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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 29 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. However, the Journal is now more of an "open-access" journal, so subscriptions are less relevant.

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. Most recently, we have published *A Proposal to Establish a Set of Ethical Principles & Guidelines for EAP Organisations*.

International Journal of Psychotherapy

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear Readers and Fellow Psychotherapists,

Psychotherapy – as different from psychology – is much more distinctive in Europe due to the 30+ years of work by the EAP. We (in the EAP) are about to submit a document to the European Commission entitled, "Evidence of the Existence of an Independent Profession of 'Psychotherapist'", which is another attempt to get psychotherapy properly recognised. This document is still in draft form, so we will probably publish it in the next issue.

We are part way there as the European Commission's European Skills, Competences, Qualifications and Occupations (ESCO), the European multilingual classification of Skills, Competences and Occupations, which works as a sort of 'dictionary', describing, identifying and classifying professional occupations and skills relevant for the EU labour market, education and training, has already acknowledged that: *"Psychotherapists are **not** required to have academic degrees in psychology or a medical qualification in psychiatry. It is an independent occupation from psychology, psychiatry, and counselling."* (My emphasis)

This was as a result of submitting the results of the EAP's Project to Establish the Professional Competences of a European Psychotherapist. The "Core" Competences were established in 2013 [1] and, when submitted to ESCO, clearly differentiated the work of a 'psychotherapist' as being significantly different

1. www.europsyche.org/portals/0/media/docs/Final-Core-Competencies-v-3-3_July2013.pdf.

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from the competences of a European psychologist. [2] [3] It is therefore hoped that when the 2008 version of ESCO's classification is revised (which only happens every 20 years) a 'psychotherapist' will appear with a different classification and not as a sub-set of a sub-set of 'psychologist', as it is currently listed.

This EAP Project, more than almost anything else that the EAP has done over the last 35 years, clearly differentiates between the professional competences of a psychologist, a psychiatrist, a psychotherapist and a counsellor. We just have to convince the regulating authorities of the difference. Eventually the differentiation will 'trickle down' to the national bodies, and then some of the national laws that restrict the practice of psychotherapy may have to be revoked.

We would also like to draw your attention to the fact that the World Federation for Psychotherapy (WFP) is organising its next 24th World Congress in New York in June 2026 (www.wfpsychotherapy.org/world-congress-of-psychotherapy). The title of this Congress is: "Psychotherapy, Mental Health and Human Rights: Caring for Vulnerable Populations, Healthcare Professionals, and Humanitarian Relief Workers". (For more details: wfpsychotherapy.org/world-congress-of-psychotherapy). This organisation is different from the World Council for Psychotherapy which had its 10th World Congress last year in Vienna (www.worldpsyche.org).

The Psychotherapy Networker is also having its 49th annual Symposium, in March 19-22, 2026, live in Washington D.C. and online. It is nice to see some familiar faces like Bruce Perry, Dan Siegel, Janine Fisher, Deb Dana and Bessel van der Kolk, as well as 70 different presenters (see www.psychnetworker.org)

Another transcultural grouping that may be of interest is the Asia-Pacific Mental Health Congress, which was held in Bali, Indonesia, 25th-29th October, 2025 with the theme: "Future Directions: Pioneering Mental Health and Well-being Initiatives" [4]. Even if these conferences or congresses have passed, one can still get some of the presentations, but you might have to pay a bit.

As psychotherapists, we always need to keep an eye on their Continuing Professional Development, which usually requires a total of 250 CPD 'points' (hours) in every 5-year period. This can come expensive is one is travelling to conferences, staying in hotels and also paying the conference fee. There are other ways of gaining CPD 'points': obviously attending such conference online is a lot cheaper. There are many professional seminars and workshops online as well. More information is to be found on the EAP website: www.europsyche.org/ECP/CPD. However, writing a professional article or reviewing articles – as

2. epub.ub.uni-muenchen.de/123552/1/2387-Article-11797-1-10-20191205.pdf
3. europsy-bg.com/en/competences-and-profiling-of-competencies
4 www.scholarsconferences.com/asia-pacific-mental-health

for this Journal – is not listed specifically, but will surely count. We may have to ask the EAP's European Training Standards Committee to add this activity to the list.

Finally, the EAP's Science and Research Committee (SARC) has produced a substantive document that lists several research studies that support each of the 13 Domains and 126 Core Competences in the 2013 EAP's Project to Establish the Core Professional Competences of a European Psychotherapist: (www.europsyche.org/portals/0/media/docs/Final-Core-Competencies-v-3-3_July2013.pdf). This document will be presented at the next EAP meetings in mid-March 2026 in Vienna and should soon be available via the EAP's website.

It is now hoped that this SARC Project will help all the 100+ European Accredited Psychotherapy Training Institutes (EAPTI) to incorporate these Core Professional Competences into their usually more modality-based trainings.

In this issue, we have an article on "**Why Positivism in the Form of the Quantitative Paradigm May Dominate and Prevail, and its Impact on Psychotherapies, Psychotherapists & Clients"** from Susanne Vosmer, one of our Editorial Team members. She describes the rise of positivism and some of its uses, benefits and flaws, as well as its unconscious factors and processes.

Our next article is entitled, **"Dealing with Trauma after the Turkey Earthquake: Personal experiences in training mental health professionals"** from Enver Çesko, a very active and well-qualified psychotherapist from Kosovo. He outlines what can be done by a single person when dealing with a massive disaster by advising others, possibly less well-qualified.

Then comes an interesting article, **"Convergences in Somatic Psychotherapy in Biosynthesis, the Aesthetic Domain of Experience, and the Art of Singing as a therapeutic resource"** by Cecilia Maria Valentim Teixeira Coelho, a Brazilian Art Psychotherapist trained in both singing as well as in Biosynthesis (Boadella). She describes some of the interrelationships in her therapeutic work, using her singing work, both based on the affirmation of a perceptive body as a receptacle of all our different experiences.

Another article comes from Enver Çesko, **"Psychosexual Psychotherapy – A New Model of Integrative Body Psychotherapy"** where he describes an integrative approach that combines a psychodynamic and comprehensively integrative approach, including some new concepts from different psychotherapeutical approaches, derived from body psychotherapy, somatic psychology, sexual medicine, neuroscience and mindfulness practice.

Our next article comes from a regular IJP author, Clifford Edward Watkins Jr. in collaboration with several esteemed Romanian colleagues, who use the concept of existential empathy as a key component in supervision. In their article, **"Existential Empathy as the Foundation of the Clinical Supervision Process:**

Applicability within the Supervision Pyramid" they introduce the concept of a Supervision Pyramid, with different levels of interaction.

We also have an interesting research article for an American colleague, Darlyne Nemeth and colleagues, looking at **"The Polarizing Effects of COVID-19 on Individuals and Communities"**. This was a six-factor-analytic study of English respondents to a questionnaire that explored six personality adaptations: Antisocial aggressive (advantage takers); Religious adaptation (fundamentalists); Nuisance aggressive (disturbed followers); Militant preparedness vs. Denial (militia); Apocalyptic Psychoid Behavior (disturbed leaders); and Mainstream adaptation (general population). Out of these, two significant factors emerged: Factor 2 – Religious Adaptations and Factor 4: Militant Preparedness vs Denial (Militia). This led to conspiracy theories, extremist behaviours and hyper-defensiveness, paranoia and tendencies towards violence. These increased polarization and led to wide political and psychosocial schisms.

Finally, we publish the results of a survey: **"The Impact of War on Ukrainian Psychotherapists: A survey"** in both English and Ukrainian, from Kira Sedykh and Volodymyr Pohoriliy. This looked at some of the impact of war on therapists. This follows on from a previous Special Issue of the IJP on the 'Psychotherapy in the Ukraine at War' (Vol. 29, No. 1, Spring 2025) and touches into the series of online UUP & EAP Symposia of the Ukrainian & European Psychotherapy Alliance, held by the EAP and attended by an average 1000 people for each symposium. The 10th Symposium is due shortly (details on the EAP website).

We also have a double book review, **A Jungian Inquiry into the American Psyche: The Violence of Innocence** by Ipek S. Burnett and **Re-Visioning the American Psyche: Jungian, Archytypal and Mythological Reflections** by Ipek S. Burnett, both reviewed by Theo A. Cope. He questions what is meant by "psyche" in psychotherapy, which connects with the on-going Special Issue on Psychotherapy vs. Spirituality (see left-hand column on website on *Current Online Articles*).

As we enter into our 30th year of publication, I, would like to remind readers and fellow psychotherapists that the 'job' of Editor of this Journal is soon becoming vacant. I have been holding this role for about 15 years, and time is inevitably moving me along somewhat different pathways; my health is also somewhat more fragile. So, it is time to implement some succession-planning. Our Co-Editor, Marzena Rusanowska is already doing a marvellous job; we are building a 'Transition Team', and we will also need the support of others to cover all the various activities of being Editor.

Psychotherapy is not a mental health / quasi-medical treatment; it is more of a (soft-revolutionary) psycho-social exploration [1]

Courtenay Young

Abstract: The status of psychotherapy as a profession in Europe is changing away from being a subset of psychology towards being an independent profession. It is becoming more of a psycho-social exploration.

Key Words: Professional Core Competences; European Psychotherapist; European Classification of Occupations

There is a common mistake (made by health ministries in different countries) in classifying psychotherapy as being a part of the "medical model": a 'health' or 'mental health' treatment. [2] So, the basis of this article is that **it is not**! Psychotherapy has really got nothing to do with mental illness; quite a lot to do with mental health; and much more to do with the restoration of well-being.

It is worth noting that the professional competences of a **psychotherapist**, as listed by the International Standard Classification of Occupations (ISCO), is as a sub-set of a sub-set within the classification of a **psychologist** (2634). A Psychologist is listed first within **(a)** Legal, Social and Cultural Professionals (26), and then **(b)** Social and Religious Professionals (263); rather than within the Health Professionals (22).

In Europe, we have now clearly established that a 'psychotherapist' has a significantly different set of Core Competences from those

1. Written as a presentation for the Asia-Pacific Mental Health & Well-Being, Bali, Indonesia in October, 2025.
2. A medical treatment refers to the management, care, and procedures carried out by healthcare professionals to diagnose, treat, rehabilitate, or manage physical or mental illnesses, injuries, and disorders. It includes using medication, surgery, therapy, or devices to alleviate symptoms, improve, or cure a condition.

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of a psychologist and is therefore a distinct profession: this has many legal and educational implications. I quote the (new) ESCO description:

> *Psychotherapists assist and treat healthcare users with varying degrees of psychological, psychosocial, or psychosomatic behavioural disorders and pathogenic conditions by means of psychotherapeutic methods. They promote personal development and well-being and provide advice on improving relationships, capabilities, and problem-solving techniques. They use science-based psychotherapeutic methods such as behavioural therapy, existential analysis and logotherapy, psychoanalysis or systemic family therapy in order to guide the patients in their development and help them search for appropriate solutions to their problems.* ***Psychotherapists are not required to have academic degrees in psychology or a medical qualification in psychiatry. It is an independent occupation from psychology, psychiatry, and counselling.***

The significance and immediacy of this point is that the ISCO classifications get adjusted every 20 years and the next adjustment is due in 2028. This means that professional psychotherapy associations across the world therefore need to act quickly within their own countries – and internationally – to ensure that psychotherapists are **not** restricted to only being able to practice if we have a medical or psychological degree qualification.

The rationale for the EAP's 2010-2013 project to establish the Professional Core Competences of a European Psychotherapist, was to demonstrate how these competences fall within a psychosocial, mental health and well-being perspective and how they differ from the core competences of a European Psychologist. For a fuller description of these professional competences, see www.psychotherapy-competence.eu.

Strasbourg Declaration on Psychotherapy

In accordance with the aims of the World Health Organisation (WHO), the non-discrimination accord valid within the framework of the European Union (EU) and intended for the European Economic Area (EEA), and the principle of freedom of movement of persons and services, the undersigned agree on the following points:

1. Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.
2. Training in psychotherapy takes place at an advanced, qualified and scientific level.
3. The multiplicity of psychotherapeutic methods is assured and guaranteed.
4. A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.
5. Access to training is through various preliminary qualifications, in particular human and social sciences.

The founding of the European Association for Psychotherapy (EAP) in 1990 with the Strasbourg Declaration, and subsequently the World Council for Psychotherapy (WCP), declare psychotherapy to be an independent profession.

EAP defines psychotherapy as follows:

1. The practice of psychotherapy is the comprehensive, conscious and planned treatment of psychosocial, psychosomatic and behavioural disturbances or states of suffering with scientific psychotherapeutic methods, through an interaction between one or more persons' being treated, and one or more psychotherapists, with the aim of relieving disturbing attitudes to change, and to promote the maturation, development and health of the treated person. It requires both a general and a specific training/education.
2. The independent practice of psychotherapy consists of autonomous, responsible enactment of the capacities described in paragraph 1; independent of whether the activity is in free practice or institutional work. (EAP, 2003)
3. Psychotherapy is a psychological treatment for a range of psychological, emotional and relationship problems. Psychotherapists usually have a first degree followed by a professional highly specialised theoretical and clinical training which includes research methodology and continuous professional development.

EAP has representation in 41 different European countries. Unfortunately, nearly every country treats the profession and practice of psychotherapy differently. Austria, Malta and the UK have the widest acceptance of the multiplicity of different psychotherapy modalities; Hungary recognises 19 different psychotherapeutic methods. Some European countries restrict the practice of psychotherapy to just four or five different methods (usually Psychodynamic, Systemic, CBT, and Gestalt) – see the EAP's 'Legal Position of Psychotherapy in Europe' [3].

The ESCO definition of 'psychotherapist' includes:

> neuro-linguistic psychotherapist; geriatric psychotherapist; psychotherapy practitioner; person-centred psychotherapist; humanistic psychotherapist; youth psychotherapist; systemic therapist; body psychotherapist; hypno-psychotherapist; group psychotherapist; existential psychotherapist; reality therapy psychotherapist; transactional analytic psychotherapist; cognitive behavioural therapist; specialist psychotherapist; person-centred psychotherapist; integrative psychotherapist; positive psychotherapist; transpersonal psychotherapist; gestalt psychotherapist; psychodynamic psychotherapist; psychoanalytical psychotherapist; multi-modal psychotherapist; child psychotherapist; psychotherapy expert; practitioner of psychotherapy; expert psychotherapist; expert in psychotherapy; psychodrama psychotherapist.

In the various European countries that have passed laws to regulate psychotherapy, these laws tend to be restrictive and there have been a few successful legal challenges where European law has 'trumped' the national law. [4]

3. www.europsyche.org/portals/0/media/docs/Legal-Position-of-Psychotherapy-in-Europe-2021-Final.pdf
4. viz: **The Lanthaler Case**: Heinrich Lanthaler trained and registered as a psychotherapist in Austria and was awarded the ECP there. In 2002, he moved to Italy and applied for registration as a psychotherapist. Psychotherapy in Italy is only provided – according to law – by psychiatrists and psychologists. Psychotherapy is

After all, laws are just words on paper until they have been tried and tested in the courts (either upheld or dismissed). Similarly, new medical treatments are just possibilities until they have been properly researched and verified as safe.

So, my first point is that psychotherapy is **not** a medical treatment. A medical treatment is defined as the care provided by healthcare professionals to help, improve, cure, or relieve illness, injury, and/or disease through various procedures, therapeutic measures, and medications. It encompasses the diagnosis, management, and treatment of a patient's condition. Additionally, it involves the management and care of a patient aimed at combating diseases or conditions.

The closest that psychotherapy comes to such a 'treatment' is (perhaps) Cognitive Behavioral Therapy (CBT) and its various spin-offs. I contend here that CBT is not a 'proper' psychotherapy. It may well be therapeutic, but it does not engage with the person's psyche. CBT also does not see itself as a psychotherapy. No CBT association has joined either psychology or psychotherapy professional associations in Europe. It maintains that it is 'scientific' because it uses randomised controlled trials (RCT); but these are totally unsuitable to assess the efficacy of a psychotherapy as there are too many variables, and CBT does not really concern itself with the psychotherapeutic relationship, which is traditionally seen as the most significant factor in the efficacy of a psychotherapy.

We therefore need to create a 'divorce' or 'clearer divide' or separation between psychotherapy and medical treatments, in the same way that medicine has divorced itself from "barber surgeons" and 'quack' doctors selling their own potions. This divorce will happen sometime: at least in Europe, given the strength of the European Union and its major principle of the free movement of labour.[5]

Within the EU, there is a 'directive' establishing automatic recognition of qualifications for doctors, nurses, midwives, dentists, pharmacists, veterinary surgeons (which covers most of the medical professions) and also architects. Other professions are regulated by a Common Training Framework (CTF), which is a common set of minimum knowledge, skills and competences needed to practice a specific profession in participating EU countries.

Psychotherapy – as a profession – has been trying to get the European Certificate of Psychotherapy (ECP) recognised as being part of a CTF, or for there to be a specific Psychotherapy Act. The EAP is also ensuring that the training courses for the ECP has reached EQF-7 (i.e. at Masters' degree level).

The 'profession' of mental health, both for adults and children, is becoming much better

regulated by the Ministry of Justice and registers are maintained by national and regional chambers of Italian psychologists. Lanthaler's application was initially refused and he decided to take his case to the courts. In 2008, after six years and numerous court verdicts in his favour, Lanthaler made legal history. The Italian government was forced to amend their national law that (technically) contravened European legislation and the chambers of Italian psychologists were told to register Lanthaler as a psychotherapist in Italy. Two more psychotherapists have since followed Lanthaler's lead and achieved registration in Italy. The success in Italy has been replicated in Germany. In September 2010, another registered psychotherapist and holder of the ECP from Austria was accepted onto the notoriously restrictive German psychotherapy register to practice psychotherapy in Berlin. (Warnecke, *The Psychotherapist*)

5. The free movement of workers is a fundamental principle of the European Union that allows nationals of any EU member state to work in another member state under the same conditions as the nationals of that member state. This principle ensures that EU citizens have the right to accept job offers and to move freely within any EU country for working and living.

defined and established. It includes psychiatrists (specialised medical doctors), psychologists (who conduct assessments and therapy, psychotherapists and counsellors (who provide talk therapies), clinical social workers, marriage & family therapists, psychiatric and community nurses, occupational therapists, specialist art, music & drama therapists and peer support workers.

My second main point is that psychotherapy is much more of a (soft-revolutionary) psycho-social exploration than a medical treatment. What I mean by this is that – in the main – we are not 'treating' any illness or disease, but we are helping people overcome life difficulties, coping better with their reactions (anxiety, depression, OCD and various eating disorders, etc.), so as to lead better, happier lives.

Psychotherapy nowadays is typically thought of as a loosely structured verbal interaction between a therapist and client, an interaction modelled on the doctor-patient / lawyer-client relationship. The somewhat pervasive early 20th century cultural influence of Freud and psychoanalysis, with the all-knowing analyst interpreting the patient patient's thoughts has changed quite radically. Since then, psychotherapy has encompassed a more diverse array of techniques, dynamics, delivery configurations, and goals. As a general label, it can cover almost any psychological procedure addressing an individual's or a group's self-understanding or well-being and it employs a wide range of discursive strategies and instrumental techniques – including conversation, discourse, interpretation, suggestion, injunction, exposure, assessment, discussion, examination, advice, reassurance, psycho-education and practice [6].

Since World War 2, nearly all societies have metamorphosed into something radically different than before and thus psychotherapy has gone through something of a social revolution that addresses the emotional and psychological well-being of individuals. It has evolved from a marginal treatment option into a central modality in contemporary Western social and mental health services. The evolution of psychotherapy reflects humanity's growing understanding of what contributes to mental health and well-being, with innovative therapeutic techniques and research-based interventions making mental health care more personalized, inclusive and efficient. The future of psychotherapy looks promising, offering hope and healing to millions worldwide. By embracing these innovations, mental health professionals can provide better support, and individuals can access more tailored, effective, and stigma-free therapy solutions. As technology, neuroscience, and holistic approaches continue to shape modern psychotherapy, the future of mental health care looks promising, offering hope and healing to millions worldwide.

The common thread running through this process is (a) increasing specificity of the psychotherapeutic interventions, (b) increasing evidence of efficacy and safety, (c) increasing integrity and reliability in the delivery of any intervention, (d) gradually increasing equality of access, and (e) recognition of the need for regulation to provide protection for the public from unsafe or ineffective practices.

Pharmacological treatments for people with mental health difficulties do not provide any proper solutions: essentially, they just treat

6. Buchanan, R. D., & Haslam, N. (2019). The Development of Psychotherapy in the Modern Era. In: R. J. Sternberg & W. E. Pickren (Eds,), *The Cambridge Handbook of the Intellectual History of Psychology*, (pp. 468-494). Cambridge University Press.

the symptoms. So, it is now easier for someone with a difficult mental health issue to manage their condition – at least for a time, but the problems and the underlying source of the problem are not being addressed properly. Big Pharma does not provide a cure!

So, times are changing rapidly, and therefore psychotherapy is having to evolve. Since the various wars in the 20th and 21st century, there has been a growing recognition of the impacts of trauma and the development of trauma-informed psychotherapeutic approaches from people such as Bessel van der Kolk, Pat Ogden, Judith Herman and Gabor Mate.

The last 30 years we have also seen a growing interest in the integration of Eastern and Western approaches to psychotherapy, particularly the influence of Buddhist psychology, mindfulness and meditational practices.

Additionally, the 1990s and 2000s saw the continued growth and diversification of the field of psychotherapy, with the emergence of new modalities and the integration of psychotherapy with other disciplines, such as neuroscience and evolutionary psychology and the use of psychedelics. The rise of evidence-based practice and the emphasis on accountability and cost-effectiveness in healthcare have also had a significant impact on the field, leading to a growing focus on the development and validation of standardized treatment protocols and outcome measures. At the same time, there has also been a growing recognition of the importance of cultural competence and awareness and the need to adapt psychotherapy to the unique needs and experiences of diverse populations, including racial and ethnic minorities, LGBTQ+ individuals, and individuals with disabilities. Much psychotherapeutic work is now being done 'in the field' with refugees and displaced persons (be it from war and insurrection, or from earthquake, drought, fires, famine and floods, etc.). There is also a growing realisation that psychotherapy needs to de-colonialise itself.

There are many ongoing challenges and opportunities in the continuing evolution of psychotherapy, in response to changing social, cultural, and technological landscapes. In the last few years, we have seen the impact of technology and social media on the delivery and practice of psychotherapy. We have also seen political and economic (but largely ineffectual) attempts to get people back into work with the UK's 2018 'Improving Access to Psychological Therapies'.[7]

As psychotherapy continues to evolve in this 21st century, one major challenge is the need to address a growing mental health crisis, particularly in the wake of the COVID-19 pandemic and other global stressors (like armed terrorism, political insurrection, large industrial accidents, global warning and extreme weather events). This requires the development of new and innovative approaches to prevention, early intervention, and treatment, as well as a greater focus on social determinants of mental health, such as poverty, discrimination, and inequality. In this context, psychotherapy becomes more revolutionary – politically and socially.

Nowadays, as well as the multiplicity (about 500) of identified psychotherapy modalities, one can identify six main 'forces' (or mainstreams) within psychotherapy: (i) psychoanalytic; (ii) behavioural; (iii) humanistic-existential; (iv) a mixture of several significant theoretical paradigms (i.e., transpersonal psychology, family systems, feminist psychology, multicultural psychology, ecopsychology,

7. www.iptuk.net/uploads/1/2/9/0/12909346/iapt_manual.pdf

social constructivism and postmodernism); (v) social justice and advocacy, and finally (vi) an integrative, inclusive and holistic conceptualisation of psychotherapy. *"These evolutionary milestones of the field demonstrate an expanding process that has become increasingly more integrative; a more comprehensive, systemic, and holistic approach is needed to better address diverse individual, community, and global needs."*. (Fleuridas & Krafcik, 2019)[8]

As the world becomes more populated, psychotherapy also needs to adapt to the unique needs and experiences of all the diverse populations around the world, taking into account cultural, linguistic, political and socio-economic factors. At the same time, ongoing advances in neuroscience, technology, and other fields offer exciting opportunities for expanding our understanding of the mind and developing more targeted and effective interventions (though we must treat the development of Artificial Intelligence (AI) with considerable caution)[9]. As the field of psychotherapy continues to grow and evolve, it will become increasingly important to balance innovations with rigorous research, ethical practice and a general commitment to the wellbeing of individuals and communities.[10]

Thus, I maintain that psychotherapy is moving away from the 'medical model' and is also becoming more of a (soft-revolutionary) psycho-social exploration.

Author

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Why Positivism in the Form of the Quantitative Paradigm May Dominate & Prevail and Its Impact on Psychotherapies, Psychotherapists & Clients

Susanne Vosmer

Abstract: Practitioner-researchers are often asked to provide evidence for the effectiveness of psychotherapies. Psychotherapists in Britain are also expected to carry out research. So, they should know the philosophical underpinnings of research. Positivism remains dominant in the form of the quantitative paradigm, because it is used to demonstrate the effectiveness of psychotherapies. Only proven effective treatments are recommended and funded. Thus, positivism affects both psychotherapists and their clients.

Its dominance is puzzling, considering its many flaws. By illuminating positivism through historical, psychoanalytic, and group analytic lenses, possible reasons for its influence are discussed, including its function as unconscious social defence, positive transference object, and defence against death anxiety, and existential fears. Bionian basic assumptions, the colonisation of societies, secularisation, and modernity may have fostered its rise. Some psychotherapist-researchers may have a valency for positivism. Socially unconscious processes may prevent sufficient problematisation of its flaws and recognition of the economic benefits of group treatment.

Key Words: psychotherapy research, Positivism, Quantitative Paradigm, unconscious, clients

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Introduction

In Britain, many services expect psychotherapists to engage in research activities and to be familiar with a range of methodologies (Vossler & Moller, 2015). This necessitates psychotherapists having some knowledge of philosophy, because methodologies are based on philosophical underpinnings. The National Institute for Health and Care Excellence (NICE) uses the pyramid model of evidence, which prioritises meta-analyses, systemic reviews, randomised controlled trials (RTCs) (Murad *et al.*, 2016), as well as manualised treatments. Practitioner-researchers are often expected to provide quantitative evidence for the efficacy/effectiveness of the psychotherapies they use. NICE [1] emphasises value for money, ensures that 'best-practice' is followed, and offers guidance on what kind of treatment should be offered. Based on research evidence, Cognitive Behavioural Therapy is frequently recommended. Furthermore, in the NHS England's (2024) psychological therapies programme for severe mental health problems, individual CBT features prominently. Many robust quantitative CBT studies have been conducted.

Articulated by Auguste Comte (1853/1988) in the early 19th century, positivism holds that knowledge is derived by logic from sensory experience. Positivists claimed that our social world operates according to the same general laws as the physical world. When used in literature, the term 'positivism' often encompasses the meta-perspectives of logical positivism and logical empiricism. Additionally, positivism was a commitment to the evolution of sociality and an articulated philosophical tradition of logical positivism, situated within epistemology. It also denotes scientific research practices, and psychotherapists-researchers commonly mean this, when referring to positivism (Riley, 2007). 'Positivism' is used as an umbrella term, which includes all variants of positivism.

Positivism underpins quantitative methodologies. Emphasising objectivism, observation, deductive logic, experimentation and statistics are the pillars of the positivist quantitative paradigm (Park *et al.*, 2020). A paradigm is a particular set of accepted assumptions and theories among the scientific community, which explains a phenomenon (Kuhn, 1962). Historically, one paradox following the Enlightenment was that rationality destroyed itself by becoming completely irrational during the period of National Socialism in Europe (1933-1945). How could supposedly rational people otherwise kill each other? There is no rational explanation. Thus, Descartes' (2016/1644) conclusion that we are rational, and Kant's (1998/1781) suggestion that there is a moral law within us (p. 1), does not hold true for the human species. One might even say that the rise of logical positivism was an intellectual consequence of rationalism (Riley, 2013, p. 50).

As such, positivism is a puzzling phenomenon that lingers on, directly impacting on psychotherapies and clients. The reasons for its dominance are unclear. Not everybody may be aware of its impact or problematise this. One needs to illuminate the unconscious dynamics surrounding positivism so as to explain its dominance and why it still prevails. Disentangling unconscious factors and processes that permeate positivism is necessary for two reasons.

Firstly, since the task and objective of research involve the production of new knowledge, and knowledge means power, a dominant approach

1. www.nice.org.uk/

can sway researchers in psychotherapy to carry out only quantitative studies. This could reduce the prevalence of qualitative studies. Psychotherapies that are not quantitatively researched and effective are usually not recommended, and thus clients may opt only for receiving provenly effective treatment.

Secondly, philosophical schools of science, such as positivism, are social forces and embedded in society. When the focus of evidence production is mainly confined to quantitative studies, manualised treatments will dominate because they are more easily measured than in other (psychoanalytical, group analytic, existential, and humanistic) approaches. Clients have fewer choices and may lose out when particular types of psychotherapy prevail to the exclusion of others. Illuminating why positivism may be so powerful, is, therefore, relevant for psychotherapists and clients.

When viewing it through a historical, group analytic, and psychoanalytic lenses, positivism is described, as situated it within historical contexts, and then its dominance can be explained by explicating possible unconscious processes. This article also draws on the social unconscious, as defined by Dalal (2001) as the representation of social forces and power relations in the psyche, when analysing unconscious processes.

Situating Positivism Within Historical Contexts

According to the New World Encyclopaedia (2022), positivism is part of a family of philosophies that evaluates science extremely positively. Early versions believed that scientific methods could reform philosophy and society. Positivism emerged in Austria and Germany as a philosophy of science in the form of logical positivism during the 1920s (Rubinstein, 2005). Historically, we find a strong connection between physics and philosophy. Physicists (e.g., Schlick, Reichenbach) were interested in philosophy. Unsurprisingly, logical positivism then prioritised sensory modalities, mathematics, logic, observation, verification, measurement of experience, and establishing causal laws (see Popper, 1934, 1962). Logical positivists rejected idealism & rationalism. For them, only phenomenal perception was important. Anything else that could lead to any transcendental experiences was judged irrelevant. People relied on direct perception and were able to determine whether a particular perception (or proposition) was accurate. This type of thinking formed the structure of logical positivism. In conceptualising the human mind as a black box that mediates between perceptual stimulus and response, behaviourists eagerly adopted positivism (Gabriel, 2023).

After Hitler became the German Chancellor in 1933, many Jewish intellectuals sought refuge abroad. One could speculate that Nazism inadvertently led to the spread of positivism. When Reichenbach moved to the USA to escape Nazism, he brought positivism to America, founding an intellectual circle in Los Angeles (Eberhard, 2021). Together with Carnap, he edited the *Journal Insight*. His students Putnam, Salmon, and Grünbaum refined empirical methodologies. Grünbaum (1984) severely criticised psychoanalysis. Their Editorial boards were largely comprised of logical/empirical positivists, enabling the spreading of certain perspectives only. Unsurprisingly, positivism thrived.

Advanced by Reichenbach as logical empiricism, the doctrine of logical positivism postulated that there had to be an unambiguous relation between scientific language and its sense-data referents (Gigerenzer, 2000). Carnap (1958) insisted that people were enslaved by metaphysical ways of thinking. Thus, he advocated for the use of scientific methods and a scientific articulation of philosophy. When

Popper (1934) showed that logical positivists had failed to satisfy their own verification principle, they had a problem. Science must be falsifiable, Popper (1962) insisted. This created a further problem for empirical positivists. Even when one accepts that any theory must be always fallible in principle, how could they claim that they were providing true accounts of the social world? Positivism is predicated on the Correspondence Theory of Truth, which states that 'd' is only true, if 'd' is consistent with reality. Truth corresponds with an objective reality (Mondal, 2023). It also assumes the existence of *the* truth. If theories are potentially fallible, then they can never express an absolute truth. So, the basis of empirical positivism crumbles. Nevertheless, positivism is a dominant philosophy, which lives on in the quantitative paradigm.

Research rests on philosophical assumptions and researchers must make these explicit. All variants of positivism prioritise epistemology, the study of knowledge (Vasilachis de Gialdino, 2009). The scientific overcoming of metaphysics and eclipse of ontology under the logical positivists has led to an emphasis on epistemology *per se* (Horkheimer, 2004). Metaphysics is that branch of philosophy, which attempts to establish the structure of reality which underlies the totally of being (Horkheimer, 1999), and ontology tries to explain reality (Varzi, 2011).

While empiricists aim to also show what lies underneath sensory experience, they still regard data derived from the senses as the source and endpoint of all knowledge, and they do use established frameworks through which sensory experiences are interpreted (Allmark & Machaczek, 2018).

Many favour robust evidence and randomised controlled trials (RCTs). Whereas in Britain RCTs are more common in clinical psychology and CBT (Dalal, 2018), psychodynamic and group analytic psychotherapists/researchers have also started to focus on providing quantitative evidence for the clinical effectiveness of their approaches. Others, such as Dalal (2015, 2023), are vocal opponents of the quantitative paradigm, arguing that group analysis and psychoanalysis are more akin to hermeneutics (theory of interpretation). They seem to dismiss that Freud aspired to be positivist and that group analysis has elements of positivism (Vosmer, 2021).

Dalal (2018) highlighted that a positivist conception of science lingers on, despite exposure of its flaws. To counter criticism, post-positivism (Popper, 1934, 1962) embraced the notion of fallibility, so theory ought to change, if the data do not support it. Furthermore, Bayesian statistics calculates probability.

Statistical techniques enable researchers to predict and manipulate variables. Flaws of statistical analyses were pointed out by the psychotherapist Dalal (2015, 2023), who claimed that positivist methods cannot capture the intricacies of human exchange (Dalal, 2023).

Notwithstanding these criticisms, postitivism still dominates psychology and CBT, mainly in the form of operationalism (Dalal, 2018). In Britain, positivism and its legacy influence how many policy makers, psychotherapists and clients think about evidence; the line that has been drawn between the sciences and the humanities, what norms researchers should follow, what a good explanation should look like (Rutzou & Steinmetz, 2018), and what type of evidence is acceptable for NICE. Other countries also adopt the hierarchy of evidence and most health insurances, or public providers of mental health care, only fund evidence-based psychotherapies. This means that positivism directly impacts on psychotherapies. Considering its many flaws, its dominance is puzzling, indicating that unconscious factors may play a role.

Unconscious Factors & Processes

According to Gadamer (1979), once the sciences had developed, positivism claimed to be the only valid approach for examining reality. It was done in a manner that the metaphysical tradition of 2000 years was suddenly deprived of its own legitimacy (p. 79). One explanation for this phenomenon could be the colonisation of societies, which needed to be civilised through science. Colonialism is linked to secularisation, which emerged in the 1850s, Wilson (2017) explained. Originating in a Euro-American context and associated with binary oppositions (modern/primitive, Western/non-Western, reason/emotion, or secular/religious) and colonialism (Ibid.), secularism could be viewed as an ideology. It has a distinct philosophy, which is associated with reason, rationality, and science. The emphasis on science and rejection of religion overlap with positivism. Secularisation, which was first articulated by George Holyoake (Ibid.), arose two decades after Comte's (1988/1853) *Introduction to Positive Philosophy*, which expresses Conte's scientific and religious ideas.

Some scholars (e.g., Mahmood, 2016) argued that secularisation represented a total shift in how the Self, morality, ethics, space and time were viewed, resulting in specific practices that are expressed through class, gender, or religion (Asad, 2002). Furthermore, as an ideology, secularisation makes normative assumptions about the value of the secular. Both the supernatural and religion are devalued.

Existentialism and fear related to existence might explain why German philosophers in the 20th century felt the need to equate philosophy with science. Placing so much emphasis on science is also linked to 'objectivity'. However, what this term means is by no means shared by all philosophers. Interestingly, Heidegger thought that in Western civilisation objectivity was based on an understanding of Being (Sein) as presence (Gadamer, 1979). Since death is an inherent part of Being, it is possible that intellectuals repressed death anxiety, which was relegated to the social unconscious.

Prior to Enlightenment, the supernatural was a means to deal with death anxiety, Vosmer (2022) noted. Beliefs about the immortality of the spirits protected individuals from the transient nature of their existence. Religion may fulfil a similar function. By believing in an afterlife, death loses its scary quality (Ibid.). However, positivism and modernity have challenged these metaphysical beliefs. Due to secularisation, the supernatural and religion no longer fitted into the modern world, which emphasises rationality and technological developments. Variants of positivism can also be linked to modernity.

For Nietzsche (1884/2019), the essence of modernity was the death of God. Indeed, how could one empirically prove the existence of God and so satisfy scientific desires, and fulfil Popper's (1962) falsification principle that distinguishes science from pseudoscience? Hence, God had to be relinquished. This is also in line with Giddens (1990). He viewed modernity as a way of social life that is characterised by scientific advances. Since science did not integrate spirits and faith, metaphysical beliefs had to be discarded (see Vosmer, 2022).

So, positivists' emphasis on science could be linked to secularisation, modernity, and fear of death. We must remember that historically, logical positivism/empiricism is situated within the bloody events of the two World Wars. Annihilation anxiety in society and within groupings of philosophers had to be managed somehow. Psychological defences were employed to deal with existential fears. Defence mechanisms are also prevalent in groups. If we conceptualise the positivist movement as large groups, then Bion's (1961)

theory of basic assumptions (group defences) can be applied.

Groups defend against anxiety by oscillating between three basic assumptions: In pairing and dependency, groups unconsciously select a pair or search for a leader, who will save them. They engage in aggression or avoidance in the basic assumption 'fight/flight'. Basic assumptions interfere with making rational decisions. In the midst of fascism, war and trauma, all basic assumptions need to be identifiable. However, politico-economic circumstances probably brought 'dependency' to the fore. This could explain why each logical positivist circle in Vienna and Berlin had so many followers.

Alternatively in traumatised societies, massification or aggregation occur (Hopper, 1997). People feel compelled to act due to group dynamics that they are unaware of. Freud (1921), Hopper (2003), and Volkan (2004) showed that groups affect the emotions and behaviour of individuals. The positivist movement might have served the unconscious societal function of fending off death anxiety, which passes through the generations as transgenerational haunting (Rose, 2020). Importantly, since death anxiety had no place in science, it was repressed, disavowed, denied or projected into other groups. This would explain the need for developing a scientific positivism. Its rise and dominance could be viewed as a wider societal defence. Even the originally chosen word 'positivism', which was never replaced, signifies a denial of the bloody reality of life. For positivists and proponents, who subscribed to their ideas, identification with the logic of science might be necessary to defend against death anxiety.

Historically, logical positivism/empiricism and the Philosophy of Science developed during economic hardship, political instability, the rise of fascism, and the two World Wars. Defence mechanisms (disavowal, repression, splitting, projection, projective identification, denial, intellectualisation) may have protected philosophers from anxiety and the experiencing of psychic pain. Ironically, splitting may have prevented logical/empirical positivists from fully appraising their own conceptualisations and assumptions. Instead, positivism could have become an idealised part-object, conceptualised by Foulkes' (1964) as the projective level of communication, the domain of part-object relations. It is characterised by splitting, seeing a person/thing only as bad or only as good. In Kleinian theory, splitting belongs to the paranoid-schizoid phase (1988/1946). The psychoanalyst Melanie Klein formulated the sequential 'paranoid-schizoid' (P-S) and 'depressive' developmental phases (Klein, 1988/1940). While the P-S is mainly characterised by splitting, envy, and hate, in the more mature depressive phase, guilt, sadness, and mourning occur. People oscillate between the P-S and the depressive phase throughout life. But during periods of severe stress, they regress to the P-S position.

Many logical positivists, such as Carnap (1963), held the conviction that their cultures were incapable of developing measures to deal with politico-economic disasters (Pearson, 2018). This was one reason why they developed logical positivism. History proved them right with regard to such disasters, and Carnap's (1958) scepticism regarding the missing societal morality is warranted. After the Great Depression in 1928, fascism spread rapidly in Germany, partly due to high inflation and unemployment. However, they were wrong about other assertions. Carnap's insistence that people were enslaved by metaphysical, unscientific ways of thinking, including theology, indicates splitting. He failed to see that logical positivists and empiricists were equally enslaved by science. Unconscious dynamics were of no importance to positivists, so they would

not have considered that some of their thinking was biased. It is presumptuous to claim that all religious people or people of faith are enslaved.

Logical/empirical positivists might have also been caught up in a positive transference towards science, which could have resulted in an idealisation of science and positivism. Positive transference means that good relationships from early life are transferred onto present people/things/institutions. Psychotherapists, who vehemently argue against positivism, may have developed a negative transference towards it.

A positive transference can explain Morris' (1935) claim that any conception of philosophy, which does not rely on scientific methods should be rejected. Psychoanalytic and group analytic approaches postulate that individuals and groups are not logical or rational (see Hopper, 2003). The social unconscious enables an understanding of the paradox, which is an inherent aspect of logical empiricism/positivism itself. Notwithstanding that it is a philosophy of science, this discipline is peculiar, because it has justified its legitimacy through the existence of science. As Benjamin (1938) so poignantly noted, it does not make any sense to class itself as a separate discipline when it studies itself. The positivist philosophy of science is either reducible to a tautology (saying the same thing), or to an oxymoron (apparently contradictory terms appear in conjunction). Because its philosophical hypotheses explain science, which itself is a metaphysical hypothesis, and as such must lie beyond the realm of scientific philosophy (Ibid, p. 424).

Unless the term 'science' is loosely defined as the realm which makes something known by relying on descriptive methods, Benjamin (1938) argued, it is unjustified to call positivism the philosophy of science. This strong argument has not been problematised by proponents of positivism, suggesting the presence of socially unconscious forces (see Hopper, 2003). It should be noted that by combining philosophy and science, all variants of positivism are powerful by association.

An explication of the socially unconscious dimension of philosophy can explain another aspect of logical/empirical positivism, namely its neglect of ontology. This could be a defensive disavowal of structural oppression (Nazism). Ontology could have been relegated to the social unconscious, because reality was too painful. The emphasis on epistemology, logic, and empiricism could have been a denial of reality. Possibly, logical empiricism or positivism does not want to know its own history, because it is linked to war, (threat of) annihilation and involuntary migration. Many scholars and philosophers had to leave Germany due to Nazism and could have been just too traumatised to query why they ignored ontology.

Of course, this does not explain why many contemporary researchers are attracted to positivism and others vehemently reject it. Drawing on the psychoanalyst Bion (1962), it can be suggested that people, who have a valency for positivism, overlook or minimise its flaws. Valency refers to a person's preparedness to act on basic assumptions. A group is governed by primitive unconscious anxieties, which impede its capacity to function rationally. Basic assumptions are then unconsciously employed to defend against anxiety (Bion, 1961). Valency may also be described as resonance, where several people are in synchrony with each other. A high congruence of thinking and feeling between people exists during resonance (Hohenstein, 2017). Janis (1971) referred to this phenomenon as "Group-think". It is a mode of thinking we engage in when we are in a cohesive group, overriding our ability as an individual realistically to appraise our decisions.

Phenomenologists may not have had a valency for positivism, because they were opposed to it. This means that they could assess positivism more objectively. Writing about the crisis in modern sciences when Nazism was on the rise, Husserl (Husserliana, 1859-1938) criticised logical positivism for how it conceptualises the acquisition of knowledge. It necessitates the acceptance of a determinist hegemony of thinking (science). Philosophy lost its reflective core, Husserl argued (Coole, 2001).

Existential psychotherapists and qualitative researchers may agree with Husserl. When he started to formulate his criticism, fascism was rapidly spreading. One could say that socio-politico-economic dynamics had already corroded human rationality. Outlining the resulting disorientation and meaninglessness of cultural life, Husserl reclaimed phenomenology by eschewing dominant positivist ideas (Ibid.).

Nonetheless, positivism became so pervasive in the social sciences that it even dominated history (Riley, 2007). Possibly, because it was used as a social defence. Considering that logical empiricism/positivism was formed during times of severe economic hardship, there is an association between economic instability and positivism. Hence, one would expect the rise of positivism during economic crises, if employed as a social defence against existential (financial) fears. This could explain historical fluctuations of its dominance and decline.

By the 1960s, many philosophers identified themselves in opposition to logical positivism. It was a time when Western societies started to flourish economically. Peace became a preoccupation. Consequently, positivism was no longer needed to defend against annihilation anxiety. Psychologically speaking, as repression loosens, people no longer view the world through the paranoid-schizoid position, and more mature defences are employed, such as rationalisation. Many philosophers, psychotherapists, and researchers become acutely aware of the shortcomings of positivism. Consequently, its influence declines.

In the 1980s, a resurgence of positivism occurred (Steinmetz, 2005). The world economy was suffering and 1982 was a dismal year for many economies. Unemployment and inflation were high, and the world trade was collapsing (Green, 1983). Evidence-based practice emerged in the 1990s, which strengthened the dominance of the quantitative paradigm. The demand for clinical effectiveness has risen ever since. This paradigm continues to dominate psychotherapy research since the 2000s in North America, Britain, and other European countries.

Interestingly, faltering economies resulted in European and American recession during 2000-2001 (Kliesen, 2003), the global financial crisis from 2007 to 2008 (*Positive Money*, 2024), and high European inflation rates from 1997 to 2023 (McEvoy, 2024). Over the past two decades, we have also witnessed terrorist attacks, wars in the Middle East, the Ukraine and elsewhere, resulting in involuntary immigration to Europe.

An increased focus on evidence-based psychotherapies (e.g. NICE) supports my explanations. Positivism and the quantitative paradigm thrive, affecting the social sciences (Rutzou & Steinmetz, 2018), psychotherapies, clients, and researchers. Commonly, individual psychotherapies are recommended, although group approaches are more economical (Whittingham *et al.*, 2023). This is astonishing, considering that NICE and policy makers prioritise value for money. Tversky and Kahneman (1974) identified factors, which make people decide against their own economic interest, possibly, because the irrational social unconscious (Hopper, 2003) can seduce them into making unwise decisions.

Summary & Conclusion

Positivism and the quantitative paradigm have been described, because practitioners and researchers are commonly expected to carry out quantitative research. Several reasons for positivist's emergence, dominance, and prevalence were discussed, including the colonisation of societies and modernity. Variants of positivism may have emerged as an unconscious social defence against overwhelming trauma due to dire economic circumstances, fascism, and political unrest related to the two World Wars. Group defences, basic assumptions, may have prevailed. Positivism has something in common with secularisation. By dismissing metaphysics and ignoring ontology, the emphasis on science, empiricism, and epistemology may serve an unconscious function, distracting people from the bloody realities and death anxiety. Positivism's dominance has continued in the form of the quantitative paradigm. Both may also function as positive transference object and defence against existential fear. Some psychotherapists/researchers may have a valency for positivism. When no resonance occurs, they may reject it. Due to socially unconscious processes, flaws of the positivist quantitative paradigm and economic benefits of group approaches may not be sufficiently considered. Then, clients can lose out.

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Dealing with Trauma after the Turkey Earthquake: Personal experiences in training mental health professionals

Enver Çesko

Abstract: This is an account of a workshop presentation for mental health professionals from Istanbul after the massive earthquake in Turkey [1], February 2023. The main issue in this workshop was helping people to deal with a traumatic incident by using some integrative body psychotherapy techniques. This workshop was voluntary, free and unpaid: it was offered during five working days consisting of 10 hours daily. This workshop was initiated and organized by the Turkish Ministry of Education and Ministry of Family. Each of the Ministries selected the psychologists, pedagogues, social workers and other mental health professionals: in total, 350 participants, divided in five groups with 60-70 participants daily. The method used was basic theoretical information on how to deal with crises situations, pre-treatment interventions, and a body psychotherapy process treatment plan for dealing with trauma.

Key Words: Traumatic incident, trauma, earthquake, integrative body psychotherapy techniques

The needs of the article:

The inspiration for this article came immediately after the massive earthquake in the Hatay region of Turkey in February 2023. While delivering my regular Body Psychotherapy training workshops in Istanbul, I witnessed an emergency situation involving homeless and injured people in

1. In 2022, the Republic of Turkey changed its official name to the Republic of Türkiye.

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need of psychological support due to the consequences of the earthquake. The organizer of the workshop requested that the Turkish Ministry of Education and Family offer a five-day intensive workshop on how to respond to emergency situations. I gladly accepted this initiative and immediately began preparing the workshop content. First, I had a short meeting with a group of professionals in psychology, psychiatry, and psychotherapy to design basic information and practical tools for providing psychosocial support to people affected by the earthquake.

The main approach was to work with the body and integrate the mind, feelings, and spirituality to cope with the traumatic incident. The main goal was to create a safe, supportive environment for all workshop participants, helping them relax and find calm. The participants asked for specific tools to deal with this kind of emergency. However, the purpose was first to provide specific techniques to help participants protect themselves and offer more suitable assistance for dealing with traumatic memories. During the workshop, participants used all the exercises for themselves first to understand how to apply them with their clients.

After the five-day workshop ended, I received many requests from participants, organizers, and authorities from different NGOs and associations to write an article about my experiences at the workshop and how it could benefit the entire professional community.

Introduction about the trauma sources

In the last forty years, the world has been involved in many economic and social crises, political wars, and natural disasters, with thousands of people dead, and hundreds of thousands of people injured, probably millions of buildings have been destroyed, and almost 20–22% of population are traumatized (Wentzel *et al.*, 2009). People in middle age, who have witnessed and suffered in these times, are now a bit more resilient to trauma from the new crises and atrocities, but the new generation, who are experiencing these sorts of crises for first time, are developing the consequences of trauma more readily. For example, the estimated prevalence of PTSD symptoms in Albanian women at the end of the Kosovo conflict in 1999 was 20% and grew to 22.7% in 2005 (Wentzel *et al.*, 2009).

It is possible that such women, who already have had PTSD symptoms from years ago, might re-experience their trauma and may also show biological changes from transgenerational trauma. Identifying the biological processes whereby the negative effects of trauma are passed across generations and defining groups at high risk is a key step to breaking the intergenerational transmission of the effects of mental disorders. (Hjort *et al.*, 2012).

But some other research findings have shown different consequences from PTSD, especially after natural catastrophes such as earthquakes (Laor *et al.*, 2002) and consequences were also found in their children and adolescents (Bal & Jensen, 2007). Long-term consequences have also been seen in survivors, who have had limb pains, or amputation of some body parts. The common conclusion from these research findings was that the psychopathology of dominant symptoms are post-traumatic dissociation, lost and grief, which can be followed with anxiety and depression (Bal & Jensen, 2007).

Listening to all the stories of survivors from the earthquake in Turkey disaster, they were

mostly expressing the loss of shelter, family members, relatives, and jobs. Their social circles, including their daily activities, were completely destroyed, and feelings of hopelessness were strongly dominant. These were directly affected by the current rising uncertainty, stress, anxiety and depression, given the complete devastation that they faced. Many of them were now struggling with the consequences of trauma with new triggers, repressed memories, hyperarousal, flashbacks, ruined relationships, sleep difficulties, mood disorders and psychological problems. All these reactions can rise within the main symptoms of PTSD, such as anxiety, psychosomatic complains, psychotic reactions with hopelessness and depression symptoms.

Helping people to face their trauma and helping them to find hope, is very motivational and eye- and mind-opening, giving an incentive to build and develop knowledge more and more. It was also possible to share experiences of attending many international conferences and training institutes worldwide.

As a result of these, it becomes clearer that trauma does not derive from a disease, nor from a disorder; but it can lead to consequences of many diseases and disorders. Simply, trauma develops after an incident, caused by an atrocity in nature, or it has happened as a result of the actions of other human beings: however, trauma is always processed in the human body. And the human body is always "keeping the score" (van der Kolk, 2019) by triggering neuroplasticity in the brain functions, so as to register all the memories from the traumatic incident (Porges, 2009).

Trauma can thus be described as a source of an accidental event that manifests itself with neuro-biological changes in the human body. All these manifestations have impacted on the homeostatic state in the body and resulted in a destabilization with a dozen different outcomes. Trauma is not what we have experienced, but is our reaction to it, happening inside of our body. Our feelings can be seen as a kind of roadmap, letting us know what is right or wrong, good or bad for us, or whether we are loving ourselves or abandoning ourselves. Our nervous system is forced to play an active role, influencing changes in our emotions, cognitions, behaviours and neurobiology. Psychologically, people who have had traumatic experiences, mostly suffer from grief and loss. During these processes of mourning, anxiety and depressive moods are often present, which may continue for years, or over a long life, because they have lost a limb and are trying to adjust to their new 'normal' way of life. So, the *deep understanding of trauma is rooted in the dynamic process of conflict, which means that trauma is also a psycho-mental conflict between the perpetrator and the victim.* Trauma happens because the perpetrator (or the traumatic event) attacks the victim either fulfilling the interests and desires of the perpetrator, or just as a consequence of the event, without having any of consideration of the resulting damage, disaster, chaos or disappearances and killings. Trauma is thus also a psycho-mental conflict, which is happening in the cortex and is influencing in the limbic system, and empowering the sensory-motoric part of the brain for action.

In natural disasters, as is the case with earthquakes, many people who have experienced a sudden and surprising catastrophic situation, find their traumatic behaviors have largely been induced as a result. People react to such a traumatic situation by copying other's behaviours in a collective way and that is why this form of trauma is called "collective trauma".

If the traumatic incident is repeated in a different context and time, the prefrontal cortex activates the hypothalamus and amygdala that prepares the body how to deal with that situation. By the time that this traumatic inci-

dent has accumulated in the brain's memory, it takes a long time to be released, and all this can be remembered in the body (Rothschild, 2000). This process causes post-traumatic stress disorders with lots of consequences and symptoms. So, post-traumatic stress disorders arise after exposure to a traumatic event, which manifests with various clusters of symptoms, focusing the time, place, and kind of disaster (nature or human being).

In this instance, 'time', refers to the child and adolescent period where mostly sexual abuses happened; 'place' refers to the content and environment where a traumatic event has happened, and the 'kind' of traumatic event refers to the subject that caused the traumatic incident. According to this interpretation, the phenomenon today is called Complex-Post-Traumatic Stress-Disorders (CPTSD). Now, there is a consensus of sorts about CPTSD that acknowledges the wide range of psychological consequences that can follow from the above types of traumas. This is recognized by the inclusion of CPTSD in the International Classification of Diseases, 11th Revision (ICD-11), which is based on some studies that identified a broader set of difficulties than those typically seen in PTSD alone (Marylene *et al.*, 2014).

The Concept and Methodology of the Workshop

The main concept of this workshop was to give basic information on dealing with traumatic incidents as a form of first aid and to stabilize the participants' neuro-vegetative systems through encouraging their parasympathetic nervous systems to take over from their sympathetic systems.

There was a lot of complex trauma, beside that from the actual traumatic incident, and that is why time had to be spent in contact with, and having psychotherapeutic sessions with, individuals and small groups of mental health professionals to explain and give a short basic information about different kind of traumas.

As there are in Turkey, many different kinds of professional associations with different modality-based approaches, there was interest from the organizers in a unique approach, which is not very well-known: this was the body psychotherapy approach.

After an initial acceptance, there was a question: how it is possible to use some of the methodological aspects in dealing with traumatic stress symptoms. In the beginning of this presentation, it was highlighted that these techniques that were going to be presented and demonstrated, are only in the phase of stabilizing the current situation of victims, which are not the same as in a longer-term treatment process.

Theoretical Part of the Workshop Presentation

In this current situation, which is called "emergency aid", it is good to present the steps of treatment process dealing with traumatized victims. These steps are as follow:

1. **Knowing Oneself** (*Who am I and what are my strengths, even after this traumatic event?*)
2. **Re-enacting the Event (Desensitization)** once the victim is in a safe area, *as we want him to talk about the deepest details.*
3. **Focussing on the body** (*What kind of reactions does the body give? How does it evaluate them? By talking to our body, we realize what our body needs right now.*)
4. **Focussing on emotions** (*What are we feeling? What kind of meaning do we give to the emotions we feel? What do we need our*

emotions to look like? Please try to show the here and now.)

5. **Trying to express all the thoughts in one's mind** (*If there are wrong, bad, worried, frightening, etc., don't hesitate, please speak up; like "No one can criticize or blame you".*)
6. **Traumatic Box**: *You should put the traumatic event you have experienced in a memory box. This event is something that has happened outside of us. No one can be criticized or blamed. In this case, our experiences are enriched, and we emerge from the incident from which we learned lessons by strengthening ourselves. As we get stronger, we transform and develop and continue on a new life path as healthy and mature.*
7. **Re-encountering traumatic events**: *Helping ourselves first and then others from our own experience.*

The presentation was continued with basic concepts from a body psychotherapy approach that are useful in stabilizing the acute traumatic stress situation, such as breathing, safety place, movement, and replacement. The function of body, mind and feelings was then explained and how all these three domains in the Autonomic Nervous System (ANS) are processing a traumatic event by activating a mechanism with four main responses, when the victims are witness of trauma. These four responses are Fight, Flight, Freeze and Fawn.

We all know that some people in traumatic incident try to survive by using their existing actual capacities to fight or cover up feelings with aggressive or passive-aggressive behaviour, usually by punishing, blaming, or justifying with human factors rather than with natural ferocity. And the role of the therapist is on how to maintain the relationship, so that the situation remains in control. Then the victim is more able to be in the present and to be aware of fulfilling their basic needs by having their feelings which are in a safe place now.

Very often, when a victim is trying to survive, for a while he/she is not aware about him/herself. He/she tries to avoid the actual trauma through distraction or/and denying it. Usually, he/she utilises flight in these kinds of situation. Victims are trying to focus on their surviving that is good they are alive by minimizing the whole situation, even they feel sadness, sorry or shame for the others that didn't survive. But after a while, they are closed down into their inner world by exposing a lot of traumatic symptoms in their body and in whole neuro system. Very soon, they might develop difficulties in somatic, cognitive, emotional, and behavioural aspects.

Some of the victims' immediate reaction was that their body went into a freeze state. Thus, they could not understand what had happened and why the person had survived. For a moment, they had escaped from their reality (through fantasy or imagination) by putting off dealing with the traumatic situation using the seclusion, distraction, or in the short term, excessive sleep. Often victims had not expressed their emotions and feelings because they already in cognitive function "checked out" in difficult moment. Part of this is an avoidant pattern, as well as being a motoric shut-down.

Some of the victims were excessively passive with flat emotions, trying to pacify the source of feelings about the traumatic incident, suppressing their true feelings in trying to rationalize the inner conflicts between body, mind and feelings. They were trying to demonstrate to themselves that it is good that they survived, and now everything will be okay, and they can do things that even a therapist were suggesting that it is to not a good idea to do right now. Somehow, they are trying to hide their true feelings to avoid any possible symp-

toms or – later on – also some dysfunctions. They are not fully aware of themselves and do not understand how to put some boundaries on their primary needs.

Almost all psychotherapy approaches, the so-called "talking method" have a central spot where the process is starting, flowing, and ending by talking and discussing between the therapist and client. In body psychotherapy, the "talking method" means talking from one person's awareness of their body to the other person's body, from their feelings to their emotions and from their psyche to their psychology. The purpose of this method is to use a variety of techniques, such as self-awareness, relaxation, imagery, meditation, exercise, yoga, qi gong, somatic resonance and self-expression, in order to mobilize the mind to affect and transform itself and the body, and to mobilize the body to affect and transform the mind (Çesko, 2020).

One of successful approaches in the treatment of PTSD is by using mind-body skills with traumatized people, which showed good results in reducing pathological symptoms of post-traumatic stress (Gordon *et al.*, 2008), and other major symptoms, such are pain, self-image (Malmgren-Olsson *et al.*, 2001), and depression (Danielsson *et al.*, 2014; Price *et al.*, 2007).

In some studies, some specific exercises, such as dance movement (Bräuninger, 2012), body awareness exercises (Danielsson *et al.*, 2014b), and Biosynthesis exercises (Boadella, 1987), seemed to have a good acceptance among of traumatized people – no matter from the origin of culture. This was a good somatic experience that I decided to integrate by combining with other exercise used in this workshop.

Experiential Part of the Workshop

In the experiential part of the workshop, the participants were divided into five groups, with a group leader in each group who was a trainee in body psychotherapy. The role of the group leaders was to facilitate the group dynamic and follow the instructions given by main trainer who was leading the workshop. The experiential work included practicing four exercises based on the Mind-Body Medicine approach (Gordon, 1996).

First exercise was called; *"Drawing"* where participants asked to make drawings on three different pages of paper by using crayons of different colours. On the first page, they were asked to draw 'How they feel right now'; on the second page, they were asked to draw themselves 'With their biggest problem'; and on the last page, they were asked to draw 'How they would like to be'. After drawing these three pages, the members of each group shared their pictures with the group, but the therapist instructed the group members not to judge or criticize the other people's pictures. The purpose of this exercise is to allow the members to express some of their suppressed feelings from the trauma event.

The second exercise, called *"Autogenic Training"*, involves a relaxation technique that uses a guided meditation, where the therapist encourages the members to visualise the different parts of their body. Also, in this technique, the therapist suggests that the members put 'biodots' in their non-dominant hands, so as to see any subsequent colour changes in these Biodots.

In the **next session**, some *kundalini* music [2] was used, and the members of the group were

2. *Kundalini* music is a genre of sacred and spiritual music used in Kundalini Yoga and in meditation practices

asked to shake their bodies according to the music. This technique helps any stuck and blocked body-energy to release which allows the mind to feel the body's memories in the group in a relatively safe space.

In the **last session**, the technique called "*Traumatic Box*" was used. In this exercise, participants were asked to remember one last traumatic event, which is hard to deal with, disinhibiting the details in the memory scan and trying to put it in a box and put the same box in a place of safety. The purpose of this exercise is to become aware of changes in somatic experiences in the body and of feelings after putting the memories of the (past) traumatic event into the box and leaving these memories there, so as to cope better with any new life challenges.

At the end of each session, all the participants had the opportunity to share their feedback regarding the exercise and after all the groups had finished, the participants were asked to rejoin the main group. The members were more prepared to feel their autonomy, any release from fear and trauma, and greater independence and it was suggested they could use all these techniques at any time, if they needed them, even to continuing to use them in other settings in their lives. That is why the therapist asked each member of the group to bring to this final session something that is culturally important for them, to share with all the members of the group. This emphasized the spiritual aspect of integration of the mind-body skills in the process of healing from traumatic experiences.

As the participants were interested to know some more concrete and specific details about using these techniques, some of their requests were met with a role-play case study, done in front of all participants. The purpose of this kind of demonstration was to bring alive a body psychotherapeutic session so that all the participants would be able to see the whole process of impact that body psychotherapy techniques use in the process of healing the consequences of trauma.

Conclusions

During the discussions after this role-play workshop, it was explained that deep work with the body is possible, but only by integrating aspects and concepts from different approaches in body psychotherapy into the treatment as a whole. People are so individual, and trauma is so complex that work with trauma consists of applying appropriate techniques from a variety of different schools and approaches in body psychotherapy.

It is very important to mention that work in body psychotherapy with different kind of traumatic events and especially with limb pain involves a very delicate process of building the relationship between therapist and patient. If the therapist does not have enough experience and concrete knowledge about limb pain, organ amputation and trauma, the treatment process may re-traumatize the patience.

The integrative body-mind approach, which is the main method usually used with trauma survivors, is based on psychodynamic & humanistic psychotherapy in conjunction with new developments from neuroscience and the integration of techniques of alternative medicine. In this approach, natural diaphragmatic breathing is to encourage which allows feelings to be expressed appropriately in each situation. (Çesko, 2020)

to facilitate the awakening of 'Kundalini energy', a primal spiritual and healing force believed to reside at the base of the spine. It is quite fast, chaotic music, often played with some chanting.

Creating a greater awareness of one's body and being aware of the need to express feelings appropriately, and unifying the whole of the person's organism is the means by which the traumatized people can master their traumatic events and bring themselves more into the present situation. The role of the body psychotherapist is to bring attention to these changes in the body and to help create a person's friendly relationship with their body. Therefore, to work effectively with traumatized survivors, it is important to understand the neurobiology of trauma and why it is so difficult to erase its deep tracing on the nervous system.

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Personal Outlook on Mankind

As a professional, experienced clinical psychologist and psychotherapist with an Islamic philosophy, I strongly believe in the concept of mankind and life after death. My voluntary work is not because the majority of people from Turkey belong to Muslim religion, but because people are suffering and in need, no matter who they are or what their religion or philosophy of life is, they are all human beings.

As a result of my 30 years of experiences in offering treatment for people who suffer the effects of war trauma, war survivors, mostly tortured, raped, abused and injured, I have learned how to understand and develop empathetic feelings. I felt the expectations of those who put their hope and trust in me to help them navigate through the dark tunnel of traumatic stress. The feelings of being lost, in grief and mourning, are a continuing process that is influenced by outside events and impacts inside the body. To listen, to support them, offering some safety, and providing a respectful space without judgement, and also trying to avoid what was happened all around, is the best way to cope with sources of trauma. In the beginning, I was afraid that I would not be able to help them, or worse, that I might cause them harm. But staying with them, understanding their traumatic events, their feelings and reactions, I accepted my role was to offer trust and commitment for professionals working with these victims of trauma. My general concept of mankind no matter what kind of disasters are connected with faith and belief values.

One of the Islamic philosophers (Imam Ali Ibn Abi Talib) used to say: "It is not important what God is doing for you, but much more important is what you are doing for God." This motto is

deeply rooted in my belief system and especially given such difficult conditions for people, no matter to what religion or philosophy they belong: I feel the need to express my deep gratification for knowing how to help people to feel healthy, safety and supportive. And I hope that this my work has been accepted and appreciated not only from the people in Turkey, but also from the God, in whom I believe and to whom I strongly pray.

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Convergences in Somatic Psychotherapy in Biosynthesis, the Aesthetic Domain of Experience, and the Art of Singing as a therapeutic resource

Cecília Maria Valentim Teixeira Coelho

Abstract: This article seeks to provide a deeper understanding of the relationship between Art and Somatic Psychotherapy based on the confluence of three areas: Somatic Psychotherapy in Biosynthesis, formulated by David Boadella; the contemporary understanding of aesthetics according to Arnold Berleant; and the Art of Singing as an expressive and therapeutic resource, based on the author's work and studies over three decades of singing workshops and as a postgraduate researcher in Art Psychology at the Institute of Psychology of the University of São Paulo.

When describing each of these areas, the author found interrelations based on the affirmation of a perceptive body as a receptacle of any and all experience. In this article, she seeks to demonstrate that in the somatic psychotherapeutic process, similar to the *doing* of art in the aesthetic domain of the experience woven by singing, all the senses of all components are engaged in a co-creative, sensitive and transformative field of forces. Next, she affirms the usefulness of singing as a therapeutic resource in the interconnection with the therapeutic practice of '*Sounding*' in association with the concepts of *Inner Ground* and *Resonance* conceived by David Boadella.

In addition, she presents the practice of singing as a "technology of us" in the relationship between music and health and its effective contribution to the feeling of well-being and belonging to a community, as well as the development of a person's ability to sustain a network of relationships and affection. Finally, she considers that, although this article highlights the aes-

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thetic domain of the experience woven by singing in the therapeutic practice in Biosynthesis, these connections extend to any artistic modality that can be integrated in the field of Somatic Psychotherapy.

Key Words: Somatic Psychology, Biosynthesis, Art, Aesthetic Experience, Singing

Introduction

For a long time, we have tried to understand the primacy of perceptive experience in the range of human subjectivity and expression and its relationship with art and psychology. Despite the diversity of perspectives and meanings, when addressing this question for the purposes of this article, an understanding had to be reached that was supported by the interconnection of three particular areas:

1) the field of Biosynthesis, a somatic psychotherapy approach created by English educator and psychologist David Boadella (Boadella, 1986, 1992, 1999), who developed this method from his contact with Wilhelm Reich's work, a part of the confluence of the neo-Reichian approaches emerging in the 1960s;

2) the *doing* of art based on the contemporary understanding of aesthetics formulated by Arnold Berleant (Berleant, 1971, 1997, 2010), a musician and philosopher and professor emeritus at Long Island University (USA); and finally,

3) singing as an artistic practice that contributes to shared sensibility and the self-perception and co-regulation of the subject and the community, as understood within the field of Social Psychology, based on doctoral research in Psychology of Art at the Institute of Psychology, University of São Paulo (Coelho, 2023).

In defining this territory, I needed to examine my own experience as an artist/singer, music educator and somatic psychotherapist in Biosynthesis: both in the expressive practice of singing and in psychotherapeutic practice. I observed that it is an experience in which all the senses are engaged in a kind of *doing* that occurs while it is being done (Frayse-Pereira, 2005), in a time and space that is simultaneously singular and collective (Berleant, 2010). It is both singular in the personal way of perceiving, moving and expressing feelings, and it is collective, given the context in which it occurs, what is involved, and that which modulates relationships, evidenced in the values, beliefs and conditioning that emerge in the sensitive field that both create.

Somatic Psychotherapy in Biosynthesis

This method of psychotherapy was formulated by David Boadella (Boadella, 1987, 1992), based on his understanding of the work of Wilhelm Reich, and its interaction with the approaches that emerged in the 1960s. Somatic Psychotherapy in Biosynthesis can be understood as a school of neo-Reichian body psychotherapy. [1] Among the main influenc-

1. Biosynthesis is one of the schools of neo-Reichian body psychotherapy originally based on the concepts and clinical practices of Wilhelm Reich. It differs from the original Reichian proposal of character-analytical vegetotherapy and has developed its own approach, based on the integration of other fields of knowledge. In

es on the early period of its development, the importance of Gerda Boysen (the creator of Biodynamic Psychology), Alexander Lowen (a student of Reich and the co-creator of Bioenergetic Analysis, along with John Pierrakos (Boadella, 1986, 1992)), and Stanley Keleman (to whom Boadella considers that he owes the reading of expressive qualities and the understanding of an Emotional Anatomy (Boadella, 1986)) can all be highlighted.

However, in the course of its development, Boadella (1986, 1992; Bastos, 2020) includes other theoretical sources, such as studies on the prenatal experience by the English researcher, Francis Mott, the mother-child relationships of Frank Lake, and the psychoanalysis of object relations of Melanie Klein. It also includes studies on neuroscience, Robert Moore's conception of energy, and David Bohn's quantum physics (Boadella, 1986, 1992; Bastos, 2020). Regarding art, it is important to emphasise the influence of his wife, Sílvia Boadella.[2] Trained in Butoh dance under Kasuo Ono, Sílvia developed her own combination of art, therapy and dance, which became part of the therapeutic practice in Biosynthesis.

Thus, David Boadella (1986) conceives of Biosynthesis as an open system, able to absorb different perspectives and integrate them into its actions. In addition, he proposed the idea of a bio-spirituality (Boadella, 1992) that, together with the somatic and psychodynamic aspects, make up, for him, the integrality of the human (Bastos, 2020). In his words:

> Biosynthesis is an open system, not a closed one. This means that it is not a fixed or definitive set of therapies or methods, but rather an ever-evolving network of concepts and practices, drawn from multiple sources and integrated at a higher level. Like an ecological system that thrives in diversity and yet is unified by coherence and cooperation among its components (practice and principles) (Boadella, 1986, p. 4, *my translation*).

Biosynthesis means "integration of life" (Boadella, 1986, 1992), a term based on Francis Mott's studies of intrauterine life that Boadella (1986, 1992) later incorporated into his approach. By introducing embryology, Boadella (1986, 1992) sought to deepen the understanding of the integrality of the body and the formation of the *self* by articulating it with different fields of knowledge. This highlights self-formative and self-regulatory processes involving corporal and psychic dimensions (Boadella, 1986, 1992; Bastos, 2020). For Boadella (1986), the objective of Biosynthesis therapy is to "reintegrate the person into a state of healthy pulsation, in which basic vital activities are rhythmic, pleasurable and oriented towards a deeper contact with oneself and with others" (Boadella, 1986, p. 11).

Far from intending to describe the theoretical field in all its complexity, I focus on three concepts related to therapeutic practice that contribute to the aims of this article: *Sounding*, *Inner-ground* and *Resonance* (Boadella 1983, 1992, 1999). These concepts are intertwined with the three primary therapeutic methods developed by Boadella (Boadella, 1986): *Centring*, *Grounding*, *Facing*, which are derived

1998, the European Association of Psychotherapy (EAP) recognised Biosynthesis as a scientific psychotherapy modality (Bastos, R, 2020, p. 234). This was re-validated in 2023.

2. Silvia Boadella holds a Ph.D. in philosophy and is a writer and somatic psychotherapist. She was a visiting professor at Kanazawa University in Japan, where she also studied butoh dance under Kazuo Ohno. From 1985 onwards, she contributed to the development of Biosynthesis, in collaboration with her husband, David Boadella. She is currently director of the International Institute for Biosynthesis (Switzerland), where she teaches her unique integration of art, therapy and dance. (Information from: www.silviaboadella.com)

from the primary cell layers in the embryological organisation of the foetus: endoderm, mesoderm and ectoderm, referring to the integration and cooperation between them, as well as to the flow of metabolic energy, the balance of the nervous system and muscle tone. First, the concept of *Sounding* (Boadella, 1992) is introduced, which is related to the aspects involved in the quality of vocalisation and emotional expression. Then, the notion of *Inner Ground* (Boadella, 1999) is addressed and, finally, the concept of *Resonance* (Boadella 1983; Bastos, 2020) is discussed, pertinent to the relational field between patient and therapist during the therapeutic process. These are described concisely:

1) *Sounding*: this refers to the ability to express oneself vocally in connection with one's feelings and in harmony with movements (Boadella, 1992). Vocal quality is linked to muscle tone, breathing rhythm and emotional state. The therapeutic work of *Sounding* seeks to dissolve somatic patterns and beliefs that inhibit the voice and recover expressive capacity and establish a bridge of deeper contact between the person and him/herself and others (Bastos, 2020).

2) *Inner ground*: The existential dimension in which body and spirit [3] are inextricably intertwined from the beginning of the formative process (Boadella, 1986, 1999; Bastos, 2020), constituting the essence of the human being. It is from this dimension that the qualities of the human spirit emerge. In the words of Boadella (1999): [4]

Then we have grounding, which is basically the rebalancing of muscle tone, all the work with movement changing muscle tone. This work also has an internal level, which I call "inner ground," which is more of an existential field of the values of a being in life, that which sustains us. (Boadella, 1999, p. 2).

From this perspective, therapeutic work with *Inner ground* (Boadella, 1986, 1999) seeks to connects a person's inner life with their external reality, enabling them to find inner support in their values and qualities and appropriate their own mode of expression.

3) *Resonance*: a synchronous somatic state between therapist and client that reveals the quality of the energy field created by both. For Boadella (1983), "resonance produces an illumination in the energy fields" (p. 104), highlighting a life-promoting interaction in a bilateral process in which the therapist is willing to be in somatic harmony with the client's needs. As Bastos (2020) explains:

> The idea of resonance, in its somatic aspect, indicates the therapist's need to develop a self-perceptive sensibility to their own muscle tone and breathing rhythm, as well as a perceptive sensibility to these same aspects in the person they are endeavouring to assist, to establish a tonal dialogue. The ability to perceive muscle tone and breathing enables the therapist to recognise their own emotional state, as well as that of the individual being treated. In summary, somatic resonance signifies the necessity for the therapist to be in tune with their own body and emotions, as well as with the body and emotions of the client, to establish a bond that adequate-

3. According to Bastos (2020), for Boadella, "the spirit is a third dimension of reality and from which the other two, matter and energy, originate" (Bastos, 2020, p. 260, my translation).
4. Conceptualisation transcribed and translated by Sílvia Lessa Bastos from a lecture given by David Boadella at the 7th European Congress of Body Psychotherapy, Travemünde, Germany, September 2-6, 1999.

> ly satisfies their emotional needs (Bastos, 2020, p. 270).

Thus, the notion of resonance in the therapeutic context can be understood as the therapist's ability to be attuned to the client on a deeper level, establishing a type of communication that involves an exchange of affective, sonorous and corporal experiences.

Finally, in describing the above concepts, attention is drawn to Boadella's (1983, 1986, 1992) proposition that therapeutic practice presupposes a flow of interactions in which the bodies and emotions of the therapist and patient are attuned in such a way as to enable a dynamic of balance and reciprocity that contributes to the creation of a pulsating field of shared presence. Furthermore, the therapeutic practices emphasise and nurture the human need for interaction and relationships, as well as the establishment of a favourable environment for the transformative process to occur.

The aesthetic domain of experience woven in the *doing* of art

The word art, derived the Latin *Ars*, means "skill in doing". Observing the etymology, we can infer that this "doing" is imbued with a function, since skill refers to a refinement of dexterity to accomplish something. The philosopher, educator and founder of American pragmatism, John Dewey, argues that art is *"the most direct and complete manifestation that exists of experience as experience"* (Dewey, cited in Cunha, M.V. 2015, p. 75) and that its function is to consciously restore *"the union of the senses, of the need, impulse and action of the living creature"* (Dewey, cited in Berleant, 1991, p. 17). It is the process of transforming what we learn into *doing* gives form to the experience, which is aesthetics, in a continuous process: *"Once again: art is a doing. But a specific doing. That is, it is a doing that, while doing, invents what to do and the way of doing"* (Frayse-Pereira, 2005, p. 57, *my translation*). In this way, the aesthetic field of experience is introduced, based on Arnold Berleant's concepts of aesthetic experience, aesthetic engagement and the aesthetic field (Berleant, 1971/1999/2010):

Aesthetic Experience

Understood by Berleant (2010) as a theory of sensibility, it is based on the aesthetic domain of experience and rooted in the human, social world (Coelho, 2017). For Berleant, *experience* encompasses everything: our body, our movements, and all that we perceive via our senses and sensibility, which ultimately, are ourselves. In contrast to the Kantian view of disinterested contemplation, Berleant (2010) re-introduces the etymological meaning of the Greek word *Aesthesis*, literally, "perception through the senses," to broaden and deepen its meaning. In his view, *aesthetics* involves perceptive experience and the ability to recognise it. It includes the comprehension of meanings that emerge from the dynamic interaction between people and an environment that is alive, and not objectified (Berleant, 1992). For Berleant (1992), environment and humans form an indivisible unity: we are shaped by the environment in which we participate. In the same way, we shape it into a mutual and simultaneous influence, which is intertwined with a complex network of relationships, not only sensory, but sensitive, that includes all ranges of human sensibility and emotions: from the bizarre to the erotic, from the disgusting to the attractive, from the beautiful to the sublime, from the ugly to the tragic, from intense love to hate, from the oppressor to the oppressed, and so on. In the words of Berleant (2010):

> I return to the recognition that aesthetics is, fundamentally, a theory of sensibility. Broadly speaking, it leads us to recognise the aesthetic dimension in all experiences,

> whether edifying or degrading, dignifying or brutalising (Berleant, 2010, p. 8).

In this sense, *aesthetic experience* offers us a more subtle understanding of what happens in a process that is, inevitably, personal and social. From this perspective, we can refer to *aesthetic experience* as an "aesthetics of everyday life," since the flow of life and relationships occur "during," while we are living.

Aesthetic Engagement

Aesthetic engagement is an alternative model developed by Berleant to understand the appreciative value of experience (Berleant, 1991). According to this model, *aesthetic engagement* represents the most complete stage of aesthetic experience. It is an "essential aspect of the world in action" (1991), in which our senses are fully immersed in the situation in which it occurs (Berleant, 1991 *cited in* Coelho, 2017). In its involvement with art, *aesthetic engagement* is intensified by the creation of a perceptive field in which feelings and connections are externalised through a sensitive *doing* that, corporified, includes everything that constitutes us as humans and what we are confronted with in light of what we discover about ourselves:

> Art does not look like an experience, it is not a reflection or imitation of real life, but it is, in fact, experience, present in the most direct and poignant form. Art, then, is not a pale reflection of life and the world, but the real thing, in its clearest and purest form. We experience "the feeling of what is true" in us. (Berleant, 2000, p. 102)

Aesthetic Field

The *aesthetic field* comprises all the components of experience, in which all the senses are engaged and in which everyone participates. According to Berleant (2000), it is a single, integrated whole composed of four main components: the *appreciator*, that is, the person who experiences the aesthetic value; the *focus of appreciation*, which can be an object, an artistic work of any nature, a landscape, a thought, a mental image; the *activity or event* bringing the agent of the appreciative focus into existence, such as the artist, a process of nature, or the act of identifying the generator of appreciation; and the *factor that activates the field or situation*, such as the performer and the engaged participant: *"This is the aesthetic field, the context in which the focus of attention is actively and creatively experienced as valuable"* (Berleant, 2000).

Once again, for Berleant, the environment, art and aesthetics are intertwined in an aesthetic that "operating through the artistic field, is not different from that expressed by the world of life, in which the participation of the body is essential for the occurrence of the configurations of an elaboration whose synthesis is inseparable from the place" (Andriolo, 2021). In Berleant's words:

> We do not just see our lived world; we move in it, we act upon it and in response to it. We understand places not only through their colours, textures and shapes, but with our breath, our sense of smell, our skin, our muscular and skeletal actions, our position, the sounds of wind, water and traffic. Those major dimensions of the environment – space, mass, volume and depth – are encountered not primarily by the eyes, but with the whole body, in our movements and actions. (Berleant, 1992, p. 19)

In short, by describing the concepts set out above, Berleant directs us towards a contemporary understanding of aesthetics that contributes decisively to its study in psychology (Andriolo, 2021), especially in the context of somatic psychology, by considering the predominance of sensory experience at the origin

of our understanding of sensible experience that, embodied, includes all relationships and aspects of everyday life.

The aesthetic and expressive dimensions of singing, the "Technology of Us"

Singing as artistic practice

Based on the concepts formulated by Berleant (2000), I briefly outline the aesthetic dimension of singing as an artistic-musical action. According to Berleant (2012), experience in general, and musical experience in particular, involves a series of factors, events and conditions to occur and should be understood as the human experience in the face of the acoustic phenomenon (Berleant, 2012). As a perceptive phenomenon, our understanding and its expression involve the context, the culture, the environment in which it occurs and the understanding of a subject who defines the parameters of what is called music. Music, like any artistic manifestation, does not exist *per se*: for music to exist, someone is needed to perceive, create, express and appreciate it as such. Extending to any artistic practice, these actions make up a totality and should not be perceived in isolation, since each one involves and requires the other (Berleant, 2010). Together, they constitute the aesthetic field of experience:

> What makes such a situation aesthetic is that the centre around which the appreciative experience takes place, which is primarily perceptive, involves all the senses, not just the auditory, mediated and shaped by multiple cultural factors that affect perception and, through it, confer a value. Calling a situation aesthetic, then, identifies the type of complex normative experience in which we engage, here with music, sometimes with other arts, in other domains of experience. (Berleant, 2010, p. 48)

In this way, singing as an artistic practice can be seen as an aesthetic experience of the sensitive order, lived in the body of the one who sings, whose expression includes the understanding of what is expressed and the manner of doing it.

Corporeality woven by singing: sensibility and presence

Initially, it is important to situate the body as the place where all experience resides (Coelho, 2017). It is from the body that the person perceives themselves and others, through which they understand the world around them and express their being; a body that occupies a physical place in the world, a space and a time, where the sensible experience takes place. For Berleant (2004), an aesthetic, sensitive body:

> We can think of an aesthetic body, then, as culturally shaped, interwoven and embedded in a complex web of relationships, each with a distinct character and dynamic. Race, class, gender and geography are experienced through corporal forms and structures. These different cultural, sexual, racial and social structures are embedded in living bodies. The aesthetic body, as a receiver and generator of sensory experience, is not static or passive, but has its own dynamic force, even when inactive. Aesthetic embodiment is occurring, fully present, through the characteristic presence of the body, through the sensory focus and intensity that we associate with the experience of art. (Berleant, 2004, p. 10)

For it is in the body that the voice sings, hears itself and feels itself vibrate. As a sound wave, it finds in the body the ideal environment for its propagation: *to produce it, I activate my en-*

tire organism, expand my perception, activate my cognition, my memory, move my muscles, modulate my breathing, transform air into sound, vibrate my skin, my flesh, my bones, my liquids. Amplified in the internal cavities of my body, when externalised, I fill the entire space around me with sound. Thus, when expressing myself through singing, I become audible to myself. By becoming audible, I legitimise my presence: I make public that which internally guides me in my expression, in a sensitive dialogue of the self with myself, with the other, and the entire environment around me (Coelho, 2023).

As listeners and producers of sounds, we distinguish ourselves from others, while we share our worlds. We become visible and audible in our singularity before the other. In this way, revealed by my voice, I find the possibility of perceiving myself and becoming aware of my movements.

In short, the expressiveness woven by singing is constituted by a voice that, generated internally in the body of the one who sings, is externalised in its attributes in an unparalleled manner. Thus, I reveal to myself what composes and decomposes my expression, and I present myself in the sensible field forged by my own voice.

Singing, Belonging and Community

Beyond being an isolated and individual experience, singing is an interconnected and interdependent act that involves all the aspects that constitute the one who sings and the one who listens and who "sings along": *when I hear the voice of another, I hear what resonates within me, in an imaginative and co-creative process that occurs internally, which brings me closer and, simultaneously, differentiates me by what I hear in my own voice. In fact, it is an intersubjectivity constituted by coexistence, by continuous involvement with the world, by what I qualify and feel that I am, in what I hear from myself and vibrate through my voice, and by what I hear and vibrate in the voice of the other* (Coelho, 2023).

This way, I come to understand singing as a collective and communal practice. For my doctoral research in the Department of Social Psychology at the University of São Paulo, I conducted singing workshops in Brazil and Portugal, combining the roles of conductor and researcher in a participatory agency. This research resulted in my thesis, *"What happens when we sing together? or the shared sensibility from singing together: a study on its implications in the field of Social Aesthetics"* (Coelho, 2023). I witnessed the creation of a favourable field for the engagement and acceptance of the expression of each participant and the emergence of a feeling of integration and belonging to a community, supported by the coexistence of a sensitive practice. Using the phenomenological method in my research (Coelho, 2023, p. 17) and analysing data collected from the participants' logbooks narratives about their experiences during the workshops led me to conceive of singing together as a "Technology of Us" (2023).[5] This concept emerged from the intersection of Tia DeNora's (DeNora, 2007) understanding of the relationship between music and health as a "Technology of the Self" and the *Psychological Sense of Community* proposed by McMillan and Chavis (McMillan & Chavis, 1986, *cited in* Amaro, 2007). In general terms, DeNora (2007) defines the "Technology of the Self" as the acquisition of resources for self-regulation, self-knowledge, personal care, a sense of integrity and social integration. She also emphasises the cooperation between corporal perception, which

5. I leave this term in quotation marks because the epistemological implications of the use of the terms techné and technology are well known, especially with respect to aesthetics.

houses the emotional being and the constitution of self-image, as well as considers music as a technology of the body, as a modality for the cognitive process and the acquisition of knowledge. McMillan and Chavis (2007) base the *Psychological Sense of Community* in the feelings of belonging and well-being experienced by community through the shared belief that they care about each other, and that their needs (exchanges) will be met, as well as a commitment to remain together. They ground this concept on "the amplitude of contacts that individuals in a group have with each other and the quality of these interactions" (McMillan & Chavis, 1986, p. 9, *cited in* Amaro, 2007, p. 26).

I include these perspectives in my understanding of the practice of singing together as a "Technology of Us" (2023) in which the effects of the relationship between music and health are intertwined in an interconnected and interdependent "I" situated within an "us" in a historically situated context and pertinent to it. This model contributes to the maintenance of the capacity of both the subject and the group to establish and sustain a network of mutually supportive relationships involving significant exchanges for all participants.

In short, the results of my research confirmed that the mutuality experienced in the coexistence provided by singing together significantly contributed to participants' feelings of belonging and well-being, as frequently commented on their workshop narratives. It also fostering new perceptions of oneself and others, in a process filled with the amalgamation of voices that vibrated not only in the acoustic space, but in the sensitive bodies of each one as they touched each other sonorously. Moreover, the collaborative form and intimacy developed in the workshops allowed the pains and embarrassments observed in the logbooks reports to find a place of acceptance and elaboration, as exemplified by the narratives that follow:

> When the song enters me, it is cleansing, soft, the vibration of my body becomes harmonious, light, smooth. Singing together brings unity, common goals. Singing together adjusts loneliness. I love to hear my voice. (Isadora, 55, p. 71)

> (Today) there were experiences of contact with the internal saboteur – the critic, the judge. Sitting down with the discomfort it leaves. Question it, not validate it, and let it go. Freeing myself from any judgment and conception of right or wrong, like flowing with the sea...

> Feeling the vibration, the pulsing of my chest in connection with who I am, in the here and now. Freedom from control, which is also distortion and illusion and the free exploration of my voice without letting the mind control it. (Joana, 25, p. 90)

Evidently, not all suffering found the right occasion for its expression, and there was some that remained hidden in places not accessible during the workshop encounters. However, by sharing an art that expands from what we have in common as humans, and in which we find ourselves in solidarity, we find ourselves creatively free to connect and integrate new landscapes within ourselves in a sensible field in which "the transmutation of sensibility was not restricted to the perspective of personal transformation. It also extended to the involvement of the sense of solidarity and interconnection." (Andriolo *et al*., 2022, p. 7)

Perspectives on the interrelationship between Somatic Psychotherapy in Biosynthesis, Arnold Berleant's conception of Aesthetics and the art of singing as a therapeutic resource

In describing the three approaches for this article, I sought to relate the points of convergence between them. Without exhausting all the possibilities that this interrelation offers, I will highlight two points of intersection: the interrelation between Biosynthesis, the *doing* of art and the aesthetic field of experience; and the practice of singing as an expressive and therapeutic resource interconnected with Biosynthesis.

The interrelation between Biosynthesis, the "doing" of art and the aesthetic field of experience.

For Boadella (1986), the therapeutic experience, rooted in a context of relationships and energy, is lived in a unique and multidimensional body, simultaneously personal, social, cultural and environmental. This resonates with Berleant's (1992) assumptions of an aesthetic experience as embodied in a perceptive body embedded in a complex network of relationships that includes all the nuances of human sensibility and emotions. From this, we can affirm that:

1) For David Boadella (1986), Biosynthesis evolves continuously through the integration of a network of concepts and practices from diverse sources. Berleant (2010) understands the aesthetic situation as an experience in which we engage, whether with art or with other domains of experience. For both authors, therapeutic practice and the aesthetic domain of experience are open systems, supported by the multiplicity and complexity of human interactions.
2) Both share an understanding of the predominance of perceptual experience in shaping the subject's way of understanding, moving, and expressing themselves in the world.
3) Similar to the aesthetic field, defined by Berleant (Berleant, 2010) as the context in which all components of the situation are active and creatively related, the energy field between the therapist and client, described by Boadella (1983, 1986), is embodied in an experience of shared presence engaging all the senses. In this way, the values, beliefs and conditioning present in the perceptual field created between them can emerge to be understood and transformed reflectively and consciously.
4) As occurs in the *doing* of art, in the therapeutic encounter the course of time fades and feelings and connections are externalised in a process experienced as a flow of interactions in which bodies and emotions become attuned in a way that enable a dynamic of balance and reciprocity, contributing to the constitution of a transformative context co-created by the participants.
5) The therapist's conscious participatory action and quality of contact in the constitution of a favourable sensitive field can enable the generation of new connections, the restoration of the regenerative pulse and the integrity of the patient's expressive capacity.

The practice of singing as an expressive and therapeutic resource connected to Biosynthesis.

When reflecting on the practice of singing as a means of intensifying a perceptive field where

feelings and connections are externalised and discovered through a sensitive practice that includes what constitutes us as humans and what we are confronted with when expressing ourselves vocally, I can affirm its potential as a therapeutic resource, intertwined with the aesthetic dimension of experience and Biosynthesis. Associated with the concepts and practices proposed by Boadella (Boadella 1983, 1986, 1992), I find their application in conjunction with the therapeutic practice of *Sounding* (1992) in the activation of breathing, in dissolving somatic patterns and beliefs that inhibit the voice, and in recovering the subject's expressive capacity connected to feelings and attuned with their movements. Related to the concept of *Inner ground*, the benefits of singing as a therapeutic resource presents itself as a means for rooting in a deeper connection with movements, with the way of perceiving and understanding the world, and for the perception and support of one's values. In terms of *Resonance*, the interconnection lies in the capacity to attune to an energy field formed by the voices of the therapist and client, within which both are engaged and vibrant.

Furthermore, the articulation between singing as a "Technology of Us" (Coelho, 2023) and the field of somatic psychotherapy in Biosynthesis is evident in its effective contribution to the feelings of well-being and belonging to oneself and to a community, as well as the person's ability to sustain a network of relationships and affections.

The practical application of singing as a therapeutic resource in Biosynthesis can occur in different ways, both in groups and in individual sessions. To achieve this, the therapist must be conscious self-awareness, and aware of the expressive attributes of their own voice, as it is necessary to connect with one's own feelings and sensations to guide one's movements to generate a creative path to be followed together. Below, I briefly outline three possibilities for practical applications:

1) By activating the memory of the soundtrack that composes the images of the patient's life. Activation can occur through songs, sounds and soundscapes stimulated by the therapist.

2) By composing new soundscapes that reconfigure the traumatic situation of the client in a mutually creative process of free vocal improvisation, integrated with corporal movement.

3) As a resource for regulating the Autonomic Nervous System and the patient's regenerative pulsation through breathing practices and exploring the sonorous possibilities of the voice.

Final Considerations

By relating Somatic Psychotherapy in Biosynthesis (Boadella, 1983, 1986, 1992) to the aesthetic domain of experience proposed by Berleant (Berleant, 1971, 1997, 2010) and to singing as a therapeutic resource (Coelho 2020, 2023), I sought to demonstrate, firstly, the interconnection between these three approaches in the recognition of the primacy of the body as the recipient of any and all experience. I then asserted that, as in the process of artistic *doing*, the psychotherapeutic process is equally present in a creative field in which we are immersed in our sensibility, and from which our values, perceptions and conditioning emerge. Associated with singing, this entire process is intensified in the integration of hearing and voice as evidence of the person's presence in the world, in an expressiveness that is generated internally in the body of the one who sings and externalised in an unequalled way in its attributes. I have observed that both in the scope of therapeutic practice and in the *doing* of art, similar components are activated, such

as: inventiveness, imagination, creativity and the values that govern the situation, as well as the generation of a perceptive field in which occurs the engagement of the senses of all the components of a situation that is created together.

By this, I refer to the psychotherapeutic process as the *doing* of a specific art that enables the transformation and reintegration of the person's expression in a living and pulsating body, constantly shaped by the context in which they are embedded. A process in which, through coexistence with the therapist willing to accompany them on their journey, they feel safe enough to embark on the adventure of new discoveries and connections, becoming a work of art and the artist of themselves.

Finally, while this article highlights the aesthetic domain of the experience woven by singing in the therapeutic practice in Biosynthesis, it is important to emphasise that these connections extend to any other artistic modality that can be therapeutically integrated into the field of Somatic Psychotherapy.

Author

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Psychosexual Psychotherapy – A New Model of Integrative Body Psychotherapy

Enver Çesko

Abstract: This article presents the author's theoretical model developed from his clinical work over the last twenty-five years with couples and partners who have had difficulties in their sexual lives. [1]

Psychosexual Psychotherapy is an integrative approach to treating sexual difficulties by using a variety of techniques and methods where the therapist first has to identify the roots of the sexual problems that are manifesting as symptoms by identifying the disorders that need to be treated through the integration of four aspects: body, mind, emotions, and behaviours. Psychosexual Psychotherapy integrates the use of a variety of techniques.

The essential aim of psychosexual psychotherapy is to identify the roots of what caused the person's sexual problems and then to treat them properly by using a variety of specific techniques that all involve psychical, cognitive, emotional, and behavioural aspects.

Psychosexual Psychotherapy, as a psychodynamic and comprehensive approach, includes some new concepts from different psychotherapeutical approaches, derived from body psychotherapy, somatic psychology, sexual medicine, neuroscience and mindfulness practice.

Key Words: psychosexual psychotherapy, body psychotherapy, somatic psychotherapy, integrative, sexual disorders

1. The author acknowledges that his background, training and experience are mostly from within a middle-European culture. He has considerable experience of working in Middle Eastern & Muslim communities, where there are many different attitudes towards sexuality (some very constrained). These differences inevitably have significance when considering the 'cultural' aspects of sexuality and the practical aspects of treatment.

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The History of Sexuality and Psychotherapy

One of the researchers who has explored modern sexuality was Michel Foucault (1926-1984). His theory, partially based on the hypothesis of repression, (especially since – in his opinion – the rise of the bourgeoisie, is the main theoretical framework for understanding modern sexuality) (Foucault, 1978). According to Foucault's theory, the development of sexuality is not a natural, innate drive, but a historical and social construct created by systems of power and knowledge. This is centred around the concept that sexuality emerges from power relationships, in that it is shaped by actions and relationships that induce people to act, understand themselves, and shape their identity. He argued against the "repressive hypothesis" – the idea that Victorian society suppressed sex – and instead claimed that power produced and proliferated discourse on sexuality, encouraging confession and classification (e.g., creating categories like "homosexual"). This modern approach linked sex to a person's identity and truth, a concept he contrasted with classical antiquity, where he saw "practices of the self" focused on moderation and self-mastery.

Traditionally, sexuality has been focused on four dimensions: the sexuality of children, the sexuality of women, sexuality in couples, as well as pervasive (and sometimes distorted) sexuality (Foucault, 1978). All these four dimensions are powerful aspects that are present in modern families and are spread throughout society.

Cultural and sexual attitudes differ perhaps most highly – and most profoundly – when considering the study of human sexuality and its problems (Bancroft, 2009; Davies & Whitten, 1987; Ubillos, Paez & González, 2000; Goddard, 2024). *"Culture is one of the most important elements influencing the sexual lives of people. Factors like traditionalism, religion, polygamy, machismo, and feminism influence sexuality and cultural ideas about [sexuality – especially involving women]. … Cultural differences exist not only by merit of geographical distance since cultures get intermingled through economic migration, political refugees, and global traffic."* (Atallah & Redón, 2023)

According to Freud's theory (Freud, 1977a), natural human sexuality tends to result as a complex of drives that develop over time, and that childhood experiences are a foundation for adult sexuality. Normally, there are also some bisexual attributes, which is why everyone is sexually attracted (more or less) to both sexes. His theory was later developed as a personality development model, which consists of five stages: oral, anal, phallic, latent and genital stage. Sexuality is sometimes wrongly confused with libido [2], which is more physical and emotional and is expressed in different ways; this libido, as an inner 'energy', can flow through the whole body. On this basis, a psychoanalytic theory was developed about sexuality. Later, this became known as the Psychosexual Theory (Freud, 1977b), which starts with the newborn child feeding orally and ends with the genital stage when the person becomes in contact with another in an intimate and sexual relationship.

Therefore, therapists from different cultures may need additional levels of training and awareness. Cultural and social boundaries must always be worked with very sensitively and carefully.

2. Libido, which means sex drive or the desire for sex, varies dramatically from one person to the next. It also varies depending on a person's preferences and life circumstances. Libido can be affected by medical conditions, hormone levels, medications, lifestyle and relationship problems.

Wilhelm Reich developed his own theory of sexuality in *The Function of the Orgasm* and *Character Analysis* as a radical development of Freud's theories. The term 'libido', as used by Freud, was interpreted as energy that drives from within the body, whereas Reich used the term 'sexual energy' to understand the character of human beings (Reich, 1973). Reich theorised that repressing the need to discharge bodily energy through a healthy orgasm led to different kinds of neurosis and illnesses that were symptomatic because of repressed sexual energy. This repressed energy often results in a 'blocking' of energy, physiological (muscular and fluid) restrictions, and if this kind of blocking is happening continuously, this creates a form of 'armouring' or desensitisation, that Reich called "character armour" (Reich, 1972).

It is known that Reich had some early sympathies for Marxist theory and for the psycho-social structures of community, where beliefs and behavioural patterns related to sex are a powerful element in the struggle to overcome class differences and the dynamics of social oppression. He combined his libido theories and 'sexological' work in clinics with his communist political convictions in a socio-political movement that became known as "Sex-Pol" (Moir, 2022). Reich struggled in those times of political crises (in the late 1920s) because of his sympathy for Marxist ideology, and yet he had the courage to put these in written form under the Sex-Pol label (Reich, 1966).

The 1960s years characterized a sexual revolution, where a lot of sexual disorders became more common, and it became easier to approach for help from doctors. From within the medical community, mostly gynaecologists and urologists had started to offer different techniques in the treatment of sexual disorders, from which later sexual therapy was developed.

Modern theories about sexuality and sexual therapy began with psychoanalytic underpinnings and from specific behavioural therapeutic techniques, developed by Masters and Johnson (Masters & Johnson, 1966). Their "sexual response cycle", has four distinct phases: excitement, plateau, orgasm, and resolution. This model provided a starting point for the exploration of the body's responses to sexual activity. Their techniques encouraged Helen Singer Kaplan to integrate Masters & Johnson's techniques with her three stages of sexual response: desire, excitement, and orgasm (Kaplan, 1974). She was the founder of the first clinic for sexual disorders in the USA. Part of her advocacy was the idea that people should enjoy sexual activity as much as possible, as opposed to seeing it as something dirty or harmful.

In psychotherapeutic settings, sex and sexuality also had an important role in understanding the roots of many psychological and psychiatric disorders. In earlier days, psychotherapists started to deal with symptoms that caused sexual disorders, and these were largely based on a cognitive-behavioural approach (similar to Masters & Johnson's theory), where the focus was on de-emphasise the emotionally painful thought patterns that have become associated with sex and re-building new sexual skills.

Stella Resnick (2004) developed a body-centred Gestalt approach, which identified three views on sexual problems: (i) sexual problems can be fixed; (ii) increased sexual intimacy can enrich relationships; (iii) both these involve personal growth – i.e., some form of therapy.

The more holistic approaches, where the mind and emotions need to include the body, required a new approach in sexual therapy. Therapists in the past mostly dealt with sexual problems, rather than with realizing the client's sexual potential. It therefore became

necessary to shift away from mostly symptoms and emphasize the relational patterns of partners, so as to increase their sexual potential and achieve certain levels of performance, which would then improve their quality of life. If partners wanted to have better sex during their intercourse, it is not important to have more physical events or techniques, but to have a higher degree of qualitative intimacy and eroticism that can be enjoyed together (Schnarch, 1991). This is also an essential point in the Gestalt theory on sexuality, which emphasizes the quality of contact of sexual encounters.

Body-Oriented Psychotherapy approaches to sexuality developed from the Reichian period until nowadays and sexual therapy has developed through different techniques in the treatment of different sexual disorders. A Body Psychotherapist compares the experiential model approach with different psychotherapy approach outcomes, considering the clients' personal values, different beliefs, and cultural backgrounds.

From Sexual Therapy to Psychosexual Psychotherapy

Talking about sex and sexuality in our culture can often provoke uncomfortable feelings. In mental health practitioners, this discomfort, unfortunately, does not stop at the consultation door, but continues to be embarrassing even when we are talking with our parents, relatives and friends. The more complicated issues become even more difficult when we have to talk about sexual disorders, which are harder and difficult, not only to speak about, but also to treat.

> *"A basic understanding of sex and sexuality can help us sort out myth from fact and allow us increased enjoyment of our lives. Today's myths and misunderstandings surrounding sex were not created deliberately by us but grew up because of people's discomfort in accepting the word sexuality."* (Çesko, 2023, p. 104).

Traditionally, the existence of sexual needs in human beings is expressed biologically by the assumption of a 'sexual instinct' (Freud, 1977a). According to psychoanalytical theory, sexuality in human beings can be designated in many different ways. Seemingly, the most important is of these about our sexual identity, however we can still talk about personality identity and gender identity meaningfully.

Freud, in his theorising about sexuality, described ideas about the nature and characteristics of sex and sexuality with a pan-sexual model, concluding that: *"A pencil is never just a pencil, and everything in the world is imbued with sex"* (Freud, 1977b).

In human beings, sexual 'libido' develops normally in various stages from birth, and (hopefully), *"childhood sexuality passes without interruption to puberty. [If] the parents do not try to suppress their children's sexuality, there is neither castration anxiety nor Oedipus conflict"* (Peseschkian, 2023, p. 67).

The history of sexual therapy has been mainly focused on biological and pharmacological treatments, mostly for male sexual dysfunctions. Many authors (Masters & Johnson, 1970; Kaplan, 1979; Fisher, 1992; Leiblum & Rosen, 2000; Balon, 2009; etc.) all discuss treatments largely from this historical perspective, and the modern treatment for many sexual dysfunctions has largely been pharmacological, rather than psychotherapeutic, with quite a few treatments coming more recently from behavioural psychology.

In biological and behavioural approaches, therapists usually focus on the treatment of symptoms rather than on interpersonal re-

lationships. Many of these therapists (often with a quasi-medical background) have addressed biological, organismic, and pharmacological treatments, and not focused on analysing the aetiology (or cause) of these sexual disorders. Their main purpose was still to treat the 'symptoms' of the disorder and not to see any disorders as a function of interpersonal relationships between the partners. To 'heal' the disorder from this perspective, the therapist must go deeper psychologically and balance the functional aspects of symptoms with the interpersonal relationships between the partners.

Traditionally, those therapists, who like to call themselves "sexual therapists", tend to see almost all sexual dysfunctions as biological (organic) dysfunctions, or they are trying to identify these dysfunctions as pathological relationships between partners, even though their clients' relationships might have been 'good enough' and reasonably balanced, but the satisfaction derived from their intercourse was not good enough. The goal of offering sexual psychotherapy is "a chance to find a less burdensome" form of relationship (Levine, 1992, p. 136) and to increase awareness about actual sexual problems and needs that their clients are asking for.

Today, the concepts of "sex therapy" are mostly misperceived and misunderstood, not only by ordinary patients, but also by many healthcare professionals. However, the professional understanding of sexual therapy is now undergoing changes with education and development of the profession.

According to the American Association of Sexuality Educators, Counselors and Therapists (AASECT), professional and certified sex therapists *"are mental health professionals, trained to provide in-depth psychotherapy, who have specialized training in treating clients with sexual issues and concerns, who are prepared to provide comprehensive and extensive psychotherapy over an extended period of time in more complex cases."* [3] Significantly, AASECT *"opposes all psychological, social, cultural, legislative, and governmental forces that would restrict, curtail, or interfere with the fundamental values of sexual health and sexual freedom that we espouse. AASECT also opposes all abuses of sexuality including, but not limited to, harassment, intimidation, coercion, prejudice, and the infringement of any individual's sexual and civil rights."* [4]

To understand sexuality better within a psychotherapeutic context, it is therefore important to develop a cognitive framework about sexual phenomena. This can then be classified into five different categories: biology, individual psychology, interpersonal relationships, sexual equilibrium, and culture (Levine, 1992). These five categories are crucial to one's understanding of healthy or impaired sexual life in every person's unique construct of their sexual thoughts, feelings, and behaviours. Human sexuality involves the physical body, the neuro-biological mechanism of the human organism (Houts *et al.*, 2011), psycho-emotional activities (Laan, 2011), and the socio-identification of gender identity (Meana & Jones, 2011).

As humans, we experience and express sexuality through our bodily images of how and what we feel about our bodies, our desires, thoughts, fantasies, sexual pleasure, sexual preferences, and sexual dysfunction, as well as our society's values, attitudes, beliefs, and

3. American Association of Sexuality Educators, Counselors, and Therapists: Frequently Asked Questions. (Available from www.aasect.org/faqs.asp. Accessed 21-Dec., 2009)
4. www.aasect.org/our-mission.html. (Accessed 14-Nov. 2024)

ideals about life, love, sexual relationships, and sexual behaviours. These attributes are present in almost all psychotherapy schools, beginning with psychoanalysis to the modern more integrative psychotherapy modalities.

In sexual therapy, the psychotherapeutic process has to be understood as a mutual relationship between therapist and client, where they are involved in different issues and cases, where both sides are discussing ways how to treat the symptoms by becoming aware of the client's conflicts as they resolve them. They usually discuss a variety of problems, such as sexual trauma or abuse, sexual difficulties, pain, addiction, dissatisfaction, gender identity, and many other organic or psychological background issues and work how to understand the link between symptoms and causes

Some neuroscience research (Chung *et al.*, 2013) shows how the 'neural' model of sexual arousal may result in the development of a four-component neuro-phenomenological model of sexual arousal: with cognitive, emotional, motivational and physiological components. Also, some other studies are showing that there are not significantly large differences in the brains of men and women during sexual arousal (Stoléru *et al.*, 2012). Recent studies suggest that dominant sexual scripts, which play a crucial role in perpetuating the orgasm gap, have gender differences between partners (Dickman *et al.*, 2024).

Also, the new findings in neuroscience (NaturePortfolio [5]) about how the brain regulates emotions, suggest that the effects of psychotropic drugs on depression and other mental health disorders may work in part by altering how we think about life events and our ability to self-regulate. This may help explain why drugs, particularly psychedelics, are likely to be ineffective without the right kind of psychological support. The study could help improve therapeutic approaches by increasing our understanding of why and how psychological and pharmaceutical approaches need to be combined into integrated treatments (Bo *et al.*, 2024). Some other research shows correlates of sexual arousal between men and women in heterosexual and homosexual relationships (Sylvia *et al.*, 2013).

One of the founders of Integrative Body Psychotherapy, Jack Lee Rosenberg, in his theory about sex and sexuality, uses the concept of 'energy which drives our organism' (Rosenberg *et al.*, 1991a). Sexuality, he opines,

> *"is just the tip of the iceberg, symptomatic of more massive disturbances underneath. A person may go through much of his life largely unaware of this basic disturbance, but when an emotional or psychological problem surfaces as a sexual problem, his distress is often sufficient to propel him into therapy"* (Rosenberg *et al.*, 1991b, p. 230).

What has to be understood in this context – is how a person's sexuality is intimately involved with their whole system of functioning in their personality, in their social matrix, and in their physical body. Furthermore, in relation to any form of treatment, while sexual problems can be seen as dysfunctions in sexual intercourse, the clients also have to be seen as having a psychodynamic relationship between their biological, psychological, emotional and social interactions.

What is Psychosexual Psychotherapy?

The psychotherapy community that largely deals with sexual issues mostly focuses on

5. www.nature.com/subjects/neuroscience

three pillars. One deals with sexual issues as sexual problems; a second looks to enrich sexual intimacy between partners; and a third regards sex within a paradigm of personal growth (Resnick, 2004). All these three pillars show a fairly holistic model in the treatment of a lot of sexual problems.

It is not only to understand the problem of disorders or symptoms concerning sexuality and to offer an appropriate therapy, but there is more than this. It is also important to understand the psychodynamics behind the symptoms as a mutual reaction in a relationship among partners, which means: what is going on in their bodies; how they are expressing their feelings; how they understand their occurring emotions; how they behave sexually in their intimate relationship and in intercourse; and what are their thoughts about how they are bonding with each other. This demonstrates the psychodynamic component in psychosexual psychotherapy, which is a more holistic and integrative approach than just to understanding and treating sexual disorders.

The author of this paper is working on developing a model where the transcultural aspects of sexual disorders are also presenting as important elements.

Having in mind ethical standards about protecting client's rights, names and descriptions in the case study presented in this paper has been altered, so it can be used to illustrate this particular approach to the treatment of a sexual disorder.

A couple came to my practice: they had lived together in their marriage for twenty-two years. They told how that, for the last few months, their sexual intercourse was not satisfying their expectations, because they had a feeling that something was not physically right with their genitalia. The man, who was 51 years old, had visited a urologist, and the woman, 45 years old, had visited a gynaecologist. Both the doctors said that the couple may have an organic problem; the urologist said that the man might have a problem with his prostate, and the gynaecologist said that the woman might have problems with possible tumours. Both doctors suggested doing further examinations and checking out their organic functioning.

This first exploration, which was very direct, created unhappiness in the couple and broke their mood, and from that moment on they stopped having regular sexual intercourse, which had a very negative impact on their relationship. The couple had become very worried about their future, and this was why they didn't want to go any further with the recommended examinations.

They came into my office and asked for advice as to whether they really should go for these examinations. I recognized how worried and scared they were about their genitalia and sexual functioning. For that reason, I focussed, for the first three sessions, on psycho-education about their anatomy, physiology, and the functioning of their nervous systems, especially during the reproduction period. I also explained the possibility of having some pathological diseases, and if that was the case, they should first have a checkup examination with the medical laboratory.

After my deep and broader explanations, the couple agreed to go for the checkup. They were lucky, the result from the lab examinations showed no pathology and they returned to my practice, and, after some more sessions, their sexual relationships became more satisfying, and their mood improved, and lust increased during their sexual intercourse. Given their psychological aspects, the couple increased their self-esteem, and their desire and love were renewed to become similar to the first years of their marriage. This was a good starting point, and I recommended they have some

additional sessions on how to have a better quality in their sexual life by applying the psychosexual psychotherapy model.

This case demonstrates how often many sexual dysfunctions manifest themselves through somatic complaints and, at the same time, can disappear in the course of life event experiences and using bodywork exercises without any medication. Applying bodywork by using different breathing techniques, increased body awareness, expressing feelings and emotions, and focusing on life events in relationships, forms the basis of this type of Psychosexual Psychotherapy.

Psychosexual Psychotherapy should be seen as a form of a phenomenological awareness, where the person's sexuality is not just biological (Freud, 1977b), nor just fulfils some primary biological needs (Maslow, 1970), but also includes emotional and socio-relational partnerships (Levine, 1992). From this phenomenological point of view, it is helpful to see Psychosexual Psychotherapy as consisting of two terms, 'psycho' and 'sexual', but these are not diverse and understood separately: there is a much deeper level of understanding.

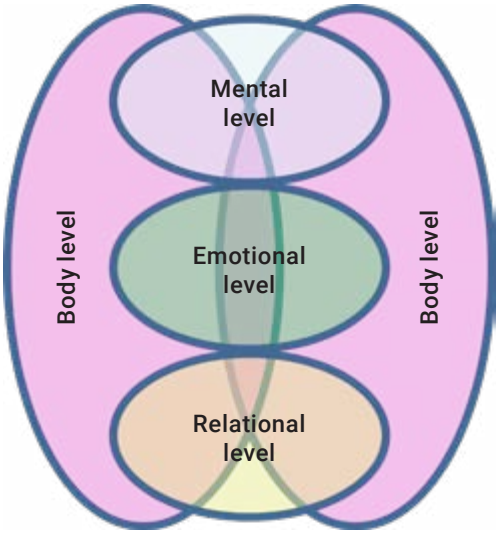

Figure 1. *Four levels in the Psychosexual Psychotherapy model. (Çesko, 2023)*

Psychosexual Psychotherapy

'Psycho' includes the primary scenario from the early childhood period throughout a person's various life event experiences, developing out of primary concepts that develops into a **"primary we"** (Peseschkian, 1980), which means how we have developed an existential philosophy of our life through all the various influences from our grandparents, parents, family traditions, values, belief systems, school, social, peer and societal surroundings, etc., thus creating conceptualisations of our inner and outer self.

One of the common difficulties in relationships among couples and/or partners can be seen as conflicts between different intergenerational patterns, passed down from grandparents to parents to children (Resnick, 2004). This is why these kinds of patterns are transmitted as ineffectual habits from unhappy marriages and then mechanically inflict those same patterns on their own relationships (Schwartz, 2000; Teachworth, 2000; Zinker, 2000). This concept also includes the emotional, social, and relational aspects that are building the psyche of human beings.

'Sexual' includes all the biological and physiological factors that are nevertheless undivided from the primary scenario (Rosenberg & Morse, 1996), as the interactions between the psychological and sexual elements that go towards building the whole concept of psychosexual understanding. To understand this 'Psychosexual Psychotherapy' approach, it is necessary to emphasize comprehensive and optimal sexual health care, which usually includes physical, mental, emotional, social, and spiritual approaches. Integrating these

aforementioned elements enriched the operationalization of the field of Psychosexual Psychotherapy in the treatment of different psychosexual problems and difficulties. Problems, difficulties, and/or disorders are seen from within Psychosexual Psychotherapy as an integrated whole within the partnership relationships. This is similar to how Rosenberg sees sexuality as: *"a person's total energetic process and finds that the ways he uses and/or blocks his energy apply to all areas of his life."* (Rosenberg, Rand & Asay, 1991a)

This concept of Psychosexual Psychotherapy is an integrative, psychodynamic, and humanistic model that uses the salutogentic method [5] in the treatment of sexual disorders, problems, and difficulties by increasing the awareness of the ability to achieve a healthy and qualitative sexual life in partnership relations, rather than focussing on possible pathologies.

Psychosexual Psychotherapy was created to help teach mental health professionals by offering professional services to people, who have psychologically based sexual disorders that are too severe or complex to resolve on their own. Psychosexual Psychotherapy is not just a therapy – a treatment, but it is much more than this: it is a psychotherapy that involves the integration of body, mind, emotions, and behaviour.

Incorporating one's basic needs (Maslow, 1954) and aspects of the salutogenic method (Antonovsky, 1979) = in the Psychosexual Psychotherapy model are among the main concepts that focus on human beings' actual capacities. The central point in Psychosexual Psychotherapy is not the 'symptom' approach, but the source of the symptoms. Psychosexual Psychotherapy does not deal with symptoms

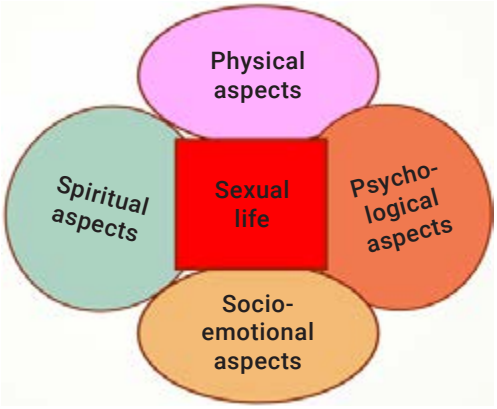

Figure 2. Balance model in four aspects of sexual life according to the Psychosexual Psychotherapy model *(Çesko, 2023)*

of disorders, but it focusses on the causes that provoke the symptoms, trying to approach from a person's capacities so as to reach a better quality and healthier life.

The essential goal of psychosexual psychotherapy is to identify the roots of causes of sexual problems and difficulties and then treat them appropriately by using specific techniques that involve body, mind, emotions, and behavioural aspects.

According to Psychosexual Psychotherapy, sexuality is the processing of energy in four distinct aspects with the purpose of keeping the balance between these four aspects that will produce a healthy, balanced life. These four aspects are: **a)** a somatic aspect, which includes the physical body, which means how our body is confident with its own body; **b)** psychological aspects, which includes the cognitive body, which means how we recognize and respecting own thoughts, knowledge's and capabilities; **c)** social-emotional

5. 'Salutogenic' here refers to an approach to health that focuses on the factors promoting well-being and resilience, rather than solely on the causes of disease.

aspects, which includes the emotional body, that means how we are dealing and coping with our feelings and senses, and how we are confident and enjoying our sexual relationships; and **d)** spiritual aspects, which includes the spiritual body, which means how we are integrating body, mind, emotions, and behaviours in a whole system of operating, and development of inner and outer self through concepts, values and believe systems. (Fig. 2.)

If one of these aspects is not in balance with the other, or the energy is more and less in one of these aspects, our overall life system is not functioning in a healthy way. The energy in these four aspects is flowing continuously, outside of our control, but the balance will become broken when our daily activities avoid the attention of one of these aspects. Because of the imbalance of these aspects, our sexual life is not functioning in a proper way, and it is this imbalance that causes many sexual dysfunctions. Many of our clients are asking for Psychosexual Psychotherapy treatment because of a imbalance in these four aspects.

Understanding our sexuality in this way can help us to enjoy our lives more, and the enjoyment of life produces a better quality of life. All of these make up the harmonious balance in a healthy organism. All human beings are sexual from the day that we are born until the day we die, and a basic understanding of our sexuality shapes how we express ourselves as human and thus as sexual beings. It is a matter of how we experience and express different aspects of the sexual being, such as body image, sexual pleasure with its satisfactions and dysfunctions, sexual relationships, sexual behaviours, sexual health, sexuality as the reproductive function, and sexuality as unity in mankind. (Çesko, 2023)

Sexuality is – in part – a hormonal energy that flows throughout all the organism and makes the body feel excited by activating the various neurotransmitters and hormones (oxytocin, endorphin, vasopressin, serotonin, dopamine, prolactin, DHEA, etc.), and so the sexual stimulus becomes closer to resembling the act of 'doing'. This process pushes the body to "wake up" from one state of being "silent" to another state of being "emotionally excited". When we are talking about sexual feelings, we can compare sex with a fire: the fire gives heat, and heat gives warmth. The more body heat we have, the more it heats up. Comparing sexuality with energy means that sexuality drives our organism to activate the whole-body machine in realizing the positive hormones and neurotransmitters that are important for our health. Sexuality, according to Psychosexual Psychotherapy, is thus a process that activates four levels in human beings:

- **Biophysiological level** – somatic-physiological changes. The bio-physiological level includes all the somatic and physiological changes that occur in sexuality, which concern the Autonomic Nervous System (ANS) and the hormonal system. Essentially, this means how our body responds to external stimuli. This we call the "Body Self".
- **Psycho-mental level** – cognitive challenges. The psycho-mental level includes all cognitive challenges after the external stimulus that our mind receives and processes consciously or subconsciously to satisfy the personal and social balance. This we call the "Mental Self".
- **Emotional level** – experiences of sensitivity. The emotional level refers to all experiences that take place in a person during sexual energy and cause stronger sensual erotic feelings up to stimulation of orgasmic reactions. This we call the "Emotional Self".
- **Level of Behaviour** – reaction of all three levels (Physical, Mental, and Emotional).

The level of behaviour refers to all three levels integrated so that the person as a whole responds in accordance with appropriate actions to sexual energy. This we call the "Relational Self". It means how a person enters into a relationship with the right person at a given moment and reacts to the sexual energy that occurs.

Basic concepts within the Psychosexual Psychotherapy model

The different concepts within Psychosexual Psychotherapy means that it is not a completely new approach. It uses some integrative frameworks from various psychotherapy schools that already exist as well as some Eastern healing treatments that use many different techniques and tools. In Psychosexual Psychotherapy, the process of treatment sessions is undergone only when working with couples/partners, but not with individuals. Sometimes, individual sessions are given with only with the man and sometimes only with the woman (or the sexual partners separately), but always integrating these individual sessions into the whole process of treatment of the couple. Also, it is important to say that the concept of Psychosexual Psychotherapy is not only a specific technique or tool, but is a holistic deep psychotherapy that is more than just techniques and tools. Otherwise, it would only be a 'psychosexual therapy', as it would be similar to sexual therapy, but Psychosexual Psychotherapy is wider and deeper.

Psychosexual Psychotherapy is reasonably effective as an integrative psychodynamic model in the treatment of many sexual dysfunctions, such as premature ejaculations, impotence, anorgasmia, vaginismus, or prolonged orgasm and lack of sexual desires – as emotional partnership relational functions that start from the point of developed concepts about sexuality. The basic concepts that are mostly used in Psychosexual Psychotherapy are:

- Life events from early childhood period: It is very important to know the past experiences about the process of sexual development from childhood.
- Conflicts between concepts and energy: This includes how the concepts of sexuality were developed and the challenges faced during the development process, including conflicts and difficulties.
- Sex and sexuality: Differences between the concept of sex and sexuality, according to different values, belief systems, personal experiences and social influences.
- Love, desire, satisfaction and lust: Understanding, knowing, consolidating, and mutually accepting the concepts of love, desire, satisfaction, pleasure, and lust in sexual life.
- Breath techniques: Learning and practicing breathing techniques during the treatment process.
- Beyond orgasm: Learning how to reach the orgasm and even trying to go beyond orgasm (Klisic, 1995).

The Psychotherapeutic Treatment Process in Psychosexual Psychotherapy

Five levels of the treatment process

Psychosexual Psychotherapy, as a psychodynamic and humanistic model with a body-oriented psychotherapy approach, uses five levels of treatment that were borrowed from Positive Psychotherapy theory (Peseschkian, 1988) and that have been adopted into clinical practice.

Before any clinical treatment process starts, the therapist formulates a preparation plan, which includes the first medical checkup for **Medical Anamnesis**[6], using the clients' medical histories with any medication used. It is very important to know some results from **physical examination** by doing some basic neurological, periphery vascular examination, and genital-urological examinations. The last important examination has to be done with laboratory blood checkups, including the hormones, vaginal secrets, and sperm analyses. After these above-mentioned examinations, the therapist can do some psychoeducation about the anatomy and physiology of sexual acts.

In the process of treatment in Psychosexual Psychotherapy, the therapist asks that both partners should become involved in the treatment procedure. It is important to emphasise that during the first two weeks of starting the treatment process, both partners should abstain from full sexual intercourse. The five levels of treatment are explained below.

1. **Level of being aware of actual sexuality: Observation of sexual disorders:** This includes subjective anamnesis from the partner's point of view, how partners see their complaints, how long they have had problems, whether they have had medical examinations, and which of the partners perceives their sexuality as a pathology. Partners are reflecting on their own perceptions of sexuality to each other. The goal at this level is knowing / understanding / connecting with their partner's sexuality and how they are functioning between themselves. These levels of the partners' own sexuality might be taken over 3-5 sessions.
2. **Level of information about sexuality: Knowledge of partner's capacity:** This level starts with some psychoeducation about sexual organs and the physiology of sexual intercourse. Also, both partners are asked about: their subjective and objective acceptance of their capacity to know and their capacity for love; how long the partners have known each other and how much they love each other; about primary and secondary capacities; and how they are using their capacities in certain situations. Partners should reflect on their concepts of two main capacities: their capacity to love (primary capacity) and their capacity to know [understand] (secondary capacity). The goal at this level is a deeper **understanding** about their relationship in their sexual life. These capacities might be focussed on during the 2-4 sessions.
3. **Level of active investments of the partners in each other: Stimulation and encouragement for taking positive steps:** After becoming more aware about their sexual life and knowing more about their actual capacities in their relationships. The partners are encouraged to take some specific actions in the direction of closer sexual intercourse, to do something different, new patterns, styles, or approaches didn't use before. The goal at this level is **taking steps** towards solving the problems in their sexual life. Encouragement at this level might take between 4 to 6 sessions.

6. **Anamnesis** is a medical term that refers to the process of gathering a patient's medical history through interviews with the patient and their partners. The purpose of anamnesis is to help diagnose and treat a patient's condition by collecting information about their past and present health. Here, anamnesis applies to both partners. This is usually done separately. As always, cultural considerations must be taken into account.

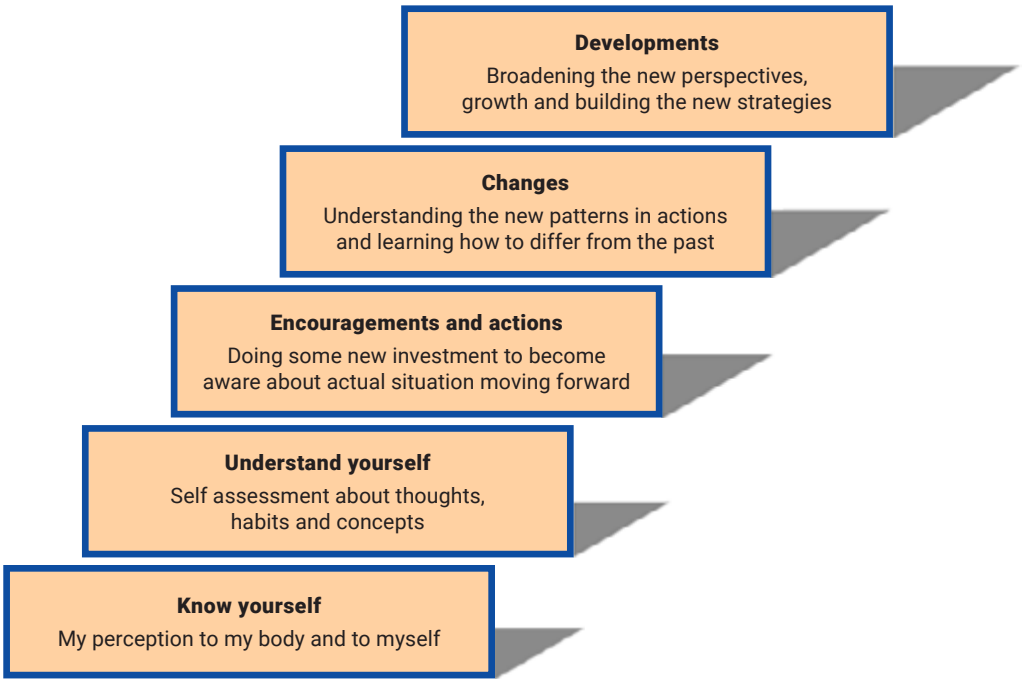

Figure 3. *Five levels of treatment in the Psychosexual Psychotherapy model (Çesko, E., 2023)*

4. **Level of improvements and changing of sexual lifestyle among partners: Meetings being aware of changes and reflecting on any achieved results:** Partners, after their greater investments in new patterns, are becoming aware of their new sexual lifestyle that was changed "from the past to the present" and are aware of sources of new achievements and better quality in their ongoing sexual life. The goal at this level is **changing** some non-functioning patterns by investing in new ones to have a better quality of sexual life. This level might be taken for 2 to 3 sessions.
5. **Level of increasing the orgasm: Beyond pleasure:** In their ongoing sexual life, partners are increasing the orgasm gap, reaching multiple orgasms. At this level, partners are learning new paths "from where we came to where we want to go". This covers the retrospective point of view, what else is needed, and the desire to design a new sexual script to reach the multiple beyond of orgasm. The goal in this level is to the **growth and development** of their sexual life. This level might be taken for 3 to 5 sessions. (Fig. 3)

Techniques used in the treatment process

Psychosexual Psychotherapy is based within the field of psychodynamic & humanistic psychotherapy, focusing on new findings from neurobiological sciences by using the techniques from gestalt, bioenergy, transpersonal, psychodrama, positive psychotherapy, yoga, meditation, dance, and music therapy.

In the first week, partners practice breathing exercises, explore and discover their own

bodies by learning how to touch them, and do individual and pair physical exercises. In the following sessions, partners learn how to do body massages, sometimes with a half-naked body.

The exercises are specifically designed separately for each sexual disorder. Each exercise is followed by breathing techniques and coordination of the client's movements. Some of the exercises have to be done individually (depending on the client's sexual problems), and some will be done in pairs, as always coordinating movements with their breath. The starting order of the exercises is as follows:

- Isometric exercises with the purpose of energizing the sexual hormones and being close to each other.
- Contacts with the clients' emotional body, especially where partners are expressing their deep feelings from emotional body contacts.
- Appling gently soft body touching between the partners who are starting to learn erotic massage over their whole body; focussing, in due course, on the so-called erogenous zones, but excluding the sexual organs. They start off doing it separately, on themselves, and, by the end, both should be able to express feedback about this.
- After continuing with the erotic massage on their own sexual sexual organs and then on sensitive points in their partner's sexual organs, being very aware not to excite each other too much and certainly not so far as to provoke an ejaculation or orgasm.
- This is followed by meditation exercises on sexual images that the partners continue to use after the above-mentioned exercises, and trying to imagine themselves using some sexual positions with each other, before feeling ready for proper intercourse.
- By continuing with their meditations on sexual images, partners are now beginning to start in with their sexual intercourse, going slowly to reach the orgasm. This may bring a degree of emotional and spiritual relaxation, where the partners will start to feel more realized from their complaints and difficulties.
- After all these exercises, the partners should talk about their experiences and give each other feedback on how well they had reached their goals.

All the exercises should be started off with the partners being half, partially and/or fully naked at the clients' discretion. Exercises are practiced for 45-60 minutes daily for 5 days, weekly, over several weeks. It is important to inform the clients that their own inner psychotherapeutic processes are asking for engagement and investment of both parties through these trust-building exercises, building increased confidence, and hoping to reach towards their aim of resolving their sexual problems and healing the dysfunctions in the clients' sexual life. There are no mathematical formulae that can be found to chart each couple's process, but it is possible there may be some defaults or set-backs, which can prolong the treatment process.

Conclusions

Psychosexual Psychotherapy, as a psychodynamic, humanistic and integrative model, gives a new perspective model in the Body-Oriented Psychotherapeutic approaches, applicable to the treatment of different psychosexual problems, difficulties, and disorders. Since each client couples are unique in their personality make-up, successful treatment must be based on an appropriate ap-

proach that will fit the clients' problems, disorders and personalities. In the Psychosexual Psychotherapy model, the treatment approach uses the five levels (mentioned above); which is why Psychosexual Psychotherapy supports the Hippocratic ethos, "There are no diseases, but there are sick people".

Using a variety of techniques and methods, Psychosexual Psychotherapy is on the way to demonstrating its development in clinical practice with different transcultural participants in different settings, such as case studies, workshops, seminars, and training education. Our experiences show that no matter what type of clinical or educational approach the participants have, the Psychosexual Psychotherapy model is very adaptable and readily acceptable for all types of clients and students in many different cultures and religions. As much we are applying and using the model in psychotherapy settings, the integration of different techniques with clients is becoming easier to be accepted by participants and by the surrounding psychotherapeutic culture.

This model is a newly developed integrative approach to the developmental process that is also open to new updates. It uses the clinical experience of different professionals from different societal and cultural backgrounds, who work with sexuality and psychotherapy.

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Existential Empathy as the Foundation of the Clinical Supervision Process: Applicability within the Supervision Pyramid

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Ioana-Eva Cădariu & C. Edward Watkins, Jr.

Abstract: Existential empathy has long been recognized as an essential element of the therapeutic relationship, focused on deeply understanding and being an accompanist to human suffering. In this conceptual-to-practical paper, we consider how the Pyramid of Supervision model (Vîșcu & Watkins, 2021) can support the development of existential empathy in the process of supervising psychotherapists in training. The study's specific objective is to integrate existential empathy into each level of the Supervision Pyramid (Vîșcu *et al.*, 2023; Vîșcu & Watkins, 2021). Through a conceptual and applicative approach, an integrative framework is proposed that supports authentic therapeutic presence in the face of the client's existential pain. Conclusions highlight the importance of clinical supervision centered on meaning, humanity, and authenticity in the professional training of psychotherapists.

Key Words: existential empathy; supervision in psychotherapy; supervision pyramid; therapeutic relationship; professional training

As human suffering has taken on increasingly fragmented and complex forms, the search for meaning accordingly has become an increasingly profound need: the process of training psychotherapists emphasizes once again that it can no longer be reduced to the accumulation of techniques or training in a single therapeutic orientation. Training therapists from an integrative perspective, in our view, is fast becoming a necessity. Seemingly, more so than ever before, training in psychotherapy involves becoming acutely aware of those ever

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affecting forces so that professional training meets inner labor and the willingness to inhabit the uncertain space of human encounter. Supervision becomes, in this context, not just a formal framework, but a transformative *space of encounter* in which existential empathy emerges as a (if not the) central resource. The training of specialists competent in dealing with human suffering thus becomes sine qua non and a concern of public policy (Bostan *et al.*, 2024).

This paper proposes a rendering of the Pyramid of Supervision model (Vîșcu *et al.*, 2023; Vîșcu & Watkins, 2021) through the prism of existential empathy – that deep capacity to be with the other in the face of the quintessential existential questions: suffering, freedom, responsibility, loss and meaning. Each level of the (four-level) pyramid is examined as an inner territory to be explored, in which the supervisor-supervisee relationship takes on deep intersubjective dimensions. Case analysis, its supervision no longer only relevant to the client and therapist/supervisee, also becomes relevant in the way supervisors find themselves in the client's story, confront their own existential themes and learn to remain present in the face of the unknown. Supervision, when understood in this way, is a living relational practice in which empathy is not a technique but a *way of being* – an act of accompanying, journeying, joining; of *being with*, neither saving nor correcting.

We will present the concepts addressed in the paper from a humanistic-existential perspective: existential empathy, the framework of supervision, the Supervision Pyramid. Then, the focus will be on: (a) detailing the four levels of the Supervision Pyramid through the lens of existential empathy and (b) identifying the possible strategies that can be used for each level of the pyramid. Going through each level of the Supervision Pyramid helps the supervisor and the supervisee to reflect on the existential themes, to acquire the courage to be with the client and with one's own self in dialoguing with the existential challenges.

Existential Empathy

Empathy occupies a central place in humanistic/existential psychotherapy, as it is the foundation through which the therapist authentically connects with the lived experience of the client, thus facilitating the process of healing and personal growth (Cădariu & Vîșcu, 2025; Elliott *et al.*, 2011; Rogers, 1957). Although the literature has intensively explored the cognitive and affective dimensions of empathy, **existential empathy** is a deeper and more subtle concept. This goes beyond mere emotional resonance and involves penetrating the existential landscape of the human being: suffering, freedom, loss, isolation and the search for meaning (Spinelli, 2005; Vanhooren, 2022).

Existential empathy is not just about understanding what the client is feeling: it is foremost an act of defiant submission, of radically opening oneself to stand in the places and spaces with the other person in the face of life's most troubling quintessential questions. That deep phenomenological openness renders ever possible a therapeutic stance that preeminently privileges presence (*being here*, *being now*, *being with*, *being for*; Colisimo & Pos, 2015), suspending theories or corrective interventions in favor of authentic human encounter (Cooper, 2003; van Deurzen, 2010). Vanhooren (2022) emphasizes that this type of empathy is not learned through theory alone but involves ongoing training – in presence, reflection, and emotional availability, a willingness to bear witness to and immerse oneself in the client's existential reality. In this sense, existential empathy becomes not only an essential quality for an authentic therapeutic relationship but also becomes prerequisite for co-creating a space of meaning in therapy

(Vanhooren, 2018). This approach prioritizes supporting clients through *dignity and humanity accompaniment*, without minimization or reinterpretation of their painful life experiences (Geller & Greenberg, 2012). Likewise, existential empathy also becomes a *sine qua non* feature for an authentic, supportive supervisory relationship, necessary for quality supervision and development of the supervisee's professional identity (Krug & Schneider, 2016).

Recent contributions have significantly clarified the construct of existential empathy. Vanhooren *et al.* (2022) developed the Existential Empathy Questionnaire (EEQ), providing a valuable tool for measuring therapists' ability to respond to the existential dimensions of human experience. Experiential-existential training and reflection-centered supervision processes play a fundamental role in cultivating these competencies (Cooper & Dryden, 2016; Vanhooren, 2014). These training contexts privilege the therapist's personal development in concert with humanistic values.

The current socio-cultural context is increasingly marked by existential crises – anxiety, loneliness, loss of meaning – and the therapist's ability to respond with existential empathy seems more needed than ever (Cădariu & Vîşcu, 2025; Wong, 2020). We contend that psychotherapy training programs, regardless of the therapeutic orientation, need to contain modules that emphasize the formation and cultivation of existential empathy, what we view as a common factor in psychotherapy. Existential empathy, humanizing the therapeutic relationship, also challenges therapists to examine their own existential positioning in the encounter with the suffering of the other. The therapist's existential positioning in the encounter with the client and the client's suffering is practiced in the supervision traineeship in the framework of the supervision dialogue. In this respect, supervisors are also concerned with creating a supervision framework that facilitates the development of existential empathy in supervisees. Thus, existential empathy in supervision – as in therapy – is an act of defiant submission and radical openness, of *being here*, *being now*, *being with* and *being for* the supervisee and the client. Supervisors' existential empathy thereby transcends technique, providing the framework for authentic encounter: not to save but to accompany; not to explain but to understand.

The Supervisory Framework

Martin Buber (1972) emphasized the transformative potential of dialogue as an encounter that fosters authenticity and reduces feelings of existential alienation. In the therapeutic context, this 'I-Thou' relationship offers a profoundly humanizing alternative to objectification via 'I-It' encounter, inviting both therapist and client into a living, co-creative process (Buber, 1988). It is precisely in such an encounter that clients, feeling that their own resources are no longer sufficient, seek the help of a psychotherapist – not just for techniques, but for relational presence.

And so it is in supervision, too: a genuine dialogue based on honesty, presence and mutual openness becomes not just a method but an existential attitude, a *supervisory way of being*. The supervisor is receptive to the emotional and cognitive experiences of the supervisee, recognizing the autonomy of the supervisee and validating that the first contact with the client is their own. The dialogue becomes a shared process of reflection and meaning, in which both participants construct not only strategies but also identities (Habermas, 1984).

The supervisory dialogue is the crucial ingredient in the development of the psychotherapist's identity. Thus, supervision becomes a dialogic space in which lived experience is not

dissected but explored as living narrative. As Stolorow (2015) has emphasized, reflective self-understanding is a natural fruit of the relational process. Supervision invites both parties to reframe meanings and generate a new conceptualization – a shared intersubjective understanding (Harrison & Tronick, 2022; Yerushalmi, 2024). Supervision is about acquiring new meanings in working with the client, in understanding the personal world.

But authentic dialog is not without tensions. Dialectic, as defined by Hegel (1812/2010), is a process of reconciling opposites – self and other, autonomy and vulnerability. Supervisees and supervisors may have divergent perceptions of the same clinical situation described by the supervisee case presentation. This divergence, however, is not necessarily an obstacle but can be an opportunity for relational humility and curiosity. When supervisees overly occupy the conversational space, they risk overshadowing the co-creative process, but a posture of "knowing through not knowing" opens pathways to mutual transformation (Watkins *et al.*, 2025; Watson *et al.*, 2017). Because contemporary therapeutic dialogue has increasingly shifted from an epistemological to an ontological framework (Yerushalmi, 2024), supervision accordingly is best positioned to focus on genuine emotional engagement, 'being', and collaborative reflection. Dialectics – knowing and not knowing, being present and keeping distance – shape supervision into a living field of becoming.

This dynamic is also reflected in the master-slave metaphor formulated by Hegel (1807/1977), but reinterpreted by Butler (2000). The desire for recognition, when unfulfilled, leads to alienation. But through creative action and mutual recognition, freedom is regained. Within the supervisor-supervisee dyad, mutual recognition supports authenticity, breaking down narcissistic defenses (Gurevitch, 2001), and allowing each to see themselves more clearly. Supervision therefore becomes not just a framework for technical analysis, but a profound mirroring of the professional self. Blum (2018) describes this process as a meta-conceptualization, allowing those involved to overcome their own subjectivities. When the dialogue is sustained in a dialectical spirit, supervision aligns with the promise of humanistic psychology: that of sustaining becoming – for both the supervisor and the supervisee.

The supervision setting, we contend, is a sacred space. Striving to establish that safe, sacred, supportive supervision space, regardless of therapeutic orientation, is supervisor *sine qua non* and foundational for the beginning of a good supervision. Early supervision meetings provide opportunities for supervisor and supervisee to begin building a constructive working alliance and real relationship. Furthermore, the supervision framework can be greatly facilitated by the utilization of a supervision agreement, which ideally is invitational, clarifying, educational, empowering, and transparent (Watkins *et al.*, 2024). The agreement, a discussion stimulus, is designed to provide information about the nature and specifics of the supervisory relationship (e.g., responsibilities, rights, process, expectations) for both supervisee and supervisor to consider and review. The supervision agreement, once reviewed, discussed, and jointly agreed upon, is a commitment, an assumption of dyadic responsibility – *to be* and *to do* together.

Having made that commitment *to be* and *to do* together, supervisor and supervisee are now perfectly positioned to move dyadically forward. In facilitating that forward movement, we consider the four-level Supervision Pyramid to be eminently useful; its level-by-level description follows, along with the particularization of each level in concert with existential empathy.

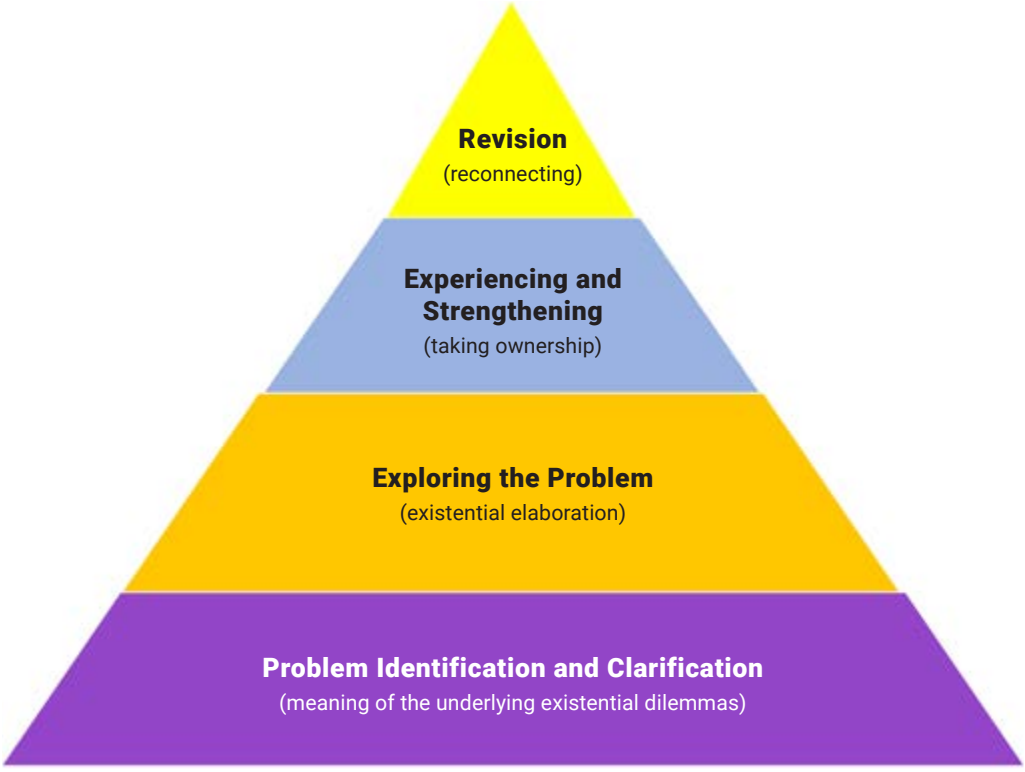

Figure 1. *The Supervision Pyramid as Existential Tool* [1]

The Supervision Pyramid from the Perspective of Existential Empathy

The Supervision Pyramid is not only a didactic tool, adaptable to the personality and learning style of the supervisee, it is also an existential map of reflection, designed to facilitate an authentic supervisor-supervisee encounter. From an existential perspective, each of the Pyramid's four levels becomes an opportunity to confront one's own personal limits and potential. The questions that structure each stage are not just methodological tools, but genuine invitations to introspection, responsibility and the assumption of personal freedom in the face of professional choices. In this way, supervision becomes a deep dialogue in which the focus is on meaning, presence, and human understanding in all their myriad nuances and complexities (Geller & Greenberg, 2012; Vanhooren *et al.*, 2022). Figure 1 provides a visual depiction of the Pyramid as an existential tool for supervision use.

1. Adapted with permission of the publisher, Elsevier, from p. 48 of Vîşcu, L. I. & Watkins, C. E., Jr. (2021). A guide to clinical supervision: The supervision pyramid. Elsevier. [Publishing License available.].

Pyramid Level 1: Problem identification and clarification – or from the expressed needs of the supervisee to the meaning of the underlying existential therapeutic dilemmas

The first level of the Pyramid of Supervision – problem identification and clarification – requires a deep awareness of the difference between expressed needs and the underlying existential problem or gift. The process becomes an exercise in lucidity, in which the therapist-in-training is invited to explore not only the case presented, but also how it potentially evokes personal tensions, limitations, or fears (Vanhooren, 2014). Reflexivity, at this point, transcends the technical plane and becomes an act of examining one's own humanity.

For many supervised therapists, the Pyramid's first level poses significant challenges. The process begins by exploring supervisee expressed needs (i.e., what the supervisee needs now in supervision), with the supervisor guiding a gradual journey towards identifying any existential needs/themes. This stage is characterized by a participatory and co-creative approach, in which the supervisee is actively encouraged to engage reflectively and authentically in the supervisory encounter. In this context, reflexivity takes on a complex dimension – not only the clinical case itself, but also the relationship with the client, the therapist's and client's internal experiences, and the relational dynamics specific to supervision.

Questions in the supervisor-supervisee dialog are opportunities for meaning-making in a reality co-created with the supervisee. Let us imagine that we are in an individual or group supervision session; as supervisors, we invite the supervisee to present their case or section of the case. This is followed by an invitation for the supervisee to formulate their supervision needs (i.e., 'What do you need with this specific case at this time?'). We welcome the totality of those needs with openness, curiosity, challenging wonder.

Formulating the needs for supervision on the part of the supervisee are forms of existential data, some examples being: expressions of existential anxiety; ways that supervisees take responsibility in working with the client; connections to the meaning of personal and professional life; consequences of or difficulties with the managed supervisory framework; difficulties with supervisor presuppositions; and the expression of dialectics in therapeutic dialog. Useful questions for the supervisor therefore would be similar to these:

- How do I prepare myself to best receive the supervisee in the supervision interaction?
- How do I manage the dialectic in the dialog with the supervisee?
- How do I identify the risk of approaching a possible conflict generated by our different worlds, mine and the supervisee's?
- How do I turn the interaction into something positive and constructive?
- Do I trust in my spontaneity as a supervisor, in my creativity to quickly find the common path of constructing new meanings?
- How does my learning style differ from and affect my supervisee's learning style?

A safe supervision environment encourages supervisees to express themselves freely and co-construct new meanings of the interaction with the client. Supervision is a space of awareness predicated upon at least three worlds – the client, supervisee, and supervisor – where experiential learning takes place and new meanings are acquired. As supervi-

sors, we enlarge the safe space of supervision via Socratic dialog, "not knowing" and manifesting an attitude of awe and wonder, precisely so that the supervisee can acquire new awarenesses and, thus, new meanings about self, client, and the world at large.

Learning is for better personal and professional adaptation to the data of the world. So, the focus of supervision is on:

- Formulation and reformulation of supervision needs by the supervisee;
- Identification of the sources of the need for supervision: difficulties in managing existential data, inadequate ways of being, of attitudes as a therapist, distancing from the therapeutic relationship with the client; difficulties or lapses in setting the framework of therapy;
- Establishing agreement between supervisor and supervisee on supervision needs and redress of those needs;
- Initiating learning in supervision by expanding the meanings of acquired awarenesses so that both supervisor and supervisee learn;
- The areas or directions where the awareness of the supervisor will be raised and how the awareness will be implemented, with its meanings in the personal and professional life of the supervisor.

What is the basis of the co-construction between supervisor-supervisee:

- Agreement integrating both supervisor-supervisee viewpoints,
- Recognizing the supervisee as an autonomous, independent person;
- Recognizing clients as experts on their suffering, striving to understand why clients act as they do and why;
- Identifying rules of engagement for therapist-client and supervisor-supervisee;
- Recognizing the personal, historical, social, cultural contexts that are brought into the supervision space, the worlds of the supervisee, client, and supervisor

In stimulating advancement through the Pyramid's first level, the supervisor can draw on a repertoire of open-ended questions and invitations to reflect that valorise the existential experience of the supervisee, such as:

- "Help me understand what it means to you ..."
- "You say you feel ... What does that feeling mean to you?"
- "How would you define this experience in your own words?"
- "What other words could express this feeling that seems to demand your attention?"
- "At what stage in the therapy did you feel that this came alive for you?"
- "I would suggest that we gently revisit that moment that seems to have significance."
- "Has this theme come up in other therapeutic contexts? What does this tell you about your journey?"
- "What do you think it might mean for you if this problem recurs or persists in the background?"
- "What moment in your client's experience has triggered discomfort or made you reflect on existential dilemmas?"
- "What questions could you formulate for your client to encourage them to explore their existential themes?"

In order to facilitate work at this level, the supervisor can integrate a range of supportive

strategies that are grounded in an empathic presence, attentive to the existential dimension of the supervisee's process (Vîșcu & Watkins, 2021):

- **Focus**:

  "I invite you, with gentleness and openness, to dwell together on this moment that seems to carry within it something important to you. What do you feel is asking to be seen here, together?"

- **Maintaining the direction of supervision**:

  "I'd like to stay anchored in what we've chosen to explore, but I notice that you return to this with particular intensity. What does the repeated presence of this theme convey to you? What might it want to tell us about you, here and now?"

- **Defining and redefining the problem**:

  "We have reached together a possible formulation of the difficulty. From your inner space, how would you describe this experience that accompanies you?" "What makes the act of naming it difficult?" "If you could speak to it from a place of your truth, how would you reformulate this problem?"

- **Clarifying the problem**:

  "This difficulty seems to have arisen at a particular point in your experience. How did you experience that moment in your body, in your emotions, in the thoughts and meanings you gave to your reality then?"

  "If you would allow yourself to review your journey with a compassionate gaze, where do you feel this pain, this restlessness, this unspoken question?"

  "Do you feel that this difficulty is new in your professional life or does it seem to have older roots, resurfacing in a different form?"

- **Structuring tasks generated by the problem**:

  "In what other contexts in your professional or personal life do you feel this theme might re-emerge, again demanding attention and meaning?"

  "How do you think this difficulty shapes your presence – in relation to your clients, but also to yourself?"

  "What signs do you feel might show you, in therapy, that this theme is alive and present? What about in your daily life – in the intimacy of your relationships, in the way you feel with others or with yourself?"

Through these interventions, supervision at this first level becomes a space of deep questioning and self-reconnection. It is a process where difficulty becomes a gateway to meaning and questioning, opening the way to personal and professional transformation. By formulating and reframing the need for supervision through meaningful dialog, the meaning of existential themes can accordingly be identified and clarified.

Pyramid Level 2: Exploring the problem – from influence to responsibility or existential problem exploration and elaboration in supervision

Once the problem is identified and clarified, the second level proposes an existential decomposition of its influence via exploratory deepening. It is a space for amplified reflection, which remains faithful to the supervision framework. The supervisor is mindful of the possibility that the identified problem may have been expressed in both the therapeutic and supervisory relationships – in the form of a parallel process or even a transposition into action. The aim of this level is to help therapists understand the extent and uniqueness

of any such impact on them. It is a process of turning inward, in which meaning is (re)constructed through a careful examination of relationships, experiences and meanings.

Questions aimed at clarifying the relationship with the client, self and supervisor become opportunities for identifying recurrent relational or existential patterns (Spinelli, 2005; van Deurzen, 2010). This is where parallel processes and unconscious mechanisms are often made manifest, juxtaposed with the possibility for empowerment and reconfiguration of the relationship with the self and therapeutic act (Vanhooren, 2018). Questions for the supervisor to ask at this juncture would include:

- "The problem identified in the client, what did it trigger in you as an emotion?"
- "How are the client's existential themes similar to yours? Have there been one or more such themes?"

Some supervisor strategies, informed by existential empathy perspective, are:

- **Break down the problem and explore its influence**:

  "How do you feel this issue has touched you in your relationship with your client? What about in relation to others around you … and me, here in this space where we meet? What is revealed of you in these different relational mirrors?"

- **Identifying the components of the problem**:

  "We notice together that this problem seems to be made up of several facets. Which one resonates most deeply with you?" "How do you feel these issues have touched you in your work with this client? How have they echoed in your relationships with other clients? What part of you moves when these dynamics arise?" "What did you notice in the client's reaction when you brought this issue into the dialog? What was alive for you in that moment – in your feelings, thoughts, in your body? And how do you think the client experienced that exchange? What reverberated between you?"

- **Emphasizing the critical components of the problem**:

  "Which part of this issue do you feel touches a sensitive spot in you? What seems to be the hardest to look at or contain? And how do you think this intensity reflects on the client?" "Do you feel you are sharing some of this deep theme with the client? If so, how does it feel to inhabit a shared space of vulnerability and meaning?" "Have you noticed if any of this experience has made itself felt here between us? Perhaps subtle, perhaps fleeting – but present?"

- **Analyzing therapeutic goals through the prism of the problem**:

  "Now, having a deeper understanding of the problem, how would you rewrite the therapeutic goals from a place of clarity and compassion? How would you reframe the intention of your work with the client?" "What directions in therapy do you feel have been most overshadowed or diverted by these sensitive core issues?" "If you could reframe the goals of therapy, what would you make central? What would you bring into the space between you with more awareness?" "How do you feel you could bring these new perspectives into the relationship with the client? How would you create a space where they feel seen, invited and valued in renegotiating this journey?"

The end of this stage often brings new energy to the supervisee, a sense of clarity, curiosity and vitality. By breaking down the problem, by recognizing its relational and professional in-

fluences, the therapist not only sees the therapeutic process differently, but begins to look forward to it with a more authentic presence. The client is no longer a source of anxiety but becomes a partner in meaning. At the end of this second Pyramid level, the supervised therapist has the opportunity for further personal and professional identity development: the supervisee can acquire new meanings in their personal and professional life via self-identifying dilemmas, value congruence crises, and even their role as therapist (e.g., elaborations upon Who am I as therapist?). Frequently brought up by the supervisee at this Pyramid level is the impostor complex, the therapist feels `fake`, the desire emerges to do something specific for the client in order to achieve imagined therapeutic goals. The supervisee's *flight into 'doing'* can reflect their difficulty in staying with clients and their identified existential problems or challenges. So, the existential empathy displayed by the supervisor in dialog with the supervisee can help identify how the client's problem might reverberate in the supervisee. The supervisor bears witness to any such possible reverberations.

Pyramid Level 3: Experiencing and strengthening – taking your own freedom, returning to presence and taking ownership

Stage three marks a *return to the present*, but one enriched with meaning, awareness and authentic choices. The supervisee is encouraged to experiment with alternatives, reframe goals, take on frustration, uncertainty, and at the same time, recognize their resources and limitations (Wong, 2020). This stage is a *space for ethical engagement* and for strengthening the presence of the supervised therapist in working with the client.

At this stage, the supervisory relationship becomes a living space of experimentation, in which the supervisee integrates all the understanding gained so far. The supervisory relationship is also a space for the therapist's assumption of responsibility and freedom. It is a transitional zone between clarification and commitment, between professional self-awareness and genuine desire for transformation. Previously identified problems are now analyzed, experienced, integrated and have been converted into developmental potential. The supervisor, as an existential partner, supports the process through an empathic presence and a deep attention to what is alive in the supervisee. Questions no longer seek quick answers, but become open spaces for reflection:

- What do you feel has limited you, what you have not identified ...?
- What might have caused you not to identify your resources?
- What has been added now – as opposed to before the supervision session began?
- What will you change in your reporting on existential data?
- Which question do you think would help your client to authentically engage in the therapeutic relationship?
- What aspect of yourself is now demanding to be heard?
- How does the decision to act differently feel in the body?
- Where do you encounter resistance and how would you like to deal with it?

Strategies used by the supervisor at this stage include:

- **Navigating frustration and inner discomfort**:
  Through a compassionate approach, the supervisee is invited to explore their inner tensions:

  - How might frustration manifest in your relationship with the client, with me, or with yourself?
  - What do you need in order to allow yourself to feel?

- **Bringing parallel processes to light**:
  A gentle awareness is cultivated, oriented toward identifying repeated relational patterns:
  - Might part of your relationship with the client be playing out now between us?
  - How do you recognize when you are being "pulled" into a familiar game?

- **Exploring alternatives and latent resources**:
  Through collaborative dialog, the space of internal and external resources opens up:
  - Where are your resources today, however subtle?
  - How can you bring your authenticity to the therapeutic relationship?
  - Let's test through a role-play: if I am your client, how would you like to talk to me about what you understand?

This stage is one of courage – the courage to stay in touch with what is uncomfortable, but also with what can become fertile. It is the space where transformation takes root, guides, and abides; and the fear of failure is replaced by the courage to try and learn, to constructively and productively act.

Pyramid Level 4: Revision – circular closure of meaning and reconnecting with the wounded self

In the final stage, reviewing and 'bracketing' the problem reflects an existential approach to the ongoing process of learning and meaning. Unresolved issues are accepted as part of the human condition and can be acknowledged without shame or self-blame. This level provides a space for the integration of insights, transformation, and a kind of professional wisdom that is not reduced to knowledge but also includes acceptance of one's own fragility and complexities (Vanhooren *et al.*, 2022).

At this stage, supervision becomes a space for re-encountering the vulnerable self, the self that thought it had overcome a problem, only to discover that the problem persists, silent, in the depths of the therapeutic experience. This is not about failure, but about the natural cyclicity of awareness, about how what seemed resolved demands new meaning in the light of the present. Existential empathy supports the process of coming to terms with limitations, of re-evaluating meaning, of integrating the lessons into the personal and professional identity of the supervised therapist. Revision as the last level of the supervision pyramid is a *hermeneutic process of reconfiguration* of the therapist-client and supervisee-supervisee relationship: supervision is a growth experience for both therapist and supervisor.

Existential empathy becomes the relational compass: the supervisor does not judge, does not explain, but accompanies, serving as witness to the process by which the supervisee recognizes shame, disappointment, self-punishment – not as forms of regression, but as points of access to authenticity. Any issues that resurface are signals that there are still unhealed parts inside, fragments that demand understanding. By 'bracketing', supervisees learn not to avoid but to respect their own pace of processing. Questions at this stage are not centered on performance, but on attendance:

  - What part of yourself have you found today?
  - How did you feel as you discovered that the problem was not "closed"?
  - What changes for you when you let go of judging yourself for the recurrence of this difficulty?

The strategies used by the supervisor are:

- **Assessing lived gain, not just cognitive**:
  - What was meaningful to you today beyond what you learned?
  - What remains with you after this session that cannot be written down in a summary?
- **Exploring emotional maturation in relation to the original issue**:
  - How do you know you responded differently in your relationship with your client?
  - What specifically did you do differently?
  - What new emotion were you able to embrace without rejecting it?
  - What have you personally learned about your existential empathy in this case?
  - What question would you ask to end the therapy hour?
  - What question would you formulate to end the supervision hour?
- **Validating humanity in imperfection**: The supervisee is encouraged to notice the self-penalizing tendency and bring it into dialogue:
  - What might you be trying to protect when you criticize yourself?
  - How about letting go of the burden of disappointment fears and simply `be` you, the one who feels and experiences?

This stage is about coming to terms: with one's limits, with the rhythm of the process, and with the relationship that holds collective space for all its inhabitants. In the silence of the moment, it is not a conclusion that is sought, but a genuine silence in the face of a question that can remain open.

Therefore, the Supervision Pyramid can be seen, from an existential perspective, as a living and dynamic framework in which the therapist-in-training is supported to (re)discover their own voice, presence and meaning in therapeutic practice. Again, it is not just a tool but can be used to instigate a profound formative experience, requiring the courage of reflection, confrontation and self-transformation – in line with the values of humanism and existential psychotherapy

Conclusion

Looked at from an existential perspective, the Supervision Pyramid reveals itself not only as a logical structure, but as a journey of awareness, assumption and reconnection with the profound humanity of the therapeutic act. The encounter between supervisor and supervisee becomes a scene of becoming, in which difficulties are seen not as obstacles but as opportunities for reflection and meaning. The open questions, empathic presence, and willingness of the supervisor to patiently inhabit ambiguity contribute to an authentic formation in which the therapist finds their voice, courage and place in the world.

The Pyramid of Supervision, reinterpreted through the prism of existential empathy, takes on profound values that transcend the mere didactic structuring of the supervisory process. In this perspective, each level becomes a stage of authentic approach to oneself and the other, in which the relationship between supervisor and supervisee is constituted as a phenomenological space of encounter, mirroring and transformation.

Existential empathy supports the supervisor's and supervisee's professional becoming not through solutions but through presence. It encourages not only listening to the client, but also listening to the self – vulnerable, incomplete yet so full of potential. In this sense, su-

pervision is not just about how to do therapy, but about how *to be* a therapist – and also how *to be* a supervisor. And this "being" is learned in relationship, in dialog, in the meaningful silences between two human beings – be they therapist-client or supervisee-supervisor – who choose to meet through encounter.

Existential empathy – understood not as a technique, but as a *way of being* with the other – underpins the entire process of supervision and implies a conscious presence, an attitude of suspension of judgment and radical openness to what is experienced, even when this experience is ambiguous, uncomfortable or contradictory. In this framework, supervision is constituted as ontological dialogue rather than as knowledge transfer.

Each stage of the pyramid provides a context in which the supervised therapist can explore not only technical dilemmas but also inner conflicts, relational vulnerabilities, and existential tensions. From clarifying the problem, through reflecting on the relationship with the supervisee, to integrating experiences and re-signifying personal recurrences, the whole process unfolds in a climate where humanity is valued, and imperfection is not pathologized but understood as a source of meaning.

Supervision is a reflective practice centered on presence and responsibility, which supports not only competence training but also the development of an inner ethic of accompaniment. We refer to an ethic of empathic presence, in which supervisors offer themselves as forever involved witnesses and facilitators of the professional and personal becoming of the supervisee, of the creation of the professional identity of the supervised therapist, while remaining open to and respecting each supervisees own unique process of developmental unfolding.

In conclusion, the incorporation of existential empathy into the process of supervision favours not only learning, but also closeness and interpersonal warmth. In this sense, supervision is no longer a mere institutional framework: it becomes a genuine encounter between two evolving consciousnesses that – in collaborative and courageous fashion – studiously engage and vigorously pursue the ever-unfolding processes of exploration and transformation.

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The Polarizing Effects of COVID-19 on Individuals and Communities

Darlyne G. Nemeth, Cody Capps, Kevin McCarter, Fernando Pastrana, Olesia Palamar & Andrew Nesbit

Abstract:

Objective: During times of worldwide pandemics, personality adaptations tend to emerge. Social isolation occurs when individuals feel separated or disconnected from their community (McIntyre, 2023). Unfortunately, the COVID-19 pandemic did just that. Social connectedness improves individuals' biological, psychosocial, and behavioral functions; however, as social isolation increases, personality functioning decreases.

Method: This six-factor-analytic study of English respondents to a SurveyMonkey questionnaire explored the following six personality adaptations: Antisocial aggressive (advantage takers), Religious adaptation (fundamentalists), Nuisance aggressive (disturbed followers), Militant preparedness vs. Denial (militia), Apocalyptic Psychoid Behavior (disturbed leaders), and Mainstream adaptation (general population). Of these, two significant factors emerged: Factor 2 – Religious Adaptations and Factor 4 – Militant Preparedness vs. Denial (Militia).

Results: Factor 2 focused on the imposed limitations on community gatherings, resulting in conspiracy theories and extremist behaviors. The general public had become vulnerable to disinformation through "deep fakes." The concept of *biophilia*, the human instinct to connect with nature and other living beings, was thwarted (Zelinski, 2012), while loneliness, depression and cognitive dysfunction increased (Cacioppo & Patrick, 2008).

With Factor 4, hyper-defensiveness, paranoia, and tendencies toward violence grew. People prepared for the worst and acted accordingly. The more isolated and paranoid people became, the more trust diminished. Weapons and supplies were stockpiled and used to defend against perceived violations of individual freedoms.

Conclusions: With the increased polarization of these two personality adaptations in communities, wide political and psychosocial schisms emerged.

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Now, the need for community resilience, communication, socialization, collaboration, and healing is critical. Perhaps, psychotherapeutic interventions, via individual and group psychotherapy, positive psychology, and community workshops can be used to bridge this gap.

Key Words: Personality Adaptations, COVID-19 Pandemic, Community Isolation, Biophilia

Isolation During the COVID-19 Pandemic

The field of Ecopsychology combines the science of Ecology, which assesses the relationship of humans to their environment, with Psychology, which evaluates and seeks to understand human behavior (Nemeth *et al.*, 2015). Considering the psychological impact that COVID-19 has had on communities, the COVID-19 pandemic can be viewed as a significant environmental stressor. One key detriment caused by the COVID-19 pandemic was the isolation that occurred within communities (Czeisler *et al.*, 2021). This isolation weakened communities' ability to meet the challenging demands posed by the COVID-19 pandemic. As a result of this, the impact was significantly more damaging than it could have been had there been a united community response. Research has shown that high levels of community cohesion lead to greater levels of resilience in the face of drastic structural changes in one's environment (Nemeth & Whittington, 2012; Kuriansky, 2012; Ojala *et al.*, 2023).

This study examines the relationship between *ecokinietics*, how changes in the environment affect human beings, and *ecodynamics*, how human beings affect their environment (Nemeth *et al.*, 2015). As mentioned by Nesbit and Nesbit (2015), understanding this relationship is challenging but essential in the fight to protect and/or maintain one's environment and/or community. Prior research has shown that certain excessive personality adaptations appear during times of community and/or environmental stress (Lam, 2021; Nemeth *et al.*, 1999). In other words, changes in one's environment can cause excessive personality adaptions to emerge. Some of these adaptions may serve to undermine the community's recovery efforts, making communities less resilient in the face of disaster. Recent examples of this are the COVID-19 pandemic and the ongoing global warming crisis. In order to protect communities from these existential threats, it is essential that any excessive personality adaptations be identified to reduce fallout. Increasing community resilience while reducing isolation is seen as essential.

Due to the chaotic effects of the COVID-19 pandemic, the vulnerable relationship between individuals and their environment was changed. These changes were sudden and unanticipated, occurring with little to no warning. Perceptions, rather than facts, influenced people's reality (Nemeth & Olivier, 2015). As is common in the face of tragedy or disaster, the lasting effects of such a crisis are more often psychological than physical (Nemeth *et al.*, 2000; Cameron, 2000; Ojala *et al.*, 2023).

At the beginning of the COVID-19 pandemic, people generally accepted the recommended health and safety protocols (e.g., self-isolating, quarantining, and eventually welcoming protective vaccines); however, maintaining that level of commitment would prove difficult (Czeisler *et al.*, 2021). In order to assess

compliance over time, Czeisler *et al.* (2021) developed a one-week online, transnational, cross-sectional survey. The survey was administered to respondents via Qualtrics in both the United States (n = 3000) and Australia (n = 1500). Additionally, specific surveys were created for New York (n = 500) and Los Angeles (n = 500). The results from Czeisler *et al.*'s survey found that, among other things, anxiety or depressive disorders were more common among those who reported being in quarantine or voluntarily spending most of their time at home. Thus, anxiety and depressive disorders were more common in individuals who were isolated from their communities.

Community isolation or social isolation occurs when individuals feel separated or disconnected from their community (McIntyre, 2023). According to McIntyre, the number of social connections people have affects them at the biological, psychological, and behavioral levels. He further explains that a higher level of social connectedness can improve these factors, while lower levels of social connectedness can prove to be detrimental. McIntyre adds that loneliness, which is often correlated with community isolation, can lead to increased levels of depression, anxiety, drug use, and suicidal ideation. He notes that rates of social connectivity have been steadily declining at the national level. This increase in social isolation is detrimental to both communities and the members of those communities. Referring back to the bidirectional relationship between humans and their environment, the increased levels of social isolation weaken the social fabric that connects communities. This can result in the emergence of excessive personality types that further strain these communities.

At the turn of the millennium, the perceived Y2K crisis caused people to panic (Nemeth *et al.*, 1999). There was speculation that computerized systems, such as banks and government databases, would cease to function in the year 2000. This projected Y2K bug was caused by a programming error. Historically, dates programmed in computers used an abbreviated two-digit year format that could not accommodate the shift into the year 2000.

It was hypothesized that, at times of worldwide distress, excessive personality adaptations would emerge (Nemeth *et al.*, 1999). This research endeavor began in 1997 when Peter de Jager, a Canadian computer engineer, appeared for a business and industry seminar in Baton Rouge, Louisiana. After hearing de Jager's presentation, Bonnie Bray of Bray Media Services requested that a research project be conducted to explore the effect of Y2K on business and industry. The Y2K data was collected and factor analyzed, revealing four salient outcomes: Content Knowledge of Y2K; Depression/Discouragement; Anxiety/Aggression; and Denial/Resistance (Nemeth *et al.*, 1999).

A follow-up questionnaire, known as The Year 2000 Questionnaire, was developed by a think tank at the Boston University Center for Millennial Studies (Nemeth *et al.*, 1999; Nemeth *et al.*, 2000). Factor analysis results of this millennial study found that six excessive personality adaptations emerged. These were labeled as follows: Antisocial aggressive (advantage takers), Religious adaptation (fundamentalists), Nuisance aggressive (disturbed followers), Militant preparedness vs. Denial (militia), Apocalyptic Psychoid Behavior (disturbed leaders), as well as our unique Mainstream adaptation (general population).

An analysis by Lam (2021) examined COVID-19 personality adaptations that occurred during the COVID-19 pandemic. Lam discovered that COVID-19 personality adaptations that emerged during the pandemic contributed to the spread of the virus and inhibited community responses aimed at preventing the spread

of COVID-19. Lam's results reinforce the notion that unique personality adaptations appear at times of great environmental and community distress.

Several of the personality adaptions, observed by Nemeth *et al.*'s (1999) Y2K study and Lam's (2021) COVID-19 study, reflect a lack of cohesion, leading to a less resilient community in the face of a potential disaster. A precursor of the present study appeared in the 2022 edition of the Lurian Journal (Nemeth & Capps, 2022), which states the following:

> When where one lives is by choice, not by chance, preparedness is the key. In such cases, adversity does not have to become a catastrophe. Facing adversity with a resilient plan of action, that is, 'being prepared,' is the key to a positive outcome. Without such a plan, paranoid and catastrophic thinking take over.

Objective

The objective of this COVID-19 study was to understand the excessive personality adaptations that emerged due to this pandemic and resulting in community isolation. The purpose of this study, *The COVID-19 Questionnaire*, was two-fold:

1. To see if the same factors would emerge at times of global distress as in the Year 2000 Questionnaire.
2. If so, to compare them to the factors that were identified in The Year 2000 Questionnaire.

Method

The COVID-19 questionnaire was usually completed in 10 minutes or less. Beforehand, participants were asked to read and provide consent to participate in the project. If necessary, the study moderators were available for research/consent questions. The questions, which were posted on SurveyMonkey in English, Spanish, and Russian, were related to general demographics, life experiences, and beliefs regarding COVID-19. An IRB review conducted by Advarra (2021) revealed no ethical or informed consent issues. Participants were invited to voluntarily participate in the survey. They were able to skip any question and were able to stop the survey at any time. The questions were based on the 53-item Millennium questionnaire and were altered to substitute the concept of COVID-19 for the concept of the millennium. Other than this substitution, all questions remained the same. See Figure 1 for the Millennium Questionnaire and Figure 2 for the altered COVID-19 Questionnaire.

The authors have taken precautions to comply with Transparency and Openness Promotion (TOP) guidelines. The COVID-19 questionnaire was available in 3 languages, English, Russian, and Spanish. The 3 questionnaires accumulated a total of 262 responses, with 160 English responses, 72 Russian responses, and 30 Spanish responses. Considering their sample sizes, the Russian and Spanish questionnaires were not factor-analyzed. No preregistration of analysis plans was submitted prior to beginning research.

This research serves as the foundation for future studies to assess for alterations in personality adaptations in times of worldwide and/or national crisis. Replication of this study is strongly encouraged.

Results

Preparation of the data for analysis

As seen in Figure 2, many of the questions were of the True/False variety. There were actually three responses possible for each of

these True/False questions: True, False and 'Choose not to answer'. SurveyMonkey assigned the following numerical codes to these three responses: 'Choose not to answer' = 0; True = 1; False = 2.

Latent constructs that result from a factor analysis are interpreted using the loadings of a given factor on the manifest variables used in the factor analysis. When the factors are orthogonal, a loading is the correlation between the factor and the manifest variable associated with the loading. With this in mind, in order to facilitate interpretation of the factors in relation to these True/False questions, the responses were reverse-coded so that they had the following numerical values: False = 0; True = 1; Choose not to answer = 2. With this coding, respondents that scores higher in a factor with a positive loading on a True/False question tended to respond either True or 'Choose not to answer', rather than False, on that question.

In addition to the True/False questions, a number of questions were asked that had categorical responses with many response levels. For example, the question requesting information on Marital Status had eight response levels, which were assigned the following numeric values by SurveyMonkey: 1 = Cohabitating; 2 = Divorced; 3 = First Marriage; 4 = Never Married; 5 = Remarried; 6 = Separated; 7 = Widow(er); 0 = Other (please specify). A few of the categorical variables had ordinal response levels, but most had non-ordinal, nominal-level response levels like the Marital Status question. Since nominal response levels cannot meaningfully be interpreted in terms of correlation, the information provided in response to questions with categorical response levels was re-coded by creating dichotomous dummy variables, one dummy variable for each response level. These new dummy variables were then included in the factor analysis instead of the original categorical variables. Factors can be easily interpreted in relation to these new "presence/absence" type of variable.

For example, eight new dichotomous dummy variables were created to code the information provided in response to the Marital Status variable. Each of the dichotomous dummy variables was set equal to one if the corresponding level of the Marital Status variable had been selected and set equal to zero otherwise.

Factor Analysis Model Building

SAS version 9.4 was used to perform the analysis. An exploratory factor analysis was performed using the FACTOR procedure in SAS. Several factor analytic models were considered. In each case, principal component factor analysis was used to obtain initial factor analytic solutions. VARIMAX orthogonal rotations of these initial solutions were then used to obtain final factor analytic models. The minimum absolute loading used in interpreting factors and constructing factor plots was 0.3.

Factor analytic models were fit using a number of factors ranging from five up to fifteen. In evaluating these various models, important criteria used to determine the number of factors to retain were a balanced factor structure and interpretable factors possessing single, uncomplicated interpretations. It was observed that as the number of factors used in the model was increased, the number of trivial factors with only one or two factors increased as well. Based on these criteria, a factor analytic model with five factors was decided upon.

The original dataset included 160 observations with respondent IDs, however not all of these observations could be used for analysis. Of the original 160 observations, 44 had no responses to any of the questions, and 5 observations had missing values for at least one of the respons-

YEAR 2000 QUESTIONNAIRE

T	F	1.	I believe there is still plenty of time to prepare for the millennium.
T	F	2.	People say that I change my mind a lot.
T	F	3.	I believe that the millennium will bring a period of great upheaval or adversity.
T	F	4.	Although it might seem like boasting, I know others say that I set a good example.
T	F	5.	I need to carry a knife or even a chain or a club to protect myself.
T	F	6.	I am delighted when others are happy or have good fortune.
T	F	7.	I am stock piling food and munitions to survive the turn of the century.
T	F	8.	I am seriously concerned with what problems the year 2000 may bring.
T	F	9.	When someone does something to me, I frankly say, "I'll get even," or "You won't get away with that," or simply, "I'll show him."
T	F	10.	I am planning to keep considerably more non-perishable food on hand in preparation for the millennium.
T	F	11.	I believe in a religious significance to the millennium.
T	F	12.	No special preparations are needed for the year 2000.
T	F	13.	People tell me my eyes often have a "far away look."
T	F	14.	I believe that a military struggle will occur at the millennium.
T	F	15.	My family and I plan to join a religious community before the year 2000.
T	F	16.	I believe that Christ will return shortly before or after the year 2000.
T	F	17.	Others tell me that I say things that do not make sense to them.
T	F	18.	To be honest, I sometimes make "big plans" that don't work out.
T	F	19.	I believe that the answers to my millennium questions will come soon.
T	F	20.	I believe that the religious will be rewarded around the millennium.
T	F	21.	I believe that the end of history, as we know it, will come at or around the year 2000.
T	F	22.	At times, I have planned or helped to plan parties or dances.
T	F	23.	I believe that the millennium will bring an apocalyptic (revelatory) experience.
T	F	24.	I believe that the millennium will bring understanding of God's plan.
T	F	25.	Sometimes I need to demand my share of things or stick to my rights or people would get away with their unfairness.
T	F	26.	I believe that the rapture will come at or around year 2000.
T	F	27.	I believe that the Sabbath millennium of peace will begin in the year 2000. *
T	F	28.	I carry a gun on me or in my car to protect myself.
T	F	29.	I have fenced off my property to protect my family at the time of the millennium.
T	F	30.	I have or will have a large amount of cash in my home for the year 2000.
T	F	31.	I have or will have a weapon to protect my family and myself against civil unrest at the time of the millennium.
T	F	32.	Sometimes I know that I use words some people think are "dirty" or even tell what they think is a "dirty" story.
T	F	33.	I have plans to isolate my family from large groups of people in anticipation of the millennium.
T	F	34.	I have purchased or will purchase a generator for my home prior to the millennium.
T	F	35.	I will have no need for material possessions or stocks after the millennium.
T	F	36.	Somehow, I find myself getting into a lot of arguments.
T	F	37.	I help others who may need it.
T	F	38.	I know there is something wrong with my body or the way I look.
T	F	39.	I have built or plan to build a shelter to protect my family against the government at the time of the millennium.
T	F	40.	I often sit and stare off into space and when I'm asked about it I say, "Oh, I was just daydreaming."
T	F	41.	I plan to purchase a diesel-powered vehicle as gasoline may not be readily available at the time of the millennium.
T	F	42.	Regardless of millennium issues, I plan to purchase a weapon within the next year.
T	F	43.	In order to protect myself and my family at the time of the millennium, I plan to store diesel fuel on my property for use in generators and/or vehicles.
T	F	44.	I play what others think are dangerous sports or I have a hobby they think is "risky business."
T	F	45.	My close friends are of both sexes.
T	F	46.	Others say that I think I am the only one who knows how to do things and that I like to "be the boss."
T	F	47.	I am ready to fight for my rights when martial law is declared.
T	F	48.	Sometimes I have said things that others think are threats.
T	F	49.	The millennium will pass like any other year.
T	F	50.	The police have arrested me for attacking others.
T	F	51.	There is little need for the government to allocate additional funds for the upcoming millennium.
T	F	52.	I believe that I will be prepared by the year 2000.

Thank you for completing the Year 2000 Questionnaire.
Your completion of the demographic information on the following page would be greatly appreciated.

Figure 1. *The Original Year 2000 Questionnaire*

COVID-19 QUESTIONNAIRE

T	F	1.	I believe there is still plenty of time to prepare for COVID-19.
T	F	2.	People say that I change my mind a lot.
T	F	3.	I believe that COVID-19 will bring a period of great upheaval or adversity.
T	F	4.	Although it might seem like boasting, I know others say that I set a good example.
T	F	5.	I need to carry a knife or even a chain or a club to protect myself.
T	F	6.	I am delighted when others are happy or have good fortune
T	F	7.	I am stock piling food and munitions to survive COVID-19.
T	F	8.	I am seriously concerned with what problems COVID-19 may bring.
T	F	9.	When someone does something to me, I frankly say, "I'll get even," or "You won't get away with that," or simply, "I'll show him."
T	F	10.	I am planning to keep considerably more non-perishable food on hand in preparation for COVID-19.
T	F	11.	I believe in a religious significance to COVID-19.
T	F	12.	No special preparations are needed for COVID-19.
T	F	13.	People tell me my eyes often have a "far away look."
T	F	14.	I believe that a military struggle will occur during COVID-19.
T	F	15.	My family and I plan to join a religious community during COVID-19.
T	F	16.	I believe that Christ will return shortly before or after COVID-19.
T	F	17.	Others tell me that I say things that do not make sense to them.
T	F	18.	To be honest, I sometimes make "big plans" that don't work out.
T	F	19.	I believe that the answers to my COVID-19 questions will come soon.
T	F	20.	I believe that the religious will be rewarded after COVID-19.
T	F	21.	I believe that the end of history, as we know it, will come after COVID-19.
T	F	22.	At times, I have planned or helped to plan parties or dances.
T	F	23.	I believe that COVID-19 will bring an apocalyptic (revelatory) experience.
T	F	24.	I believe that COVID-19 will bring an understanding of God's plan
T	F	25.	Sometimes I need to demand my share of things or stick to my rights or people would get away with their unfairness.
T	F	26.	I believe that the rapture will come at or around COVID-19.
T	F	27.	I believe that the Sabbath time of peace will begin after COVID-19.
T	F	28.	I carry a gun on me or in my car to protect myself.
T	F	29.	I have fenced off my property to protect my family during COVID-19.
T	F	30.	I have or will have a large amount of cash in my home.
T	F	31.	I have or will have a weapon to protect my family and myself against civil unrest during COVID-19.
T	F	32.	Sometimes I know that I use words some people think are "dirty" or even tell what they think is a "dirty" story.
T	F	33.	I have plans to isolate my family from large groups or people during COVID-19
T	F	34.	I have purchased or will purchase a generator for my home during COVID-19.
T	F	35.	I will have no need for material possessions or stock after COVID-19
T	F	36.	Somehow, I find myself getting into a lot of arguments
T	F	37.	I help others who may need it.
T	F	38.	I know there is something wrong with my body or the way I look.
T	F	39.	I have built or plan to build a shelter to protect my family against the government during COVID-19.
T	F	40.	I often sit and stare off into space and when I'm asked about it I say, "Oh, I was just daydreaming."
T	F	41.	I plan to purchase a diesel-powered vehicle as gasoline may not be readily available during COVID-19.
T	F	42.	Regardless of COVID-19, I plan to purchase a weapon within the next year.
T	F	43.	In order to protect myself and my family during COVID-19,1 plan to store diesel fuel on my property for use in generators and/or vehicles.
T	F	44.	I play what others think are dangerous sports or I have a hobby they think is "risky business."
T	F	45.	My close friends are of both sexes.
T	F	46.	Others say that I think I am the only one who knows how to do things and that I like to "be the boss"
T	F	47.	I am ready to fight for my rights when martial law is declared.
T	F	48.	Sometimes I have said things that others think are threats
T	F	49.	COVID-19 will pass like any other virus.
T	F	50.	The police have arrested me for attacking others.
T	F	51.	There is little need for the government to allocate additional funds for COVID-19.
T	F	52.	I believe that I will be prepared for COVID-19.

Thank you for completing the COVID-19 Questionnaire.
Your completion of the demographic information on the following page would be greatly appreciated.

Figure 2. *The COVID-19 Questionnaire*

Factor 1		Millenium	COVID
Antisocial Aggressive (Militia)			
Items:			
41.	I plan to purchase a diesel-powered vehicle as gasoline may not be readily available at the time of the millenium (during COVID-19).	✓	×
50.	The police have arrested me for attacking others.	✓	×
29.	I have fenced off my property to protect my family at the time of the millenium (COVID-19 pandemic).	✓	×
5.	I need to carry a knife or even a chain or a club to protect myself.	✓	×

Factor 2		Millenium	COVID
Religious Adaptation (Religious)			
Items:			
27.	I believe that the Sabbath millenium of peace will begin in the year 2000 (after COVID-19).	✓	(F2-Q28)
23.	I believe that the millenium (COVID-19) will bring an apocalyptic (revelatory) experience.	✓	(F2-Q24)
26.	I believe that the rapture will come at or around year 2000 (COVID-19).	✓	×
16.	I believe that Christ will return shortly before or after the year 2000 (COVID-19).	✓	(F5-Q17)

Factor 3		Millenium	COVID
Nuisance Aggressiveness (Disturbed)			
Items:			
25.	Sometimes I need to demand my share of things or stick to my rights or people would get away with their unfairness.	✓	×
40.	I often sit and stare off into space and when I'm asked about it I say, "Oh, I was just daydreaming."	✓	(F3-Q41)
47.	I am ready to fight for my rights when martial law is declared.	✓	×
46.	Others say I think I am the only one who knows how to do things and that I like to "be the boss."	✓	(F2-Q47)
42.	Regardless of millenium issues (COVID-19), I plan to purchase a weapon within the next year.	✓	×

Figure 3. *Year 2000 Questionnaire and COVID-19 Questionnaire Comparison*

es, leaving 111 observations with responses for all variables. Since the FACTOR procedure in SAS excludes any observation with missing values for any of the response variables used in the analysis, these 111 observations provided the basis for the factor analysis.

The factor analysis model building process proceeded in four phases. In the first phase, a principal component factor analysis was used to obtain an initial factor analytic solution, which was then followed up by a VARIMAX orthogonal rotation to obtain the final phase one factor analytic model. Using this model, factor scores for the five factors were computed for all 111 respondents. Pairwise scatter plots of these factor scores were then constructed

Factor 4		Millenium	COVID
Militant Preparedness vs. Denial (Militia)			
Items:			
31.	I have or will have a weapon to protect my family and myself against civil unrest at the time of the millenium (during COVID-19).	✓	(F4-Q32)
7.	I am stockpiling food and munitions to survive the turn of the century (COVID-19).	✓	(F2-Q8)
51.	There is little need for the government to allocate additional funds for the upcoming millenium (COVID-19). (***negative loading***)	✓	(F1-Q52)
12.	No special preperations are needed for the Year 2000 (COVID-19). (***negative loading***)	✓	(F5-Q13)

Factor 5		Millenium	COVID
Apocalyptic Psychoid Behavior (Disturbed)			
Items:			
35.	I will have no need for material possessions or stocks after the millenium (COVID-19).	✓	×
14.	I believe that a military struggle will occur at the millenium (during COVID-19).	✓	×
17.	Others tell me that I say things that do not make sense to them.	✓	(F4-Q18)
11.	I believe in a religious significance to the millenium (COVID-19).	✓	(F2-Q12)
13.	People tell me my eyes often have a "far away look."	✓	×

Factor 6		Millenium	COVID
Mainstream Adaptation (General Population)			
Items:			
45.	My close friends are of both sexes.	✓	×
52.	I believe that I will be prepard by the Year 2000 (for COVID-19).	✓	×
6.	I am delighted when others are happy or have good fortune.	✓	×
37.	I help others who may need it.	✓	(F4-Q38)
7.	I am stockpiling food and munitions to survive the turn of the century (COVID-19). (***negative loading***)	✓	(F2-Q8)

for the purpose of identifying outlying or influential respondents. Based on the distribution of scores observed in these scatter plots, five respondents were considered to be outliers and their response data was investigated. Upon examination, it was determined that the primary reason that these respondents were unusual was a tendency to respond "Choose not to answer" to a rather large number of the True/False questions. Because these respondents were not supplying specific True/False answers to these questions, the decision was made to remove them from the analysis.

Phase two of model building consisted of the same factor analysis with these five respondents removed. Therefor the phase two anal-

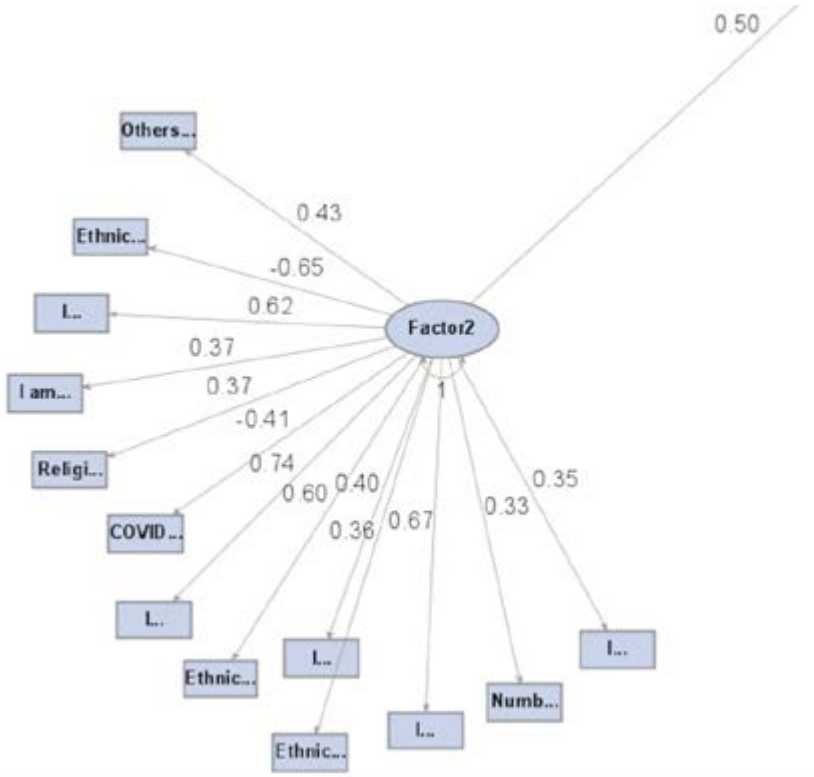


Figure 4. *Factor 2 Loadings*

ysis was based on 106 respondents. The same procedure used in phase one for fitting the model was used in phase two. Factor scores were again computed for all respondents and pairwise scatter plots of these factor scores were then constructed. Four respondents were identified as outliers at this stage and were removed from the analysis.

The third phase of model building was based on 102 respondents. The model was fit as before, and factor scores were computed for each subject. Investigation of the pairwise scatter plots revealed five more outliers, which were then removed from the analysis.

The final phase of factor analysis model building was based on the remaining 97 respondents. The model was fit as before, factor scores were computed for all respondents included in the analysis, and pairwise scatter plots were constructed to look for outliers. At this point no outlying respondents were identified. In addition, the five factors had a relatively balanced structure in terms of the number of manifest variables with absolute loadings greater than or equal to 0.3. In particular, Factor 1 had 16 absolute loadings greater than or equal to 0.3; Factor 2 had 14 such loadings; Factor 3 had 17; Factor 4 had 14; and Factor 5 had 13. In addition, the amount of variance explained by the five factors was well-balanced: the amount of variance explained by Factor 1 was 5.45; the amount explained by Factor 2 was 4.9; the amount explained by Factor 3 was 4.8; the amount explained by Factor 4 was 4.3; and the amount explained by Factor 5 was 4.0. Finally,

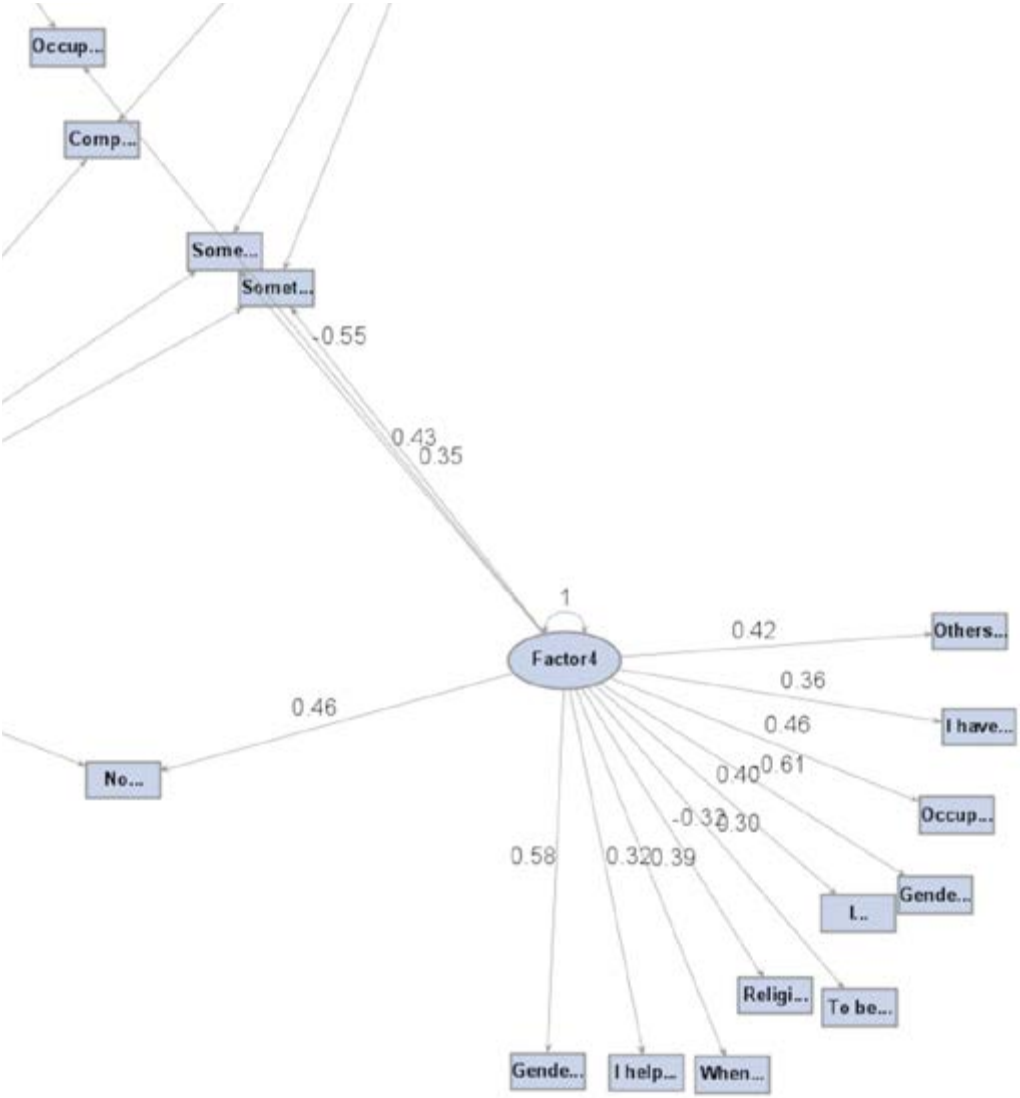


Figure 5. *Factor 4 Loadings*

the resulting factors possessed well-focused, singular interpretations, as opposed to being a combination of two or more latent constructs.

Given the reasons listed above, at this point the model building procedure was considered complete, and the final model was used for the identification of latent constructs by interpreting the resulting five factors.

Attached in Figure 3 below are the comparisons between the millennial study findings and the COVID study findings. In regard to the latter, 2 clearly identifiable factors emerged: Factor 2 – Religious Adaptation (Fundamentalists) and Factor 4 – Militant Preparedness vs. Denial (Militia).

Discussion

Research was conducted to identify possible personality adaptations that might emerge during the COVID-19 pandemic and to compare these adaptations to the personality adaptations that surfaced during the millennium. In comparing the data to the Year 2000 Questionnaire, it was noteworthy that 2 of the original 6 personality adaptations re-emerged. The 2 factors that re-emerged are Factor 2 (Religious Adaptation) and Factor 4 Militant Preparedness vs. Denial (Militia). These factors and the impact they had on community responses to the COVID-19 pandemic are discussed below.

Factor 2 (Religious Adaptation)

In 2020, the Center for Disease Control and Prevention (CDC) urged communities to refrain from congregating. Shortly thereafter, first-term "President Donald Trump suggested limiting gatherings to ten people or less," (Norris, 2020). As church leaders began to contract COVID-19, Norris indicated that it became too dangerous to continue hosting in-person religious services. The increasing limitations accompanying the rampantly spreading virus posed a daunting challenge. The religious turned to alternate means of adoration, such as virtual services with leaders delivering sermons from the confines of their homes, and social media, which often presented a biased picture. According to Tom Gjelten of NPR (2020),

> A survey by the Pew Research Center in April found more than 90% of regular churchgoers in the United States saying their churches had closed their doors to combat the spread of the coronavirus, with the vast majority saying that worship services had moved entirely online.

The utilization of online services provided convenience, but traditional communal worship was drastically affected with no end in sight. With the increasing use of the internet, there was an increase in misinformation, which was not always beneficial. Since the beginning of COVID-19, the dissemination of ominous and hateful misinformation skyrocketed. Velásquez et al. (2021) reported that,

> As individuals react emotionally in their online posts to the growing death toll and economic peril, online extremists are rebranding their conspiracy theories around current events to draw in new followers. This growth in hateful online activity may have contributed to recent attacks against vulnerable communities and government crisis responders (p. 1).

Without censoring unofficial and/or spiteful comments, the general public had become vulnerable to disinformation through *deep fakes*. Deep fakes are realistic videos that have been edited using an algorithm to replace an individual's image with that of another person. Less-moderated platforms like Telegram and 4Chan were breeding grounds for mis- and disinformation, as well. Extremists used multiple platforms to develop influence across the internet.

When the COVID-19 crisis began, many changes arose, with one common thread being isolation. Religious people wondered how they would be able to continue to practice their religion, which was typically done in a group setting. With the COVID-19 demands of isolation, people were deprived of their ability to spend time with their religious community, as well as with nature in general. The concept of *biophilia*, the human instinct to connect with nature and other living beings, was impaired (Zelinski, 2012).

Cacioppo and Patrick (2008) explored the psychological effects of loneliness, which included: the level of vulnerability to social discon-

nection (i.e., increased paranoia), the ability to self-regulate the emotions associated with feeling isolated (i.e., increased depression), and any mental representations and expectations of, as well as reasoning about, others (i.e., increased cognitive dysfunction) (p. 25). These dynamics were evident in the required COVID-19 isolation. According to Zelinski (2012), "spiritual and religious traditions are often culturally rooted, this interruption of religious practices took a toll on people's support system" (p. 173). Rajkumar *et al.* (2008), as cited in Zelinski (2012), showed that 67% of survivors "cited their religious beliefs as the single most important factor contributing to their resilience" (p. 175). Zelinski concluded that integrating mental health services with community spiritual groups was salient to recovery. Due to the isolation required by COVID-19, this process did not occur. As Cacioppo and Patrick (2008) pointed out, loneliness can cause depression, paranoia, and distorted thinking. These dynamics became rampant during COVID-19, especially among the religious extremists.

Although COVID-19 posed significant difficulties, religious beliefs persisted. Factor 2's loadings found that religious adaptations occurred in the Year 2000 and once again during the COVID-19 pandemic. Devotees signified their beliefs through questions such as: "I believe that The Millennium or COVID-19 will bring an apocalyptic (revelatory) experience". Responses to this question received an overwhelmingly positive loading, which indicated that an increase in religious beliefs did occur in times of crisis.

Factor 4 Militant Preparedness vs. Denial (Militia)

In some instances, people bypassed the peace of religion and turned to violence. Factor 4's, Militant Preparedness vs. Denial (Militia), loadings were geared toward hyper-defensiveness, paranoia, and/or denial. Paranoid individuals typically withdrew from society because they perceived the world as a dangerous place. COVID-19 restrictions regarding socialization only fueled this paranoia. When ignited by a strong leader, such thinking can lead to violence. The January 6th, 2021, insurrection was just one example of the dangers of militant groups, such as the B Squad, Three Percenters, or Guardians of Freedom, gathering to engage in militant aggression (Kunzelman, 2022). The question to answer is what path leads to militant aggression.

Suthaharan *et al.* (2021) stated that "people were most paranoid in the presence of rules and perceived rule-breaking, particularly in states where people usually tend to follow the rules" (p. 9). Such individuals were prone to preexisting prejudices and often felt forgotten. These individuals likely resorted to stockpiling foods and munitions to survive COVID-19, in order to protect themselves and their families. In order to make their presence heard, these individuals and/or groups may use force to achieve their ends. An example of this strategy was seen in the individuals who attempted to kidnap the Governor of Michigan, Gretchen Whitmer, to ignite a civil war (Smith, 2022). In the COVID-19 survey, the question: "I have or will have a weapon to protect my family and myself from civil unrest during COVID-19" addressed this phenomenon. Not only did people fear civil unrest, but like in the Michigan case, felt justified in creating it. Instead, however, becoming resilient is the key to survival. According to Nemeth and Olivier (2017, p. 121) resilient people:

1. Are firmly grounded in today. They
    a. Recognize, label, and share/resolve their feelings.

   b. Take care of their internal and external selves
   c. Take care of their relationships, both personal and professional
   d. Maintain good ethical boundaries
   e. Seek therapy when needed

2. They benefit from yesterday by
   a. Using memories to create balance
   b. Maintaining perspective
   c. Resolving past issues
   d. Making wise choices

3. They see themselves in tomorrow by
   a. Creating/planning stimulating experiences
   b. Engaging in ongoing activities
   c. Continuing to learn and grow
   d. Staying related
   e. Choosing to keep their minds and bodies full of life.

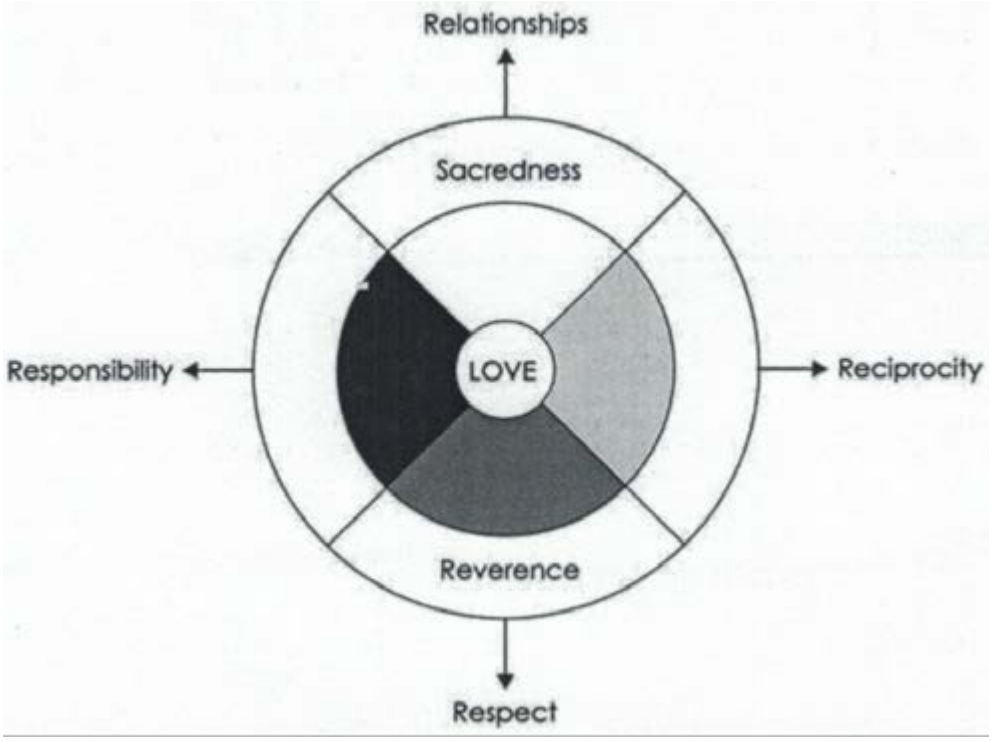
Conclusion and Suggestions

The threat of a major societal disruption, like the Y2K/Millennium, the COVID-19 pandemic, or the ongoing Global Warming crisis, appears to cause certain personality adaptations to emerge. These personality adaptations are likely influenced by increased levels of community isolation. Adverse personality adaptations can inhibit community efforts to weather and recover from disasters, reducing overall community resiliency to threats. The increased vulnerability of people influenced by increased isolation makes them more susceptible to being manipulated by malicious actors. In order for communities to increase resiliency in the face of disaster, community-based strategies for preventing and accounting for the emergence of these adverse personality adaptations should be considered.

In order for Factor 2 and Factor 4 to be reduced, resilience must be re-established. Resilience is a biological, psychological, and social phenomenon. It requires both external and internal growth and development. Thus, learning to cope and seeking social support may overcome the emotional polarization that currently exists in the United States. One of the major factors with the isolation that occurred due to COVID-19 was resource loss. Specifically, according to Jones *et al.* (2009), the loss of personal and social resources results in diminished capacity and psychological distress. Negative experiences may include loss of home, employment, skill, energy, and/or money to name a few. These are major psychosocial predictors of post-traumatic stress disorder (PTSD). Resilience, however, can result in self-enhancement and "coping self-efficacy," which is defined by Benight and Bandura (2004), as believing that one has the capacity to handle trauma. Prayer can also help.

The importance of family and social-connectedness cannot be overstated. Families have strength and can find meaning even in the worst of circumstances (Davis *et al.*, 1998). According to Garrison and Sasser (2009), a resilient family is one that remains hopeful, focuses on how their strengths can help them through a situation, adopts a can-do attitude, and accepts the aspects of the situation that are out of their control. Such families were ever-present during Louisiana's great flood of 2016.

According to Garrison and Sasser (2009), the following keys to resilient coping are offered: 1) make people and pets a priority; 2) weather happens; and 3) hope rules and humor helps; but Garrison and Sasser also warn: 1) one size does not fit all; 2) life does not stop because one perceives a disaster; 3) do no harm; 4) do not underestimate the sapping ability of heat and humidity; and 5) ripple effects are greater than the storm surge.



Currently, national politics reveals the consequence of ripple effects. The emotional polarization that has gripped this nation has become an attitudinal nightmare. The choices that people make, in the days, weeks, and months ahead will determine the very survival of the United States. Understanding one another is essential. The importance of family and culture, attitudes, beliefs, and philosophies, and the cognitive, affective, and behavioral choices that people make matter. Changing from the emotional polarization of the present to a more integrated opportunity to move forward will require a few, if not many, of the following twelve ideas: 1) accept support; 2) arrange to be heard; 3) set realistic goals; 4) plan the next step; 5) continue healthy habits; 6) learn from the past; 7) get adequate sleep and exercise; 8) schedule "self-time"; 9) continue family traditions; 10) share the burden; 11) be flexible; and 12) maintain hope and humor. Learning to listen is first, responding comes second. These require the four cornerstones of resilience: "responsibility, reciprocity, respect, and relatedness". Rising to the occasion rather than maintaining comfort in one's familiar positions will determine the future. According to Gloria Mulcahy (2012, p. 194), the figure below represents the ways of being that reflect love and foster a connection with the earth and one another that creates harmony and balance.

Implications

When the Y2K Millennium research was conducted, internet surveys were quite new; therefore, thousands of people responded. Now, so many surveys are available on the internet that it is no longer an intriguing draw. Perhaps new ways of conducting surveys can be developed to attract more respondents.

Limitations

An apparent limitation to the study was the small sample size of 262 total responders, with 160 being obtained from the English questionnaire, 30 from the Spanish questionnaire, and 72 from the Russian questionnaire. Due to their small sample sizes, the Spanish and Russian questionnaires were not factor analyzed. By contrast, the Bray Y2K and Year 2000 questionnaires amassed 5,300 responses. Therefore, comparisons to the Year 2000 Questionnaire were limited; however, only 100 of the 5,300 Millennium questionnaires were randomly selected for factor analysis. Thus, reasonable comparisons to the COVID-19 sample of 97 was possible.

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The Impact of War on Ukrainian Psychotherapists: A survey

Kira Sedykh & Volodymyr Pohoriliy

Abstract: The modern war has introduced significant changes to the daily lives of Ukrainians, altering their routines, work environments, relationships with loved ones and overall lifestyle. Psychotherapists find themselves on the front lines of both the informational and real war. Some have fled abroad or become internally displaced, while others continued to provide therapy despite being under shelling or enduring power outages. It is clear that the military situation and its aftermath have heightened the demand for psychotherapeutic support. Consequently, the resilience of mental health professionals has become even more crucial, as the effectiveness of their work heavily depends on their own emotional stability.

Key Words: psychotherapist, impact of war, factors, disorders, disturbances, traumatic events, values, stress, stabilization, level of readiness

To assess the impact of the war on Ukrainian psychotherapists, both those currently residing in Ukraine and those who have moved abroad, an online survey was conducted. The survey included 76 psychotherapists: 57% of whom are located in Ukraine and have not relocated to other regions or abroad.

The study found that during the initial months of the war, 56 respondents (74%) experienced eating disorders. Among them, 37% reported issues with overeating, 35% began eating less, and 28% experienced changes in their tastes and eating habits. Further, 68 respondents (89%) reported sleep disorders. Of these, 29% had difficulty falling asleep, 22% experienced early awakenings, 25% struggled with both falling asleep and waking up, 17% reported insufficient sleep, and 7% slept almost all day (see Figs. 1a, b).

49 respondents (64%) reported experiencing conflicts or tension in their relationships. Among them, 58% noted conflicts within their families, 26% at work and 16% with neighbours. All respondents reported experiencing some form of well-being disorders. The majority initially faced sleep and eating disorders

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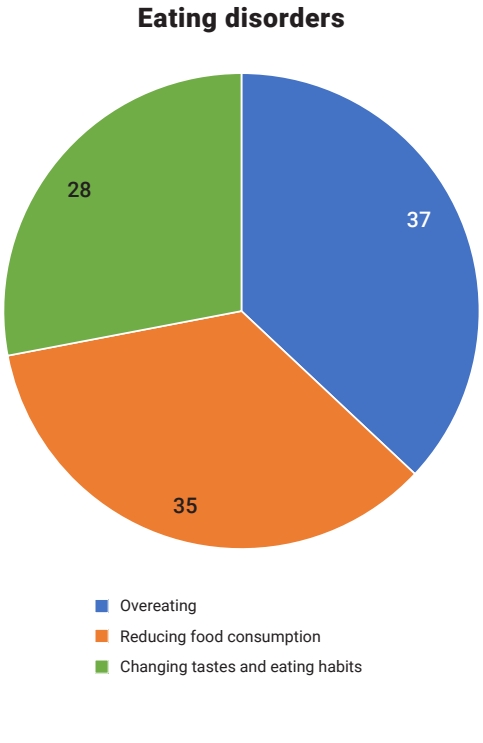

Figure 1 a.
Psychotherapists with Eating disorders, % (n = 56)

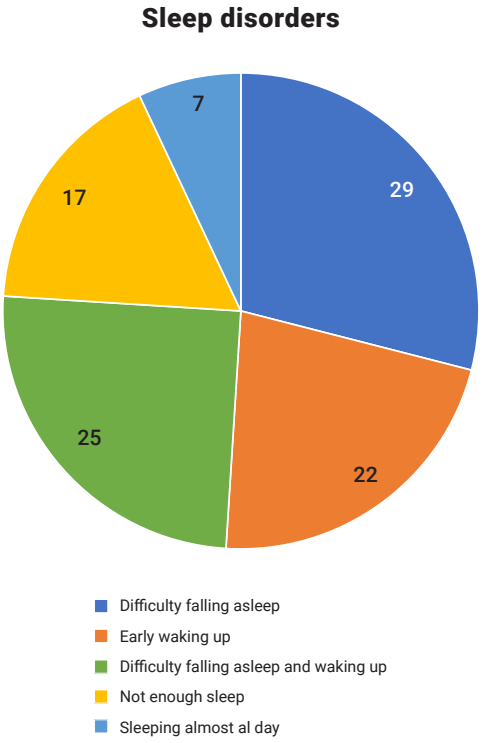

Figure 1 b.
Psychotherapists with Sleeping disorders, % (n = 68)

at the beginning of the war. Moreover, these issues persisted for 45 respondents (59%) over time. (Fig. 2).

The results of the study revealed that 64% of respondents had experienced traumatic events prior to the war. Among those who relocated, 70% reported having such experiences. Thus, this means that those who left were 10% more likely to have a history of traumatic events before the war than those who stayed (Fig. 3).

According to 54% of respondents, their family history helped them cope with stress, while 8% felt it worsened their stress.

To stabilize themselves, most respondents attempted to: communicate more with relatives (10%); organize their daily lives more effectively (10%); engage in hobbies and favourite activities (7%); limited interactions with "toxic" people (7%); participate in volunteering activities (7%); and reduce their consumption of information (7%).

When asked what helped them cope with the challenges of wartime conditions: 33% cited professional values; 32% family values; 22% natural optimism; 12% religious values; and 1% their civic position (Fig. 4).

51% of respondents reported that the conditions of their practice changed under martial law. Further, 71% adjusted their service fees. Nearly all respondents (99%) provided psychotherapeutic assistance either free of charge or at a reduced social rate.

During the war, 36% of respondents increased their workload, 35% redistributed their pa-

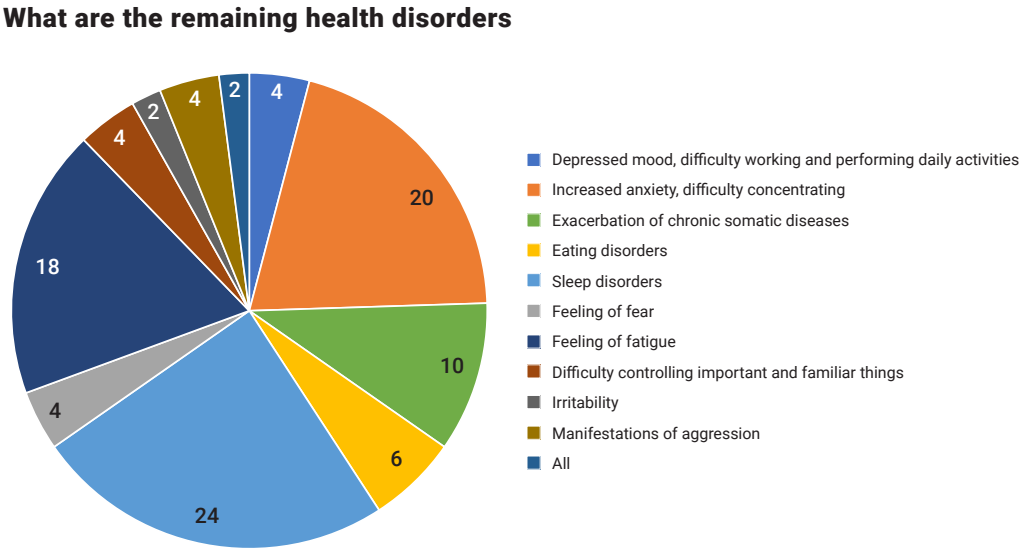

Figure 2. *Data on the mental health disorders that remained in respondents 2 months after the start of the war, %*

tient categories, and 28% reduced their workload. Furthermore, 58% of respondents participated in peer support groups UUAP (Fig. 5).

The survey results revealed that the onset of the war had a significantly greater impact on women's well-being, with a substantial number continuing to experience health problems afterward.

Among men, the prevalence of traumatic events was 13% higher, and they were 5% more likely to believe that their family history helped them cope with stress.

The distribution of stabilization methods used by respondents indicates that men and women employ almost identical strategies. Similarly, values were reported to be equally important for both genders. Key gender differences observed included:

- Women were: 12% more likely to change their working conditions; 17% more likely to adjust pricing; and 9% more likely to redistribute patient categories.
- Men, on the other hand, were: 10% more likely to reduce their workload.
- Participation in UUAP peer support groups was nearly equal among both genders.

Analysis of stabilization methods by psychotherapy approach during the war found that psychoanalysts primarily relied on optimizing daily routines and household organization (11%); symbol drama practitioners emphasized engaging in favourite activities, professional work, personal therapy, and further training (10% each); and Rogerian psychologists mainly stabilized themselves through professional activity and restricting information consumption (50% each).

Representatives of addictionology primarily used medical care, psychoactive substances, limiting communication with "toxic" people, controlling information consumption and engaging in volunteering (17%). Specialists practicing Adlerian psychotherapy stabilized themselves by communicating with relatives,

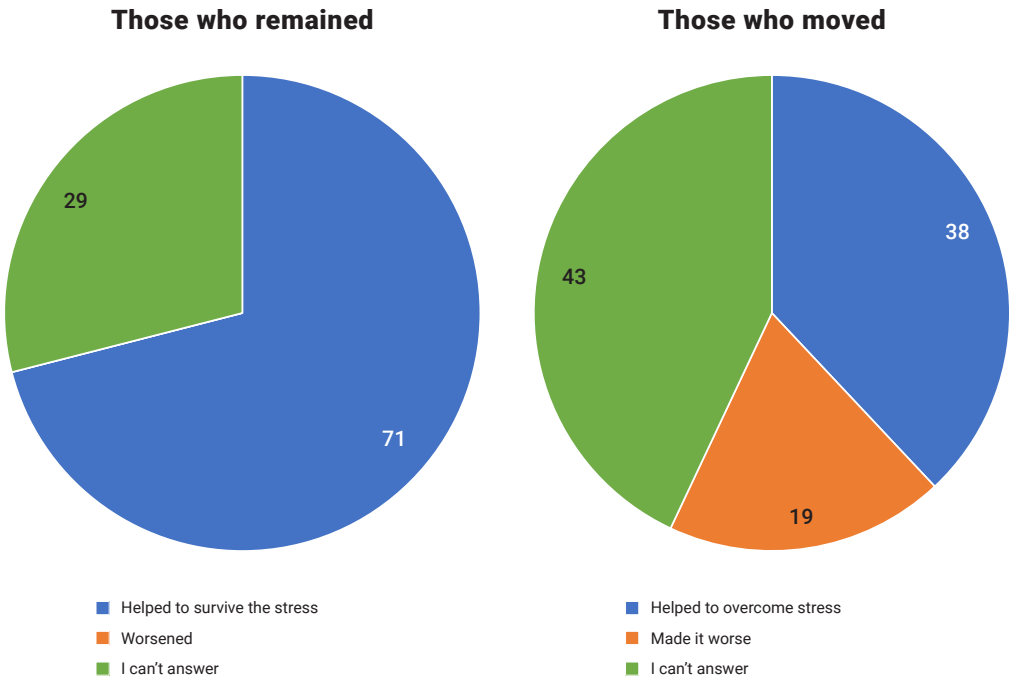

Figure 3. *Data on respondents' own experience of traumatic events before the war, %*

engaging in volunteering, and optimizing their daily routines (33%).

Art therapy specialists primarily used physical exercise and structured daily routines (50%). Representatives of other areas of psychotherapy approaches relied on various other stabilization strategies.

Thus, this war became a new challenge for psychotherapists, revealing different levels of readiness of specialists in navigating the difficulties of working under war-time conditions.

Conclusions

1. The study found that among respondents who remained in Ukraine, depression, heightened anxiety, and the exacerbation of chronic health conditions led to eating and sleep disorders. Many who remained in Ukraine experienced fear, panic, a sense of loss of control, aggression, irritability and fatigue which strained relationships within families, workplaces, and communities. To cope, respondents in this category used medications and psychoactive substances, while worsening chronic conditions necessitated seeking medical assistance. Those with strong religious values turned to religious communities and prayer for support.
2. Those who relocated also faced depression and increased anxiety at the beginning of the war, as well as feelings of irritability and aggression, and eating and sleep disorders. Emotional distress led to family conflicts, difficulties in maintaining normal routines, and a struggle to control

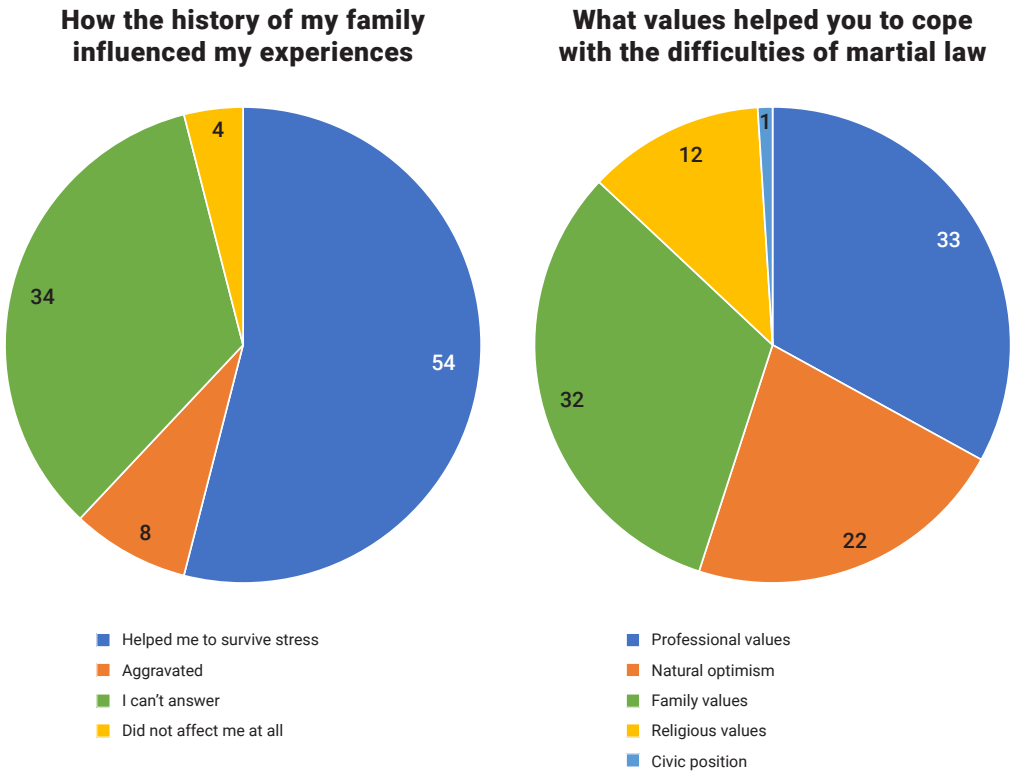

Figure 4. *Data on the influence of family history and values on respondents, %*

familiar aspects of life. However, some experienced an adrenaline surge that temporarily increased energy and work productivity. To cope, respondents in this category focused on arranging proper rest and engaging in activities they enjoyed. Additionally, to cope with emotional distress and work challenges, some respondents adjusted their patient caseloads.

3. The study revealed that family history influenced how respondents experienced the war. A high prevalence of past traumatic experiences was a significant factor in the decision to relocate abroad.
4. Respondents who remained in Ukraine demonstrated greater resilience, experiencing fewer negative emotional effects and adapting more quickly to war-time conditions.

The authors believe that the experience of Ukrainian psychotherapists during the genocidal war against us deserves to be researched, documented and disseminated as a benefit to all humanity. We are interested in conducting additional research in this area and would be glad if anyone who reads these articles would contact us for detailed information about assistance in continuing this research or organizing joint research or possible funding for further joint research. Those interested are asked to write to Volodymyr Pogorilyy at vulfv@ukr.net.

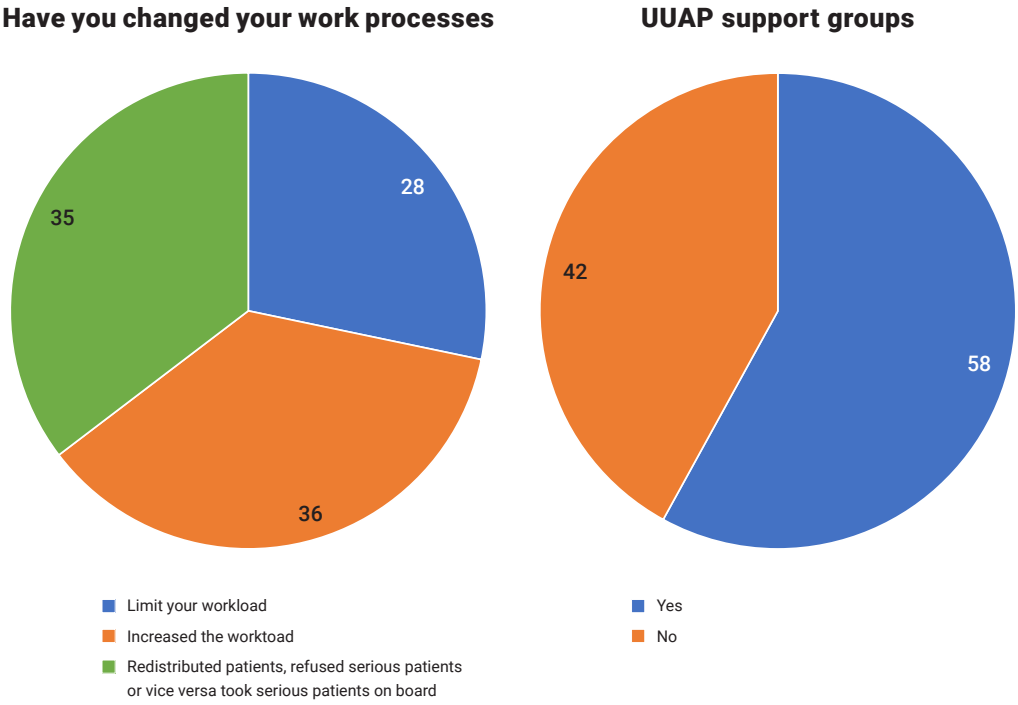

Figure 5. *Data on the influence of family history and values on respondents, %*

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Вплив війни на українських психотерапевтів

Седих Кіра, Погорілий Володимир

Анотація: Сучасна війна внесла значні зміни в повсякденне життя українців, їх рутину, особливості роботи, контакти з близькими та організацію життя в цілому. Психотерапевти знаходяться в полі інформаційної та реальної війни, деякі з них виїхали за кордон або стали внутрішньо переміщеними особами, інші навіть під обстрілами та в умовах вимкнення світла продовжили працювати. Очевидно, що військове положення та його наслідки підвищили важливість надання психотерапевтичної допомоги населенню. Отже, стійкість фахівців із психічного здоров'я стала ще важливішою, оскільки ефективність їхньої допомоги залежить від їх власної емоційної стабільності.

Ключові слова: психотерапевт, вплив війни, фактори, розлади, порушення, травмуючі події, цінності, стрес, стабілізація, рівень готовності

З метою визначення впливу війни на українських психотерапевтів, які проживають на території України або виїхали закордон, було проведене онлайн-опитування. Респондентами стали 76 психотерапевтів. 57% опитуваних знаходяться в Україні та не переїжджали в інші регіони чи за кордон.

Дослідження виявило, що в перші місяці війни у 56 респондентів спостерігались розлади харчування (74%), серед яких 37% респондентів мали проблеми з переїданням, 35% стали їсти менше, а у 28%досліджуваних спостерігалась зміна смаків та звичок харчування. У 68 респондентів спостерігались порушення сну (89%), серед яких 29% приходилось на складність заснути, 22% – раннє прокидання, 25% – важкість засинання та прокидання, 17% – мало спали та 7% спали майже всю добу (рис. 1).

49 досліджуваних відмітили наявність сварок чи напруженості в стосунках (64%). Серед них 58% респондентів відмітили сварки в сім'ї, 26% – на роботі та 16% – з сусідами. Всі респонденти відмітили на-

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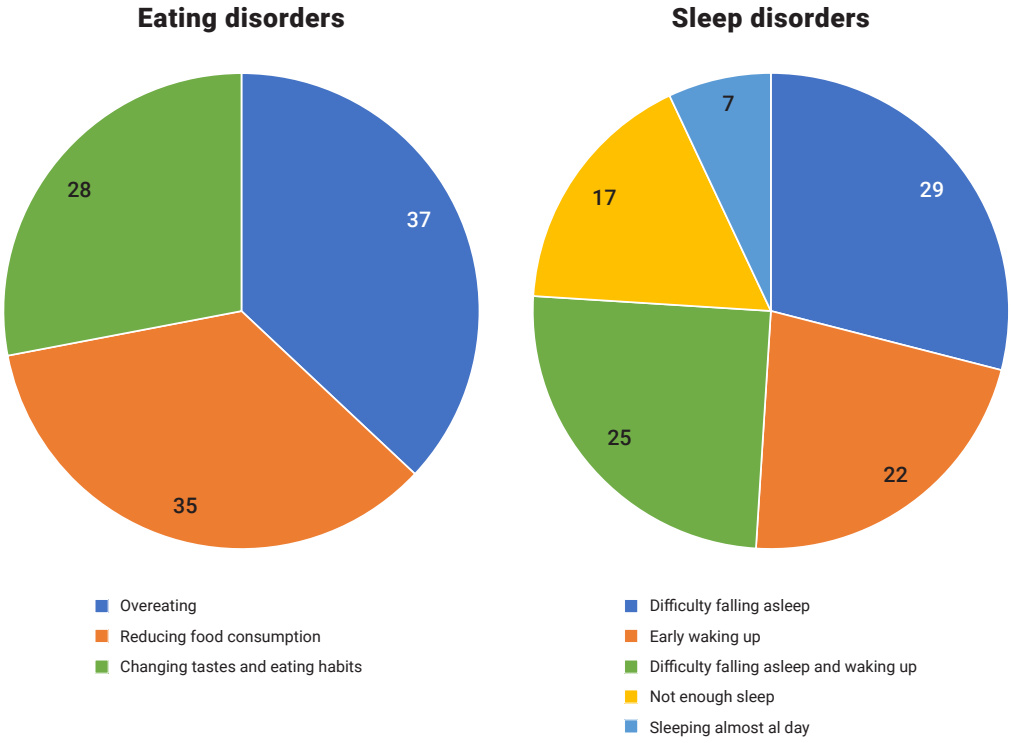


Рис. 1. *Дані щодо порушення харчування та сну у респондентів, %*

явність розладів самопочуття. У більшості досліджуваних на початку війни спостерігались порушення сну та розлади харчування. При цьому вказані розлади самопочуття залишились у 45 респондентів (59%). (рис. 2).

За результатами проведеного дослідження було виявлено, що 64% респондентів мали власний досвід травмуючих подій до початку війни. 70% респондентів, які переїхали, відповіли, що мають досвід травмуючих подій до початку війни. У тих, хто виїхав, наявність власного досвіду травмуючих подій до початку війни на 10% вище, ніж у тих хто залишився (рис. 3).

На думку 54% досліджуваних історія їх роду допомогла їм пережити стрес чи погіршила його (8%).

Для стабілізації себе респонденти в більшості своїй намагались більше спілкуватись з рідними (10%), оптимально організувати побут (10%), приділяти увагу улюбленим справам (7%), обмежити спілкування з «токсичними» людьми (7%), займатись волонтерством (7%), обмежити споживання інформації (7%).

На думку 33% справитися із складнощами військового стану їм допомогли професійні цінності, 32% – сімейні цінності, 22% – природний оптимізм, 12% – релігійні цінності і 1% – громадянська позиція (рис. 4).

51% респондентів відмітили, що в умовах військового стану змінили умови сетінгу. 71% змінили розцінки своєї роботи. Практично всі респонденти надавали безоплатно психотерапевтичну допомогу або за

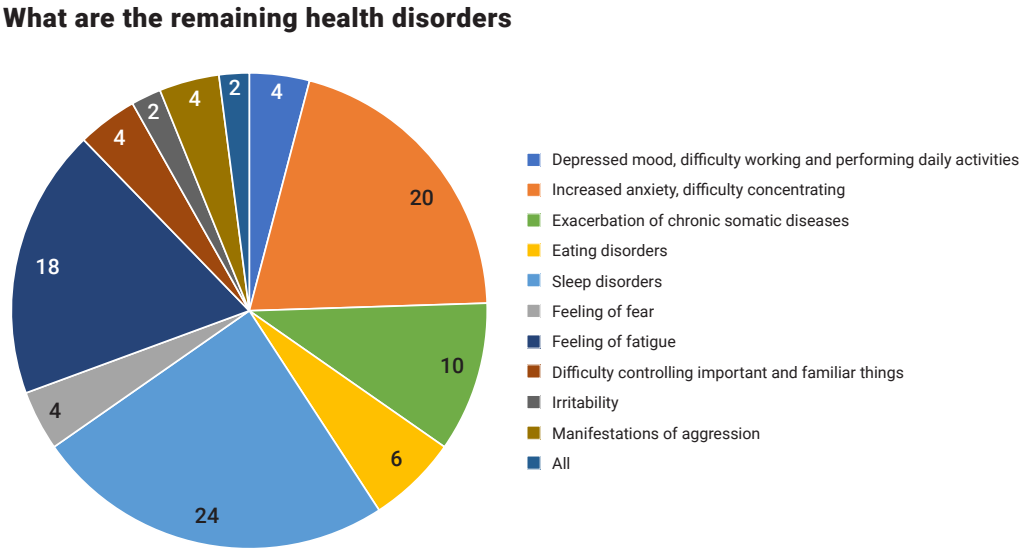


Рис. 2. *Дані щодо розладів самопочуття, які залишились у респондентів через 2 місяці від початку війни, %*

соціальною ціною (99%).

Під час війни 36% досліджуваних збільшили своє навантаження, 35% здійснили перерозподіл класів пацієнтів і 28% обмежили навантаження.

58% досліджуваних беруть участь у групах колегіальної підтримки УСП (рис. 5).

За результатами опитування виявлено, що початок війни значно більше відобразився на самопочутті жінок і у значної частини з них розлади самопочуття залишись й потім.

На 13% вище показники наявності травмуючих подій у чоловіків і чоловіки в більшій мірі схильні вважати, що історія їх роду допомогла їм пережити стрес (на 5%).

Отримане співвідношення структури способів, які респонденти використовують з метою стабілізації себе, свідчить про те, що для чоловіків і жінок вони є майже однаковими. Цінності розподілились у відповідях чоловіків і жінок теж однаково.

Жінки в більші мірі змінили умови сетінгу (на 12%) і розцінки (на 17%), а також на 9% більше здійснили перерозподіл класів пацієнтів. При цьому чоловіки в більшій мірі обмежили своє навантаження на 10%. Участь в групах колегіальної підтримки УСП розподілилась практично однаково.

Аналіз способів стабілізувати себе у представників різних напрямків психотерапії у період війни показав, що представники психоаналізу в більшій мірі для стабілізації себе використовують організацію оптимального побуту, розпорядку дня (11%), символдрами – увагу улюбленим справам, професійну діяльність, власну психотерапію та навчання (по 10%). Спеціалісти, що практикують психологію Роджерса, в основному для стабілізації себе використовують професійну діяльність та обмежують себе у споживанні інформації (по 50%).

гії в основному для стабілізації себе використовують медичну допомогу, вживання

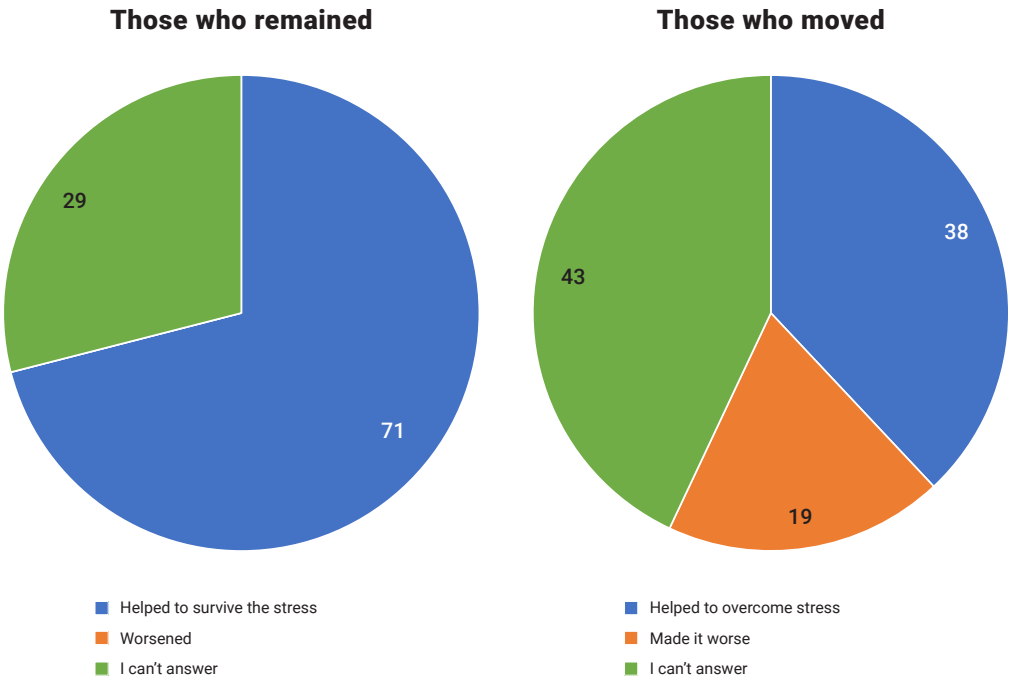


Рис. 3. *Дані щодо наявності у респондентів власного досвіду травмуючих подій до початку війни, %*

психоактивних речовин, обмеження спілкування з «токсичними» людьми, споживання інформації та волонтерство (по 17%). Спеціалісти, що практикують адлеріанську психотерапію, для стабілізації себе спілкуються з рідними, займаються волонтерством та оптимально організують побут, розпорядок дня (по 33%).

Фахівці з арттерапії в основному для стабілізації себе використовують фізичні вправи та оптимально організують побут, розпорядок дня (по 50%). Представники інших напрямків психотерапії використовують інші різноманітні способи стабілізації себе.

Таким чином, війна стала новим викликом для психотерапевтів та виявила різний рівень готовності фахівців орієнтуватися в складнощах роботи в умовах війни.

Підсумки

1. Дослідження виявило, що у респондентів, які залишились в Україні, пригніченість, підвищена тривога та загострення хронічних соматичних захворювань призвели до розладів харчування та порушення сну. Люди, що залишились в Україні пережили страх, паніку, почуття втрати контролю, агресії, дратівливості, втоми. Це призвело також до напруження стосунків в сім'ї, на роботі та з сусідами. Для стабілізації себе респонденти даної категорії вживали ліки, психоактивні речовини. Загострення хронічних соматичних захворювань призвело до необхідносте звернутись по медичну допомогу. Люди, які мали сформовані релігійні цінності, почали відвідувати релігійні громади та молитись.

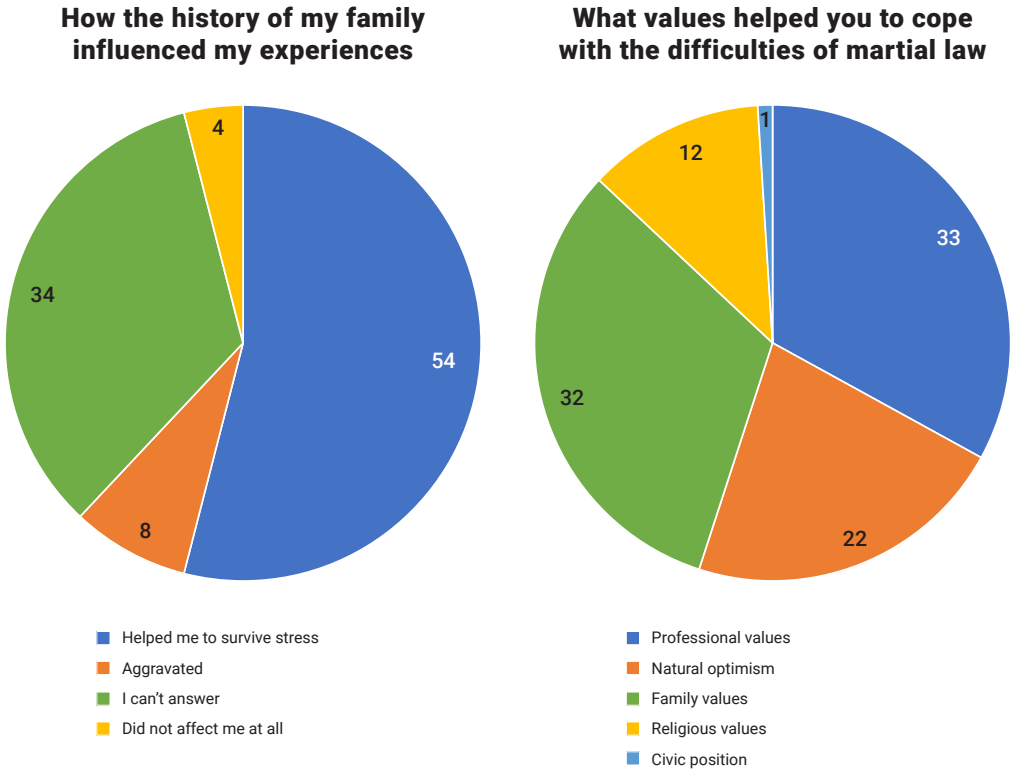


Рис. 4. *Дані щодо впливу історії роду та цінностей на респондентів, %*

2. Ті, хто переїхав, також мали пригнічений настрій та підвищену тривожність на початку війни, відчуття дратівливості та агресії, порушення харчування та сну. Пригнічений настрій та відчуття втоми призвели до сварок та напруження в сім'ї, складності контролювати звичні та важливі речі. У деяких з них викид адреналіну призвів до приливу сил та підвищення працездатності. Для стабілізації себе респонденти даної категорії налагодили свій відпочинок та стали приділяти увагу улюбленим справам. Також щоб справитись з пригніченим настроєм і складністю працювати респонденти даної групи здійснили перерозподіл класів пацієнтів.
3. Дослідження показало, що вплив на переживання респондентів мала історія їх роду. Серед негативних факторів, що призвели до рішення переїхати закордон, відмічена висока доля власного досвіду травмуючих подій до початку війни.
4. Респонденти, які залишились в Україні, виявились більш стресостійкими і змогли в меншій мірі піддаватись негативним проявам самопочуття та швидше адаптуватись до умов військового стану.

Автори вважають, що досвід українських психотерапевтів під час геноцидної війни проти нас заслуговує на дослідження, документування та поширення як благо для

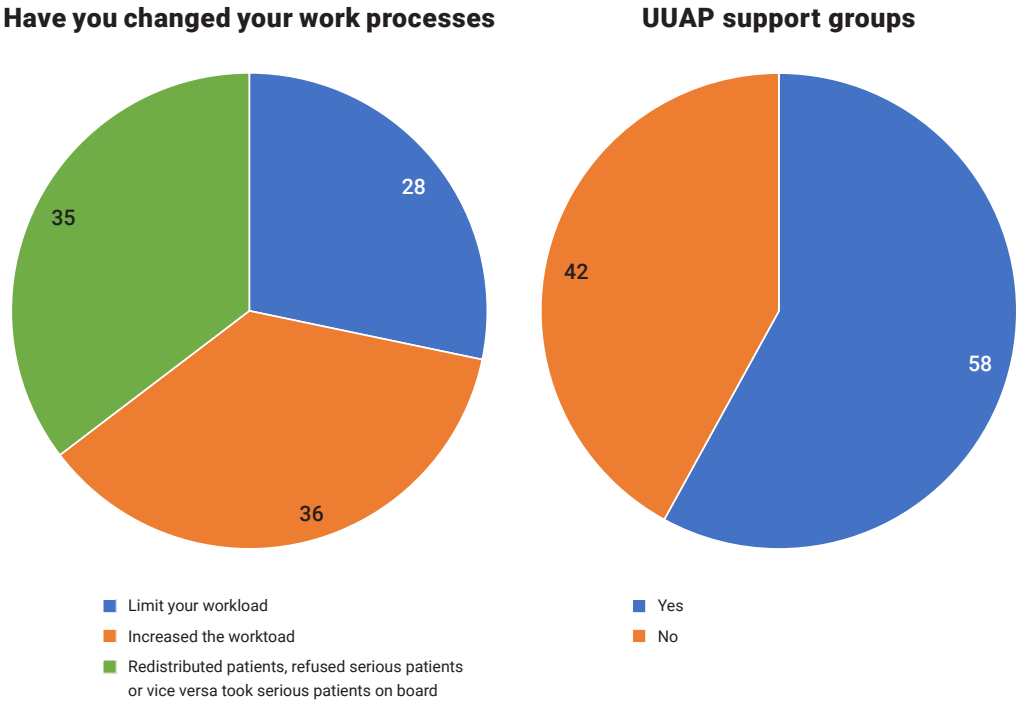


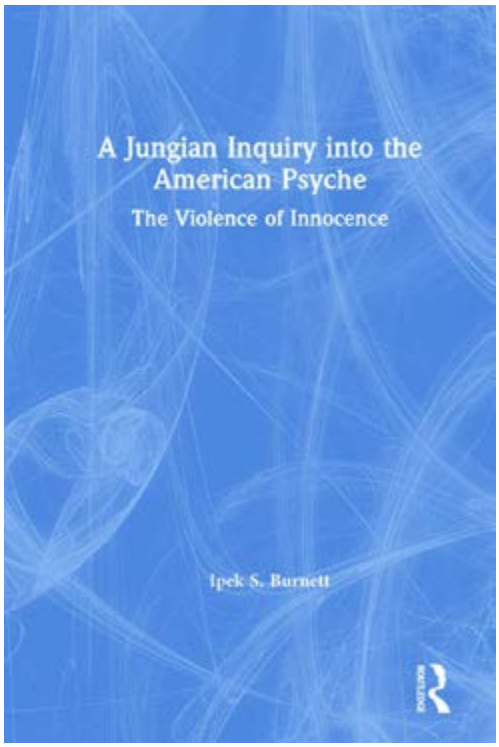
Рис. 5. *Дані щодо впливу історії роду та цінностей на респондентів, %*

всього людства. Ми зацікавлені в проведенні додаткових досліджень у цій галузі та були б раді, якби будь-хто, хто читає ці статті, зв'язався з нами для отримання детальної інформації щодо допомоги в продовженні досліджень, організації спільних досліджень або можливого фінансування подальших спільних досліджень. Зацікавлених просимо писати на адресу vulfv@ukr.net на ім'я Володимира Погорілого.

Автори

СЕДИХ КІРА ВАЛ професор кафедри психології та педагогіки факультету філології, психології та педагогіки Національного університету «Полтавська політехніка імені Юрія Кондратюка», доктор психологічних наук, професор, психотерапевт з хімічних узалежнень,- системний сімейний психотерапевт, навчаючий терапевт, супервізор.

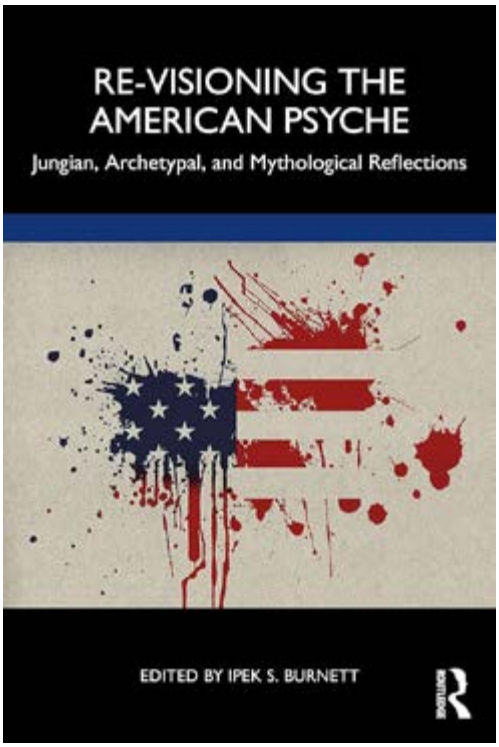
TWO BOOK REVIEWS



A Jungian Inquiry into the American Psyche:
The Violence of Innocence

Ipek S. Burnett

Routledge, 2019, 130 pp.
ISBN: 978-0367192778
RRP: £119.48 (h/back);
£33.43 (p/back); £31.78 (Kindle)



Re-Visioning the American Psyche:
Jungian, Archetypal, and Mythological Reflections

Ipek S. Burnett (Ed.)

Routledge, 2023, 290 pp.
ISBN: 978-1032351889
RRP: £119.60 (h/back);
£31.99 (p/back); £31.99 (Kindle)

When I first read the titles of these works by Jungian, Archetypal & Jungian-inspired therapists, mythologists and academics, I was intrigued. I wondered: *what* is this 'American psyche' that is being inquired into and re-visioned and whom were the books written to appeal to? I searched the internet for book reviews of Burnett's book, hereafter referred to as, *Inquiry*, and the one that she edited, hereafter *Re-Visioning*, but found only the sort of reviews one can find on the book jackets or front pages.

So, I approached these works in a critical manner; critical because, as an American holding a Ph.D. in Analytical Psychology and Chinese Culture, gained in Guangzhou, China under Prof. Shen Heyong, I was intrigued by any work attempting to reflect on "the American psyche". This seemed like some personified or reified concept, but then I recalled that James Hillman had expressed:

Soul, psyche, anima, and animus (unlike "self," which is a more abstract and reflective symbol) have etymological associations with body experiences and are concrete, sensuous, and emotional, like life itself.

We have difficulty with these terms because they are not true concepts; rather they are symbols which evoke meanings beyond any significations we give them through definitions. (Hillman, 1972, p. 51)

Let's pause a moment to reflect on what Hillman expressed here, "psyche" like the other terms he lists has *"...etymological associations with body experiences and are concrete... like life itself."* Hillman's work reflected his archetypal, mythopoetic and polytheistic propensities and psychological views towards the 'inner dimension' that the terms above seek to express. I have read many of Hillman's books, as well as all of Jung's Collected Works, and I have written a couple of books and articles about the Baha'i religion referencing these thinkers, among others.[1] I have also composed a book, *Fear of Jung*, where I attempted to bring Jung's 'emotional complex' doctrine into the more empirical-psychological disciplines of the psychology of emotions.

In *Re-Visioning*, a chapter by Dr. Kulkarni, which captures what my intuition was regarding the concept of the "American psyche", she wrote, *"I will not be making claims about "the" American psyche since asserting something about an entire nation has been negated by Samuels and by advances in archaeogenetics."* (p. 165). Her statement seems to undermine, in one sentence, what *Inquiry* and *Re-Visioning* both set out to do. Though potentially undermining, one of the strengths of *Re-Visioning* is the collection of diverse thinkers reflecting on a theme that can be negated—the "American psyche". It is an important enough psychological theme and concept, broad and nebulous enough, yet worthy of being expressed by psychoanalysts, spiritual thinkers, and mythologists.

I fundamentally agree with Kulkarni and will reference Andrew Samuels' view from the 'classic edition' of his 1993 work, *The Political Psyche*, where he says, *"Psychological reflection on culture and politics needs to be muted ..."*. So,

1. Cope, T. A. (1997). *Neo-platonic Framework for Bahá'í philosophy*. Accessed 4-Jan., 2026: www.bahai-library.com/cope_neoplatonic_framework
   Cope, T. A. (2000). Heaven in China without "Religion" and Manifestation. *Singapore Baha'i Studies Review*, Vol. 5, pp. 33-61.
   Cope, T. A. (2001). Dialogue among Civilisations: Ancient and Future, Transitions and Potentials. *Singapore Baha'i Studies Review*, Vol. 6, pp. 39-85.
   Cope, T. A. (2001). *The Firm Cord of Servitude*. In: *Lights of Irfán*, Bk. 2. pp. 35-44.

why did I contact Routledge asking to review these works?

In 1998, at 42 years old, I and my 16-year-old son left the United States and relocated to China. In 2000, he went to live in Taiwan. I remained in China until the end of 2022, with a 15-month hiatus in Panama in 2017-18. I lived and taught at different universities in 7 different cities in China, from the northwest, south, northeast and ending my career as a psychotherapist and head of the mental health department at a private hospital in Beijing during COVID.

Upon returning to the US with my wife in May 2022, I felt a desire to understand more about my 'homeland', as over the quarter century abroad, many changes occurred, of course. I recall being in Haikou, Hainan Island in China and watching the news on 9-11-2001. It was surreal and so distant and, in a way, 'understandable', only if one can discern what drives another to such an act of violence. I was in China in 2021, during COVID, and the centennial celebration of the founding of the Communist Party of China; I traveled in China, as going out was too difficult and costly.

I wondered if these two books written and edited by Dr. Burnett, Jungians and others, provided a notion, a clarification, or even an operational definition of how the symbol or term *'psyche'* is being used and the relation to psychological health and wellbeing of *an* "American psyche". *The* 'American Psyche' is conceptually vague, and can be negated, as Kulkarni and Samuels asserted. Neither book provided clarification about what 'psyche' is or what it might be. Each author operates with her or his own conception.

I wondered about how, as a symbol and a term, 'psyche' is manifest in its relation to the body, experiences, and is sensuous, etc. What about 'an' American psyche: an individual that can be identified and is unique in ways, common in others and can be 'divided' against itself. This is what Kulkarni's article draws one's attention to and what these two books fail to adequately address, though the chapters in *Re-Visioning* do broach this topic.

It is a historical and yet sad commentary that many political leaders use almost any means to foster division among people in many countries; some thinkers assert the US has stepped into autocracy while others breathe a sigh of relief for a 'return to normalcy'. The multicultural milieu in the U.S. implies a diversity of historical and cultural experience, myths, and thus psychological perspectives. With this given, I wondered just what an "American psyche" might be and how these books help grasp it, subtle and symbolic as it may be. I finished reading these works and found no clarity on what concept of 'psyche' most authors were using.

Both *Inquiry* and *Re-Visioning* are works that could be called 'woke' – to use current U.S. terminology for a term originating in the Black community for someone aware of social and racial injustice. The Merriam-Webster dictionary still uses this definition, indicating it also connotes someone being politically liberal or progressive (as opposed to conservative). I assert this cautiously, though one familiar with current political positions in the U.S. can find myriad articles and books on what 'wokeism' is. *Inquiry* and *Re-Visioning* are both 'woke', in both senses of the usage: highlighting historical patterns of violence, racial and social injustices in the U.S. – beginning with Columbus – and in the sense of liberal. Burnett asserts, *"The archetypal images that seized Columbus's imagination and fed his relentless illusions turned out to be inborn in the American psyche"* (p. 18). I wondered how Columbus's imaginations could have been *"inborn in the American psyche"* – there was no *'America'* at that time. I also wondered if there are many Jungian or archetypal analysts who would identify as 'far

right' conservative or even with the populist MAGA movement.

These books focus on the violence, historical, and mythological 'justifications' given for what has been perpetuated in the U.S. upon different groups of people since its founding, evoking the historical roots of U.S. racism, sexism, deceit and manipulation by people representing the U.S. government. The books were written as a clarion notifying the readers of the psychological impact of such features, and for Burnett, an attempt to offer a Jungian and archetypal contribution to the need for *"reflection and critical thinking, and imagination"* for the political dilemma in the U.S. (np). This is the purport, yet I mused on what can even be said about the 'American psyche' when no definition is proposed for consideration? She does, however, assert the need for "a complex view of the psyche itself", and that *"The term, 'American psyche', as invoked here also refers to a bridge between consciousness and the unconscious"* (p. 6).

In the first book, *Inquiry*, Burnett cites Jung's 1909 essay, *"The Complications of American Psychology"* and quotes Jung's memory of *"walking down the streets of Buffalo"*, NY., and imagined he intuited 'Indian blood' in the Americans he saw. Somehow Jung proposed there was an assimilation of the people by the land and 'the land' affected people. Burnett quotes Jung about his puzzlement regarding this cultural assimilation and she asserts Jung had seen *"something invisible to the European-descendants themselves"* (p. 19). However, when a quote is shortened by an author, it makes interesting rumination. Burnett drops a critical sentence from Jung's essay that alters its purport. Instead of confirming his intuition, he ended the paragraph with: *"Subsequently I learned to see how ridiculous my hypothesis had been"* (CW 10: 502-503). Burnett's omitting this sentence speaks to her motivation and enthusiasm.

Inquiry does a good job of drawing out the racial inequities and cultural dynamics of the U.S. economy, American myths and social reality over time, and cites many authors who focus on such history. Tellingly, such views are currently being glossed over or written out of public works and texts by the current Trump administration, in favor of different myths and stories. This 'glossing over' is a theme that runs through *Inquiry*: there is a feature of American life that wishes to maintain innocence in the face of national and historical violence, *"Because in the beginning was violence"* (p. 26). This seems valid for most nations and world history, but the psychological consequences become, in this Jungian sense, "cultural complexes" that wreak havoc within the American psyche and the "cultural unconscious" (p. 6). "Success", in Burnett's view, *"has become an autonomous complex causing polarization in the collective psyche"* (p. 65). In a neo-Jungian view, it seems anything can become some sort of 'complex' in the psyche, personal or collective.

A value-drawing attention to the psychological impact of America's violent history – and more importantly the various myths that vie for attention, from 'manifest destiny' to systematic exploitation of indigenous and minority people. It would have been helpful to have had the focus more on the embodied and personal impact of social and political division for an individual American (or groups) rather than some nebulous "the American psyche". But this is, perhaps, too individual-psychological and not archetypal or Jungian enough.

Re-visioning, the work edited by Burnett, has 15 chapters and authors, maintains focus on the various sociopolitical myths, genders, wars, history and archetypal implications of the United States of America. 'America' is used in a personified manner, typical of archetypal psychology and Hillman's stance: America has complexes, has a soul – one that

is divided – has shadows, is collective, and it is asserted that *"America has always been an angry and violent nation"* (p. 110), that *"has a sickness of soul"* suffused with the child archetype (p. 204-5) that impacts its' citizens. The final 3 chapters of the book do focus on Democracy, and more personal impacts on Americans, the Occupy Wall Street movement and the TV series, *Nomadland*.

Overall, these books fit comfortably within the Jungian and neo-Jungian oeuvre and may be a draw for others of like psychological disposition. For a reader who is not Jungian inclined, the works reflect how Jung's ideas have undergone re-thinking: from Jung's psyche and emotional complex doctrine, grounded in an individual and their body, yet with an 'archetypal core', we find the concept of cultural complexes and a cultural unconscious that nations suffer. The books do evoke thought, and sometimes this is adequate. As an inquiry and re-visioning, this reader was left wondering what was re-visioned after all? It did set me exploring one question which was evoked: What is "a" human psyche?

Reviewed by Theo A. Cope
china.psyche@hotmail.com

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All the articles published in the IJP are **double-blind**, **peer-reviewed** (whereby the reviewer is unaware of the author's name; and the author is unaware who has reviewed their article) by two different people. There is a fuller description of the "double-blind peer-review" process available. There is also a sample of the IJP Reviewers' Form – with guidelines and instructions on the back.

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.

So, if you would like to join our team of reviewers and review one of these articles, please contact our **Assistant Editor: Marzena Rusanowska**: assistant.editor.ijp@gmail.com

Or, if you know of anyone who might be interested in becoming a peer-reviewer of articles for the IJP: please ask them to contact **Marzena Rusanowska**.

(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.)

The International Journal of Psychotherapy is available free (as an eJournal (PDF file) to all individual psychotherapists, who are members of a professional association or a member organization which is an organizational member of the European Association of Psychotherapy (EAP).

*Others can subscribe via the IJP website (**www.ijp.org.uk**).*

Information and Guidelines for Authors

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

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

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

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

Further Information and contact details are available on the IJP website: **www.ijp.org**

This is only an indication – an extract:
Full and up-to-date **"Information and Guidelines for Authors"** are on
the IJP website: **www.ijp.org.uk** – Please click on the **"Authors"** tab.
Please read all that information very carefully before submitting an article.

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