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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 using 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 as directly downloaded PDF files by using the Catalogue on the IJP website. Payment is by PayPal. We still have some printed copies of most of the Back Issues available for sale.

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

There is also a whole cornucopia of material that is currently freely available on-line (see the top left-hand corner of the website). **Firstly**: there are several "Open Access" books on Psychotherapy available, free-of-charge; **next** there are an increasing number of free "Open Access" articles; **then** there are often a couple of articles available from the forthcoming issue, in advance of publication.

There is also an on-going, online 'Special Issue' on **"Psychotherapy vs. Spirituality"**. This 'Special Issue' is being built up from a number of already published articles and these are available 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 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: *"EAP Statement on the Legal Position of Psychotherapy in Europe"*, which we published in a recent issue.

International Journal of Psychotherapy

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear **Readers of** – and **Subscribers to** – the **International Journal of Psychotherapy** (IJP),

As I write this Editorial for the winter 2022 issue of the IJP, the war in the Ukraine is still going on and our friends and psychotherapist colleagues in both the Ukraine and Russia are still suffering. We feel, hope and pray for them and many of us are actively supporting them in one way or another. Many of our Ukrainian colleagues are dealing with numerous issues: not only having to help resist the Russian invasion themselves (some have been conscripted); as well as trying to help the massively increased number of people traumatised by invasion, with loss of homes, businesses, relatives, and family members fleeing to different countries. We are planning a Special Issue on 'Psychotherapy with Refugees', but may need to include working with other sorts of trauma as well.

Outside of this, there seems to be an increasing number of articles being circulated about how to make psychotherapy more effective. We have put a number of these articles on the IJP website: so, you will find a large list of **"Open Access" Books and Articles** on the IJP website under the *"Read Current Online Articles Here"* in the top left-hand corner of the website. Please feel free to enjoy these!

Here, you will also find a series of articles that comprise an *On-going 'Special Issue' on "Psychotherapy vs. Spirituality"*, which was stimulated initially by a 2014 Guidelines (or more like an 'edit') from the Austrian Federal Ministry of Health on *"Guidelines for psychotherapists on the issue of differentiating between psychotherapy and esoteric, spiritual and religious methods."* Our contention is that this is a form of 'restrictive practice' and is also scientifically invalid – maybe another form of discrimination. But, please, read on!

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In this issue, first of all, there is the fourth part of a series by **James C. Overholser** entitled, *A Pragmatic Framework for the Supervision of Psychotherapy: Part 4: Individual Customization*. This has been an excellent series and I can only recommend that readers interested in the topic of supervision go back and read the earlier parts, in IJP Vol. 25, No. 2, No. 3 and Vol. 26, No. 1. These are all available on the IJP website (www.ijp.org.uk) under the "Current Issues" tab, and then the "Previous" tab.

Next, we have an article from a very eminent psychotherapist, **Richard Erskine**, who is the Clinical Psychologist, a Transactional Analyst, the author of several books, with four decades of experience, and who is Training Director at the Institute for Integrative Psychotherapy. His article in this journal is entitled: *Social Façade, Vulnerability and Relational Withdrawal: A Case Study on the Psychotherapy of the Schizoid Process*. We hope that you will enjoy this offering.

One of our colleagues, **Susanne Vosmer**, has written an intriguing article on *Black Humour and Fear of Death in Modernity*. This is an interesting look at how psychotherapists may now be needed to deal with the fearful tragedies that we are increasingly being faced with as the 'normal' use of black humour – indicating a fear of death – is no longer sufficient to reduce the general level of fear.

Next, we have an article from **John Robert Rilveria**, a university lecturer in the Philippines, who writes about, *Does the Location of Motivation Matter: A pragmatic concern in clinical work*. This article – albeit basically theoretical – can have profound implications in one's clinical practice.

We then have an article from **Ali H. Haider**, a Clinical Psychologist in private practice in Lahore, Pakistan, entitled, *Cognitive and Dialectic Behavioural Therapies for Post-Traumatic Stress and Conversion Disorders; a Case Study*. Case studies are an important method of research in psychotherapy and this case study demonstrates and effective method of treating a client with PTSD.

Lastly, I would like to draw your attention to a short article from **Éva Hosszú**, *Remembering Tom Ormay: An Obituary* ... of the previous editor of the IJP. We have included some bits of his poetry and also a short piece from myself, *Tom's Legacy to the Journal*. He was a good friend, a lovely man and will be greatly missed.

We end this issue with 3 Book Reviews from an American colleague, **Lily Wu**, from New York University. Truly, we are an international community!

A Pragmatic Framework for the Supervision of Psychotherapy Trainees: Part 4: Individual Customization

James C. Overholser

Abstract: Supervisors can learn to customize their meetings in order to adapt to the needs of the trainee as well as the issues presented by each client. Supervisors help trainees to explore possible pathways for the optimal treatment of each client. Supervisors can adapt to the strengths, weaknesses, and developmental level of each trainee. There are three basic levels that capture the developmental stages of professional training. Supervisors can adapt to the trainee's developmental level, with different strategies needed for the novice, the intermediate, or the advanced trainee.

Key Words: supervision, psychotherapy, developmental models

The amount of training that is required to become a skilled psychotherapist is extensive and spans across several years of supervised work in the field. The background training begins with coursework on the theories and research foundation for various psychological treatments. However, the core of graduate training involves actual clinical experience that is supervised by a qualified mental health professional.

The supervision of psychotherapy entails a series of meetings between trainee and supervisor, usually discussing recent sessions and exploring ideas for upcoming meetings. These supervisory meetings may rely on different strategies, including direct educational sessions with clear instructions to guide the trainee's work, a strong and supportive alliance between supervisor and trainee, and a willingness to explore various ideas in a collaborative fashion (1). Furthermore, these supervision meetings can be adapted to the needs, strengths, and developmental level of the trainee.

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Individual Customization

Supervision works best when the procedures have been adapted to the unique needs of each situation. The customization process suggests that supervision should be adapted to the needs of each client, the type of therapy that is provided, and various aspects of the trainee. Supervisors often need to adapt to the trainee and customize the supervisory style so it aligns with the needs of the trainee as well as the issues presented by each client.

Supervisors should be sensitive to specific aspects of therapy that could be influenced by each client's age, gender, racial background, cultural heritage, sexual orientation, psychiatric diagnosis, and personality style. Every client presents unique challenges and offers many opportunities for learning, by both the novice therapist and the supervisor. However, some trainees may have difficulties working with certain clients because of the client's age, presenting problem, or interpersonal style. These issues should be taken into account through a supportive and caring supervisory style.

The approach to supervision may be should adapted to the stage of treatment, because therapy shifts from intake through discharge. In addition, therapy is different during a crisis versus a period of stabilization. Even when setting the basic priorities to be addressed in therapy, there remains a vital need to assess and confront any risk of harm to self or others. Any risk of danger takes priority over other less urgent matters, such as managing client resistance (2). Thus, the therapist may need to become more active and directive during a crisis when a client poses a risk of injury, whereas the therapy style may be subtle and exploratory when confronting developmental antecedents.

The process of customization takes into account the trainee's interests, the trainee's personal background, the trainee's personality style, and the developmental level of trainee. The supervisor should be aware of the trainee's developmental level, educational background, professional interests, and cultural heritage. Furthermore, as the supervisor gets to know the trainee, it may be possible to identify key strengths and weaknesses in the trainee.

A developmental approach provides a useful framework to help guide the process of supervision (3). Changes across the developmental stages has been supported by research (4). Through the stages of professional development, the supervisor should remain sensitive to each trainee's perceived level of professional competence, personal struggles for autonomy, level of emotional awareness, and the trainee's overall professional identity (5). Each of these factors should be taken into account when providing psychotherapy supervision.

Developmental Levels of Training

Supervision changes as trainees improve their understanding and skill from time spent involved with coursework and clinical experience (4). Different levels of professional growth are based on personal maturity and professional experience. As trainees gain knowledge, experience, personal maturity, they are able to refine their abilities and manage more complex issues (6). It is advisable to adapt the style and focus of supervision to the developmental level of the trainee (7, 8). Assorted developmental models have been proposed to help supervisors to understand the stages of professional growth that most trainees move through (9, 10). Various experts use different names and levels for the developmental stages. It can be useful to view three levels of professional development: the stage of the novice, the intermediate, and the advanced trainee.

It can be extremely important to adapt the supervisor's standards and expectations to the developmental level of the trainee (7). A survey of 102 psychology interns (11) found that trainees view their ideal supervision as including direct feedback from a supportive supervisor. However, these supervisory qualities vary across the developmental stage of the trainee. A survey of 69 supervisors (12) examined their views about the components of supervision that are best for beginning trainees versus predoctoral interns. Results revealed that beginning level trainees benefit more from didactic instruction, with directive guidance and assigned readings. In contrast, advanced trainees benefit more from sessions focused on a deeper understanding of the client, exploring issues related to resistance and transference. Finally, both groups of trainees were seen as benefiting from a supportive relationship with their supervisor, frequently receiving emotional support.

The Novice Trainee

When first learning to become a psychotherapist, the trainee has high motivation but limited knowledge (13). Psychotherapy is an ambiguous activity, and the novice struggles to understand rules and guidelines that structure psychotherapy sessions (14). Thus, the novice often seeks structure, guidance, and support from the supervisor. the optimal training environment for the novice is heavy on instruction (15). It can be helpful to provide a fair amount of directive guidance through mini-lectures, assigned readings, paired with advanced seminar. Prescriptive approaches work well at this stage (16). The novice is likely to need guidance about proper assessment procedures and validated measurement tools, accurate psychiatric diagnosis, especially pertaining to the personality disorders. Further, the novice is likely to need direct guidance about the process of psychotherapy, difficulties encountered with poor attendance, and plans for therapy that accurately conceptualize each case.

A novice trainee wants information, guidance, and instructions for how to conduct psychotherapy sessions, but also needs a safe place to explore their strengths and weaknesses. A supportive alliance provides the safe foundation on which the trainee can explore their knowledge and test their skills. The novice therapist struggles with performance anxiety whenever being observed and evaluated (14). The supervisory meetings should be filled with as much praise as possible, relying on principles of shaping to begin at the trainee's level of performance and highlighting improvements along the way. Without a supportive alliance, the trainee's doubts and fears may grow. The novice is usually quite eager to learn but often struggles with anxiety and self-doubts (17). At times, the novice can be hindered by high anxiety, especially as related to worries about being evaluated. Furthermore, the novice struggles with high levels of anxiety because of their tendency to observe their own behavior and focus on their own shortcomings (8). The novice typically prefers high levels of support, structure, and guidance from the supervisor (13).

The novice lacks confidence and prefers a fair amount of direct instruction (15). Because of their feelings in insecurity, the novice is likely to benefit from frequent praise. During this early stage of professional development, praise should be frequent and aimed to highlight specific behaviors displayed by the trainee. However, it can be difficult to find praiseworthy actions with some weak trainees. In some cases, it may be helpful view mistakes as opportunities for learning (18). Furthermore, it is important to protect the supervisory relationship. The supervisor can retain a bit of intellectual modesty by remembering their own prior struggles as a trainee (18, 19, 20). If supervisors remain calm when discussing critical remarks, there is a better chance that

trainees will accept the feedback and begin to make appropriate changes.

During the novice stage, trainees benefit from planful learning opportunities in controlled situations with mildly disturbed clients so as to boost their confidence (21). A novice therapist may avoid sensitive topics, such as the assessment of suicidal ideation or exploring a client's history of sexual abuse. However, the novice therapist can begin to appreciate the essential differences between a supportive chat with a close friend versus a therapeutic conversation with a trained professional. In many situations, the novice therapist tries to reduce the client's emotional distress. However, therapy often requires helping clients to explore and express their emotions, helping to identify the source of the problem. The novice therapist may need guidance to use the therapeutic relationship as a vehicle for change, no longer seeing emotional support as an end in itself. Furthermore, a client's emotional distress may provide the most potent motivating force, encouraging clients to make changes in their life.

Trainees at an Intermediate Level

Supervision can be most challenging when working with trainees at the intermediate level. At the stage of intermediate skill, trainees have learned the basics and gained a modicum of clinical experience. The trainee at the intermediate stage has developed basic skills in listening and supporting clients but still remains dependent upon a skilled supervisor for advice and guidance (21). During this intermediate stage, trainees may focus so much on seeing the situation from the client's view to the point that the trainees lose their objectivity (21). A trainee at the intermediate stage often needs to develop more sophisticated critical thinking skills (16).

During the intermediate stage, the trainee usually understands the basics of assessment and psychotherapy, but may prefer to function in an autonomous manner prematurely as they appear more resistant to new ideas (13). The intermediate level trainee is less likely to value didactic training or directive guidance as part of supervisory meetings (13). At this intermediate level, the trainee still needs support but prefers less structure and more autonomy (15). The supervisor may emphasize a supportive alliance and Socratic exploration in order to guide psychotherapy through a collaborative effort.

As trainees gain experience and enhance their skills, they begin to focus more on the client than on their own performance in session (8). However, during the intermediate stage, the trainee is still insecure and feels quite sensitive to criticism, and thus they can be reluctant to share their mistakes, doubts, or struggles in supervision, trying to appear more capable than they really feel (21, 13). Confidence and motivation tend to fluctuate, as mood and attitude seem heavily influenced by the successful performance in the most recent sessions. With added experience, trainees shift from reliance on external support and direct guidance to a more internalized view of their own conceptualization and plans for treatment (14). The intermediate stage is characterized by a desire for independence (16) and a struggle for autonomy (13). The striving for independence may create a rift if the supervisor maintains a strong focus on directive guidance.

During the intermediate stage, the trainee may vacillate from dependence on the supervisor for advice and guidance while also rebelling in a struggle for autonomy (21). Because of their desire for increased autonomy, trainees at the intermediate level may resist direct advice and clear instructions from their supervisors (21).

Because of their desire for professional independence, trainees at the intermediate stage may disagree with or openly reject direct guidance from their supervisor (21). During the intermediate stage, the trainee may need a sound rationale in order to be convinced of the utility of the supervisor's suggestions (13). During the intermediate stage, the trainee's behavior can come across as rude and disrespectful to a sensitive and caring supervisor. For example, a trainee was in her 4th year of graduate training and her 3rd year of being supervised by the same psychologist. During her first two years, she was pleasant, cooperative, and eager to learn. However, during her 4th year, she often disagreed with her supervisor and sometimes disregarded directive guidance. It was easy to view her as annoying, rude, and disrespectful. However, it was more helpful to view her as a strong student who was trying to prove to herself that she is ready for internship and no longer needs close monitoring of her clinical work.

The trainee strives for autonomy in a manner that appears similar to the adolescent's struggle for independence from parental rule, sometimes behaving in a rebellious manner, and often trying to establish their independence from authority figures. In some situations, trainees begin to think they know more than they truly understand, and they can challenge or disregard advice from their supervisor. It can be useful to view this rebellion as a normal stage of development, akin to the rebellious teen who opposes parental leadership on the path toward independence.

In an attempt to manage power struggles, it can be helpful to downplay the supervisor's expertise. Ideas for upcoming sessions can be framed in terms of teamwork and collaboration where "two heads are better than one". Furthermore, it can be helpful to inform students that sitting in the chair of supervisor makes it easier to see things differently, from a more distanced perspective. When sitting in the chair of a therapist, you have to react to the momentary changes in dialogue, subtle expressions of emotion, and nonverbal forms of communication that occur in most sessions. In contrast, the supervisor has a calm and objective view of the client's struggles, making it easier to look beyond the surface ripples caused by recent events and instead focus on the underlying currents that drive the client's behavior.

During this intermediate stage, a collaborative style of discussion and exploration may help to avoid a battle of wills and retain an air of teamwork. The rebellious tone of the intermediate level trainee can be managed by a supportive and tolerant supervisory style. With trainees at the intermediate level, it can be helpful to use questions to get the trainee to explain and defend their case conceptualization and plan for upcoming sessions (21). The Socratic method (22) provides a useful strategy for managing the rebellious attitudes and exploring the needs of each client. Questions can be used to solicit ideas and input from the trainee, avoiding the dogmatic style of didactic training (23).

The patient supervisor will use a series of questions to request input from the trainee (22, 23) and collaboratively search for ideas that could improve the upcoming therapy sessions (24). In addition, it can be useful to ask the trainee to explain and support their own view of the client's struggles as well as their vision for upcoming sessions (21). These discussions require a supervisor to trust the trainee's ability to think creatively and explore the core psychological issues that underlie the client's struggles.

The Advanced Trainee

Supervision of an advanced trainee is often fairly direct, straightforward, and relatively easy. An advanced trainee typically does well

even with minimal supervision. The trainee has learned assorted issues relegated to therapy, has gained experience with a range of clients, yet remains open to refining their own clinical acumen. The advanced trainee has moved beyond their struggle for autonomy and now appreciates the value of input from a supervisor (13). The supervisor is able to work with the trainee like a young colleague (15). However, a developmental approach remains useful because the supervisor should increase expectations while lowering their structure and directive style (7).

During the advanced stage, the trainee has become more confident and secure in their therapy style. At the advanced level, trainees are more open and willing to confront both their strengths and their weaknesses as a professional. During supervision, the advanced trainee is often willing to share their concerns and struggles as a way of gaining support and guidance.

During this stage, the trainee uses supervision time efficiently, and seems willing to share their doubts, concerns and struggles. However, even when on their internship, trainees may need guidance for the proper and efficient use of supervisory time (25). In some situations, supervisors help advanced trainees to integrate the personal and professional aspects of becoming a professional in the mental health field (16).

Advanced trainees tend to value supervision that focuses on case conceptualization and provides a deeper psychological understanding of each client (12). Case conceptualization is one of the more advanced skills that requires time and experience to develop and refine. As part of psychotherapy supervision, it is important to address complex topics (e.g., case conceptualization) or challenging issues (dealing with strong emotions expressed in session) as part of psychotherapy supervision (26). Pressure on the trainee can be reduced by explaining the role of supervisor as consultant whereas the trainee sits in the "hot seat" as therapist. Supervisory meetings can rely on Socratic exploration and case conceptualization as integral to the supervision of advanced trainees.

At times, a supervisor may act like a coach, focused on devising a game plan and strategy that adapts the strategy to the teams, players, and specific situation during the game. The supervisory role of strategist is helpful at all stages of professional development, but becomes more important with the advanced trainee, especially when working with complex cases. The supervisor functions as an experienced strategist, sharing years of experience in the field of psychology. The coach might send in the play, but the quarterback can make an audible to change the play in the moment. A good coach will devise different strategies for different opponents, creating a plan to address the visiting team's strengths and weaknesses, as well as the home team's strengths and weaknesses. Further, different strategies are needed for different situations (e.g., third and short versus first and goal). Finally, a solid game plan needs different strategies at different times (e.g., opening quarter versus two minutes left in the game). Thus, a creative supervisor can continue to help advanced trainees to refine their approach to case conceptualization and treatment planning.

Discussion

Becoming skilled in psychotherapy supervision can be a long and convoluted process (27, 28). Clinical supervision is an important and rewarding skill that is necessary for the development of future therapists. A developmental framework can help supervisors to approach their trainees with a more tolerant style and appropriate expectations (see Table 1). In

general, all trainees respond well to praise but only when it is deserved. The supervisor may play an active role directing the novice. In contrast, supervisors may need to tolerate the rebellious attitude displayed during the intermediate stage. Finally, the supervisor can collaborate with the advanced trainee as a young colleague.

Problems can arise when the supervisor is not aligned with the developmental level of the trainee (29). The supervision 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 the trainee at the novice level manage their insecurities 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.

Despite its benefits, there are downsides to the use of individual customization. The process of individual customization adds to the complexity of the supervisory process. At times, it can make therapy appear overly complex, adding to the anxiety experienced by a trainee. When therapy moves from a structured treatment manual into the actual therapy sessions, a trainee may feel overwhelmed if each client is viewed as a unique case. However, in actual clinical practice, it is important to adapt the treatment plan to the needs of each client as well as the skills and strengths of the trainee.

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Table 1. Adapting supervision to the Trainee

	Novice	Intermediate	Advanced
Directive Guidance	+ + + +	+	+
Supportive Alliance	+ + +	+ + + +	+ +
Socratic Exploration	+	+ + +	+ + + +
Case Conceptualization & Clinical Strategy	+ +	+ +	+ + +

Note: + means this strategy is used occasionally, + + + + means this strategy is used frequently

Social Façade, Vulnerability and Relational Withdrawal: A Case Study on the Psychotherapy of the Schizoid Process

Richard Erskine

Abstract: This article details a Relationally-focused Integrative Psychotherapy for a female client who originally presented with symptoms of both depression and narcissism. As the psychotherapy progressed the client revealed her Schizoid Pattern of internal criticism, vulnerability, shame, and relational withdrawal. The psychotherapy of the client's schizoid process is highlighted through examples of "therapeutic description", "pregnant pauses", prolonged silence, affect attunement, and countertransference.

Key Words: case study, schizoid, narcissism, social façade, phenomenological inquiry, shame, relational psychotherapy, integrative psychotherapy

"I wanted to descend into some sort of safe place where I could be all alone."

John Katzenbach (2004), *The Madman's Tale*

Perplexed, *challenged*, *tender*, *patient*, *gratified*, *sorrowful* – these words portray the variety of countertransference feelings that dominated my therapeutic involvement with 'Louise'. As I tell you the story of Louise's psychotherapy journey, I want to share my jumble of internal sensations so that you can have a richer sense of the affectively-based, nonverbal, intersubjective dynamics between the client and me. So much of what was crucial in Louise's psychotherapy defies language, because the essential healing aspects of our interpersonal contact were in the facial expressions, body gestures, and timing of our therapeutic dialogue. These non-verbal interactions, along with our therapeutic dialogue, profoundly influenced and impacted each of us.

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Louise came for psychotherapy in order "to try it for a while" because she was "fed up with constantly being depressed". She said, *"No one at work, or even my friends, would think I'm depressed. Sometimes, I am not completely depressed because I continually push myself to be active."* In these first few sessions, Louise frequently described her social life as "active". She said, *"I go to many theatre performances and I have a subscription for two people to the symphony. I always invite someone to join me."*

Over the next couple of months, I noted that Louise arrived precisely on time, impeccably dressed in stylish business attire. She carried herself with an elegant posture. I imagined that her appearance evoked both women and men to turn their heads for a second look. In each of our sessions, Louise talked in great detail about how she had mastered the intricacies of trading on the stock market, the lucrative transactions that she made, and how her clients profited because of her skill. She seemed to enjoy the prestige of working in the financial market. *"I'm not depressed at work. There I have a good business woman's way of thinking."*

Throughout the first few months Louise talked extensively about her wealthy clients and her love for symphonic music. Her conversation was usually about her accomplishments. She said, *"The job requires me to be very personable … but it is all an act"*. I was left to wonder if Louise was authentic with me, or if her stories and genteel behaviour were also an 'act'. I felt perplexed; we were not talking about her 'depression', which is what she initially said was her reason for engaging in psychotherapy. As I made inquiries about her depression, her responses were evasive. She was intent on telling me about the day-to-day activities in her life.

In early months of our weekly psychotherapy sessions, Louise was resistant to my inquiry about her feelings; she was offended when I inquired about her physiological sensations. She arrogantly rebuffed my inquiry about her childhood with "the past is the past. I don't believe in dredging it up". She approached psychotherapy as though talking about her social life, shopping for fashionable clothing, and her business successes would somehow relieve the 'depression' she felt at home. I had the inkling that her self-aggrandizing stories provided a momentary antidepressant. It was 10 months before Louise was willing to tell me anything about either her family history, or what she experienced internally. From time to time, she would allude to her 'depression', but then would be elusive in response to my inquiry.

Narcissistic Style

Throughout the first year of our psychotherapy, I considered the possibility that Louise's behaviours constituted a *narcissistic style* (Johnson, 1994), and that her relational withdrawal was her way of coping with an absence of emotional validation throughout her early life. Similar to how I approach psychotherapy with narcissistically-inclined clients, I responded to her with consistent empathy, rather than comment on the content of what she was telling me (Kohut, 1971). I chose not to focus on her behaviour, nor offer any conceptualizations; I refrained from making any interpretation or confrontation. I felt challenged by this daunting task ahead of me. Several case reports describing effective therapeutic involvement indicate that it is necessary to provide the narcissistically-inclined client with consistent empathic responses to their needs for validation and self-definition prior to exploring their early life experiences and comprehending how they compensate for early childhood relational disruptions (Bach, 1985; Basch, 1988; Kohut, 1977; Stolorow, Brandschaft & Atwood, 1987; Wolf, 1988). Could I live up to the challenge of *consistent empathy*

without being lured into discussing current events or focusing on behavioural change?

My primary way of trying to connect with Louise was by being fully present, carefully listening to each word she said, and responding empathically to her stifled affect. But, I had no evidence that she felt my presence. Although Louise continued to come for psychotherapy, there was very little emotional contact between us. I was left to ponder the question raised by Marye O'Reilly-Knapp in her 2001 article, *"What is required in a therapeutic relationship so that the uncommunicable, walled-off parts can be spoken, heard, and understood?"* (p. 44). It became clear to me that my task was to open the door for interpersonal contact and then to wait patiently until she peeked through that relational door.

My quiet, empathetic responses to Louise's self-aggrandizing stories seem to have an effect. After the first six months, Louise's bragging about her accomplishments diminished. She began to tell me vignettes about her "secret depression": *"I don't want anyone to know what I feel"*. Although, she professed to know many people, the central feature of her stories was that she was alone. She did not speak directly about being lonely – she hid her vulnerability – but I could sense that something was amiss; her life was devoid of intimate relationships.

Each time Louise talked about being alone, I responded to her with facial expressions and body movements that mirrored her unspoken affect. Although it was not initially her word, I introduced the term "lonely" as a way to refer to, and clarify the "depression" she described – a depression that enveloped her when she was in her apartment. During these sessions in which we talked about her "depression" and "loneliness", the rapid speed in which Louise usually talked decreased. She was increasingly vulnerable, and far less social in her dialogue with me. In response, I could feel a growing sense of tenderness within me. My rhythm of interactions slowed; I became more protective. I wanted to connect with the vulnerable and vital facets of Louise.

As the therapeutic dialogue with Louise became more intimate, I reflected on the possibility that my sensitivity to Louise's need for validation, my attunement to her loneliness, and my adjustment to her pace were changing the nature of our communication. To paraphrase the previous quotation by Marye O'Reilly-Knapp, I had the hope that the previously uncommunicable, walled-off parts of Louise were beginning to speak, because she was being heard by me, and that we were gradually forming a communication between us in which she felt understood.

Early on in our psychotherapy sessions, Louise had said that she had an "active social life", but, as I repeatedly inquired, it became clear that she had no close friends, no one with whom she could talk heart-to-heart. Although she frequently invited a guest to accompany her to the symphony or theatre, she and the other person never talked about the play or music after the performance. She would just go home with the excuse that she had much to do the next day and, once in her apartment, she would become "depressed". Eventually, I discovered that Louise often spent the entire weekend *"alone, sleeping most of the time and then playing on the internet"*. She recounted, *"There are times when I can be charming and active with people, but then it all gets to be too much. I need to retreat and replenish."*

In other sessions, I explored the quality of Louise's friendships and her personal interactions with clients and colleagues. As I listened to her stories, it seemed to me that all of her interpersonal contacts were superficial. Louise made a noteworthy comment: *"I am friendly to everyone, but I don't say anything about*

myself." In response to my questions about her possible romantic life, she reluctantly said, *"Several years ago I had a boyfriend who lived in Minneapolis. We talked on the phone each week and we would vacation together twice a year. But, for some unknown reason, we both lost interest."* When I asked if she missed him, Louise wasn't sure, *"I miss the boating we always did. We were always very active. But, I don't know if it is him I miss, or if I miss all the activities he arranged."* Another day she said, *"Frequently men ask me out, but I'm not really interested. I don't want to get into a relationship. Life is easier alone."*

I repeatedly inquired about Louise's sense of "depression". She told me how she sometimes dreaded going home after work, and that she would regularly go to the same restaurant *"because the waiter likes serving me. I reserve the same table every time. After dinner I just go home to my stupid internet"*. Then Louise lowered her head, stared at the rings on her fingers, and remained silent for several minutes. When she again looked in my direction, Louise said that she wanted to end this session early. I encouraged her to stay and focus on what she was feeling. Her shoulders slumped, her breathing became shallow, the contours of her face changed: she suddenly looked many years older. After several minutes of silence, she said, *"This is what it is like in my apartment. No matter how beautiful I decorate it, I still feel depressed."* After a long pause, she added, *"I don't want you to see me like this."* The door to her vulnerability was open for a few minutes, then it was abruptly closed.

I thought about Louise's "depression" and wondered if it was similar to Marye O'Reilly-Knapp's description of her schizoid client's "isolated attachment". For clients who rely on a schizoid process to emotionally stabilize themselves, relationships with other people are difficult to sustain. Therefore, they are often overwhelmed by a profound sense of depression, *"cut off from people and the world, cut off from his or her needs and wants, the person withdraws so far into "nothingness" that no one is there, and even the sense of one's being is nullified."* (2001, p. 49)

An **isolated attachment** pattern can be revealed through the quality of interpersonal contact made by individuals, who use withdrawal to manage relationships. In my psychotherapy practice, I have found that clients, who use emotional withdrawal to manage relationships, report that significant caretakers were consistently mis-attuned to their physiological rhythms, misinterpreted their emotional expressions, and were controlling or invasive of the client's sense of identity. To be vulnerable is sensed as dangerous. The child may then develop patterns of relationship marked by a social façade, psychological withdrawal, intense internal criticism, and the absence of emotional expression (Erskine, 2015). Clients, like Louise, with an isolated attachment pattern, have an implicit fear of invasion.

Schizoid Pattern

Could Louise be diagnosed as having a **schizoid disorder**? Probably not. However, Louise does fit the profile of someone with a **schizoid pattern** – a pattern of behaviour and emotional reactions that shape most of her life and all of her potential relationships. When in dialogue with me, Louise curtailed her affect; with other people, there was an absence of emotional involvement, and she spent a considerable amount of time in her internal world. Any affect that she may have felt was hidden by a well-polished social façade. Louise was the only one who knew her misery. The frequency, intensity, and duration of both her relational withdrawal and social "act" is certainly more acute than someone with a *schizoid style*.

On many weekends, Louise isolated herself in her apartment, *"usually depressed"*. She said: *"Even when I'm on the internet it often seems*

meaningless in the end". Louise reported how she had to be *"charming and engaging at work"* and then added, *"being with people exhausts me. Yet, when I am alone, I am not happy. But it is better to be unhappy alone than to be swallowed up by people"*. Ronald Fairbairn (1952) and Harry Guntrip (1968) aptly termed this internal conflict as the **schizoid's dilemma**. Ray Little vividly describes this dilemma when he writes,

> *"Retreating from contact leaves the individual isolated, lonely, and in pain. In some cases, the longing for contact will re-emerge and the person may move toward others; however, such movement also brings with it the anxiety of being close"* (2001, p.39).

Gary Yontef clearly illustrates a schizoid pattern, like Louise's, when he says,

> *"It is dangerous to move into intimate connection if you cannot separate when needed. If you think you are going to be caught up, devoured, or captured in the connection, it is terrifying to move into intimate contact. On the other hand, if you do not feel connected with other people, especially if you do not believe you can intimately connect again, the separation or isolation is both painful and terrifying."* (2001, p. 9)

Louise certainly had a narcissistic social presentation in that she sought continuous affirmation of her value. While her narcissistic characteristics were obvious, her schizoid pattern of emotional withdrawal constituted the undisclosed, yet dominant, features of her personality. Louise is a good example of how schizoid withdrawal and narcissistic self-aggrandizement may be contemporaneous and congruent – together they form a narcissistic/schizoid matrix. Ronald Fairbairn (1952) in writing about his schizoid clients identified three salient characteristics: an attitude of omnipotence; preoccupation with an internal life; and, detachment from relationships. These three attributes are also used to describe narcissistic clients (Kernberg, 1975; Masterson, 1981; DSM-5; American Psychiatric Association, 2013).

It is interesting that the British object relations literature tends to emphasize schizoid phenomena (Fairbairn, 1952; Guntrip, 1968; Khan, 1974; Laing, 1960) while the American psychoanalytic literature emphasizes narcissistic dynamics (Bach, 1985; Johnson, 1987; Kernberg, 1975; Kohut, 1971, 1977; Masterson, 1981). These two bodies of psychoanalytic literature, the British and the American, apparently exist in isolation from each other, even though they seemingly refer to two coinciding personality constellations (Melniker, 1988).

Louise's narcissistic traits were a manifestation of her life-long struggle to self-regulate and maintain some semblance of relationship while her relational withdrawal is a manifestation of desperate attempts to self-stabilize (Erskine, 2021a & 2021b). Her narcissistic-like persona was an effective disguise of her schizoid traits. If we theorize these two constellations of behaviours with the metaphor of "splitting", as illustrated in Ray Little's 2001 article, we can concretize each of these as constituting *a split in the sense of self*, and therefore manifestations of both a *Social Self* and a *Vulnerable/Sequestered Self*. For a detailed illustration of "splitting" see the article entitled *"Relational Withdrawal, Internal Criticism, Social Façade: Psychotherapy of the Schizoid Process"* (Erskine, 2022).

Phenomenological Inquiry and Therapeutic Description

On several occasions, I noticed that Louise seemed annoyed whenever I engaged in any phenomenological inquiry, or asked any questions about her life when she was a child. Each time, I inquired about her annoyance with me she became even more irritated. She eventual-

ly said, *"I don't like your controlling questions."* I was surprised by her depicting my inquiry as "controlling"; that was far from my experience. I asked myself if she was giving me useful feedback about my therapeutic methods. I had to make a quick assessment of both my intentions and the effects that my inquiry had on Louise. It was clear to me that the impact of my inquiry was more significant than my intentions; therefore, I needed to change how I interacted with Louise.

At the same time, I surmised that Louise was transferring old relational conflicts into our therapeutic relationship. By reacting so strongly to my phenomenological inquiry, she may have been revealing a relational pattern formed with other people in another time. Through the transference, Louise was demonstrating the relational-needs that had been thwarted, how she has compensated, and what was needed in our therapeutic relationship. (Erskine, 1991; Stern, 1994; Little, 2011)

After a thoughtful pause, I made a statement, *"Perhaps you have a strong reaction to being controlled."* She responded immediately with, *"You're just like my mother. She was always poking her nose into my life. She asked me question after question; she was so controlling."* Louise continued to talk about how her mother, *"tried to know everything I felt, thought, or did"*. I replied with words that I hoped would describe her inner experience, *"I imagine that you must have felt invaded"*. After a long pause, she softly said, *"My teenage years were awful. I had no personal space. My mother wanted to know everything about me."* Then she looked down at her lap and was silent for a few minutes. Louise's expressions of annoyance with me, and her telling me about her mother's controlling behaviour, was the most open she had been up to this point in her psychotherapy. This transferential encounter was the beginning of our exploring the effects of her mother's *"controlling behaviour"* at various developmental ages.

In response to Louise's annoyance with my inquiry, I changed the nature of how I constructed my questions; rather than phrasing my inquiries in an interrogative form, I rephrased them in the form of an indefinite declarative. Instead of phenomenological inquiries such as, *"What are you feeling when you want to be alone?"*, I changed the structure of the sentence to, *"You must have various feelings when you are alone."* As an alternative to phenomenological inquiry (Erskine, Moursund & Trautmann, 1999), I used *therapeutic description*, a non-authoritative, tentative voice that hopefully allowed her to dismiss or disagree with my statement. Like other clients, who struggle with internal criticism and use relational withdrawal to self-stabilize, Louise responded to my inquiries about her feelings, physical sensations, or thoughts as though they were a criticism. When I rephrased my inquiry as a description of how I imagined Louise felt, she was more revealing.

Criticism and Shame

Throughout the second half of this first year, it became apparent that Louise was distressed by self-criticism. At first, her self-criticisms were subtle, in the form of little disparaging remarks or self-putdowns, usually veiled in the midst of a story. In response to my inquiry about her internal criticism, Louise would change the topic or lapse into silence. On a December day, in the second year of her psychotherapy, Louise was caught in a cold rainstorm without an umbrella or protective clothing. She came into my office with her clothes and hair completely wet, her makeup running down her face. She immediately fled to the washroom. I could hear her cursing herself with, *"stupid me"*, *"I'm a mess"*, *"I can't do anything right"*.

When she finally emerged from the washroom, Louise did not speak, she evaded eye contact,

she hung her head. I was intrigued by the contrast between the self-chastising comments she made in the washroom and the silence in our therapy room. I realized that she was probably feeling shame. After a few minutes of silence, I said, *"When a person is defined as 'stupid' or 'a mess', they often feel a sense of being unworthy, ashamed of who they are."* She looked up at me and nodded her head in agreement.

I added, *"I picture a little girl who is being criticized and doesn't know what to do because she is full of shame."* She remained silent, but again nodded her head in agreement. I said nothing more about shame in that session. She had allowed herself to be vulnerable in my presence. I too remained silent; I didn't want to encourage her to reveal more of herself before she was secure in our relationship. I would follow her lead.

On that rainy day, when Louise was shivering from the cold, I offered her a blanket and invited her to curl up on the couch. She pulled up her knees and cuddled under the warmth of the blanket. Although I initially spoke to her about the self-criticism, the remainder of our session was in silence. With the blanket pulled up around her neck, she watched me intently. During the last 15 minutes of the session, she periodically closed her eyes for several moments. Louise removed a façade; I could now see a different facet of her – her *vulnerable/sequestered self*.

When Louise returned the following week, I had the blanket folded, on the couch. As she sat down, she pushed it aside with a scornful expression on her face. After a long pause I said, *"You must have a lot of feelings today"*. She eyed me suspiciously and then eventually said, *"I don't want to talk about it."* We both sat in silence for several minutes and then I said, *"Talking about feelings is difficult, particularly if we expect to be ridiculed."* After another long pause, she continued, *"I was a mess last time. I hate it. I have been upset all week."* I asked her to tell me more about being "upset". Louise added, *"I could not sleep a couple of nights, knowing that you would think I was acting like a helpless little child."*

Rather than address this transferential comment directly, I continued with, *"Perhaps you are feeling shame … shame because I saw how distraught you were."* As I said these words, she began to stroke the fabric of the blanket. Her gesture reminded me of a very young child seeking soothing by clinging to something soft. After a short pause, I added a validating comment, *"You seemed so natural cuddled up with the blanket"*. With that comment, Louise picked up the blanket and clutched it to her chest. After a pause she said, *"I'm torn. I just want to curl into the blanket but that's just being a stupid kid."* I added, *"I think your need to be comforted is so important. I wonder if you were humiliated for having natural needs."* We spent the rest of the session in silence, while Louise pulled the blanket around her. As we sat in silence, I was reminded of Gary Yontef's comment:

> *"… shame is a fundamental process for schizoids. They are easily shamed, although that is not always obvious because they deny that they are attached or that they need anything. When they feel safe enough to start exploring their shame, they manifest a great deal of loathing for their needy self."* (2001, p. 12)

This led me to reflect on the many things that I had learned about shame from other clients, such as, when a child grows up in a relationship tainted by criticism, ridicule, or other humiliating behaviours, the result is an increased vulnerability in all relationships. They tend to withdraw – to hid their vulnerability. They also disavow their anger and focus instead on two other aspects of shame: the sadness of not being accepted as they are; and the fear of

abandonment in the relationship, because of who they are. They either comply with how they have been defined, or they engage in self-criticism, and/or they become self-righteous, arrogant. As a self-protective strategy, a person will use either shame-filled relational withdrawal, or self-righteous arrogance, as a protective dynamic to avoid the vulnerability of being humiliated again. (For an elaboration on the psychotherapy of Shame and Self-righteousness, see R.G. Erskine, 1994 & 1995).

As I look over my notes, it is clear that, on the day Louise got drenched in the rainstorm, she and I entered a new phase of her psychotherapy. Several themes were vying for therapeutic attention:

- Louise had inadvertently allowed me to see her vulnerability; her superficial sophistication was on pause. I wanted to connect with her *vulnerable self* before she could put on a social façade. It was essential that I stay attuned to her affect and not get side-tracked into talking about her day-to-day activities. Perhaps Louise was ready to show me her secret self.
- Louise had exposed a bit of her self-criticism. I was certain that there was much more. I knew that it would be therapeutically necessary to uncover all of the self-imposed ridicule, much like a medical doctor opening and draining an abscess. We would then investigate the psychological functions of the self-criticism as a way to lessen their internal influence.
- Louise's transferential comments revealed a significant story about being devalued for being vulnerable. I already had some information about her mother's criticisms and harsh demands.
- Louise's shame was suddenly apparent; she no longer had an entitled and arrogant persona. It was time to attend to the sadness, fear, and compliance that are were at the core of her shame.

Over the next several months, we talked about shame, usually for several minutes in most sessions. I intentionally steered our dialogue away from spending more than a few minutes talking about her current life. At first, she seemed confused when we talked about her intense fear of ridicule and her desperate attempt to conform to *"the image of a daughter that my Mother wanted."* In a later session, she exclaimed, *"Shame ... that's the same as being unworthy. Hell, UNWORTHY is what I have felt all my life."* I made a quick retort, *"It must be hell to live with a constant sense of not being worthy of a mother's love"*. She had tears in her eyes as she clutched the blanket.

In that one, and in following sessions, I encouraged her to close her eyes in order to sense what was happening inside. She would alternately close her eyes for a few minutes and then open them briefly as if to see if I was still present. I responded with, *"I am still here. Just take your time being inside."* As we were ending a session, she described her ten minutes of withdrawal as, *"I go into the fog where everything is meaningless."* When she returned to her "fog" in another session, she added, *"If I'm in a fog my mother can't nag me. All is quiet. I am hidden"*. I was reminded of Marye O'Reilly-Knapp's description of the schizoid conditions,

> *"In the withdrawn and hidden place there is only existence, with no true sense of self and no sense of self with another. The person remains uninvolved, unintegrated, and lives in quiet desperation."* (2001, p. 48)

Homeostatic Functions of Self-Criticisms

As Louise's psychotherapy progressed into the third and fourth year, our therapeutic work

had two primary focal points: one, a lessening of her internal criticism; and two, therapeutic support to withdraw into her internal world. However, for her withdrawal to be therapeutic, I would have to be fully present, watch over her like a parent may watch over a sleeping sick child, and be a witness of her feelings and memories – memories that had no defining pictures or descriptive words. To lessen Louise's internal criticism, we would first have to find a way for her to externalize what was secretly internal and then to discover and appreciate the homeostatic functions of the internal criticism. It seemed important to me that I focus our psychotherapy on diminishing Louise's internal criticism prior to supporting a therapeutic withdrawal.

She began one of our sessions with a realization, *"I often reprimand myself … and then I spend time in self-pity."* I encouraged her to speak the internal criticisms out aloud. It seemed important that she now externalize what she had been keeping internal. I had an idea that, if Louise could diminish the self-criticism, that much of her "depression" might also diminish. At first, Louise had a difficult time articulating her various self-chastisements, but – with my patience and encouragement – she was eventually able to say aloud, *"I'm worthless"*, *"I'm a fool for wanting"*, *"I'm unlovable"*, and, *"I won't make it"*. In several sessions, I encouraged Louise to reiterate these criticisms aloud. Analysing the various homeostatic functions of her criticisms was an important step in diminishing their intrapsychic effects.

I focused our therapeutic work on helping Louise understand the original purpose of her self-condemnation and the psychological functions that it may still have in her life today. As we explored some of the events of her childhood, she remembered criticizing herself prior to going to high school and that, *"I had perfected my self-criticism by the time I was 16. By then, I did not need anything from anyone. I was better off alone, in my own quiet world."* When we talked about her family interactions when she was a school-age child, Louise added, *"If I can criticize myself before my mother does, I escape her awful words … also my criticism makes me productive."*

Together, we identified four homeostatic functions of her continuous self-criticisms (Erskine & Moursund, 2022). First, her criticisms provided an archaic sense of *identity* that defined her place in relationship to other people; they provided an archaic organizing schema about herself, others and the quality of her life. Second, the criticisms provided *consistency*. With self-criticism, she maintained the same familiar sense of worthlessness that she had lived with throughout her childhood. Like most of us, familiarity was preferable to the unknown. Third, the self-criticisms provided a strategic *distraction* from the painful awareness of her mother's constant criticism. She heard the criticisms in her own voice, not in her mother's voice. Fourth, the self-criticisms functioned to provide *predictability* about what might occur; by criticizing herself first, she could brace herself for any external criticism.

Together, we devised a plan to help Louise stop the internal ridicule: each time she engaged in a self-condemnation, Louise would think about the functions of the criticism. I suggested that Louise ask herself, if she still needed that old identity, or still required a distraction from knowing what had occurred between herself and her mother. Louise realized that she no longer wanted, either the consistency, or predictability, that the self-condemnations provided. Together, we worked out a plan; each time Louise made a self-criticism, she asked herself, *"What is the function of this criticism?"* This questioning of herself, particularly when she was at home, helped Louise become aware that the self-criticizing might have had an original purpose, but that the purpose was no

longer a benefit to her. Through our constant attending to her self-condemnations, and their various homeostatic functions, Louise's self-criticism largely diminished.

As the self-criticism diminished, Louise became increasingly aware of her mother's influence. She was now able to have some vivid memories of her mother's caustic comments when she was in elementary school, *"By the time I was an adolescent, I could drown out her voice. She was constantly trying to make me the perfect daughter that she wanted. Most of the time, she did lovely things for me, but then it would all be spoiled by some criticism"*. Louise realized, *"I learned to criticize myself to blot out her criticisms; and, it worked."*

In the ensuing sessions, I focused our psychotherapy on the quality of the relationship between Louise and her mother at various childhood ages. She cried with painful memories: of her mother's controlling demands about school work when she was 8 and 9 years old; of *"my mother's great disappointment when I was 6 and I forgot my lines in a school performance"*; of *"my mother's control in how I dressed"*; and, an implicit memory of *"being forced to eat food that I didn't like"*. Throughout these sessions, we were identifying and decommissioning the introjected attitudes of her mother. As a result, she increasingly allowed me to see her vulnerability.

Therapeutically Supported Withdrawal

During the third and fourth years, as we focused on externalizing the internal criticisms, and deciphering the homeostatic functions of such criticisms, I watched for the moments in which Louise would lapse into her semi-concealed withdrawal. In some sessions, she would avert her eyes, clutch the blanket to her chest, and have long pauses in her dialogue with me. When I picked up on those moments of Louise's partial retreat, I would encourage her to close her eyes and to remain quiet. In our discussion, during the last 10 minutes of our session, she described her inner space as, *"I just go into a thick, silent fog. I don't think about anything."*

When we first began the supported withdrawal, Louise would open her eyes every half-minute or so, as if she was checking to see if I was still present. I thought of Harry Guntrip's (1968) description of his client's half-in/half-out compromise: a seeking of relationship (as in her checking to see if I was present); and, a seeking of security (as in her repeated relational withdrawal). I would respond with *"I am staying here with you. Just take your time to go to your quiet place"*, or *"It's important to be silent"*, or *"I am watching over you"*.

When I did speak, my voice was slow and reassuring. Louise, like other clients moving into relational withdrawal, required a particular sensitivity to her unique rhythm, fear of relationship, and possible loneliness. I provided time for her to make internal contact without having to talk. An important aspect of our psychotherapy was my continual self-reminder, *"Don't try to make something happen; remain fully present and observant"*. I wanted to create the place and time for Louise to feel the security of her "fog", any possible loneliness that I suspected was at the core of her vulnerability, and perhaps a sense of security-in-relationship with me.

As our sessions continued over the next few weeks, she was able to stay in her "quiet" place for as long as 15 or 20 minutes. As I watched her silently curled under the blanket, I would relax into deep yoga style breathing that helped me to stay centred and sensitive to her little gestures and sounds. Louise's withdrawal engendered an unusual patience in me. Although I was periodically distracted by the over-detailed stories that Louise told me, in

the first couple of years, I was acutely present during this phase of the psychotherapy.

I kept my awareness on the *pregnant silence* – a silence that was gestating with emotions and implicit memories. It was essential that I be fully patient in order to catch each nuance of her silent communication. I wanted to create a healing environment where she could make full internal contact without any requirement for interpersonal contact. Arnold Beisser's (1970) "Paradoxical Theory of Change" served as a constant reminder that I needed to be calm and patient, to find her rhythm, to not attempt to effect any change within Louise, to just accept Louise as she was.

During this time, our psychotherapy sessions moved into a routine. The first 10 or 15 minutes were often spent on either some current event, or in review of the previous session. Following this initial discussion, she would withdraw into silence for between 5 to 20 minutes. I reserved the last 10 to 20 minutes to have a therapeutic dialogue about what she had experienced during her silence. The relational qualities of our interpersonal conversations, before and after the supported withdrawal, were an indispensable ingredient in Louise's psychotherapy.

In the first several weeks of our therapeutically supported withdrawal, Louise would lapse into a quiet and restorative internal place. In most of our sessions in which I supported her withdrawal, Louise experienced a sense of calmness in her "fog" and her muscles relaxed. Then, as the weeks went on, Louise gradually had emotional and body memories of intense fear – a fear that engulfed her whole body. I would reassure her that I was with her and watching over her. At one point, she talked about descending into a dark, damp and mouldy-smelling place. She cried for me to hold her hand. I moved near her and grasped her left hand between my two hands. She shook and wept with terror. After 10 minutes, she opened her eyes and was able to talk. As we reviewed what Louise had experienced, she realized that she was reliving being in the basement of the house where she had lived as a child. As we talked in later sessions, she was aware of at least two occasions, perhaps more, when her mother had forced her into the basement as a punishment. She was terrorized by the darkness. She wept with a profound aloneness that she must have felt as a 7-year-old child.

We spent most of the following session talking about Louise's fear of being in the dark. She revealed that she always slept with the television on. In her words, *"The TV is always on, silent, but always on … I need the company"*. I thought about how the TV provided not only light, but it also provided pseudo-companionship – a companionship that did not invade or criticize. Rather than make an interpretation, as I might with other clients, I kept this idea to myself and used it to help me understand the increased dependency that Louise was displaying in our relationship (Price, 2016).

Another significant point in our work occurred when Louise called me on a Sunday morning to tell me about a nightmare. I urged her to come to the office immediately. When she arrived an hour later, she was shaking with fear and asked me to sit next to her and hold her hand. She told me about a dream, *"I have no clear images, just these horrible body sensations. In my dream, all is black. I am completely alone. I know it will get worse. I'm paralyzed. No one comes"*. As she squeezed my hand, her whole body trembled. She cried like a desperate baby. After 10 minutes of agony, she opened her eyes and looked at me. At that moment, she reached out and grasped my arm to her cheek and chest. She then wept differently, as though her crying was releasing the tensions in her body.

When she had finished crying, I made what I hoped would be a useful interpretation. *"You remind me of a baby who needs her mother to pick her up and comfort her."* As I was saying these words, her face, shoulders, and chest muscles constricted. She pulled back and screamed, *"I don't want her awful touch"*. Later, we talked at length about her repulsion at the thought of being physically close to her mother. In our follow-up discussions, we assumed that Louise's dream, age regression, and physical repulsion were a reliving of pre-symbolic, procedural memories – memories that had no pictures, only intense affect and physiological reactions. However, rather than Louise's age regression being a mere reliving that may have been retraumatizing, my presence and touch were therapeutic, because they provided a new experience that allowed her nervous system to relax (Porges, 2009; Porges & Dana, 2018).

We had several conversations about Louise's inner turmoil over her need for security-in-relationship and her fear of invasion and control. In a later discussion, Louise related her fear to a sense of *"utter aloneness that I have felt all my life"*. As we explored her "utter aloneness", she realized that, *"This loneliness is the depression I often feel. Whenever my mother didn't like how I was, I felt utterly alone"*.

On several occasions, she wept with the sadness of "never feeling loved for who I am". After crying with loneliness, she would open her eyes and engage in conversation with me about her inner experiences. Now, when she would talk with me after a 15- or 20-minute withdrawal, I had the perception that she was fully present, engaging with me in a more authentic and lively way. Louise was changing: she related it to both her intense internal focus, facilitated by the therapeutically supported withdrawal, and the significance of our end-of-session discussions about her internal, non-verbal experiences.

As the months went on, she was less inclined to withdraw. She had many more impressions of her early life, and how she coped with the relational disruptions, by both criticizing herself and withdrawing from people. She was increasingly able to tell me memories of her childhood. It was as though previously non-visualized and never-spoken memories became more explicit. As Louise told me these stories of her early childhood, she was increasingly open and vulnerable in my presence. I felt a sense of fulfilment in that we were accomplishing a healing psychotherapy. At the same time, I questioned my countertransference: *"Was my sense of fulfilment my own quest to be important, or was I being therapeutically responsive to what Louise needed in order to heal from her history of neglect and criticism? Or, both?"* I was certainly involved and invested in Louise's healing from the wounds of neglect and criticism.

Shifts in Perspective

In the spring of our fourth year of psychotherapy, Louise often complained of fatigue, no appetite, and that she was losing weight. I was again perplexed and hesitant; I worried over the question, *"Is the psychotherapy too intense for Louise to integrate her intense affect and physical reactions?"* Louise, for the first time, cancelled a session. I was then shocked when she again left a second phone message to say that she was cancelling another session. She did not return my phone calls. I was distraught. What was I missing? What had I done wrong? Finally, Louise called to confirm her next appointment and said that she had "medical reasons" for missing her two sessions.

When Louise returned after three week's absence, I noticed immediately that her face was thinner and that there was a yellowish tint to her complexion. She said that she had been in Minnesota at the Mayo Clinic for a thor-

ough medical evaluation. My worries that our psychotherapy was too intense and perhaps reinforcing the old patterns of self-stabilization were immediately replaced by concern for her health. Louise slowly told me that she had stage-four pancreatic cancer and that it had already metastasized to her liver. She tightly gripped my arm as we wept together.

In our next session, Louise surprised me when she said that she wanted to *"continue my psychotherapy until I can't come any longer"*. She said that she had already quit her job and that she would work only until the end of the week. She had started to investigate home nursing care for when the time came. As she was leaving, she asked if she could come *"much more often"*, and then she added, *"I need you to be with me."*

Louise continued to come for two, and sometimes three, sessions a week. During these last three months, she withdrew into her "fog" only a few times. There were no further age regressions to traumatic memories. We spent most of our time focusing on her saying "goodbye" to her sister and mother. In a couple of intense sessions, she talked to an image of her sister in an empty chair, where she expressed her anger and sorrow. In doing so, she revealed several "private resentments" that had prevented her from being close to her sister.

Then, I asked her to express her appreciations to the image of her sister in the empty chair. At first, she struggled; her resentments seemed to dominate. Eventually, she was able to say to the image of her sister, *"I'm grateful that you kept mother off my back"*. She went on to speak about several examples of how her sister *"took the brunt of mother's demands"*.

Louise cried as she acknowledged her longing for a caring relationship with her sister. Following this work, she arranged a 4-day weekend retreat with her sister. She was pleased with *"our real conversation"*. She said that they had talked openly to each other, for the first time since they were children. She said, *"I now know that it was my resentment that prevented us from being close"*. In the following sessions, she commented on talking to her sister *"almost every day"*.

When talking about her sister, Louise made several comments that led me to think that she was living with a lot of resentment toward her mother. I suggested that she put her mother's image in the empty chair and to *"tell your mother everything that you have always wanted to say"*. Louise said that my suggestion to talk to the image of her mother was *"too difficult. I just hide inside at the thought of telling her anything about me."* With this comment, I assumed that she was telling me that I needed to do something differently. So, I relied on one of my guiding principles: *"When in doubt about what to do, be relational."* I changed my approach, and asked Louise to look me in the eyes, and to tell me what she did not like about her mother's behaviour.

Louise tensed up, *"My mother has been dead for several years ... but it's like she is still hovering over me, ready to boss me around."* I asked about their mother-daughter interactions at various ages of her childhood: adolescence, school years, pre-school years, and toddler years. Louise told me story after story of being *"smothered" ... "over-loved" ... "without any freedom to be me"*. She was vehement in expressing her anger and resentment, and very reluctant to speak of any appreciations that she may have felt for her mother. Eventually, she told me that she appreciated her mother's work ethic and how her mother *"tried to have perfect children" ... "She tried so hard, but it just wasn't right for me. I withdrew from her and it broke her heart. And then she tried harder and harder to mould me into the image she wanted me to be ... and I hid more and more."* She cried deeply as she said, *"I missed out on having a*

mother with whom I could confide, to be close". Our sessions in these last months were primarily focused on working with Louise's grief about the absence of any emotionally close relationship with her mother; it was her way of saying, *"Goodbye to what I never had."*

In this last phase of our psychotherapy, Louise and I addressed her regrets, resentments, and remorseful feelings towards with her sister and mother. I also reserved time, in many sessions, to speak directly to Louise about her impending death and what she understood about her life. Louise had changed; she was no longer resistant to my phenomenological inquiry; in fact, she seemed to welcome some of my inquiries. Now, our psychotherapy was shaped by existential perspectives: *"What is the meaning of life?"*; *"What happens when we die?"*; *"What influence have we made in this world?"* (Becker, 1973; Frankl, 1959; Yalom, 1980). I was touched by a sense of the sacred that infused our interpersonal dialogue.

As these three months went on, Louise was continuing to lose weight and strength. When her sister invited Louise to live in her home near Boston, we had only three more sessions in which to talk about our relationship with each other. We cried together – a cry of separation and a cry of joy – joy in having the rich interpersonal connection that we had created together and our mutual sorrow – an intense sorrow that we would never be with each other again.

Postscript

Writing this story of Louise's psychotherapy was a challenge, because I would have liked to write about how our psychotherapy unfolded in an orderly sequence, but that is not how our psychotherapy proceeded. The crucial therapeutic junctures did not happen in a timely order, one after another. Our psychotherapeutic work would suddenly move to a new theme, then we would return to a previous issue, then we would proceed to another focus. Often, I had to keep several pertinent themes in mind. Yet, eventually, the fragmented, hidden, and split-off aspects of Louise's sense of Self became integrated into a new cohesive sense of Self.

Was Louise "narcissistic"? No, not any more. Perhaps she never was. Perhaps the arrogance, entitlement, and self-aggrandizement that I had observed in the first year of Louise's psychotherapy was just a cover for her *"fear of being controlled"*. Did she exhibit a schizoid pattern? Yes, most of the time during our years together; she continually relied on self-criticism and relational withdrawal as her way to self-stabilize. But Louise worked hard in her psychotherapy: we spent many sessions addressing her internal criticism, and many more in a therapeutically supported withdrawal.

Louise changed – the change occurred at a time when one might expect her to be more withdrawn. Instead, Louise's dialogue with me became intimate; she talked about having intimate conversations with her sister. I wish Louise was still alive, because I would like to interview her these many years later to in order to know her subjective version of our intense therapeutic interactions. My story of Louise's psychotherapy is from the point of view of a participant-observer, but it does not tell the whole story. It is Louise's subjective version of our psychotherapeutic journey that intrigues me. I am sure that we both would have learn a lot more, if she could have shared her phenomenological experience between us.

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Black Humour & Fear of Death in Modernity

Susanne Vosmer

Abstract: I argue that, in modernity, the impulse to directly articulate fear of death has been relegated into the Social Unconscious in Western cultures. When people become aware of it, it is displaced or disavowed. Furthermore, cryonics and the 'Double' are briefly outlined. By analysing films, literature and music, I show what functions different types of black humour serve. One function is indirectly to express fear of death. Since responsibility for the dead and death has been largely transferred to a small number of professions, who do not normally address emotional and psychological issues, the role of psychotherapists becomes even more vital. Black humour is beneficial, but it does not solve the problem of inevitable mortality. Psychotherapists may need to provide encouragement and the space for open discussions about death so that fear of death becomes less uncanny.

Key Words: impulse, black humour, fear of death, social unconscious, modernity

Introduction

Humour comprises an experience of perceiving something as funny. Normally, it entails a deviation from cultural norms, which results in laughter and amusement (Murray, 2007). Jokes rely on accepted social practices, but then often include an unexpected, surprising punchline. While humour is commonly light-hearted, the events of the two World Wars and other atrocities have affected our sense of humour profoundly, it has become somewhat crueler (Murray, 2007). Historically, Breton (1997) coined the term '*l'humour noir*' in 1940 to describe a particular dark, surreal style of comic writing. The words '*black humour*' came into use in English during the 1960s, when it was introduced by Friedman (1965) in the anthology '*Black Humor*'. Etymologically, the word 'black' originates from the Old English word 'swart', meaning dark in colour and wicked. It involves malignant or deadly purposes. 'Black' became associated with sharp, cynical, grotesque and absurdist humour from the 1960s onwards. Such humour is found in black comedy, films, literature and music (Simpson, 1989).

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Black comedy captures images of death, connecting these with cheerfulness. Humour is frequently expressed through irony and cynicism. While in irony, words signify the opposite of what a person means, modern cynicism seems to be more bitter. Stanley (2007) suggested that cynicism guards against despair by anticipating the worst. Not necessarily funny, black comedy tends to reverse societal norms. Reizen (1993) found that the more dreadful something is in a particular nation, the blacker its humour about certain topics. Thus, black humour becomes increasingly prominent during events like, economic depression, war and revolution.

Black humour can be situated between cynicism and gallows humour (White, 2019). Gallows humour expresses gruesome events (Rosenberg, 1991) and the horrors of professional tasks (Christopher, 2015; Moran & Massam, 1997). By injecting deliberate comedy into a tragic situation, it enables people to remain sane in insane places, such as psychiatric hospitals (Kuhlman, 1988). The 1975 film of Ken Kesey's book, *One Flew Over the Cuckoo's Nest*, is an exaggerated illustration of this.

Introduced in the beginning of the 20th century, gallows humour was originally used to cope with death by execution, hence the name. Freud adopted the term 'gallows' from 'Gallows Songs', which play with words. They protest against an existence in utter seriousness and express grotesque, resonant, poetic humour. Gallows Songs are a parody with roots in folk etymology, which assume that language enacts life. [1]

We find these examples of gallows humour in Freud (1905, 1927): a criminal led to the gallows on a Monday said *"This is a good beginning to the week"* (1927, p. 1). Furthermore, Freud wrote, alluding to Jung: *"I often think how the war saved us from unpleasant discussions with the Swiss."* (cited in Hoffer, 2004, p. 9)

Nowadays, the label 'black humour' is more commonly found than 'gallows humour', although both terms have been used interchangeably (Murray, 2007). This is problematic, because gallows humour is a distinct form of black humour. It is neither a source of pleasure nor does it produce a smile. Moreover, since gallows humour has often been mistranslated as black humour, their difference may be missed. Gallows humour has been used to cope with death and black humour to deal with tragedy.

In contemporary society, encountering actual death is an alien experience due to its medicalisation over the past two centuries (Murray, 2007). The extant literature suggests that (talking about) death in Britain is almost taboo, albeit not totally (Curtlin, 2019). Be this as it may, for most people, death is as alienating as graveyards, which are spooky at night (Ezquerro, 2015).

Death has often been linked to the uncanny. Freud (1919) suggested that this was because it was a particular frightening phenomenon. However, he also regarded female genital organs as 'uncanny': the womb being simultaneously a source of life and death, since our prenatal Self dies at birth: maybe there is also a close association between 'womb' and 'tomb'. Furthermore, Freud (1919) wrote about the 'uncanny' in relation to (fear of) death, sexuality and dualities (or Doubles) when analysing Hoffmann's *The Sandman*.

In psychoanalysis and fiction, the Double is a representation of the Ego, indicating that it

1. *"Hangman, Hangman, slack the rope"* by Bentley Ball (1920) and *"The Maid Freed From the Gallows"* http://jopiepopie.blogspot.com/2015/06/gallows-tree-1920-maid-freed-from.html

mediates between the Id (instincts) and the Superego (conscience). The Double can assume various forms, such as shadow, reflection and twin. It is also be found in primitive animism as guarantee of immortality.

Thus, the Double does not necessarily have a physical shape, but arises from the splitting of the Self. Both the uncanny and the Double form part of the Social Unconscious, hence, they impact on black humour, cynicism and our psyche. The Social Unconscious is a concept, which explains, for example, why traumatic societal and cultural events may be rendered unconscious, or how particular societal prohibitions affect us. According to Hopper (2003a), the Social Unconscious refers to cultural and social practices and norms, of which people are unaware. Even if these cultural constraints are perceived, they are denied, and if acknowledged, not taken as problematic.

McConnell (2019) suggested that, in literature, drama, comedy and film, black humour conveys the absurdity, insensitivity, paradox and cruelty of our world. Black humour may express death, trauma and ruthlessness through grotesque allusions by creating a connection between seemingly incompatible ideas and emotions. So, cynicism has the same function. It is increasingly prominent in modern societies, especially those which are characterised by radical social changes. Modernity has resulted in advanced techno-industrial societies and scientific developments, and metaphysical beliefs have been discarded. Instead, it favours ideas about unlimited technological progress and rationality (Linehan, 2009). These notions have affected people's attitudes towards death. In Western countries, although individuals are frequently exposed to death via the media, it is rarely publicly discussed (Murray, 2007). Hence, people have to resort to other socially accepted means to convey issues surrounding death: black humour being one of them.

Cynicism serves as an armour against despair (Stanley, 2007). Moreover, being cynical protects against disappointment (Small, 2020). Historically, cynics have debased the currency of conventional morality (Branham, 1994) and cynical folly has been viewed as an outrage against socioeconomic inequality (Revell, 2010). Cynicism and other types of black humour are powerful cultural phenomena. While societies naturally differ in how people employ various types of black humour, its use seems to be universal. Transmitted within and across cultures, not only does it form part of everyday life, but it is engrained in our psyches. It affects individuals and groups. However, we are not always aware of this. In exploring the Social Unconscious, the hidden aspects and functions of cynicism and other forms of black humour can be made (more) conscious.

Stanley (2007) suggested that our impulse towards cynicism "may lie buried in modernity, in Enlightenment itself" (p. 285). In this article, I shall argue that it is the ***underlying function*** of cynicism as an armour against death, which lies buried in the Social Unconscious. Furthermore, I hope to demonstrate that, in modernity, the impulse (innate urge) to directly articulate fear of death has been repressed, relegated into the Social Unconscious, in Western cultures. Hence, we do not voice any fear of death. I shall analyse popular films, literature and music to illuminate how death is presented. By outlining fear of death, cryonics and the Double, I hope to show why and how the impulse has been repressed. Implications for psychotherapy are then discussed. My focus is on death rather than on dying.

Impulse, Fear of Death & Modernity

Fear is a universal biological emotion, which has adaptive functions (see Adolphs, 2013). I suggest that individuals have an impulse,

that is, an innate biological and psychological urge to articulate directly their fear of death. However, in modernity, they are not being allowed to voice it. An urge to express fear can be observed during child development. When frightened, infants cry and articulate their fear by screaming. They do so, because they are genetically programmed. Screams signify a need for protection. With the acquisition of language, children begin to voice fear through words, provided caregivers and their social environment allow this.

Fear of death seems to develop between the ages of 6-8 (Derevensky, 1974) and seems to affect everybody (Sinoff, 2017). Children can often learn to become fearful of death due to exposure to verbal/visual information and by observing that others are frightened.

While children may ask questions, not all parents will speak openly about death. Bridgewater *et al.* (2021) found significant cultural differences. American parents were more reluctant than Mexican ones to discuss death (as portrayed in animated films). When children are not allowed to voice their fear of death, the impulse is often relegated into the social unconscious. One implication is that their fear cannot be psychologically processed. I shall explain this further by linking my argument to the unconscious, medicine, death and black humour.

Humans often find death dreadful. Hence, *"... in the unconscious every one ... is convinced of his own immortality"* (Freud, 1915, p. 291). However, when such loss occurs, individuals are forcibly confronted with their mortality (Garwood, 2001). Hence, a solution to the problem of death is needed. Death is defined by doctors as the point where a person cannot be revived, but in contrast, advances in medicine and science hold promises of a cure (see Smith, 2018). Creating the man of the future through genetic engineering may possibly free us from death (Jaeger, 2015). However, modernity may solve our problem with mortality through cryonic suspension (Hughes, 2001), but until it does so, fear of death remains.

Cryonics was first introduced by Robert Ettinger (1962) in his book, *The Prospect of Immortality*. Ettinger argued for the possibility of a longer and even infinite life. Cryonics involves several disciplines, including computer science, biology, medicine and nanotechnology. It aims to preserve dead bodies until medical technology can cure the disease, or condition, from which people have died, and also stop, or reverse, the aging process (Ettinger, 2022). Hence, in modernity, the question becomes when, not if, medicine will beat death.

I suggest that the impulse to voice one's fear of death is collectively relegated into the Social Unconscious in Western cultures, because the fear is not *in sync* with the optimistic, technological vision of modernity. When the impulse is buried in the Social Unconscious, adults are reluctant to discuss fear of death with children. This avoidance is passed on from generation to generation. There are two caveats. Firstly, when people become aware that their hope of immortality is unfounded, i.e. that death cannot be defeated in their life-time (see Smith, 2018), they resort to denial. The impulse to articulate their fear of death becomes disavowed. Secondly, especially in countries, such as the UK or the US, where people are bombarded daily with deadly images in the news, people become temporarily aware of their fear of death when the impulse re-emerges. The same happens when individuals encounter death in films, on social media, and of course, when someone close to them dies. Hence, they resort to black humour. So, the fear impulse is displaced and finds its outlet in humour. Expressing opposite feelings can have a dampening effect and restore emotional balance (see Herbert, 2014).

I propose that black humour is therefore particularly important for modernity. Prior to the Age of Enlightenment, religion, myths and the supernatural were means to deal with death anxiety. Beliefs about the immortality of the soul/spirit protected individuals from the transient nature of their existence. If there was life after death, death lost its scary nature and people could voice their fear of death. Modernity has challenged those metaphysical beliefs. Religion does not fit easily into a world of rationality and technological developments. For Nietzsche, the essence of modernity was death of God (Social Sciences Blog, 2022). Giddens (1990) viewed modernity as a way of social life, characterised by scientific advances. Science does not integrate spirits and faith. Ancient beliefs have therefore been discarded. However, without an immortal soul, once regarded as the Double of the body that protected our Ego from destruction (Rank, 1915), everything connected with death again becomes frightening.

The Significance of the Double

The Double, a duplication of the Self, can protect us from the terrifying fear of death. In primitive societies like Fiji, the Double assured immortality. According to Frazer's (1913) *The Belief in Immortality and the Worship of the Dead*, the Fijians believed that every man had two souls: a dark soul, consisting of his shadow, and a light soul. At the time of death, the dark soul moves into Hades, while the light, immortal soul stays near the place where the person died.

In fiction and psychoanalysis, the Double does not necessarily have a physical shape, but arises from the division of the Self. While it may present as an altered ego or delusion, when perceived as something that returns from death, the Double becomes an immortal Self, that negates the finiteness of life. So, it can be even more comforting than gallows humour. Let me elucidate the Double's function in more detail by incorporating Phillip's (1991) concept of the obstacle.

To experience joy fully, we must be aware of obstacles to its gratification. What is an obstacle? Focusing too much on dissociation, without describing what is put between states of mind to keep them apart, is the essence of an obstacle (although it also connects them). Applying Phillips' (1991) definition, when we do not talk about how dissociation from death occurs and instead resort to black humour, awareness of death becomes an obstacle. How do we deal with this barrier? Splitting is the most obvious defence mechanism employed to dissociate from the awareness of our demise, even though black humour serves a similar function, as I have shown. How does the Double fit into this?

In the initial conceptualisation of the Double, dividing the Self ensures an immortal Self, because only the darker side dies. Hence, I suggest that we unconsciously place the Double between different states of mind. It also connects these states. To enable feelings of joy, the obstacle (awareness of death) has to be eliminated through splitting of the Double. Both awareness of death and the dark side of the Double disappear into Hades. No longer aware of death, people have no conscious experience of fear relating to death, because the Double now resides metaphorically speaking in the underworld (Hades). Here, I equate the underworld with the Social Unconscious.

The importance of the Double becomes even clearer when considering that it is found in the social unconscious of many cultures. Let me explain how this happened. Originally, the Double was only engrained in the psyches of native populations (see Frazer, 1913). When texts about the Double were circulated, it

started to influence Western societies. Partly compatible with modernity due to the notion of an immortal Self, it gained prevalence in the Western world. The dark side of the Double, and with it an awareness of death and the impulse to voice fear of death, were collectively repressed. This explains how and why our impulse was silenced. Over the last century, this silence has become more pronounced (Murray, 2007). I suggest that this silence is also related to the fear of the dead.

If the Double's darker side re-emerged (in psychoanalytical terminology referred to as the 'return of the repressed'), which may happen when exposed to reminders of death, this would be too frightening. Thus, the dead and everything related to them, have to be avoided at all cost. Cremation could be viewed as a partial attempt to do this. This could account for the increase in the number of cremations. Similarly, we can view technological advances in cryonics and the immense popularity of satirical films, where the dead are resurrected (in one form or another: as a ghost, mummy, or a vampire).

Sarcasm, Gallows Humour, Cynicism & Absurdity in Literature and Films

In films and literature, black humour has been used to discuss the ruthlessness of death and trauma through grotesque allusions (McConnell, 2019). Great war writers have described the nature of war (Winter, 2013). Faced with horrifying situations, many authors resorted to black humour. *A Journey* is one literary example. Adler (1999) expressed his own pain, rage and horror related to the Holocaust by creating grotesque verbal connections. Did black humour offer him meaning about death (Murray, 2007)? I do not know, but I doubt that mass murder makes death meaningful.

Several film directors have employed black humour to express a fear of death. Examples included here are: *2001 A Space Odyssey* (Kubrik, 1968); *The Princess Bride* (Goldman & Reiner, 1987); *World of Glory* (Andersson, 1991); *Saving Private Ryan* (Spielberg, 1998); *Pearl Harbor* (Bay, 2001); the TV series about undertakers, *Six Feet Under* (Ball, 2001-2005); *Fury* (Ayer, 2014); and *Jojo Rabbit* (Waititi, 2019).

Based on Goldman's (1973) book, *The Princess Bride* is a black comedy. A story is narrated about the love relationship between Princess Buttercup and the farmer boy Wesley. After he is assumed to be dead, Buttercup must marry the dreaded Humperdinck. At the altar, she exclaims, *"I'm killing myself, once we reach the honeymoon suite."* The clergyman replies: *"Well, that'd be nice"*. The directors Goldman and Reiner (1987) use gallows humour and fantasy to convey dilemmas related to evil, love, good, torture, revenge, fighting and death. At the end of the story, after Wesley and Buttercup have disappeared on their white horses, Goldman (1973) writes that *love was the best thing in the world, except for cough drops*. He is cynical about all existential feelings.

Popular books and films impact on our identity. Crosley (2018) regarded *The Princess Bride* as a culturally influential film, which formed a facet of adolescence and building block of people's worldviews. But what message does this pickup line convey to young viewers, *"Please consider me as an alternative to suicide"*? Why is gallows humour needed to allude to suicidality, instead of discussing it directly? This points to societal constraints and the force of the social unconscious to repress discussions about suicide.

Throughout this medieval adventure, the audience is confronted with emotional allusions and a juxtaposition of satirical humour with violence: *"Have fun storming the castle."* And when the grandfather reads the story of how

Westley's ship is attacked by the dreaded pirate Roberts, his grandson says: *"Murdered by pirates is good."* Are viewers presented with a morality, where killing pirates is not only acceptable, but beneficial? Films are symptoms and expressions of the social unconscious. As psychotherapists, what do we make of such binary morality? Luckily, death is defied in *The Princess Bride*. Fear of death is overcome by resorting to gallows humour and sarcasm. Black humour is a culturally sanctioned means to express fear, which becomes apparent in many films.

Kubrick's (1968) science fiction satire, *2001 A Space Odyssey*, is regarded as a major artistic work of the 20th century. The audience is taken on an intergalactic tour beyond the Earth, with mysterious unseen aliens, who have progressed from biological beings over to immortal machines, and into beings of pure energy with limitless capabilities and intelligence. The music is adapted from Nietzsche's (1976) *Zarathustra*. It raises questions about humanity and the human species. We see a white image of a foetus in utero, symbolising that life does not end with death. This satire is consistent with modernity and cryonics, where death is not accepted. In contrast, *World of Glory* (Andersson, 1991) does. Otherwise the film could not demand from nations to assume responsibility for the contribution to the Holocaust (Brunow, 2010).

Andersson uses the grotesque purposefully to express socio-political criticism. Tragic scenes of naked Jews, who are living in the shadow of their unescapable end (Simor, 2019), are presented. They become a social force (Boskin, 1997). Andersson (2010) does not dissolve issues surrounding death, the lingering on of experiences nobody can leave behind, as he calls them. What do people do with horrific experiences? The term 'lingering on' indicates that they form part of human consciousness. Unprocessed, they will indeed negatively affect individuals and their offspring, unless post-traumatic stress is therapeutically treated. War is traumatic and has resulted in millions of casualties. There were not enough psychotherapists who could offer treatment. Hence, it is no coincidence that so many 'funny' war films have been produced. I regard their popularity as an attempt to make sense of and come to terms with loss and death.

The 1969 film, *Oh! What a Lovely War*, outlandishly parodies British reactions and attitudes to the First World War. *Pearl Harbor* (Bay, 2001) is another example where gallows humour, cynicism and laughter are used to comment on war: the dyslexic McCawley cannot read the letters required for the eye test. Nevertheless, the nurse passes his medical examination so that he can train as a pilot.

In addition to gallows humour, sexual innuendos are often found in war films. Collinson (1988) studied the interrelationship between humour and masculinity in workers. But the rigours of psychological survival cannot be achieved through jokes. The vulgar and crude language used by military personnel is equally cruel and characterised by swearing and sexual gestures. It may serve as means to assert masculinity, as in this scene: Flying loops to show off, McCawley is reprimanded by the major. Unable to suppress a smile, McCawley defends his reckless stunt by claiming that he wanted to inspire his men, simultaneously flattering the major: *"I believe the French even have a word for that. When the men get together to honour their leaders, they call it Hormage. Sir." "What?"*, asks the major. *"An hormage." "That's bullshit, McCawley"*, the major responds. After a pause, he adds: *"But it's very, very good bullshit."*

The tone of voice and facial expressions are distinct markers of black humour. Linguistically, McCawley attempts to amuse the major by referring to the French word 'horma-

ge' [horror], instead of 'homage' [tribute or honour], which is also phonetically similar to 'fromage' (cheese): the French are not only famous for cheese, but for their lack of success in battles. His pun is used to distract from his flying stunt and fears related to being a fighter pilot during the war.

The film director Ayer (2014) also resorts to laughter, gallows and sexual humour in *Fury*. While their tank moves through Nazi Germany in 1945, the men joke about religion, chocolates and sex. Tank commander Collier asks his men: *"Do you think Jesus loves Hitler?"* The technician, Bible, replies: *"I assume so."* Then Collier asks: *"Do you think Hitler would f*** one of us for a chocolate bar?" "I hope so."* We often encounter dark, sarcastic allusions related to religion and sex in war films.

Psychoanalysis recognises that violence is often erotized due to our primordial libidinal (sexual) and aggressive instincts. It is inevitable that physical fights and black humour are used in war films for reasons of authenticity and detachment. Hence, Spielberg (1998) also employed gallows humour. Set during the battle of Normandy in World War II, *Saving Private Ryan* focuses on Captain Miller and his squad as they search for Private Ryan. In amongst the very realistic war scenes, Spielberg inserts *bon mots* of humour and even obscenities. Gallows humour distracts from fear, bloody bodies and death. It is a coping mechanism, which enables soldiers to function. Unsurprisingly, we encounter gallows humour in many war and natural disaster films.

It is also used in satirical comedies, such as *Jojo Rabbit* (Waititi, 2019), which focuses on Nazism . Waititi (2019) uses gallows humour, puns and cynicism to highlight the effect Nazism had and to problematise the Holocaust and politics. This prevents death from being met with silence (see Azquerro, 2016). Many war film directors have resorted to grotesque humour and juxtaposition of images, words and music to make the dreadfulness of war somehow more authentic and palatable.

The Impulse to Articulate Fear, Black Humour & Music

In Kubrick's (1968) film, classical music evokes strong emotions, for example, using Strauss' (1894) compositions. He uses chapters from Nietzsche's (1976) *Also Sprach Zarathustra*. Performed by the Berliner Philharmonika Orchestra, *Sunrise* is a passionate, joyful song. Strings prevail in Strauss' composition *The Song of the Grave*, inducing melancholy in the listener. Hence, trauma and death can also be powerfully expressed through songs and musical instruments.

Ritchie's (2020) composition of Aitken's (2018) memoir, *Gallipoli to the Somme*, or Lithgow's (1917) *Invercargill March* and *The March of the Anzacs* are other examples. The musical interludes (United States Navy Band, 2015) fade into fragments when the strings take over with ominous chromatic lines. They point to Aitken's arrival under the cover of darkness in Gallipoli during the first World War. Fear of death is powerfully expressed. Ritchie's (2020) musical interpretation of *Gallipoli to the Somme* is filled with the absurd, communicated through a mixture of text and melodies taken from Aitken's (2018) memoir. The impulse to communicate fear of death surfaces from Aitken's unconscious. Hearing a German soldier play a flute in the muddy trenches near him, he recognises the tune as the *Dead March from Saul* by Händel (1739), which was played prior to military executions. The juxtaposition of Aitken's flute with the trenches is absurd.

Gallows humour is often used as a defence mechanism. It enables detachment (Kobassa & Pucchetti, 1983), denial, avoidance (Haig, 1986) or withdrawal (Mulkay, 1989). In Monty Python's film, *The Life of Brian* (Idle, 1979),

the masses are admonished to smile, whistle and sing, *Always Look on the Bright Side of Life* (Almond, 2019) whilst Brian is being crucified. The song combines tragedy with cheerful, grotesque laughter: *"... always look on the bright side of death. Just before you draw your terminal breath ... Life's a laugh and death's a joke, it's true. You'll see it's all a show ..."* The audience is thrown into the midst of death through images of Brian's crucifixion. Venturing into gallows humour offers perhaps the only opportunity to psychologically distance oneself from pain and torture. Interestingly, even though this film has many religious connotations, religion does not appear to be an effective means for Brian to distance himself from the inflicted trauma. Because, ultimately, it is Brian and **not** '*death, that is the last enemy that shall be destroyed*', as written by the Corinthians in the Holy Bible (15:2-26).

Can religion eradicate agony and fear? Piper (1977) suggested that the prospect of reuniting with God after death, through our relationship with Christ, diminishes our fear of death. Jesus is regarded as a transitional object, who reconnects us with God and thus ourselves, since we were created in the image of God.

However, in line with modernity, we also seem to have discarded religion. Heaphy (2007) wrote that, *"the decline of the sacred, increasing individualization and the growing significance of the body ... imply that death is more problematic in late modernity than ever before ... [T]he risk of death is profoundly threatening ... Death and dying are nowadays individual problems and there are few collective resources that can be drawn upon to make sense of them."* (cited in Curtlin, 2019: 188)

Thus, gallows humour is needed. It also helps Brian manage his bodily pain. In modernity, gallows humour may also function as a transitional object, instead of Jesus. By connecting life with death, it may reduce fear. However, this is irrelevant when *"Death's just a joke"*. Such assertion is more than collective denial, it verges on delusional displacement, signifying that modernity does not accept human mortality.

The Role of Psychotherapists

That song, *Always Look on the Bright Side of Life* is also a popular British funeral song (Newman, 2014), which shows how deeply repressed the impulse to articulate fear of death is. Not only is the absurd, "Life's a laugh and death's just a joke", engraved in the British Social Unconscious, but it also demands obedience. When being expected to *always look on the bright side*, expressions of fear and grief are effectively prohibited. What happens to fear? Who deals with the distress of death and the dead? Who supports people, whose profession it is to take care of death? The obvious ('modern') answer is *"psychotherapists"*, since Western societies have abdicated from assuming responsibility. Instead, modernity has transferred its care for the dying and the dead to doctors, nurses and funeral directors. To manage distress, these often tend to use gallows humour as a form of self-preservation (Watson, 2011). I contend that psychotherapists have to pick up the pieces that modernity leaves behind. Psychotherapists must make the impulse to voice fear of death conscious, attend to all resulting emotional issues, treat fear, trauma and loss, and decipher black humour.

Of course, I am not suggesting that all cultures transfer responsibility onto psychotherapists. Different civilisations handle death and their dead in different ways. However, it is noteworthy that Western funeral practices have changed and in Britain more people nowadays choose to be cremated than buried. Cremation is 'cleaner' and simpler and more final, whereas graveyards can be linked to the uncanny.

These have been relegated into the social unconscious due to taboos and, therefore, inevitably impact on all kinds of humour, defence mechanisms and the psyche. So, psychotherapists are also needed to explain these cultural phenomena to their clients in order for clients to understand them. This includes information on what happens when unprocessed grief emerges from the social unconscious.

People, resorting to denial, easily become overwhelmed by trauma and annihilation anxiety arises (Hopper, 2003b). Investigating causes and aspects of traumatised societies, he concluded that aggregation and massification arise due to fear of annihilation. When fear surfaces, as in hospitals, (Penna, 2015), medical staff tends to resort to gallows humour to manage fear or death anxiety (Christopher, 2015). Thus, working therapeutically with traumatised clients and those, who are affected by death and dying, it may be useful to have some understanding of gallows humour. Otherwise, psychotherapists might misinterpret why people resort to cynicism and gallows humour, and become unable to respond to their clients' grief with compassion.

Since all forms of black humour are universal societal phenomena, I suggest that psychotherapists need to encourage clients to voice their fear of death more directly, so that the impulse does not have to be displaced. Existential psychotherapists might be more inclined to address existential difficulties than therapists trained in other modalities.

Additionally, many psychotherapists work with organisations and the public to make death less of a taboo and to raise awareness of the consequences of unprocessed fear of death. Changing cultural attitudes towards death is difficult. Currently, attempts are being made to de-medicalise death by influencing how people think about death in different countries (Smith, 2018).

Unless individuals work in medical professions, the military or emergency services (Schwab, 2002; Villeneuve, 2005), most people have never seen an actual dead person. However, being constantly confronted with death leaves neither time nor space to directly articulate fear of death. They may not psychologically digest other people's demise by resorting to gallows humour. Whilst this form of humour is powerful, because it can alleviate suffering without losing contact with the painful experiences of life, it only does so momentarily. It is now recognised that people working as "first responders" could benefit from counselling to deal with the emotional overload of facing the death of others and, thus, their own mortality.

Algini (2009) viewed gallows humour as a reaction to death anxiety. It is noteworthy that gallows humour needs neither denial nor negation. It acts contrary to repression. According to Freud (1905, 1927), instead of relegating pain to the unconscious, the Ego refuses to suffer, claiming to gain pleasure from pain. Hence, gallows humour is based on the triumph of narcissism, the Ego's victorious assertion of its own invulnerability. Since gallows humour mocks and enables escape from adversities without negating these, it can be momentarily beneficial for traumatised staff and patients (Danzinger, 2018). Moreover, gallows humour is apparently helpful for suicidal and dying patients (Lecher Švark, 2017). So, clinicians could perhaps record whether their clients find gallows humour beneficial.

Interestingly, the Ego does not need to split due to fear of death, because gallows humour is its comforter. Freud (1905) wrote that gallows humour trivialises (with a consoling smile) the fear over the inescapable death. This smile, which connects the fear of dying with the desire to die, makes gallows humour also important for dealing with our own death, or accompanying a dying person.

Additionally, it has been used to express harboured homicidal wishes. Danzinger (2018) provided this conversational example: *"My husband is an angel." "How lucky! Mine is still alive."* (p. 9). As a saboteur of repression, gallows humour enables people to cope with very challenging circumstances through grotesque, absurd and ironic allusions. Despair may also be transformed into acceptance (Maier, 1989).

Be this as it may, it does not resolve the conundrum of voicing fear directly. I have suggested that we have a biological and psychological impulse to do so. When this impulse remains repressed, life may become less meaningful, because open discussions are avoided or denied (MacDonald, 2002). So, in addition to individual therapy, large analytic groups could possibly be facilitated to discuss death (see: Tubert-Oklander & Hernandez-Tubert, 2022).

Conclusion

Following the Age of Enlightenment, religion and the supernatural no longer provided a means to deal effectively with the fear of death. Hence, in Western cultures, the impulse to voice fear about death was relegated into the Social Unconscious. When the impulse emerges, it is usually disavowed, displaced or repressed again. Modernity does not properly accept death. It focuses on technological and scientific developments, such as cryonics, which creates the hope that death can be cured (or avoided) one day. This has implications for how we deal with fear of death, the dead and death itself.

My analyses have demonstrated that the Double and black humour have an important function related to death. While the Double ensures that we never really die, types of black humour act like an armour against the fear of death. Dark humour is therefore particularly culturally significant for societies, where articulation of fear has been silenced. However, while this may be beneficial temporarily, it does not solve the problem of inevitable mortality. Therefore, psychotherapists have to deal with the social, emotional and psychological consequences of death.

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Does the Location of Motivation Matter? A pragmatic concern in clinical work

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Abstract: This theoretical paper presents arguments for the significance of the location of motivation in the practice of clinical psychology. Identifying the externality and internality of motivation is argued to be clinically relevant in assessing psychopathology as this can potentially resolve comorbidity issues and improve diagnostic reliability. Furthermore, psychotherapeutic interventions can be tailored to the location of motivation. Extrinsically motivated pathological behaviours can be addressed through behaviour-based approaches, while intrinsically motivated behaviours need more long-term and in-depth therapeutic approaches. Lastly, prognosis can be assumed when the location of motivation has been identified – with extrinsically motivated behaviours having better prognosis than intrinsically motivated behaviours. Some directions for future research include testing the validity and reliability of motivation-based diagnosis, evaluating the effectiveness of matching the location of motivation with type of psychotherapy intervention, and comparing the effectiveness of motivation-matched interventions and disorder-based interventions.

Key Words: intrinsic motivation, extrinsic motivation, diagnosis, psychopathology, psychotherapy

This paper seeks to apply the extrinsic-intrinsic motivation constructs of Ryan & Deci (2000a; 2020) in the context of clinical assessment and psychotherapy. Primarily, this paper focuses on addressing the question, "Does the location of motivation matter"? Clinical insights and arguments are presented regarding why the location of motivation matters and how it can provide essential information for clinical work.

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Extrinsic-Intrinsic Motivation

Motivation toward psychological growth can be distinguished based on distinct underlying processes: goal orientation and value endorsement which occurs along the continuum of extrinsic and intrinsic motivation (Ryan & Deci, 2000a, 2020). Intrinsic motivation refers to motivation to do tasks or activities because of their inherent interest and enjoyment. On the other hand, extrinsic motivation refers to motivation to engage in behaviours for reasons other than their inherent interest and enjoyment. This conceptualization implies that behaviours contingent on goals and outcomes are associated with extrinsic motivation while behaviours guided by values regardless of outcomes are associated with intrinsic motivation.

Over the last two decades, a plethora of research on extrinsic-intrinsic motivation, as well as its overarching theory, self-determination theory, has tested its theoretical and empirical value across various areas (Silva, Marques, & Teixeira, 2014). The success of this theory is attributed to its comprehensiveness and testability (Legault, 2017). Research has consistently shown that the quality of experience and performance can greatly vary depending on whether one is behaving for intrinsic or for extrinsic reasons. These had been applied and validated in different contexts: workplace and occupational context (Hardré & Reeve, 2009; Rigby & Ryan, 2018), health context (Ng *et al.*, 2012; Ntoumanis *et al.*, 2021), teaching and learning contexts (Niemiec & Ryan, 2009; Perlman, 2013; Ryan & Deci, 2020), sports context (Hagger & Chatzisarantis, 2008; Standage & Ryan 2020), interpersonal context (Van Lange, 2000; Knee *et al.*, 2013).

While the constructs of extrinsic and intrinsic motivations have already been applied and tested in various areas and contexts, there are still relatively few papers utilizing them in the area of clinical psychology. If there is a motivation towards psychological growth, can arguments be made for a motivation towards some degree of pathology using the same principle? In the succeeding sections of the paper, arguments are made to establish the clinical significance of the location of motivation.

I *Complexity of Motivation for normative populations and Rigidity of Motivation for clinical populations*

Extrinsic and intrinsic motivation are commonly treated as separate and distinct. However, human behaviour is multi-faceted and people may often be motivated both extrinsically and intrinsically. For instance, a marathon trainer might be extrinsically motivated by a desire to gain social approval and, at the same time, be intrinsically motivated by the satisfaction gained from the activity itself (Ryan & Deci, 2000b). These simultaneous motivational forces reflect the complexity of motivation underlying human behaviours. Nonetheless, this complexity of being (simultaneously) extrinsically and intrinsically motivated are observed in "normative populations". Looking at clinical populations, a different manifestation of extrinsic and intrinsic motivations can be argued. It is possible that people with psychological disorders can be categorized into being extrinsically or intrinsically motivated, but not both. This can be explained by the concept of *psychological rigidity* or inflexibility associated with people with psychological disorders.

Psychological rigidity is observed to be a crucial factor in explaining the cognitive and behavioural processes (e.g. rumination, perfectionism, avoidance, thought & emotional suppression, selective attention & worrying, etc.) that maintain psychopathology. According to the systematic review done by Morris and Mansell (2018), transdiagnostic processes

(cognitive or behavioural process that perpetuates psychological distress across psychological disorders) are only clinically related to psychopathology when these are "rigidly" applied. Psychological rigidity is defined as the difficulty in switching from one set way of responding to a different way of responding, or the tendency to develop and perseverate in particular cognitive or behavioural patterns. In relation to psychopathology, it becomes possible to pinpoint the location of motivation whether one's pathological behaviour is extrinsically motivated or intrinsically motivated. Based on the cognitive and behavioural patterns they rigidly apply, the underlying goals and value endorsements can be argued to be rigid as well. It makes sense to say that while people with psychological disorders have difficulty changing their behavioural patterns, they also have underlying difficulty letting go of their motivations in the form of personally held goals and values.

Furthermore, psychological rigidity that is associated with psychopathology can be explained from a neurobiological perspective – linking cortical executive functioning and emotion regulation system to subcortical approach and avoidance motivations (Beauchaine & Zisner, 2017). It would make sense to say that such cognitive and behavioural patterns that are "rigidly" and continuously applied despite their inefficiency in certain situations reflect some degree of impairment in executive functioning and emotion dysregulation. Furthermore, goal orientations and value endorsements (as aspects of extrinsic and intrinsic motivations, respectively) require higher-order processes and therefore related to executive functioning. With psychological rigidity as a mediating variable, we can assume rigid motivational levels for people with psychological disorders (e.g. either their maladaptive behaviours are extrinsically motivated or intrinsically motivated).

II *Clinical Assessment based on the Location of Motivation*

Now that the idea of being able to pinpoint the location of motivation behind maladaptive, pathological behaviours has been established, the next question to ask is, *"How can this be useful in clinical practice?"* There is clinical significance in distinguishing between extrinsic and intrinsic forms of motivation. In clinical assessment, the location of motivation can serve as a potentially useful index in informing diagnostic assessments. Multiple diagnostic categories share the same "behavioural symptoms", but are distinguishable in complexity and type of the disorder (American Psychiatric Association, 2013). It can be argued that the type of disorder can be further distinguished in terms of location of motivation. For example: 1) Social withdrawal in social anxiety disorder can be viewed as extrinsically motivated (avoiding people results in an outcome, which is alleviation of anxiety), while social withdrawal in schizoid personality disorder can be viewed as intrinsically motivated (underlying the avoidance is a deeply held value for solitary activities more than social contact); 2) Symptom fabrication in malingering is extrinsically motivated (fabricating and exaggerating symptoms results to social incentives or personal gain) while symptom fabrication in factitious disorder is intrinsically motivated (inherent interest in assuming the sick role regardless of outcomes or consequences); 3) Compulsive behaviours in obsessive-compulsive disorder is extrinsically motivated (compulsions temporarily alleviate the anxiety from the obsessions) while compulsive behaviours in obsessive-compulsive personality disorder is intrinsically motivated (compulsive behaviours are associated with values on order and perfection that have become internalized).

In this regard, conceptualizing psychopathology at the motivational level can aid in making differential diagnoses. By looking at

motivations in terms of underlying goals and values for one's behaviours, clear distinctions between psychological disorders that share the same behavioural symptoms can be made, thereby increasing diagnostic utility (see Table 1). The process of making differential diagnoses is based on the location of motivation in reference to either goals or values.

In the practice of clinical assessment, self-reports can provide data on motivation. The information about motivation behind pathological behaviours are not usually paid attention to in clinical practice as the focus of assessment are usually about the topography, context, and adaptiveness or maladaptiveness (degree of dysfunction) of such behaviours. The inclusion of motivational aspects of pathological behaviours in assessment can facilitate the development of more accurate diagnosis and the formulation of more appropriate interventions. For instance, via interview, inquiring about aspects of the person's behaviours would provide insight on their motivation (underlying goals and values). Questions like: *"Why do you engage or continue to engage in this behaviour"*; *"What do you get/achieve from doing this"*; *"What is keeping you from changing your behaviour"*; *"What are the consequences of this behaviour"*; *"What happens if your desired outcome is not achieved"*; *"Does your behaviour persist regardless of the consequences"*, may tap into the underlying goals and personally-held values associated with the behaviour of interest that can help in making hypotheses about the location of motivation. Moreover, a series of behaviour chain analyses (analysis of antecedents, behaviour chains including thoughts and emotions, and consequences) can also reveal features of situations and patterns of thinking, feeling, and behaving that lead to particular outcomes (Heard & Swales, 2016). Consistencies in antecedents and consequences explaining the persistence of behaviour across different chain analyses reflect an extrinsically motivated behaviour, such that it only occurs when a specific environmental condition and/or outcome is present.

On the other hand, variabilities in antecedents and consequences in relation to persistent behaviour across different chain analyses imply an intrinsically motivated behaviour, because it has become functionally independent (persistence of behaviours regardless of environmental conditions and outcomes). Also, an objective self-report inventory, like the Situational Motivation Scale (SIMS), is a good instrument in assessing the location of motivation (Guay *et al.*, 2000). This can be administered in different times to ascertain the reliability of the identified location of motivation. Lastly, because self-report data can be influenced by subjective bias, these can be further validated by using projective techniques like the Thematic Apperception Test (TAT). In TAT, the prevalent needs, presses, and outcomes across the client's narratives or stories can be extracted (Cramer, 1996; Rosenwald, 1968). Arguably, such themes reflect underlying goals (if the TAT stories are more focused on outcomes) or values (if the TAT stories are more centered on valued tasks/behaviours). Through the examples mentioned above, adding an assessment of motivation in the battery of tests can provide a better diagnostic picture of the client's symptoms.

III Psychotherapy Approach based on the location of motivation

After identifying the location of motivation of target behaviours at the time of assessment, we can argue for the formulation of appropriate interventions based on the location of motivation (see Table 1). A behavioural symptom that is extrinsically motivated can be addressed through behaviour-based approaches. Because extrinsically motivated behaviours are contingent on outcomes, or in behavioural terms, environmental histories of

reinforcement, behavioural strategies can be argued to be effective forms of intervention (Corey, 2017). For instance, evidence-based behavioural intervention strategies involve teaching and guiding the client to change their behaviour by changing aspects of their environment. These are referred to as 'contingency management strategies' that have something to do with modifications of environmental conditions that occur before (also known as antecedents or prompting events) or after (also known as consequences which can be rewards or punishments) the behaviours of clinical interest (Farmer & Chapman, 2016). Antecedents can be modified by changing the physical and social environment from which the behaviour occurs. The client may get out of the environment, seek a different environment, or take steps in changing some features of the environment. For example, 1) an extrinsically motivated substance use behaviour can be addressed by restricting access to physical and social environments where substance use is tolerated and reinforced; 2) An extrinsically motivated gender-conforming behaviour implies societal pressure to conform to gender norms. This may be associated to the frustration associated with gender dysphoria because of a mismatch between identified gender and behavioural expression and the lack of validation from other people. This can be addressed if the person can get out of the unsupportive/disrciminating environment and seek supportive/accepting environments. Consequences, on the other hand, can be modified by withholding rewards or applying punishment procedures to decrease the probability of the behaviour to occur again. For example, an extrinsically motivated symptom fabrication associated with malingering, which is not a psychological disorder, can be addressed by facilitating negative consequences. The person should be called out for such deceptive behaviour. Social incentives gained as a result of malingering should also be removed so as not to tolerate the behaviour and avoid collusion in the deception. Aside from these, another set of behavioural intervention strategies involve the assessment of the function of the behaviour and teaching the client alternative adaptive behaviour that serve the same function or goal. This is also called behaviour modification.

Unlike contingency management strategies, in which antecedents and/or consequences are manipulated to influence behaviour in desirable directions, the primary targets in behaviour modification are deficits in the client's behavioural repertoire (Farmer & Chapman, 2016). For example, 1) an extrinsically motivated avoidant behaviour associated with social anxiety can be addressed through teaching the client relaxation techniques and tolerance for anxiety as replacement for avoidance, both of which serve to eventually alleviate the anxiety and experience a sense of comfort; 2) an extrinsically motivated compulsive behaviour associated with obsessive-compulsive disorder can be addressed through exposure and response prevention, that instead of engaging in immediate compulsions to temporarily alleviate the anxiety brought about by the obsessions, the client is taught to stay with the obsessions, delay the compulsions, and eventually stop the compulsions to allow for the experience of anxiety and dissipation of anxiety without compulsive behavioural rituals.

On the other hand, those behaviours that are intrinsically motivated would need long-term and in-depth psychotherapy approaches that involve clarification of personal needs and values, exploration of deep-seated issues, and promotion of behavioural insight (e.g. schema therapy, psychodynamic therapy, acceptance & commitment therapy, existential therapy). When a behaviour is based on a chosen set of values that has become part of the person's lifestyle, it no longer relies on immediate outcomes and becomes integrated with the rest

of the personality system. In this case, the intervention is no longer about changing the behaviour but guiding the client toward a productive, adaptive way of living in accordance to their endorsed values. Insight-oriented and acceptance-based approaches emphasize the significance of *valuing* (endorsement of values and engaging in behaviours based on chosen values) which serves as a compass that directs behaviours and tends to be relevant across situations over long periods of time (Hayes, Strosahl, & Wilson, 1999). For example, 1) an intrinsically motivated social withdrawal has an underlying value which is solitude. Preference to be alone and feelings of indifference toward other people have been integrated with the person's lifestyle and personality system. This is usually associated with schizoid personality disorder. The social withdrawal can be addressed through schema therapy (Young, Klosko, & Weishaar, 2003) involving imagery work – helping the client recognize some unmet childhood emotional needs for attachment and allowing for a corrective emotional experience. Moreover, the client is helped to recognize the value of both solitude and relationships such that they do not have to choose one over the other; 2) an intrinsically motivated symptom fabrication is associated with factitious disorder and implies an inherent interest in the sick role (regardless of environmental conditions and reactions). Through psychodynamic therapy, the client is helped in gaining a conscious understanding of symptom fabrication and wandering in hospitals as a way of life. The psychodynamic lens views this as a cycle of a masochistic submission to a parent figure due to traumatic, hostile parental upbringing. This is then displaced onto another symbolic parent figure, in this case, an institution (hospital) that involves inflicting pain on the self to elicit care and dependence on hospitalization and physician consultations or medications (Riser, 1985). The client is helped to recognize both the sick role and the nurturing role that they can assume for themselves without having to choose one role over the other; 3) an intrinsically motivated rumination and worrying is associated with clinical depression that involves a value attached to certainty and perfection. Constantly asking "why" and "what if" reflects the so-called self-oriented and socially prescribed perfectionism. The existential model establishes the link between perfection and depressive symptoms mediated by rumination and other perseverative thinking patterns. An existential, depth therapy approach guides the client toward a more coherent understanding and a more accepting stance toward past mistakes or undesirable events (Smith *et al.*, 2020). The client then recognizes the value of both achieving a sense of certainty and tolerating some degree of ambiguity; 4) an intrinsically motivated substance use implies that the behaviour has been internalized as part of the person's lifestyle. The associated value is novelty and stimulation. In the lifestyle model of addiction, the way persons engaging in substance use live their lives is also surrounded with a chaotic context – unstable housing, unemployment, financial difficulties, commitment of crimes, and unstable relationships (Davies *et al.*, 2015). These highly stimulating experiences (characterized by some degree of chaos and anxiety) become integrated with the rest of the personality system such that even through rehabilitation (changes in environmental conditions), there are still cases of substance use relapse. An acceptance-based harm reduction approach can be used to address intrinsically regulated substance use behaviours. This involves an acknowledgement that substance use "exists" in the person's life (Leslie, 2008). On one hand, there is valuing of the client's need for substance use, and on the other, teaching the client how to minimize its adverse consequences and mitigate the potential for abuse and misuse.

IV *Prognosis based on the Location of Motivation*

Furthermore, knowing the current location of motivation behind behavioural symptoms can provide insight about the current prognosis. We can argue that extrinsically motivated behaviours are easier to treat or change (have better prognosis) than intrinsically motivated behaviours. Suppose behaviours are contingent on outcomes or some other ends, the behaviours may be vulnerable to change (either by changing the antecedent and/or consequence or changing the behaviour). Being reliant on outcomes/consequences and environmental conditions imply that the behaviour is externally regulated and therefore, externally controlled. The source of control comes from outside the individual. However, when people start endorsing the value within the behaviour regardless of outcomes (intrinsic), it becomes self-sustaining or from the words of Allport (1937), *functionally autonomous*, and, therefore difficult to change. Consistent with the definition of intrinsic motivation, behaviours are enacted no longer because of a previous history of reinforcement or anticipated outcome but because of an inherent interest. In the context of psychopathology, that an interest-system is developed in the process (from habituation, achievement motivation, to valuation, congruence with other values, and integration). When an interest-system is developed, it creates a tensional condition, in this case, an internal input rather than an external input, that facilitates a behaviour or set of behaviours related to it (Allport, 1937). Intrinsically motivated pathological behaviours then become resistant to change (incorporated as part of one's lifestyle, integrated with personality system, and internalized behaviours that may persist across situations). In this case, the "interest" being served in the maintenance of pathological behaviours is the "stability" of the personality system. This is also supported by the idea of psychological rigidity mentioned earlier – that such functionally autonomous behaviours persist in spite of inefficiency or maladaptation. Nonetheless, the nature of intrinsically motivated pathological behaviours as being resistant to change does not necessarily mean that it can never be changed. It only implies that such behaviours are difficult to change and would definitely take time for in-depth psychotherapy interventions to facilitate such change.

Table 1: Sample list of differential diagnoses and corresponding therapy approaches based on location of motivation

Behavioural symptom	Location of Motivation	Implication for Assessment	Goal orientation/ Value endorsement	Psychotherapeutic Approach
Social withdrawal	*Extrinsic*	Wanting to be with other people but afraid of anticipated rejection or criticism; Possible symptom of social anxiety disorder	goal = security (sense of security is obtained after avoidance)	Behavioural exposure therapy – operantly conditioned by replacing avoidance with confronting a social situation and allowing the anxiety to peak and dissipate

Social withdrawal (continued)	*Intrinsic*	Indifferent to social relationships; Possible symptom of schizoid personality disorder	value = solitude (solitude is not obtained but is already experienced and personally held)	Schema therapy: needs assessment and provision of unmet childhood needs (parental attachment); identifying dysfunctional schema (abandonment: "I am alone")
Symptom exaggeration or fabrication	*Extrinsic*	Deliberately producing or feigning symptoms for personal gain; not a mental disorder – malingering	goal = social consequences (incentives, sympathy, etc.)	Behavioural consequences: withhold reinforcement; apply some forms of punishment
	Intrinsic	Inherent interest in illness; mental disorder – factitious disorder	value = sick role (assumption of the sick role is personally held)	Multi-modal therapy – medical treatments, psychodynamic therapy (gaining insight about the problem and possible links to childhood experiences)
Compulsive behaviour	*Extrinsic*	Obsessions elicit anxiety or fear which trigger compulsions; alleviation of anxiety is experienced to be linked to the compulsion (operantly conditioned); cycle in obsessive-compulsive disorder	goal = relief (anxiety brought about by obsessions is relieved after engaging in compulsions)	Behavioural exposure and response prevention – exposure to obsessive thoughts and delaying (and eventually deliberately stopping) the compulsion, allowing the anxiety or fear to peak and dissipate
	Intrinsic	Obsessions are belief systems embedded in one's personality that guide behaviours; clinical picture of obsessive-compulsive personality disorder	value = perfection and order (perfection and order are not obtained but personally held)	Schema therapy – identifying schema (unrelenting standards: "I need to be perfect"); clarification of values: realistic acceptance of the self over perfection

Dissociation symptoms (separation of self from environment)	*Extrinsic*	"Zoning out"; out-of-body experiences as a form of escape from past tauma ("That place/person is dangerous") – negatively reinforced; symptoms related to PTSD	goal = comfort and security (comfort is obtained after dissociation); life is normal when trauma-related stimuli are avoided	Behaviour therapy – prolonged and gradual exposure to trauma-related stimuli; attaining sense of comfort without resorting to avoidance (in the form of dissociation)
	Intrinsic	Assumption of new/other identity(ies); internalization of the trauma ("I am weak"); clinical picture of DID	value = power (multiple identities are introjected to protect the fragile self); the normal life is a fragmented personality	Schema therapy – reframing the identities as schema modes (what do the alters serve?); allowing awareness, communication, and eventual integration among the schema modes
Substance use/ other addictive behaviours	*Extrinsic*	Contingent on reward/consequences; not yet pathological	goal = pleasure (pleasure is experienced after engaging in the behaviour)	Behavioural approach – stimulus control (removal of access from source of addiction); total abstinence
	Intrinsic	Substance use as internalized lifestyle; possible addictive disorder (because of unsuccessful attempts to stop and interference with social functioning) leading to other addictive behaviours	value = stimulation or novelty	Acceptance and commitment therapy (substance use exists in the client's system) and facilitation of psychological flexibility; harm reduction approach
Gender-conforming behaviours	*Extrinsic*	Pressure from societal expectations; may lead to gender dysphoria when socially expected behaviours do not match one's identified gender	goal = social approval and validation	Behavioural approach (stimulus control) – getting out of the discriminating and imposing environment and seeking out supportive/accepting environments

Gender-conforming behaviours (continued)	*Intrinsic*	Societal dictates match one's identified gender; identification as "cisgender"	value = genuineness/ authenticity	N/A (does not warrant clinical intervention)
Ruminative thinking and worrying	*Extrinsic*	Engages in cognitive work to come up with solution; normative response to an objectively distressing problem or situation	goal = solution to a problem	Solution-focused therapy; Problem-solving approaches
	Intrinsic	Engages in perseverative thinking about an internalized belief (e.g., "I am worthless"; "I am hopeless") leading to a personally held metacognition (" I am a worrier"; ruminating/worrying is part of my life"); perpetuates depressive symptoms		

Limitations

Certainly, there are limitations to the clinical applications of the extrinsic-intrinsic motivation constructs. Psychotic disorders (e.g. schizophrenia spectrum), sleep-wake disorders (e.g., insomnia, nightmare disorder, sleep-walking disorder, sleep apnea, etc.), neurodevelopmental disorders (e.g. autism spectrum disorder, attention-deficit hyperactivity disorder, intellectual disability, etc.), and neurocognitive disorders (e.g. delirium, dementia, etc.) are heavily neurological and genetic in nature so a motivational model may not provide an additional variance in explaining such disorders. Furthermore, referring to the location of motivation just to inform diagnosis and treatment may only be irrelevant in such cases as these disorder clusters can easily be distinguished from all other disorders because of their unique symptomatology. While it may be interesting to know the goal orientations and endorsed values of people with these kinds of disorders and their current motivational level, these do not relate significantly to their behavioural symptoms.

This theoretical paper also acknowledges the limitation in the conceptualization of psychological disorders. It cannot be denied that there are nuances and complexities in the behaviours and symptoms across disorders. Inter-individual variability of the same disorders must be taken into account. Perhaps other factors aside from the location of motivation must be explored to paint a more holistic clinical picture and formulate more individualized psychotherapy interventions.

Summary and Conclusion

This theoretical paper argues for the importance of motivational source (i.e., intrinsic versus extrinsic) for psychopathological behaviours and their relation to assessment and treatment of different disorders.The location of motivation behind pathological behaviours matters and provides relevant information in the practice of clinical psychology. Normative and clinical populations can be further distinguished based on the nature of their motivation to engage in adaptive and maladaptive behaviors. On one hand, there is "complexity" in the motivation behind normative behaviors (can be simultaneously extrinsically and intrinsically motivated) and on the other, there is "rigidity" in the motivation behind pathological behaviors (either extrinsically or intrinsically motivated but not both). Identifying the externality and internality of motivation, based on goal orientations and value endorsements respectively, is clinically useful in assessing psychopathology as this can resolve comorbidity issues, address symptom overlaps, and improve diagnostic reliability. Furthermore, the distinction between extrinsic and intrinsic motivations as viewed in terms of goal orientations and endorsement of values facilitates interventions that are tailored to the location of motivation. Extrinsically motivated pathological behaviours can easily be addressed through behavioural approaches, while intrinsically, more functionally autonomous behaviours need more long-term and in-depth therapeutic approaches.

This paper outlines arguments, examples, and possible applications of Ryan and Deci's motivational model in areas of clinical assessment and psychotherapy. Empirical research is warranted to further test the assumptions made on this paper. Some directions for future research include: **(1)** testing the validity and reliability of motivation-based diagnosis (discriminant validity of motivation-based diagnosed can be established by exploring its diagnostic value as compared to DSM-based diagnosis particularly in making distinctions across disorders that share some set of symptoms – for example, OCD vs OCPD, Social anxiety vs Schizoid personality, factitious disorder vs malingering; furthermore, test-retest reliability can be established by performing repeated motivational assessments of psychopathology); **(2)** evaluating the effectiveness of matching the location of motivation with type of psychotherapy intervention (pre-test posttest design of measuring effectiveness of motivation-matched intervention where extrinsically motivated pathological behaviours are treated using behavioural therapy techniques like contingency management, exposure techniques, behaviour modification, problem-solving strategies and intrinsically motivated pathological behaviours are treated using depth psychotherapy approaches like existential therapy, psychodynamic therapy, acceptance and commitment therapy, and schema therapy approaches); **(3)** assessing the prognosis of extrinsically and intrinsically motivated pathological behaviours (comparing the prognostic rate via t-test comparison of means of extrinsically motivated behaviours and intrinsically motivated behaviours as treated similarly – treatment-as-usual approach), and **(4)** comparing

motivation-matched interventions with the traditional disorder-based interventions (mixed anova design comparing effectiveness of motivation-matched interventions and disorder-specific interventions – evaluating effectiveness in alleviating symptoms and enhancing well-being and comparing degrees of effectiveness of each group).

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Cognitive and Dialectic Behavioural Therapies for Post-Traumatic Stress and Conversion Disorders: A Case Study

Ali H. Haider

Abstract: The present study is the case of an eighteen-year-old young adult going through post-traumatic stress disorder (PTSD) with newly onset of the conversion (functional neurological) symptoms. This case study is the first example of determining the effectiveness of the two combined therapies i.e., cognitive-behavioural therapy (CBT) and dialectic-behaviour therapy (DBT) on a male in Pakistan. Before, only females were treated for conversion disorder and males and females both were treated for PTSD by the application of CBT only. In a 4-month period, the client attended 12 therapy-sessions. The conceptualization of the case to devise the treatment plan on the Fear-Escape-avoidance model and the cognitive model was supported by the case study results. The post-test scores of the used scales (PTSD Scale-Self Report for DSM-5 and Somatic Symptoms Scale-8) showed improvement in the symptoms than the pre-test scores. Both the therapies remained effective to decrease the intensity of the symptoms of the dual disorders.

Key Words: PTSD; Pakistani; Conversion; CBT; DBT; young adult

The main objective for the present case-study was to report the treatment of Post-Traumatic Stress Disorder (PTSD) and Conversion disorder in a Pakistani male, applying and checking the effectiveness of cognitive and dialectic behavioural therapies for the treatment, and to establish the protocol of treating these disorders with similar symptoms in Pakistani hospitals and mental health clinics. Conversion disorder is a continuation of newly developed functional neurological symptoms in the relevancy of ongoing PTSD symptoms. The symp-

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toms of PTSD include intrusive thoughts and memories with their negative appraisals that may create the symptoms of pain in the body. This pain leads to avoidant somatic symptoms especially tremors in the body with perceived body jerks as psychogenic-non-epileptic seizures (Myers *et al.*, 2017, p. 86). The other symptoms that are the hallmark of post-trauma are: experiencing a traumatic event (fatal accident) for a longer time (almost half an hour to an hour); intrusion symptoms like distressing memories or dreams (nightmares); and flashbacks of re-occurring traumatic events. Internal or external cues resembling any aspect of trauma are another symptom of PTSD. Avoidance to stimuli such as external (as people or object) or situations that remind of trauma aspects and internal as thoughts and feelings reminding trauma events are included in avoidance symptoms. Negative cognitive alteration (trying to remember trauma events) is also a PTSD symptom. Some other symptoms are negative beliefs about one's own self, not understanding the cause of trauma, emotional state of fear, anger, guilt or shame with some arousal symptoms (irritable behaviour or angry outbursts). Self-destructive behaviour, hyper-active gestures of the eyes (alertness), startled responses, concentration problems, and sleep disturbances for more than one month are also symptoms of PTSD. The Conversion symptoms may occur during the early course of PTSD and these symptoms include; voluntary motor tremors, gait abnormalities (imbalance during walking), abnormal limb postures (strong perception of deformation of hands and legs). The hallmark of conversion is to have pseudo/psychogenic-non-epileptic seizures (dizziness and jerks to the body for less than 10 seconds), altered skin sensations (such as visual, auditory or olfactory disturbances) and lump feelings in throat. In the case where both the disorders co-exist in a client, the PTSD always develops its onset earlier than conversion symptoms. Though, only the PTSD should be diagnosed if conversion symptoms start after the post-trauma symptoms, but if the traumatic event is directly expressed in somatic symptoms and no post-trauma symptoms come first, then only the conversion disorder should be diagnosed. Otherwise, both disorders may co-exist and the diagnosis may be given for both the disorders if conversion symptoms co-exist with the post-trauma symptoms as per Diagnostic and Statistical Manual of Disorders, 5th edition (DSM-5) (American Psychiatric Association, 2013, p. 321). The theoretical link between PTSD and conversion originated from Freud's concept of hysteria (from the times of DSM-III), that was the amalgam of dissociative and bodily symptoms of a person over a repressed idea (traumatic event). Pierre Janet considered the conversion symptoms as a stimulus for the pain avoidance (Kanaan & Craig, 2019, p. 1584) and as an avoidance strategy, the person may go through an accident (as a fixed traumatic event). Still, there is a link between both the disorders having a very weak empirical evidence for co-existence and method of treatment effective for both the disorders so far in the researches turned out to be prolonged/imaginal exposure (Myers *et al.*, 2017; Ehler & Clark, 2000, p. 340).

Case Study: Case History, Conceptualization and Management Plan

Case History

Client (Mr. M) is an eighteen-year-old young adult. He is living in a joint family consisting of parents (both alive and having ages above 50's). His birth order is 5th among seven siblings (6 brothers and a sister). He contacted the therapist by phone for having sessions for PTSD and conversion symptoms. The 12 therapy sessions were planned with him in

the private office of the therapist (3-sessions a month). The plan for the therapy sessions was to first take the client through the management of PTSD that he presented in the first session.

Presenting Complaints

The client experienced trauma when watching the death of a person on the road in a car-truck accident, and then developed a fear of dark (as, a month later, he was kidnapped by some unknown people, who took him to a dark room far away from his home blind-folded for more than 20 days). He started experiencing flashbacks when he was brought back home by his father after his release, after the kidnappers came to know that they had picked the wrong person. Other symptoms that he started feeling were:

- An imbalance in gait
- Intrusive memories about the events
- Visual disturbances
- Motor difficulties and
- Lumps in the throat
- Tremors and bodily jerks (less than 8 seconds).

Other complaints were:

- Trembling in hands and jaw-muscles (conversion symptoms)
- Concentration problems
- Hyper-vigilance (arousal symptoms) and fear of dark room.
- Avoidance remembering the dark room

He also experienced external reminders associated with both the traumatic events such as:

- The stretcher on which the patient was taken to the ambulance
- The crashed car
- The truck-driver, who was arrested by the police
- The ambulance
- The policemen
- The gun in the hand of policemen
- Unknown kidnappers having pistols in their hands
- The dark room and the chair on which he was roped
- The dishes used to provide food to him
- The glass in which he was given the water to drink.

Assessment Methodology

The formal assessment was done by using Mini Mental Status Examination or MMSE (Folstein, 2002) to determine about the presence of any cognitive impairment. The PTSD Scale-Self Report for DSM-5 (Fait *et al.*, 2018, p. 133) and The Somatic Symptoms Scale-8 (Gierk, *et al.*, 2014) for PTSD and conversion to screen out the severity of symptoms were used respectively. Only, the pre-test scale scores were obtained. The informal assessment was done by using DSM-5 criteria based on detailed diagnostic interviews and pre-post Subjective Unit of Distress Scale (SUDS) ratings (Mccabe, 2015) from 1-10 before and after every session. The MMSE maximum score is 30 and any score below 24, shows mild to severe cognitive impairment. The PSS-SR-5 consists of 20 items for re-experiencing, avoidance, negative alterations in cognitions and mood, and arousal symptoms. The symptoms are measured on a scale ranging from 0-4 ranging from not at all to six or more times a week. The PSS-SR-5 also includes first 2 questions to determine whether the trauma exists or not. Cronbach's α for PSS-SR-5 was 0.89. The intense severity score is > 51. The SSS-8 alpha reliability was 0.81. The item-options vary from 0-4 (not at all to very much) on a Likert-type scale. The total score may be 32. A high somatic burden score is 12-15 and onward.

Psychological Evaluation

The client's MMSE score was 26: that showed no cognitive impairment. His immediate recall, attention, perception, reading, copying, writing and concentration were better. On PSS-SR-5, the client showed higher scores on the items regarding alertness, falling asleep and symptoms onset and duration. The client's scale score indicated that client had acute level of PTSD symptoms as their score was 48 and the severity score started from 51. Symptoms didn't get chronic. In SSS-8, the client's score was 15 (a 12-15 score indicates high somatic-symptoms burden). He pointed out his stomach bowel problems, headaches, dizziness and trouble in sleeping.

Case formulation (4 P's of DSM-5)

The prodromal manifestation was watching a severe motor vehicle accident and witnessing the death of a person hit by the truck in head about 7 months previously. Kidnapped, 6 months later, by some unknown group of people in a mistake for some other person. The predisposing factors were: visual triggers, such as truck, car, dark room, stretcher etc. The precipitating factor was taking stress of intrusive memories related to the events of trauma and perceiving them the cause for other bodily symptoms. The perpetuating factor is intrusive memoirs (of trauma) and avoidance behaviours (bodily jerks; psychogenic non-epileptic seizures). The protective factor is the social support (brother and parents). The fear developed from the dark room led him to the nightmares and sleep disturbances. The careful clinical interview and matching the DSM 5 criteria for symptoms applied on the client gave dual diagnoses of PTSD (code: 309.81: F43. 10) and Conversion Disorder (Functional Neurological Symptom Disorder) (code: 300.11) according to the Diagnostic and Statistical Manual of Disorders "DSM 5" (APA, 2013, p. 271 & 318). The prognosis of the client was determined by the factors that the client's level of motivation and insight were good. Prognosis was favourable (more than 50% chance of recovery) and he had social support in the form of parents and siblings.

Case Conceptualization

The case was conceptualized with the Cognitive model (Ehler & Clark, 2000, p. 321) and the Fear Avoidance model (Voon *et al.*, 2016, p. 168). According to the aforementioned model, the intrusive thoughts and memories (of external stimuli; dark room, ropes, guns, kidnappers, dead-body, telephonic conversations of kidnappers and stretcher, etc.) maintain these intrusions, emotions (fear of the dark room) and the arousal symptoms (hyper-vigilance, startled response, etc). These memories receive a negative appraisal by the cognitions and trauma characteristics; they lead the client to maintain the current threat situation of these intrusions. Arousal symptoms and strong emotions emerge with that. Here, according to the fear avoidance model, when the state of arousal is maintained, it leads the person to a situation of feeling the body pain (being exhaustive, while fighting with the intrusive thoughts and memories). To escape these fear and pain feelings, the person tends to choose the behaviours of avoidance/conversion symptoms (visual and motor distortions; tremors in hands and feet, lump in throat, bodily jerks (non-epileptic-seizures), gait abnormalities, dizziness and sense of fear, with hyper-vigilance or avoidance to go in the dark room). These symptoms become the catastrophes in the cognitive process of trauma appraisal. The other avoidant behaviours that arose as catastrophes developed in the client's mind were concentration problems over work and sleep disturbances with sleep nightmares. All the symptoms started in January, 2021 and the management plan with the sessions started from June, 2021.

Management Plan

The treatment involved cognitive behavioural therapy to lessen the pain threshold for arousal and intrusive memories leading to conversion symptoms by use of cognitive techniques. The techniques were; suppression technique, different analogies of metaphors such as green-parrot beak, train analogy, emotional regulation (nightmare-protocol), sleep-hygiene checklist (for sleep disturbances), cognitive metaphors for threat arousal, identifying the pre-seizure aura and focus re-focus technique for conversion symptoms and imaginal exposure (through cognitive techniques) for the symptoms of both the disorders i.e. post-traumatic and conversion symptoms were chosen as a management plan for the current case. One session of stress-reduction script was also included in the later sessions.

Validity and Reliability Issue

The generalisability issue is the main reason for the low external validity of a single case study but on the other hand, the internal validity of the case studies is usually high because it is closer to that of qualitative study (A × B × A; single case research design). The ample and similar attributes in a study make it more generalized than having many unique attributes not being supported by the previous literature at all. In the present study, all the therapies chosen were only those which were previously developed and used by many therapists (for the post-traumatic stress and conversion disorders). Having no unique attribute explained in the study makes the generalisability issue lesser for the present case study (Wikfeldt, 2016, p. 2-5). The only cultural and contextual difference from the cognitive therapy metaphor, "fluorescent-green-bunny-rabbit" (Ehler & Clark, 2000, p. 337) was replaced and coined with the term "green-parrot" as the client was more familiar with the later term than the former one. The reliability of a case study doesn't come from a robust research strategy, but it refers to understanding, exploring and describing the phenomenon, which the researcher or the therapist picks for the case study. To maintain the reliability and validity, the process of collecting, analysing and interpreting the data of the client was done in a qualitative way for the present case study (Yin, 2017). The goal or main objective was stated in the beginning of the study. The research design was stated even in the abstract (pre- & post-test design). The data preparation and collection was done by informal detailed interviews from DSM-5 criteria based interview and average SUDS ratings. To screen out PTSD and conversion, PSS-SR-5 and SSS-8 were used as only pre-test scales. The comparison of the pre-test (pre-sessions) SUDS ratings with the post-test (post-session) SUDS ratings was a valid way to establish the reliability of the used methodology. The external validity can only be established, if the sample size and number of settings is increased for a single case study, however this area is compromised. Still, for the present case study, the unique therapy techniques were assigned to unique symptoms of the dual diagnosis. Multiple case studies (Mills *et al*., 2010) could be adopted, but the fortunate part for this case study was missing, as it was the only considerable unique case study which could be chosen by the therapist for the present study as all the other cases the therapist took didn't involve the complication of dual diagnosis and were managed by using CBT only. This case study was therefore different as the therapy approaches with techniques were chosen from both therapies: CBT and DBT.

Synopsis of Sessions

First Session:

Symptoms were not seen in the client during the session (even while client was saying that after only 3, 5 minutes that he felt he was going to receive a 'jerk' (a non-epileptic seizure) but he didn't. A rapport was tried to be built up with the client by using empathy and positive regard with mirroring and reflecting techniques. The client's brother was there, who gave some history which the client validated. This session was successful, due to good rapport built with the client and due to the client's brother, who validated most of the history. The client was complaining about (possibly) receiving a seizure, but he didn't get one during the whole session.

Second Session:

This session was held so as to conduct an informal assessment with the client to confirm his symptoms (criteria) from DSM-5 criteria-based interview and SUDS ratings. The formal assessment was done to screen for his cognitive impairment, PTSD and conversion symptoms by using MMSE, PSS-SR-5 and SSS-8. All the formal and informal assessments helped to give the client a dual diagnosis of PTSD and Conversion Disorder.

Third Session:

The client was psycho-educated and he was made to realize information about his traumatic stressors and about the risk and diagnostic factors with respect to his present symptoms. The client was well aware of the symptoms and he was motivated to work on them to minimise his situation.

Fourth Session:

This session was done with the client and his brother. His brother was told about the neurology of his symptoms and about the triggers that were perpetuating the symptoms. The nagging trigger for the client to talk about those memories and the aggression used to pop-out in the response to avoidance of intrusive memories by his brother were discussed. His brother told that the client was a working man and he used to help him and other brothers in the family. Then, the brother was told about the overall condition of the client and was asked to cooperate with him as he was going through a mental disorder. The client's brother was asked to talk about the favourite things that the client liked to eat or wear in the home. The client's brother understood the communication (genuine communication) and the message behind the conversation that the therapist conveyed to him and conveyed indirectly to the client also.

Fifth Session:

The client was introduced to the thought suppression experiment (Ehler & Clark, 2000, p. 337) to try to bring a change in his intrusion symptoms (flashbacks) that were maintaining his faulty coping strategy (of avoiding thinking about trauma). This task was done in three phases: (I) monitor; (II) suppression; and (III) monitor again. In the first phase of Monitor thoughts, the client was asked to identify the intrusive thoughts and rate them on the 0-10 scale, on the basis of the severity of these thoughts. He identified several thoughts (watching a dead-body, ambulance, kidnappers, wounds on his own body, and a dark room) and he gave an average rating of 7 to these. In the second 'Phase of Suppression', the client was given the example of an analogy of a train and he was told that the thoughts are like the train and the mind is like a platform. It's not necessary to catch every train (i.e. thought) that comes to the platform (i.e. mind) and then leaves it. We should 'let come' and 'let go' the trauma-related thoughts from our mind-passage. The whole conversation was done in a Socratic-questioning style.

The client was further introduced to a metaphor of a green parrot (intrusive thought) that is sitting on the shoulder (i.e. the mind) and is constantly putting its beak on to the throat and neck area (emotional stability). If the parrot (intrusive thought) is led away from the shoulder (mind) and left to walk around freely (giving a passage to an intrusive thought to come and let go from mind freely), the throat and neck (emotional stability) will remain intact from being beaked (emotional disturbance of thoughts). This metaphor was also presented in a Socratic-questioning style. In the third phase of the Monitor, he was asked to apply this 'train' analogy and 'parrot' metaphor on his thoughts which he identified, and the client reported, after doing this experiment, a relief in his intrusive thoughts. He was then asked to rate the severity of the thoughts again and he reported an average rating of 5, which was less than the rating of the first phase (7). He was asked to practice this experiment in home and compare his ratings each time after this experiment was done. The client was motivated to try this experiment in home.

Sixth Session:

The client was asked questions about their homework and was asked about what he had learnt in the previous section. Then, the grounding technique (Covington, 2003, p. 317) of senses (taste, touch, smell, hear and see) with a behavioural origin was applied on the client in the present session. The client was asked whether he sensed something that makes him avoid remembering about trauma. He was asked how he becomes vigilant or over-conscious about his present environment, where he feels any environmental danger. He was asked to think about the fact that the trauma will happen again or not? The client replied that whenever he hears a sound of a cane, or any sound that resembles a cane, he wants to avoid that thought and feels danger and becomes more hyper-vigilant. The client was then taught to dissociate any trauma-related images containing any trauma-related stimulus. He was then taught to associate one or more of his senses with the image of the present-moment stimulus and dissociate his sensory perception with the image of the trauma-related image in the past. The client then performed this experiment by associating the present moment stimulus of hearing a cane, or cane-related sound, with his senses in the present moment and dissociating the image of cane-beatings (that he had received on his back, while he was in the dark room) with the senses of trauma-related hyper-vigilance (not been able to remember the trauma due to fear of the being beaten again). The client was then asked to generalize the disconnection of that trauma-image with any cane or cane-like sound that he hears in the present moment and he may feel safe afterward. The client was asked to remember the model of the therapy again, and the goal again, and that he has to remember and accommodate the trauma events that he is avoiding to think of and then to disconnect them with the present moment. The client actively participated in performing this grounding technique. He also agreed to make a list of safety/faulty behaviours that he used to avoid trauma.

Seventh Session:

The client, in this session, was asked to provide the list of behaviours that he does to push the trauma-details out of mind. He provided the list with some significant points. He avoided trauma memories. He became hyper-vigilant. He got ashamed when he thought that he was the reason for trauma. He developed a fear of a dark room when thinking that some unknown people would kidnap him again. He feels he had a difficulty to talk to anyone, especially to his brother, about the traumatic incidents and flashbacks that came to his mind and he had a feeling of shame that he can't talk to his own brother about this. The

client was told that these were all the safety behaviours (being fearful, being avoidant, being ashamed, being hyper-vigilant and being distracted). These behaviours are maintaining the negative appraisals ('I would be kidnapped again', 'I would not be able to tell my brother about anything', 'I would experience a trauma again', 'I would not be able to cope with the flashbacks' and 'I would not be able to get my aggression over'). These behaviours were keeping him away from remembering and accommodating the trauma memories in his mind and brain systems (in the amygdala). He was then introduced to reliving the trauma (imaginal exposure) technique (Foa, 2009, p. 97). He was told that if he relives the trauma moments in detail and remembers and accommodates the trauma memories and negative appraisals associated with the trauma, he should be able to accommodate them in the mind. It would also help him to drop his safety/faulty behaviours that he adopted to stay away from trauma memories. The client was attentive in the session and he was now familiar with the trauma-focused (Imaginal Exposure) technique. Due to the shortage of time, this technique could not be done in this session, so the client was told that this technique would be practiced in next session.

Eighth Session:

Reliving the trauma (imaginal exposure) technique was practiced in this session by the client. First, the rationale was given to the client again, as it was given in the previous session, and then the client was asked to restate the whole trauma verbally. The client restated the whole trauma-event and some new points were added to the trauma details. For example, he saw the tragic coalition of the car with the truck, the man in the car came out of the windscreen flying. He saw the truck-driver escaping from the situation. He saw the car broken from the front and the engine-hood was destroyed. He saw the ropes on his body when he was kidnapped, and the moustaches of those unknown kidnappers were scary. He saw many ants running over his body. He was verbally abused by the kidnappers for a sin that he didn't commit at all, etc.

Questions during the exposure were asked from the client in the present tense like, "What do you see? What do you feel? Where are you standing? The client was asked whether he had no light or any torch in his own room, so his room might have remained lightened. To which the client replied that the light is there in the room and also the torch is available. Then the client was asked to lighten up the room with the room-light or when the light goes on, with the torch, he may lighten up the room again. The client was relieved after re-stating the traumatic event and that he realized the trauma memories. He stated that his feelings of guilt and shame were less.

Ninth Session:

The client was told that, unknowingly, he gave his symptoms a lot of hype in response to a trigger (intrusive trauma thoughts and memories). It created a fear in his mind about not being able to handle those responses or symptoms, and his body response (abnormal limb posture, gait disturbance and visual distortions) were generated due to the response (psychogenic-non-epileptic seizures), which were the product of the trauma memories he experienced on himself before. He was taught the Attention / Re-focus technique by telling him to not give his symptoms enough importance by saying to himself that he knows the cause of the symptoms and he will no more be vulnerable to these symptoms. Then, he could think about the other tasks at hand (re-focus). He was taught to retain his focus from the trauma symptoms and to re-focus his energy and thoughts on the present-moment tasks. The client understood and he was determined

to apply the technique that he learnt during the session to himself.

Tenth Session:

The nightmare-protocol (Linehan, 2015, p. 220) was applied to the client in the 7 steps: (i) Practice relaxation (pace-breathing with the belly); (ii) Choosing a nightmare to work on; (iii) Writing down the target nightmare; (iv) Choosing a change outcome for the nightmare; (v) Writing down the full nightmare again with the changes; (vi) Rehearsing the changed outcome before going to bed; and, (vii) Rehearsing and relaxing during the day. His target was to see a person in his dream having a gun and trying to shoot him. He, in return, saw himself running away to save his life from the gun and the person. The changed outcome version of the nightmare was, *"I saw the person with the gun, I hit him on his hand and the gun fell down, I asked the person to run away from me"*. After completing the seven steps of this protocol, he was given the Sleep Hygiene checklist (Reid *et al*., 2010, p. 4), which included sixteen instructions that were explained to the client i.e., (i) select a bed time; (ii) if not asleep in 15-20 minutes; (iii) leave the room and read a book (a boring book for example); (iv) repeat the cycle if not asleep in 15-20 minutes; (v) no food or drink after dinner, no television, radio or mobile after dinner; (vi) the bedroom must be quite and comfortable and dark, if possible; (vii) getting up every morning at the set time; (viii) eating lunch and dinner at the same time, with last food intake at least three hours before bedtime; (number ix was omitted from the instructions, as that was about alcohol use); (x) tea intake, only at breakfast time; (xi) no herbal tea or any other medicine before discussed with the psychiatrist; (number xii was omitted as it was about eye-shades and ear-plugs); (xiii) no day time naps; (xiv) keeping the same schedule in weekend and other days of the week; (xv)take a brisk walk at the time of low sun-exposure (5 in the evening and 6:30 in morning; (number xvi was omitted as it was about sitting near a light box emitting 3000 lux).

Eleventh Session:

In this session, the client was introduced to the stress reduction script (Boone, 2010, p. 183) based on the deep breathing. It was read for the client (in Urdu) that contained the successive method of deep breathing by first choosing a comfortable position (sitting in a supportive chair), then letting go any future plans and what already happened. Then, remembering that this was not the time of problem-solving, but just letting go of worries about the family, job and daily life stressors. Other techniques were: (a) allowing the mind to trust a spiritual being that is sitting there and imagining taking all the worries to hide, or put in the ocean, or to hand over that spiritual being (God); or (b) allowing the sorrows to disappear for a time being, doing deep breathing while counting from 1-7 while inhaling and exhaling; or (c) letting go of the toxicity (physical and mental); or surrendering to the basic source from where you came; or focusing on one's legs, calves, upper-legs, thighs, hips; relaxing and feeling safe by deep breathing; or focusing on the stomach and letting the butterflies of anxiety and stress go; or focusing on the chest and feeling the sense of caring and specialness; or focusing on shoulders and hands, while keep breathing deep and letting the responsibilities go; or focusing on neck and inside the head and jaw, where feelings of anger exist and letting them go; or focusing on top of the head, expanding the muscles when inhaling, contracting the muscles when exhaling, and, letting the stress and headaches go. First, this script was read by the therapist and then the client just read the script when doing it. The client felt relaxed and almost got sleepy while listening to and then reading and doing this script.

Twelfth Session:

The client was given the therapeutic blue-print and was asked some questions about what he had learnt in the therapy session. The feedback about the therapy sessions and therapy management strategies was taken. Termination of the sessions was done with the client by asking him to contact us immediately in case of any emergency and otherwise, getting back to healthy socio-occupational life.

Three follow-up sessions on the different occasions were also held with the client to evaluate the effect of the therapy sessions and to check the post-adjustment in the socio-occupational life after taking good therapeutic treatment.

Discussion

The factual statement of the present study was that the PTSD and Conversion symptoms may co-exist in a client under the influence of major life stressors (traumas) and these co-morbidities can be treated with cognitive therapy (specially prolonged exposure, reliving with restructuring and behavioural experiments in Cognitive Behaviour Therapy) and Dialectic Behaviour Therapy. Both the notions are supported by the study of Ehler & Clark (2000, p. 338) and by Foa (2008, p. 123). The grounding technique from DBT focusing on here-&-now was suggested by Covington (2003, p. 317) for the PTSD. The Nightmare-protocol from DBT for the sleep problems of the PTSD client was used in Bohus (2013, p. 224) and was found effective. Holmes (2005, p. 16) used focus, re-focus techniques from cognitive therapy modules for post-traumatic stress and conversion disorders successfully and the same techniques were used for the client in the present case study and it turned effective for the client.

The Change

The SUDS ratings measure the pre- & post-test change on the scale of 1-10. Ratings were found to have an overall lower score (4) in post-test after the completion of the sessions from the overall pre-test score (7) in the very first session. On completion of all the twelve sessions, the client gave a positive feedback that his symptoms were getting better by understanding and performing the therapy techniques in the needed hours in real life. Client was able to control his distress regarding the intrusive symptoms and memories and was able to revive his sleep back with least number of nightmares. He accepted that he was no more afraid of the dark room or of nightmares and he was giving his full time to complete his study.

Author

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OBITUARY

Remembering Tom Ormay

23/02/1934 – 20/02/2022

Éva Hosszú

I'm not the one who knows all the facts about Tom, but here are some thoughts. I just keep remembering mainly feelings, memories and illuminating thoughts about him.

The first meeting I had with him was with him at the Sports Hospital, in the training of the Overseas Department of the London Group Analytical Institute in 1989. (He was not living in Budapest at that time.) He was able to sit rather like a Buddha as he waited patiently and confidently for us to speak. He conveyed his views with great conviction, which he later expressed in his book: that one could truly find oneself in a relevant group.

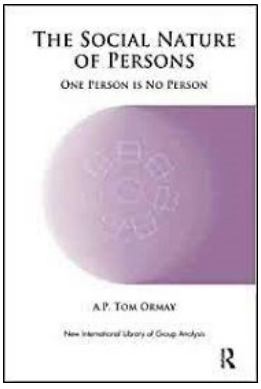
I gathered most of my experience about him when he was the president of CSAKIT (the Hungarian institute for group analysis) which I was the treasurer of for 8 years (if I recall correctly). I understood how important "Tom Ormayness" was for him here in Hungary as well. He claimed that he had acquired his identity for life in England. We went back and forth between the bank and the notary public to have his signature authenticated. We used to meet in a mall on Saturdays to handle banking matters. I always had to remind him, to sign the documents by his formal birth name: Antal Pál Ormay.

I listened with great interest his story of his escape in 1956 (when the Hungarian Revolution against the Soviet Regime took place, which ended in a Soviet victory). When it was dangerous to travel by train, he got off and continued by foot, using the embankment of the Danube as a guide so as to arrive to Vienna. He told this story several times, almost reliving it. Arriving in Vienna, he immediately resumed work, helping to organise things in the quasi-refugee camp. It was his job to assign students to various host countries. He organized a team to go to Oxford – then it crossed his mind that he was a student himself, and so

why couldn't he go there as well. It was a coincidence. He did not succeed in getting in to Oxford, given the absence of a scholarship, but he graduated from the University of London with a degree in philosophy. He also received support in the form of free psychoanalysis: and he enthusiastically went to the analyst, John Klauber, for ten years.

Once, I asked him why he returned home. The simple answer that he gave me was: "As I began to get older, I started to be cold in England". I always wanted him to be honoured at one of the anniversaries of the 1956 Revolution, but, as far as I am aware, this never happened: I'm sorry about that.

The Hungarian group analysts have a lot to thank him for. He encouraged us to think independently and to take up new initiatives. He introduced the idea of a Winter Workshop, which was a good one and which has since become a tradition. We didn't help him fill it with content for a long time, as we also relatively left him alone in the editing of 'The Matrix' (the Hungarian group journal). But he was always ahead of us. I learned from him that serving good causes is important!



Some Poems by Tom

Ars Poetica

Az élő emberek szavától élek,
de nem halok meg, ha ők nem beszélnek.
Kihasználom a pillanatnyi csendet,
és valami másról beszélni kezdek.

Ars Poetica

I live by the words of living folk,
but I don't die if they don't talk.
I take advantage of the silence,
and begin to say something else.

At Best

At best I want to be a man.
Not a he man,
Not a she man,
But a human.

At best I want life.
Not a good life,
Not a bad life,
A human life.

At best I want to be dead.
Not a saint dead,
Not evil dead,
When I am dead.

At best I have a child.
Not a good child,
Not a bad child,
Only my child.

Legjobb

Legjobb, ha vagyok csak ember.
Nem macsó ember,
Nem is nő ember,
De csak ember.

Legjobb, csak az élet.
Nem a jó élet,
Nem a rossz élet:
Emberélet.

Legjobb csak a halál.
Nem a szent halál,
Nem gonosz halál,
Ha jön a halál.

Legjobb a gyermekem.
Nem jó gyermekem,
Nem rossz gyermekem,
Az én gyermekem

Visitation

This morning, in a sleepy moment,
Death came to visit me.
He appeared in the deep doorway, and
Knew where I would be.

As I saw him I knew who he was there,
Even if no bones
Rattled, nor trumpets bugled where
He quietly rose.

With official simplicity he
Came in a grey suit.

With his serious eyes lit, dimly
Looked into my look.

He put his hand into my chest
Underneath my heart.
But then I felt that life was best,
Head shaking, I denied.

Like someone, who did his deed,
With this removed his lame
Hand, turned, disappeared, and did
Not even leave his name.

Odakint

Odakint valaki hazatéved.

Out There

Out there, somebody wanders home.

Tom's Legacy to the Journal

When the first version of this Journal collapsed in 2003 after the first 8 volumes – EAP having decided that the contract with Carfax / Brunner Routledge was just too expensive – it was resurrected by Tom Ormay, with Alexander Filz and a few others, after a year's abeyance. The new format now meant that it was produced in Lviv, Ukraine and was then distributed from Tom's office in Budapest. This second version of the Journal ran successfully for 7 years under Tom's Editorship, at which point I became the Editor and ran it under the same production system until March 2019.

It is safe to say that Tom undeniably "rescued" the Journal and that it probably wouldn't be in existence without his timely intervention. As mentioned above, he had had previous experience in being the Editor of another journal, The Matrix – the Hungarian group analysis journal. He had also lived in England for several years and so, whilst his spoken English was excellent, his appreciation of written English was not quite as strong, so after a few issues, I joined him on the Editorial team as the English-language Editor. We worked together incredibly harmoniously and slowly this second version of the Journal took shape and strength. The logistics of having between 300 and 500 copies printed in Lviv, and then shipped to Budapest were complex and involved Alexander Filz often carrying copies in his car from Lviv across 2 or 3 international borders to Budapest and Vienna. It was even more complicated when we held EAP meetings in other countries.

Together, we developed the Journal, with a bank account, a website, an Editorial Board, with several 'Special Issues', and a growing appreciation from the European Association of Psychotherapy (EAP) for having an important scientific journal.

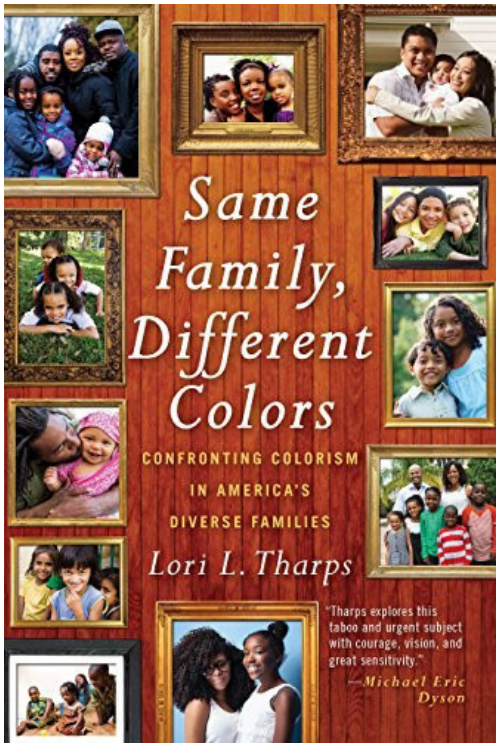
Tom and I had many quiet lunches together after the Editorial Board meetings discussing our next steps during which a strong friendship built up. On a couple of occasions, I also visited him in Budapest and he was a very generous host. After 7 years, Tom passed the Editorship over to me (with the approval of the EAP's Governing Board), yet retained himself as the Administrative Editor, liaising with the printers in Lviv, and posting out all the Journals from Budapest to the EAP member organisations and IJP subscribers. This collaboration continued smoothly until March 2019: at which point, the EAP suddenly decided to cut the Journal's costs by 20% and so we had to drop the production & printing in Lviv and come up with a totally different solution for the production of the Journal.

For the first eighteen months, we struggled on without actually printing any copies, and then Covid-19 struck and everything changed again. Some time, during the next two years, Tom and I lost touch a bit – as all the EAP face-to-face meetings were cancelled and we could only meet by Zoom conferencing. By this time, the Journal had taken on its 3rd incarnation, as being much more of an eJournal, and so, we were now moving into a different era. We managed to get back the Journal into production again, but when I rang him at the beginning of 2022 to ask him a technical question about what we needed to do about all the printed back issues in his office – I discovered that he was already in hospital. However, he seemed quite cheerful, as always. Sadly, I learnt that he had died just a few days after I had spoken to him.

He will be missed!

Courtenay Young
IJP Editor

BOOK REVIEW 1



Same Family, Different Colors: Confronting Colorism in America's Diverse Families

Lori L. Tharps

Reviewed by: *Lily Wu, New York University*

Boston, MA: Beacon Press: 2016

ISBN: 978-0-807-07678-1
203 pages
Includes bibliographical references and index

Available in Hardcover / Paperback & eBook
RRP: Hard/cloth: £22.50; US$25.95;
P/back: £12.91; Kindle £12.26

Tharps calls for more attention to be paid to colorism, a term first coined by activist and writer, Alice Walker, and defined as *"prejudicial or preferential treatment of same-race people based solely on their color"* (p. 9). The effects of Colorism are not often recognized or addressed, but Tharps's book, *Same Family, Different Colors* provides a convincing argument that colorism is as persistent and pervasive an injustice as racism. In fact, she states that *"racism and colorism in the United States were both cut from the same, suffocating white-supremacist cloth"* (p. 170). The aim of this book is not to demarcate the boundaries of colorism, but instead, to relay the varied experiences of individuals and their families, in order to convey the urgent need to confront it.

Tharps demonstrates the importance of identifying the bias of colorism within self and family, segmenting the book into four chapters focusing on specific cultural communities, stating that *"colorism is everybody's problem"* (p. 31). The chapters delve into the family dynamics of colorism within African American, Latino, Asian American and inter-racial communities and are accompanied with a brief historical primer in order to provide contextual relevance to the narratives. This combina-

tion of historical context, personal stories and analysis allows Tharps to dissect the desire and preference for certain skin tones. More specifically, Tharps engages in investigative work on the effects of color differences on the dynamics of nuclear families.

One of the book's strengths lies within the structure of the chapters. The addition of historical contexts of each community serves to provide an insight into the motives behind light skin desire. Whilst they are relatively short (the Asian American and colorism history section was just thirty-one pages long), Tharps provides a well-researched and referenced "historical primer" that frames the narratives of the individuals (p. 12). While it is definitely not a comprehensive study of the history of each community's relationship with colorism, it is however, a balanced vignette of colorism's place within the communities. For instance, the relationship between Chinese culture and pale skin is storied and often mischaracterized as a want to be white, rather than an issue of classism. Tharps, however, does not fall into the trap of the euro-centric perspective and instead, sensitively considers non-western beauty cultures in terms of their own aesthetics, politics and history.

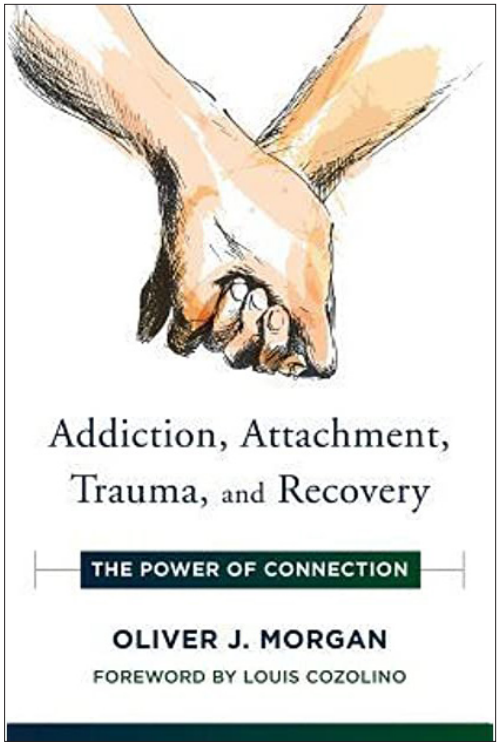
She does a great job of illustrating the insidious nature of colorism. She shows that this bias is everywhere, dictating our sense of belonging and therefore, is consistently within each and every one of us. It's seemingly impossible to escape and Tharps demonstrates its stronghold on the collective conscience. She argues for the importance of analysing our own attitudes and actions, especially with the ubiquity of overt and covert marketing of light skin. We must ask ourselves, 'Why purchase that skin-lightening face cream?' What purpose does it serve? At the very core of it all and the point at which all the varied narratives converged was not the desire for a particular skin color (or even light skin) but rather, the *"simple desire to be an obvious member of a group"* (p. 168). Belonging and acceptance is what is lusted after.

Same Family, Different Colors holds within it an accessible conversation about colorism in the United States by focusing on the family and its dynamics. By utilising the institution of family as it is both *"personal and political, public and private"*, Tharps parses through the tricky and tender topic of colorism in a framework well suited for a diverse audience (p. 123).

LORI L. THARPS is an associate professor of journalism at Temple University and an award-winning content creator, whose work examines the intersection of race and popular culture. Tharps's content aims to broaden the conversation about race in America; to dismantle white supremacy; and to celebrate diversity.

LILY WU graduated in 2019 from New York University with a BA in Psychology and minors in Studio Art and Mathematics. She has interned at the ROSES program at NYU and worked as an assistant to a Social Psychology PhD candidate. In addition to working for IJP, she writes reviews for Somatic Psychotherapy Today.

BOOK REVIEW 2



Addiction, Attachment, Trauma, And Recovery: The Power of Connection

Oliver. J. Morgan

Reviewed by: *Lily Wu*, *New York University*

New York: W.W. Norton & Co: 2019

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384 pages
Includes bibliographical references and index

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Hardcover & eBook:
RRP: £27.00; US$ 45.00; €33.50

Oliver Morgan's book, *Addiction, Attachment, Trauma, And Recovery* presents a progressive paradigm for the understanding of addiction and clinical practice of its treatment. Embodied firmly within the book and in Morgan's own practice, is the principle of "consilience". This is defined as the convergence of insights across a multitude of disciplines to form comprehensive knowledge. Thus, in *Addiction, Attachment, Trauma, And Recovery*, Morgan links together interpersonal neurobiology, attachment psychology, social ecology and trauma science into an articulate, humanistic analysis of addiction. Consilience is paramount: as we live in a world that is increasingly complex, we require a mode of thinking or framework that is both dynamic and integrative.

Addiction, Attachment, Trauma, And Recovery guides the reader through Morgan's personal and clinical experiences with addiction, his and others' theories surrounding addiction as well as, propositions for its long-term and sustainable treatment. The conception of the book followed Morgan's questioning of the classical disease model of addiction (the default theory of addiction that is adopted by most researchers) as it didn't inform his own experience: personally, clinically or academi-

cally. He saw that people within his own life were able to change their pattern of addiction, move forwards and be productive within the community, a feat deemed impossible or rare by the disease model. Instead, Morgan puts forward the theory that underlying most addictive behaviour is trauma and borrows from interpersonal neurobiology in order to understand the path from trauma to addiction.

The strength of the book is shown in its structure. The language is jargon free and the content is structured in a way that allows for a diverse audience of readers, from family members to practicing clinicians. As per the title, Morgan focuses on specific attachment styles and trauma and presents their relationship as a central path or prelude to later addiction. This thesis is introduced through the case study of an individual with addiction named "Joe". By tracing back through Joe's childhood, trauma is unearthed and his later addictions or "chemical comforters" are analysed as a substitute and "futile search (...) for connection" (xxx). While Morgan does not claim that trauma informs each and every addict's experience, he believes that it holds a prominent space within addiction and should be acknowledged as such. Furthermore, through an examination of Joe's attachment style to others, Morgan emphasises the importance of belonging and human connection. He quotes Johann Hari, *"The opposite of addiction is not sobriety; the opposite of addiction is connection"* and discusses this sentiment within the treatment section (p. 1).

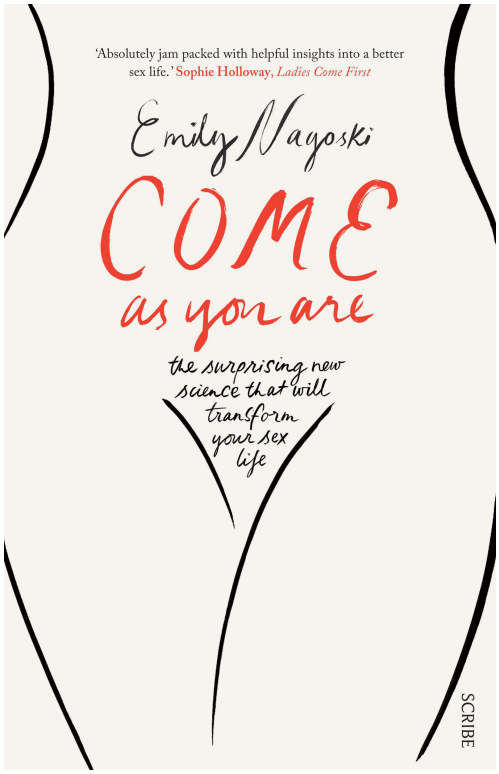
Another defining feature of *Addiction, Attachment, Trauma, And Recovery* is Morgan's discussion of addictions other than "chemical comforters", such as drugs and alcohol. He talks about behavioural compulsions: sex, gaming, gambling, and a third type of "comforter": workaholism, addiction to wealth and addiction to status. The last is not often referred to or recognised as an addiction, but Morgan makes an argument by weaving together research from social ecology to propose that this type of addiction may be much more dangerous than the others.

Finally, especially as America is confronted with the growing opioid crisis, Morgan's work will remain particularly relevant. Treatment and strategies that consider "consilience" within their framework will enable addicted persons to have a viable and sustainable recovery.

OLIVER J. MORGAN is a Professor of Counseling & Human Services at the University of Scranton. He has spent thirty years researching, teaching, and writing about mental health and addiction.

LILY WU is a Psychology graduate from New York University and has interned at NYU's ROSES Program. In addition to working for IJP, she writes reviews for Somatic Psychotherapy Today.

BOOK REVIEW 3



Come As You Are: The Surprising New Science That Will Transform Your Sex Life

Emily Nagoski

Reviewed by: *Lily Wu, New York University*

New York City: Simon & Schuster: 2015

ISBN 978-1-4767-6209-8 416 pages
Includes bibliographical references and index

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Emily Nagoski's thesis is represented clearly in the introduction of *Come As You Are*. Sexuality is completely individualistic and personal, and for the most part, never "abnormal". Nagoski writes this book with "women" in mind, whom she defines as people born in female bodies, raised as girls, and who now have the "social role and psychological identity of "woman" (p. 8). *Come As You Are* engages the reader through a journey of understanding the physical body and brain mechanisms of sexual response, and when once understood, is argued to equip the reader with the ability to control their immediate environment and brain. The result can be a maximisation of sexual potential through change and healing of sexual functioning.

Come As You Are is told through the stories of four women. These four women are not actual individuals but rather, a weaving together of many narratives in order to introduce common themes that Nagoski has encountered time and time again throughout her long career. The book is segmented into four parts, allowing the reader to progress naturally through the material. The first segment begins with a discussion of the "basic hardware": body, brain, and world (p. 5). Nagoski emphasises the im-

portance of understanding the sexual response mechanisms and how they interact with other systems within the brain and environment, to shape the 'turn ons and turn offs' of an individual. The second segment is self-labelled as "Sex in Context" (p. 5). Within these chapters, Nagoski explores the pervasive effect of environment on sexual wellbeing. Oftentimes, neglected as less important, Nagoski characterises context as incredibly crucial and just as significant as the physical body and brain is to sexual wellbeing. Included within the third segment of *Come As You Are* is a much-needed "busting of dangerous and long-standing myths" surrounding sex (p. 6). Lastly, the final segment concludes by discussing how to own your own sexuality. Nagoski drives home the idea that in order to improve an individual's sex life is not about improving the singular parts or its organisation but rather, how the individual feels about those parts.

Come As You Are is a perfect foil to many of the outdated books before it. It offers a new, science-based way of thinking about women's sexual wellbeing without unnecessary technical jargon and prejudice. This is shown through an important section of the book and one of this book's strengths: chapters dedicated to addressing man-centric misperceptions surrounding sex. Nagoski argues for the difference between spontaneous sex and responsive sex through a discussion of why sex is not a drive but rather, an "incentive motivation system" (p. 388). She argues that sex is not a drive, like hunger, as individuals will not die if they don't have it. This idea of sex as a drive leads to individuals believing that they are somehow faulty and abnormal if they don't have a desire to have sex. It is emphasised that spontaneous sex or desire is not normally the prelude to sex but is simply expected to be, because that is how men typically experience desire. Nagoski ends by urging the reader to start thinking of responsive desire (response arising due to contextual arousal) as what is normal and healthy.

Come As You Are offers something new to the landscape of sexual education – it talks about sex not just as behaviour or 'what has happened' but instead more importantly, as 'why and how it happened'. Nagoski asks the reader to truly analyse and examine how their individual behaviour came to be and how it makes them feel. Through exercises strewn throughout the book's chapters, such as interactive activities and worksheets, the reader is able to gain an understanding that they are not disordered or abnormal but instead, that they are "already sexually whole and healthy" (p. 11)

EMILY NAGOSKI is Wellness Education Director and Lecturer at Smith College, where she teaches *Women's Sexuality*. She has a PhD in health behaviour with a concentration in human sexuality from Indiana University, an MS in Counseling and internships at the Kinsey Institute Sexual Health Clinic and IU GLBT Student Support Services Office.

LILY WU graduated in 2019 from New York University with a BA in Psychology and minors in Studio Art and Mathematics. She has interned at the ROSES program at NYU and worked as an assistant to a Social Psychology PhD candidate. In addition to working for IJP, she writes reviews for Somatic Psychotherapy Today.

PROFESSIONAL ISSUES

English-language Book Reviews

We have a large number (about 45+) of review copies of brand new books to do with psychotherapy sent to us by the publishers. We have a whole raft of people "out there" who might be interested in writing a review about one of these books and who would then get to keep the book. Please go to the IJP website: **www.ijp.org.uk** and click on the "Book Reviews" tab in the middle of the top menu bar. Please, just let us know which book you would like to review and we will send it to you.

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We have a team of professional reviewers to look at the articles that have been submitted for publication: these people are all either members of our Editorial Board; or the International Advisory Board; or any other psychotherapist professionals with particular specialisations (like research); and ... we also ask all our published authors to join in with our peer-review process.

We would also be delighted to accept – as reviewers and book reviewers – any trainee psychotherapists from European Accredited Psychotherapy Training Institutes (EAPTI) and from Masters & Doctoral training courses in psychotherapy – and if you are not so sure about reviewing – we have written guidelines about how to review a book for a professional journal.

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(N.B. We like all our reviewers to submit a few professional details about themselves and their interests so that we can 'best fit' them to the available articles.)

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

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

- **Long articles**, which should not exceed 5000 words; or
- **Medium articles** (2000-3000 words); or
- **Short reports & reflections** for rapid publication (1000-1500 words); and
- **Book Reviews:** short (600-800 words) not peer-reviewed, or longer (800-1200 words) reviewed;
- **News Items** can be 100-500 words (not peer-reviewed).

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

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

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

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

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

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This is only an indication – an extract:
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Please read all that information very carefully before submitting an article.

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