A New Look For The IJP

International Journal of PSYCHOTHERAPY

Journal of the European Association of Psychotherapy

Volume 24 | Number 2 | July 2020

EAP
European Association for Psychotherapy

ISSN: 1356-9082 (Print) ISSN: 1469-8498 (Online)

International Journal of
PSYCHOTHERAPY

Volume 24 | Number 2 | July 2020

The International Journal of Psychotherapy is a peer-reviewed, scientific journal and is published three times a year in March, July, and November, by the European Association of Psychotherapy (EAP). The EAP is a member of the World Council for Psychotherapy (WCP); and an International NGO member of the Council of Europe.

Published by: European Association of Psychotherapy (EAP)
Mariahilfer Straße 1d/e, Stock/Tür 13, A-1060 Vienna, Austria
E-mail: eap.admin@europsyche.org
Website: www.europsyche.org

ISSN: 1356-9082 (Print); ISSN: 1469-8498 (Online)

International Journal of
PSYCHOTHERAPY

Volume 24 | Number 2 | July 2020

International Journal of
PSYCHOTHERAPY

Volume 24 | Number 2 | July 2020

The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally. It is properly (double-blind) peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students. The Journal is published by the European Association for Psychotherapy (EAP), three times per annum. It has been published for 24 years. It is currently working towards obtaining a listing on several different Citation Indices and thus gaining an Impact Factor from 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 Europ ean 'mother-tongue' languages, as well as in English.

This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide. We have recently developed several new 'Editorial Policies' that are available on the IJP website, via the 'Ethos' page: **www.ijp.org.uk**

International Journal of
PSYCHOTHERAPY
Volume 24 | Number 2 | July 2020

The IJP Website: www.ijp.org.uk

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

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

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

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

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

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

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

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

We are still increasingly caught within an extraordinary period of change: not only is the world changing, inevitably, in its own unique and intimal fashion – as it always does; but human society (being predominant on this planet) is also changing – and will continue to change – now increasingly radically – because, in this instance, of a microscopic bug (labelled as Covid-19). All of our human inspirations, dreams, plans, projects, hopes, etc., etc. just get ripped up in the face of this – almost anarchic – event: this pandemic.

It seems incredible, meaningless, extraordinary, tragic. However, there have been at least 4 influenza pandemics within the last 100 years. Very few of us now remember the last seriously major pandemic in 1918: when what was then called (incorrectly) "Spanish Flu" (H1N1 virus) that wiped out more people world-wide, in a number of months, than had been killed in the whole of the four previous horrific years (1914-1918) of the First World War: in effect, about 50 million people world-wide; actually about 5 times of the amount of military losses.

An influenza pandemic is a global outbreak of a new influenza (A) virus that is very different from current and recently circulating human seasonal influenza (A) viruses. Influenza A viruses are constantly changing and adapting, making it possible – on very rare occasions – for non-human influenza virus to change, in such a way, that they can now infect people easily and also spread very efficiently from person to person. This is – somewhat extraordinarily – the "life purpose" of such a virus.

There have been several pandemics since then: there was also the 1957-1950 pandemic (H2N2 virus); and then the 1968 pandemic (H3N2 virus); and then the 2009 (H1N1 virus); and lastly the Influenza A (H7N9) virus in 2016-2017, which overtook the more basic (H5N1) virus that had been steadily escalating since 2003.

International Journal of Psychotherapy
July 2020, Vol. 24, No. 2, pp. 5-8; ISSN 1356-9082 (Print); ISSN 1469-8498 (Online)

Published Online: July 2020; Print publication: July 2020; DOI: 10.36075/IJP.2020.24.2.1/Young

We – probably, rationally – need to "factor in" such pandemics into a somewhat wider world view, in the same way that we are beginning – only just beginning – to "factor in" – global warming; economic exploitation between rich and poor countries; multi-national companies avoiding tax; the ever-present "Me Too" exploitation of women by rich and powerful men; the increasingly and persistently prevalent disparity between black and white people (especially in America) with the "Black Lives Matter" movement; the racial prejudices that almost inevitably exist world-wide – but become more transparent in conflicts between the Han Chinese and the Uzbeks; between Sunni and Shia Muslims; between Muslims & Hindus in Kashmir; between Hutus and Tutsis in central Africa; etc. etc.

However, our world **is** becoming ever more crowded, and **is also** becoming even more connected, and also – significantly – the worlds of humans and animals are increasingly converging, as we increasingly exploit our powerful position amongst all the 'other' species: because most human 'flu' and several other viruses (like HIV & Ebola) have "crossed-over" from animal species to human species – mainly because of human exploitation of other species.

We are therefore "responsible" for much of these conflicts. But do we take any "responsibility" for any of this? We are also the victims, as well as the instigators.

There are, therefore, increasingly higher potential disruptions in travel, transportation, social isolation, and supply chains of food and medical supplies – as we are now seeing. There is – because of the morbid potential – also a considerable potential disruption (or overwhelming) of healthcare services... and these eminently deserve every acclamation that we can possibly give them.

However, the main 'impact' will inevitably be on the individual, economic and social costs. The individual costs: whereby each death brings a number of "ripple effects" to their family and friends; and whereby the poor and socially disadvantaged are usually hit harder than the rich and cushioned; as well as the social costs that are becoming horrendous – especially to the hospitality, travel and business sectors (**N.B.** the cost of the 2017 HHS flu pandemic was estimated at $181 billion world-wide, and the SARS epidemic estimated cost was at least $30 billion within 4 months).

So... much of all this pandemic effect... was almost inevitable – albeit that we preferred to be somewhat short-sighted. It is probably more apt to consider this particular pandemic, not as "if", but perhaps more as "when".

And there are also a number of similar "ifs" – should we include (because we probably should include)... shifts in tectonic plates; terrorist threats; militaristic take-overs; increasing weather abnormalities: storms, droughts, floods, heat-waves, etc.; futuristic wars about water and access to natural resources; inevitable 'power struggles' between 'major' and 'minor' powers – e.g. China and Tibet; Russia and the Ukraine; militaristic 'take-overs' – as in Greece, Sudan, Philippines, Afghanistan, Panama, Nigeria, etc. etc.; political oppression,

such as in Zimbabwe; and all the various 'incidents' or 'coups', or disruptive attempts world-wide in 2019 / 2020 – in Gabon, Sudan, Amhara, Bolivia, el Salvador, Saudi Arabia, Venezuela, Mali, etc.

The "petty people" with their "petty powers" – on a macroscopic level – are 'mirrored' on much more limited – microscopic – levels: power plays in the office and on the factory floor; in 'committees' for this or that; and especially in the family and even the school yard.

So, we – as psychotherapists – need to be very, very careful of our position: as we are also – inevitably – affected by these dynamics. We are – by definition – a part of the (somewhat traumatized) human species. Their dynamics also work within us. The professional training that we have had – as a psychotherapist – can help us a little – if we are sufficiently conscious and aware – to be able to 'differentiate' between what is Ours and what is Theirs – and what is Here and what is Now – and "what works" and what doesn't. But this takes a constant level of awareness – and levels of CPD – and work on our professional practice: can I recommend Scott Miller's latest book, *"Better Results: Using Deliberate Practice to Improve Therapeutic Effectiveness"* here: it seems to speak to a better way of working? Another colleague, Joel Vos, has just written about *"The Psychology of Covid-19: Building Resilience for Future Pandemics"*.

Let us hope that someone would like to review these books for the IJP soon. It would be very nice and would like all readers – to look at the Books for Review page of the IJP website and select one of the 60 review copies there. Then we can send it to you; you write a review; we publish it; you get to keep the book; and everybody is just a little bit happier. And so it goes!

Now, enough proselytizing! Our first article in this issue, *"Can't Sing, Won't Sing: Singing and the Self of Self across the Life Span"* is by **Anne Colgan**, an extremely talented colleague who also displays a large part of her talents within EAP meetings and at the social events connected with these. Here, she writes about the need for everyone to be heard. Sometimes this is more in song (so this is perhaps not just words), however, it indicates how psychotherapists – if they are sufficiently talented – can use music and song to help their clients to find their own voices and be heard. There are many forms of the "expressive therapies" or psychotherapies (Dance Movement, Art, Music, etc.) and there seems to be quite a gulf between Them and Us, which is a great pity. This article helps to bridge the gap a little.

In the next two articles, we are extremely privileged to be able to present something somewhat seminal. These are two articles about *"Psychology & Religion: Towards a Phenomenology of Change"* from **Paul B. Whittemore**, from California and consist of a Part 1 and a Part 2. They could / should perhaps be published – as well – within the IJP Online Section on "Psychotherapy and Spirituality" (see IJP website: **here**). Maybe, we will make these into a 'Section 4' of this "Special Online Issue".

Next comes, "A Brief Report" on a particular research project about the beneficial impact of a positive supervisory alliance and cultural discussions on supervisory alliance and cultural discussions on supervisee developments. This piece of research comes from **Jarice Carr**, **Patricia Kaminski**, **Nina Calmenson** & **C. Edward Watkins, Jr.** Edward Watkins is one of our regular contributors, mostly with articles about supervision. We may decide – once we are back on track – to put similar articles together into "Special Collections" about different aspects within psychotherapy. These will be available – soon – via the IJP website.

This article is followed by an article from another regular IJP contributor: **Richard J. Erskine**, writing – this time with a colleague – with a colleague, **Janet P. Moursund**, writing on: *"Contact and Relational Needs in Couple Therapy: An integrative psychotherapy perspective"*. They outline several of the "relational needs" that arise in couples' relational therapy; describe potential toxicities that often arise; and suggest several interventions. Much needed!

Our next contribution is a "download" of a 2020 questionnaire about the Covid-19 Lockdown. This relatively simple questionnaire – even though the 'entry' time has now expired – indicates what appropriate 'research' can be done, especially given such a new situation that we are facing. We hope to publish the results of this research in a future issue – however, this is not just research, for the results of this type of questionnaire can be very useful in our political strivings to establish "psychotherapy" as an independent profession in Europe.

We finish with three Book Reviews: one about *"Skills in Psychodynamic Counselling & Psychotherapy"* by **Susan Howard**, reviewed by Susanne Vosmer, a UK Clinical Psychologist, who may well join our Editorial team in due course. She also reviewed the next contribution: *"Lithium: A doctor, a drug, and a breakthrough"* by Walter A. Brown. Finally, we have a review of seminal book (in both English & German) on the theme of scientific research: *"The Great Psychotherapy Debate: The evidence for what makes psychotherapy work"* by Bruce E. Wampold and Zac Imel. Again, this is a seminal book and our excellent reviewer, **Peter Schulthess**, is also the Chairperson of the EAP's Science and Research Committee (SARC).

The next issue of the IJP is the long-awaited Special Issue on Gestalt psychotherapy. I am sure you will enjoy this, so "Watch This Space"!

‘Can’t Sing, Won’t Sing’: Singing and the Sense of Self across the Life-span

Anne Colgan

Abstract: Everyone needs to be heard: we announce that we are alive at birth through sound. When this sound is silenced, people feel rejected and not good enough. *“As adults, many of us have lost touch with our voice as an expressive tool”* (Campbell, 1997, p. 90). This can also lead to a hesitancy in verbal expression, fear of sound, or of making any sound. This paper considers the changing role of music in society and social cohesion; the different ways philosophers and scientists have seen the relationship between mind and body and. following that, how psychotherapists can use music to help clients find their voices.

Key Words: singing, breath, fear; loss; authenticity; psychotherapy

Introduction

The world is made up of vibrations. Singing is good for all human beings because it causes vibrations in the body, facilitating flow. There is a group of people who, when they were young, were told they could not sing by people who were not qualified to make that assessment or judgement. It often happened in a classroom, where only the best singers were picked out, and the rest were told they were “crows” or “non-singers”. This type of discrimination leaves many people with a false belief that they could not sing. There is very little written about this group; they are silenced in the literature, as they are in reality. People have many songs inside them, but western education and social conditioning may well have silenced those songs (Goodchild, 2015).

The Development of Music Through History and Culture

Five or six million years ago, forms of music and language existed in early ape communities – as they still do today. First, they communicated by grooming (Mithen, 2005), then by sound, especially when more friendships developed so that grooming became too time-consuming. Musical engagement

International Journal of Psychotherapy
July 2020, Vol. 24, No. 2, pp. 9-18: ISSN 1356-9082 (Print); ISSN 1469-8498 (Online)

Submitted: March 2019; peer-reviewed twice and reformatted: May 2020; resubmitted and accepted: June 2020; DOI: 10.36075/IJP.2020.24.2.2/Colgan

emerges early in life, is routed deeply in inter social engagement, and is highly pleasurable (Peretz, 2017). It is estimated that our ancestors/forebears, between one and two million years ago, worked a 30-hour week and had plenty of time for singing (Powell, 2016). Mothers have been singing to their babies for centuries. Schoen-Nazzzaro quotes Plato, *"All young creatures are naturally full of fire, and can keep neither their limbs nor their voices quiet"* (Schoen-Nazzaro, 1978, p. 261) (Goodchild, 2015). She writes about how music gets in to the innermost soul through the senses and moves the listener emotionally.

In some cultures, today, music is still associated with birth. The Namibian people engage in song from the time the mother decides that she wants to have a baby (Goodchild, 2015), when she goes off and sits under a tree by herself waiting for the baby's song to come to her. When it does, she finds the child's father and teaches it to him. During labour, the mother, the father and the midwives sing the child's song so as to welcome the child into the world. The parents and the community get to know this song and sing it to the child throughout its life. This song is used to encourage the child and also to heal anti-social behaviours. At death, the song is sung to the person again to facilitate their leaving the world.

Music, the Brain and the Body

Philosophy: Descartes and Merleau-Ponty

Descartes (1596-1650) stated that mind and body were two different things. In "The Age of Reason", he said *"Cogito, ergo, sum"*, (*I think, therefore, I am*). He knew that he had a mind, but he was in doubt that he had a conscious body. He then rationalised music into mathematical forms (DeMarco, 1999). However, music is not just about numerical rationality and intervals; music is about the body, emotions and fun.

Merleau-Ponty (1908-1961) emphasised the body as the prime site of knowing about or experiencing the world as a corrective to the long philosophical tradition on placing mental consciousness as the source of knowledge. Merleau-Ponty maintained that the body – and that which is perceived – could not be distinguished from each other. He stated that we are in the world and our bodies are always with us: *"My body is the primordial habit the one that conditions all others and it is how we are understood"* (Merleau-Ponty, 2014, p. 92). We are naturally embodied beings with an emphasis on perception: *"The body is not just a causal but a transcendental condition of perception, which is to say that we have no understanding of perception at all in abstraction from a body and world"* (Merleau-Ponty, 2014, p. xv).

Amusia

Amusia (Tone Deafness) is the inability to know that you are not singing the right note, or if others are singing the right note: the musical term is "off-key". Amusia exists, but only in a small percentage of the world population: O'Connor (2017) and Sachs (2008) suggest 5% and Peretz (2017) suggests between 1.25% - 4%. It is important to note that amusia is not the same in everyone. Amusics will sing songs like 'Happy Birthday' off-key and not know it; others will sing in key, but be unaware that they are doing so (Peretz, 2017). Everybody has a sound, but people with Amusia can still experience singing by banging pots and pans (Sachs, 2008). Well-meaning people (in voice workshops) can cause further embarrassment to this group of people by not understanding and trying to make them sing. Their experience of music is not comforting or pleasant, and it is important that neither their own sound, nor other people's sound, is forced upon them.

Isabelle Peretz stated that Amusia is: *"impoverished connectivity in a right-hemisphere based*

network, involving the inferior frontal cortex and the auditory cortex" (Peretz, 2017). She claims it is related to a gene, which she continues to research.

Body Psychotherapists

Many Humanistic and Body-oriented Psychotherapists have, for a long time, held that the body, mind and spirit are a single entity. This view is substantiated by neurobiological findings, which contradict the traditional natural science (Descartian) idea of the body-mind split. Gottwald, a neurologist, psychiatrist, and medical psychotherapist states: *"The previous separation between organically based and mentally conditioned suffering essentially no longer exists and cannot be substantiated"* (Marlock *et al.*, 2015, p. 128). He says that *"... the body operates as an energy system, in harmony with the natural environment"* (Marlock *et al.*, 2015, p. 634).

Reich, who studied with Freud, observed that his clients' non-verbal language: how they held themselves and how they took a breath. When emotional pain is experienced throughout childhood, our muscles contract and suppress the emotions associated with those experiences. Reich believed that some of the clients became so contracted that pleasurable sensations become alien to them: sadness and depression became their norm. Reichian psychotherapy helps to release the emotional blocks, using breath and the body. When clients can let go of their holding patterns, they become more integrated, their body has more "flow" and becomes more alive: greater balance and more resilience is achieved:

> *"This incorporation creates an inner state of constancy, of consistency of being that allow us to reintegrate disowned parts of the self and often leads to a shift of consciousness to deal with the existential issues of life"* (Marlock *et al.*, 2015, p. 674).

The body is visible and therefore the way in which I live is available to others. *"Consciousness is the first place, not a matter of 'I think that' but of 'I can'"* (Merleau-Ponty, 1962: cited by van Deurzen & Arnold-Baker, 2005, p. 43). The role of the body is to transform ideas into things and the freedom to be in the world or not. We can be both in the world, or withdraw from the world, with our bodies:

> *"At the very moment when I live in the world and am directed towards my projects, my occupations, my friends or my memories, I can close my eyes, lie down, listen to the blood pulsing in my ears, lose myself in some pleasure or pain and lock myself up in this anonymous life that underpins my personal life"* (Merleau-Ponty, 2014, pp. 167-168).

As people can choose to remove themselves from the world, so they can choose to come back in to the world, towards existence with others. Working with voice on a one-to-one basis, or in a creative music workshop, can facilitate this. In accessing the repressed or frozen voice, the client can rediscover his/her voice again – not through intellectualism or abstraction, but vocally, which engages the entire body. This can be achieved when the body opens up to others and to its past, i.e. to co-existence.

Research on singing in a choir (Moss, O'Donoghue & Lynch, 2017) concludes that choir singing can help someone to meet people and develop better social skills. Regular rehearsals and singing improve social bonding and connectedness. Physical benefits were reported, including improvements in blood pressure, posture, physical pain and tension in muscles. An awareness, and control of breath, can alleviate symptoms of asthma, other breathing disorders; and a general strengthening of the lungs were also reported. Singing in a choir can therefore keep the brain active and stimulated.

Neurobiology, Emotion and Music

Music involves different areas of the brain *"... music recruits key brain regions for processing emotions"* (Juslin & Sloboda, 2011, p. 14). These areas include: the striatum, involved in aspects of cognition, such as planning, decision-making, motivation, reinforcement and reward perception; the amygdala, which is the centre for emotions, emotional behaviour and motivation; the orbito-frontal cortex, involved in decision-making; and the anterior cingulate cortex, which connects to the "emotional" limbic system and the "cognitive" prefrontal cortex. The pre-frontal cortex covers a range of behaviour, including planning and personality development. It assigns appropriate control to other areas of the brain. Research has moved from acknowledgement of musical emotions to controlled studies.

Basic emotions – such as anger, fear, happiness and sadness – are today the focus of many neuropsychological studies. Although basic emotions may differ, according to an adult's experiences, many believe that music can induce happiness, sadness and fear, which are considered to be the easiest to recognise (Juslin & Sloboda, 2011). Music is effective for bonding, when it exaggerates non-verbal features. This can be experienced when working creatively with voice and also in opera and musical theatre. Music thus can involve several emotional systems, which have their roots in animal communication.

Humming and singing in the psychotherapy room can also help the client to feel their emotions (induced) and to express emotion. Sometimes, a piece of music can even break down defences and release a build-up of sadness. Gottwald writes, *"... even an empathic 'hmm' contains more nuanced and multidimensional information on how the therapist relates to a client's expression than any long verbal explanation"* (Marlock *et al.*, 2015, p. 142).

Voice-work can help to express our emotions. When someone has been silenced by a person or circumstances, consciously or unconsciously, silence may be chosen as a defence. Singing is a way of working that can give clients a fuller experience of themselves. The sounds of the voice can reveal emotions, like giving the client a mirror. We have become much too cognitive and often disconnected from our body. This can make us tight and tense, and can limit our experience and any expression of ourselves. This is evidenced in increased levels of anxiety, which is often brought about by the current constant engagement with technology. There is a danger of the virtual world taking the place of humans in everyday interactions: a false reality that encourages a false self.

However, not everyone is touched by music. In "Musicophilia", neurologist Oliver Sachs says that *"Freud who (as far as we can judge from accounts) never listened to music voluntarily or for pleasure"* (Sachs, 2008, p. 320). Apparently, he would only go to a Mozart opera and would use the time to think about his patients and theories:

> *"I am no connoisseur in art... nevertheless, works of art do exercise a powerful effect on me, especially those of literature and sculpture, less often of paintings... [I] spend a long time before them trying to apprehend them in my own way, i.e. to explain to myself what their effect is due to. Wherever I cannot do this, as for instance with music, I am almost incapable of obtaining any pleasure. Some rationalistic, or perhaps analytic, turn of mind in me rebels against being moved by a thing without knowing why I am thus affected and what it is that affects me"* (Freud, 1914, *cited by* Sachs, 2008, p. 321).

Music contributes to well-being in a way that is more than a purely social function. *"Music has become such a key element in the human behavioural repertoire that it might be considered*

as a "defining human attribute" (Juslin & Sloboda, 2011, p. 120). Emotion can be induced by singing or listening to music. The emotion can be joy, sadness and/or anger. The feeling may be just a feeling and not be able to be named by the client. A favourite song can take someone to their favourite place in their mind, evoking feelings connected with that place. Not all induced music will bring about the need to do something; it can also bring about relaxation. When people are afraid to make their own sound, they often miss experiencing the emotions, induced by their own sound.

(Mithen, 2005) writes that if music is about anything, it is about expressing and inducing emotions. There are two philosophical positions in neuroscience: "cognitivists" and "emotivists" (Juslin & Sloboda, 2011), the former claims that music expresses emotion, the latter that music induces emotion. Music is thus a channel through which emotions can be expressed and facilitated – and the emotions can be varied.

Ecstasy

Maurice Merleau-Ponty refers to 'ecstasy' in relation to 'vision'. *"Vision is an action... that always goes beyond its premises, and that is only prepared for by my primordial opening to a field of transcendencies, or again through an ecstasy"* (Merleau-Ponty, 2014, p. 295). He continues *"... what I discover and recognise is the profound movement of transcendence that is my very being, the simultaneous contact with my being and with being in the world"* (Merleau-Ponty, 2014, p. 396).

Singers often talk about ecstasy when singing, like being in a "higher" place. People claim that both Eastern and Western music can represent emotions – and can even arouse them. Singing instigates, one of the most important aspects of engaging in musical performance (Juslin & Sloboda, 2011). The strongest version of this form of arousal is ecstasy, which can be religious or cultural. When Sufi musicians in Pakistan and North India play for religious ceremonies, they can sing themselves into a form of ecstatic trance. In Bali, exorcists use music to neutralise negative powers. When we sing and dance ourselves into a type of frenzy, is this the same as ecstasy?

Voice and Psychotherapy: Authentic Voice

The Clinician: Anne's experience

From an early age, I was aware of how singing could affect my emotions. When I was training to be a Psychotherapist, and experienced the impact of psychodrama, I began to explore with both my voice and with psychotherapy. When people told me they could not sing, I offered to work with them. Sometimes, they just wanted to learn how to sing a song. During these lessons, I was aware of how the discovery of their voice affected people differently and how cathartic this could be. I knew about tone deafness (Amusia), but the people I worked with did have potential. In 1998, I began working with groups and voice as well as individuals.

Jill Purce says that, *"Liberating the voice means liberating a human being. It is our means of expression"* (Campbell, 1991, p. 239). Laurie Rugenstein has worked with women to reclaim their power within (Campbell, 1991). Young women in the middle of the 20th century were taught to be "ladylike", to be quiet, and were not allowed to be spontaneous. One woman that she worked with described Laurie's work with her voice as *"a means to Sonic Individuation"* (Campbell, 1991). From the Existential Perspective, Emmy van Deurzen claims that we are not fully human, unless we can feel. She says that our emotions are: *'a movement through which we move out of ourselves and*

that they are important in how we see others and ourselves' (van Deurzen & Arnold-Baker, 2005). In accessing my own authentic voice, I experienced a shift – from ego-driven singing to singing from my soul and trusting that my sound was 'good enough'.

The Client: 1. Mary

Mary had lost her singing voice; her speaking voice had become hesitant and quiet. She told me that she had been bullied a few years ago, and this had resulted in the loss of her singing voice. We explored the loss that she felt, that she had loved to sing:

> Mary: *"I do remember that initially, when telling my story, I hated actually telling my story because it was bringing me right back to the unpleasantness and I suppose there was some anger there and the unfairness and injustice, when I had worked so hard and how I had felt totally destroyed. I suppose my spirit was destroyed and I do remember that your voice, your smiling voice; you introduced some fun, some childlike fun; you brought me back to the goodness in people, the potential for goodness, that is in the world as well".*

She is describing the sound breaking up the energy, which had become stuck in negativity and feelings of devastation. Loewy (Baker & Uhlig, 2011) describes singing as enabling clients to bypass their intellectual defences by connecting with the breath and the body. The voice-work brought about a flow of energy, experienced as emotional release, warmth, vitality and a greater liveliness of tissue (Marlock *et al.*, 2015). The vocal holding is the holding of the voice with breath. About a year later, Mary was able to become more vocal and visible, and was able to return to her work. It was less frightening for her because of the voice work and the vocal holding that she had experienced. It freed her from the negativity of the past experience. Mary then said:

> *Voice – that the music became my voice. It didn't matter – my presentation was that I had lost my voice. When I presented, and in the process, I found a voice. It might not have been quite the same voice I had lost, but I remember your presence as encouraging and enabling and allowing my voice to, allowing me to express and feel happy with my voice as it was. It didn't matter that it wasn't the voice that I had lost, but that it was my voice. I do remember, actually, as I speak seeing and hearing and feeling your enjoyment of music and whatever sound I made contributed to that feeling of being able, whatever sound I made, it was music and it was my voice. I felt your support and holding, helped me to lose my inhibition.*
>
> *Reflecting this is what I remember, and it is what I needed and what my voice needed back then to help me to find, rather than and pain and the hurt the comfort of going forward and the feeling held. It didn't matter that it was croaky, I remember my grandmother's voice was wavy and croaky, and it was a good memory, and that I could accept my voice now and look forward to the potential that I could find when working with you for goodness and kindness and fun and comfort. It is the process, your smile, your smiling voice".*

Mary was anxious to retrieve her voice and it was important that we move slowly in the process and not force the sound. The 'homework' in the beginning was to play with sound for limited periods of time. Relaxation and acceptance of whatever sound emerged is a vital part of the work.

2. Patricia

Patricia told me that she has always been hesitant about her voice, her speaking and singing voice. She speaks quietly:

> *I have always felt that my voice isn't good enough – I sing to myself, but I wouldn't*

> *consider my voice a singing voice, I would need training.*

In my work with Patricia, in the transference, I was conscious of a lack of flow in various areas of her body. I could feel it in my own body, as a 'resonance' of blocked energy. With voice, the challenge for me is to **not** get in my own way, to feel and hear what is coming in to me, and then to trust. We began with diaphragmatic breathing. I sang myself to show Patricia how breath can support the voice and help to control the voice: this applies to both speaking and singing. For instance, when dealing with conflict, some people can lose their voice, or it can become weak. The diaphragmatic breathing can give strength and control to the voice, especially when under emotional pressure.

So, I asked Patricia to lie on her back on cushions on the floor to enable her to learn how to breath more effectively, to feel it in her body. I then asked her if I could do some body scanning with my voice and she agreed. Then, I sang a lullaby which I had written myself. It has two pitches: a low pitch and a high pitch. When I sang the high part (pitch), I felt a struggle, a block within myself, in the transference. In the countertransference, I wondered if I should stop singing that part and go back to the low part. I did not stop but continued singing to the end of the lullaby. When I asked Patricia how the singing was for her, she said that she did not like the high part:

> *It was challenging, I liked the comfort of the low part, but I could still feel the holding in the challenge. It felt safe and held all the way through and I realised that I can go in to the shadow, which was the high part for me, and I can be supported, and can work on the shadow and feel held and safe. When the session ended, I felt energised and eager to address things. I could feel the support in the connection, the relationship with the Psychotherapist's voice.*

Loewy writes about the voice having a strong connection with the self. *"It always writes the anthology of our emotions, mirroring aspects of transference and countertransference"* (Baker & Uhlig, 2011, p. 31). I suggest that – if a psychotherapist can incorporate creative sound and voicework in to their practice – it brings a substantive other creative dimension in to the work. James Kepner (Marlock *et al.*, 2015, p. 601) refers to this: *"Skilled therapists can also affect the frequency, temperature and tonality of subtle energy by using their practiced intention"*.

Singing Techniques in Psychotherapy

One of the techniques used by music psychotherapists is 'vocal tonal' holding. It is used to encourage vocal expression through exploration of sound, breath and voice. When emotions are repressed, this technique can bring about crying and the release of sad emotions. In the beginning, many clients hold their breath, which can inhibit feeling. The physical work of vocal toning will often distract the client from holding on to their defences, as they concentrate on making a sound while breathing out. This can be seen in infants when they release a voiced sound. 'Vocal toning' can be done in a sitting or standing position. Making any sort of sound helps the client to turn emotions into sound and to express those emotions. Toning, in particular, is a good way of working with emotions, rather than shouting out emotions. Shouting usually comes from the throat, whereas toning comes from the throat, solar plexus, the base of the spine, and the crown of the head, in fact from the whole body.

> *By making elongated vowel sounds and feeling the vibration of the body and the mind rather than attending to the outer sound, the brain waves synchronize and balance within minutes.* (Campell, 1992, p. 92

Breath

When working with breath and the body, it can be frightening to work with areas which may have been shut down. When clients are working on something that is difficult for them, they often forget to breathe; they may even hold their breath. Their breathing is often shallow, which suppresses emotions. This makes matter worse, because it decreases one's oxygen intake and increases tension, especially in the diaphragm (Austin, 2013, p. 11). This results in insufficient breath in the lungs to support vocal sounds. Breathing is the first stage of working in vocal psychotherapy.

> *Breath has long been an essential part of the quest to understand the human condition, to promote health, and to alleviate suffering."* (Marlock *et al.*, 2015, p. 633)

Breath supports voice and the exploration of emotions. Deep breathing, diaphragmatic breathing, facilitates the client in filling up their lungs. "*The Diaphragm is considered the most important muscle for breathing…*" (Brown, 1999, p. 26). The concentration brings focus away from nervousness to the task. Speaking becomes easier, no wobbles, and more powerful, especially when it is supported by strong breath. The breath does the work of holding and helps to ground the client/speaker.

Breath (both the client's and therapist's patterns of breathing) is as important in the psychotherapy room (especially when working with traumatised people) as it is when working with voice. Mirroring the person's breathing can be a form of "holding" for the client, as they can then let go of some of the feelings that they have been holding back or repressing. Shallow breathing is often the opposite of grounding, as it usually indicates anxiety. Deep breathing slows down the person's heart-rate and slows, calms and nurtures their nervous system. Relaxation and trust are two essential elements of this work, both of which can be challenging for the client. As the client engages in deeper breathing, natural 'primal' sounds of emotions that may have been repressed, can emerge. This may cause some initial anxiety in the client because of their associations to times in their lives when they were told, "Don't sing". Accessing these sounds in a non-judgemental environment can bring the client much more into their authentic sound, which leads to a richer more fulfilling life (Austin, 2013). Creativity and fun are also important. The 'vocal' psychotherapist can play with the sounds and thus create a space for fun and exploration.

Some pieces of music can also evoke a desire to express an emotion. I have worked with clients who – on the surface – seemed to be coping. Then, something might happen to heighten their anxiety and that is when they present for psychotherapy. This may be as a result of repressed feelings, of being busy keeping feelings at bay, or (in other words) some level of avoidance. When clients have been holding down sad emotions, the client being 'held' by the therapist in some way, while they are singing, can trigger a release of these feelings and the dam of sadness can burst. It can be cathartic. This 'holding' gives permission to the client to move on, to shift.

When clients have been sexually abused, we sometimes have to go back to them being in the womb. Here, I might invite the client to lie on the floor in a foetal position and wait for their sound to come. This can take a little while, and it requires firm holding, deep concentration, and relaxation. When their sound starts to come, I invite the client to turn on to their back on the floor and stretch out. This breaks through the contraction that was present around their voice. It also facilitates diaphragmatic breathing, as it is easier to do this when you lie on your back.

After a while, I will start to engage with the client with my voice and then we can play with our sounds. I respond to (or mimic) the sounds of the client and also encourage the client to expand more and more with their own sounds. These often begin very gently and can then develop in to a very good and satisfying sound. One of the other things that I do is 'body scanning' with my voice. This is intuitive and improvisational. When I 'tone', the sound can pick up blockages in the client's body. The sound might get stuck, or I may get pushed into a different sound (as in a higher or low pitch). As I resonate with the client, I also try to experience a connection with the vibrations of the earth. This type of work is influenced by developments in neo-Reichian Bodywork.

Singing in Psychotherapy Practice

Singing has always been part of human culture. Music involves areas of the brain and induces emotion (Juslin & Sloboda, 2011). Voicework and singing in psychotherapy enable the client to discover their own sound, reclaim a lost voice and strengthen an existing voice. It is imperative that the psychotherapist who works with music is aware of the necessity to be vigorous about their own self-care, in order to be able to 'hold' the catharsis that may emerge when working with voice. In "talking psychotherapy", the client can often be 'held' in the silence; in voice or music psychotherapy most of the holding is done with the psychotherapist's voice.

Conclusion

Childhood experiences, especially when learning how to sing, can influence's future enjoyment and engagement of one's voice. A friendly and fun approach is important when learning how to sing. When a voice is silenced, fear and shame can often enter into the experience, and these can shut down any further attempts to sing. The importance of having a voice is self-evident, so restoring a voice to the unvoiced is a worthy aim of psychotherapy. Psychotherapists can use voice techniques in psychotherapy to help access their client's voice when it has previously been lost, rejected or undiscovered. This process can bring about significant changes in the client by revealing the magic of their own sound and the power of being able to be included in sounds of others. This work can also provide a type of 'holding', especially when working through trauma. Singing is therefore a potent media for experiencing and accepting unknown parts of the Self, introducing a new way of being in the world which heals and excites.

Author

ANNE COLGAN is a Musical Psychotherapist; the Clinical Director of the Haven Group Psychotherapy Practice in Gorey, Co. Wexford, Ireland and she is Vice-Chairperson of the Irish Council for Psychotherapy. She is the group supervisor for the Gorey Family Resource Centre. She is also a board member of the European Association for Psychotherapy (EAP) and a member of their Marketing Group. Anne works in the area of the authentic singing voice with groups and individuals who want to learn how to sing and who want to access their emotions and feelings through voice.

E-mail: anne@thehavengroup.ie

Ethical Note:

The experiential music is conducted in a therapeutic setting, therefore sound and written examples are cognisant of the ethical requirements with regard to confidentiality in the writing. The names in the cases have been changed to protect the clients and written permission has been obtained from the clients.

References

AUSTIN, D. (2013). *The Theory and Practice of Vocal Psychotherapy: Songs of the Self* (Kindle ed.). London: Jessica Kingsley Publishers.

BAKER, F. & UHLIG, S. (Eds.). (2011). *Voicework in Music Therapy.* London: Jessica Kingsley Publishers.

BROWN, O. L. (1999). *Discover Your Voice How to Develop Healthy Voice Habits* (4th ed.). London: Singular Publishing.

CAMPBELL, D. G. (1997). *The Mozart Effect.* London: Hodder Mobius.

CAMPBELL, D. G. (1991). *Music Physician For Times To Come.* Wheaton: Quest Books.

CAMPBELL, D. G. (1992). *Music and Miracles.* Wheaton: Quest Books.

DeMARCO, D. (1999). Descartes – Mathematics and Music. In: B. Sweetman, *The Failure of Modernism*, (pp. 35-44). Mishawaka: American Maritain Association.

GOODCHILD, C. (2015). *The Naked Voice: Transform Your Life Through the Power of Sound. https://www.philosophybasics.com/philosophers_descartes.html.* (2017). Retrieved from https://www.philosophybasics.com: https://www.philosophybasics.com

JUSLIN, P. N. & SLOBODA, J. A. (Eds.). (2011). *Handbook of Music and Emotion, Theory, Research, Applications.* Oxford: Oxford University Press.

MARLOCK, G., WEISS, H., YOUNG, C. & SOTH, M. (Eds.). (2015). *The Handbook of Body Psychotherapy & Somatic Psychology.* Berkeley: North Atlantic Books.

MERLEAU-PONTY, M. (2014). *Phenomenology of Perception.* London: Routledge.

MITHEN, S. (2005). *The Singing Neamderthals.* London: Weidenfeld & Nicolson.

MOSS, H., O'DONOGHUE, J. M. & LYNCH, J. (2017). Sing Yourself Better: The health and well-being benefits of singing in a choir. *University of Limerick Institutional Repository.*

O'CONNOR, K. (2017). Retrieved from www.singwise.com.

PATEL, A. D. (2008). *Music, Language and the Brain.* New York: Oxford.

PERETZ, I. (2017). *https://webcolleges.uva.nl.* Retrieved November 11, 2017, from https://webcolleges.uva.nl/Mediasite/Play/a07645de89ce49be8c9b36e2e8c7f8ab1d

POWELL, J. (2016). *Why You Love Music: From Mozart to Metallica – The Emotional Power of Beautiful Sounds.* New York: Little, Brown and Company.

SACHS, O. (2008). *Musicophilia.* New York: Vintage.

SCHOEN-NAZZARO, M. (1978). Plato and Aristotle on the Ends of Music. *Laval théologique et philosophique*, 34 (3).

VAN DEURZEN, E. & ARNOLD-BAKER, C. (Eds.). (2005). *Existential Perspectives on Human Issues a Handbook for Theraputic Practice.* Basinstoke: Palgrave MacMillan.

Psychotherapy & Religion: Towards a Phenomenology of Change: Part 1

Paul B. Whittemore

Abstract: Positive changes in thoughts, feelings and behaviour that take place through psychotherapy and religion are compared and analysed using primarily a phenomenological approach. Drawing on insights from William James, Edmund Husserl, and Alfred Schutz, the "unseen order" is defined in a way that reveals common processes, structures, and pre-conditions to the ways in which consciousness is modified to induce positive change. Despite differences between religion and psychotherapy, similarities exist in the structure and sequence of how conscious attention is directed and re-directed: in the preconditions for participation; in the role of indirect communication; and in the fact that both realms utilize paradigms that act like lenses, which render "the unseen order" visible and constitute a "therapeutic hermeneutic". Additionally, both psychotherapy and religion benefit in following an unseen "hierarchy of attention". By describing, comparing and contrasting these shared features, the present work aims to expand our understanding of the process of positive human change.

Key Words: attention, phenomenology, psychotherapy, religion, paradigm

> *"Were one asked to characterize the life of religion in the broadest and most general terms possible, one might say that it consists of the belief that there is an unseen order, and that our supreme good lies in harmoniously adjusting ourselves thereto."*
>
> William James, (1902/1958, p. 58)

With his characteristic insight and lucidity, William James offers us this remarkably accurate, generic definition of religion. Despite the absence of any reference to God, gods, spirit, soul, sacred texts, or rituals, it nonetheless encompasses the religions of Judaism, Christianity, and Islam in the West, as well as Buddhism,

International Journal of Psychotherapy
July 2020, Vol. 24, No. 2, pp. 19-31: ISSN 1356-9082 (Print); ISSN 1469-8498 (Online)

Submitted: March 2019; peer-reviewed twice and reformatted: May 2020; resubmitted and accepted: June 2020; DOI: 10.36075/IJP.2020.24.2.3/Whittemore.1

Hinduism, Confucianism and Daoism in the East (Hopfe & Woodward, 2011; Noss & Grangaard, 2011; Smith, 1991). The reference to religion's "unseen order" and the importance of human alignment with it provides a rare, heuristic framework for comparing it with changes that takes place in psychotherapy. What James has said of religion may be seen as describing psychotherapy in its various forms, except the latter usually makes no claim to one's "supreme good". By replacing "supreme good" with "life improvement" we can similarly describe psychotherapy "in the broadest and most general terms possible" by saying "*that it consists of the belief that there is an unseen order, and that our … [life improvement] … lies in harmoniously adjusting ourselves thereto*".

This theoretical exposition attempts to show many of the common ways in which the various psychotherapies – and religions – direct and re-direct the attention of their respective leaders and participants. By analysing the structure, preconditions and constitutive elements in how attention is directed and re-directed by psychotherapy and religion, this exposition hopes to illuminate some aspects of positive human change.

We begin with a few important qualifications: first, our comparison of psychotherapy and religion in no way intends to conflate the two. Religions differ from the psychotherapies in numerous ways but most significantly in their aim to promote the individual's "supreme good," "ultimate concern," or participation in "transcendent meaning" or "the sacred" (Paloutzian & Park, 2013; Pargament *et al.*, 2013; Park, 2013; Tillich, 1957). Psychotherapies may aim to promote optimum adaptation or even "self-actualization" (Maslow, 1970/1954; Rogers, 1961) but they do not claim to induce participation in the "sacred".

Second, our use of James' generic definition of religion in no way intends to minimize important differences between religions. The very title, as well as the content of William James' classic, *The Varieties of Religious Experience*, reminds us of the reality of significant differences between the various religions and religious experiences (James, 1902/1958). Similarly, important differences exist between the various psychotherapies despite their common goal of improving the quality of life. However, because we are interested – not in the particular content of these approaches – but in their similar processes for bringing about change, we can safely bracket the differences in content and ontological presuppositions within and between the various psychotherapies and religions.

Third, the present study is limited to the common features of change shared by the psychotherapies and religions. Obviously, some human changes occur outside the domains of either psychotherapy or religion, such as those induced by stress, duress, sudden insight, etc. And, of course there are aspects of psychotherapy not shared with religion (e.g. techniques such as EMDR and "The Empty Chair"), and there are aspects of religion not shared with psychotherapy (e.g. prayer and worship). The subtitle of this work "towards a phenomenology of change" is an explicit acknowledgement of the limited scope this study.

Fourth, the present exposition in no way presumes that all psychotherapies and religions induce constructive or healthy improvements in the human condition. The current epidemic of violence, associated with militant branches of some religions, is only the most recent reminder of how quickly religion can become intolerant and rationalize the use of violence against so-called "unbelievers" or "heretics" (e.g. the 7th century spread of Islam; the Christian Crusades from 1096-1291; the Spanish Inquisition; etc.). As inhumane as this dark side of religion is, it does not, and should not obliterate recognition of the good that has been generated at times by the religions of the

world. The current exposition focuses on this latter phenomenon.

While the psychotherapies do not have as dark a history as religions, they have not always been as positive and successful as they aimed to be. Sometimes people have gotten worse as a result (Dimidjian & Hollon, 2010; Lilienfeld, 2007). On other occasions, people have not noticeably improved despite considerable time and money being spent (Krebs *et al*., 2018). Nonetheless, as with religion, we will focus on what appears to characterize common processes of change when they do work in reducing suffering and improving well-being.

One further proviso is needed in order to proceed: the concept of an "unseen order" need not be mystical, supernatural, or limited to religion. Indeed, every scientific discipline may be viewed as constituting an "unseen order", which can only be known or "seen" with the mind's eye and then, only with the help of specific paradigms, theories and concepts that need to be learned. The Krebs cycle in physiology, ionic bonding in chemistry, and the "uncertainty principle" in quantum physics, all represent an "order" in their respective disciplines that is totally "unseen" and unknown to anyone who has not had the opportunity to learn the concepts and the evidence for them. While most sciences use the scientific method to illuminate the "unseen order" of their discipline (rendering the "order" more "seen" and understood), scientific revolutions such as those associated with Copernicus and Einstein involved a radical reconceptualization of the existing data that is seen in the mind's eye of the discoverer well before it could be confirmed empirically (Isaacson, 2007; Kuhn, 1973). And there are some disciplines, such as mathematics and logic, that develop without any empirical testing; they are proved or demonstrated rationally… through the mind's eye empowered to see them by learning the relevant theories and concepts.

Exactly what the relationship is between the "unseen order" and the rest of reality is an issue that involves ontology and the philosophy of science and goes far beyond the scope of this article. However, for our purposes, it appears that the methods for human transformation, like the methods for changing grapes into wine, and flour into bread, appear to be limited and far from arbitrary. At least to this author, the fact that some approaches work better than others in facilitating beneficial human change suggests that there is some form of connection between our knowledge of what works and the structure of reality that grounds this, even though that foundation is unknown to us in its pristine "objectivity" because of the limits of our mind (cf. James, 1890/1950, p. 301; Kant, 1787/1965).

While acknowledging our epistemic limitations, we may nonetheless proceed with a careful description *of what we do know*. Fortunately, there is an established method well suited for describing *experienced reality* without making claims about what exists beyond our experience: that method is phenomenology.

Method

Phenomenology as a method for comparing psychotherapy and religion

Before defining and describing the relevance of phenomenology, it is helpful to understand philosophical history prior to its emergence. In contrast with the British empiricists (e.g. Locke, Berkeley & Hume), who regarded all knowledge arising from experience, Kant's *Critique of Pure Reason* maintains that – while all knowledge *begins* with experience, not all knowledge *derives* from experience (Kant, 1787/1965). In what Kant himself called a "Copernican Revolution" in the theory of knowledge, he argues that, instead of reality simply impressing itself upon our mind (as the empiricists taught), the mind actively orders and

organizes all our experience as it occurs. For Kant, all minds possess innate "forms" and "categories" that structure our experience of the world, so that our sensations and perceptions make sense to us and don't occur as a "buzzing, blooming confusion" of data. While the mind structures our experiences in ways that are meaningful and intelligible, it simultaneously prevents us from seeing reality as it is "in-itself" (the latter Kant called "noumenal" reality). All we can know, he argues, is reality as perceived by the mind... which is always a synthesis of the mind and so-called "objective reality". This mixture he calls "phenomenal" reality. While we can know *that* things are apart from our experience, we can never know *what* they are because of the inescapable impact of our mind on our experience (Kant, 1787/1965). What is left is the realm of phenomena-experienced reality. Phenomenology is the study of this realm.

The *Stanford Encyclopedia of Philosophy* defines phenomenology as *"the study of structures of experience, or consciousness. Literally... the study of 'phenomena', appearance of things, or things as they appear in our experience..."* (Smith, 2013). Phenomenology's origin is usually traced to the work of Edmund Husserl in the early 20th century, who was heavily influenced by the philosopher-psychologist Franz Brentano, who offered a fundamental insight about the "intentionality" of all conscious experience (Husserl, 1900/2001; Husserl, 1913/1983; Spiegelberg, 1971). "Intentionality" refers to the fact that, whenever we are conscious, we are always conscious – of something (with the exception of some advanced forms of meditation). Husserl's work in phenomenology began by describing the structures of our conscious experience; this led, eventually, to a more sophisticated agenda which included describing the presuppositions and implications of our conscious experience, our attention and our intentionality (Husserl, 1900/2001; Husserl, 1913/1983; Kockelmans, 1967; Natanson, 1973; Zaner, 1970).

Rudolf Otto was one of the first scholars to apply this method to understanding religious experience in his classic book, *The Idea of the Holy* (1917, trans. 1923/1950). The academic mythologist, Eliade was influenced by Otto's work in his understanding of the "sacred and the profane" realms of human experience, a distinction which recurs throughout the world's religions (Eliade, 1949/1974; 1958/1972). By mid-twentieth century, the influence of phenomenology appears in the philosophical theology of Paul Tillich (1951; 1957; 1959), in the religious philosophy and hermeneutics of Paul Ricoeur (1950/1966; 1960/1967), and later, in the application of Husserl and Alfred Schutz to theology by Edward Farley (1975). The philosopher, Jean-Luc Marion, coined the term "saturated phenomenon" in his phenomenological analysis of religious experience (Marion, 1999; Masterson, 2013).

In the field of psychology, some 20th century psychologists and psychiatrists used the phenomenological method, frequently combining it with existentialism (with which it is closely related); notably May (May, 1977, 1950; May, Angel, & Ellenberger, 1958), Wheelis (1973) and Yalom (1980). In recent years, phenomenology has been used by psychologists to enrich the interviewing process and to identify common human experiences (cf. Hood, 2013, pp. 91-93; Pollio, Hensley & Thompson, 1997). Most recently, a phenomenological analysis of psychotherapy identifies "attention" as the key component in training psychotherapists and in understanding how psychotherapy works (Whittemore, 2018). The scientific usefulness and standing of this method has been enhanced recently by its integration with empirical measures of neuronal activity in the new hybrid discipline of neuro-phenomenology (Lutz & Thompson, 2003; Miskovic, Kuntzelman & Fletcher, 2015).

Noted sociologist, Robert Bellah uses phenomenology extensively in his interdisciplinary magnum opus, *Religion in Human Evolution: from the paleolithic to the axial age* (Bellah, 2011). In particular, he expounds on the phenomenology of Alfred Schutz, who describes all the various realms or "worlds" of human interest (beyond just staying alive) as the many "multiple realities" that populate and pervade human social existence (Schutz, 1945). All the sciences, arts, and humanities, all businesses and professions, and all types of specialized knowledge – be it for work or play – constitute their own "worlds". Schutz's work is also foundational to the book, *The Social Construction of Reality* (Berger & Luckmann, 1966) and to social constructionism in general. Far from being esoteric, what Schutz means by "multiple realities" are simply the various "worlds" that absorb our attention, capture our interest, and temporarily define our reality, as when we say, *"He is in his own world right now".*

This could apply to Einstein, absorbed in his world of theoretical physics, an adolescent absorbed in a video game, or the confluence of sustained attention and engagement that Csikszentmihalyi has called "flow" (1990). This would also include all types of psychotherapy and all forms of religion; for when you are "into them", you are in that "world" or "province of meaning" (another phrase that Schutz uses to describe any one of the "multiple realities" that make up our social world; Schutz, 1945). The realities and lingo of each "province of meaning" are known to those who inhabit that specialized realm, but not to "outsiders" who have not immersed themselves into that particular "world". As we shall see below, people engaged in different paradigms, "... do *in some sense* live in different worlds" (Kuhn, 1970, p. 193, italics in original).

The reality of each realm is determined by what is being paid attention to by the participants. Phenomenology is particularly well suited to elucidate these shared features because it consists of describing the nature, preconditions and processes of our conscious attention. The main thesis of the present work is this: *throughout their teachings and practices, both psychotherapy and religion "work" by directing and re-directing the attention of their leaders to their respective "unseen order," and subsequently by directing their practitioner's attention so they may "harmoniously adjust ... [themselves] ... thereto".* Furthermore, what makes it possible for both psychotherapy and religion to attend to their "unseen order" is the respective paradigm, theories, concepts and techniques that constitute whatever specific orientation is being utilized.

Psychotherapeutic and religious paradigms as "lenses"

One cannot enter the world of astronomy without a telescope, nor the world of microbiology without a microscope. The proper lens is needed to perceive what is invisible to the naked eye. As noted earlier, the "multiple realities" ("worlds") of every human cultural endeavour (including all the sciences and humanities) can only be seen, understood and entered with the assistance of specific paradigms (i.e. theories, concepts, and practices) which have to be learned. Thomas S. Kuhn, in his highly influential book, *The Structure of Scientific Revolutions* (1970), uses of the term "paradigm" to describe the worldview and all of its traditions in which scientists do their work. Because the present exposition uses "paradigm" in a similar way, Kuhn's explanation of it is worth quoting: *"... it stands for the entire constellation of beliefs, values, techniques and so on shared by the members of a given community ... [and] ... it denotes one sort of element in that constellation... employed as models or examples ... [for solving problems] ..."* (Kuhn, 1970, p. 175). He proceeds

to note how paradigms enables one to "see" what others in that community "see;" while being invisible to those outside that of tradition (Kuhn, 1970, p. 189). Our phenomenological method will proceed with the understanding that the paradigms (i.e. theories, concepts and practices) of all psychotherapies and of all religions function like a compound lens, which makes it possible to see the "territory" of a person's life in a different way than was previously known and that potentially leads to improvement.

Results

The phenomenology of one's attention in psychotherapy and religion reveals important similarities. First, with regard to psychotherapy, each paradigm (i.e. theory, associated concepts, terms, and techniques) provides the psychotherapist with a lens that makes it possible for the therapist to "see" what has gone awry and needs attending-to for the client's improvement. The more comprehensively and thoroughly the paradigm and its applications are learned, the clearer it becomes as a lens through which the therapist can see and attend to important aspects in the client's life and world that are unknown and initially invisible to the client. For instance, the psychodynamic paradigm include processes (e.g. psychosexual and psychosocial development) structures (e.g. the unconscious and the ego) and automatic tendencies (e.g. transference and resistance), that are initially invisible to clients, but that also have potential for helping them (Curtis & Hirsch, 2003; Douglas, 2011; Freud, 1933/1965; Jones, 1953; Kernberg, 1980; Kohut, Goldberg, & Stepansky, 1984; Wolitzky, 2003).

Similarly, the humanistic paradigm provide a lens which enable therapists to pay attention, for instance, to an invisible "real self" that is latent, not yet manifest, and emerges optimally with the proper therapeutic climate, such as empathy, unconditional positive regard, or focusing attention on body awareness (Perls, 1969; Raskin, Rogers & Witty, 2008; Rogers, 1961; Yontef & Jacobs, 2008). Behavioural paradigms provide the therapist with the lens by which they may recognize, for example, the unseen realities of conditioned stimuli, unintended reinforcement, and desensitization, all of which are initially unseen by clients (Wahler, 1980; Wilson, 2008; Wolpe, 1990). Cognitive paradigms provide a lens to see "the unseen order" of maladaptive assumptions and ways to correct them (Beck *et al.*, 1979; Beck & Weishaar, 2005).

Narrative paradigms provide a lens for seeing, for instance, limiting life scripts along with numerous remedies that empower clients (White, 2007). No matter what the specific paradigm is, its theory and associated concepts provide a lens which guide *what the therapist pays attention-to* in order to help the client. (The grammatically incorrect usage of "attends-to" and related iterations throughout this article is intentional and done to emphasize the "directedness" of conscious attention *to* something, as Brentano originally recognized). To use William James' analogy, these theories provide the lens needed to attend to an "unseen order" which, when properly adhered to, will produce constructive change in the client.

In a similar manner, each religious world view, its related theories and teachings (such as the "yin and yang" of Daoism, "the Four Noble Truths" of Buddhism, or "the Beatitudes" of Christianity), provides their leaders and followers with a lens which renders their respective "unseen order" visible, e.g. "living in harmony with nature", "reducing suffering", "participating in the kingdom of heaven", (Smith, 1991). Children and newcomers in each religion are usually gradually immersed in that religion's paradigm through its basic teachings, concepts, etc. while – at the same

time – participating in the specific practices common to their religion, such as prayers, sacraments, chanting, singing, meditating etc. Such practices need to be recognized as part of the paradigm because they appear to facilitate participation in the "world" of each religion regardless of how little (or how much) of the traditions' theories and concepts are understood. These sorts of religious practices serve to redirect the attention of the participants from what is commonly seen and known in the everyday world about them, to the "unseen" world of their religious faith. While the theories and teachings help them to "see" what to attend to, the practices help them to "enact" what they attend-to and thereby participate-in.

It seems that for the "average believer" of any given faith, they become initiated into that tradition by gradual immersion in it, without any sudden memorable "religious experiences" (James, 1902/1958). Local religious leaders use their understanding of the conceptual "lens" of their tradition to guide what the congregants in their religious community "pay attention-to" in understanding their lives (e.g. "the providence of God" in monotheistic religions; the need for "detachment" in Buddhism; etc.). The religious practices (sacraments, prayers, etc.) are used to guide what believers *do* to embody and enact important aspects of their tradition's "unseen order" in ways that enhance their affective appreciation of, and social solidarity with that tradition. There are obvious exceptions to this gradual process of immersion, as when someone undergoes an unusual experience that suddenly redirects what is being paid attention to, as in the well-known cases of Buddha's "Enlightenment" and the "conversion" experiences of St. Paul (Acts 9: 3-22, RSV) and Augustine (Confessions, 8:12).

Just as the *"practices" in religious traditions* serve to *guide what the participants' attend-to* within their particular "unseen order", the various *"techniques" of psychotherapy* serve to *guide what their clients attend-to* in their thoughts, feelings, behaviour and relationships. For instance, as the psychodynamic therapist interprets transference and resistance in the client, (ideally) the client begins to "see" this previously "unseen order" and, in time, the unconscious "acting out" is replaced with more conscious, reasonable and realistic behaviour. As the humanistic psychotherapist immerses the client in the therapeutic atmosphere of unconditional positive regard, empathy and congruence, (ideally) the client begins to "see" the previously "unseen order" of his or her unhealthy inauthentic behaviour and, in time, their "false self" is replaced by their "real self" and experiences a healthier, more satisfying life. As the behavioural psychotherapist teaches "assertive communication" and practices it with the client, (ideally) the client begins to "see" the previously "unseen order" of his passive over-compliance and, in time, replace it with improved interpersonal effectiveness.

In each case, the psychotherapeutic techniques aim to redirect what clients attend-to and how to behave so as to align themselves more and more to the "unseen order" of that particular "world" (e.g. psychodynamic, humanistic, behavioural, etc.). As therapy succeeds in redirecting the client's attention to their respective unseen order, and to "harmoniously adjust themselves thereto", the client feels better, functions better, or both. Just as religions believe in an "unseen order" (i.e. their theological or religious "world") and as they attempt to guide adherence thereto via their specific practices, so do the psychotherapies believe in an "unseen order" (i.e. their psychotherapeutic orientation) and thus attempt to guide adherence thereto via their particular psychotherapeutic techniques.

Across all the various psychotherapies and religions (as and when they are successful),

the participants do far more than just mimic prescribed rituals and memorize major concepts of their tradition. The "lens" provided by the tradition's paradigm (which includes its theories, teachings, and practices) endows the participants with a new identity and new ways of understanding their past, their present options, and their future possibilities. They view themselves as different than before their therapy or religious involvement had empowered them with hope for a better life, and guided by the respective principles and practices, successful participants in religion and psychotherapy actually enter into a different "world," one that is different from our shared "filmable" environment. As the participants leave the counselling room, or the sacred place of worship, they take their new "lens" with them and with practice and support, implement new thoughts, feelings and behaviours that slowly and subtly transform the pathways of their lives and the quality of their relationships.

The "lens" as a "therapeutic hermeneutic"

We have seen how the respective paradigms of the various psychotherapies and religions can be likened to "lenses" that enable participants to see previously unseen territory in their life, including superior options for improved coping and problem solving. The *paradigmatic lens* does more than render visible previously unseen options: it also provides new and beneficial ways of making sense of the events of one's life that have already occurred. It *provides an interpretive grid* through which the past becomes more understandable and the future more hopeful. For instance, the psychodynamic paradigm might help a client understand some of her previous, counter-productive 'acting out' as the result of a developmental arrest and transferred emotions originating from earlier relationships; the behavioural paradigm might help a client understand some of his maladaptive reactions, as the result of classical and operant conditioning and unintentional learning by observation in the family of origin. Such interpretations not only help to make sense of the past, but they also offer guidance and hope for the therapist and client in what to attend to in order to get better.

The same may be said for the beneficial effects of religious paradigms when they are effective. For instance, the Christian paradigm includes explanations of human waywardness and misery through various interpretations of "the Fall", "sin", and "evil"; it also includes teachings and practices that illumine and activate "salvation", "faith" and "grace". The Buddhist paradigm includes explanations of human suffering through various explanations of "ignorance," "delusion" and "addiction"; it also includes teachings and practices to "enlighten", to "detach from craving", and to foster "acceptance". Because the paradigms of psychotherapy and religion facilitate healing, learning and growing, the interpretative lens that they provide deserves to be regarded as *a "therapeutic hermeneutic"*.

Hermeneutics is the science of interpretation, and originally referred to methods for the proper understanding of classical texts, scriptures and other ancient literature, so their truth or meaning might be understood more completely. Since the early nineteenth century, it has emerged as a rigorous philosophical and literary discipline for understanding all forms of communication, verbal and non-verbal (cf. Ramberg & Gjesdal, 2014). Hermeneutics was born out of the recognition that one's immediate perception of meaning may be wrong, misleading, or incomplete, thus the need for assistance in understanding more fully. As noted above, each theory of psychotherapy offers its' own way of under-

standing human behaviour and thus, provides a "hermeneutic" – or method – of interpreting what has gone wrong. Each therapist attempts to explain to herself (and others) why the diagnosis (or problems) developed and she uses the essential concepts of her preferred psychotherapeutic paradigm to conceptualize why these particular clinical problems arose for this particular client at this particular time. *In addition to providing a plausible explanation, the chosen theory or theories guide what the therapist pays attention-to in formulating a remedial treatment plan which hopefully facilitates some degree of healing, learning and/or growing.* As a result, it makes sense to say that the paradigmatic lens that is used provides a "therapeutic hermeneutic".

For instance, cognitive-behaviourists use a 'learning theory' paradigm and interpret behaviour as the result of classical and operant conditioning, learning by observation, and/or by unwittingly absorbing (or adopting) maladaptive assumptions and behaviours. This "hermeneutic lens" *directs the therapist's attention* to the specific, relevant realities in the client's life that illumine what has gone awry and subsequently, what to focus on for remediation. Furthermore, the hermeneutic lens *guides the therapist in directing what the client needs to pay 'attention-to'* in order to undo and redo the needed learning. Without the hermeneutic aspect that the theory provides, neither therapist nor client would know what to pay attention-to! The hermeneutic of each theory is its interpretation of what has happened and ways to improve it. Hence, the lens of each paradigm is a "therapeutic hermeneutic". Without the remedial interpretation that the paradigms provide, it's just "one damn thing happening after another" (which is often the way that clients feel about their own life when they come to therapy).

Religions too, through their histories, narrative myths and theoretical teachings, also provide a "therapeutic hermeneutic", even if indirectly. For instance, the belief in "the Providence of God" (i.e. God as Lord of all, including history) in the Jewish, Christian, and Islamic faiths, may lead the believer who is facing a difficult and unchangeable situation to think: *"There is an important reason for this"* or *"I am supposed to be dealing with this right now"*. As a result of this hermeneutic, they find themselves accepting what is going on for the purpose of searching for the best ways to handle it instead of acting on counter-productive interpretations that reinforce ignoring, blaming or complaining. Similarly, Buddhism's "Four Noble Truths" offers an interpretation of suffering, its causes, and its cures, which can endow the believer with a greater adaptive acceptance of what is happening (Smith, 1991). This acceptance imbues her with a greater readiness to consider solutions not previously sought or recognized.

There is true potency here; they do far more than merely re-frame situations – *they make it possible to see and to find solutions that otherwise would have been missed* with other interpretations such as: "I'm screwed," or "Why does bad luck always happen to me," etc. This illuminating and empowering capacity of interpretations which are embedded in the world's religions is not always recognized, as evidenced by Marx's famous dismissal of religion as the "opium of the masses" (Marx, 1843) and Freud's portrait of religion as an "illusion" (Freud, 1927/1961). When religious interpretations are successful (e.g. facilitating forgiveness, kindling compassion, inspiring respon+sible stewardship of nature), they redirect behaviour and transform the interpersonal landscape in positive ways unmatched by opiates and illusions.

End of Part One; To Be Continued in Part Two

Author

PAUL B. WHITTEMORE, Ph.D., is a board-certified (ABPP) Clinical Psychologist in Newport Beach, California. He also teaches "Theories of Counseling and Psychotherapy" in Pepperdine University's Graduate School of Psychology. Prior to obtaining a Ph.D. in Clinical Psychology from the University of Tennessee, Knoxville, the author earned a B.A. in Religion at Eastern Nazarene College, an M.Div. from Nazarene Theological Seminary, and an M.A. and Ph.D. in Philosophical Theology from Vanderbilt University. Before becoming a Psychologist, he taught undergraduate and graduate philosophy and religious studies for 12 years. His publications include work on personality changes, the genetics of depression, interdisciplinary work on Kant and psychotherapy, and a recent analysis of "attention" in psychotherapy.

E-mail: paulwhittemore@earthlink.net

Author's Note:

The author thanks his wife, Jane L. Whittemore, for her helpful support and editorial assistance in preparing the manuscript. Additionally, much gratitude is expressed to Drs. Rolly Spradling and Jacqueline Gray for their valuable support and input at various stages of the work, and to Dr. Steven Jay Lynn and anonymous reviewers for their support and helpful comments on previous versions of this article.

References

AUGUSTINE (1976). *Confessions* (R. S. Pine-Coffin, Trans.). Baltimore: Penguin Books. (Original translation published 1961).

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

BECK, A. T. & WEISHAAR, M. E. (2005). Cognitive Therapy. In: R.J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (7th ed.), (pp. 238-268). Belmont, CA: Thomson.

BELLAH, R. N. (2011). *Religion in human evolution: From the paleolithic to the axial age.* Cambridge, MA: Belknap Press of Harvard University Press.

BERGER, P. L. & LUCKMANN, T. (1966). *The social construction of reality: a treatise in the sociology of knowledge.* New York: Penguin Books.

CSIKSZENTMIHALYI, M. (1990). *Flow: the psychology of optimal experience.* New York: Harper & Row.

CURTIS, R.C. & HIRSCH, I. (2003). Relational approaches to psychoanalytic psychotherapy. In: A. S. Gurman & S. B. Messer (Eds.), *Essential Psychotherapies: Theory and practice* (2nd ed.), (pp. 69-106). New York: Guilford Press.

DIMIDJIAN, S. & HOLLON, S.D. (2010). How would we know if psychotherapy were harmful? *American Psychologist*, 65 (1), pp. 21-33.

DOUGLAS, C. (2011). Analytical Psychotherapy. In: R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (9th ed.), (pp. 113-147). Belmont, CA: Thomson Brooks/Cole.

ELIADE, M. (1972). *Patterns in Comparative Religion* (R. Sheed, Trans.). New York: World Publishing Co. (Original work published 1958).

ELIADE, M. (1974). *The Myth of the Eternal Return: or Cosmos and History* (W. R. Trask, Trans.). Princeton, NJ: Princeton University Press. (Original work published 1949).

FARLEY, E. (1975). *Ecclesial Man: A social phenomenology of faith and reality.* Philadelphia: Fortress Press.

FREUD, A. (1966). *The Ego and the Mechanisms of Defense.* (Rev. ed.). New York: International Universities Press. (Original work published 1933, revised 1936).

FREUD, S. (1961). *The Future of an Illusion* (J. Strachey, Trans.). Garden City, NY: Anchor Books. (Original work published 1927).

HOOD, R.W. Jr. (2013). Methodological Diversity in the Psychology of Religion and Spirituality. In: K. I. Pargament, J. J. Exline & J. W. Jones (Eds.), *APA Handbook of Psychology, Religion, and Spirituality (Vol. 1): Context, theory and research*, (pp. 79-102). Washington, DC: American Psychological Association.

HOPFE, L. M. & WOODWARD, M. R. (2011). *Religions of the World (12th ed.).* Upper Saddle River, N. J.: Pearson.

HUSSERL, E. (1983). *Ideas I: Ideas pertaining to a Pure Phenomenology and to Phenomenological Philosophy,* (F. Kersten, Trans.) Dordrecht & Boston: Kluwer Academic Publishers. (First published in German, 1913).

HUSSERL, E. (2001). *Logical Investigations. (Vols. 1 & 2)*, (J.N. Findlay, Trans. & Ed.) New York: Routledge. (First published in German: First edition, 1900-01; 2nd ed., 1913. First published in English 1970).

ISAACSON, W. (2007). *Einstein: His life and universe.* New York: Simon & Schuster.

JAMES, W. (1950). *The Principles of Psychology (Vol. 2).* New York: Dover Publications. (Original work published 1890).

JAMES, W. (1958). *The Varieties of Religious Experience: A study in human nature.* New York: New American Library. (Original work published 1902).

JONES, E. (1953). *The life and work of Sigmund Freud.* New York: Basic Books.

KANT, I. (1965). *The Critique of Pure Reason* (N. K. Smith, Trans.). New York: St. Martin's Press (Original work published 1781; revised, 1787).

KERNBERG, O. F. (1980). *Internal World and External Reality: Object relations theory applied.* New York: J. Aronson.

KOCKELMANS, J. J. (Ed.). (1967). *Phenomenology: The philosophy of Edmund Husserl and its interpretation.* Garden City, N. J.: Doubleday & Co.

KOHUT, H., GOLDBERG, A. & STEPANSKY, P. E. (1984). *How Does Analysis Cure?* Chicago: University of Chicago Press.

KREBS, P., NORCROSS, J. C., NICHOLSON, J. M. & PROCHASKA, J. O. (2018). Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology*, 74 (11), pp. 1964-1979.

KUHN, T. S. (1970). *The Structure of Scientific Revolutions (2nd Ed).* Chicago: University of Chicago Press.

LILIENFELD, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science, 2 (1), 53-70.*

LUTZ, A. & THOMPSON, E. (2003). Neuro-phenomenology: Integrating subjective experience and brain dynamics in the neuroscience of consciousness. *Journal of Consciousness Studies*, 10, pp. 31-52.

MARION, J.-L. (1999). 'In the Name.' In: J. Caputo & M. Scanlan (Eds.), *God, the Gift and Postmodernism.* Bloomington, IN: Indiana University Press.

MARX, K. (1843). https://www.1843magazine.com/intelligence

MASLOW, A. H. (1970/1954). *Motivation and Personality (2nd Ed.).* New York: Harper & Row.

MASTERSON, P. (2013). *Approaching God: Between phenomenology and theology.* New York: Bloomsbury .

MAY, R. (1977/1950). *The Meaning of Anxiety (Rev. ed.).* New York: Norton.

MAY, R., ANGEL, E. & ELLENBERGER, H. F. (1958). *Existence: A new dimension in psychiatry and psychology (1st Softcover ed.).* New York: Simon & Schuster.

MISKOVIC, V., KUNTZELMAN, K. & FLETCHER, N. (2015). Searching for affect in affective neuroscience: challenges and opportunities. *Psychology of Consciousness: Theory, Research and Practice*, 2 (1), pp. 1-18.

NATANSON, M. (1973). *Edmund Husserl: Philosopher of infinite tasks.* Evanston, Ill.: Northwestern University Press.

NOSS, D. S. & GRANGAARD, B. R. (2011). *A History of the World's Religions (13th ed.).* Upper Saddle River, N. J.: Pearson.

OTTO, R. (1950). *The Idea of the Holy: An inquiry into the non-rational factor in the idea of the divine and its relation to the rational* (J. W. Harvey, Trans.). London, England: Oxford University Press. (Original work published 1917: first English trans. published 1923).

PALOUTZIAN, R. F. & PARK, C. L. (2013). Recent Progress and Core Issues in the Science of the Psychology of Religion and Spirituality. In: R. F. Paloutzian & C. L. Park (Eds.) *Handbook of the Psychology of Religion and Spirituality (2nd ed.)*, (pp. 3-22). New York: Guilford Press.

PARGAMENT, K. I., MAHONEY, A., EXLINE, J. J., JONES, J. W. & SHAFRANSKE, E. P. (2013). Envisioning an integrative paradigm for the psychology of religion and spirituality. In: K. I. Pargament, J. J. Exline & J. W. Jones (Eds.), *APA Handbook of Psychology, Religion, and Spirituality (Vol 1): Context, theory and research*, (pp. 3-19). Washington, DC, US: American Psychological Association.

PARK, C. L. (2013). Religion and Meaning. In: R.F. Paloutzian & C.L. Park (Eds.), *Handbook of the Psychology of Religion and Spirituality (2nd ed.)*, (pp. 357-379). New York, N. Y.: Guilford Press.

PERLS, F. S. (1969). *Gestalt Therapy Verbatim.* Lafayette, CA: Real People Press.

POLLIO, H. R., HENSLEY, T.B. & THOMPSON, J. C. (1997). *The Phenomenology of Everyday Life.* New York: Cambridge University Press.

RAMBERG, B. & GJESDAL, K. (2014). Hermeneutics, In: E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy.* Retrieved from: http://plato.stanford.edu/archives/win2014/entries/hermeneutics/

RASKIN, N. J., ROGERS, C. R. & WITTY, M. C. (2008). Client-centered Therapy. In: R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies (8th ed.)*, (pp. 141-186). Belmont, CA: Thomson Brooks/Cole.

RICOEUR, P. (1966). *Freedom and Nature: The voluntary and the involuntary* (E. V. Kohak, Trans.). Evanston, Illinois: Northwestern University Press. (Original work published 1950).

RICOEUR, P. (1967). *The symbolism of evil.* (E. Buchanan, Trans.). Boston: Beacon Press. (Original work published 1960).

ROGERS, C. R. (1961). *On Becoming a Person: A therapist's view of psychotherapy.* Boston: Houghton Mifflin.

SCHUTZ, A. (1945). On multiple realities. *Philosophy and Phenomenological Research*, 5, (4), 533-576. https://www.jstor.org/stable/2102818.

SMITH, D. W. (2013). Phenomenology. In: E. N. Salta (Ed.), *The Stanford Encyclopedia of Philosophy.* Retrieved from: http://plato.stanford.edu/archives/win2013/

SMITH, H. (1991). *The World's Religions: Our Great Wisdom Traditions.* New York: Harper Collins.

SPIEGELBERG, H. (1971). *The Phenomenological Movement (2nd Ed.)* Dordrecht: Springer.

TILLICH, P. (1951). *Systematic Theology: Vol. I.* Chicago: University of Chicago Press.

TILLICH, P. (1957). *The Dynamics of Faith.* New York: Harper & Row.

TILLICH, P. (1959). *Theology of Culture.* London: Oxford University Press.

WAHLER, R. G. (1980). The Insular Mother: Her problems in parent-child treatment. *Journal of Applied Behavior Analysis,* 13 (2), pp. 207-219.

WHEELIS, A. (1973). *How People Change.* New York: Harper & Row.

WHITE, M. (2007). *Maps of Narrative Practice.* New York: W. W. Norton & Co.

WHITTEMORE, P. B. (2018). The central role of attention in psychotherapy. *International Journal of Psychotherapy*, 22 (1), pp. 26-36.

WILSON, G. T. (2008). Behavior therapy. In R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies (8th ed.),* (pp. 223-262). Belmont, CA: Thomson Brooks/Cole.

WOLITZKY, D. L. (2003). The theory and practice of traditional psychoanalytic treatment. In: A. S. Gurman & S. B. Messer (Eds.), *Essential Psychotherapies: Theory and practice (2nd ed.)*, (pp. 24-68). New York: Guilford Press.

WOLPE, J. (1990). *The Practice of Behavior Therapy (4th ed.).* New York: Pergamon Press.

YALOM, I. D. (1980). *Existential Psychotherapy.* New York: Basic Books.

YONTEF, G. & JACOBS, L. (2008). Gestalt Therapy. In: R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies (8th ed.)*, (pp. 328-367). Belmont, CA: Thomson Brooks/Cole.

ZANER, R. M. (1970). *The Way of Phenomenology. New* York: Pegasus.

Psychotherapy & Religion: Towards a Phenomenology of Change: Part 2

Paul B. Whittemore

Abstract: Part One of the present work began with an insightful quote by William James who defined religion as consisting *"of the belief in an unseen order, and that our supreme good lies in harmoniously adjusting ourselves thereto"* (1958/1902). It was noted that the same thing could be said regarding the various psychotherapies except for the need to replace "supreme good" with "life improvement." Hence, psychotherapy consists of the belief in an unseen order (i.e. those revealed by each psychotherapy theory), and that our life improvement lies in harmoniously adjusting ourselves thereto (via the respective psychotherapy techniques associated with each theory).

A phenomenological method is used to describe the similar ways that the leaders' and practitioners' attention is directed by psychotherapy and religion to induce positive change. Drawing upon Thomas Kuhn's understanding of scientific paradigms, all psychotherapies and religions are characterized as involving different paradigms (theories, teachings, practices) that function like different lenses though which the leaders (i.e. psychotherapists or clerics) and practitioners (clients or believers) are enabled to attend-to their respective "unseen order" and take steps to benefit from adjusting thereto. In addition to these paradigm-lenses revealing an "unseen order", they also function as a "therapeutic hermeneutic" for both psychotherapy and religion because they provide unique ways of interpreting one's past, present and future that can heal and empower the participants compared with most people's "default" understanding.

Part Two now proceeds next, to describe the similar ways that psychotherapy and religion address the universal problems of resistance to change.

International Journal of Psychotherapy
July 2020, Vol. 24, No. 2, pp. 33-45: ISSN 1356-9082 (Print); ISSN 1469-8498 (Online)

Submitted: March 2019; peer-reviewed twice and reformatted: May 2020; resubmitted and accepted: June 2020; DOI: 10.36075/IJP.2020.24.2.4/Whittemore.2

The precondition of personal readiness for change

Not all engagements with psychotherapy are focused on personal change. For instance, some clients may only be seeking support, or help in understanding someone else's behaviour. Similarly, not all engagements with religion are motivated by needing personal change, as in the case of those celebrating a religious holiday or bringing a baby for christening. But for those who turn to either psychotherapy or religion because of distress, there are shared pre-requisites for helping them change in ways that will relieve their suffering. The changes that usually take place in psychotherapy and religion first require a personal readiness for change and this entails an awareness of one's problems and one's need for help... emotionally, cognitively, behaviourally, relationally, spiritually, and any combination of these. Because the conscious awareness of such need is frequently absent in people, a phenomenological analysis of this common "blindness" may illumine contributing factors.

The first challenge to overcome is the universal fallacy of presuming that our personal assumptions about truth and reality are correct and complete as we face any difficult problem, not just psychological or spiritual ones. Instead of presuming our partial ignorance, we often act as if we are aware of all the important aspects of the problem and all the options available to us at any given time. This blindness to our actual ignorance is ubiquitous and usually not conscious. Cognitive scientist and Nobel Prize winner, Daniel Kahneman (2011) calls this the "What You See Is All There Is" mistake (abbreviated WYSIATI). He points out that this common fallacy is actually part of a double problem that besets our faulty thinking: we are – in effect – blind the larger realm of issues and options that are there, and so, *"We are blind to our blindness"* (Kahneman, 2011). The situation can be remedied, but only if individuals recognize that their current stock of knowledge along with its' assumptions (which Kahneman calls our "System 1") is incomplete and often wrong, partly because it is based on the accretion of one's limited, personal experience. Many cognitive errors can be recognized and corrected by a different type of thinking – one that is critical and questioning, which Kahneman calls our "System 2" (Kahneman, 2011); but this requires that people first of all realize their vulnerability to error and be willing to doubt and question their assumptions.

Besides this double problem of our blindness to unseen solutions and our blindness to our blindness, there is a third obstacle to our readiness to face the "unseen order". This obstacle is the universal tendency to not see accurately and completely the problems needing attention. The psychoanalytic tradition beginning with Freud, and then elaborated by his daughter, Anna Freud (1936/1966), identifies "defence mechanisms" such as "denial", "repression", and "resistance" referring to processes that shield us from clearly seeing and fully facing our personal shortcomings. They accomplish this by automatically redirecting our attention away from conscious awareness of particular negative emotions, such as anxiety and shame. These "defences" not only contribute to individuals being not ready for change through psychotherapy or religion, but they can also derail the change process at any point along the way. Therapists of all persuasions learn to be vigilant, continually exercising deft skill in redirecting clients' attention away from their automatic tendency to avoid issues, minimize problems, or blame others, and then to refocus on any unfinished business that remains. As any experienced therapist will attest, accomplishing this redirection of attention is not easy and requires constant

vigilance. Recent forms of therapy have been developed specifically to address this problem (Miller & Rollnick, 2013).

This makes three invisible obstacles that need overcoming to enter the worlds of psychotherapy or religion and to make progress therein: **1)** the initial blindness to the fact that there are other "worlds" (including solutions) besides our current stock of knowledge in our current "world"; **2)** the blindness to this blindness; and **3)** denial and/or resistance to recognizing our blindness, even when it is pointed out. The net result is that most of us, most of the time, do not see the full extent of our own limitations – they are invisible to us.

Since recognizing one's limitations and need for help is not commonplace, and yet is a pre-requisite for the change process in psychotherapy and religion, both of these domains have needed to find effective ways to deal with this deficiency. How do they elicit personal awareness of the invisible problems and unseen solutions relevant to each person? One of the most effective ways they have done this is... indirectly.

The "Unseen Order" and the "Indirect Method"

We live amidst many different phenomenological (i.e. experiential) worlds: our "everyday reality" that is shared by all who live in our immediate physical and cultural environment, and all the other "worlds" that mean something to us such as our profession, our nuclear family dynamics, our hobbies and games, and all the other realms of meaning that absorb our attention from time to time (Schutz, 1945; Bellah, 2011). The language that we use in each of our "worlds", is usually understood by others in the same "world" but may not be understood by those outside that particular world (e.g. "This wine is dry"). Language used and understood within any particular "world" is sometimes designated as "direct" communication in contrast with "indirect" communication (Schutz, 1945). Direct communication includes all the written, verbal and non-verbal forms of communication that are commonly used, and whose meanings is more or less understood by those sharing the same phenomenological "world". The more "into" any particular world the participants are, the better they understand each other, and the less explaining that they need to do with one another when using the "lingo" of their realm. For those outside that world, 'translation' is often needed using terms from "worlds" with which the recipient is familiar; frequently it is the common, everyday language of one's culture.

Direct communication rarely facilitates an *entrance* into an alternate world because that world involves a different paradigm and language that is not part of the common parlance from one's everyday world. The worlds and the unseen realities of psychotherapy and religion appear best introduced indirectly, and this is accomplished by redirecting the subject's attention through *using the known to approach the unknown*. Examples of this abound in history, literature, religion and psychotherapy.

It is noteworthy that Socrates did not use direct communication, either to instruct or to "wake people up" to their own ignorance. Instead, he used the indirect method of questioning, both to teach (see Plato's *Meno*) and to expose unrealized ignorance (see Plato's *Euthyphro*). Kierkegaard was deeply impressed by this approach and made it the subject of his dissertation, *"On the Concept of Irony – with constant reference to Socrates"* (Thompson, 1972). All of Kierkegaard's subsequent writings – literary, philosophical and religious – draw extensively on indirect literary techniques due to his belief that only "indirect" communication can give birth to "authentic subjectivity" (i.e. entry into the "true world" of Christianity), which he re-

garded as the highest form of consciousness (cf. Bretall, 1946; Lockhart, 2011; Thompson, 1972).

The world of literature abounds with similar indirect techniques in its' poetry, narratives and drama. The listeners' or readers' attention is repeatedly directed and then re-directed though devices such as metaphors, similes, analogies, allegories, allusions, irony, symbolism, etc. Tennessee Williams cleverly reminds us of the special capabilities of the indirect method in the opening lines of *"The Glass Menagerie"* where the narrator, Tom, says: *"Yes, I have tricks in my pocket, I have things up my sleeve. But I am the opposite of a stage magician. He gives you illusion that has the appearance of truth. I give you truth in the pleasant disguise of illusion"* (Williams, 1945/1987).

Religions have universally relied on indirect methods to communicate on three different levels. The first level refers to attempts to convey what is deemed as the "ultimate", or the supremely sacred reality, such as the Dao, Brahma, or God (Armstrong, 2009). Such realities would defy simple, literal description because they would, necessarily, fall short as inadequate. After all, if one is trying to talk about the 'Ultimate Source' or the 'Definer of All Things', one could not use the already defined to define the Definer.

The second level for using indirect communication has been to help "wake people up" to their folly, evil, or regression from previous revelations: examples of this include, stories and prophesies of "divine judgement", found not only in the Old and New Testaments of the Bible, but also in other non-biblical religions as well, such as the cataclysmic flood stories in the *"Epic of Gilgamesh"* from Mesopotamia and the *"Festival of Drunkenness"* in Ancient Egypt.

The third level for using indirect communication in religion has been to guide the participants to new, different, or deeper levels of understanding and experience (TeSelle, 1975). Examples of this type include: the personification of wisdom prevalent in the Jewish 'wisdom' literature, and the use of parables and metaphors in the New Testament (e.g. *"the kingdom of heaven is like…"* and *"you are the salt of the earth…"*). The "Eightfold Path" in Buddhism (which are indirect methods for detaching from the cravings that cause suffering); the "koans" (mental puzzles) of Zen Buddhism, used to stimulate higher awareness indirectly; and the narrative epics in Hinduism such as: the "Bhagavad-Gita"; the use of nature in Daoism's portraits of "the Way", as an indirect reference to ultimate reality; the use of anecdotes about exemplary individuals in order to characterize excellence and virtue in Confucianism (Smith, 1991; Noss & Grangaard, 2011). Common to all these indirect methods is the use of the familiar, "the seen", in order to introduce the unfamiliar, "the unseen."

Because religions frequently use indirect communication in the form of various literary devices, they are often misunderstood. When the words used "inside" a religious tradition are presumed to have exactly the same meaning that they have "outside" the religion, a misinterpretation results. For instance, early non-Christian Romans heard of the Christian sacrament of Communion that involved "the body and blood of Christ" and this was misunderstood as some form of perverse cannibalism and drinking of human blood (Latourette, 1953, p. 82). Similarly, many religious stories and myths (e.g. the stories of creation and the exodus) intended inside their respective "world" not to provide a pre-scientific explanation or "objective history", but rather to elicit adaptive emotions and inspire corrective behaviours, such as awe, humility, gratitude, and courage to replace arrogance, whining and despair (Bellah, 2011; Bright, 2000; Eliade, 1958/1972, 1949/1974; Geertz, 1973).

Indirect methods also permeate the history of psychotherapy. Freud used several indirect

methods to uncover the unconscious: hypnosis, dream analysis, free association (Freud, 1900/1965; Jones, 1953). Carl Jung used the "Word Association Test" to demonstrate, indirectly, the reality of "the unconscious" and to provide clues to unresolved "complexes" (Cloninger, 2013; Douglas, 2011). Carl Rogers discovered that he could best facilitate his clients' actualization process indirectly, by providing them with an atmosphere of empathy, unconditional positive regard and congruence (Rogers, 1961). Even therapies that utilize direct teaching methods, such as cognitive and behavioural therapies, are often most effective when they guide clients indirectly to evaluate their interpretations and behaviours. For instance, Beck's technique typically challenges the client with: *"Let's see if there is evidence supporting your assumption"*; and McCullough teaches therapists to pointedly ask the client, *"Why didn't you get what you wanted in that situation?"* (Beck & Weishaar, 2005; McCullough, 2000).

Wahler, a behaviourist, recognized how often parents unwittingly reinforce a child's unwanted behaviour by their negative attention, i.e. yelling and other forms of punishment. He guided parents to recognize and apply positive attention to children so they wouldn't need to act out for attention, thereby solving the problematic behaviour indirectly (Wahler, 1980). EMDR (Eye Movement Desensitization and Reprocessing) can reduce PTSD symptoms rapidly by having patients picture a traumatic memory in their mind and then follow a trained therapist's hand movements with their eyes (or other forms of bi-lateral stimulation) (Shapiro, 2018). Narrative therapies don't tell clients how to re-construe their lives, but guide them indirectly towards re-writing their own life story (White, 2007). Other well-known indirect methods used in psychotherapy include humour and paradoxical techniques.

Having shown how prevalent the "indirect method" is, for both religion and psychotherapy, we may now describe how one's attention is directed and then re-directed by that method into new "worlds". By using language that is familiar in one's current world, but *by using it in a different way*, (as with analogy, metaphor, parable, humour and other associative ways), one's attention is at first directed by the familiar, then toward the unfamiliar. This re-direction of attention begins with the familiar and known; and then, attention is directed to the fact that the familiar is being used in an unfamiliar way pointing to a new and different "world" (meaning) that appears adjacent to the world that one currently occupies (Wheelwright, 1962). Like a window linking two different "worlds", the indirect communication allows the inhabitants of one world to see that there is another world (i.e. the "world" of whatever psychotherapy or religion present) that seems better than the one currently "occupied". This adjacent world has the capacity to beckon an entrance into that world because, as noted earlier, its' full meaning cannot be grasped from the "outside"; it can only be known by voluntary participation with those "inside". While it can beckon, it does not and cannot impose the new realm. As if respectful of the person's ability to choose, these methods only invite and guide… they don't force. This has vital implications for both psychotherapy and religion. For instance, when it comes to "facing one's problem" (in either realm), if someone is in denial or minimizing, you can't make them understand their need by telling them directly to "face the problem". They either "get it", or they don't. As with a joke, if someone doesn't "get it", you can't make them "get it" by telling them to laugh. However, when one indirect method fails, other indirect methods may succeed, as shown by motivational counselling techniques, which refocus attention on various unpleasant consequences (Miller & Rollnick, 2013).

For those who are facing their need for help and turn to either psychotherapy or religion, there is another invisible ingredient in the "unseen order" that is indispensable for success. The common name for this ingredient is hope.

Hope as an unseen catalyst for change

Because of the emotional pain involved in turning within to face one's problems, the individual needs to have hope for relief and for "a better world" (however that is interpreted) to embark on the process. Not only is hope needed to begin, it is also necessary to sustain the change process long enough for recovery to emerge. Without hope, the individual is at a high risk of despair, discouragement, dropping out and, in extreme cases, suicide (Brown *et al.*, 2000; Beck *et al.*, 1979).

But what is hope? Hope is part of the "unseen order" because, while its' manifestations can be seen on someone's face, or located neuro-anatomically with an fMRI scan of the brain, these data are not the same as the phenomenon of hope as we experience it. Phenomenologically, hope is not a direct object of one's conscious attention; rather, it is the indirect or tacit awareness (cf. Polanyi, 1966, on "tacit" knowledge) of another – better – reality available to one, besides the reality one presently "occupies". If one loses awareness of positive potentials that are outside of one's painful present… hope vanishes. Furthermore, this hoped for "world" needs to be felt as "near" to one's present world or else it will seem beyond reach, too far removed to provide relief (e.g. *it isn't hopeful* to a client suffering severe depression to hear that their symptoms are likely to be less severe in six months from now, even though this is statistically correct).

How is this invisible catalyst of change elicited? As might be expected, the answer appears to be… indirectly. As with "facing one's problem", hope is not stimulated by sheer exhortation. It emerges indirectly, if at all, as the result of realizing that one's present reality may, in fact, be a prelude to a better world, a better self, or a better future. This reframing of one's experience occurs indirectly through exposure to an "alternate world" (religious or psychotherapeutic) that one is attending to, if only as an "outsider." In psychotherapy, clients catch a glimmer of the possibility for their healing, learning, or growth through reading, hearing the testimony of others, and/or through meeting a therapist who, by their demeanour and credible treatment plan, "inspires" hope. In religion, a similar process occurs indirectly if the individual is exposed to, or raised in, an environment with a believable paradigm portending new possibilities for a better world.

The monotheistic religions have used the indirect method to inspire hope in the hopeless. In Judaism and Christianity, for instance, God is presented as the liberator, protector, healer, who "sets His people free" (e.g. Deuteronomy 5: 6; Psalm 34: 19; Psalm 51: 1-15; Isaiah 35: 4; Galatians 5: 1; Ephesians 2: 8-9). The message of divine deliverance contrasts sharply with the heavy weight of 'needing to save oneself'; the so-called "saving grace" is well-known and highly extolled in these traditions. The Christian hymn, "Amazing Grace" is a classic testimony of indirect help, which inspires hope (*"… T'was grace that taught my heart to fear, and grace my fear relieved…"*) (*Praise & Worship*, n.d. 418). Not just in Christianity, but in the other two major monotheistic religions (Judaism and Islam), hope is predicated on the belief in divine grace and mercy, not on one's individual merit or effort.

It is worth noting that all the "Twelve Step" programs, patterned after Alcoholics Anonymous, utilize the indirect method for inspiring hope and kindling motivation. 'Step 2' explicitly draws attention to belief in "a Power

greater than ourselves" that can bring about change beyond what one can do alone (see also Steps 7 and 11, for further references to help from beyond oneself) (Alcoholics Anonymous, 1987).

As pointed out earlier, the paradigms of psychotherapy and religion not only change what is attended to, but they also change the interpretation of whatever occupies one's current world. When individuals are offered a new paradigm for understanding their life, they sense the possibility that a "paradigm shift" will not only alter what is attended to, but will change the meaning of what has already happened and, in so doing, provide an entrée into different "world" or "province of meaning" (Schutz, 1945).

Hope for a "better world" is always a present possibility, because we are always surrounded by numerous unexplored "worlds" that are not immediately recognized but – nonetheless – are present "around us" as it were. What activates hope is the breaking of one's fixation on what one is currently attending to and the simultaneous glimpsing of an adjacent realm that appears to offer relief. The lens of the "therapeutic hermeneutic" is what makes this glimpse and redirection possible.

The unseen "hierarchy of attention"

There appears to be, not only a common set of unseen realities in psychotherapy and religion, but also a loose form of "hierarchy" in the sequence of what is attended to by the leader and participant in order for optimal change to occur (cf. also in Whittemore, 2018). As Erikson attempted to show in his description of the "Eight Ages of Man" of psychosocial development (Erikson, 1963, pp. 247-274) and Maslow theorized in his "Hierarchy of Needs" (Maslow, 1954/1970), that which occurs (or fails to occur) at each stage impacts what occurs in later stages. The epigenetic schema conceptualized by Erikson and Maslow does not produce "all or nothing" consequences but suggests cumulative benefits that may (or may not) accrue from one stage to another during the life-time (Erikson, 1963, pp. 271-274; Maslow, 1954/1970, pp. 38ff). The same qualification applies here in what is meant by the term "hierarchy".

The first stage or precondition for significant human change (when individuals in distress turn to psychotherapy or religion) is that the individual realizes that something is wrong with him or her, or with their world; if there is no recognition of this, the change process usually does not occur. Religions universally begin with the assumption that the seeker realizes his or her need for help, or needs to face that fact. The calls to repent in the monotheistic religions, and the point of many myths, stories and koans in the other religions can be viewed as methods to induce the realization of one's need to change (Smith, 1991).

Throughout the history of psychotherapy, leading theorists and therapists have noted the indispensability of facing one's need for help. Carl Jung described four stages of therapy, beginning with what he called "Confession", by which he meant expressing the distress that arose from awareness that something is wrong (Douglas, 2011). Rogers believed that all therapy (not just "client-centred") starts with the client being "vulnerable" or "anxious", resulting from an awareness that something is wrong with oneself or one's world (Rogers, 1957). When that awareness is lacking, as is often seen with sociopaths and in some clients undergoing court-ordered therapy, therapeutic changes (i.e. transitions to better "realms" of reality) don't occur until the participant faces his or her need for help.

The challenge of achieving and maintaining this precondition is not limited to those with

personality disorders, or addicts in denial. Given the pervasiveness of minimizing, blaming, self-exonerating, and general pain-avoidance common to us all, this perennial pre-requisite for positive transformation is not easily maintained by anyone. Arthur Kovacs, Ph.D., a highly experienced clinical psychologist and Founding Dean Emeritus of the California School of Professional Psychology in Los Angeles, has suggested that psychotherapists begin each therapy session asking the client: *"What do you need to do here today?"* as an indirect way of positioning clients to face their need to work on themselves (Kovacs, 1997). The author has found that particular "opener" to be clinically valuable, along with other indirect approaches such as *"What would you like from me?"* when a client seems to be stuck complaining – non-productively – about someone else.

In Alcoholics Anonymous and other Twelve-Step programs, "Step One" is a form of "facing the problem" that one's existing coping mechanisms don't work: *"We admitted we were powerless over... and that our lives had become unmanageable"* (Alcoholics Anonymous, 1987). Even though Twelve-Step programs are neither psychotherapy, nor religion, we may interpret their effectiveness (when they work) as due to the redirecting of attention in a structured way, beginning with recognizing one's need for change (Brown *et al.*, 2002; Humphreys *et al.* , 1999; Ouimette *et al.*, 1997). Brown and Miller specifically note the direct parallel of AA with the Judeo-Christian tradition, which calls for individuals to face the problem of one's own 'sin' (2005).

Once an individual recognizes his/her need for personal change, the next pre-condition for positive change to occur is a physically and psychologically "safe place", an undistracted "safe field" (a term suggested by Lynn, 2015), where our attention is released from perceived immediate everyday pressures, so that one may focus on something else of importance necessary to induce beneficial change.

Religions have provided this with the help of dedicated sacred spaces, such as sanctuaries, synagogues and mosques, and "time-out", such as the Sabbath, designated prayer times, and spiritual retreats from every-day demands. Religions further promote a psychologically safe field by prohibiting ordinary work, or problem-solving during religious services, rituals, etc. The safe field that is needed is both "objective" – regarding environmental protection and "subjective" – regarding freedom from being pre-occupied with paying attention to something else.

Psychotherapists use similar methods to produce a 'safe field' in the physical environment, such as a private, quiet consultation room, free from distractions, lighting that is neither too bright nor too dark, and a designated timeframe dedicated to their entrance into, and confidential participation in, the therapeutic world. As with religionists, therapists also provide a psychologically 'safe field' by assurances of privacy, confidentiality and professional boundaries so as to protect the client's vulnerability. Within the different worlds of psychotherapy, a safe field is further promoted by various methods such as: reclining on the couch and free associating (in traditional psychoanalysis); the use of serene scene visualizations that alternate with exposure techniques in behaviour therapy; and the common use of non-judgmental acceptance and empathy by therapists of most persuasions. Regular checking in with the client each session (to see if they are preoccupied with anything else) also helps to maintain a safe field for ongoing work.

As this pre-condition is satisfied, the stage is set for inducing hope for a "better world". Both psychotherapy and religion succeed in introducing the new reality by redirecting atten-

tion away from *the visible*, (i.e. what is already seen and known about the pain and problems in the participants' present reality) *and toward the invisible* (i.e. what is not yet seen or recognized... the elements of the leader's paradigm). The participants begin the process of re-interpreting themselves and their life, according to the "therapeutic hermeneutic" of the paradigm; as they do this, they construe the facts of their life and their current situation in a manner that will reduce suffering, empower more adaptive behaviour and improve the quality of their life according to their values, and those embedded in the paradigm in which they have engaged.

Summary and Discussion

William James' generic definition of religion involving attention to an "unseen order" (1902/1958, p. 58) has been shown also to apply to understanding the various forms of psychotherapy. Using a predominantly phenomenological method, drawn from Edmund Husserl and Alfred Schutz, this "unseen order" is described and is shown to consist of common features, pre-requisites, and assumptions that are also "unseen", yet nonetheless real. The major points made are as follows:

1. Despite different contents, world views, goals, and practices, there are important shared realities in how psychotherapy and religion direct and redirect attention to the "unseen order" so as to bring about beneficial change.
2. The *theories and teachings* of the psychotherapies and religions are viewed as paradigms that function as "lenses" rendering the "unseen order" visible and *guide what the leaders need to attend to.*
3. The *techniques* of psychotherapy and the *practices* of religion (which are part of their respective paradigms) *guide what the participants need to pay attention to* in order to understand and align themselves more fully with their respective "unseen order" and to benefit thereby.
4. The capacity for the paradigms of psychotherapy and religion to provide adaptive and empowering interpretations of one's life has been identified and labelled as their "therapeutic hermeneutic."
5. "The indirect method" has been identified as a common feature in the successful redirection of attention characteristic of both psychotherapy and religion. It is shown to illumine: **a)** the transition process from the "seen" to the "unseen order"; **b)** how psychotherapy and religion facilitate personal readiness for change; **c)** how hope is evoked; and **d)** why the "inside" language of each realm is frequently misunderstood by those "outside" the paradigm.
6. The widespread problem of denial in religion and psychotherapy is described phenomenologically as involving at least three components, all of which entail the failure to recognize that what one is presently paying attention to (i.e. one's current "world") is inadequate in relation to superior alternate "worlds" that are ever present to us, albeit unseen.
7. A "hierarchy of attention" is identified that appears to characterizes an optimal sequence in what is attended to by psychotherapy and religion.

The above conceptualizations offer a fresh approach to understanding religion that is different from, yet consistent with, recent formulations by psychologists of religion (Paloutzian & Park, 2013; Pargament *et al.*, 2013; Park, 2013). The present work's contribution to psychotherapy and religion depends on the validity and utility of the above observations. Because validation in phenomenolog-

ical analyses takes the form of intersubjective verification, subsequent observations by others is needed to confirm, modify, or disconfirm the descriptions herein. Other phenomenological analyses may find different, additional, or better ways to describe the operations of attention in the change process, or challenge the similarity between the way attention is directed in religion and in psychotherapy. Some claims, such as the importance of the "indirect method", or the "hierarchy of attention", are testable by various methods including analyses of recorded psychotherapy sessions, or by comparing psychotherapy sessions that use the "indirect method" or "hierarchy" with those who do not use them, or use them far less.

Important questions remain to be answered: *"Why do some 'therapeutic hermeneutics' (i.e. lenses) 'work' for some people and not for others?"*; *"Why do some people enter and progress in the worlds of psychotherapy or religion more quickly than others?"*; *"Are there predictable ways to prevent or retard entrance into 'unseen orders' that breed violence, typical of the worlds of terrorists and racists?"* These are among the many unanswered questions that await further investigation. Hopefully, others will find these initial observations helpful and heuristic for improving our understanding and facilitation of healthy human change in whatever setting it occurs.

This two-part article suggests that both psychotherapy and religion can effect human change, partly by redirecting attention from the "seen" to the "unseen". As with quantum particles, what is real for individuals is impacted by what is attended to. Exactly how "what we attend to" is related to "what is really there" is an intriguing question, but this is beyond the scope of the present study. Yet, once again William James offers us – in his own inimitable way – another thoughtful quote suitable for our conclusion: *"Strange mutual dependence this, in which the appearance needs the reality in order to exist, but the reality needs the appearance in order to be known!"* (James, 1890/1950, p. 301).

Author

PAUL B. WHITTEMORE, Ph.D., is a board-certified (ABPP) Clinical Psychologist in Newport Beach, California. He also teaches "Theories of Counseling and Psychotherapy" in Pepperdine University's Graduate School of Psychology. Prior to obtaining a Ph.D. in Clinical Psychology from the University of Tennessee, Knoxville, the author earned a B.A. in Religion at Eastern Nazarene College, an M.Div. from Nazarene Theological Seminary, and an M.A. and Ph.D. in Philosophical Theology from Vanderbilt University. Before becoming a Psychologist, he taught undergraduate and graduate philosophy and religious studies for 12 years. His publications include work on personality changes, the genetics of depression, interdisciplinary work on Kant and psychotherapy, and a recent analysis of "attention" in psychotherapy.

E-mail: paulwhittemore@earthlink.net

Acknowledgements:

The author presented a brief, earlier version of this article at the 12th Mid-Year Conference on Religion & Spirituality, sponsored by APA Division 36, April 25, 2014. The author thanks his wife, Jane L. Whittemore, for her helpful support and editorial assistance in preparing the manuscript. Additionally, much gratitude is expressed to Drs. Rolly Spradling and Jacqueline Gray for their valuable support and input at various stages of the work, and to Dr. Steven Jay Lynn and anonymous reviewers for their support and helpful comments on previous versions of this article.

Correspondence concerning this article should be addressed to: paulwhittemore@earthlink.net.

Declaration of Interest:

No potential conflict of interest was reported by the author.

References

ALCOHOLICS ANONYMOUS. (1987). *The Twelve Steps of Alcoholics Anonymous* (1st Harper/Hazelden ed.). San Francisco: Harper/Hazelden.

ARMSTRONG, K. (2009). T*he Case for God.* New York: Anchor Books.

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

BECK, A. T. & WEISHAAR, M. E. (2005). Cognitive Therapy. In: R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (7th ed.), (pp. 238-268). Belmont, CA: Thomson.

BELLAH, R. N. (2011). *Religion in human evolution: From the paleolithic to the axial age.* Cambridge, MA: Belknap Press of Harvard University Press.

BRETALL, R. (Ed.). (1946). *A Kierkegaard Anthology.* New York: The Modern Library.

BRIGHT, J. (2000). *A History of Israel.* (4th ed.). Louisville, KY: Westminster John Knox Press.

BROWN, G. K., BECK, A. T., STEER, R. A. & GRISHAM, J. R. (2000). Risk factors of suicide in psychiatric outpatients: A 20-year prospective study. *Journal of Consulting and Clinical Psychology*, 68 (3), pp. 371-377.

BROWN, S. & MILLER, W. R. (2005). Transformational Change. In: W. R. Miller & H. D. Delaney (Eds.), *Judeo-Christian Perspectives on Psychology*, (pp. 167-184). Washington, D. C.: American Psychological Association.

BROWN, T. G., SERAGANIAN, P., TREMBLAY, J. & ANNIS, H. (2002). Process and outcome changes with relapse prevention versus 12-step aftercare programs for substance abusers. *Addiction*, 97, pp. 677-690.

CLONINGER, S. (2013), Jung: Analytical psychology. In: *Theories of Personality* (6th ed.), (pp. 44-63). Upper Saddle River, NJ: Pearson.

DOUGLAS, C. (2011). Analytical Psychotherapy. In: R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (9th ed.), (pp. 113-147). Belmont, CA: Thomson Brooks/Cole.

ELIADE, M. (1972). *Patterns in Comparative Religion* (R. Sheed, Trans.). New York: World Publishing Co. (Original work published 1958).

ELIADE, M. (1974). *The Myth of the Eternal Return: or, Cosmos and History* (W. R. Trask, Trans.). Princeton, NJ: Princeton University Press. (Original work published 1949).

ERIKSON, E. (1963). *Eight Ages of Man in Childhood and Society* (Second Ed.), (pp. 247-274). New York: W. W. Norton & Co. (First Edition, 1950).

FREUD, A. (1966). *The Ego and the Mechanisms of Defense.* (Rev. ed.). New York: International Universities Press. (Original work published 1933, revised 1936).

FREUD, S. (1965). *The Interpretation of Dreams.* (J. Strachey, Trans.). New York: Avon Books. (Original work published 1900).

GEERTZ, C. (1973). Religion as a cultural system. In: C. Geertz (Ed.), *The Interpretation of Cultures* (pp. 87-125). New York: Basic Books.

HUMPHREYS, K., HUEBSCH, V. D., FINNEY, J. W. & MOOS, R. H. (1999). A comparative evaluation of substance abuse treatment: Substance abuse treatment can enhance the effectiveness of self-help groups. *Alcoholism: Clinical and Experimental Research*, 23, pp. 558-563.

JAMES, W. (1958). *The Varieties of Religious Experience: A study in human nature.* New York: New American Library. (Original work published 1902).

JONES, E. (1953). *The Life and Work of Sigmund Freud.* New York: Basic Books.

KAHNEMAN, D. (2011). *Thinking, fast and slow.* New York: Farrar, Straus and Giroux.

KOVACS, A. (1997). *Personal communication.*

LATOURETTE, K. (1953). *A History of Christianity.* New York: Harper & Row.

LOCKHART, J. R. (2011). *Kierkegaard: Indirect communication and ignorant.* New York: Harcourt, Brace & World.

MASLOW, A. H. (1970/1954). *Motivation and Personality* (Second Edition). New York: Harper & Row.

MCCULLOUGH, J. P. (2000). *Treatment for chronic depression: Cognitive behavioral analysis system of psychotherapy.* New York: Guilford Press.

MILLER, W. R. & ROLLNICK, S. (2013). *Motivational interviewing: helping people change* (3rd ed.). New York: Guilford Press.

NOSS, D. S. & GRANGAARD, B. R. (2011). *A History of the World's Religions* (13th ed.). Upper Saddle River, N. J.: Pearson.

OUIMETTE, P. C., FINNEY, J. W. & MOOS, R. H. (1997). Twelve step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology*, 65, 230-240.

PALOUTZIAN, R. F. & PARK, C. L. (2013). Recent Progress and Core Issues in the Science of the Psychology of Religion and Spirituality. In: R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the Psychology of Religion and Spirituality* (2nd ed.), (pp. 3-22). New York: Guilford Press.

PARGAMENT, K. I., MAHONEY, A., EXLINE, J. J., JONES, J. W. & SHAFRANSKE, E. P. (2013). Envisioning an integrative paradigm for the psychology of religion and spirituality. In: K. I. Pargament, J. J. Exline & J. W. Jones (Eds.), *APA Handbook of Psychology, Religion and Spirituality: Context, theory, and research. (Vol. 1)* (pp. 3-19). Washington, DC: American Psychological Association.

PARK, C. L. (2013). Religion and meaning. In: R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the Psychology of Religion and Spirituality* (2nd ed.), (pp. 357-379). New York: Guilford Press.

POLANYI, M. (1966). *The Tacit Dimension.* Garden City, NY: Doubleday & Company.

POLLIO, H. R., HENSLEY, T. B. & THOMPSON, J. C. (1997). *The Phenomenology of Everyday Life.* New York: Cambridge University Press.

PRAISE & WORSHIP (n.d.) "Amazing Grace," #418. Kansas City, Mo.: Lillenas Publishing Company.

ROGERS, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, pp. 95-103.

ROGERS, C. R. (1961). *On Becoming a Person: A therapist's view of psychotherapy.* Boston: Houghton Mifflin.

SHAPIRO, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy, (3rd Edition): Basic Principles, Protocols, and Procedures.* (3rd ed.). New York: Guilford Press.

SCHUTZ, A. (1945). On multiple realities. *Philosophy and Phenomenological Research*, 5 (4), pp. 533-576.

SMITH, H. (1991). *The World's Religions: Our Great Wisdom Traditions.* New York: Harper Collins.

THOMPSON, J. (Ed.). (1972). *Kierkegaard.* Garden City, NY: Doubleday Anchor Press.

TESELLE, S. (1975). *Speaking in Parables.* Philadelphia: Fortress Press.

WAHLER, R. G. (1980). The Insular Mother: Her problems in parent-child treatment. *Journal of Applied Behavior Analysis*, 13 (2), pp. 207-219.

WHEELWRIGHT, P. (1962). *Metaphor and Reality.* Bloomington: Indiana University Press.

WHITE, M. (2007). *Maps of Narrative Practice.* New York; W. W. Norton & Co.

WHITTEMORE, P. B. (2018). The central role of attention in psychotherapy. *International Journal of Psychotherapy*, 22 (1), pp. 26-36.

WILLIAMS, T. (1987). *The Glass Menagerie.* New York: Dutton Signet. (Original work published 1945).

The Effects of Multicultural Discussions and Supervisory Working Alliance on Perceived Counseling Competence: A Brief Report

Jarice N. Carr, Patricia L. Kaminski,
Nina Calmenson & C. Edward Watkins, Jr.

Abstract: Based on current conceptualization about the beneficial impact of a positive supervisory alliance and cultural discussions on supervisee development, we studied the following hypothesis: The quality of multicultural discussions in supervision will enhance the relationship between the supervisory working alliance and trainee multicultural counseling competence. Pre-doctoral interns, doctoral students, and 2 individuals in their first post-doctoral position were sampled and completed online questionnaires about three variables: Perceived strength of the supervisory relationship, degree of multicultural counseling competence, and extent to which multicultural discussions occurred in supervision. Based on hierarchical multiple regression analysis, supervision and multi-cultural discussions were found to contribute significantly to supervisees' perceptions about the supervisory alliance and their multicultural counseling development. Furthermore, where multicultural discussions occurred within the context of a most positively perceived supervisory alliance, the combined effects on multicultural counseling development appeared even more additive.

Key Words: multicultural, supervision, alliance, competence, discussion

International Journal of Psychotherapy
July 2020, Vol. 24, No. 2, pp. 47-52: ISSN 1356-9082 (Print); ISSN 1469-8498 (Online)

Submitted: May 2020; peer-reviewed twice and reformatted: June 2020; resubmitted and accepted; DOI: 10.36075/IJP.2020.24.2.5/Carr.Kaminski.Calmenson.Watkins

Clinicians in training develop multicultural counseling competence by the systematic infusion of multicultural concepts throughout their training programs (Arredondo & Arciniega, 2001; Clauss-Ehlers *et al.*, 2019). But considerable variation exists in the multicultural training opportunities offered amongst psychology programs (e.g., Magyar-Moe *et al.*, 2005). Despite that variability, empirical evidence suggests that both multicultural training and a positive supervisory alliance are related to greater multicultural competence (Inman & Ladany, 2014; Wise & Swartz, 2018). Multicultural discussion in supervision is the predominant method that supervisors use to assist supervisees in achieving multicultural competence (Inman & Ladany, 2014). Research about such discussion, while supportive (Gatmon *et al.*, 2001; Phillips *et al.*, 2017; Soheilian *et al.*, 2014), is highly limited, and there is compelling need for more such study (Phillips *et al.*, 2017).

We wished to add to the limited research on this topic, investigating the role of multicultural training, supervisory working alliance, and multicultural supervision discussions on doctoral trainees' multicultural competence development. We specifically hypothesized the following: 'The quality of multicultural discussions in supervision enhances the relationship between the supervisory working alliance and trainee multicultural counseling competence'.

Method

Participants: All participants were from American Psychological Association accredited doctoral programs and had engaged in supervised practice as part of their training. The sample consisted of 57 participants, 73% being female, 25% male, and 2% self-identifying as queer. The participants ranged in age from 25 to 60 years, mean age being 29.5 years (*SD* = 5.4 years). Twenty-eight participants (49.1%) were current doctoral interns, 27 (47.4%) were doctoral students, and two (.5%) were post-doctoral clinicians under supervision. Participant's years in program varied from 2nd-year to 10th-year doctoral students; modal and mean program year was, respectively, 4 and 4.7 (*SD* = 2.5 years). The majority of the participants identified as white (74%); other represented racial/ethnic groups included Hispanic or Latino (11%), African-American, Afro-Caribbean or African (5%), Asian American or Asian (5%), multi-racial (3%), and Middle Eastern (2%). The majority of the sample identified as heterosexual (84%); other represented sexual orientations included bisexual (7%), gay (7%), and lesbian (2%). Most participants were from Counseling Psychology Ph.D. programs (56%), followed by Clinical Psychology Ph.D. (39%) and Clinical Psy.D. (5%) programs.

Materials / Instruments

- ***Demographic questionnaire***: Participants were asked to provide the following information: their age, gender, sexual orientation, race/ethnicity, year in doctoral program and program type, their perceived differences/similarities with their current supervisor on variables of gender, race/ethnicity, and sexual orientation, their multicultural training experience and months receiving individual supervision with their current supervisor, and estimates of the frequency of their experience with clients from different genders, racial/ethnic backgrounds, and sexual orientations.
- ***Supervisory Working Alliance Inventory–Trainee*** (SWAI-T; Efstation *et al.*, 1990). The SWAI-T, a 30-item, self-report measure of supervisee perceptions about the supervisory alliance, is composed of two subscales: Rapport and Client Focus. We used only the Rapport subscale because of its

exclusive emphasis on trainee perceptions about supervisor attempts to build rapport by providing support and encouragement (Efstation *et al.*, 1990). The SWAI-T Rapport scale has displayed strong internal reliability (coefficients of .90 and above) and concurrent validity (r = .85, p = .001) (Efstation *et al.*, 1990). Items are written in a Likert-scale format, anchored from 1 (almost never) to 7 (always). Due to error, three items from the original questionnaire were omitted, resulting in a nine-item online scale. The (nine-item) Rapport alpha coefficient for our study's sample was 0.97, indicating high internal consistency.

- ***The Multicultural Counseling Inventory*** (MCI; Sodowsky *et al.*, 1994). The MCI, a 40-item self–report measure of perceived multicultural competencies, is composed of four subscales: Multicultural Counseling Skills, Multicultural Awareness, Multicultural Counseling Knowledge, and Multicultural Counseling Relationships. Items are rated on a 4-point Likert scale (4 = very accurate to 1 = very inaccurate), with higher scores indicating superior multicultural competence. Internal reliability for each subscale and the total scale have ranged from acceptable to good (Sodowsky *et al.*, 1994). The full-scale reliability coefficient for the present study was 0.83.
- ***Multicultural Discussions in Supervision Questionnaire*** (MDSQ), a 16-item, Likert-format questionnaire developed specifically for this study, measured the quality of multicultural discussions in supervision. The MDSQ focused on (a) supervisees' perceptions about supervision discussions concerning race/ethnicity and sexual orientation (e.g., initiation, frequency), and (b) the effect of such discussions on their clinical development and the supervisory relationship. Participants recorded their responses on Likert scales. Question development/selection was informed by previous research about multicultural discussions, relationship with supervisor, and supervisee sense of safety (e.g., Gatmon *et al.*, 2001; Phillips *et al.*, 2017). Sample items included: *"Do you discuss race/ethnicity during individual supervision?" "Is race/ethnicity significant to your identity?" "Are you satisfied with the outcome of discussion of race/ethnicity in supervision?"* Scores ranged from 16 to 75, with higher scores indicating better multicultural discussions in supervision. Each scale item was standardized to z-scores by subtracting the mean from the raw score and dividing by the standard deviation to account for Likert scales differences. Z-scores were summed to create a total scale score ranging from −29.72 to 16.09. Internal reliability for the current sample was 0.90.
- ***Multicultural training scores***: Participants provided the number of multicultural courses, multicultural workshops/didactics, multicultural case presentations, and multicultural conferences they had attended or participated in since beginning their doctoral training. The number of multicultural training experiences was added to create a multicultural training experiences score.
- ***Salience of race/ethnicity to identity***: A single item measure, created to assess participants' perception of the importance of race/ethnicity to their identity, was asked: *"Is race/ethnicity significant to your identity?"* Participants recorded responses on a Likert-type scale, with anchors ranging from 1 (strongly disagree) to 7 (strongly agree). Higher scores indicated that race/ethnicity was highly significant to participants' identity.
- ***Salience of sexual orientation to identity***: A single item measure, created to assess participants' perception of the importance

of sexual orientation to their identity, was asked: *"Is your sexual orientation significant to your identity?"* Responses were made on a Likert-type scale with endpoints ranging from 1 (strongly disagree) to 7 (strongly agree). Higher scores indicated that the participants' sexual orientation was highly relevant to their identity.

Participants completed a demographic questionnaire, the nine-item Rapport subscale (SWAI-T; Efstation *et al.*, 1990), Multicultural Counseling Inventory (Sodowsky *et al.*, 1994), and the Multicultural Discussions in Supervision Questionnaire. All questionnaires were completed online, the completion time being approximately 30-45 minutes.

Results and Discussion

Initial analyses assessed data entry accuracy, out-of-range values, and missing data. The total number of missing responses on each scale was less than 5%; therefore, cases with missing data were excluded from the analyses. Frequencies for the categorical variables of ethnicity, sexuality, and gender were determined; extreme outliers were identified by implementing Box Plots for each scale, and each outlier was examined for reporting or scoring errors, with none being found; and continuous scales were assessed for normality of distribution. Multicollinearity was tested; the data met the assumption for lack of multicollinearity, the variables not being highly correlated. Means, standard deviations, and correlations across measures are provided in Tables 1 and 2.

The SWAI-T Rapport scale scores (M = 53.93) were found to be skewed, indicating that participants generally rated their supervisory working alliance as positive. Therefore, as recommended by Tabachnick & Fidell (2007), a log-linear transformation was performed on the Rapport data to normalize the distribution and make hypothesis testing possible. The logarithmically transformed scale resulted in a new mean of .755 (SD = .464), with the directionality of the Rapport scale being reversed:

Table 1: *Measure Means, Standard Deviations, and Reliability Coefficients*

Variable	*M*	*SD*	*a*	*n*
Supervisory Working Alliance Trainee Rapport	54.53	9.84	.97	55
Supervisory Working Alliance Trainee Rapport Logarithmic	0.76	0.46		55
Multicultural Discussions in Supervision Questionnaire	61.26	10.38	.90	54
Multicultural Discussions in Supervision Questionnaire Standardized	0	10.18		54
Multicultural Training Experience Score	10.93	7.08		57
Multicultural Counseling Inventory	123.65	10.57	.83	57

Note: M = mean; SD = standard deviation; a = alpha coefficients; n = number of respondents

lower scale scores reflected higher rated supervisory working alliances, whereas higher scale scores reflected lower rated supervisory working alliances.

As shown in Table 2, multicultural discussion in supervision was positively related to favorable supervisee perceptions about multicultural training, multicultural competence, and supervision rapport.

Table 2: *Intercorrelations for Independent and Dependent Variables*

Measure	1	2	3	4
1. *Multicultural Training Experience Scores*	—			
2. *Multicultural Discussions in Supervision Standardized*	.32*	—		
3. *Supervisory Working Alliance Rapport Factor Logarithmic*	−.12	−.56**	—	
4. *Multicultural Counseling Inventory*	.39	.34*	.09	—

Note: Coefficients significant at * $p < .05$ and ** $p < .01$

The moderation analysis is presented in Table 3. In the first step, we entered supervisory working alliance and quality of multicultural discussions; those variables accounted for a significant amount of variance in perceived multicultural counseling competence, $R^2 = 0.14$, $F(2, 49) = 3.96$, $p < .05$. In Step 2, the centered interaction term between supervisory working alliance and quality of multicultural discussions was added to the regression model, accounting for a significant portion of multicultural counseling competence variance beyond that of Step 1, $\Delta R^2 = 0.09$, $F\Delta(1, 48) = 6.06$, $p < .05$, $b = -.33$, $t(48) = -2.46$, $p < .05$. Multicultural discussions significantly moderated the relationship between supervisory working alliance and multicultural counseling competence when discussion scores were high ($\beta = -11.09$, $p < .05$): as multicultural discussions in supervision increased, so too did the direct, positive relationship between supervisory working alliance and multicultural counseling competence.

Table 3: *Hierarchical Regression Analysis Summary for Multicultural Discussions moderating Supervisory Working Alliance and Multicultural Counseling Competence (N = 52)*

Step and Predictor variable	*B*	*SE B*	β	R^2	ΔR^2
Step 1				0.14*	
Supervisory Working Alliance Trainee Rapport	−3.79	3.76	−0.16		
Multicultural Discussions in Supervision	0.28	0.17	0.26		
Step 2				0.24**	0.09*
Supervisory Working Alliance Trainee Rapport x					
Multicultural Discussions in Supervision	−0.65	0.26	−0.33		

Note: *B* = unstandardized beta; *SE B* = standard error for unstandardized beta; β = standardized beta; R^2 = *R* squared; ΔR^2 = Delta *R* squared; * $p < .05$; ** $p < .01$

Conclusion

This study, not without limitations (e.g., small sample size), is an additive effort to examine a purportedly critical supervision variable: Multicultural supervisor-supervisee discussions. Do they matter? Our findings answer that question affirmatively (cf. Gatmon *et al.*, 2001; Phillips *et al.*, 2017; Soheilian *et al.*, 2014) and also suggest that – while supervisory working alliance and multicultural supervision discussions each contribute significantly to perceived multicultural counseling competence – their combined impact has a greater effect. Strong relationships between supervisors and supervisees may lay a foundation that is absolutely essential for the occurrence of constructive multicultural discussions, resulting in cumulative positive impact on supervisee multicultural competence development.

Authors

JARICE N. CARR, **PATRICIA L. KAMINSKI**, Associate Professor, **NINA CALMENSON** & **C. EDWARD WATKINS, JR.**, Professor, Department of Psychology, University of North Texas.

CORRESPONDING AUTHOR:

ED WATKINS, University of North Texas

E-mail: watkinsc@unt.edu

References

ARREDONDO, P. & ARCINIEGA, G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, Vol. 29, pp. 263-273.

CLAUSS-EHLERS, C. S., CHIRIBOGA, D. A., HUNTER, S. J., ROYSIRCAR, G. & TUMMALNARRA, P. (2019). APA Multicultural Guidelines executive summary: Ecological approach to context, identity, and intersectionality. *American Psychologist*, Vol.74, pp. 232-244.

EFSTATION, J. F., PATTON, M. J. & KARDASH, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, Vol. 37, pp. 322-329.

GATMON, D., JACKSON, D., KOSHARIAN, L., MARTOS-PERRY, N., MOLINA, A., PATEL, N. & RODOLFA, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? *Journal of Multicultural Counseling and Development*, Vol. 29, pp. 102-113.

INMAN, A.G. & LADANY, N. (2014). Multicultural competencies in psychotherapy supervision. In: F. T. L. Leong (Ed.), *APA handbook of multicultural psychology: Applications and training (Vol. 2)*, (pp. 643-658). Washington, DC: American Psychological Association.

MAGYAR-MOE, J. L., PEDROTTI, J. T., EDWARDS, L. M., FORD, A. J., PETERSON, S. E. & RASMUSSEN, H. N. (2005). Perceptions of multicultural training in predoctoral internship programs: A survey of interns and training directors. *Professional Psychology: Research and Practice*, Vol. 36, pp. 446-450.

PHILLIPS, J. C., PARENT, M. C., DOZIER, V. C. & JACKSON, P. L. (2017). Depth of discussion of multicultural identities in supervision and supervisory outcomes. *Counselling Psychology Quarterly*, Vol. 30, pp. 188-210.

SODOWSKY, G. R., TAFFE, R. C., GUTKIN, T. B. & WISE, S. (1994). Development of the Multicultural Counseling Inventory (MCI): A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, Vol. 41, pp. 137-148.

SOHELIAN, S. S., INMAN, A. G., KLINGER, R. S., ISENBERG, D. S. & KULPE, L. E. (2014). Multicultural supervision: Supervisees' reflections on culturally competent supervision. *Counselling Psychology Quarterly*, Vol. 27, pp. 379-392.

TABACHNICK, B. G., & FIDELL, L. S. (2007). *Experimental Design Using ANOVA*. Belmont, CA: Duxbury.

WISE, E. H. & SCHWARTZ, J. L. (2018). Clinical supervision for multicultural and professional competence. In: M. M. LEACH & E. R. WELFEL (Eds.), *The Cambridge handbook of applied psychological ethics*, (pp. 511-530). New York, NY: Cambridge University Press.

Contact and Relational Needs in Couple Therapy: An Integrative Psychotherapy Perspective

Richard J. Erskine & Janet P. Moursund

Abstract: The term "contact" implies full awareness of both internal and external events. Relationship is based upon contact; people need both internal and external awareness in order to maintain a healthy relationship. In any relationship, healthy or unhealthy, relational-needs are experienced by the partners. In this paper, we describe eight major relational-needs that arise in couple relationships. When these needs are not responded to, the relationship becomes increasingly toxic and is likely to go through predictable stages of dysfunction. Intervention strategies are suggested, based on the relationship's progression through these stages; and specific intervention techniques are described.

Key Words: couple therapy, relational-needs, contact, healthy relationships, couple disfunction, integrative psychotherapy

"Contact" is a core concept in Integrative Psychotherapy; we believe that establishing and maintaining full contact – full awareness of internal and external events – is a *sine qua non* of mental and emotional well-being (Perls, Hefferline & Goodman, 1951; Erskine, Moursund & Trautmann, 1999; Erskine & Moursund, 2011). For couple therapists, this notion of contact is centrally important for it determines the quality of the relationship, as well as the psychological health of the individual partners.

In a healthy couple relationship, the internal and the external facets of contact are interdependent, interrelated, and mutually causal. Contact with one's partner requires contact with one's internal processes, for only as one is aware of those processes can s/he share them with a partner. And, conversely, full internal contact is supported and expanded by contact with a partner who is interested in and sensitive to internal experiencing – of both self and partner.

International Journal of Psychotherapy
July 2020, Vol. 24, No. 2, pp. 53-60: ISSN 1356-9082 (Print); ISSN 1469-8498 (Online)

Submitted: May 2020; peer-reviewed twice and reformatted: July 2020; resubmitted and accepted; DOI: 10.36075/IJP.2020.24.2.6/Erskine.Moursund

Therapy with couples brings to the foreground specific experiences which, though certainly relevant to individual work, are not generally a primary focus in individual therapy. These are the experiences which we call "relational-needs": the attachment-based needs of one person with regard to the behaviours of another. In this context, what is desired and needed includes both external behaviours and internal responses: we want those with whom we share our lives not only to behave in certain ways with us, but also to experience certain internal reactions to us (to care about us, to sympathize, to be interested). And so, we return to the notion of internal contact, for only an internally contactful partner will be aware of – and able to share – many of those private, not-externally-visible responses.

When external contact is distorted or broken – when relational-needs are not responded to appropriately – the relationship is damaged. Damage occurs when one partner does not respond in the needed way; it also occurs when the partner does make an appropriate response, but the response is missed or mis-perceived by the other. The critical factor is not what "actually" happened, but rather the experience of need-acknowledged or need missed. If I believe you to be unaware of or uncaring about what I need from you, I am not likely to experience our relationship in a positive way. I won't trust you, won't be willing to be vulnerable in your presence, and will be increasingly reluctant to respond to what you need from me. Conversely, if I do experience you as noticing, being interested in, and responding to my relational needs, I am likely to feel safe with you and increase my attention to your needs.

Notice that nowhere in all of the preceding have we suggested that partners must or should always satisfy their partner's relational-needs. To "respond" to a need may indeed mean acting so as to satisfy it, but it may also mean simply acknowledging it, recognizing it as a valid internal experience, while at the same time being unable or unwilling to fulfil it. Couples who recognize and respond to each other's relational-needs, sometimes attempting to meet them and, at other times, simply acknowledging them, are likely to have a healthy relationship; couples, who always feel compelled to meet those needs in each other, are in danger of falling into confluence or symbiosis.

While it is neither realistic nor healthy to expect one's partner to meet all of one's relational-needs all of time, it is equally unrealistic and unhealthy for the partnership when no relational-needs are met by one's partner or when specific needs are chronically neglected. There are many things that I can't or won't always do for or with my partner, and there may be some things that I will seldom do (even though I may recognize and even sympathize with his or her desires for them). But, for the most part, it is essential that I gain satisfaction and pleasure from activities that are need-meeting for my partner, as well as for myself – or why should we bother to be in a relationship at all? A subtle challenge for any partnership, then, is to find a healthy and comfortable balance between those relational needs that are met within the partnership and those that are met elsewhere.

The Eight Relational-Needs

At this point, it may be useful to get more specific about what we have thus far referred to generally as "relational-needs" (Erskine, 1998). There are probably as many different ways of describing relational needs as there are people in relationship. Humans are remarkably creative in how they relate to each other and describe their relationships. In our work with clients, both in private practice and in our workshops, we have noticed that eight partic-

ular relational needs keep coming up again and again. Let's take a look at what they are:

1. ***Security***: In a relationship, one needs to feel secure in order to thrive. One needs to know that the relationship is a safe place to be who one really is, to show all of oneself without fear of losing the other person's respect and liking. Security requires more than verbal reassurances. It is the visceral experience of having one's vulnerabilities respected and protected. It grows out of repeated experiences of sharing a new aspect of self and discovering that the relationship is still there, still solid, still okay.

2. ***Valuing***: The need to be valued, cared about, thought worthy, is an obvious part of any relationship. Why would one want to be in relationship with someone who didn't value or care about or respect him or her? But "valuing" as a relational need goes even beyond this general sort of caring about. It has to do with one's psychological process being understood and that process being valued. Not just (or even necessarily) what one does, but why they do it, is the key to valuing. When I am valued in a relationship, I know that my partner expects and believes that whatever I do must have a reason that makes sense to me, and that s/he wants to understand the sense-making of my behaviour.

3. ***Acceptance***: Being cared for, respected, needed. And not by just anybody – by a reliable, stable, and protective partner, a partner from whom one can draw strength, and whom one can care for, respect, and need in return. This kind of acceptance allows each partner to support and to accept support from the other. It keeps in balance the kind of emotional "taking turns" that is essential if all of the other relational needs are to be dealt with in a fair and satisfying way.

4. ***Mutuality***: The need for mutuality is the need to be with someone who has walked in one's shoes – who understands what one is experiencing because s/he has experienced something similar, in real life or imagination. Part of this need arises from the natural desire to not have to explain everything fully, to be understood without words. And part of it has to do with being able to believe that the other person really does understand and accept and value: if you have been there too, then of course you know what it's like for me – and I am not alone.

5. ***Self-definition***: Self-definition in a relationship involves experiencing and expressing one's own uniqueness, and having the other person acknowledge and value that uniqueness. In some ways it's the mirror image of the need for mutuality: the need to be different, as contrasted with the need to be similar. We need our partners to acknowledge our differentness, our disagreements, and even our irritation or anger, when these emerge as a facet of our individuality. When this happens, each partner can grow and individuate with full support from the other.

6. ***Making an impact***: An essential part of any meaningful relationship is the ability to have an impact on the other person: to be able to change their thinking, to make them act a different way, to create an emotional response in them. And not only to cause these effects in the other, but to be able to see the effects, to be shown that something has happened to the other person in response to one's input.

7. ***Having the other initiate***: A relationship in which one partner must always make the initial approach, always initiate, always take first step, will eventually become dissatisfying if not painful for that

partner. We need our significant others to reach out to us in a way that acknowledges and validates our importance to them, to demonstrate their desire to be involved with us.

8 ***To express love***: In any close, positive relationship the participants experience caring, affection, esteem and appreciation for each other. Expressing these feelings is a relational-need; not doing so requires that one push aside and deny the internal experience. When we deny the need to express love we also fail to express self-definition within the relationship. Part of who I am with you is how I feel about you, and – if I am to be fully contactful – I must be able to express those affectionate feelings.

And what about the need to be loved? The need to be loved is fulfilled within the relationship when all eight of the other needs are satisfied, at least some of time.

Relational-Needs Unmet

One of the things that interferes with appropriate, timely and satisfying responses to relational-needs between partners is the fact that each partner is an individual, following his or her own experiences from his or her own point of view and with his or her unique history. Relational-needs are not always complementary; what I need and want from you at any given moment may be quite out of sync with what you need and want from me. In a healthy relationship, such mismatches are temporary and time-limited. Partners learn to take turns, to put their own needs to one side for a while and attend to the other, with the certainty that the partner will soon do the same for them.

When relational-needs are consistently not responded to in relationship one or both partners are likely to become irritable, indifferent, or depressed. The longer this situation exists, the more acute the discomfort. Over time, a relationship in which one or both partner's relational needs remain unmet will become toxic. Contact between the partners becomes a source of pain rather than of pleasure and satisfaction and the partners act so as to protect themselves from that pain. The ways in which the protection manifests itself form a familiar list of relational disruption: withdrawing, criticizing, accusing, arguing. Each disruption leads to a further reduction in contact with even less likelihood of meeting relational needs.

When couples seek therapy, it is almost certain that one or both partners are not getting their relational-needs met within that relationship, and that one or both are creating some form of contact distortion as a consequence. Rudolph Dreikurs (1964), in his studies of children's behaviour, developed a hierarchy of behaviour dysfunction which seems to apply to adult relationship ruptures as well. Initially, when a partner feels needy and that need is not met, s/he is likely to act so as to get the other partner's attention. *"Notice me! Notice that I need something from you!"* the behaviour says. If the partner notices, and responds, the relationship has a good chance of getting back on course. Over time though, if the partner fails to notice and respond, the partner with needs-not-met moves into some sort of attempt to gain power. Either *"I'll make you notice"* or *"I'll stop needing you at all (by getting my needs met elsewhere, or by being so powerful I don't need anybody)"*. Power-seeking behaviour tends to be more aggressive, more attacking, than attention-seeking behaviour in both children and adults.

If power-seeking fails too, the next step in the hierarchy is likely to be a quest for revenge. Revenge-seeking, however it is acted out, is of course likely to damage the relationship even further. Worse, it sets up a dynamic in which

the revenge-seeking partner feels that s/he cannot accept what was once so badly needed because that would be tantamount to giving up the possibility of "getting even" with the partner who is now seen as the source of pain.

Revenge does not nourish; it may provide momentary distraction but it leaves the original need untouched. People who stay in a revenge-motivated relationship eventually reach the stage of despair, in which the only thing left is proving (to the other and even to self) that everything is truly hopeless, that they are without worth, and that nothing really matters.

So, what can be done to reverse this dismal progression? The thrust of the therapeutic intervention depends, logically enough, on where a couple is in the hierarchy. If one or both partners has reached the fourth stage, the stage of despair, the therapist's efforts will be designed to restore a sense of worth and a sense of hope; nothing else will make much difference until this is at least partly accomplished. The revenge-seeking partner must be persuaded that his or her self-interest is best served by finding a way to respond, and be responded to, in the relationship, rather than be lashing out and punishing. S/he must be encouraged to choose meeting current needs over being "right" or evening the score and to accept the fact that no amount of vengefulness now can change the partner's past behaviours. Power-seekers need to find alternative ways of interacting with and impacting their partners. The partners of power-seekers need to learn that it is possible to respond to their partner's needs while at the same time maintaining their own boundaries and integrity, that is, not to cave in and also not to withdraw. And attention-getting is usually the least difficult of all, for it simply involves teaching the partners how to ask for attention in ways that their partner can hear, can notice, and respond to their requests.

Origins of Couple Dysfunction

While all of above is very logical and useful in terms of setting an overall frame for therapeutic intervention, it is still not very specific. In order to choose a particular intervention, another facet of diagnosis is useful: let's look at how the rupture of relational need-meeting gets started in the first place.

The simplest situation is that of ignorance: one or both partners honestly don't know what is happening between them, or what to do about it. They know that they are unhappy but they don't know the source of the unhappiness. They know that they are often disappointed in or irritated with their partner but they don't know why. Or the "why" is always related to some specific incident, and they see no underlying pattern.

Sometimes this not-understanding is related to a more deeply-rooted lack: one or both partners have no sense of what relational-needs are all about. They have never learned to identify their own relational-needs nor to attend to the relational-needs of others. They may have grown up in families in which such needs were never recognized or in which people were put down for needing anything from each other. Such people cannot ask for what they want because they don't know that they want it; and they are often similarly deaf to the requests of others. Talking to them about their relational-needs is like discussing the difference between red and green with someone who is colour-blind.

Both of these varieties of dysfunction are often learned and reinforced during the early history of a relationship. Couples tend to train each other during the early courting process; they learn what works with the other person, what to expect, what is expected of them, and how to make up for not getting what they really want. The map is drawn, the familiar routes become well-worn and invariant, and nearly

impenetrable walls grow up around the unexplored areas. It is as though the map is a non-verbal contract, and when one partner fails to respond as the other expects, the contract is broken.

Another factor in the evolution of a relationship has to do with the kinds of self-protective patterns each partner has learned throughout his or her life. Both bring to the relationship unconscious expectations and core beliefs that may form their life scripts (Erskine, 2008, 2009, 2010). In a relationship, these individual life scripts become interlocked. One partner, for instance, may bring to the relationship a basic belief that he is stupid and unable to figure things out, that his relational need for valuing can never be satisfied. The other partner may have decided, and believed for years, that nobody can really understand her, and that her need for self-definition cannot be met in a relationship. What a splendid fit! The "stupid" partner cannot be expected to understand his partner, because after all he's incapable of understanding. Moreover, it's useless to even try to understand because nobody could possibly value his feeble and doomed-to-failure efforts at the impossible. The other partner will never challenge that belief, because she knows that nobody will ever understand her anyhow. She cannot ever feel supported for being herself in a relationship, because that self cannot possibly be understood. Each partner's belief supports and reinforces the other's in a kind of mutual dance of dysfunction (see Chapter 7, Erskine, 2015)

In addition to problematic patterns in the relationship itself, a partner may be trapped in their own history of dysfunctional relationships and be literally unable to attend to needs and demands of the partnership. For such a person, the individual life script pattern may need to be addressed before couple work proper can begin: notice, though, that word "proper". Work on a partner's individual script pattern can be and often is done in the context of couple work, with the other partner there to observe and support the work (Kadis & McClendon, 1998). Also, since partners' scripts nearly always interlock, change in one will inevitably invite change in the other, as both partners begin to understand how their old script beliefs are reinforced by interactions in their current relationship.

Discussing the ways in which a therapist facilitates changes in an individual life script is beyond the scope of this paper; the reader is referred to our previous writings (Erskine, 1997; Erskine & Moursund, 2011) and most especially to both "*Beyond Empathy: A Therapy of Contact in Relationship* (Erskine, Moursund & Trautmann, 1999) and *Integrative Psychotherapy: The Art and Science of Relationship* (Brooks/Cole-Thomson Learning, 2003) for detailed discussion of our theory of individual therapy. Let's turn our attention back to the couple work, with partners who are able to invest energy in improving their relationship as such.

Intervention Strategies

The first step in intervention is analysis: getting a clear sense of what unmet relational-needs are in the foreground and what contact disruptions have developed as a result of these unmet needs. When the therapist has a sense of how these dynamics are working themselves out, s/he can help the couple to begin to understand what is happening. Teaching a concept is probably the easiest of interventions and may be sufficient to help the couple to initiate small changes which can take on their own momentum over time.

The effect of pointing out patterns, and how they are enacted in the relationship, is further strengthened by using both naturally-occurring and therapist-prescribed interactions between the partners to enhance their awareness of relational needs in themselves and

each other. They can share these awarenesses with each other and check on and correct their partner's perceptions. They can learn to inquire about their partner's inner experience and to value that experience even when it doesn't match their own perception of what is happening. Teaching and practicing the skill of inquiry is, in fact, a central focus of our work with couples.

It is necessary to provide a safe therapeutic environment when we invite the partners to explore new ways of listening and responding to each other. We do not allow partners to take revenge or to punish each other (either accidentally or deliberately) as they experiment with new behaviours and new vulnerabilities. On these occasions we may intervene, attending to the relational-needs of each partner, making sure that neither is neglected. Then we encourage each person to take turns being the focus of the other's inquiry. We model contactful self-disclosure and we consistently translate non-verbal into verbal communication, encouraging both partners to "talk straight" with each other.

Couple work in which relational-needs and their satisfaction are seen as the core of the relationship, and the key to both partners establishing and maintaining internal and external contact, is a constantly shifting kaleidoscope of patterns and interactions. The focus moves from the perceptions and needs of one partner, to those of other, to those of both partners in relationship – and back again. Nothing is static; as one set of relational-needs is dealt with, another can move into foreground. Like a child walking upstairs with a yo-yo, the momentary ups and downs are parts of an upward progression. Even though the relationship may seem to worsen at times, the overall trend is positive, toward healthy growth and contact. As one partner learns that his or her current relational-need can be met in the relationship, s/he is energized and encouraged (literally, infused with courage) to let go of some bit of protective armour, to allow himself or herself to be more aware of what s/he is experiencing and of what his or her partner is experiencing as well. In so doing, s/he is able to respond to that partner's relational-needs in a more contactful way. Changes in each support positive change in the other and the downward spiral of dysfunction is reversed.

There is no panacea here, no "magic" that is guaranteed to mend broken relationships or to create positive change overnight. Some relationships are remarkably resistant to change; some partners are so damaged by their own pain, so stuck in power-seeking or revenge or despair, that they have little or no concern for the well-being of the partnership. Nevertheless, we believe that attention to the interaction between relational-needs and contact can help the therapist to focus on those aspects of a relationship that are most malleable, most open to intervention. It allows us to encourage, even in difficult relationships, the kinds of small changes that allow the partners themselves to cultivate and build upon their success.

This paper was presented as a keynote speech entitled "A Therapeutic Relationship?" at the 1st Congress of the World Council for Psychotherapy (WCP), Vienna, Austria, 30 June to 6 July, 1996. Portions of this paper were also included in a closing address, "The Psychotherapy Relationship", at the 7th Annual Conference of the European Association for Psychotherapy (EAP), Rome, Italy, 26-29 June 1997. Copyright (1998) European Association for Psychotherapy. The citation for the original article is: Erskine, R. G. (1998). Attunement and Involvement: Therapeutic Responses to Relational Reeds. International Journal of Psychotherapy, 3, 3, pp. 235-244.

Authors

RICHARD J. ERSKINE, Ph.D. is a clinical psychologist and training director of the Institute for Integrative Psychotherapy in New York City. He is Visiting Professor of Psychotherapy, University of Derby, U.K. and conducts several training programs throughout Europe, the USA and South America.

E-mail: Richard@IntegrativeTherapy.com.

JANET P. MOURSUND, Ph.D. is Associate Professor Emerita at the University of Oregon, where she served as Director of the DeBusk Counseling Center and as Acting Chair of the Counseling Psychology Program. She has published seven books in the fields of psychology and psychotherapy. Now retired, she enjoys teaching computer skills to seniors and auditing classes at the University of Oregon

References

DREIKURS, R. & SOLTZ, V. (1964). *Children: the challenge*. New York: Hawthorn Books.

ERSKINE, R. G. (1998). Attunement and Involvement: Therapeutic responses to relational needs. *International Journal of Psychotherapy*, 3, 3, pp. 235-244.

ERSKINE, R. G. (1997). *Theories and Methods of an Integrative Transactional Analysis.* San Francisco, CA: TA Press.

ERSKINE, R. G. (2008). Psychotherapy of Unconscious Experience. *Transactional Analysis Journal*, 38, 2, pp. 128-138.

ERSKINE, R. G. (2009). Life Scripts and Attachment Patterns: Theoretical Integration and Therapeutic Involvement. *Transactional Analysis Journal*, 3, 3, pp. 207-218.

ERSKINE, R. G. (2010). Life Scripts: Unconscious Relational Patterns and Psychotherapeutic Involvement. In: R. G. Erskine (Ed.), *Life Scripts: A Transactional Analysis of Unconscious Relational Patterns,* (pp. 1-28). London: Karnac Books.

ERSKINE, R. G. (2015). The script system: an unconscious organization of experiences. In: R. G. Erskine (Ed). *Relational Patterns, Therapeutic Presence: Concepts and Practice of Integrative Psychotherapy.* London: Karnac Books.

ERSKINE, R. G. & MOURSUND, J. P. (2011). *Integrative Psychotherapy in Action.* London: Karnac Books.

ERSKINE, R. G.; MOURSUND, J. P. & TRAUTMANN, R. L. (1999). *Beyond Empathy: A Therapy of Contact-in-Relationship.* Philadelphia: Brunner/Mazel.

KADIS, L. B. & MCCLENDON, R. (1998). *Concise Guide to Marital and Family Therapy*. Washington, DC: American Psychiatric Press.

MOURSUND, J. P. & ERSKINE, R. G. (2003). *Integrative Psychotherapy: The Art and Science of Relationship.* Pacific Grove: Brooks/Cole-Thomson Learning.

PERLS, F. S., HEFFERLINE, R. F. & GOODMAN, P. (1951). *Gestalt Therapy: Excitement and Growth in the Human Personality*. New York: Julian Press.

EAP
European Association for Psychotherapy

Member of the World Council for Psychotherapy (WCP)
NCO with consultative status to the Council of Europe
Headoffice: Mariahilfer Str. 1d/13 | 1060 Wien/Vienna/Austria
+43 699 15131729 | eap.headoffice@europsyche.org
www.europsyche.org

COVID19 LOCKDOWN 2020 QUESTIONNAIRE

This Questionnaire aims to gather information from Psychotherapists in 41 countries, and from the different modalities represented in EAP, on the impact on the profession of Psychotherapy of the lockdown across Europe because of the Covid19 pandemic 2020. From accounts we have received we think that Psychotherapists across Europe have adapted their work to conduct it safely and online in remarkable ways, and have continued to offer Psychotherapy to those in need of it. We would like evidence of this, and to make public the great work of Psychotherapy! The Questionnaire is being sent to all EAP Board member organisations and to all ECP holders. We wish to learn from what has happened, what you have observed, and what new and unforeseen learning and opportunities in the profession of Psychotherapy have been created by this extraordinary situation.

Deadline for completed Questionnaires: Monday October 26th 2020

Please fill in all the questions of the questionnaire. It will take you perhaps 15-20 minutes to complete. We will circulate the results in the following ways:

- Document with a summary of the results to circulate on the EAP website and distributed to the EAP Executive and Board Members
- Report of the full results to be published in the International Journal of Psychotherapy
- Report to be sent to the President of the European Parliament, David Sassoli, for use and benefit to the EU community
- Report to be sent to the EU Commissioner Responsible for Health, Stella Kyriakidou, for the use and benefit of the EU community
- Report to circulate to CEPLIS – the liberal professions organisation which EAP is a member of.

Name ..... (optional – please leave blank if you prefer)

Country ..... Gender ..... (optional)

Modality ..... Age ..... (optional)

1. In what ways were you conduct Psychotherapy in the period **before** March 2020? (Please put a cross for all relevant answers) and give an indication of the number of sessions per week.

Face to face (individual)	.....	No of sessions p.w.	.....
Face to face (couples or group)	.....	No of sessions p.w.	.....
Online	.....	No of sessions p.w.	.....
Telephone	.....	No of sessions p.w.	.....

2. In what ways have you conducted Psychotherapy in the period **since** March 2020? (Please put a cross for all relevant answers) and give an indication of the number of sessions per week.

Face to face (individual)	.....	No of sessions p.w.	.....
Face to face (couples or group)	.....	No of sessions p.w.	.....
Online	.....	No of sessions p.w.	.....
Telephone	.....	No of sessions p.w.	.....

3. What specific problems did you notice that emerged, were caused by, or exacerbated by, the CoVid-19 pandemic & lockdown? (Please put a cross for all relevant answers)

Loneliness / isolation	...	Comment: .....
Claustrophobia	.....	Comment: .....
Anxiety	.....	Comment: .....
Panic Attack	.....	Comment: .....
Depression	.....	Comment: .....
Suicidal ideation	.....	Comment: .....
Relationship difficulties	.....	Comment: .....

Interpersonal conflicts ..... Comment: .....

Domestic violence ..... Comment: .....

Physical deterioration ..... Comment: .....

Increased drug, alcohol misuse ..... Comment: .....

Internet dependency ..... Comment: .....

Technology fatigue ..... Comment: .....

Other problems – please specify .....

4. What helped you as a Psychotherapist to be able to continue your work?

.....

.....

5. If you worked online, in what ways was Psychotherapy **more** effective for your patients/clients?

.....

.....

6. If you worked online, in what ways was Psychotherapy **less** effective for your patients/clients?

.....

.....

7. What lessons have been learned which are valuable for the future?

.....

.....

8. Might there be any changes, in the long-term, to your professional psychotherapy practice?

.....

.....

9. In 70 words please summarise in what ways lockdown has affected you as a Psychotherapist.

“.....

.....

.....

.....

.....

.....

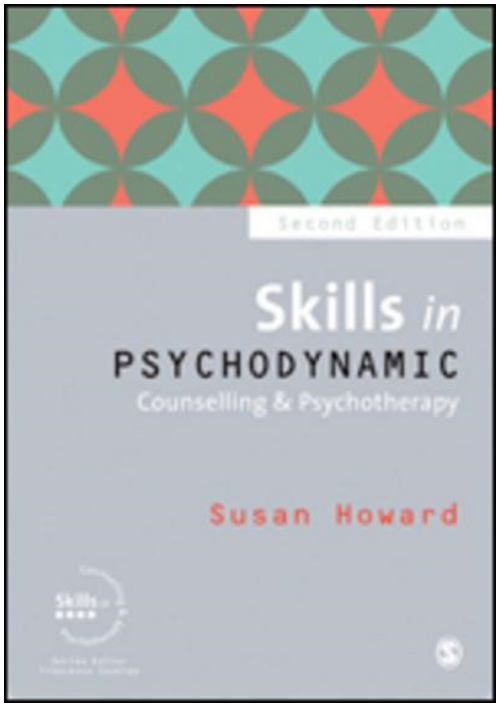
.....

.....”

(70 words max)

THANK YOU SO VERY MUCH for completing this questionnaire. Please email it to Nataliya in the EAP office **before Monday October 26th 2020**. Her email address is **info@europsyche.org** – and, if you wish to be sent a copy of the final results, please ask for this in your email.

BOOK REVIEW 1



Skills in Psychodynamic Counselling & Psychotherapy (2nd Ed.)

Susan Howard

Sage, 2017
Hardcover; P/back.
203 pages
ISBN 978-1-4462-8567-1
RRP: £27.27; €34.29; $36.23

Susan Howard has written an interesting book, which – ideally – requires some basic prior knowledge of concepts and theory; but perhaps this is not necessary as she skilfully illustrates basic concepts, although the readers would benefit from knowing some psychodynamic theory. But then again, it is mainly a 'How to do therapy' book.

Helpfully organised around systematically addressing major core competencies, Susan Howard's new second edition will be welcomed by trainees. There are fourteen chapters, which start by her very briefly outlining what psychodynamic theory and therapy are.

One of the skills or personal attributes, such as being able to mentalise, are described in Chapter two. The reader can accompany 'Rona', 'Julia' and 'Richard' on their journeys of becoming qualified counsellors, at least for a short duration. Having one's own therapy and being supervised are an important part of the training in psychodynamic counselling. Topics like: infant observation; attending experiential groups; 'journaling'; reading and ways to work with diversity, all form part of the third chapter: short, but to the point.

"Understanding the Brain and the Implications for Psychotherapy" explains some crucial neuroscientific processes. Therapists, who like to convey to their clients the structural mechanisms underlying change, will find Howard's introduction to this rapidly expanding area useful. Throughout her book, suggestions for further reading are made: for example, Cozolino's and Wilkinson's work on how

therapy changes minds. Recommended texts also include key authors in psychodynamic theory.

Features of the therapeutic frame are a 'therapy map' for Rona's first training client. Vignettes offer a glimpse into the normally hidden world of psychodynamic therapy. Furthermore, Howard provides advice on how to manage difficulties, for example, when clients do not pay, want contact outside the session and how to set boundaries.

Novices can gain an insight into a first session, particularly on how to establish a therapeutic alliance. Having "created the conditions that facilitate clients to bring unconscious preoccupation", they then need to "tune into" and "decode" their clients' unconscious. Typical techniques, for instance: include free association; listening to and interpreting latent (unconscious) content; working with vertical splits of the mind and resistance; are skilfully illustrated in Chapter 7.

In the chapter, "The Theory Underlying Technique", a brief history of transference and countertransference is given. A description of the different types of interpretations, and how to interpret, reads a bit like a recipe book. Beginners will find solace and comfort in the next two chapters. It is – apparently – not easy to interpret: 'not' rushing into it, is certainly prudent. Inexperienced clinicians are reminded that they can wait, there is no need to hurry.

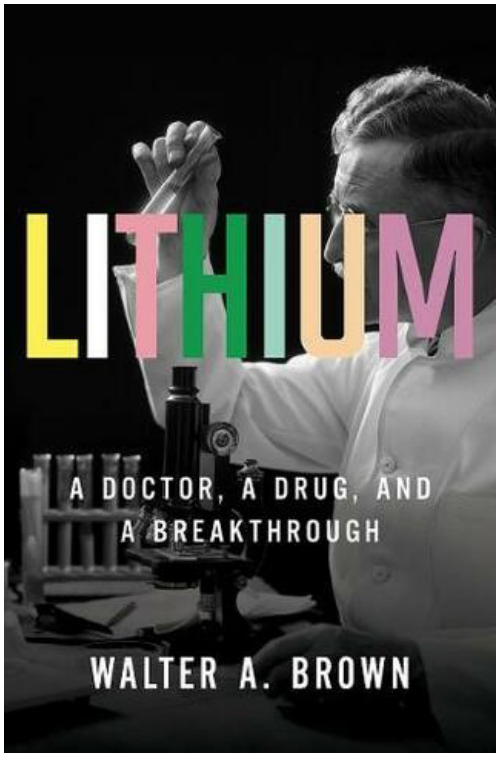
Working with client's defences, by using Milan's triangles, are outlined in Chapter 11. Some of the basic defences (e.g. splitting, projection, projective identification, etc.) are easily understandable and Howard explains these beautifully.

The last three chapters of the current book address: "Managing the Therapeutic Process", "Assessment and Formulation", and The Evidence for Psychodynamic Therapy". On the back of its cover, Hannigan states that it offers "*An essential, contemporary and empirically informed overview of the necessary skills and qualities for effective psychodynamic therapy*": indeed, it does. I just wish that this guide to psychodynamic practice had been written when I was training. Whilst it cannot equip readers with clinical expertise, which only comes with experience, it does provide an essential overview about how to start.

Be this as it may, there is a plethora of books on the market. This begs the question why someone would buy Howard's latest edition. Well, there are several reasons. Often, psychodynamic writing can be mystifying, more obscure than revealing. The present book is one of those exceptions. Engaging, easy to grasp, the reader can dip in and out, without losing the thread. Howard uses a language that is usually found in textbooks for psychologists. Hence, I would also recommend it to students and lecturers on courses in clinical psychology, particularly courses that offer very little psychodynamic teaching. Trainees of that sort should find this book very accessible.

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

BOOK REVIEW 2



Lithium: A Doctor, A Drug, And A Breakthrough

Walter A. Brown

New York: W. W. Norton & Co., 2019
Hardcover, Paperback, Kindle
272 pages
ISBN: 978-1631497902
RRP: £13.99; $15.23, €24.76 (h/b), €11.98 (Kindle)

"I don't believe in God, but I believe in lithium", Lowe provocatively wrote: a strong statement, which might offend. Whether Walter Brown holds the same view is unknown, but he most certainly believes in the power of lithium. Through interweaving Lowe's moving narrative, Brown illustrates the impact lithium has had on sufferers from manic-depressive illness. He also takes the reader through the history of Bipolar Disorder and its conceptualisation in psychiatry. Symptoms can be alleviated and prevented by lithium without people having to suffer effects of demonic treatments such as lobotomy. American psychiatrist Brown tells a gruesome but also captivating story. He describes research studies in easily understandable language, includes French articles, and draws on email exchanges and interviews with lithium pioneers to convey his fascination with this naturally occurring element.

Cade's accidental discovery of lithium in 1949 represented a radical departure from prevailing ideas about the treatment of mental illness and launched a pharmacological revolution in psychiatry. In high doses, lithium is toxic, this is why frequent blood level measurements are necessary. When Cade experimented with lithium, no pharmacological sources were available to tell him what the right dosage in manic patients was. Faithful to the medical principle 'first do no harm', Cade took lithium citrate and lithium carbonate himself, before giving it

to his patients. Without guidance, he managed to prescribe effective and safe doses. "A doctor, a drug and a breakthrough", it becomes clear why Brown chose this title. He pays tribute to Cade.

Other major figures in the discovery and acceptance of lithium include Trautner, Schou, Lange, Talbott Blackwell and Shepherd. Nowadays, lithium is no longer the 'Cinderella of psychiatric drugs', or is it? Approved in 50 countries, this mood stabilizer is widely used in the treatment of Bipolar Disorder. Brown admits that lithium is not the perfect drug, it has limitations and 30% of patients do not benefit from it. However, lithium has provided a normal life for millions of people, brought about a reduction in suicide and saved billions of dollars in health care costs. That is impressive, if true.

Cade and the other pioneers become alive in the six chapters. At times, Brown's descriptions read like science fiction. But it is better. Due to real accounts of psychiatric illness and recovery owed to lithium, which occurs throughout the earth's surface. A highly reactive element, lithium bonds with other substances and only occurs in combination with these. For example, as lithium carbonate and lithium chloride.

Brown discusses the slow acceptance of lithium. Since it is a natural substance, drug companies cannot patent it, so it is of no commercial interest. Later-promoted drugs drew attention away from lithium. Talbott and Trautner saved lithium from the 'dustbin of medicine'. Brown's use of language provokes but also disappoints. He brings lithium to the masses: indeed. However, if you prefer scientific writing, this book might not be the best buy, even though it may tempt the younger generation of psychiatrists to review lithium. It also includes noteworthy historical anecdotes about psychopathology and normality. If homosexuality is perverse and an illness, surely deliberately inhaling large quantities of filthy disease-producing smoke into one's lungs day after day should also be defined in similar terms. It was Cade, who said this.

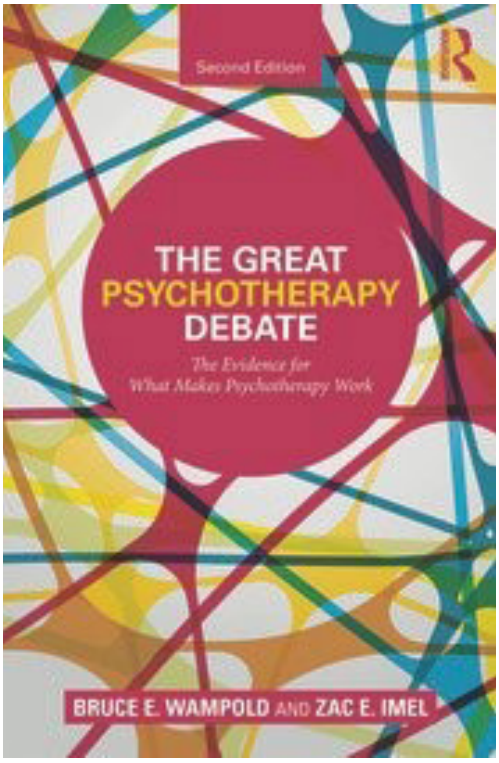
Welcomed by the Catholic Church, which viewed Cade's beliefs as an antidote to the godless and repugnant psychoanalytic concepts, Cade did not dismiss psychoanalysis entirely, the author writes. Unless you share Brown's passion for lithium, the question arises nevertheless as to why one would want to read 272 pages on this topic. However, psychotherapists might find his writing style and content engaging.

But, why did it take until 1969 for the approval of lithium by the Food and Drug Administration in the USA? Psychoanalytic concepts dominated American psychiatry at the time. Some form of psychoanalytic therapy was the gold standard for treating almost all conditions of the mind. Psychiatric drugs were considered an accessory to bona fide treatment and believed to interfere with the therapy process. Teachers in psychiatry were psychoanalysts in the late 1960s and early 1970s. Brown writes that he spent hours trying to get his patients to talk about their anger. Drugs were discouraged. Nowadays, this approach would amount to malpractice, because mental disorders are viewed as brain diseases, he comments.

Several of Brown's stories make me wonder what function psychiatry serves. Whether mental illness is a disease, still remains questionable. That cycles of mania and crushing depression are devastating, less so. Films counter stigma and educate, Brown demonstrates. In the thriller *Homeland*, lithium keeps the protagonist sane. Does lithium prevent manic episodes? Brown answers this question by describing the prophylaxis debate. It seems so! However, whether one should believe in lithium rather than God is debatable.

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

BOOK REVIEW 3



The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work (2nd Ed.)

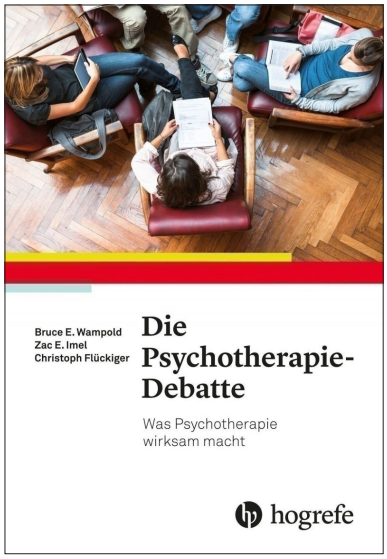
Bruce E. Wampold & Zac E. Imel

New York & East Sussex: Routledge, 2015
334 pages + 25 B/W Illustrations
ISBN: 978-0-805-85709-2
RRP: £39.99; $57.95

ACTUAL GERMAN EDITION USED:

Die Psychotherapie-Debatte: Was Psychotherapie wirksam macht

Bruce E. Wampold, Zac E. Imel & Christoph Flückiger



Berne: Hogrefe, 2018
ISBN: 978-3-456-85681-0
RRP: €39.95

This book describes the great variety of scientific debates around the question what is an adequate or an appropriate way of researching psychotherapy. It summarizes the psychotherapy research of the last decades up to 2018 and discusses them within two different, competitive models: the 'medical' meta-model and the 'contextual' meta-model.

The 'medical' meta-model stands in the tradition of pharmaceutical research and sees psychotherapy as a kind of "truth" or "fact" that creates changes, in a similar way to drugs. It thus treats the therapist as a constant variable, one that does not have to be investigated further. In this model, the psychotherapeutic treatment (or intervention) should be the only dependent variable, while all other possible variables are supposed to be controlled in the methodology of research.

The 'contextual' meta-model, developed by Wampold and co-workers, sees psychotherapy much more as a healing practice, embedded in social and cultural factors. This includes: the context in which the psychotherapy is happening; the interaction between therapist and client and vice versa; the therapeutic alliance; and the competencies of both. This approach therefore stands more within the tradition of the social sciences.

The German version of this book is an updated version of the English/American edition. The editor, Christoph Flückiger (Zürich), has contributed some additional aspects of research and settings of psychotherapy in Europe and especially in the German-speaking countries. He also actualized most of the research findings from 2015 up to 2018.

The original version of *The Great Psychotherapy Debate* was published 2001 and created considerable provocation to the community of researchers at that time. It questioned many of the findings from the 'medical' model that seemed to be 'proven', e.g. that the prevailing model in psychology of Cognitive Behavioural Therapy (CBT) would be shown to be superior to all other approaches.

Wampold and Imel have re-analysed several meta-analyses that had concluded CBT to be superior model, and had discovered several severe methodological mistakes that led to these false findings. This created an intensive scientific debate, which lead to the second and revised edition of the book in 2015. The number of the included studies has since multiplied in the last few years.

The book is structured in 9 chapters: Chapter 1 summarizes the history of medicine and the scientific methods in psychotherapy research that are rooted in the 'medical' model. Already here, the authors show that most psychological interventions can hardly be pressed into a framework of pharmacological research, because culture and healing practices are strongly connected. The authors also show how the profession of psychology had adopted the 'medical' model, in order to prove that psychology is as much a 'natural' science as medicine is. In this process, psychology forgot (or neglected) the social, cultural and philosophical sciences, which are also significantly important sources for the study of psychotherapy.

The basics of the history of this sort of "evidence-based" medicine are described and their adaption to psychotherapy research is demonstrated and criticized. This methodology leads to an unjustified dominance and privilege of CBT, because – when using this approach – it became quite easy to create treatment manuals that neglected the person of the therapist as an important factor.

Those RCT-comparative studies that showed the superiority of CBT were often manipulated in a way that the so-called 'therapists' from other modalities were usually students, who had just had a crash course in another manual-

ized modality, that never would have been applied in this way in the reality of clinical practice: the students had just learned to behave empathically and nothing else. These "therapies" – mostly from humanistic approaches – were used as 'control groups' which then had a negative effect on them.

The most important finding of all these revised studies (with the method of meta-analysis) is that – over all – psychotherapy is really effective, relatively independent of which modality is used. There is no evidence that any one of these psychotherapeutic modalities is superior to others.

In Chapter 2, the authors describe the 'contextual' meta-model. The chapter picks up the findings of existing research that show a number of 'common factors', shared by all modalities, that seem to be an important component for outcomes. These 'contextual' models root onto clear definitions about what psychotherapy is and on philosophical reflections that are important in interpreting the evidence in psychotherapy. Psychotherapy is thus understood more as an inter-personal therapeutic treatment, where the process is co-created by patient and therapist.

Psychotherapy is based on psychological knowledge, which should start with a commitment between therapist and patient on goals, indications and aims and should also include information about the approach itself. The contextual meta-model proposes 3 modes of action that lead to change in psychotherapy: real relationships, expectations and treatment procedures.

In Chapter 3, the 'medical' meta-model is opposed to the 'contextual' meta-model. These models are put in relation to the philosophy of science. It ends with the conclusion that meta-analyses are appropriate to test hypotheses in the 'medical' meta-model, as well as in the 'contextual' model, which is demonstrated in the following chapters.

In Chapter 4, the current state of research concerning the absolute efficacy of psychotherapy is described. In contrary to authors such as Eysenk in the 50's and 60's, who pretended that psychotherapy has no effects (Eysenk's research method was strongly criticized), further research has shown - without any doubts – that psychotherapy, generally, is very beneficial (see: APA's 2012 Recognition of Psychotherapy Effectiveness[1]).

It was – apparently – difficult to find any studies that demonstrated inefficacy. In those studies, that seemed to demonstrate that psychotherapy is harmful, it was shown that these were looking at modalities, without any psychological foundation, and that – in clinical practice – never take place, only appearing in the control groups of these studies.

In spite of extensive studies, no evidence could be found (neither in the 'medical' meta-model, nor in the 'contextual' meta-model) that any one modality has an absolute efficacy. This raises the question of relative efficacy and the topic of general efficacy, that might be more significant than any modality-specific factors for the outcome of successful therapies.

In Chapter 5, the authors deepen their questioning of relative efficacy. They re-analysed several studies that supposedly found different effects for some modalities with a focus on the research modality that has been used. Most researchers seemed to favour the modality that they themselves adhered to and this influenced the study-design and also the interpretation of data in a way that showed their modality to have better results: this is called

1. https://www.apa.org/about/policy/resolution-psychotherapy

the "allegiance effect". In correcting the data from the allegiance effect, the differences disappeared and comparable effects of all the serious modalities were found.

The "allegiance effect" is also crucial with respect to the therapists themselves: those who believe in the efficacy of their own approach get better results than someone who has to apply, to a control group, a modality whose efficacy he does not believe in. Some studies are discussed critically, for example: CBT does not show up well, even for panic and anxiety disorders, any superiority, as compared to other modalities, although several manuals and guidelines claim this. It is amazing how persistent this false belief is in the research literature, as well as in the heads of practitioners, just because of a lack of critical knowledge. Some meta-analyses on depression, PTSD, and other anxiety disorders and substance abuse are also presented and critically discussed.

As a conclusion – the authors say – there is hardly any evidence that some modalities are superior than others, with regards to all kind of disturbances. These findings give us a good rationale to doubt the hypothesis that any specific interventions can be responsible for the efficacy of a treatment for specific disorders.

In Chapter 6, other therapists' effects are described that can influence the outcome and the process of psychotherapy. These are seen to be very important for good outcomes and have been a largely neglected factor in research up to now. In many efficacy studies (according to the 'medical' meta-model), such therapists' effects are not even considered: a lack also found in somatic medicine.

As a conclusion to this chapter, the authors state that the allegiance of the therapist is a robust factor that moderates treatment effects. The differences between treatments have been overestimated in the past, while therapists' effects have largely been neglected.

Chapter 7 focusses on more general effects and on the therapeutic alliance, as a very important general effect, as well on research into the "placebo effect" and the importance of the expectations on psychotherapy, from the side of the patient, as well as from the therapist's side. Summarizing, these general factors are seen much more as "causal factors". The authors thus show that the 'contextual' meta-model can make much more complex – and accurate – predictions than the 'medical' meta-model.

In Chapter 8, more specific effects are investigated: how can robust specific effects be predicted? Evidence for this question is taken from so-called "components studies". Researchers build comparative studies in which control groups were built, where a specific component (essential for a specific modality) is either taken out, or added, and then the effects are related to the outcome. The findings here show that taking away, or adding, a specific component did not show any beneficial effect to the treatment outcome. This is in contradiction to what would have to be expected in the 'medical' meta-model. These results give considerable scepticism to studies that seem to have claimed to have found different treatment effects, without having any reciprocal 'contextual' factors. Also discussed are "patient variables" and their interdependence in treatment processes.

Neither components studies, nor pseudo-placebo studies, nor studies on the interdependence of patient variables with treatment, nor studies of adherence and competence, nor studies on change mechanisms, could show any robust evidence for the importance of specific effects.

Finally, in Chapter 9, the authors discuss the consequences and conclusions of these scientific debates and the various significant findings, with respect to the theory, politics and

practice of psychotherapy. These are the findings that have an:

- ***Importance for theory***: The 'medical' meta-model has been shown to be inadequate and inappropriate for psychotherapy research. The 'contextual' meta-model therefore has to be considered as a more favourable and progressive option, as well as giving a much more appropriate, research program.
- ***Importance for politics***: The decision about the parameters involved in the funding of research should be changed and expensive and irrelevant RCTs with limited effects should no longer be preferred by funding agencies. There is no reason to expect that further RCT's would ever give any deeper clarification or differences between modalities, because this design is much too limited for such questions.

  Research should therefore move away from searching for evidence-based modalities and treatments in order to exclude others, and change more towards a prioritization of practice-based evidence. This means investigating the person of the individual therapist and his or her practice and evaluating how effective he or she is working, regardless of his or her modality and mixtures of modalities. This could be a form of monitoring and systematic documentation of therapeutic progresses during the actual treatment process.

  From the point of view of a patient, it is therefore important to find a good therapist that can meet his or her needs and conduct a therapy that is drawn to his or her personal needs and competencies. Why should therapy modalities be excluded, as long therapists or a health system fulfil the benchmarks? The political aim – from this perspective – should be to provide a wide spectrum of serious possibilities in psychologically-rooted approaches in order to give the patient a good selection, instead of favouring one group of therapists from a certain modality and excluding others.
- ***Importance for practice***: Therapists should deliver a treatment that is coherent; that both explains – and is appropriate to support – the changes that the patient expects from psychotherapy. Therefore, it is important for any therapy not just to be limited to treatment manuals, but to be able to intervene much more flexibly and creatively, according to the needs of the patient. Therapists can therefore become jointly responsible for the success of any treatment, as well as the type of treatment itself.

  They should 'know' – at any time – about the efficacy of their treatment with any particular patient and conduct a form of monitoring that allows them to be continuously informed. In their choice of interventions, they should respect the patient's boundaries and not just stick to psychologically-grounded modalities.

  Therapists also have a duty to develop themselves and their practice continuously in their personal and professional competencies. The practice of educating psychotherapists should be evaluated regularly and should be accompanied by appropriate research.

  Training programs should not teach only one modality, but several. Training programs should be focused on the efficacy of a trainee and should install a system of monitoring for the therapies that they are conducting as trainees. Supervision is essential, but is not enough, and should be just a part of this monitoring.

In conclusion, in this excellent book, you will therefore find plenty of material about psychotherapy research, it's history and it also

gives details of the actual discussions. I can strongly recommend it to all psychotherapists so that they can become better informed about questions to do with psychotherapy research and thus become more familiar with the actual state of modern psychotherapy research.

Reviewed by:

Peter Schulthess *is the current Chairperson of the EAP's Science and Research Committee (SARC). He is a Swiss Gestalt psychotherapist, who has taken part in several multi-disciplinary research studies.*

E-mail: peter.schulthess@europsyche.org

Information and Guidelines for Authors

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

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

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

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

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

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

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

In essence, the following format is used, with **exact** capitalisation, italics and punctuation.

Here are three basic examples:

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

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

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

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

International Journal of
PSYCHOTHERAPY

Volume 24 | Number 2 | July 2020

ISSN: 1356-9082 (Print) | ISSN: 1469-8498 (Online)