient level.

Analytical Psychotherapy (AP)

AP was founded by C.G. Jung (1968) after he had separated from Freud's psychoanalytic perspective (Jacobi, 1961).

Based on Jung's concept of the psyche (Figure 4), Abebi's most differentiated function of consciousness was 'thinking', and she was more 'introverted' than 'extroverted'. Her persona was heavily influenced by family values regarding the importance of hard work, father knowing best, being successful, not dwelling on the past, and keeping the 'bright side' uppermost. Two of the key factors within Abebi's personal unconscious concerned her anger with her uncle and family. After a significant period of therapy, one archetype that might have emerged from the collective unconscious, manifesting itself through Abebi, was Osun. This would have been interpreted as a version of the 'Wise Old Man' within the animus.

This conceptualisation of Abebi's psyche is somewhat more prescriptive than using a process-oriented structure, where there are no static concepts of self or other psychic structures. A Jungian formulation of Abebi's psyche may be prejudiced by the white, male dominated, Euro-centric perspective in which Jung's views were developed. This may bias the therapist in terms of how they interact with Abebi, especially given that male dominance is a feature within her life. A POP therapist would aim to bring awareness to issues of race, sexual orientation, and culture within Abebi's life – as well as the 'rank' issues inherent within these. The Jungian perspective is likely to focus on Abebi's intrapersonal world and the associated dreams with less of a focus on external oppression. Both approaches would acknowledge Abebi's spiritual experiences. However, within AP this, and any other unconscious experience, is primarily viewed as emerging through night-time dreams, whereas POP is equally as interested in the dreaming presenting itself within relationships, body experiences, movement processes, dreaming whilst awake, and within the systems that Abebi inhabits (e.g. family).

AP with Abebi would have focused on interpreting her dreams, visions, and fantasies. Abebi had regular dreams that involved a big rat on top of her, stopping her from breathing. Sometimes, she felt like she also saw this rat during the day. Much of the first half of Abebi's therapy would have involved unfolding these dreams. With time, they would have become largely reflective of her experience of being abused by her uncle. This would

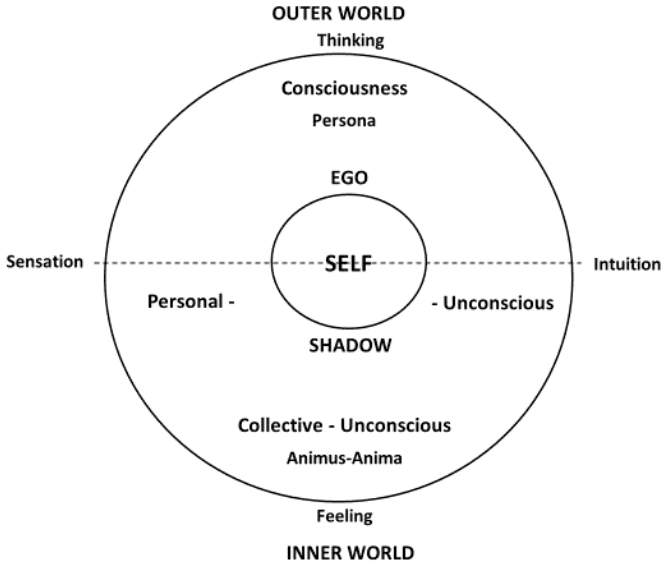

Figure 4. *Analytical Psychotherapy Formulation of the Psyche*

* Adapted from JACOBI, J. (1961).

have also involved supporting her to develop the less differentiated feeling function, so she could further express her emotions. Later work on these dreams would have revealed a significant anger towards her father and family. This too would have taken the therapy back to her childhood, but also – and in keeping with Jung's teleological approach – this would have supported Abebi in moving forward. She may have found a flying version of the rat as a powerful 'ally'. In the latter part of her analysis, Abebi's Osun, and its connection to the collective unconscious would be explored. This would have supported Abebi in taking a prospective look at her life and elements of the animus within it. The key method used throughout would be 'amplification', which would have involved Abebi and her therapist interpreting dreams.

Mindell trained as a Jungian originally and expanded Jung's methods in several ways. Jung focused on bringing the unconscious into consciousness via verbal analysis of night-time dreams within individual therapy. Mindell came to view the dreaming process as an ongoing flow of experience that emerges in a more multi-faceted and multi-channeled manner. This could be in terms body symptoms, in movement, altered states, in relationship, and within groups and systems. This led to Mindell working in the body, movement, and relationship channels, as well as the auditory and verbal channels. Mindell believed that it was not necessary to focus on night-time dreams *per se*, rather the essence of the dreaming could also be explored through the other channels. From a purely Jungian perspective, the idea of group work was not really possible. Mindell believed in the importance of working within relationships with groups and this became a central part of POP's work, as well as work with individuals.

Brief Psychodynamic Therapy (BPT)

BPT (Malan, 1995; McCullough *et al.*, 2003) – or the 'Affect Phobia' approach – is based on

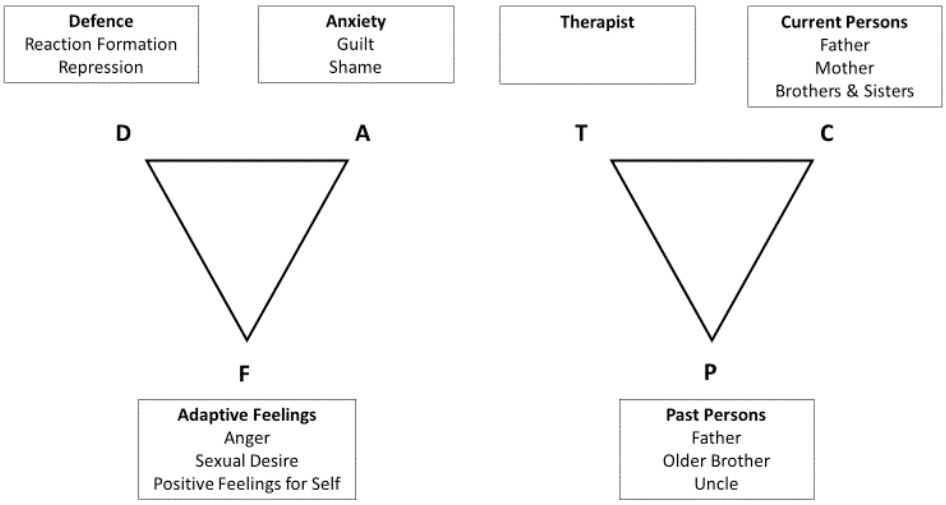

Figure 5. *Brief Psychodynamic Therapy Formulation*

* Adapted from MALAN (1995).

the work of Sigmund Freud (1913). Freud also described conducting brief therapy, using dynamic principles.

In this approach, Abebi learned that displays of anger, positive feelings towards herself and sexual feelings (F) were not acceptable (Figure 5). She came to associate feelings of anxiety, guilt, and shame (A) with these internal experiences. To manage these secondary emotions, she developed defence mechanisms, including 'repression' (expelling unwanted feelings from awareness) and 'reaction formation' (substituting unwanted feelings or associated behaviours with its opposite). These patterns began when Abebi was a child through interactions with her father and older brother and were later compounded within the abusive relationship with her uncle (P). They now emerge within relationships with all family members (C) and became features of the transferential relationship (T).

The BPT therapist would present their interpretation of this formulation to Abebi in an open, tentative manner. They would exercise more control over the formulating process than in POP, where Abebi is facilitated to generate her own formulation based on her subjective experiences. The latter involves continuous 'real-time' assessment, formulation, and intervention. The therapist would follow Abebi's signals, amplifying them where appropriate, so that the dreaming process emerges. The POP therapist – in contrast – would avoid labelling or interpreting Abebi's signals, thereby supporting their process to unfold. The BPT therapist would make more pre-judgements and hypotheses. The BPT formulation allows for Abebi's sexuality to be included however, there is probably no reference to her broader cultural background, and it is unlikely that her experiences of gender-related oppression would be contextualised within the wider societal oppression. Similarly, issues of racism and its internalised impact would probably left out of this perspective, which is more rooted in the parent-child relationship. BPT is oriented more on where Abebi's difficulties have emerged from, whereas POP has more of focus on where her process may be going to. This is

reflective of BPT's root in Freud's psychodynamic approach and POP's root in Jung's teleological orientation. Unlike POP, the language of the BPT model presumes a psychic pathology.

BPT with Abebi would have involved 'restructuring' her defences (recognition and relinquishing), restructuring her affect (experiencing and expression) and her Self, and other restructuring. Both real and transferential relationships would be considered important. Countertransference would have been noticed by the therapist and interpretations would be offered about it and about any resistances. A key distinction would probably be made between countertransferential reactions, that were due to the impact of Abebi's defences and interpersonal style, and when the reaction was more to do with the therapist's own issues.

The BPT therapist is usually direct in interpreting and pointing out defences, whereas the POP therapist focuses on signals without interpretation. Where the former appreciates the formation of defences, the latter appreciates the reasons that primary processes developed. BPT's focus on experiencing the 'affect' while desensitising to the anxiety is akin to POP's noticing an edge, tolerating the anxiety, disabling the edge figure, and crossing the edge. Desensitisation involves gradual exposure and response prevention. Much of POP's process work involves this – noticing edges and using the emergent process to develop greater awareness, crossing the edge (if that is indicated by the process). The 'edge' figure is like the past person (P). This is done in a focused way in BPT, whereas it is more naturally occurring in POP. Using roleplay, both approaches would, support Abebi in bringing the therapeutic learnings back into current relationships. Role models may be emulated in doing this. In BPT, they are discussed and introduced, whereas in POP they emerge more organically. Working with affect and within the transferential relationship is akin to working within the proprioceptive and relationship channels, while imagining scenarios is like working in the visual channel. Countertransference is like the process of being 'dreamt up'. Ongoing personal therapy and supervision are important within both modalities, especially when working with these complex dynamics.

Gestalt Therapy (GT)

Gestalt Therapy (Perls, Hefferline & Goodman, 1951) was developed around the same period as World War II and evolved throughout the second half of the 20th Century.

A GT formulation of Abebi's presenting issues and her life does not involve a theory of self, rather, it would focus on what occurs in the moment – within the therapeutic relationship – and this is used as the relationally-oriented guide to Abebi's life (Figure 6). In this way, GT's conception of Abebi's 'self' would be viewed relative to the other relationships within her life and the idea of a 'self', independent of these relationships, therefore does not make sense. The development of selfhood is viewed as occurring within relationship, as opposed to being inherently within Abebi. There is no theory or conception of 'self' imposed over what arises within the dialogical relationship between Abebi and her Gestalt therapist. The phenomena that arises within that relationship, or the subjective experiences of Abebi and therapist, are viewed as most important. Further to this relational and relative conception of selfhood, the field surrounding Abebi is viewed as being particularly important. This includes the ontological (physical and environmental elements of the field) and phenomenological (internal subjective experiences) aspects of the field.

Both POP and GT share the idea of focusing on a person' development in a relativistic sense, rather than their being some objective, static or independent 'self'. Neither holds to a nor-

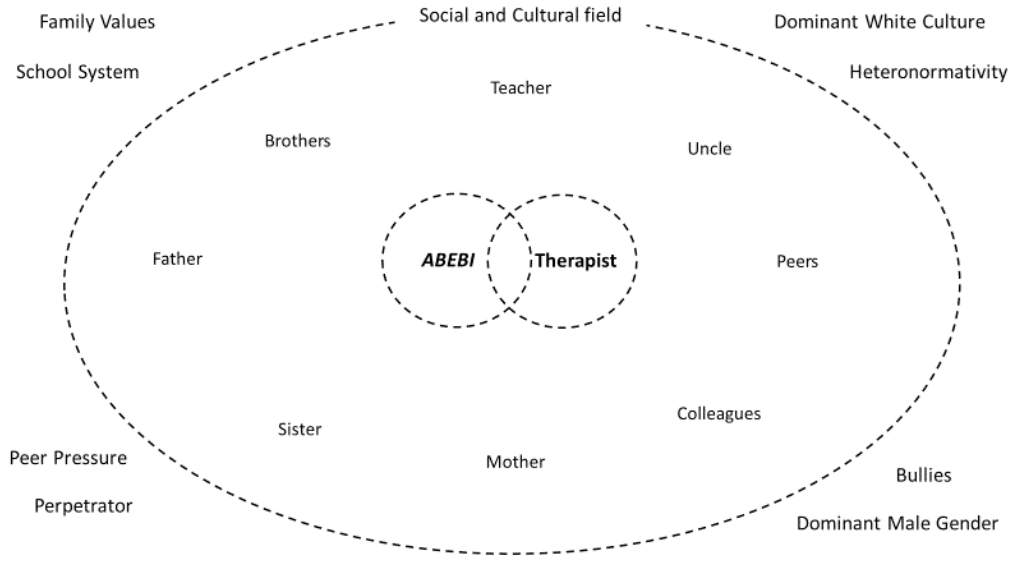

Figure 6. *Gestalt Therapy formulation*

mative conception of human development. This is not surprising given that both are strongly grounded in a phenomenology. The social and cultural field surrounding Abebi is taken to be important in GT and separating this from Abebi within the therapeutic field, or within her life outside of therapy, does not make sense from this perspective. The notion of an ontological and phenomenological field within GT is similar to the idea of the CR and NCR aspects of a process within POP.

Therapy from a GT perspective focused on bringing awareness to what occurs – in the present moment – between Abebi and therapist. It is from this awareness, or mindfulness of the present moment occurrences, that the rest of the work is based upon. It is through this that the wider social, cultural and environmental aspects of Abebi's life would have been brought into the therapy room. Therapy therefore did not stay at the level of just talking about what occurs within Abebi's life, rather it looked to become it or enact it. Use of the 'empty chair' technique, chair work more generally, and other forms of role-playing would have been used. For instance, in Abebi's case, this involved significant interactions with her uncle and father. The therapist would have used themselves and their own experiences within this as an active part of her therapy. This focuses on the 'how' of what is happening in the relationship, as well as 'what' is being said verbally.

There is much overlap between the practise of GT and POP. They are arguably the most similar of the six therapies. Both focus significantly on what emerges in the present moment from the perspective of observing, and describing the developing process rather than interpreting or explaining it. Relationships, both within and without the therapeutic hour, are viewed as being especially important – with the former representing a microcosm of the latter. Both aim to bring therapy 'alive' through inhabiting and enacting the relevant roles and sides of internal and external relationships. The therapist and their own process is viewed as being central to both and – as a result – the

personal development of the therapist is particularly important within each. In both, the therapist endeavours to trust the process and what emerges, rather than trying to 'save' themselves from it. One area that Mindell expanded on was the use of movement. Drawing on Moreno's (1975) psychodrama, Mindell incorporated body-focused therapies, lifting Pearl's role-playing out of the chairs to bring the body and its movement into POP.

Milan Systemic Family Therapy (MSFT)

MSFT is an umbrella term for an approach originally developed by Mara Selvini Palazzoli, Luigi Bosocolo, Gianfranco Cecchin and Guiliana Prata (Carr, 2012). This team was heavily influenced by Bateson (1972) and Watzlawick *et al*. (1967).

Abebi's difficulties would be conceptualised within the family's belief systems (and associated interaction patterns) as outlined in Figure 7. Difficulties that had increased since Abebi was abused and her family would be seen to have 'swept it under the carpet'. Abebi remaining 'unwell' maintained cohesion within the family, as it allows them to maintain their long-standing belief systems. The family could have retained the beliefs systems, as long as Abebi had a 'problem'. This would have served Abebi's father and older brothers, especially as they were best served by the existing dynamic. A typical interaction pattern, based on these beliefs, would have involved Abebi telling her sister about the abuse, but her sister telling her to keep it quiet.

The obvious difference between this formulation and many of the preceding ones is that it considers Abebi's 'presenting difficulties' as part of the family's 'system', as opposed to at an individual level. POP takes both the individual and the wider system into account (Figure 1) with each influencing the other. The 'family belief systems' and associated interaction patterns, as outlined within MSFT, could be viewed, from a POP perspective, in terms of being the more primary processes of the family, or more akin to the family's primary identity. MSFT does not conceptualise these processes in terms of how they influence Abebi's intrapersonal psychology.

MSFT with Abebi's family would have involved five-person therapy sessions, co-therapy, and a team behind a screen. The goal would be to alter the current belief systems and symptom-maintaining interactional patterns. One of the key issues would be addressing the beliefs and interaction patterns that contributed to the family's unwillingness to acknowledge the abuse. An example would have included redressing the 'pattern' that precluded Abebi from speaking directly to her father about what happened. Key interventions would have included: circularity, neutrality and hypothesising; circular questioning; paradox and counter-paradox; the split-message approach; and end of session interventions, like prescription of rituals and positive connotations. In terms of positive connotation, Abebi would have been praised for keeping the abuse to herself so as to protect the family; her father would be acknowledged for trying to ensure that all their children got a good education; and her mother would have been commended for trying to keep everyone in good spirits. As a ritual, the family would be asked to practise speaking about aspects of their week that were not positive and to observe the effect, especially on the others. In offering a split message to the family, it would be said to Abebi's father that (something like): *'Some of my colleagues disagree strongly with you about the total value of hard work, whereas I find myself closer to your position.'*

Within MSFT, the wider familial dynamics tend to be centralised. This may mean that aspects of Abebi's individual psychology do not get addressed. This may suit working on the

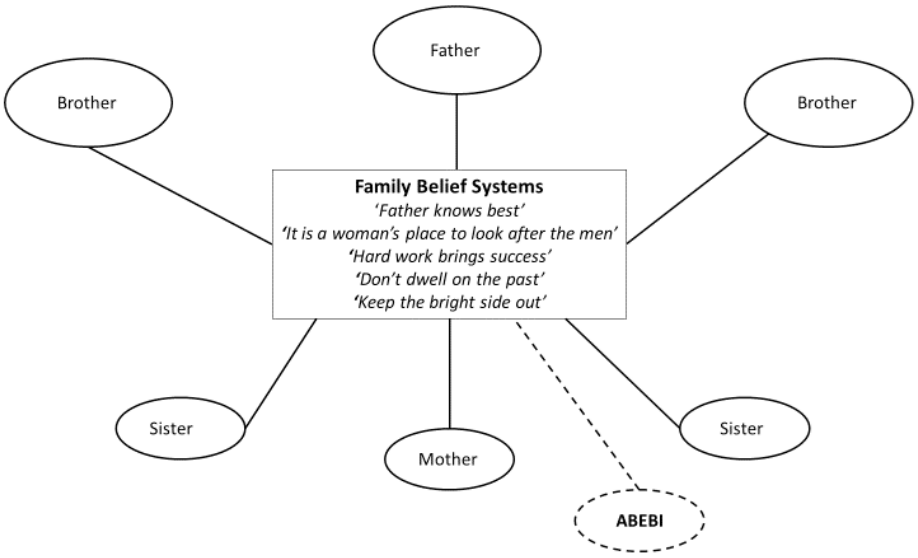

Figure 7. *Milan Systemic Family Therapy Formulation*

family's reaction to the abuse, but it may mean that Abebi's individual response to the trauma does not get adequately addressed. In POP, the therapist is endeavouring to work with both the systemic and individual levels. As in POP, understanding the history and worldview of Abebi's family would be important in MSFT. MSFT practitioners view historical issues as coming alive within current belief systems and interpersonal interactions. Like POP, the family and their therapists are viewed as one system. In both approaches, monitoring signals and communication patterns and how the system changes in response to feedback are considered important. This may reflect both approaches' being grounding in communication theory. In MSFT, the observing role is held by another team, whereas in POP the observing role is usually held by the active facilitator(s).

Concluding Reflections

In a pluralistically-informed (Teo, 2010), integrative (Norcross & Goldfried, 2005) endeavour, Mindell has given POP to the world of psychotherapy. In so doing, he combined learnings from AP (e.g. teleology of dreams, collective unconscious), CBT (e.g. cognitive restructuring, behavioural principles), PCP (e.g. real relationship, active listening), Psychodynamic Theory (e.g. transference and countertransference), Gestalt Therapy (e.g. roleplaying, role-switching) and set them within a broader systemic perspective. To this, he also added body work, 'rank' awareness, and learnings from Shamanism, as well as further considering Jung's work on Quantum Mechanics, Taoism and Alchemy (Mindell, 1985, 1993, 2012). POP looks like each of the above modalities at different points in the therapeutic process and often several at the same point. The 'process' determines which, when and for how long.

The six modalities can also be considered in terms of how the essence of each is used within POP, with regards to the level of reality it focuses on. CBT and PCP focus on CR – and to a lesser extent, the Dreaming level. The

Psychodynamic, Gestalt and Analytic schools contribute most to working at the Dreaming level. Jung's approach is the one that allows for working at the Sentient level in the most explicit manner. The systemic perspective includes the wider impact of the system on working at any of these levels.

That POP integrates many different schools of thought does not render it immune to schoolism (Clarkson, 1995). As soon as a school is formed, schoolism quickly follows. POP is grounded in post-modernism (Gergen, 1994), relativism (Kanzian *et al.*, 2019) and phenomenology (Husserl, 1970). These perspectives have influenced its formation and therefore its utility. How people are perceived via the POP perspective, and how psychotherapy is practised using it, is influenced by these overarching philosophical positions. It is important that the modality does not become more important than the utility of it with clients. The moment-to-moment awareness required to monitor the process within therapy is different to the intellectual awareness that understands all the components that comprise POP. It is the former that the psychotherapist requires in navigating the unscripted and uncertain occurrences in each moment of the therapeutic hour. For that, all modalities must be set free.

A final word goes to the perspective of the author. For the interpretation of the foregoing is just that, an interpretation. An interpretation that has been influenced by the lens through which the author has perceived each of the modalities and how they have been married together in the formation of POP. In one of his famous quotes, Jung (1968) reminds the reader that '*In psychology, the means by which we judge and observe the psyche is the psyche itself.*' All that this paper is made up of has been subjected to the biases of the author's psyche. Much of the author's early conditioning – like that of Mindell, and Jung before him – has biased his perception in a positivistic (Comte, 1997) and realistic (Kanzian *et al.*, 2019) way. However, like Mindell and Jung, the direction of travel appears to be more relativistic. The reader is left to cast their own assertions with their own biases for company.

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Building Trust: Clinical Process in Forensic Psychotherapy

Sanja Stojadinovic

Abstract: Reintegrating offenders into society is only possible through building the bridge of understanding and acceptance. From the author's point of view, there are two main directions in this process. One direction leads towards the understanding of the client's destroyed experience and dysfunctional patterns of emotional regulation. The second direction aims at gaining the client's trust by emphatic understanding and non-judgmental acceptance, enabling the client to establish better interpersonal relationships. Since treatment of mental health and substance use disorders decreases the risk of re-offending, a positive outcome in forensic psychotherapy heals the individual, also contributing to the safety of society.

Key Words: forensic psychotherapy, psychotherapy relationship, client-centred psychotherapy, attachment, psychoactive substance use disorders

Introduction

Prison bars symbolize boundaries and restrictions. A prison sentence is usually the most severe punishment for breaking binding legal norms or not fulfilling the obligations that the society poses. Incarceration imposes strict rules and limitations, restricting freedom, the sense of control, and contact with the outside world.

The goal of reintegrating persons who committed criminal offences into society can only be achieved by re-building a bridge to the person based on understanding and acceptance. Providing treatment to persons suffering from mental health and drug-use disorders, proved to lower the risk of re-offending (NIDA, 2012; Pearson & Lipton, 1999). Forensic psychotherapy based on client-centred psychotherapy principles could offer the key: establishing a bond with the person who had committed a criminal offence in a non-judgmental way could serve as a bridge to understanding and open the door for them to change.

From the author's point of view, the therapist should bear in mind two key directions in the process of forensic psychotherapy: intrapersonal and interpersonal. The intrapersonal

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perspective directs the understanding of the client's destroyed experience and dysfunctional patterns of emotional regulation. The interpersonal perspective involves gaining the client's trust by emphatic understanding and accepting in a non-judgmental way, enabling the client to establish better interpersonal relationships. Empirical support will be provided and well as clinical case examples.

Inwards to the Intrapersonal: Destroyed Experience of Forensic Clients

> *"It is not the world, not what's outside of us, but what we hold inside that traps us."*
>
> Dr Gabor Maté,
> *In the Realm of Hungry Ghosts: Close Encounters with Addiction.*

In order to understand a person better, it is necessary to understand how they perceive and experience the world, to view the world from the perspective of that person here and now, and that kind of understanding is only achieved through empathy (Rogers, 1975; 1995). In the forensic setting, what is particularly challenging is, often, a diametrically opposite therapist-client view of the world. What often challenges the therapist's capacity of understanding and acceptance is the long history of abuse and trauma often found in forensic clients, often with mental health and substance use disorders, patterns of "criminal thinking" (NIDA, 2014), distorted cognitions and consequent egocentric behaviour (Blant, 2014), their denying of responsibility and blaming others, impulsive and unscrupulous behaviour, distrust and hostility, and a general lack of motivation for change.

Understanding that the individual's frame of reference directs their behaviour and influences the experience of the self, others and the world is a crucial first step: *"Our behaviour is a function of our experience. We act according to the way we see things. If our experience is destroyed, our behaviour will be destructive. If our experience is destroyed, we have lost our own selves"* (Laing, 1960, p. 10).

In a forensic setting, a process-experiential oriented framework allows the client to feel free to express their thoughts and feeling without being pressured to change, or without the fear of being rejected, allowing them the freedom to create a new meaning of their, often, chaotic emotional experience.

We have found that one method, introduced by Greenberg, Rice and Elliott (1993; Elliot & Greenberg, 2007) using the moment-by-moment, process-experientially-oriented framework in psychotherapy can be beneficial. The treatment begins with an open, process-oriented stance. Entering emphatically into the client's internal frame of reference, the therapist explores how the client experiences their world. The goals are to help the client: symbolize their experience; change their scheme of emotional processing; stimulate new awareness and meaning construction, but not providing insight or modifying cognitions. The client becomes an active agent in the change process, while the therapist facilitates processes that will lead to new experiences.

The initial process of creating a connection with the client in a forensic setting should be particularly careful and non-intimidating, starting with the presumption that the client probably had a history of negative experiences, resulting in a lack of basic trust in other people and doubting others' intentions. Furthermore, many forensic clients have a long history of substance-use disorders and substance-related offences. Substance-use most often conceals pre-existing deeply rooted patterns of dysfunctional emotional regulation. The loss of regulatory control is a key aspect of substance-use disorders. By increasing positive emotion and alleviating negative emo-

tional states, pharmacological drugs alter and regulate emotions. So, emotional dysregulation is an early risk factor, as well as an ongoing motivator of drug use (Kober, 2014). *"Far more than a quest for pleasure, chronic substance use is the addict`s attempt to escape distress"* (Maté, 2010, p. 46). On the biochemical level, the purpose of substance-abuse is to create an altered physiological state in the brain that is more pleasantly experienced – in the very short-term. Chronic drug use remodels the brain`s chemical structure, anatomy, and physiological functioning (Maté, 2010; NIDA, 2012). The longer-term effects are not really considered.

A person's vulnerability can often be traced back to early childhood experiences with caregivers and the quality of the attachment relationship, which influence the development of their brain in a way that disrupts the development of structural right brain's neurobiological systems involved in the processing of emotion, modulation of stress, and self-regulation.

> *"A child's capacity to handle psychological and physiological stress is completely dependent on the relationship with his parent(s). A responsive, predictable nurturing adult plays a key role in the development of our healthy stress response neurobiology."*
>
> (Maté, 2010, p. 186)

The development of opiate and dopamine receptors that are responsible for emotional regulation, pleasure, incentive, and motivation, is affected in a way that the reduction in their number (caused by substance abuse) leads to a constant need for an external source of comfort. Poor self-regulation, lack of basic differentiation, lack of a healthy sense of self, a sense of deficient emptiness, and impaired impulse control result from a parent's inability to meet adequately and consistently fulfil a child's basic emotional needs.

> *"Infants come into the world fully present and alive to every possibility, but they soon begin to shut down parts of themselves that their environment is unable to recognize or accept with love.* (Maté, 2010, p. 377)

So, we are dealing, not only with a population that has been disadvantaged and rejected, but also many individuals who have been damaged in their emotional development and who have also damaged themselves through their substance misuse.

Clinical Example of Destroyed Experience

According to Serbian Criminal Law, patients committing criminal offences, who cannot be held (fully) accountable for these acts due to the influence of psychoactive substances or mental health disorders, can be sentenced to compulsory hospitalization in a Special Prison Hospital, a unique, maximum-security institution specialized for the implementation of treatment measures for drug and alcohol use disorders, as well as mental health disorders. Their involvement in individual and group psychotherapy is voluntary.

John (a pseudonym) is a 30 years old male who has been using psychoactive substances since he was 14. John left school at the age of 15. Over the last ten years, he has been using heroin intravenously. John is the second child in a family of three children (an older brother and younger sister). His older brother, John's role model, was a heroin addict, as well as his former wife. His whole lifestyle revolved around using drugs. His surroundings, social contacts, and emotional relationships were limited to people with similar interests. Long-term patterns of maladaptive and substance-use behaviour left consequences on his health, interpersonal and family relationships, poor work habits, and problems with the law (he had committed multiple counts of aggravated theft). He has never been employed, and has

supported himself and his family by criminal activities. Now, he is serving a second prison sentence of one year and ten months. John has willingly participated in the study and has given written consent to the inclusion of material about him. His name has been altered so he could not be identified. The following transcripts of parts of some psychotherapy sessions illustrate the initial phase of the treatment, exploring the client's inner world and establishing the psychotherapy relationship.

John: (head lowered) I feel sick today, feels like quitting – 'cold turkey' (symptoms of physical abstinence syndrome).

Therapist: What does it look like when you are experiencing withdrawal symptoms?

J: My palms are sweating. I cannot sleep, I sleep for an hour or two at night. I cannot concentrate. Last night, I did not sleep at all. I haven't slept for months, maybe an hour or two at night. My body is aching, my bones ache – like going cold turkey.

T: You describe some physical symptoms. When you experience withdrawal symptoms, then you need some drugs to make them disappear.

J: Yeah, but I didn't think about taking drugs. I've decided I would no longer use drugs. I don't know why I feel this way (expects a response from the therapist).

T: You haven't used drugs for months. Then, is it possible to experience withdrawal symptoms?

J: It is not possible. I shouldn't feel this way. It's probably some flashback from drugs, since I have been using them for a long time, it left consequences.

T: Can you try to remember what preceded the onset of these symptoms?

J: Yes. Last night I was thinking about everything that was going on the last 15 years, about my family, my parents, what I have done to them, about myself, my remorse. For the first time, I am clean (abstinent). For the first time, now I can see things differently. When I am high (under the influence of drugs), I don't care. I just turn my back and leave. Now I see what I have done to them.

T: You were thinking about some unpleasant things that happened, unpleasant things caused by your behaviour, and that thinking triggered anxiety, uneasiness, and some bodily reactions that you associated with the symptoms of withdrawal?

J: (surprised) You don't think it's a consequence of using drugs? (Seems like posing a question to himself).

J: (after a short pause) You think remorse makes me feel like withdrawal? It didn't occur to me. But yes, that feels right. That means that I'm packing my remorse into withdrawal!

T: And, what about other unpleasant emotions?

J: That could mean that I also experience all other unpleasant emotions as withdrawal!

T: And, when you take drugs, it all goes away. Thus, you can control the way you feel.

J: Yeah, that's it! I didn't realize it before. I don't even remember the time when I was clean, I was always using something. I could always induce the state I wanted.

T: Can you describe what inner states you wanted to avoid?

J: It was a long time ago. I haven't been clean for a long time. But, when I remember the time when I first started, I could call it mild hysteria.

T: What is mild hysteria?

J: Pain, anger, powerlessness, anxiety. But I

haven't even thought about it before; I have never made that connection. I haven't even understood what emotions I was avoiding (pause). And then, from that state, when I take the drugs, I go into apathy.

T: All the unpleasant emotions that you have mentioned disappear when you take drugs and go into a state of apathy.

J: Yes, then I feel nothing, everything becomes a flat line. Drugs bring satisfaction and fulfilment, that's how I would call it.

T: How would you describe feeling satisfied and fulfilled?

J: I am pleased because I have fulfilled myself with a feeling of my choice.

T: So, the goal is to manipulate your feelings and evoke more pleasant ones?

J: Yeah, that's right. But I've never realized it before; I've never realized that I avoided coping with those feelings. When I was high, everything was fine. I thought that everything was temporary and would go away as soon as I took drugs. And then, I didn't care about what was happening around me, what others were saying. And when I look into myself now, it seems like I was closing myself in a cocoon, it looks like my fear was locking me up.

After the session, John decided to paint his feelings. (Figure 1). He described his painting as "a baby in the heroin membrane", which symbolized the period of using drugs, insensitivity to outside circumstances and reality, emotional withdrawal, and apathy. According to his words, the volcano's eruption symbolizes the period of abstinence and the initial phase of the treatment, with emerging strong, mixed emotions (fear; happiness/pleasure; powerlessness/anger; loss/lie; rejection/hatred/envy; understanding/communication; suffering/love; suppression/pain) that were often difficult to accept and control.

At the beginning of the treatment, John misinterpreted some of his somatic sensations as symptoms of abstinence crisis, leading to unrecognized drug craving and possible relapse. Undefined physical pain and a general feeling of weakness were interpreted as withdrawal symptoms. Deeply buried feelings, suppressed for years by the effect of drugs, rejected by his self, abruptly emerged. John had tried to avoid and suppress these painful experiences, in an attempt to restore fragile internal equilibrium. Restoring confidence in his own experience and accepting his emotions as part of the Self was the most important step in his psychotherapy.

By developing an attitude of unconditional regard, the therapist enabled necessary conditions for John to begin to explore all of his experiences as they truly are. Symbolization of his experiences and changes in his emotional processing both stimulated his awareness, his depth of experiencing, and the constructions of meaning in his life. As Kirschenbaum (2007) noted of Carl Roger's work, a therapist's acceptance, recognition, and clarification of feelings are often associated with improved client insight. Emotions become accepted as part of the self, opening the possibility for further exploring the inner emotional world without fear and defence. The integration of experience into the self – in this case – was additionally fostered by creative expression, strengthening the process of symbolization. John continued to use art to paint his feelings and his view of the world.

Outwards to the Interpersonal: Establishing Bond with the Client

Psychotherapy is a unique encounter, a meaningful dialogue (Szasz, 1988) of two individuals, designated by a special quality of relationship being established and developed. A

Figure 1. *Volcano: the inner world of John*

helping relationship (Rogers, 1995) is a relationship in which at least one participant seeks to initiate growth, development, maturity, and better functioning in the other; such a relationship in which one participant encourages the other to respect, express, and more effectively use its latent, inner possibilities.

The innate need for human contact is the fundamental motive because *"our relatedness to others is an essential aspect of our being, as is our separateness … Psychotherapy is an activity in which that aspect of the patient's being, his relatedness to others, is used for therapeutic ends."* (Laing, 1960, p. 26)

Client-centred therapy emphasizes three therapeutical conditions – unconditional positive regard, empathy, and genuineness – as being necessary and sufficient for therapeutic change. Empathy was regarded as one of the most potent factors (Rogers, 1975). Clients who receive empathic understanding should (will) be better able to trust and understand themselves and make positive behaviour changes.

> *"The client's desire and capacity for change is the key determinant of choice. Desire and capacity for change are derivative of clients' and therapists' dispositions. To the degree that therapists are open and available to clients for deeper contact, clients too may, within their unique parameters, become maximally open and available."*
>
> (Schneider, 2016, p. 50)

Many individuals with substance use disorders are motivated for treatment only by social,

financial, criminal, and medical consequences of taking drugs, not by a genuine desire to deprive themselves of their pleasurable effect (Onken, Blaine & Boren, 1997). High dropout rates (Cournoyer, Brochu, Landry & Bergeron, 2007) and engaging and retaining individuals with substance use disorders in treatment (Meier, Barrowclough & Donmall, 2005) are difficulties that the therapist often encounters. Thus, establishing a strong therapeutic alliance is essential, predicting better treatment outcomes (Flores, 2006; Pantalon *et al.*, 2004). Olivenstein (1991) notes that, at the very beginning of treatment, many different motives occur in individuals with substance use disorders, which are more or less authentic, variable, and indeterminate, but which generally conceal an informal request for care. They crystallize into motivation for change only when the individual forms an attachment to the therapist.

A forensic setting usually implies caring for people "who mistrust care" (Adshead & Pfaffin, 2004, pp. 263), which makes establishing and maintaining a psychotherapeutic relationship difficult. The majority of the forensic population has anti-social personality traits and a long history of maladaptive behaviours and trauma, resulting in a basic lack of trust in other people. *"Many also have ingrained fear of authority figures and distrust institutions"* (Maté, 2010, p. 22). Yakeley & Wood (2011) particularly emphasized the importance of a patient's trust and acceptance in forensic psychotherapy. *"Incarcerated in institutions where fear and violence often rule, many will re-experience exactly what they suffered early in their lives and ever since: helplessness and isolation"* (Maté, 2010, p. 259).

Therefore, particular attention should be focused on avoiding the revictimization of forensic clients, respecting their pronounced vulnerability and their sensitivity to rejection. A negative psychotherapy experience could reactivate both deeply ingrained negative attachment experiences with caregivers and other traumatic experiences within social relationships throughout their lives. The psychotherapeutic relationship should be qualitatively different from the experiences they had in their lives, enabling a sense of freedom and promoting motivation for the change of old patterns of dysfunctional emotional processing.

Clinical Example of Establishing a Bond with the Client (The same client as in the previous section)

T: Did you only discover your unpleasant emotions?

J: No. There are also positive energy and inspiration. Inspiration is the driving energy that can trigger another person, situation, or atmosphere. Things have changed a lot. Now, I can enjoy some different things, discover something new. I paint, which I have not done before: I had not even tried. There are so many other things. For the first time, I have started thinking about myself, about my fears and inhibitions. I have been able to overcome some of them. I feel in control of myself, and it pleases me. It feels so good to rise above the situation, though sometimes it can be difficult. It's funny seeing other people behave the same way that I did at the beginning; I understand them completely. I think that I have made progress. I have changed my way of thinking, and the people around me notice that. For the first time in my life, I said I wouldn't use drugs, and that's what I truly believe. I have never before intended to stop using the drugs. I only went to treatment when my parents pressured me, only to get clean rather than get the treatment. When I realized that I needed an enormous quantity of drugs, I got cleaned to lower the quantity I needed to get high. All addicts do that. That is

the reason why they seek treatment. People around me were trying to help me. Now I realize they were right in everything they were telling me. Now I see that all the time I had an example, someone who has been using drugs and stopped using 13 years ago, he made that decision and stopped. If he could, so could I.

T: Your older brother?

J: Yes. He has a strong character. He said he wouldn't use it anymore and stopped. Now, he is a rugby coach, he has his own family, a wife, and a kid, and he is an idol to the kids from the neighbourhood. I could have been like that.

T: You could?

J: Yes, I could. No, I still can. But I am afraid of failure.

T: What does the failure represent to you?

J: When I harm my whole family and, most of all, myself – but I do not even see that. It took me a while to get back to normal so I could understand that. Now things look different. Now I see all the things I could have done, but I never did. I was great as a kid, the best at school, I went to competitions, practised rugby. Then I started using drugs and ruined everything. I have not been normal for 15 years.

T: What would success be like?

J: To be me, without drugs. I didn't even understand what I could do. Now, I try doing something new and see that I am successful, and I didn't even know how to do it before. When we started talking a while ago, I didn't even realize what was inhibiting me. Now I am noticing when I come across an obstacle, and it is not that scary anymore, all those fears seem ridiculous to me, trivial, we talked about it, it is a consequence of the way I have lived and the people around me. Now I understand what a positive story is and a healthy relationship.

T: Is that a type of relationship in which you have the trust?

J: Yes, now I have trust. There is still a little restraint, but I am going to overcome it over time. Only, I am going to become too good, and that is bad for prison. That is the reason why I still have some restraint. I am scared to open up and become completely good.

T: Having trust and being open can mean being vulnerable.

J: Yeah, but that is not good when you are in prison. People can take advantage of it. It would be different outside.

Previous painful experiences taught John not to have any trust in other people. Distrust protected him from rejection and stigmatization of society, on one side, and abuse and manipulation of other drug users and prison inmates, on the other. Loneliness and social isolation are consequences of this sort of lifestyle and of the early developmental failures that many drug users describe as "inner prison" and John described as a "cocoon".

Defensiveness and isolation created a barrier to forming healing relationships and served as an automated protective mechanism from disappointment, and prevented John from establishing meaningful interpersonal bonds that could challenge existing psychological structures and patterns of emotional processing. Psychoactive substances – seemingly – offered him some comfort and kept him momentarily safe from harm.

The psychotherapeutic relationship opened the door for a change in a way that fostered openness and offered a completely different experience, promoting the process of healing. John's fear of becoming too open was probably a fear of being judged, and, in its essence, the fear of being rejected. A new corrective ex-

perience of safety and support in the psychotherapy relationship initiated the change in emotional processing and gradually strengthened self-esteem enabling John to cope with his fears. The need to use psychoactive substances to regulate his emotional states had gradually diminished, and his intrinsic motivation for treatment was strengthened.

Discussion and Conclusion

From the developmental perspective, early attachment experiences shape the early organization of the right brain, therefore forming the neurobiological core of the human unconscious (Schore, 2007). Early in life, emotions are regulated by caregivers. Later in life, they become increasingly self-regulated as a result of neuro-psychological development. Attachment experiences, imprinted in an internal working model, encode affect regulation strategies acting at implicit nonconscious levels. The failure of primary emotional communication and attunement with subsequent patterns of the inadequate capacity of self-regulation leads to seeking alternative methods of affect modulation, often connected with substance use in an attempt to repair missing or deficient psychological structures.

Only freely symbolized experience, deprived of defensive denial and distortion, can be available to awareness (Rogers, 1959). Denying and distorting significant experiences lead to inaccurate symbolization and creates incongruence between self and experience, resulting in psychological maladjustment. *"When we flee our vulnerability, we lose our full capacity for feeling emotion"* (Maté, 2010, p. 46). Repressing painful emotions from awareness once helped in coping with painful experiences, keeping the integrity of the self. But, in the long-term, automatic use of this defence mechanism results in emotional numbness, fostered by the use of substances.

Individuals in forensic institutions are often confronted with a specific type of social isolation. They are surrounded by individuals leading a similar lifestyle, breaking the emotional bonds with family or friends who are not supporting or cannot their life choices. Prolonged incarceration builds further isolation due to reduced contact with the outside world, depriving the individual of nearly all significant emotional relationships. Defensiveness and distrust are therefore often seen in forensic clients. Cozolino (2010) concludes that social isolation created by psychological defences, *"reinforces the rigidity of neural organization as the client avoids the interpersonal contexts required to promote healing"* (p. 38). The role of the therapeutic relationship therefore is to serve as a bridge to reconnect with others (same source). By returning to themselves, and their own authentic experiences, and becoming open to them, the client becomes ready to experience an affective relationship with another person without fear or defence.

Schore (2001) concludes that the empathic therapist's capacity to regulate the patient's arousal state within the affectively charged non-conscious relationship is critical to clinical effectiveness. Implicit right brain-to-right brain intersubjective transactions lie at the core of the therapeutic relationship; thus, psychotherapy is not the talking but the communicating cure (Schore, 2007). The therapist's task is to enhance the developmental process and act as *"an interactive regulator of the patient's psychobiological states"* (Schore, 2007, p. 16). In the forensic setting, corrective emotional experiences emerging from a strong therapeutic alliance, characterized by safety and trust, *"lay the emotional groundwork necessary for stimulating new, intrinsically-motivated learning that is conductive to more pro-social thinking and behavior"* (Bland, 2014, p. 48). New experience stimulates overcoming a typically ego-centric perspective of forensic

clients that justifies abuse of other people and antisocial acts, resulting in destructive behaviour.

Forensic treatment should promote the ability to utilize one's power and resources to fulfil one's potential (Bland, 2014). If offenders are treated as objects, assuming a sense of separateness and primarily focusing on personal responsibility, promoting the vicious cycles of resistance and institutionalization, the results are poor correctional practice outcomes. By responding in a non-judgmental way, the therapist breaks the offender's sense of isolation. *"Revealing previously private aspects of oneself and being seen, validated, and accepted are [regarded] as healing"* (Greenberg & Elliot, as cited in Bland, 2014, p. 54). Therapeutic relationship providing support, emotional and neurobiological stimulation, enhances new learning. Maladaptive intra- and interpersonal perceptual and response patterns, confronted and disconfirmed by the therapist's attitude, are corrected by creating new meanings in the client's experience (Bland, 2014). Therefore, corrective experience involves the change in emotion, cognition, and behaviour.

Further research is needed in this under-researched psychotherapeutic area addressing the therapy process as well as therapy outcome in the treatment of forensic clients. Taking this into account that providing treatment for mental health and substance use disorders lowers the risk of reoffending (NIDA, 2012; Pearson & Lipton, 1999) and that therapy failure is a potent predictor of substance-related re-delinquency (Querengässer, Langenstück & Hoffmann, 2019), a positive outcome in forensic psychotherapy can lead towards healing the individual, but also contributes to the safety of the larger society.

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Why We Should Embrace Positivism in Group Analysis

Susanne Vosmer

Abstract: Positivism is a philosophy which holds that objective knowledge is acquired through experimentation and that people should only study what is measurable. Anything that is not measurable is therefore irrelevant. Quantitative research falls within the realm of the nomothetic paradigm and positivism. Many therapists are reluctant to concern themselves with such research. This article aims to make research more understandable in the context of group analytic psychotherapy. Moreover, it aims to engender interest in Group Analysis. Research characteristics are discussed by drawing on interpretations. Group vignettes are presented to facilitate comprehension. I propose that both observation and interpretation are not inferior to experimentation. Since the observed is changed through the very act of looking, I query whether objectivity can ever be achieved. Drawing on fractal theory, I suggest that divisive interactions are predictable. Researching intersubjective dialogues through correspondence analysis and integrative information theory could produce empirical evidence. The social unconscious could also be researched with quantitative methods. Group psychotherapists should embrace the nomothetic paradigm, because it enables clinicians to use novel methods and produce scientific theories.

Key Words: Positivism, Group Analysis, Research, Interpretation, Unconscious Processes

Introduction

Positivism is usually equated with science and associated with the nomothetic paradigm. Observation, inductive logic, experimentation and statistics are pillars of this paradigm, which assumes that generalisable laws exist in nature and that these can be objectively discovered. Research is the systematisation of experiences and integration of facts through observation and experimentation (Lorentzen, 2006).

S.H. Foulkes, the father of Group Analysis, regarded groups as basic to human existence,

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all individuals being born into social groups (families, cultures, societies) that shape the lifespan continuously in conscious and less conscious ways. As a form of psychotherapy, Group Analysis values communication and relationships, dialogue and exchange. It focuses on the analysis of relationship dynamics within the group.

Foulkes (1975) was a 'natural' researcher, who observed and 'experimented' with the unconscious life of groups. Admittedly, this was not experimentation in the positivist sense. Nevertheless, Group Analysis lends itself to researching groups. Whilst several group analysts have carried out randomised controlled trials and embraced positivist methods, others have been more hesitant. Some have rejected positivism. Often without appreciating that positivism pervades Group Analysis. Many group clinicians also lack research knowledge. Hearing the word 'research' can create instant apprehension. Incomprehensible terminology and mysteriously looking formulas, consisting of Greek letters, leave those clinicians feeling overwhelmed. Research remains a dread, the article is put away, and carrying out actual studies is, more often than not, not even a consideration.

In an attempt to address and change this status quo, this paper discusses research and positivism in relation to Group Analysis. The aim of this article is twofold. Firstly, I hope that it will alleviate apprehension and encourage clinicians to engage with quantitative research and embrace positivism. Secondly, it is hoped that individual psychotherapists will become curious about groups. Brief vignettes are therefore included to make common research terminology and concepts accessible. (Peoples' names have been changed and descriptions adhere to confidentiality.) Characteristics of quantitative methodology and methods will be illustrated by drawing on interpretation, because interpretation and research have commonalities. Both aim to discover something unknown. Finally, new methods are proposed to research unconscious processes.

Observation, Interpretation & Experimentation

As participant observer, I observe other group members and myself.

> *Amongst a whirlpool of thoughts, I can feel irritation arising in my chest.*

Self-observation is inherently difficult, because unlimited thoughts come into consciousness. Subsequent reflection, where some of those thoughts are suppressed (see Freud, 1920), makes it easier to distinguish, which feelings belong to me and which to the other group members.

> *I had been cheerful before the group started.*

I analyse this change. Trying to make sense of undigested feelings, my countertransference and transference have become 'instruments of research' into unconscious group processes, which are much more complex due to multiple vertical, horizontal and lateral transferences. In my head, I tentatively formulate the hypothesis

> *... that the anger in my group is related to absent mothers.*

and wait. Ideally, groups themselves interpret what is going on, since all members participate in the group (Foulkes, 1975). Nothing happens. Hence, I wonder aloud whether

> *"... the group experiences me like an absent mother and notice with an air of trepidation how members react. Scanning the facial expressions of individuals is more than a blind groping. If Dan's quizzical glance turns into a 'knowing expression', it offers me a hunch that my interpretation has led to new insight on the long journey to change."*

Such 'mutative' interpretations can be 'life-changing' according to the psychoanalytic literature. But a 'correct' interpretation (Foulkes, 1975) is not necessarily a 'good' one. Pines (1998) wrote that his best interpretations were tentative offerings of his understanding of the patient.

Observing my group, I am left with numerous questions. Do my interpretations only cultivate *awareness* of inhibited, repressed or dissociated thoughts and emotions? Is their delivery more important than the content? Are distinctions between interpretations redundant? Not knowing the answers, I am nevertheless certain that new associative processes are formed in Dan's brain, if he thinks about my interpretation, and therefore deeply processes it.

> *"No, you're wrong", Dan states. After letting out a sigh, which expresses a profundity that I can rarely voice, he looks at me, shaking his head.*

Reflecting on my interpretation allows me to ascertain why this inference was wrong.

> *I follow the dialogue in the group (evidence) and discard my hypothesis that Dan's hostility is related to his absent mother. Suddenly, others start talking about trivial daily routines in a detached manner. Marilyn looks bored. With an uncanny astuteness, she glances at me. Her boredom speaks a universal language. No translation is necessary.*

It seems to confirm my hypothesis that the group avoids connecting emotionally with each other, possibly because of hidden trauma underneath its dynamic matrix. Schlapobersky (2016) described the matrix, the hypothetical web of communication and relationships, as particle and wave. After suggesting that:

> *"... it feels safer to chat about everyday life"*, I focus on the relational and semantic field (wave). *Some agree in placatory manner, others object that routines are important. As dialogue regresses into monologues ...* I 'experiment' by saying that ... *"the group isn't feeling protected by me."*

During the long silence, my mind wanders into the world of research, where I must have independent and dependent variables. 'Manipulation' does not have the same bad name as it has in group analytic psychotherapy. On the contrary, in experiments variables must be controlled (manipulated) so that causal relationships can be discovered. Hence, the independent treatment variable (interpretation) must be carefully chosen to show that it transforms Dan's hostility (the dependent variable).

Causality, the gold standard of the nomothetic paradigm, is impossible to be demonstrated in my group. A matched control group, which is not exposed to my interpretation, is needed to achieve this. Ideally, the experimental and control group are identical in terms of gender, age, mental health issues etc. Participants should be randomly allocated and results analysed by using statistical tests. Formulas exist and computer programmes, such as the Statistical Package for Social Sciences, are commonly used to carry out statistical analyses. Many statisticians are happy to assist as well and most NHS Trusts employ them. Mysteriously looking quotations are often relatively simple and only appear very sophisticated because of Greek letters and mathematical symbols.

My distinct, heterogenous, therapy group requires a complicated experimental design, if I want to demonstrate a causal relationship between interpretation and transformed hostility. Design forms part of the methodology. My lack of experimental design is problematic. Although my interpretations have the potential of being excellent independent variables, they acquire the quality of spurious relations. Variables other than my interpretations can explain what is happening. Any outcome gets

lost on the road of this discovery. Trusting the group merely acquires face validity. Whilst plausible, my interpretations are not necessarily valid (true, accurate).

> *Certainty gives way to doubts as Jenny (another group member) sighs like an arrogant professor, who questions my technical skills.*

As clinicians, we like to believe that we really know what is effective. Evidence shows otherwise. Our estimations are not reliable, meaning that other clinicians are, more or less but not necessarily equally effective, when making the same interpretation in their groups. To achieve clarity regarding effectiveness, collaboration between researchers and clinicians is needed. Interpretations must be studied scientifically in the real world (in consulting rooms with ordinary group members) and not only in carefully selected groups, so that a solid theory of interpretations can be formulated.

> *"What exactly is an interpretation?"*, someone asks in my group.

It is a verbal communication by the conductor (group facilitator), drawing attention to a meaning that s/he thinks the group is unaware of (Foulkes, 1975). I ponder this. Is an interpretation a suggestion? By breaking through resistance, do we influence the perception of our group members' inner reality? Are mutative interpretations placebos, where something other than the active ingredient (which is supposed to heal), is given without the participant knowing this? Does their effectiveness depend on whether group members believe in what group conductors say? Without empirically studying interpretations, we cannot answer these questions.

> *Returning my focus to my group, I locate the groups' anger in the foundation matrix and translate it by interpreting the silence as expression of hostility towards mothers. This is rejected with raised eyebrows and loud noises.*

Foulkes distinguished the 'dynamic' matrix, observed in the active life of the therapy group, from the 'foundation' matrix, which refers to shared meaning, cultural images and other aspects of human life and emotionality (Weegmann, 2014).

As the silence lingers on, I continue my research. There are commonalities between interpretation and research. Interpreting is an analytic investigation that attempts to cultivate awareness by uncovering hidden meaning. Similarly, research wants to discover unknown factors. Both interpretation and research rely on observation.

Paradoxically, we change what we are observing through the very act of looking, as experiments in quantum mechanics have shown (Matteucci *et al.*, 2010). This has implications. Since experiments are observed, they may not produce objective data after all. So, systematically studying interpretations through observation is **not** inferior to experimentation. Furthermore, whether objectivity can ever be achieved remains debatable and needs to be explored further.

Group Analytic Theories & Concepts viewed through the Lens of Positivism

Freud (1900) described a theory as a statement, which seeks to explain observed characteristics from a single point of view. Theory is derived from research. In turn, research tests theoretical statements.

If my proposition:

> *"... significantly building trust increases the effectiveness of interpretations"*

is not confirmed by research data, provided that the theory of interpretation postulates this, such theory would need to be discarded, refined or newly formulated.

Foulkes (1948) adopted Freud's positivist dynamic unconscious and showed that our inner world is a microcosm of the wider world. Embracing Goldstein's epistemological principle that nothing should be considered without reference to the total situation (Foulkes, 1990), he replaced the method of free association with free floating discussion, so as to gain access to the unconscious (Foulkes & Anthony, 1957).

> *My group started talking about boats, migration and families. Babies, who had died, and babies who were born in the new country. Abandonment and loss, departure and arrival, death and love were touched on as unconscious conflicts came to the fore.*

Peeling off layer after layer of people's unconscious is a group analytic method. Does Freud's (1915) dynamic unconscious and the theory of repression, which Foulkes integrated into Group Analysis, fulfil all necessary criteria to be classed as positivist? The dynamic unconscious is a naturally occurring phenomenon from which fundamental laws can be discovered. The variables of time and space generate specific laws about the unconscious (illogical, timelessness) from a selective observational base (self-observation, through free association). Belonging to human nature, the unconscious is universal. Qualitative changes, such as becoming conscious of hidden feelings, depend on quantitative variations. There is a variable intensity of feelings amongst dissociative and neurotic disorders. The law of the dynamic unconscious is homogenous, isomorphic (similar in form and relations) and can be applied both across the human species and diverse disciplines. The theory of repression explains how phenomena become unconscious and is falsifiable. Falsifiability distinguishes science from non-science (Popper, 1992), so Group Analysis is based on scientific theories. Science means knowledge and is associated with positivism. Traditionally knowledge has been obtained by means of quantitative methodologies and methods.

Exploration of the Social Unconscious of Racism

Javid read about an event from his distant, but not, forgotten past:

> *"White chalk on fascia boards above an Arabic food stall says '~~Iranian rules~~', which is crossed out, but not erased."*

Prejudices are inscribed in language. Words like 'White', 'Arab' and 'Iranian' elicit conscious and unconscious assumptions. Reminiscent of a superiority that officially no longer exists, the effect of the word 'white' is nevertheless difficult to eradicate. It can be revealed through exploration of the social unconscious, which has been elucidated in various societies (Hopper & Weinberg, 2017).

Hopper (1996, 2003) wrote about the unconscious influences of culture, communities and nations on individuals' internal worlds. Disturbingly, even when people become aware of these constraints, they often deny them. Hopper critiqued the social order and showed to what extent its defining rules legitimise domination.

> *"Why do people assume that I'm uneducated, just because I'm black?" Javid (another group member) asks. His sense of self has been affected by the contempt of his neighbours.*

Difference is historically loaded and socially constructed (Kinouani, 2019). Associated with power, 'whiteness' is performed within the wider socio-political matrix, albeit inadvertently at times.

> *"... to learn enough about Third World 'men' ... First World 'man' must learn to stop feeling privileged as a man", someone wrote.*

My group's dynamic matrix becomes a mirror, rendering the racialised social order visible. British colonialism lies at the heart of racism (Blackwell, 2005). Like Freud's repressed, colonialism haunts and will not disappear.

> *Donald's arrogance and 'superiority' has often been challenged by the group. He is now more sympathetic towards Javid, who has become stronger through 'ego training in action'.*

Integrating intersubjective psychoanalysis, Brown gave substance to this technique (Brown & Zinkin, 1994). Strengthening the ego is important when individuals are confronted with racist societal discourses.

> *Brindly (in the group) looks at Javid with a tenderness that moves him to tears. "Who are you?" Jenny asks and offers Javid a tissue. Javid takes it, but remains silent. "Remember that you're an engineer. Once your application will have been approved, you'll make a name for yourself and they'll realise that they misjudged you," Jenny says. Javid attempts to smile. "You're right", he responds. "Sometimes I forget who I am."*

Always there, social unconsciousness and consciousness are integral parts of the matrix (Weegmann, 2014, 2015). Butler (2003) wrote that we must recognise our consciousness as same and different from others'. *"Who are you"* is central to the encounter between two consciousnesses. The other must be recognised as same and different from me. In groups, we discover who we and others are. It may be a recognition of a lost identity or a newly found one. However, the 'I' cannot assert its own position, because it is already constituted by society and culture:

> *"For how to speak with the 'I' when you're not the subject of the sentence, when you're already spoken for, when those speaking don't listen to the viewpoint of the Other, and indeed 'what it's like to live in a world that only exists for others'".* (Young, 2003)

Without the group, it is impossible to gain awareness of all the hidden forces and constraints that make up our identity (Hopper, 2003, 2012). Javid came as a refugee to Britain. Will he ever become visible as a person in an excluding community that only exists for others?

Embracing Positivism & Quantitative Methods

> *Javid tells us more about the racist words and sentences that wound him.*

Are these painful racist interactions predictable? Elias (1939, 1978) studied the social evolution of interactions between people and while interactions have unpredictable and uncontrollable consequences, patterns emerge out of an apparent disorder in numerous interactions. There is order in disorder, as fractal theory shows. Fractals are infinitely complex patterns that are similar.

A fractal can display both regular and irregular patterns simultaneously. Within a stable space or time, sequences can be unstable. And we can find stability within unstable space or time sequences. Structures operate with similar unpredictability. Deterministic, iterative, nonlinear relationships can produce unpredictable behaviours. However, order does emerge through processes of spontaneous self-organisation in the absence of any blueprint (Stacey, 2003). This would suggest, for example, that (racist) interactions are predictable. Furthermore, considering that our rational human mind follows the logic of the dynamic, lawful unconscious, mathematical models could be used to make predictions. One could also explore integrated informational theory, which can make predictive statements about consciousness (see Tononi & Koch, 2016). Could this theory be used to ex-

plain and predict the individual quantity and quality of unconscious processes? Researching this may reveal interesting findings. Unconscious processes are also measurable (see Murtagh, 2014). The social unconscious and other unconscious processes could be traced in discourses by using correspondence analysis. Geometrical representations of latent semantics can be mapped with this methodology (see Murtagh, 2014).

Whilst not every group analyst may agree with such suggestions, group analytic psychotherapy has become more scientific and acquired a positivist flavour as a result of randomised controlled trials (e.g. Lorentzen, 2006). Not every group analyst is convinced that conforming to evidence-based practice is desirable, because it relies on positivist methods. There is also another concern. Could group analysts lose their unique voice and professional identity in the wide field of psychotherapy and become just one of many methods?

Adopting an empirical approach does not automatically imply conformity. Bakhtin's Carnival discourse was not only an open critique of totalitarianism, but also challenged from within. Group Analysis could do the same. Until this is achieved, let us not forget that group analysts require funding and that policy makers favour empiricism. It is therefore suggested that colleagues, who are critical of this metatheoretical approach, analyse any of their negative sentiments towards positivism. Perhaps it is fear of the unknown, rather than rejection of the epistemological position (i.e. what counts as knowledge and how knowledge is acquired).

Be this as it may, advocates of the interpretative, hermeneutic paradigm may need to consider that Group Analysis is considerably more positivist than they would like to admit. Freud's dynamic unconscious is positivist, as I have shown, and was adopted by Foulkes. Foulkes (1948) also drew on Goldstein's positivist neurology. His (1948) binary opposition of the individual and society is partly rooted in a positivist sociology. Whilst individuals and society interact, they remain relatively fixed throughout their interaction (see Ketokivi, 2010). Hence, even interactions are lawful. Furthermore, intersubjectivity rests on a constituting law. When the subject is essentially subjected (constituted), it cannot escape its very subjectivity (Butler, 1997). This implies determinism and a constituting law, which moves intersubjectivity and related theories into the realm of positivism.

Intersubjectivity has become important in Group Analysis. Socio-political and historical aspects largely determine the human mind (Koukis, 2016) and people are also constituted by language. Discourses about whiteness (Khana, 2004; Kinouani, 2019) fundamentally affect our identity and are also strongly related to power (Burman, 2002). Racism can emerge as a surprising moment in the group:

> *"You're racist", Javid muttered, after Donald had made a racial joke. There was a sad glimmer in Brindly's eyes, an expression of familiarity. "I didn't mean it like that", Donald said.*

As they were analysing their socially constructed racial identities, Donald was able to discover shame and guilt through these intersubjective dialogues.

What stops us from researching such group dialogues and intersubjectivity more systematically by using correspondence analysis and/or other quantitative methods? We should not become complacent and rely on academic group analysts to provide us with evidence. It would probably be beneficial for Group Analysis, if we all concerned ourselves more with quantitative research. Love it or hate it, but at least learn something about positivism and quantitative research before rejecting it.

Summary & Conclusion

This paper contributes towards making crucial research concepts more understandable. Discussing quantitative research and groups has hopefully engendered curiosity. I have queried whether objectivity can ever be achieved. Since experiments are based on observation, and quantum mechanics has demonstrated that changes in the observed occur through the very act of looking, it is therefore questionable that experiments are objective. Consequently, observation is not inferior to experimentation. Furthermore, I have queried whether the effectiveness of interpretations depends on whether group members believe in them or not. Do interpretations act as placebos? This could be researched and an empirical theory of interpretation be formulated.

Group vignettes were also used to explore the social unconscious in relation to difference. Drawing on fractal theory, I have suggested that (racial) interactions are predictable. Researching intersubjective dialogues could provide us with new insight into racism. Methods, such as correspondence analysis, could be used to examine unconscious processes. Integrated information theory could also be adapted to research unconsciousness. Empirical evidence for group analytic theories and concepts could be produced in this way.

Intersubjectivity was discussed in relation to the social construction of racism and positivism. As seen, even intersubjectivity rests on a constituting law, which moves it into the realm of positivism. The positivist influence on group analytic theories is astonishing. Foulkes adopted Freud's dynamic unconscious and Goldstein's positivist neurology. Furthermore, his conceptualisation of the individual and society are also rooted in positivism. Considering the growing number of randomised controlled trials, Group Analysis is more positivist than opponents of this metatheoretical approach may like to acknowledge. If you wonder whether we need empiricism, I suggest that we do. Embracing positivism does not automatically mean that group psychotherapists are conforming to dominant policies. On the contrary, it offers the opportunity to utilise innovative research methods and generate new scientific evidence. Knowledge is power. By producing novel knowledge, psychotherapists can become more influential.

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A Pragmatic Framework for the Supervision of Psychotherapy: Part 2: Supportive Alliance

James C. Overholser

Abstract: The supervision of psychotherapy relies on a supportive relationship between a seasoned expert and a novice therapist. Supervisors will provide a safe environment and a supportive alliance to ensure that trainees to do not feel overwhelmed by the responsibilities or confused by the strategies. A strong supervisory relationship is built upon a foundation of the supervisor's clinical experience, including personal memories of being a struggling trainee. With respect and patience, the supervisor can establish a working alliance. The actual process of supervisory meetings relies on appropriate standards and expectations, honest feedback about specific actions, and frequent praise for appropriate actions. With these various elements established, the trainee is often willing to explore new ideas in a safe learning environment.

Key Words: supervision, psychotherapy, developmental models

Psychotherapy is an important service and a vibrant field. Many clients gain long-lasting benefit from their participation in psychotherapy sessions with a skilled therapist. However, the field of psychotherapy requires proper training and supervision of novice therapists in order to enhance the future of the field. Training to become a competent therapist includes a broad spectrum of graduate courses and ... supervised clinical experience. Furthermore, it is important for supervisors to remain active in the professional services they supervise and in those being performed by their trainees.

Today, there is an unfortunate – and heavy – focus on curriculum-based training combined with structured treatment manuals. However, trainees cannot learn psychotherapy from a book or a class. Instead, trainees can develop skill in psychotherapy through a supportive relationship with a skilled mentor is essential, combined with extensive experience in help-

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ing clients as they gain insight and make improvements through psychotherapy sessions.

The supervision of psychotherapy can be based on four central ingredients: (i) a strong supportive relationship between trainee and supervisor; (ii) clear guidance with specific directions for therapy; (c) a willingness to explore new ideas together as a team; and (d) an ability to adapt the supervisory process to the unique needs of each trainee (Overholser, 2004).

The present manuscript examines in detail the central role of the positive collaboration in psychotherapy supervision (see Figure 1). The supportive alliance that underlies supervision relies primarily on: the supervisor's professional experience; a relationship of trust; and appropriate expectations to guide any evaluations or feedback provided to the trainee.

The Supervisory Relationship

Supervision relies on a positive collaboration between an experienced clinician and a novice therapist. Effective supervision requires a strong relationship between trainee and supervisor (Karpenko & Gidycz, 2012). The supportive relationship between supervisor and trainee plays the central role in effective supervision (Falender & Shafranske, 2014; Ladany, 2014; Tangen & Borders 2016; Weaks, 2002) and a strong and supportive alliance is

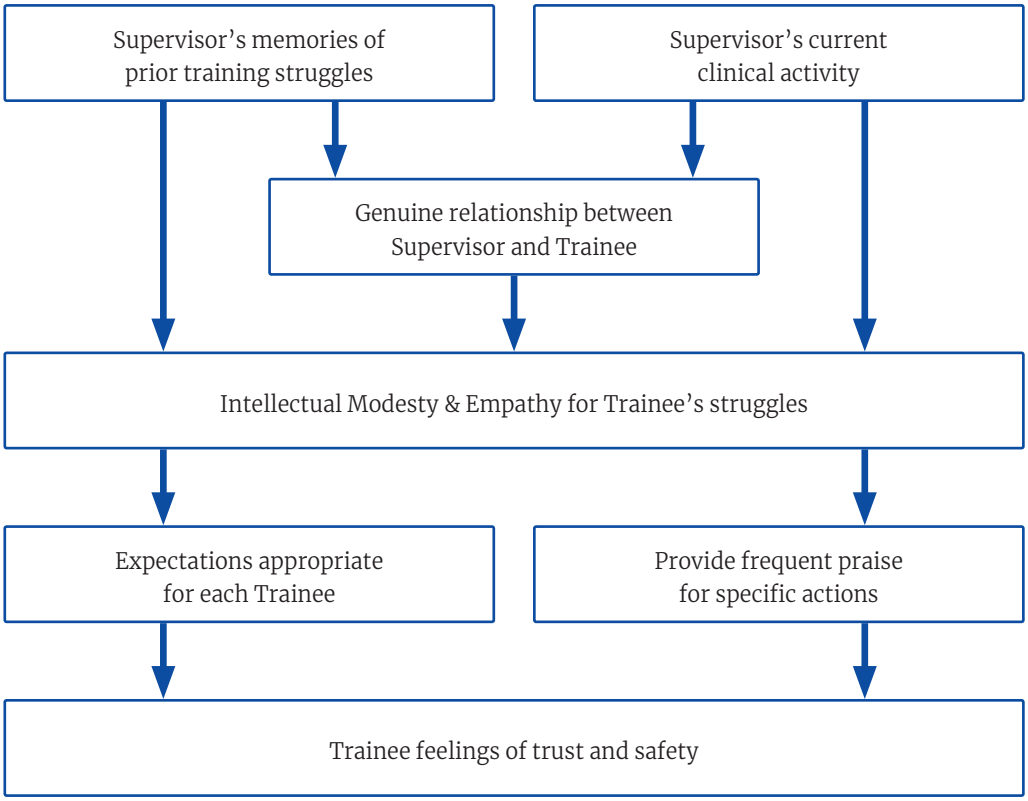

Figure 1.

important at all levels of training (Stoltenberg *et al.*, 2014). Despite the central role of the supervisory relationship, there is little consensus about what it entails.

As part of this alliance, the supervisor often serves as an advocate, looking out for the well-being of the trainee and offering gentle words of support throughout the training experience. Furthermore, the supervisor aims to protect the trainee, promoting the personal growth and professional development of the trainee. Over time, trainees establish a sense of congruence between their personal values and professional style, relying on therapeutic strategies that align with their own personal strengths (Maruniakova *et al.*, 2017).

The supervisory relationship relies on several core components, including: the accumulated clinical experience of the supervisor; the supervisor's memories as a trainee; and the supervisor's ongoing involvement with clinical services. There also needs to be a genuine compassion and understanding, both from the supervisor to the trainee, as well as a genuine acceptance and respect from the trainee to the supervisor. These components establish the credibility of the supervisor and help the supervisee to appreciate the limits and challenges of helping some clients.

Supervisor's Clinical Experience

Each supervisor's background lays the foundation for their supervisory style. The professional's background credentials and professional experiences tend to underlie the supervisor's approach to treatment as well as their style of supervision. After earning a terminal degree in psychology or allied field, the individual should accumulate several years of experience working in the field, providing the clinical services that are being trained to the novice. Classes and readings may promote knowledge of theories and an external sense of conviction, but personal experience is needed to develop skill as a therapist and internalized feelings of confidence (Maruniakova & Rihacek, 2018). There is a tremendous gap between clinical interventions as described in published research and the realities of the actual practice of psychotherapy (Friedberg *et al.*, 2009). Despite the value of classroom education, psychotherapy skills develop through experiential learning centered around work with real clients (Folkes-Skinner *et al.*, 2010). Because the essence of psychotherapy is a unique relationship that cannot be captured in a treatment manual, trainees often benefit from a competent role model that is prepared to serve as a guide on the path toward effective therapy skills (Vakoch & Strupp, 2000). Therapy skills continue to develop long after the end of formal training (Skovholt & Rønnestad, 2003). Additional time spent practicing new skills results in improved effectiveness as a therapist (Chow *et al.*, 2015). Clinical experience paves the way to teach material that is relevant to real clinical practice (Ray, Jayne & Miller, 2014). Research on the development of expertise has found that it requires 10-15 years of practice in order to reach expert level (Ericsson *et al.*, 1993). However, it should be acknowledged that clinical experience is necessary – but not sufficient – for the development of clinical wisdom (Jennings *et al.*, 2003). Whether viewed as years of professional activity or number of clients treated, results have shown that experience alone does not result in improved effectiveness as a psychotherapist (Goldberg, 2016).

In addition to years of accumulated clinical experience, it seems essential for the supervisor to remain active in the clinical services, continuing to provide weekly therapy sessions (Overholser, 2019). Ongoing direct experience working with clients helps to enhance the supervisor's ability to train students (Golia, 2015). In contrast, when (if) supervisors discontinue their involvement in clinical services

shortly after completing their own training, their skills may erode and they may rely heavily on books and articles to refresh their view of psychotherapy practice. However, the realities of clinical practice are often quite different from the therapy sessions that have been portrayed in books, movies, and training videos.

Ongoing clinical activity provides valuable insights into the mind of the trainee. Working with clients can be enjoyable, exciting, and yet include a mix of struggles, worries, and uncertainties. Remaining active in the direct delivery of clinical services can help supervisors to maintain an attitude of intellectual modesty and empathy for the trainee's struggles. When a supervisor maintains their own therapy caseload, they retain a sensitive view of the challenges faced in most therapy sessions (Overholser, 2010), and they bring a more tolerant view of the trainee's struggles and limitations.

In a survey of 114 counselor educators (Ray *et al.*, 2014), 28% reported that maintaining their own clinical practice helped to keep them humble with their supervisees, and 11% reported that clinical practice improved their empathy for the experience of their supervisees. Thus, supervisors can relate to their trainee's anxiety and struggles by maintaining their own clinical practice. Furthermore, supervisors who remain active with their own caseload of clients will be in tune with the common struggles and usual limitations of psychotherapy. The supervisor can strike a balance between certainty and uncertainty to encourage the trainee to solve their own problems (Skovholt & Rønnestad, 2003).

Remaining active in clinical practice can help to promote intellectual modesty in the supervisor. Professional modesty includes an ability to recognize and admit one's own shortcomings, mistakes and limitations (Overholser, 2010). A supervisor's modesty makes it easier for trainees to become open about their own struggles and mistakes (Watkins *et al.*, 2016). A large-scale survey of trainees (Anderson *et al.*, 2000) found that descriptions of the best supervision included times when the supervisor admitted to their own areas of weakness.

Supervisor's Struggles as a Therapist

The supervisor should hold an advanced degree in a field related to mental health and its treatment. As part of their own graduate training, the supervisors were trained through supervised field experience, providing psychotherapy in a closely monitored setting. It can be helpful for supervisors can revive memories of their own training experiences, especially during a similar stage of professional development as their current trainee. Even the most skilled supervisor began as an anxious novice, struggling to learn about psychotherapy from books, courses, and professional training videotapes. It can be helpful for supervisors to reflect on the mistakes they made early in their own career (Grant, Schofield & Crawford, 2012).

A supportive supervisor relies on empathy for the experiences of the trainee (Ladany, 2014). Similar to an effective therapist, the supervisor should become attuned to the trainee's emotional reactions and non-verbal expressions during their meeting. High levels of anxiety are common, especially with a novice trainee. In order to enhance empathy, the supervisor may need to remember their own struggles as a student. It can be helpful for the supervisor to remember their own beginnings, their own initial feelings of insecurity, and their own struggles recently or in the distant past.

While serving as a trainee, many young psychotherapists can feel overwhelmed by the stress and pressures of graduate training, the hectic schedules during predoctoral internship, the anxiety when finishing their dissertation, and the endless apprehension

when being monitored or evaluated by a clinical supervisor. It is common for trainees to struggle with self-doubts and feelings of incompetence (Thériault, Gazzola & Richardson, 2009). Trainees can also struggle with feelings of anxiety that are often exacerbated by the scrutiny and evaluations conducted by a supervisor (Skovholt & Rønnestad, 2003). These doubts can be exacerbated by unrealistic views of an effective therapist (Ibid). In some ways, trainees create their own stress by holding unrealistic beliefs and expectations about their performance as a therapist, sometimes comparing their own skill that to that of an established role model (Truell, 2001). Trainees may believe they must be effective will all clients; they must always enjoy leading therapy sessions; and that they must impress their supervisors (Pretorius, 2006). The supervisor should – of course – disabuse the trainee about these false beliefs. It is also important for supervisors to appreciate some of the common life difficulties experienced by trainees, such as relationship difficulties, childcare, or other family responsibilities (Tantam, van Duerzen & Osterloh, 2001).

Because of their anxiety and a lack of confidence, trainees can struggle to behave in a genuine manner with their clients, hiding behind a facade of professionalism (Salter & Rhodes, 2018). With experience, trainees eventually learn to listen more to their own thoughts and feelings during therapy sessions (Ibid).

Supervision can elicit high levels of anxiety in the trainee, and the anxiety can reduce the trainee's willingness to disclose their struggles to the supervisor (Mehr, Ladany & Caskie, 2015). However, a strong alliance with the supervisor usually helps to lower the anxiety in the trainee (Ibid). Trainee anxiety can be reduced through candid discussions with a supportive supervisor who shares a new perspective (Skovholt & Rønnestad, 2003). Trainees also prefer a supervisor who discusses feelings of incompetence and personal insecurities (Thériault, Gazzola & Richardson, 2009). These discussions can help trainees to confront normal developmental stages that are filled with doubt and insecurity.

As mentioned, it can be useful for supervisors to remain active with an open caseload of psychotherapy clients, because some clients can be quite challenging to treat. All therapists have some clients that they struggle with, striving to overcome difficulties related to a poor therapeutic relationship, oppositional tendencies, transference concerns, emotional outbursts in session, or noncompliance with the treatment plan. These difficulties can help temper the supervisor's expectations for trainee's to be able to conduct their own sessions in an efficient, smooth, or easy manner. Instead, it helps for the supervisor to be firmly anchored in the struggles that can arise when conducting psychotherapy sessions. To maintain this sense of modesty, it is extremely helpful for supervisors to continue to provide psychotherapy with some difficult clients who may be slow, unresponsive or uncooperative with therapy.

Relationship between Supervisor and Trainee

Throughout supervision, it is important to show respect for the trainee and for the supervision process. Supervisors should respect the trainee's input, input, preferred therapy style, random questions and time reserved for supervisory meetings. A survey of 102 psychology trainees while on their predoctoral internship at assorted internship training centers (Gandolfo & Brown (1987) found that visions of ideal supervision often involved a supervisor who was seen as warm and collaborative, and unfortunately, these qualities were more prominent than qualities found in their actual supervisory experiences.

It is vital for the supervisor to be fully present in the moment, not distracted by telephone calls, email messages, or other common distractions. Thus, the supervisor should protect time for weekly meetings, arrive on time, avoid distractions or interruptions during the meeting, and pay close attention to the trainee's point of view. In a large-scale survey of graduate trainees, 91.7% reported their best supervisors had reserved time exclusively for supervisory meetings (Anderson *et al.*, 2000). Effective supervision also requires qualitative time for in-depth discussions of clinical situations, not brief check-ins (Friedberg *et al.*, 2009).

One crucial element of this supportive alliance is warmth or unconditional positive regard for the trainee / supervisee. Interpersonal warmth is important in supervision. A survey of 142 graduate students enrolled in doctoral training programs in clinical and counseling psychology (Allen, 1986) found supervisor warmth played a central role in the best supervision experiences, while it had been less visible during the worst supervision experiences. The "warm" supervisors were seen as more patient and tolerant, remained open to feedback, and used mistakes as opportunities for the trainee to learn (Ibid.). The supportive supervisor brings a positive view of the trainee and assumes the trainee is working hard to become a skilled therapist.

Tolerance also play key roles in the supportive alliance. Even when mistakes are made, the supportive supervisor focuses on opportunities to learn from mistakes. The supervisor approaches all supervisory meetings with patience, trust, and respect for the learning opportunities that underlie the supervisory process. A survey of graduate trainees (Anderson, 2000) found that the vast majority found the best supervision used mistakes as opportunities for learning.

Trainees prefer a symmetrical relationship with their supervisor (Anderson, 2000; Reichelt & Skjerve, 2000). These professional relationships can provide a role model for a caring and competent professional. The supportive alliance seems closely aligned with the therapeutic alliance and the core ingredients described by Carl Rogers. Further, the supervisory relationship has been found to have an impact on the relationship that develops between trainees and their clients (DePue *et al.*, 2020). helping trainees learn how to bond with their clients while nonetheless respecting professional boundaries (Watkins, 2015).

The Process of Supervision

The supervision of psychotherapy usually involves regular meetings (often weekly at firat), where recent sessions are reviewed and upcoming sessions are planned. These supervision meetings require honest discussions and collaborative problem-solving, intended to educate the trainee and ensure an acceptable standard of care for all clients. The supervisory process relies on evaluative standards, clear guidance, and frequent praise or support.

It is important to set supervisory expectations and evaluative criteria at a level that is appropriate for each trainee. Clinical expectations should be appropriate for each trainee, based on the trainee's developmental level, prior experience, the client's diagnosis, and any personal life experiences that may have affected the young therapist. The process relies on 'shaping', whereby a novice therapist might be praised for relatively simple activities in therapy, whereas more complex skills would be highlighted and praised when working with an advanced trainee.

For many trainees, their anxiety becomes aroused when performance evaluations are due. If evaluations focus too much on core competencies, they risk neglecting import-

ant elements of the therapeutic relationship (Gonsalvez & Crowe, 2014)[1]. Supervisors can avoid becoming too lenient in their evaluations by setting aside their global impressions of a trainee and, instead, focusing on specific feedback derived from specific situations (Karpenko & Gidycz, 2012).

Patience is useful because change is gradual. Just as the therapist needs to begin at the client's level of functioning, the supervisor needs to begin at the trainee's level of functioning. The supervisor is patient, but not passive. Novice therapists may learn to develop a supportive relationship with their clients, but some therapists stop there and provide weak supportive therapy. Supervisors may need to push the trainee to bring a more active style into sessions, offering advice:

> *"You have a strong relationship with your client. Now, it's time to use it for therapeutic change. In the past few sessions, you let the client spend 30 minutes or more describing current events and recent problems. That time spent listening to the client has been helpful, but we want to be sure you are not viewed as just a supportive friend. Let's see if you can push harder for, or encourage them more towards, change, while still protecting the alliance you have built."*

Such directive guidance can simultaneously praise the trainee for recent actions and also gently push the trainee towards ongoing improvements.

Problems can arise if and when the supervisor is not aligned with the developmental level of the trainee (Enlow *et al.*, 2019). The plan for therapy may be perceived as overly complicated and beyond the scope of a novice trainee, or the supervision may be seen as coddling and infantilizing an advanced trainee. Further, many difficulties arise when helping novice trainees to manage their feelings of doubt and insecurity while encouraging higher levels of autonomy. Finally, it is important to be aware of developmental differences across different tasks. Thus, a trainee may appear quite skilled in research methodology and structured assessment tools, while nonetheless being a real novice when it comes to the ambiguities that pervade psychotherapy sessions.

The supervisory alliance should be genuine, a real relationship with and for the trainee (Watkins, 2011, 2015). A real relationship is a genuine bond between two people, not excessively forced into social roles and not entirely focused on professional work (Watkins, 2015). During all contacts with a trainee, the supervisor has opportunities to model the openness and honesty that should be displayed with clients, maintaining a professional demeanor while relating as a real person. A real relationship is authentic and true, not biased or distorted by relations that are disturbed by transference, or other biased views (Watkins, 2011). Research suggests that trainees become more effective psychotherapists when supervised by a supervisor who does not simply agree with the trainee (Rieck *et al.*, 2015).

The supervisor can provide frequent praise for any positive action displayed by the trainee. Frequent praise is important to reduce the trainee's sense of doubt and insecurity. However, it is best if the praise highlights specific actions and conveys a realistic evaluation of the trainee's performance, instead of feeling like a widespread, generic, and empty use of compliments (Ladany *et al.*, 2013). Sometimes the focus may be on indirect indicators of treatment progress, such as a client's regular attendance at scheduled appointments. Despite the importance of the relationship between supervisor and trainee, there are potential downsides to the supportive alliance. Feedback should be direct and straightforward (Anderson *et al.*, 2000). Frequent praise is helpful, but endless praise become empty and loses any credibility.

The support and patience can become complicated by the evaluative nature of most supervisory relationships. Evaluations are part of the supervisory process and can disrupt the relationship. Critical feedback can be important, but it must be useful for additional learning. Mistakes should be confronted, explored, and alternatives examined. If a supervisor is too gentle, critical remarks may be avoided and the opportunities for learning will be reduced.

Even though supervision typically requires a certain degree of critical evaluation of the trainee, it is essential that the supervisor creates a safe environment (Barnett & Molzon, 2014). Furthermore, without a certain amount of constructive criticism, the supervisor's compliments seem empty (Karpenko & Gidycz, 2012). For example, trainees can be instructed to, *"Stop evaluating your own behavior and criticizing your actions. That's my job as supervisor. I will tell you if you do anything wrong. You are doing a fine job, but you need to relax and be there in the moment with the client, not behind the scenes observing what you say as you say it."* Such direct instructions can help to shift the trainee's focus back onto psychotherapy process, instead of supervisory evaluations.

Encourage an Openness to Explore New Ideas

A sound and supportive alliance is one of the most important factors underlying effective supervision (Fernández-Alvarez, 2016; Majcher & Daniluk, 2009) and seems to have a positive impact on the trainees' relationship with their clients (DePue *et al.*, 2020). The trainee must feel safe in order to be open and honest during the supervision meetings (Beinart, 2014). For many trainees, the ideal supervisor is knowledgeable and experienced, yet brings empathy, respect and genuineness to the supervisory meetings (Carifio & Hess, 1987).

Supervision helps trainees explore new ideas and different strategies for upcoming therapy sessions (Feinstein *et al.*, 2015). Trainees may be reluctant to share with their supervisor any areas of weakness, struggles, or mistakes they might have made in a recent session. Trainees need a strong supportive alliance with their supervisor in order to be able to share weaknesses, listen to advice, and appreciate the input. When trainees feel safe, they become more willing to push beyond their comfort zone, explore new ideas, and try new strategies in their approach to therapy. When trainees feel safe, they are free to discuss issues related to therapy sessions, including their own frustration or annoyance with certain clients (Weaks, 2002). When there is a strained relationship with their supervisor, the trainee may be late for supervisory meetings, may disregard instructions, can seem to avoid contact, may cancel meetings, or may make excuses for not recording a therapy session. [2]

When supervision is based on a supportive alliance, the trainee can feel safe, and should become more willing to trust the advice of the supervisor: willing to share details of the session including the trainee's own feelings of confusion or self-doubt. Safety in supervision usually means the trainee's ideas and actions will be accepted without undue evaluation or judgement (Weaks, 2002).

Discussion

Becoming skilled in psychotherapy supervision can be a long and convoluted process (Gazzola *et al.*, 2013; Goodyear, 2014). However, clinical supervision is an important and rewarding process. The supervisory alliance is important in supervision (Tangen & Borders, 2016) and plays a central role in the supervision of psychodynamic approaches (Watkins, 2016), as well as in other approaches. Thus, it is important to build and maintain a

strong supportive relationship in supervision (Karpenko & Gidycz, 2012).

A focus on the supervisory alliance can help to soften the critical evaluations and occasional frustration experienced by most supervisors. The supportive alliance can help supervisors be able to lead trainees, while nonetheless remaining supportive especially when trainees behave in a sloppy, disrespectful, rebellious or unprofessional manner. The supervisor can retain a focus on positive actions, aiming to praise the trainee when deserved. Effective therapists remain flexible, ready to adapt to the needs of each client and adjust the plan for therapy (Wampold, 2011). Effective supervisors need to remain flexible and supportive as well.

It is important to acknowledge that a strong supervisory relationship may be necessary but remains insufficient for effective supervision (Goodyear, 2015). In addition, the supervision relies on other elements, including instruction, feedback, and modelling of effective therapy skills (Ibid). As trainees gain experience and confidence, the supervision can shift from a supportive alliance to a more challenging style that confronts the trainee in useful educational paths (Grant *et al*., 2012).

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Endnotes

1. **Editor's Note**: See also EAP's (2013) Project to Establish the Professional Core Competencies of a European Psychotherapist: Domain 2: The Therapeutic Relationship; Domain 9: Use of Supervision, (Peer) Intervision & Critical Evaluation: www.psychotherapy-competency.eu/Competencies/Core/index.php
2. **Editor's Note**: Recording trainee's client sessions for purposes of supervision is more common in some countries (USA, etc.) and in university settings, than in private trainings in specific modalities in (say) European countries. It also raises ethical questions of the use made of these recordings; who hears them; how they are stored; and/or are they destroyed after use.

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Psychotherapy in Russia: The past, the present and the future

Victor V. Makarov

Abstract: This article tries to describe some of the complexities of the development of psychotherapy – as an independent profession – in Russia over the last 40-50 years. As is nearly always the case, this is just one person's view – albeit a very significant person in this particular development. However, the article tries to bring out the complexities of any form of state-regulations in Russia and also the fact that Russia itself is not just one entity; and also that psychotherapy itself has its massive complexities.

Key Words: psychotherapy – Russia

The history of psychotherapy in Russia actually goes back to Tsarist times. The birth of Russian psychotherapy is associated with the foundation of V.M. Bekhterev's institute of psycho-neurology in 1907, which later became the St. Petersburg State Medical Academy. It's not quite accurate to call this school 'Russian", as it was formed with influences from European psychotherapy and also contributed significantly to its development. Bekhterev himself had a long-standing rivalry with Pavlov on the study of conditioned reflexes.

Later, during the Soviet era, two other Russian psychotherapeutic schools – in Moscow and Kharkov – emerged. Both of them were initially loyal to the then Soviet government, whereas the students and followers of Bekhterev had to make constant efforts to demonstrate their loyalty. All three schools focused on the demands of the Soviet state and fulfilled all the requirements of its censorship.

In the 1970s and 1980s, a different trend of psychotherapy started developing in Eastern Russia. The roots of this can be found in the Soviet dissident movement. Later, these ideas began to penetrate the minds of young psychiatrists and psychologists in Novosibirsk Academic City [1] and then little-by-little spread into the eastern part of the Soviet Union. In contrast to the three Soviet schools of psychotherapy, this Eastern trend was not Soviet state-oriented; it was aimed much more at common people, who nowadays reflect the seedlings of civil society.

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Thus, in the whole diverse country of Russia there were: **(i)** a school founded before the revolution; **(ii)** two schools formed during Soviet era; and **(iii)** one school, which began to grow towards the end of the Soviet epoch, and has been developing since: we call this last one, the "New School".

According to expert estimates, at the beginning of the 1990s, there were about 600 psychotherapists in Russia, mostly psycho-neurologists, neurologists and psychiatrists. We were enthusiastically enriching our education and practice with several new theories and technologies from Western methods and modalities of psychotherapy, which began to fill our country during the post-Soviet years.

In the beginning of the 1990s, for the first time in the history of our profession, psychologists also began to engage massively in psychotherapy. As foreign methods of psychotherapy became more widely introduced within Russia, young psychologists began to master these new methods with great enthusiasm and to promote them broadly throughout the country. These (so-called) 'foreign' methods, developing independently and often in competition with each other, brought previously uncommon rivalries and degrees of mutual criticism amongst Russian psychotherapists. At that time, public interest towards psychotherapy was also growing rapidly.

From 1991 to 1996, the city of Krasnoyarsk (alone) was visited by at least 2,500 professionals per year, who came to receive trainings in psychotherapy and to exchange professional experiences. These people attended numerous conferences and 'decadnicks' (ten-day workshop marathons), organized in the picturesque suburbs of Krasnoyarsk and also on the motor ship *"A. Matrosov"*, during Krasnoyarsk-Dudinka-Krasnoyarsk cruises on the Yenisei River in Siberia. They also participated in programs of advanced training in the Krasnoyarsk State Medical Academy.

The need for psychotherapy was so great; the scope of psychotherapy was so obvious; and the psychotherapeutic training was so accessible; that a large number of psychologists joined our profession. Due to the ban issued by state medical authorities, on the profession of "psychotherapist" for psychologists, psychologists were engaging in psychotherapy, but calling it by a vast majority of names: 'psychological correction'; 'practical/applied psychology'; 'psychological counseling'; 'psychological practice'; etc. The newly invented title, "non-medical psychotherapy" arose only after medical practitioners introduced the concept of 'medical psychotherapy'. Of course, the above-mentioned 'non-medical' areas of practice are not legally regulated. It is not even clear to which ministry should these 'non-medical' areas be responsible.

Since the mid-1990s, the number of medical practitioners & psychotherapists also grew. The number of 'non-medical' psychotherapists working in the institutions of the Ministry of Health in our country, according to experts, reached 5,000 employees, 3,000 of which were psychiatrists. In recent years, the number of psychotherapists employed by the Ministry of Health institutions has decreased dramatically every year.

At present, we are not able to provide any further statistical data, as a considerable number of 'psychotherapeutic' jobs has been being taken by psychiatrists – who, as it's widely known, are not yet psychotherapists, and psychologists. According to expert data, the number of medical practitioners of psychotherapy in the institutions of the Ministry of Health steadily approached the figures above, from the mid-1990s.

So, the first line of development of Russian psychotherapy lay with the state, within the

institutions of the Ministry of Health of the Russian Federation. State (mainly psychiatric) psychotherapy was considered a singular specialty; later (and still to the present) – a sub-specialty of psychiatry. During the last decade, this area is experiencing significant organizational difficulties, due to the widespread reduction of paid psychotherapeutic positions and low wages in public institutions.

In recent years, neurologists have also taken up psychotherapy with an increasing intensity and interest, and this has been very helpful for the profession of psychotherapy itself. After all, a psychiatrist's work is grounded on the 'psyche', which we consider being a function of the whole brain, whereas a neurologist's work relies on the very structure of brain, linking it with specific brain functions.

Furthermore, for more than 25 years, non-state-sponsored (private) psychotherapy has been developing in Russia. The rapid evolution of private psychotherapy resulted in the development of a number of different methods and modalities of psychotherapy. According to various sources, there are now hundreds, or possibly even thousands, of psychotherapeutic methods and modalities. The progress of non-state-sponsored (private) psychotherapy in our country has been very spontaneous; it has swept throughout the majority of the regions of our country, almost like a tidal wave. Each modality of psychotherapy develops itself within its own setting and conditions.

The European Association for Psychotherapy has had a vast experience in bringing such individual, scattered modalities of psychotherapy together. Within the Russian Federation, the unification of, and cooperation between, various modalities and methods of psychotherapy has been a large part of the activity of the All-Russian Professional Psychotherapeutic League (PPL, or the 'League') for the last twenty years. The list of mainstreams, modalities and methods of psychotherapy and counselling (as of June, 2018) is given in the table below: [2]

The Varity of Methods of Russian Psychotherapy and Counselling

Approaches, (mainstreams, modalities & methods) of psychotherapy and psychological counselling, that have received professional recognition in the Russian 'League' (PPL).

1	Hypno-psychotherapy	Rashit Tukayev	Moscow
2	Multi-modal psychotherapy	Victor Makarov	Moscow
3	Systemic Family psychotherapy	Anna Varga (representative – Tatyana Rytsareva)	Moscow
4	Existential psychotherapy	Alexander Barannikov	Moscow
5	Body-oriented psychotherapy	Lev Belogorodsky	Moscow
6	Resource-oriented systemic psychotherapy	Mark Sandomirsky Lev Belogorodsky	Moscow
7	Positive psychotherapy	Ivan Kirillov	Moscow
8	Symbol-drama	Jakov Obukhov-Kozarovitsky	Moscow & Zaporozhye
9	Transpersonal psychotherapy	Vladimir Maykov	Moscow
10	Neuro-Linguistic psychotherapy	Sergey Kovalev	Moscow

11	Therapy by creative means of self-expression by M.E. Burno	Mark Burno Inga Kalmykova	Moscow
12	Psycho-catalysis	Andrey Yermoshin	Moscow region
13	Clinical classical psychotherapy	Mark Burno Luidmila Makhnovskaya	Moscow
14	Di-analysis	Vladimir Zavialov	Novosibirsk
15	Psychodrama	Ilona Romanova	Ekaterinburg
16	Emotional-image psychotherapy	Nikolai Linde	Moscow
17	Psycho-Organic Analysis	Oksana Mironik-Aksenova	Moscow
18	Transactional Analysis	Nadezhda Zuikova	Moscow
19	Psychotherapeutic kinesiology	Irina Chobanu	Moscow
20	Erickson's psychotherapy and Erickson hypnosis	Vladimir Domoratsky	Minsk, Belarus
21	Peri-natal and reproductive psychotherapy	Elena Pechnikova Galina Filippova	Moscow
22	Religion-oriented psychotherapy	Sergey Belorusov Lyubov Bitekhtina	Moscow
23	Musical-integral psychotherapy	Valentin Petrushin Alexander Tabidze	Moscow
24	Differential Cognitive therapy	Anton Burno	Moscow
25	Clinical psychosomatic psychotherapy	Nadezhda Zuikova	Moscow
26	Healing creative psycholinguistics	Alla Semenova Elena Abrashkina	Moscow
27	Cognitive Behavioural (psycho)Therapy	Elena Korabelnikova	Moscow
28	Client-Centered psychotherapy	Alexander Kocharyan Victor Kuzovkin	Kharkov, Ukraine & Moscow
29	Integrate-dialogue, cognitive-oriented hypnotherapy (psychotherapy)	Rashit Tukayev	Moscow
30	Art therapy	Alexander Kopytin	St. Petersburg
31	Jungian analysis	Liya Kinevskaya Lydia Surina	Moscow
32	United psychoanalytic approach	Alexander Kharitonov	Moscow
33	Balint groups	Nikolai Klepikov	Moscow
34	Integrative child psychotherapy	Albina Loktionova	Moscow
35	Systemic family psychotherapy: Eastern version	Nina Lavrova	St. Petersburg
36	Eastern version of transactional analysis	Galina Makarova	Moscow
37	Integral Neuro-programming	Sergey Kovalev	Moscow region
38	System-phenomenological psychotherapy (counselling) and client-centred constellation work.	Mikhail Burnashev	Moscow

39	Ethical personalism	Alexander Bondarenko	Kyiv, Ukraine
40	Process-Oriented Psychology and psychotherapy	Liudmila Serbina	Moscow
41	Generative psychotherapy	Petr Silenok	Krasnodar
42	Eastern version of Psychosynthesis	Sergey Klyuchnikov	Moscow
43	DMO approach	Yuliya Ogarkova (Dubinskaya)	Moscow
44	Sand therapy	Oleg Starostin	St. Petersburg
45	Gestalt Therapy	Elena Petrova	St. Petersburg
46	Personality-oriented (reconstructive) psychotherapy	Vera Arseneva	St. Petersburg
47	Rodo-logic method of counselling	Larisa Dokuchaeva	Yekaterinburg

Of course, we are fully aware of the fact that this list does not include all the methods of psychotherapy and counselling that are widely spread in our country. In 2013, we (in the PPL) conducted an expert survey among the leaders of psychotherapeutic modalities regarding the number of practitioners within their different methods. We interviewed the leaders of 30 different modalities of psychotherapy, and – according to their expert opinion – the minimum estimated number of practitioners in all their modalities was 28,045, whereas the maximum estimation was 30,485. The interviewed people were also asked to make a forecast for 5 years, (i.e. for 2018) – and their estimation was that the minimum number of practitioners would be about 43,740 people and the maximum – 45,450 people. [3] Certainly, much has changed in Russia, even since then, thus we are determined to repeat the survey, especially because the number of psychotherapeutic modalities within our organization has grown to 47 in total (see above).

However, many of these new initiatives – proposed by our colleagues – are introduced as new methods of psychotherapy and do not quickly get professional acknowledgement. According to our point of view, each 'valid' method of psychotherapy must have: **(a)** a 'proper 'theoretical basis; **(b)** a practice that includes a set of technologies and techniques for psychotherapeutic work; **(c)** a proper post-graduate training program, based on a four-part education system, including personal psychotherapy within the training, and both theoretical training and supervised practice during the training: the total amount of training hours over 4 years must be at least 3,200; and **(d)** the final important issue for a psychotherapeutic modality is to have a significant number of practitioners. If not all of the four components are present within a modality, then we do not consider it a 'proper' modality or method of psychotherapy, but we call it an "author's method": i.e. it is restricted to (copyrighted by) a certain 'author' and does not yet belong to the general profession of psychotherapy.

Now-a-days, most of the legislative initiatives in the field of psychotherapy emanate from the Professional Psychotherapeutic League (PPL). Up until now, we have proposed three such initiatives in total. In 1998, the League drafted a legal bill about psychotherapy. Six months later, a project for a similar law was introduced by the Russian Federal Scientific and Methodological Center of Psychotherapy and Medical Psychology, and – within a few months – the third project was presented by the 'psychotherapeutic service' in Moscow.

So, at that point, three different drafts of a bill on psychotherapy were presented to the public and it became clear that we were not yet able to come to any agreement within our own professional community. Thus, we were not at all ready to pass the draft of the bill on to the 'Duma' (Parliament) of the Russian Federation. In 2014, the League created the second draft of the law: "On Psychotherapeutic Help in the Russian Federation", which was widely discussed in the professional communities and was submitted to the State Duma of the Russian Federation for preliminary consideration. The Health Committee of the State Duma sent the draft to the Ministry of Health for an expert opinion, and we received a brief conclusion about the unpracticality of such a law.

Later, in 2016, the League came up with a third draft of a psychotherapeutic law on "Professional Psychotherapeutic Activities in the Russian Federation". Currently, we are waiting for a favourable moment to present the draft to the Duma. All three drafts of the law introduced by the PPL, represent a successive orientation towards current professional practice, as their initial versions were all developed by same author, Professor Alexander Katkov.[4]

Legislative initiatives towards the profession of psychology in our country also have a unique history. In 2012, the work on a bill on "Psychological Help in the Russian Federation" started. The PPL participated in the discussions on a draft law, just once. However, our proposals were not taken into consideration and we were not invited to discuss that particular project any further. Ultimately, this bill was also not adopted. In 2017, we were again invited, this time by the Supreme Council of the Russian Federation, to join a working group on a new version of the bill, "Psychological Help in the Russian Federation". In future, as far as we are aware, some of the participants of this meeting (mainly personnel at the Moscow State University) have organized a working group to continue their efforts on such a draft law.

Further attempts to outline the legislative regulation of psychotherapy have brought our attention to the issue of self-regulating organisations within our country. Self-regulation in Russia was introduced by the Federal Law: "On Self-Regulating Organisations" (N-315-FZ, dated 01.12.2007). Entire branches or sections of the national economy are now regulated by this law. However, there hadn't yet been a single, self-regulating organization founded, either in medicine or in psychology.

The all-Russian Professional Psychotherapeutic League (PPL) has now been included into the National Medical Chamber (NRM) – since its inception. It was the NRM who took the initiative to pursue the amendment of the law on the self-regulation of the whole field of medicine and health. Unfortunately, this goal has not yet been fully accomplished. In October 2014, we adopted the first Charter of the Self-Regulating Organizations (SRO) – as the association for the Development of Psychotherapeutic and Psychological Science and Practice, "The Union of Psychotherapists and Psychologists" and put this organisation into operation. In October 2015, certain amendments and additions to the Charter of our National Self-Regulating Organisations, "The Union of Psychotherapists and Psychologists" were made: and as has been indicated in the full name of the organisation, this has now acquired a national status. According to the current Russian legislation, only one national self-regulating organisation is authorized to function per professional arena.

In Russia, a national self-regulating organisation (SRO) unites all the self-regulating organizations in a particular field of work; it interacts with the appropriate state regulatory bodies; and it is endowed with legislative rights. The further development of our na-

tional self-regulating organisation has led to significant adjustments in the Charter of the organization. Since the beginning of 2018, after the Ministry of Justice affirmed the amended Charter and included it into the official state register, we have been working in proper accordance with the updated Charter. During the Extraordinary Board Meeting (in March 2018), the Board of our organization came to several important decisions designed to stimulate the further development of our national SRO.

Our self-regulating organization includes: psychotherapists, psychoanalysts, counsellors, applied psychologists, mediators, supervisors, coaches and other specialists engaged in the field of psychotherapeutic science and practice, with those who are private entrepreneurs; as well as legal entities that provide psychotherapeutic assistance, vocational education and research in the field of psychotherapeutic science and practice. We are also authorized to establish branches and representative offices in the various regions of the Russian Federation. Our mission is to develop and unify standards and guidelines of such entrepreneurship among the various varieties and specialisations of applied (or clinical) psychology and psychotherapy.

It is therefore certain that our professional standards and guidelines correspond strictly to federal laws and other state legislative instruments. Standards and guidelines of the association may set additional imperatives for the professional activities of some of its members. Firstly, we are defining additional requirements for professional education in psychotherapy. We have introduced a four-part paradigm of vocational education, which includes theoretical study, practice under supervision, personal therapy and supervision during training. The required training standard for psychotherapeutic education (proposed by us) is more than six times longer than the standard adopted by the Russian Ministry of Health and conforms to the training standards of the European Association for Psychotherapy: the European Certificate for Psychotherapy (ECP) and the EAP's Professional Core Competencies. [5]

It seems necessary to list the most important functions of our organization: advanced (post-graduate) vocational professional training; the licensing of graduates; and the certification of services provided by the members of the SRO. Both licensing and certification will be conducted only within the approved modalities of psychotherapy (as above). Our other great concerns are: **(i)** research within the field of psychotherapeutic science and practice; **(ii)** the establishment of rules for psychotherapeutic practice, mediation, counselling and psychological assistance; **(iii)** the development of training standards in psychotherapy and the common 'examination' of scientific and practical techniques, as well as programs and projects in psychotherapy and psychology. We will also stay engaged with any of the drafts of federal laws and other legal acts of the Russian Federation concerning psychotherapy.

Our rules enforce a ban on any activities of SRO members that may cause damage to other entrepreneurs in the field of psychotherapy and psychology; and we also set rules against unfair competition, and the commission of acts that might cause any kind of moral harm or non-pecuniary damage to consumers of psychotherapeutic and psychological services and/or third persons; and also on any actions which might degrade the business reputation of another SRO member, or the business reputation of the SRO itself. According to the new version of the Charter, between the annual board meetings, the SRO is governed by a Presidential Council that consists of all its departmental leaders. The professional bodies that have been established within the Presidential Council of the SRO are the following:

1) **The Expert Commission**: that monitors adherence of the SRO members to the standards and rules of the Association;
2) **The Disciplinary Commission**, which scrutinizes cases on disciplinary actions against members of the Association;
3) **The Ethics Commission** that monitors adherence of the SRO members, by Rules of Professional Conduct approved by the General Meeting of the Association;
4) **The Academic Council**, which engages in development of psychotherapeutic and psychological science, practice and education, and profile research in mentioned fields; and
5) **The Supervisory Board** that exerts control over entrepreneurial activities of the SRO members concerning psychotherapeutic and psychological assistance and vocational education in terms of compliance with the requirements of the Association's Charter and the regulatory legal acts of the Russian Federation.

The Presidential Council is authorized to establish other governing bodies important for the successful functioning of our self-regulating organization. We have also signed 'cooperation agreements' with two of the largest associations of psychotherapists: the European Confederation of Psychoanalytic Psychotherapies (ECPP) [6] and the European Association of Cognitive-Behavioural Therapy (EACBT) [7].

It is especially important to realize that the lack of legislative regulation of psychotherapy and psychology leads to obvious losses, primarily for the consumers of our services and for our profession. Thus, business workshop activities, which mainly originated from psychology, have been practically separated from it; the same happened to coaching; and is now happening to personal growth training. Professionals in these areas are being replaced by charismatic amateurs, whose biggest concern is money: now such profit-oriented dilettantes are focusing on psychotherapy.

As it has already been mentioned in this article, originally there were three schools of psychotherapy in Russia, and later the fourth, 'New School' began its active development. So, what conditions are these schools in nowadays? What prospects do they have? We tried to find some of the answers to these questions in a special conference, scheduled within the framework of the annual Congress of the Professional Psychotherapeutic League of Russia, "Psychology and psychotherapy of each passing day and of whole of our lives," on 15-18th November 2018 in Moscow.

Since 2010, a new kind of psychotherapy was also emerging – for the first time in Russian history – "Applied Psychology": both of these areas largely coincide with each other in terms of the content of their activities, but only a relatively minor part of psychotherapy (medical psychotherapy and applied psychology) is being legally regulated by the Russian Ministry of Health, whereas most of all these psychotherapies and psychologies are mainly self-regulated within the methods and modalities of psychotherapy, and most of these are now united in our country within the all-Russian Professional Psychotherapeutic League (PPL).

Today, psychotherapy within state institutions in Russia co-exists with independently practiced psychotherapy. Moreover, there is a sufficient number of psychotherapists, who both work in public state-medical institutions and are engaged in private practice, at the same time. Private practice in psychotherapy,

whilst being a natural 'helping' profession, implicitly depends on the standard rules of any business. Therefore, efficient self-regulation is particularly important in this area.

The time has come for independent psychotherapy to give a helping hand towards the profession of psychotherapy, as practiced within state medical organizations, which are now experiencing great hardships, almost at the level of a systemic crisis. Nowadays, it is becoming increasingly difficult for psychotherapists to practice on their own, and for professionals in the field of psychotherapy and psychology to determine which organizations should they choose to associate with.

New modalities and methods of psychotherapy are being developed in our country every year. We welcome and support the creativity and dedication of Russian professionals and invite the leaders of these new modalities to join the committee of methods and modalities of the PPL.

Our country is proving to be one of the global flashpoints in which psychotherapy is developing. We fully realize this fact, especially whilst being actively engaged in preparations to host the IX World Congress for Psychotherapy in Russia in the summer of 2020.[8] At present, we have created what we consider as the most favourable conditions to demonstrate the achievements of Russian psychotherapy to the entire professional world. The congress will be held in Moscow, St. Petersburg, Altai and also at Lake Baikal. The theme of the congress is "The Planet of Psychotherapy".

Dear Colleagues! We all have lots of work ahead – in each and every day and through the whole of our lives, and we have very optimistic prospects towards our future! Today, in many aspects, we ourselves are actively creating our future.

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Endnotes

1. **Novosibirsk Academic City** is considered the holy-of-holies of Russian science.
2. The **European Association for Psychotherapy** (EAP) tends to differentiate between; "Mainstreams" (like Psychoanalytic / Psychodynamic, Systemic, Cognitive Behavioural, Body Psycho-

therapy; Humanistic, Integrative, Hypno-Psychotherapy, etc.) and then "Modalities" within a particular Mainstream (such as "Freudian", "Lacanian" and "Kleinian" forms of Psychoanalysis; or "Bioenergetic", "Biosynthesis" and "Hakomi" forms of Body Psychotherapy); and then "Methods" which are usually more individualistic, do not fulfil all the criteria of a proper modality, being akin to what are described (above) as "author's methods". Mainstreams and Modalities are generally represented within the EAP by European-Wide Organisations.

3. This forecast represents an increase of about 50% of psychotherapists within 5 years.
4. **Professor Alexander L. Katkov**, MD, is the rector of the International Institute for Social Psychotherapy (Saint-Petersburg). Since 2004, he has been the vice-president of the All-Russia Professional Psychotherapeutic League (PPL); since 2013, the chairman of the committee on legislative initiatives and science; since October 2016, he has been the Chairman of the Public Council for Psychotherapy of the Psychotherapists and Psychologists Union, a self-regulatory national organization of the Russian Federation.
5. **The Professional Core Competencies of a European Psychotherapist** (2013): see: www.psychotherapy-competency.eu and www.europsyche.org/app/uploads/2019/05/Final-Core-Competencies-v-3-3_July2013.pdf
6. **ECPP** is a European Wide Organisational member of the EAP.
7. **EACBT** is an organisation that brings together 53 full member and 8 affiliate associations from 45 different countries all involved with Cognitive-Behavioural Therapy: www.eabct.eu/about-eabct
8. **IX World Congress for Psychotherapy**: "Children, Society and Future: The Planet of Psychotherapy": June 26-29, 2020: Moscow, Russia: www.en.planetofpsychotherapy.com

On-going 'Special Issue' about "Psychotherapy vs. Spirituality" Part 5

Treating Spiritual Issues in Secular Psychotherapy[1]

Daniel A. Helminiak

Abstract: To offer insight and stimulate discussion regarding a burgeoning but enigmatic area of clinical concern, this paper presents an understanding of spirituality as a fully human phenomenon that is essentially independent of, yet open to, matters of personal religion and belief in God. The suggestion is that spirituality, though commonly expressed through religion and theist belief, is a universal mental phenomenon with an inherent normativity and, as such, can be legitimately addressed as a prescriptive aspect of psychology apart from theology and religion. Most fundamentally, spirituality entails attention to the felicitous unfolding of a self-transcending dimension of the human mind, whose hallmarks are the meanings and values, the visions and virtues, by which people live. Thus, as specialists in the life of the mind, secular therapists may legitimately attend to spirituality in both its religious and nonreligious expressions – and, wittingly or unwittingly, already often do. However, simply acknowledging the value-laden status of one's therapeutic stance or being respectful of a variety of clients' religions is not yet to address spirituality as a psychological concern. An adequate psychological treatment must, against verifiable criteria of human growth, also assess the beliefs and values in question, for not all are equally acceptable, not all are conducive to growth. With an elaborated psychology of spirituality, therapists can focus the psychotherapeutically relevant and spiritual issues in the client's presentation, whether couched religiously or not; build on the client's healthy

1. An earlier version of this article first appeared in *Counseling and Values* (Special Issue: Spirituality in Counseling), April 2001, Vol. 45, No. 3, pp. 163-189. It has been re-edited and added to slightly and is published here with the kind permission of the author.

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commitments and reinterpret or deflect the unhealthy; and, thus, foster the client's personal integration and, ipso facto, the client's spiritual growth. Examples are given, a contrast with pastoral counselling is made, and implications for therapists are discussed.

Spirituality often enters psychotherapeutic concern as an addendum. Spirituality or "spiritual direction" (Barry & Connolly, 1982; Nemeck & Coombs, 1985) is what some people turn to after they have worked through their basic issues (Helminiak, 1992), or it can be what people in desperate need rely on to give them strength to face major therapeutic challenges. Such an understanding risks limiting spirituality to explicit attention to the "big questions" of life: – Who am I? Where did I come from? Where am I going? What does life mean? What is worth living for? – or identifying spirituality with religion and inspiration. But as Jungian, existential, transpersonal, and humanistic psychologies have argued (Assagioli, 1965/1976; Clinebell, 1995; Frankl 1962; Fromm, 1947; Moore, 1992; Wilber, 1995, 1996; Yalom, 1980), such an understanding can fail to recognize that attending to the big questions might make other facets of life fall into place.

Moreover, human healing and wholesome growth are concerns in both spirituality and counselling. Traditionally, religiously affiliated spirituality defined wholesome growth even as psychotherapy often does today. Thus, it appears that spirituality is inherently relevant to psychotherapy, and it has been argued that every therapy entails spiritual matters (Bergin, Payne, & Richards, 1996; Browning, 1987; Tjeltveit, 1986, 1996).

Accordingly, major theoretical issues are at stake in the discussion of psychology and spirituality – like recognizing and naming the spiritual in its many and varied expressions, showing how attention to the spiritual is a legitimate psychotherapeutic concern, and assessing the validity of various spiritualities in the face of differing religious claims and psychological expertise. This paper addresses these theoretical issues by summarizing a position on spirituality presented in detail elsewhere (Helminiak, 1987, 1996, 1998, 2015) and by providing specific examples to show how a secular psychotherapist may legitimately respond to spiritual issues in counselling. A final section elaborates further considerations about pastoral counselling and the qualifications of secular therapists. Clinical examples have been disguised to protect client confidentiality.

A Psychology of Spirituality

The Challenge of Spirituality for Psychology

Spirituality is commonly thought to be a religious phenomenon or, for the nonreligious, a personal alternative to affiliation with an organized religion. Spirituality entails lived-out commitment to some set of meanings and values – credo and commitments, vision and virtues, beliefs and ethics, cognitions and evaluations – and traditionally, organized religions carry and foster these. Religion tells us what life is about and how we are to live it. This vision and its implementation in individual lives is '**spirituality**'; religion is the social organ that, at its best, proclaims and supports spirituality. In this sense, in addition to spirituality, religion also includes and connotes institutionalized structures of doctrine, ethics, rituals, texts, traditions, and practices. More-

over, religions are many, and each presumes the validity of its own perspectives and emphases. Still, a common thread of spirituality may lie beneath these different emphases and to some extent may also flourish apart from institutionalized religion (Stifoss-Hanssen, 1999). Only in recent history has spirituality been differentiated from religion (Pargament, 1999; Principe, 1983; Schneiders, 1989). For example, modern psychology proposes an account of spiritual phenomena that is independent of theological explanations and grounded in the workings of the human mind itself (Hood, Spilka, Hunsberger, & Gorsuch, 1996; Paloutzian, 1996; Meadows & Kahoe, 1984; Wulff, 1997). Given the understanding proposed here, it seems doubtful that religion and spirituality could ever be fully separated, for almost every spirituality is a socially shared phenomenon, inevitably entailing some degree of institutionalization. Nonetheless, it seems legitimate and useful to distinguish spirituality within and apart from religion and to begin to treat spirituality in itself, especially if a common core of spirituality can be discerned within its multiple religious expressions.

To be sure, the differentiation between religion and spirituality is far from clean. Most spiritualities, even when not attached to an organized religion, still center around belief in God (Bergin, 1980, 1991; Bergin, Masters, & Richards, 1991; Ellison & Smith, 1991; Kass *et al.*, 1991; Moberg, 1984; Moberg & Brused, 1978; Paloutzian & Ellison, 1982), and in the religious West, where Christianity, Judaism, and Islam predominate, the term 'religious' is virtually synonymous with 'theist' (Emmons & Crumpler, 1999; Zinnbauer *et al.*, 1997). Thus, writing for the secular nursing profession, Shelly and Fish (1988, p. 29) state unabashedly, *"That we are spiritual beings means a relationship with God is basic to our total functioning."* Likewise, Gillman (Wilkes, 1990, p. 71) explained, *"I don't know what the word [spirituality] means, but to students today it means they don't want to be Jews or rabbis just for the rituals, just for the symbolism, but in order to come closer to God"*. Similarly, Emmons and Crumpler (1999, p. 19), though granting the word 'God' a wide range of meanings, link developmental theory with theism when they insist that *"a search for the sacred or for significance should involve an internal process that leads through a set of developmental stages, the ultimate goal being union with God"*. Fowler's (1981) elaboration of the final stage of faith development – in terms of the Kingdom of God – makes the same connection. Such emphasis accords with the prevalent American view where consistently over 90% of the population profess some kind of belief in God (Gallup, 1985). Other approaches, even when attempting to be non-theist, still implicate theological issues (Assagioli, 1965/1976; Chandler, Holden, & Kolander, 1992; Hiatt, 1986; Wilber, 1996) – because they rely on Eastern thought wherein the identity of divinity with human consciousness or spirit is taken for granted.

In welcome contrast, the American Counseling Association's Summit on Spirituality (Hinterkopf, 1998, pp. 103-104; Holden, 1996; J.M. Holden, personal communication, July 13, 1999) is deliberate in making no reference to "Allah, Buddha, or God" in its general treatment of religion and its description of spirituality, and Stifoss-Hanssen (1999, p. 28) recalls that *"spirituality is expressed by atheists and agnostics, by people deeply engaged in ecology and other idealistic endeavors, and by people inspired by religious impulses not easily understood by classic religious concepts"*.

Unless counsellors and psychotherapists avoid issues of religion and theism while still respecting them, they risk overstepping the bounds of their professional competence in attempting to deal with spirituality (Stifoss-Hanssen, 1999), for matters of God fall

to the domain of religion, and matters of religion fall to clergy and theologians. Psychotherapists, as such, are not accredited in these realms (Tjeltveit, 1986). Of course, many psychotherapists already address these matters because they are central to people's lives and cannot be artificially excluded from the effective counselling session. Yet, unless therapists have pastoral credentials, they court violation of professional ethics when they delve into religion and theology, as such (Holden, 1996). Resolution of this dilemma requires delineation of what in spirituality may be proper to psychology and what is rather religious and/or theological.

The solution proposed here is to understand spirituality as an inherent human phenomenon and, thus, proper to psychology, but a phenomenon which, nonetheless, may naturally open onto religious elaboration and questions about God. That is, spirituality is understood to be a common human core that runs through all religions and cultures and might be expressed in theist terms (Holden, 1996). A coherent understanding of this spiritual core can help psychotherapists discern, respect, nurture, and purify it in any of its many religious and theist expressions or apart from institutionalized religion and belief in God. At stake here is the ideal of scientific explanation extended now to the spiritual realm (Feingold, 1994, 1995; Feingold & Helminiak, in press; Helminiak, 1987, 1994, 1996a, 1996c, 1998; Wilber, 1996). At stake is the attempt to propose a coherent psychology of spirituality. Such an achievement would delineate the structures, processes, and mechanisms inherent in human mental functioning that account for experiences that are called spiritual and, thus, allow psychotherapists to competently address such matters in their "applied science".

The Humanist Basis for Spirituality

A beginning point of such a psychology of spirituality is the assumption that, within in the human mind, there is a self-transcending dimension that can rightly be called 'spirit'. Rather than 'God', 'Ultimate Consciousness' (Wilber, 1996), or some other metaphysical principle, the human spirit would be the primordial basis for talk of spirituality. Accordingly, spirituality would be nothing other than the deliberate and lived-out commitment to the felicitous engagement of the human spirit. Such engagement requires on-going purification of the meanings and values that the human spirit generates, and the use of specified practices, exercises, or disciplines has traditionally facilitated this purification (Bouyer, 1961; Johnston, 1976; Studzinski, 1985; Tanquerey, 1930; Trungpa, 1973, 1976; VanKaam, 1975). Psychotherapy may, as well. In this view, spirituality is the lived-out commitment to the ever further integration of the dynamism of the human spirit into the permanent structures of the personality. Simply put, spirituality names the committed pursuit to become the best one can be, and the presupposition is that the guide is within oneself (Vaughan Clark, 1977). A further suggestion is that cultivated openness to this inner spiritual principle would result in an on-going way of living and/or extraordinary experiences associated with enlightenment or mysticism.

Plato (Voegelin, 1974) spoke of that self-transcending dimension of the human mind in terms of '***nous***'; Augustine (1963; 1991, chap. 10), in terms of '***memoria***'; Heidegger (1927/1962, pp. 171 & n. 2, 214, 401-402, 460), in terms of '***Lichtung***' (opening or clearing); Brentano (1874/1973, pp. 29-30, 127-129), in terms of the '***innere Wahrnehmung***' (inner perception); Trungpa (1973, 1976) in terms of '***Buddha Nature***'; and Lonergan (1957, 1972) in terms of '***consciousness***' and '***intentionality***'. Significantly, Lonergan (1957, p. 519; 1972,

pp. 13, 302) and Frankl (1969/1988, p. 17; Institute of Logotherapy, 1979) also used the term *'**spirit**'*. Because of its clarity and architectonic elaboration, Lonergan's treatment is followed here.

The Summit on Spirituality in Counseling (Holden, 1996; J. M. Holden, personal communication, July 13, 1999) also understands spirituality in terms of *"a capacity and tendency that is innate"*. But, as is the unfortunate and supposedly insurmountable standard in spiritual discussions (Barbour, 1974; Browning, 1987; Helminiak, 1998; Wilber, 1996), the Summit chose to speak only in suggestive metaphors: *"Spirit may be defined as the animating life force, represented by such things as breath, wind, vigor, and courage"* (Holden, 1996). Like all myth and metaphor, which carry a *"surplus of meaning"* (Ricoeur, 1967), the root metaphor, *'life'*, is widely ambiguous. It derives most graphically from biology, where its nature remains controverted, but is also applied to both psychological and spiritual experience, among other things. A psychological treatment of spirituality, like any proposed scientific treatment, needs more technical precision, such as offered by the analyses noted in the previous paragraph and the one summarized below. Still, it is clear that, in general, the same reality is at stake throughout, for the Summit elaborates *'**spirit**'* with reference, among other things, to *"knowledge, love, meaning, ... transcendence ... and the development of a value system"* (Holden, 1996).

According to Lonergan (1957, 1972), the human spirit is a self-transcending and spontaneous yet structured dynamism built into the human mind. It is spontaneous in that it is primordially characterized by wonder, marvel, awe, that expresses itself in formulated questions, in pondering, and in choice. Human spirit is self-transcending in that its spontaneity leads one continually to move beyond one's former self and into ever broader experience. It is dynamic in that it is a relentless movement that would rest content only in some ideal fulfilment of knowing everything about everything and loving all that is lovable. It is structured in that it expresses itself in four shifting and interacting foci: **(a)** It is empirical in that we are open to experience, aware and also aware of our awareness; **(b)** It is intelligent in that we question for understanding, arrive at insight, and formulate understandings as ideas, hypotheses, or theories; **(c)** It is rational in that we assess the sufficiency of the evidence for our understandings, make judgments, and, thus, arrive at facts and know reality; and **(d)** it is existential in that we deliberate and decide about choices to be made and values to be embraced in our everyday living.

Understood in this way, the spiritual dimension of the human mind is nothing esoteric or unusual. Its self-transcendent functioning is as ordinary as a child's *unrelenting* "Why," a lover's protest of *eternal* love, a scientist's *endless* experimentation, or a poet's *silent rapture* at the stars. Yet this dimension of the mind opens onto the universe of being. Because we are in part spirit, in the ideal we would understand everything about everything, embrace the whole, and in some way become one with all that is. Thus, this single principle, the human spirit, grounds an understanding of facets of ordinary living as well as of extraordinary experiences that could be called "religious" or "mystical."

The Normative Nature of the Human Spirit

That dynamic spiritual principle within the human mind includes its own requirements for unlimited unfolding. It has a built-in homing device geared toward its own fulfilment. Paralleling the four-fold structure of the human spirit, these requirements can be formulated as follows: **(a)** Be attentive; **(b)** Be intelligent; **(c)** Be reasonable; **(d)** Be respon-

sible. Lonergan (1972, pp. 20, 53, 55, 302, 321) calls these four "*transcendental precepts*". They are transcendental because they apply to anything and everything a human being does, yet they do not predetermine any specific concrete outcome. They do not determine the *what* of human activities, but the *how*. They require that, in everything, people act attentively, intelligently, reasonably, and responsibly. These precepts set the conditions for the possibility of the open-ended unfolding of human potential, and they are the guardians of on-going human development (Helminiak, 1987). They are inherent human norms for what is true, right, good, and wholesome. They specify the meaning of *authenticity*. One is authentic; one is a genuine human being, to the extent that, in accord with one's inherent spiritual nature: one lives according to these precepts. Violation of them entails dehumanization, inevitably resulting in some shutdown of the open-ended human system, for what is grounded in close-mindedness, obtuseness, falsehood, or evil eventually self-destructs. In this view, the human spirit, itself, is the ultimate ground of epistemology and ethics (Lonergan, 1957); the criteria of the true and the good are built into the human mind.

Understood in this way, authenticity is an inherent human requirement, so insistence on it in no way derives from or invokes an external authority that impinges on people. Moreover, insistence on authenticity in no way imposes specific rules, laws, behaviours, or outcomes. Like stages of development defined by their structure and not their content (Fowler, 1981; Kolhberg, 1977; Loevinger, 1977; Piaget 1936/1963), authenticity is a purely formal construct; it regards how one functions and not in the first place what one does. Thus, authenticity is an absolute that is not absolutist. It cuts down the middle between modern certainty and postmodern relativism (Bernstein, 1976). If it requires unswerving compliance, it does not box anyone in. Only the "devil" would protest that the requirement of authenticity is narrow and restrictive or biased and skewed, for all it entails is that one act in a way that best furthers positive and on-going growth overall. What this requirement means in any particular case remains to be discovered. Engaging in a process of honest discovery and then following through in good will is precisely the brunt of being authentic. Finally, unlike the existentialist notion of authenticity (Heidegger, 1927/1962; Taylor, 1991), which could mean something as banal as obnoxiously "doing your own thing", this construct entails no danger of selfishness or solipsism. Here, authenticity is defined by a self-transcending dynamism that is geared toward the universe of being, toward all that is objectively true and good. In Lonergan's (1972, p. 292) understanding of authenticity, objectivity and subjectivity coincide, for "genuine objectivity is the fruit of authentic subjectivity". Thus, this construct seems ready-made for application in psychotherapy. Its application is simply the therapist's and the client's open-minded, honest, and good-willed pursuit of the best life that the client could live overall, given the actual circumstances of his or her situation.

Talk here is of moral absolutes and objective truth and goodness. Though serious attention to spirituality cannot avoid these matters, such talk seems out of vogue and easily misunderstood (Bindeman, 1996; Bracken, 1997; Nelson, 2000). Readers should not assume that the present approach to spirituality would fit everyone into a prefixed mould. Though this approach is far from value-free, neither is it imperialist. The only restraints it entails are to be found, supposedly, in every individual. Readers inclined to object to this analysis are freely invited to criticize and rethink the matter and propose other formulations. But if they act in openness, questioning, honesty, and goodwill, in the very process of objecting,

they would be implementing the requirements of authenticity as defined here. And their very procedure, if not their verbal objections, would accord with Lonergan's (1972) formulation, which simply attempts to capture primordial human awareness, open-minded critical thinking, and goodwill. It seems, then, that Lonergan's (1972, p. xii) analysis is *"not open to radical revision"* because the very act of opposing it generates evidence to support it. This state of affairs is peculiar and disconcerting. It challenges the cherished modern and post-modern supposition that we can be whatever we want, but it does so precisely by claiming to have discerned what we actually are. If correct, this analysis evinces an important breakthrough in conceptualizing the workings of the human mind. At the same time, it provides a base on which to build a psychology of spirituality that might claim some universal validity.

The Dual Structure of the Mind and a Tripartite Model of the Human

Yet there is more to the human mind than that spiritual dimension. Another dimension can be called "psyche" (Doran, 1977, 1981, 1990; Lonergan, 1957, p. 456), and it includes emotions, imagery, conations, and memories (Lonergan, 1957), which cohere to form personality structures (Helminiak, 1992, 1996a, 1996c) that support and constrain habitual patterns of response. Differentiation of the psyche and the spirit within the human mind refines the standard model of the human, replacing the bipartite model: body and mind, with a tripartite model: organism (body), psyche, and spirit (Institute of Logotherapy, 1979; Frankl, 1969/1988; Lonergan, 1957; Vande Kemp, 1982). While the term 'psyche' has a wide range of meanings; here, psyche is a stabilizing dimension of the human mind. Its inclination is to sustain a comfortable homeostasis (Helminiak, 1996a). In contrast, the human spirit is dynamic, open-ended, ever unfolding, ever transcending. It fosters transformation, and its ideal goal is to attain, through continued adjustment, in an ultimate coincidence of subjectivity and objectivity, unity with all that is. Seen in this light, psyche and spirit cohere in a dynamic and shifting balance that, in a healthy person, results in both personal growth and mental stability. Insofar as positive change results from adjusting the structures of the psyche to accord with the requirements of the spirit, this change is the meaning of *spiritual development* (Helminiak, 1987). On the other hand, the mental stability that is grounded in the fixity of the psyche is the meaning of 'psychological health' or 'sanity'.

The Human Core of Spirituality

The challenge of spiritual development is to integrate organism, psyche, and spirit in a way that meets the exigencies of all three. Whatever compromises may be required in the process, the human spirit's requirement of authenticity must be ever respected, for the spirit determines the human animal as a person, and the spirit points the way to open-ended growth. Said in popular terms, howsoever one meets the needs of his or her particular constitution, one must ever remain an honest and loving person. Otherwise, dehumanization results.

Since remaining an honest and loving person means respecting the requirements of the human spirit, this very endeavour may rightly be recognized as the core of all spirituality. This understanding portrays spirituality as a fully human phenomenon and highlights its essence, namely, commitment to the on-going integration of one's inherently self-transcending spirit. Of course, this spiritual endeavor cannot go on without behavioural expression and social support – for it is human – so it could be argued that spirituality is inseparable from some form or other of "orga-

nized" religion (Pargament, 1999). Still, this nontheological understanding does elaborate a phenomenon that qualifies as spirituality, that could be discerned in a variety of theist or non-theist religions and even apart from any organized religion, that can account for most of what people mean by the word 'spirituality', and that falls within the competence of human psychology (Helminiak, 1995, 1996a, 1996c, 1998).

Relationship of Spirituality and Psychotherapy

In the Great Religions, spirituality entails deliberate attention to personal growth and perfection, and one supposedly attains enlightenment or becomes a saint by living as one's religion prescribes (Carmody & Carmody, 1996). Religions are not neutral as regards their beliefs, ethics, and practices but understand spirituality to deal *normatively* or *prescriptively* with the matter of human becoming. Even Hinduism's openness to many paths and many gods is, itself, a value-laden stance that the religion deliberately takes (Helminiak, 1998, pp. 281-284). Therefore, if the term *spirituality* is taken in its already established meaning, acceptance of prescribed norms of some kind or other is inherent to spirituality. So, a psychological treatment cannot advocate neutrality of beliefs and values and still claim to be treating spirituality. Attention to spirituality challenges psychology to abandon its self-image as "value-free" (Bergin *et al.*, 1996; Bernstein, 1976; Beutler, 1981; Beutler & Bergan, 1991; Browning, 1987; Doran, 1981; Habermas, 1970/1991; Kelly, 1990; Myrdal, 1958; Richardson & Guignon, 1991; Taylor, 1989; Tjeltveit, 1986, 1991, 1992, 1996; Wolfe, 1989, 1993; Woolfolk & Richardson, 1984).

The present psychology of spirituality meets this challenge by discerning in human mental functioning an inherent normativity – in the form of the transcendental precepts and the correlative notion of authenticity – and by insisting on this normativity. Accordingly, this psychology of spirituality necessitates an understanding of academic psychology very different from the standard notion of a "neutral" or "objective" (that is, noncommittal) science, and this psychology of spirituality also raises questions for applied psychology that requires non-judgmental openness to every person's religion or spirituality while simultaneously requiring the therapist to foster what is best for the client (American Counseling Association, 1995; American Psychological Association, 1992; Holden, 1996; J. M. Holden, personal communication, July 13, 1999). What are therapists to do when the client's religious beliefs are dysfunctional or even pathological? And if it is not the role of therapists to assess the psychological adequacy of religious beliefs, how can therapists presume to know what might be healthy or unhealthy in any case? Serious attention to spirituality entails a radical reorientation of the human sciences (Doran, 1977, 1981; Helminiak, 1996a, 1996c, 1998; Richardson, Fowers, & Guignon, 1999). Until psychology addresses the "big questions" about the meaning of life and about the nature of the true and the good – not necessarily resolves the questions but faces them openly and honestly as an unavoidable facet of human experience – psychology cannot pretend to deal with whole human beings, let alone with spirituality (Andrews, 1987; Assagioli, 1965/1976; Clinebell, 1995; Doherty, 1995; Frankl 1962, 1969/1988; Fromm, 1947; Koch, 1968, 1981; MacLeod, 1944, 1970; Menninger, 1973; Moore, 1992; Wilber, 1995, 1996; Yalom, 1980).

In contrast to other psychological treatments of spirituality known to this author, the understanding summarized here explicitly addresses these questions about normative meanings and values. The theoretical result is a conception of psychology that has 'normativity' built

into it – and the presumption is that the guiding norms presented here (the transcendental precepts) are essentially accurate and correct, or at least that the present analysis legitimates an explicit and unavoidable search for such norms. Kane (1994, 1999) presents another analysis that arrives at similar conclusions. By insisting on normative values and by grounding the quest for them in an analysis of the human mind, the present approach differs seriously from the more prevalent one that would meet religious pluralism in secular psychotherapy by advocating openness to a range of client values (Bergin *et al.*, 1996; Beutler, 1981; Beutler & Bergan, 1991; Kelly, 1990; Tjeltveit, 1986, 1991, 1992, 1996). On the present understanding, a truly psychological and empirically grounded treatment of spirituality in a global society needs to complete the task that the religions have traditionally addressed in their varied, separate, and sometimes conflicting ways, namely, to specify and foster the human good. The challenge is admittedly overwhelming, but it is essential to the current endeavour. Practical implications of such an understanding should be apparent in the applications that follow.

Relationship of Spirituality and Theist Religion

This psychology of spirituality appeals to an understanding of the human spirit as an inherent dynamism that is open to the universe of being. God is included within the universe of being when, in the mode of Western theism, God is understood to be a distinct existing being characterized as Creator, imminent as well as transcendent. Thus, this psychology of spirituality opens onto questions about God (Lonergan, 1972, pp. 101-103) and, without addressing theology directly, remains in harmony with theist religion (Helminiak, 1998).

Nonetheless, though God is the centre of most Western religion as well as the focus of most people's spirituality, it seems that the human spirit itself – and not God – must be the key to a psychology of spirituality (Helminiak, 1996a). As Thomas Aquinas (trans. 1961) stated repeatedly in his *Summa Theologica*, we may know ***that*** God is, but we do not know ***what*** God is. All explanation of God, if it is not mere dogmatic assertion, is but reasonable extrapolation from the finest and best that we find in our world and in ourselves (Lonergan, 1957, 1972). The concept of 'creator' is one such reasonable extrapolation, and there are myriad images of God, often less rigorously and less reasonably derived (Heller, 1986; McDargh, 1983; Rizzuto, 1979). We project onto God our own understandings. So, focusing on God is actually focusing on an unknown, which can be made out to be whatever one might wish. Such a starting point can hardly lead to the clarity or widespread consensus that a scientific treatment of spirituality would require. Such a starting point also exceeds the limits of psychological competence (Bergin *et al.*, 1996; Tjeltveit, 1986). These problems attend much of transpersonal psychology, dependent on Eastern philosophy and widely influencing Western spirituality today. The arch-guru of transpersonal psychology (Rothberg, 1996; Walsh, 1996; Walsh & Vaughan, 1994), Ken Wilber (1980, pp. 75-76) states the matter unmistakably: *"The core insight of the '**psychologia perennis**' is that man's 'innermost' consciousness is identical to the absolute and ultimate reality of the universe, known variously as Brahman, Tao, Dharmakaya, Allah, the Godhead."* Thus, for methodological reasons, Wilber's (1995, 1996) approach – and much of transpersonal psychology – are at variance, though not completely irreconcilable, with the present approach (Helminiak, 1998, pp. 213-292).

In contrast, the human spirit provides a starting point that, via its own self-awareness, is available to experience, and thus is amenable to various kinds of empirical investigation

(Feingold, 1994, 1995; Feingold & Helminiak, in press; Helminiak, 1994; 1996c, 1998). Accordingly, the use of the term "scientific" in this presentation has its grounding. Moreover, as a facet of the mind, the human spirit lies within the arena of psychological competence. Finally, attention to the human spirit, in its inherent concern for the true and the good, opens onto questions about God (at least insofar as Western theism understands God) as the fullness of truth and goodness (Aquinas, trans. 1961, I, q. 6, aa. 2, 4, q. 16, a. 5). Accordingly, this humanist psychology of spirituality does not preclude theist considerations, for those who want them.

Authenticity is a key construct in this psychology of spirituality, and its criteria have been specified. To account for human development and to set its goal, this psychology builds on a supposed inherent human inclination toward all that is true and good and, therefore, wholesome and healthy. Advocating such ends, and again taking God to be the fullness of truth and goodness, this psychology of spirituality could not be in opposition to God, and anything contrary to its emphases would seem not to be of God.

Thus, in the nomothetic mode of scientific analysis, this psychology of spirituality claims to cut across all religions and cultures and to formulate the universally valid. This psychology claims to unearth the human core of the spirituality that the varied religions at their best carry and foster. If this claim can be sustained, this psychology of spirituality is not only open to theist extrapolation, but it also provides a basis for criticism of religion and religion's appeal to God (Helminiak, 1996b). Even as the deployment of other sciences has allowed for the purification and correction of religious beliefs – astronomy, geology, medicine, psychiatry – so a psychology of spirituality can react back on religion. On the basis of empirically validated insight, this analysis envisages a transformation of religions and cultures and suggests a humanistic foundation for building a coherent global society (see also Kane, 1994, 1999).

Obviously, these are broad statements and bold claims, and full treatment of them exceeds the scope of this paper. What follows is an application of this psychology of spirituality to some specific psychotherapeutic issues. Hopefully, this application will help clarify these statements and make the claims more plausible.

Three Responses to a Client's Spiritual Issues

Presuming the psychology of spirituality outlined above, the therapist can make a nuanced response to religious and spiritual matters. The therapist can respond: **(a)** by validating various facets of the client's spirituality; **(b)** by reinterpreting them; or **(c)** by rejecting them outright. As is appropriate in each case, the therapist might discuss the rationale with the client, or the therapist might keep it private as part of the therapeutic strategy.

A main thrust of this paper is insistence on the validity of a non-religious and even non-theist understanding of spirituality and on the appropriateness of such an understanding for secular psychotherapists. Thus, the possible legitimacy of non-religious and non-theist spirituality can be taken for granted. The more challenging task would be to show the legitimacy of this non-theist psychology of spirituality also in the case of religious believers. Accordingly, the cases that follow are predominantly those of religiously committed clients. The point is to highlight the humanist core of spirituality within the religious presentations and thus to show how such cases are amenable to qualified spiritual treatment within nonreligious and non-theist secular psychotherapy.

Validating Aspects of Spirituality

First, the therapist can validate aspects of spirituality. As the psychology of religion makes clear (Bergin, 1980, 1991; Bergin *et al.*, 1996; Bergin, Masters, & Richards, 1987; Ellis, 1980; Hood, Spilka, Hunsberger, & Gorsuch, 1996; Jones, 1994; Moberg & Brused, 1978; Wulff, 1997), much of religious belief and practice can facilitate psychological healing and personal integration. Belief in a loving and caring God, the need to make some sense of life's happenings, commitment to honesty, compassion, and good will, requirements about repentance and forgiveness, membership in a supportive community, participation in moving and reassuring rituals, practice of private devotions and meditative exercises with judiciousness, a therapist could usually support such facets of a client's religion (Clinebell, 1995; Patterson, 1992). Insofar as these beliefs and practices facilitate the integration of organism, psyche, and 'spirit' in the client, a therapist's support of them is actually fostering 'spiritual' growth.

Reinterpreting Aspects of Spirituality

Second, certain facets of a client's spirituality can facilitate authentic spiritual growth, but only if they are purified and adjusted to actually do so. In these cases, understanding the structures, processes, and mechanisms of spiritual integration, as outlined above, the therapist can reinterpret aspects of a client's spirituality and, thus, foster the authentic spirituality that the client actually desired. Three examples follow.

- ***Prayer of Petition***: Asking God for help – petition, intercession, supplication – may be the most common expression of prayer (Selby, 1986). Whether people recognize it or not, they often pray – literally expecting a miracle. God is still the childhood fantasy of the Great Magician in the Sky (Woodward, 1997). Although sustaining hope in the face of hardship is an important facet of mental health, it seems irresponsible to build one's life around the sheer expectation of a miracle, especially while neglecting the work that could contribute to a needed outcome. One woman, for example, ran herself into tens of thousands of dollars of debt, all the while believing firmly that it did not matter because she would soon win the lottery. In fact, continued borrowing and believing were the required proof of the firmness of her faith. So, against all reason, she continued to borrow and to rely on a win. Clearly, winning the lottery is not strictly a miracle, yet given the odds of winning, counting on it is already irresponsible – all the more so, then, to rely on miracles. But irresponsible behaviour violates the transcendental precepts. Therefore, it entails misguided spirituality and prevents personal (and thus, spiritual) integration, so the responsible therapist must discourage such behaviour.

  Nonetheless, such prayer and such faith can be useful when reinterpreted. Petition can become a simple expression of trust that, somehow, one will have what one needs to resolve matters (Appleton, 1983). Religion, itself, often fosters such a re-interpretation. It advises, for example, that one should not pray for specific outcomes, but rather for whatever God knows is best. Or again, it is said, "*You should pray as if everything depended on God and work as if everything depended on you*". Alternately, it must be acknowledged that praying sometimes allows people to let go of anxious concerns. This very result is beneficial in itself. It allows one to be open and attentive, as the first transcendental precept requires.

  Accordingly, for the client, if appropriate, and especially in his or her own mind, the therapist can reinterpret the client's belief

in, and use of, petitionary prayer and, thus, support prayer as therapeutic. Without taking a theological stand on the validity of petitionary prayer or the occurrence of miracles, the therapist can understand the processes in the human psyche and spirit through which prayer sustains hope and trust and can legitimately affirm prayer as a practice that advances integration of the dynamic human spirit.

- ***God and Images of God**:* Granted the theological presupposition that God exists, there is a difference between God and people's images of God (Heller, 1986; McDargh, 1983; Rizzuto, 1979). Allowing this difference, a therapist can recognize that many supposed God issues are really issues of the client's personal history.

  Thus, a divorced and lonely woman might lose all faith in God – which is to say, lose all hope and purpose in living – for, as the woman unwittingly supposed, God made man and woman for each other, and there is a man for every woman. It turned out, however, that the woman in question was feeling obliged to replicate her mother's life, and the mother of a former generation had dedicated herself totally to the family. Then, God did not betray the woman. Only her personal expectations, projected onto God, were disappointed. This realization does not necessarily make the woman's situation easier, but it does at least disentangle God from the situation and, thus, makes the situation more amenable to therapeutic intervention. Equipped with a coherent psychological theory of spiritual growth, the therapist can competently effect such intervention.

  Similarly, surrender to *"God's will"* often actually means *"toeing the line"* as regards expectations of family, friends, and one's local congregation (Rayburn, 1985). This supposed God is a social construction, requiring surrender of one's own better judgment. As one client phrased it, *"Not to be 'selfish' was the biggest rot I learned in my religious upbringing"*. When God is distinguished from the personal and social construction of God and, in contrast to the criticism of humanistic psychology as "selfist" (Bergin *et al.*, 1996; Vitz, 1977), when fidelity to one's authentic self is distinguished from petty egocentricity (Helminiak, 1987, 1996a), therapy can begin dealing with the self-transcendent meaning and wholesome purpose of life – spirituality – without needing to deal with God and religion.

- ***Morality as Social Construction**:* Moral requirements are often projected onto God, yet they are really social constructions and expressions of the human spiritual capacity (Helminiak, 1996b, 1999). Calling them social constructions is not to discount the possibility of objectively valid moral norms (Kane, 1994, 1999), and attribution of morality to God legitimately serves to insist that moral requirements are important and to suggest that these or those particular ones are valid. But when the validity of religious moral requirements honestly comes into question – as in current debate regarding gender roles, sexual practices, or medical interventions, for example (Bergin *et al.*, 1996; Crabb, 1975, 1977; Tjeltveit, 1991) – the moral requirements can be sorted out from their association with God. This sorting out frees people to engage in the spiritual process of applying their honest and good-willed judgment in the matter. That is to say, it allows people to rely on their own authenticity and to engage in the kind of "soul searching" that therapists are trained to facilitate in their clients. Thus, a religious or theological issue

is transformed into a human one that lies within the competence of secular psychotherapy. At the same time, since authentic humanistic spirituality is open to theological extrapolation, as already suggested, authentic moral judgments can be related back to God when God is understood as the fullness of truth and goodness. Hence, in yet another example, competent psychotherapy and the enhancement of authentic spirituality coincide and can proceed apart from, yet not in opposition to, theist religion.

Superego and Neurotic Guilt versus Conscience and Healthy Guilt:

That sorting out of moral issues calls for another important distinction regarding morality. Freud's superego is not the same thing as conscience (Griffin, 1986b; Gula, 1995). Superego depends on internalized social expectation; it preserves the status quo. Conscience urges correct judgment about good and evil; it points towards personal enhancement, self-transcendence, and social responsibility, all at the same time.

So, a therapist needs to treat a client's experience of guilt carefully. It is usually a mixture of what can be called 'neurotic' and 'objective' guilt (Griffin, 1986a). Neurotic guilt results from the superego; it is learned discomfort surrounding certain specified behaviours. **Shame** may be a synonym here. Objective guilt results from conscience; it is spontaneous discomfort regarding real wrongs that one has done or intends to do. The discomfort is grounded in self-awareness and the capacity for judgment, which are constitutive of the human spirit. The awareness is both of what one has done (or plans to do) and of its discrepancy with spirit's inherent predilection for the open-ended promise attached to the true and the good. Awareness of the discrepancy shows in an emotional disruption in the psyche (Mackleburgh, 1992; Perry, 1970, p. 50) and perhaps even in physiological distress in the biological organism (Saxe, 1991).

Not only must the therapist help free clients from neurotic guilt or shame, but the therapist also needs to help clients own their objective guilt, repent their wrongdoing, and reform their lives (Andrews, 1987; Doherty, 1995; Menninger, 1973). In twelve-step programs, such requirements are taken for granted (Dan, 1990). But they apply across the board in therapy. As matters of authenticity – with or without a Higher Power – they are matters of spirituality. They set the conditions for the flowering of the dynamic human spirit, and, as understood here, that means the possibility of human integration and healing.

These are examples of reinterpreting religious concerns. Reinterpretation takes the client's religious concerns seriously, but teases apart their theological and their spiritual dimensions and thus focuses issues amenable to psychotherapeutic, in contrast to theological, competence (Bergin *et al.*, 1996). Though these religious concerns are most commonly expressed in terms of relationship with God, reinterpretation discerns and highlights the psychotherapeutic issues at stake in the religious concerns. The therapist's psychological understanding of the dynamics of spiritual growth, as outlined above, guides the re-interpretation process. Without being religious or theological, yet dealing with matters of the human spirit, this process is simultaneously psychotherapeutic and spiritual.

Rejecting Aspects of Spirituality

Finally, there are some facets of spirituality that the competent therapist needs to reject outright. They are antithetical to psychological healing, personal integration, and wholesome growth. They violate the transcendental precepts. On the basis of the above analysis of spirituality and regardless of their religious

endorsement, they are expressions of a false spirituality and are pathological. As Tjeltveit (1986, p. 522) says, "*A therapist who fails to attempt to persuade a client to adopt values conducive to improved psychological functioning would likely be judged incompetent*".

- *Satanic Control and Hexes*: The protest, "*The Devil made me do it*", offers a first example. Such protest might be part of literalist biblical religion, or any religion that believes in supernatural powers, hexes, and curses. The danger in such belief is that it eschews personal responsibility (Bergin *et al.*, 1996). Thus, it short-circuits the possibility of personal integrity and, *ipso facto*, counters spiritual growth, as understood here. To the extent that it does, the helpful therapist must somehow dismantle such belief. Without ever engaging the metaphysical questions, the therapist could suggest to a client that a hex can work only to the extent that we, ourselves, provide an opening for it. The therapist could then help the client think about him- or herself and what personal flaws made him or her vulnerable to outside powers. Thus, the therapist is able both to circumvent the therapeutic obstacle and to point an unknowing client toward a different spirituality. The ethics of such covert manoeuvres is discussed below.
- *Prohibition against Being Angry with God*: Another instance is the religious belief that one must not be angry with God. But, when reinterpreted, anger with God is really anger with life in general; it is to feel the losses, disappointments, and hurts that are an inevitable part of life and to respond in aggressive protest against the whole lot. This reinterpretation reveals how incompatible this religious belief is with effective psychotherapy. This belief blocks emotions, and to block them is to prevent integration and healing. The caring therapist must oppose such a belief, for, in the name of religion and God, it hampers human well-being.

Entering into the client's worldview and using the client's religious symbol system (but with a precise psychotherapeutic strategy in mind), a therapist can respond to this spiritual matter by giving the client permission to be angry with God. The therapist can note that others have done it and that God is big and loving enough to deal with the anger. Going further, a therapist can appeal to basic honesty: the client should be honest, especially with God. And, since the client is hurt and angry, and since God would already know that, the more honest approach would be to admit the anger, express its intensity, and discuss the matter with God. This, then, is the psychotherapeutic payoff: under these circumstances, the client may be willing to admit and face pervasive frustration and anger about his or her life. Here, as elsewhere, the key is to draw out from the client's relationship with God its spiritual core, in this case, the client's anguished inability to find satisfaction, meaning, and purpose in life. This core, unlike the client's relationship with God, *per se*, is amenable to secular psychotherapeutic intervention.

Therapists will also be aware that, behind this religious issue of anger with God, lies the issue of the client's own learned understanding of what is permissible in communication between intimates. A whole array of standard psychodynamic issues is tied up in the bag of one's relationship with God (McDargh, 1983; Rizzuto, 1979). For this reason, a ministry called "spiritual direction," devoted to fostering a person's relationship with God, can effect profound personal transformation

by focusing almost exclusively on that relationship, howsoever the client construes it (Barry & Connolly, 1982; Conn, 1989; Gratton, 1995; Nemeck & Coombs, 1985). In contrast, from the secular point of view, effective psychotherapy needs to sort out the theological and the psychological/spiritual issues of a client's relationship with God and to address the latter, whether in the client's own religious symbol system or in more standard psychological terminology (Bergin *et al.*, 1996). To address them entails dissolving the humanly destructive facets of the client's spirituality, just as a therapist would help a client work through some other emotional issue. Understanding the mental structures, processes, and mechanisms of spirituality, as explained above, equips the secular therapist to do that.

- *Prohibition against Questioning*: Similar to the prohibition of anger with God is another facet of some religion, especially the fundamentalist type (Bawer, 1997). It prohibits questioning, inquiry, reading, and challenging thought, as well as exploration of inner experiences. In the face of such universal close-mindedness, which violates the transcendental precepts, therapy is unlikely to make much progress.

  A secular therapist is unlikely to encounter such a believer, for in most instances the very use of secular psychotherapy would be contrary to such religion (Rayburn, 1985). But when such a client does need to approach secular psychotherapy, early on, the therapist and client will have to come to some agreement about the challenge that will be part of the therapeutic process (Tjeltveit, 1996). This initial contract gives the therapist the opening needed to address the matter of open-mindedness when it surfaces in the treatment of specific issues.

  Then, by entering the client's religious world with a clear psychotherapeutic strategy in mind, the therapist could invoke a variety of motivations to support open-mindedness: the client's religious commitment to honesty before God, the expectation that valid religion and true belief could sustain questioning, an acknowledgment that truth is one and, thus, there could be no real conflict between God's truth and human truth (Carter & Mohline, 1976; DeVries, 1982; Dueck, 1989; Farnsworth, 1982; Hill & Kauffmann, 1996; Jeeves, 1969; Vande Kemp, 1996), the consideration that God would not have given us questioning minds if we were not to use them, the realization that faith entails trust in the face of uncertainty and not simply adherence to ready-made answers, the recognition that, sometimes, the pieces of life simply do not all fit together neatly, the supposition that on-going experience would naturally reveal new meanings in valid beliefs acquired earlier in life, or the reassurance that others have arrived at deeper understanding without having had to abandon the essence of their faith. In one way or another, each of these motivations expresses the humanistic core of spirituality, as sketched above: openness, seeking, honesty, and surrender to the sources of self-transcendence that are built into the human mind.

That list of motivations in this particular case suggests how precarious and far-reaching is the matter of engaging a person's spirituality. At stake is a fundamental shift in worldview, philosophy, belief, and religion. The shift is from reliance on an external authority that provides an all-too-clear picture of life to reliance on an internal process that continuously

self-adjusts to find a fit between internal and external reality. This shift implicates not only one's personal world of meaning and value but also the social world of affiliation and support.

In purely psychological terms developmental theorists have focused on that very shift (Fowler, 1981; Helminiak, 1987; Kohlberg, 1977; Loevinger, 1977). A number of implications follow: a matter that is presented in religious terms contains a core of developmental issues. So, working through the religious issues in a religious context effects psychological growth, or conversely, one can treat psychotherapeutically the developmental issues at the core of the religious issues. When it is recognized that the human being is inherently spiritual, psychological growth in anyone, religious or not, can rightly be affirmed as a spiritual process. So, in the religious person, mature religion and psychological health ought to coincide.

These considerations help elucidate the intent of this paper. When the spiritual is understood as, in the first place, a generic human reality, and not necessarily something specifically religious or theist, on the one hand, all competent psychotherapy is seen as actually effecting spiritual growth, and on the other hand, a client's religious or theological concerns, often being expressions of psychological/spiritual issues, as such, can fall directly under the competence of secular psychotherapy. As academic disciplines, adequate psychology and spirituality are one and the same.

Equating Inner Peace with the Will of God:

One last example lies on the opposite end of the religious spectrum. This is the case of a client who was familiar with spiritual writings and, in some regards, was deeply sensitive to inner experience. Rather than be locked into external social or religious requirements, this client appealed to his own inner peace as the final indicator of the will of God and – in so doing – had the support of many a classical spiritual writer (e.g. Ignatius of Loyola, 1964). This one-sided criterion might have been sufficient if the client were a hermit in the ancient desert, and, in fact, the client identified with the desert tradition of spirituality (Bouyer, 1969; Gannon & Traub, 1969; Holmes, 1980). The only problem was that he was married and on the verge of divorce, had children and a job, and lived in a late-twentieth century metropolis.

Counselling revealed that the client had a severely narcissistic personality and carried a burden of isolation and abandonment from growing up in a large middle-class family where practical needs for survival superseded personal needs for belonging. The desert spirituality of *"peaceful presence with God"* served to meet the needs of his deeply aching heart and, by means of isolation, to protect him from further hurt.

Of course, that client's understanding was a grossly romanticized portrayal of the desert experience, which actually requires facing oneself quite nakedly, a challenge similar to contemporary psychotherapy. Though needing to proceed with utmost care, a therapist would be irresponsible to allow that counter-productive spirituality to stand completely unchallenged. But it must be left to the creativity of experienced therapists to imagine how they would deal with this case. It is introduced to challenge an overly simplistic understanding of spirituality that would assume that cultivation of inner experience is the universal key to spiritual growth. Cases of psychosis make the same point in the extreme (Grof & Grof, 1989). Though spiritual practices are geared toward enhancing inner experience, mere richness of inner experience is no guarantee of spiritual and psychological health. Understanding these matters in terms of known human mental processes, the

competent psychotherapist cannot but take a stand, if only in his or her own mind, and build on the positive elements in the client's religious beliefs and practices and direct the client away from those that are self-debilitating.

Further Considerations about Spirituality in Psychotherapy

Making Judgments and Prescriptions about Religion

This paper has presented three approaches to spirituality in psychotherapy: validation, reinterpretation, and rejection. The treatment may appear facile or even irreverent. Breaking a taboo in American society and in psychotherapeutic circles, this treatment has freely arrived at judgments and prescriptions about people's religion and spiritual life. This treatment claims the right to make such judgments on the basis of an elaborated account of spirituality.

Once the core of spirituality is discerned and formulated normatively, a powerful tool is available. It not only allows the competent treatment of spiritual matters in secular psychotherapy. It also allows incisive criticism of spiritual matters attached to religion. Developments in the medical field provide an analogous case. An understanding of infection allows not only the prescription of appropriate antibiotics, but also the criticism of hallowed folk practices that are unhygienic. Similarly, a breakthrough in the understanding of spirituality reconfigures the relationship between psychology and religion. Such a breakthrough is what Lonergan's (1957, 1972) analysis of the human spirit seems to allow, and it is the foundation of the present enterprise.

Psychotherapists are always making and acting on assessments of spirituality; that is to say, they are always facilitating the adjustment of the meanings and values that structure people's lives (Andrews, 1987; Assagioli, 1965/1976; Bergin *et al.*, 1996; Beutler, 1981; Beutler & Bergan, 1991; Clinebell, 1995; Corey, 1996; Doherty, 1995; Frankl 1962, 1969/1988; Fromm, 1947; Helminiak, 1989; Kelly, 1990; Koch, 1968, 1981; MacLeod, 1944, 1970; Menninger, 1973; Moore, 1992; Richardson & Guignon, 1991; Taylor, 1989; Tjeltveit, 1991, 1992, 1996; Wilber, 1995, 1996; Yalom, 1980). Every psychotherapeutic system entails an implicit metaphysical worldview (Bergin *et al.*, 1996; Browning, 1987; Tjeltveit, 1986, 1991, 1992, 1996; Woolfolk & Richardson, 1984). The present approach merely highlights the matter while being quite explicit about the criteria of assessment it uses and quite bold in claiming a unique validity for its criteria. This forthrightness makes judgments relatively easy, but granted the overall analysis, the conclusions are far from superficial.

The key to the matter is the articulation of a coherent and comprehensive psychology of spirituality (Helminiak, 1996a, 1998, 2015) – including: **(a)** the differentiation of psyche and spirit within the human mind:; **(b)** the elaboration of spirit as structured on four levels; **(c)** the normativity of spirit as expressed in the transcendental precepts; **(d)** the on-going integration of spirit and psyche as the substance of spiritual growth; and **(e)** the self-transcending nature of this process that is open to theist extrapolation and to elaboration in a wide range of religious formulations. And, there is the further consideration that anyone who would oppose this approach in the name of genuine openness, tolerance, and pluralism, is in practice only demonstrating its validity and exemplifying its intent by urging further discussion toward a shared, correct understanding (Kane, 1994, 1996; Lonergan, 1972, pp. 16–20).

Comparison with Pastoral Counselling

Much of what was presented above may appear to be covert pastoral counselling, but there is a difference. Pastoral counselling is psychotherapy that goes on within the explicit context of the shared faith of an organized religion (Clinebell, 1995; Crabb, 1975, 1977; Rayburn, 1985; Wicks, 1985). The shared religion entails a tradition of beliefs, symbols, rituals, ethics, and texts. Sharing this tradition with the client, the skilled pastoral counsellor may easily appeal to any of its elements to make the therapeutic intervention. For example, knowing the Gospels, the therapist can cite the example of Peter, who repented of denying Jesus, to cancel a client's identification with Judas, who hung himself after betraying Jesus. The pastoral counsellor uses the client's religion to effect wholesome change. Thus, validation, reinterpretation, and rejection of spirituality proceed within the boundaries of the mutually accepted religion.

The present approach is similar in that it sometimes also appeals to various facets of religion to reinterpret or reject certain other facets. This approach presupposes more knowledge about religion than has been indicated. Nonetheless, therapists can learn the intricacies of a client's religion by asking, listening, and reading (Lovinger, 1984, 1990; Shafranske, 1996; Stern, 1985).

Knowledge about someone's religion is not the key issue. More important is a psychological understanding of spirituality within which to situate the specifics of the client's religion. Supplying this understanding as a generic, humanist, and normative analysis is the novelty in the present approach. This novelty allows three dimensions that pastoral counselling does not: **(a)** to sort out and interrelate the theist and humanist facets of the religion; **(b)** to conceptualize the religion's spiritual wisdom in humanist terms – which is to say, to coherently integrate psychology and religion; and **(c)** to name and correct pathological facets of the religion. Psychotherapy that addresses spirituality only on the basis of openness to, and respect for, every client's religious beliefs (Bergin *et al.*, 1996; Beutler, 1981; Beutler & Bergan, 1991; Kelly, 1990; Tjeltveit, 1986, 1991, 1992, 1996) functions, in effect, like pastoral counseling, ultimately self-constrained by the worldview that the religion in question requires.

Requirements for the Therapist

In these matters, the successful therapist will be more than psychotherapeutically trained at least if "psychotherapeutic" is taken in the standard sense of the term (Tjeltveit, 1986, 1992). The analysis here, transforming the meaning of spiritual, suggests that good psychotherapy includes spirituality at its core. So, psychotherapeutic training must include what the religious traditions have called "spiritual formation". Without it, the therapist can treat people only as one fixes machines. This approach might work to help clients meet the minimalist mental-health standards of appropriate demeanour and employability, but it is not sufficient for internal healing, core personal stability, and a life worthy of a human being.

In the present discussion it comes clear that the more effective psychotherapist will be the one who is more deeply authentic, more spiritually integrated. That is, the effective psychotherapist is honestly open to marvel and question, sure of where he or she stands on this matter, and securely committed to wholesome values – and truly so, not just as a professional facade that would allow one to deal with clients cleanly and efficiently and to collect one's standard fee. Jesus' contrast between the hireling and the good shepherd provides an image that is apropos (John 10:11-13). And appeal to

this religious image suggests once again what is a stake in this whole discussion: the radical transformation of traditional religion into a secular form that respects the distinctiveness, while embodying the humanist core, of the engendering religion (Helminiak, 1996a, 1998, 1999); or, said in other terms, the psychology of spirituality. Psychotherapists' low ratings on measures of religiosity may be another matter (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990), but their commitment to lived spirituality is a *sine qua non*.

Conclusion

Addressing the role of spirituality in psychotherapy, this paper has summarized a fully psychological theory of spirituality, applied it in specific examples, and discussed its implications. Thus, this paper has suggested ways in which an integration of secular psychotherapy and spirituality might be achieved without exceeding the professional competence of secular therapy or diluting the meaning of the term "spirituality". Contributing to this desideratum, this paper has clarified the humanist core of spirituality as it relates to, and is operative in, effective psychotherapy. In the case of psychotherapy, this paper has taken the term 'effective' to imply facilitation of lasting and wholesome change in people. Understood in this way, psychotherapy cannot be effective unless it attends to spiritual matters.

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IN MEMORIAM

David Boadella

Just as we were going to press – we received some sad news, we have to announce that a "great psychotherapist" **David Boadella** passed away on 18th November, 2021 after a short illness (a lung infection). He had had his 90th Birthday a couple of months ago, with his family present. We will be writing an obituary a little later and we now encourage all those who wish to send in some memories or commendations to do so and we will put these together in a proper memorial.

We are sure that all those who knew him will miss him greatly.
We would also like to publish some of his last words – and his poem – overleaf.

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First of all – my immense gratitude for the gifts of life:

For the deep care and support as a child from my parents: for the songs and paintings of my mother Jessie, and for the bedtime myths and spiritual "glimpses of the light" from my father, Harold.

For the time with my first wife, Elsa, who shared her love of poetry and mountains and swans with me.

For my deep partnership with Silvia, with whom I could share my love, my therapeutic work and my search for clearer knowledge. For her love of beauty, in healing, in art forms, in her flower gardens and in her creative writing. For her deep therapeutic work in our trainings which she has organised so well for the past thirty years and more. For her endless support and care at so many levels and for the love from the depth of her heart.

For what I could share with my three children:

Adam – who wished me a crown of stars and the everlasting flowers
Eilidh – who taught me how to reach out from my heart, and to find my inner ground
Till – who has showed me his passion for creativity, strength of freedom and natural pride

"I and my body"

Do I carry my body through this life,
or does it carry me?
do I take care of it,
for richer, for poorer,
for better, for worse,
in sickness, in health,
as long as we stay together,
or does it take care of me?
when I rise out of bed,
I leave an imprint in the sheets,
the shape of my body.

When I rise out of my body,
I leave an imprint in the flesh,
the shape of who has been living there.

When the light goes out
my shadow is gone;
when the life goes out
my body is gone.

Who dies?
Not I.

EAP 30th Anniversary Congress
Vienna, March 12th – 13th 2022

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- **Keynote Speaker Prof. Kyriaki Polychroni** – *"There is a crack, a crack in everything . . . that is how the light gets in"*
- **Keynote Speaker Irvin Yalom** – *"A matter of death and life"*
- **Keynote Speaker Sue Daniel** – *"All Hands On Deck!"*
- **Keynote Speaker Prof. Renos Papadopoulos** – *"Therapeutic applications in humanitarian contexts."*
- **Keynote Speaker Jessica Benjamin** – *"Only One Can Live: Transforming the Reactivity of Survivalism."*
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On Becoming Secure: Adult Attachment in Couple Relationships - Angela Dierks

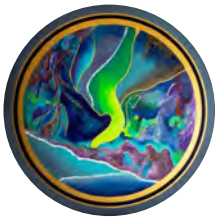
Angela is a London based, BACP accredited integrative counsellor and psychotherapist, couple's therapist and clinical supervisor. Her particular interest is to work integratively on all aspects of being in relationships. She is also an acclaimed artist.

Date: 7 May Price: £99
Time: 11:30am – 6:30pm CPD: 6

Principles of EMDR Therapy, Neurobiology and Implications for Trauma Informed Care - Alicia Avila

Alicia is an EMDR Institute trainer, EMDRIA approved consultant, and psychotherapist specializing in trauma and cultural issues. She has +25 years of experience and has been trainer for local and national institutions and conferences. She is currently an EMDR Institute senior trainer working on the latest update of the EMDR training curriculum.

Date: 27 May Price: £99
Time: 3:00pm – 10:00pm CPD: 6



Psychological Treatment of OCD: Effective and Practical Strategies - Martin Antony

Dr. Antony is professor in the Dept of Psychology at Ryerson University, Canada, and provincial clinical and training lead for the Ontario Structured Psychotherapy Program. He has published 33 books and over 300 scientific articles and chapters in areas related to cognitive behavior therapy and anxiety-related disorders. He has given more than 425 presentations to audiences across four continents.

Date: 9 & 10 July at 5pm - 8pm on both days Price: £99 CPD: 6

Polyvagal Principals for Clinicians: Applications for Safety, Attachment, Trauma, and Anxiety - Debra Alves

Debra is one of the most in demand speakers in the USA and around the world. She is a licensed psychologist and private practitioner with over 25 years of clinical experience in supporting clients' recovery from shame, trauma, anxiety, depression, and relational concerns. A seasoned international presenter and consultant, Dr. Alvis retired as faculty from the University of Georgia where she developed and led the Mind/Body Program.

Date: 13 July at 4:30pm – 11:30pm Price: £99 CPD: 6

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