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Freedom in Letting Go

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From the Editor:

Dear Colleagues,

As I write this editorial for the Autumn edition, the country is basking in glorious sunshine, perhaps a little too hot for some, but a welcome relief from the grey skies and indeed the grey headlines we have been experiencing over the last number of months. The country is still learning to live with Covid-19 and the challenges that it is presenting to us as a nation, thus, it continues to be a demanding time for those of us working in this profession. The issues we have always met with, have not changed, but have been compounded by the environment people are living in and it has been for longer than anyone had expected. Thus, as our clients continue to face difficulties in these trying times, we, as professionals, persist in supporting them despite the conditions. At the heart of this support is, of course, the relationship we develop with our clients. However, in expanding our knowledge through the sharing of others' work and research, we are enabled to further facilitate our clients to make choices about how they could live their lives. The articles included in this edition offer us insights on how to empower our clients to make changes and as, Thich Nhat Hanh states "Letting go gives us freedom and freedom is the only condition for happiness."

One issue encountered with clients in therapy is resistance. Clive Rooney's article 'Managing Client Resistance' focuses on clients with narcissistic personality disorder and illustrates how cognitive and behavioural profiles of such clients can lead to an understanding and treatment of their aversion to change in the therapeutic process.

Another very challenging subject matter we may face in therapy, is that of sex addiction. Dr. Marion Mensing in addressing this in her article, proposes that some knowledge of neuroscience is required when treating clients with this addiction. Dr. Mensing shares her knowledge from her own experience in this field, but also the research that has been carried out. She concludes that sharing this information with the clients may be an explanation that might be more tolerable for them to hear, thus opening the way for them to work on their issues.

Our section on poetry continues to attract many of our members and we are so glad that we have such willing creative contributors. Unfortunately, for a few, we were unable to include their submissions, due to the volume received. Hopefully though, this will not deter any of you from presenting your work again in the future.

Cheryl Murphy's article is a research piece on clients who disclose self-harming behaviours. She looks at how difficult it can be for these clients to disclose this behaviour in therapy due to a perceived stigma associated with it. The author acknowledges that there were some limitations in her research, due to conditions outside of her control. However, the information obtained from those she interviewed gives an insight into what they need from us. We are encouraged to look past the behaviours, connect with the clients and accommodate their reconnection with the Self, hopefully, allowing them to make changes as to how they cope with their pain.

Lastly, we have the final part of Dr. James Overholser's simulated interview with Carl Jung, where Jung empaphises the importance of therapists engaging in their own psychoanalysis before attempting to work with clients. He also illustrates Jung's views on issues relating to the psychotherapy process and training in this area.

We are fortunate that we have two book reviews, one on creative psychotherapy and the second, on depression, presenting more research and materials to use when working with our clients.

Many thanks to all of our contributors and on behalf of the Editorial Committee of the IJCP, may I wish you well in the coming months.

Annette Murphy

Practitioner Perspective

Managing Client Resistance in Clinical Practice: Utilising a Cognitive Behavioural Formulation for Non-Compliance to Change with Personality Schemas

By Clive Rooney

Accurate case conceptualisation can be used to inform therapists in managing client resistance to change. Narcissistic Personality Disorder typifies the developmental and transferential challenges that are frequently encountered in therapy and the underlying motivation for the client to resist personality modification

Introduction

During the 19th century, psychopathology was viewed principally in terms of resistance by neurologists. The psychiatric observation of such behaviour was attributed to the practice of malingering or feigning psychological symptoms for the purposes of social or financial benefit (Shorter, 1997). Breur (1895) & Freud (1955) attribute this phenomenon to conflicts in the psyche that are out of the remit of consciousness.

Psychoanalysis understands client resistance from the perspective of ego defences – a symbolic representation of the true inner conflict. The practicing analyst proposes, that only a working through of the client's resistance using the transference relationship can the conflict be resolved (Kernberg, 1975, 1978). This article will emphasise the utility of cognitive behavioural approaches to client non-compliance in clinical practice. Aaron Beck's Schema Model (1990) will be utilised to stress the importance of avoidance and compensation strategies employed by clients to resist therapeutic change. To illustrate this, the clinical presentation of Narcissistic Personality Disorder (NPD) will be examined.

Cognitive models of resistance

Ellis's (1985) model of resistance emphasises the dysfunctionality of client's thinking. His model explains the client's tendency to be resistant in terms of absolute thinking and 'irrational beliefs'. Ellis stresses the importance of client's global statements about themselves, stating that such terms are meaningless. According to Leahy (2001), Ellis "indicates that concepts such as 'worthlessness' are not empirically verifiable" (p.18).

Similarly, Burns (1989) underscores the existence of cognitive distortions and how they operate to impede compliance

with self-help exercises. Burns further addresses this through the identification of specific client strategies used to evade progress in therapy such as perfectionism, emotional reasoning, sense of entitlement and reactance all being prominent in deflecting from therapeutic compliance.

Beck & Freeman (1990) enhanced the Schema model traditionally employed to understand depression and anxiety (Beck, 1967; Beck, Rush, Shaw & Emery, 1979) to comprehend the intricate processes involved in personality disorders. Recurrent problems are attributed to the existence of core and rigid cognitive processes developed from early childhood. These 'schemas' direct the selection to and recall of information in the client's current and past life that is consistent with their ideas about the self and others (Beck, Emery, & Greenberg, 1985). Personality schemas correspond to specific patterns and themes arising from specific vulnerabilities triggered by current environmental stressors (Beck, et al, 1985).

Beck (1990) stresses the importance of avoidance and compensation as strategies used by clients who have inflexible personality schemas. The strategy of avoidance relates to the client's tendency to evade situational and environmental stressors that could trigger their schematic processes. Compensation relates to the practice of adopting behaviours that aim to counter the activation of their schema in a variety of interpersonal and social situations.

Leahy (2001) emphasised the concept of 'extra-adaptive behaviours' in the clinical setting, such as being overly pleasing, overly attached, and even overly critical of the therapist. Young, Klosko & Weishaar (2003) speak about the concept of early maladaptive schemas arising from unmet developmental needs. The disruptive attachment patterns of such clients are compensated by overdeveloped strategies: "Certain overdeveloped and repetitive strategies are used to compensate a distorted view of self and others that have emerged as a response to negative developmental experiences," (Beck, Davis & Freeman, 2015, p. 43).

It is prudent to expect such a personality-disordered client to expect others to fulfil their needs without any purposeful or active behaviour...

Narcissistic Personality Disorder

According to the *DSM-V* (American Psychiatric Association, 2013) NPD is a "pervasive, inflexible, and maladaptive pattern of inner experience and behaviour" (p. 300). Beck et al (2015) speak about the self-aggrandizing and competitive expectations of being given special treatment in therapy. Self- esteem for the narcissistic client equates to positive self-evaluation and admiration from others (Neff, 2011). Beck et al (2015) discusses the personality structure of NPD as typifying "overcompensating schema modes" in their self and other schemas (p. 304).

Milton (1996) offers an interesting perspective on NPD based on Social Learning theory. Due to the anticipation of the child's needs by the parent, the child has been denied the skill of obtaining gratification, as no effort has been expended by the child. He further adds that this pattern is continued into adolescence and early adulthood, culminating in the formation of the narcissistic personality structure. I have personally observed in clinical practice this transference phenomenon of the expectation of therapist-led 'cure' without any active participation of the client. As discussed, Milton (1996) describes this personality formulation as "passive-dominant" (p. 243). From a clinical perspective, more often than not narcissistic clients tend toward depression when the environment does not provide the gratification to which the individual feels entitled (Wessler, Hankin & Stern, 2001, p. 244).

Clinical presentation of narcissistic resistance

As we have seen with Milton's (1996) Social Learning Theory, the clinical presentation of an NPD client typically resembles a passive-dominant personality style. It is prudent to expect such a personality-disordered client to expect others to fulfil their needs without any purposeful or active behaviour on their own part, hence the passive aspect of the personality circumplex.

From an interpersonal perspective, the NPD client will attempt to procure a dominant stance in any given interaction. Such intersubjective vacillation between these two styles confers a sense of entitlement without any instrumental act or behaviour on the part of the client to earn this gratification.

Beck, Davis and Freeman (2015) speak about the threatening imbalance in relationship dynamics that therapy provides for the client. Not infrequently, the NPD client will view themselves in a subordinate or weaker position due to the 'educated' status of the therapist and this would typically evoke a sense of humiliation on the part of the client. It is worth mentioning that when conceptualising a case formulation for a NPD client, Wessler, Hankin and Stern (2001) classify the NPD personality presentation as either a 'true narcissist' or a 'defensive narcissist'. The former presents as lacking any form of empathy in the transference relationship; the latter will habitually overcompensate for perceived lack of confidence by projecting a polar opposite

version of self that has the effect of portraying a highly self-centred personality style.

The true narcissist seldom, if ever, requires such a compensatory style as they genuinely believe themselves to be superior. In the words of Wessler, Hankin and Stern (2001): "The true narcissist already has more than enough self-regard" (p. 244).

It is worth noting that the overriding behavioural indicator characteristic of this personality mode is the abundant paucity of social reciprocity – an almost compulsive yearning for appreciation in the absence of appreciating others.

Cognitive consistency with NPD

When we discuss personality schemas it is more often the case that familiarity does not breed contempt. Swann, Stein-Seroussi & Giesler (1992) discuss a self-verification model when conceptualising clients who actively seek out, attend to, and cognitively recall confirmation of their self and other schemas. Indeed, this serves an internal motivational vehicle to procure and maintain an internalised familiarity that is consistent and predictable, and it is this consistency that Helder (1958) called a 'cognitive balance'.

Cognitive behavioural therapy in the tradition of Socratic questioning would collaboratively and scientifically address any inconsistency in beliefs as a therapeutic conduit to guide the client to belief change. Conversely, however, Leahy (2001) underscores the motivational desire of certain clients to reject and vehemently repudiate such inconsistent discoveries to preserve the omni-presence of certain hypertrophied early maladaptive schemas, "rather than change the negative belief, the patient may reject the positive evidence – and perhaps even the therapist" (Leahy, 2001, p. 58).

NPD self-justification and cognitive dissonance

When understanding the complexity of the cross-sectional and developmental formulation of the NPD client, it is worth considering the undeniable role that cognitive dissonance plays in the maintenance of such long-standing mental structures. Festinger (1957) identified the elaborate task of individual's efforts to justify their hypertrophied cognitive schemas – even in the face of contradictory evidence:

"Individuals are motivated to reconcile their psychologically inconsistent beliefs" (p. 90). This is typically a personality constant for NPD clients in therapy, owing to their unfaltering belief that the 'problem' resides outside of themselves. As is often the case when clients present in my practice with characterological difficulties, I fail to recall a single occasion where the initial presenting issue was one that was attributed to the actions of the client or to the modest acceptance that it could be their own behaviours as the genesis of the problem.

Clinical treatment of narcissistic resistance

To illustrate this dissonance effect in my experience with NPD clients, it is useful to provide some clinical examples. Several years ago in the opening initial assessment, an NPD client remarked that he was not sure if I could help him in any beneficial way. The client repeatedly probed into my skills and abilities to help him with his difficulties engaging and interacting with colleagues in a new job. I hypothesised at the time that this was an initial 'test' to empirically confirm his underlying schema of superiority and entitlement on his part and weakness and inferiority on mine.

In this situation I was careful not to be provoked into re-enacting this cognitive interpersonal cycle, but to neutralise the client's expectations by offering an anti-complementary, disconfirming interactive style. It was crucial for therapeutic success that I came across as equally strong, competent and confident, as to not do so would recruit me in the service of his cognitive-interpersonal schema cycle, i.e. weak and someone to be dominated interpersonally. To my recollection I retorted with the following: "Thank you so much for asking me this very important question. I believe that after listening to your difficulties and concerns I might be the most appropriate therapist to help you. I also believe that I am the most qualified to assist you in what clearly are very special struggles over all the other therapists that I think would not really appreciate the special nature of these recent stressors."

This was a timed choice intervention that conveyed to the NPD client that I was technically qualified and self-assured in my abilities to handle the client's 'special' problems. This is one of the few occasions in the practice of CBT with personality disorders, and especially NPD, that an immodest approach is optimal in laying the foundation for therapeutic success.

This strategy precipitated over the course of therapy – a series of put-downs and deliberate condemnations of my character, my expertise, qualifications and personality to provoke a schema-confirming response. The client had experienced an anti-complimentary interpersonal style, which created dissonance between what was expected (a timid, modest and acquiescent therapist) and what was experienced (a confident equal with capable skill). In this example, the client's condemnations acted as a defensive strategy to reduce this unfamiliar scenario – hoping to re-establish the more familiar interpersonal schema of the dominant, superior client and the frail, feeble psychotherapist. Over time, these caustic put-downs

diminished in frequency as the transference relationship became increasingly of a correctional emotional and social experience. From here, a less directive approach was utilised to point out for the client the gulf of difference between his private constructed version or reality and my own socially-attuned version.

This was demonstrated in one session where the client's self-aggrandizing stories, with no other motive, but to impress and pull adulating responses from me, were met by timed observations and remarks on my part of the client's obvious lack of empathy. On one occasion the client manifested what appeared to be a vain, glorious boast of having verbally accosted a flight attendant for not coming to his service immediately when he pressed the button for assistance. Despite the fact that the flight attendant was occupied with another issue on the plane at the time, this was seen by the client as a conscious and direct attempt to deny him gratification. I retorted with an alternative version of reality, with the aim of illuminating his own private version. "You know, if that were me in that situation, I would feel quite upset, or even hurt, that I wasn't being appreciated. I might also feel angry that I was being demeaned by someone for actually doing my job. I would also wish in that situation that someone would understand the demand of my job and be more respectful to me." Predictably, this strategy was met with counter rationalisations to maintain the cognitive consistency that people should cater to his every need when he wants it.

To truly understand NPD we need to fully comprehend the interpersonal context with which the disturbances arise – that is, in a social context with people. So why should it be any different to the transference relationship

In my own clinical practice, I have found it therapeutically useful to

To truly understand NPD we need to fully comprehend the interpersonal context with which the disturbances arise – that is, in a social context with people

'impress' the narcissistic client from the onset when inevitable reassurances for optimal therapeutic performance are made. Wessler, Hankin and Stern, (2001) state that narcissistic clients 'expect' only the best. Not surprisingly, this 'demand' will also extend to "the best therapist" (p. 244). Novice therapists or therapists in training might find this position difficult to adopt, owing to covert confidence issues of their own, leading to provocative counter-transferential reactions.

According to Milton (1996), the passive-dominant cognitive-interpersonal cycle adopted by the narcissistic client would mandate on their part a transference-related test. Leahy (1991, 1995) refers to these as 'life scripts' and I have observed such life scripts unfold in the transference relationship.

Safran and Siegal (1990) discussed the concept of the Cognitive Behavioural Cycle to be utilised *in vitro* (in session). They go on to state that such a cycle can be examined with regards to the transference relationship – "an experiential disconfirmation of the client's cognitive interpersonal cycle" (Wessler et al, 2001, p. 160). Recently, a client in practice started to belittle my professional approach to treatment and elevated this to inappropriate remarks of the therapeutic office. The cognitive-interpersonal cycle of the client was clearly operational. In an attempt to model a non- defensive way of reacting, I provided a schema incongruent response that provided a form of dissonance in what clearly was not the 'typical' reaction that the client expected from others *in vivo* or other significant relationships outside of therapy. I decided to use humour, indicating that perhaps the client is right and that "I should have gone on to get my Doctoral to get better furnishings". From the perspective of the avoidance/compensation strategies that were formulated through accurate case conceptualisation, the therapeutic relationship assumed a shift in trajectory. This strategy and many more like it during treatment obviated the schema-driven protective strategy to 'defend' his 'superior status'.

Gilbert (2010) adds to the feelings of superiority by the narcissistic client to include reward- seeking behaviour as part of the overdeveloped strategies employed by clients with NPD. Such clients develop an illusory bias in self-image (Colvin, Block, & Funder, 1995), which has implications for clinical treatment. This is another example of providing dissonance between the narcissistic client's illusory self-image and the therapist's socially appropriate concept of reality and conventional social behaviour. Typical remarks on my behalf would draw attention to how I would feel in a similar position. This strategy could also be utilised as a specific form of empathy training to demonstrate in session the effects of the client's remarks and behaviour on myself the therapist. Such in-session transference observations can then be related to the client's outside therapy affect, on other significant people and interpersonal relationships. Neff (2011) outlines how these techniques can be used as alternatives to the grandiosity and competitive comparisons made all too frequently by narcissistic clients. In therapy, the use of empathy training can strategically neutralize these self-aggrandizing image preoccupations by clinically connecting the client to his developmental maladaptive patterns.

An example of this can be seen when my client typically monopolised the session with unending yarns about his triumphs in sport and business. When it was brought to his attention that such exuberant overinforming was learnt in childhood to procure acceptance and love and that in the transference relationship it confers no special condition for care, such transference configurations can be explored leading to corrective and latent learning.

Conclusion

This article highlighted the existence of schema resistance to change and addressed the specific overdeveloped strategies employed by NPD clients that are demonstrated and presented in clinical practice. The cognitive and behavioural profile of clients presenting with personality disorders provides the essential backdrop to optimising the effectiveness of an accurate case conceptualisation approach to understanding and treating client resistance to change in the therapeutic process.

Becks' (1990) avoidance and compensation overdeveloped strategies employed by clients provide the instruments to deflecting positive change in treatment. Clients who present with NPD typically adopt extra adaptive behaviours to protect their surface schemas of entitlement and superiority (Leahy, 2001). Building on the early maladaptive schemas formed in childhood (Young, 1990), the narcissistic client typically learned to compensate for unmet developmental needs and a lack of reinforcement for obtaining gratification (Young, Klosko & Weishaar 2003). The clinical implications of this for treatment have been observed in the transference relationship whereby the learned strategies are manifested in a passive-dominant personality style, (Milton 1996).

As a mental health practitioner, I have observed this resistance working with both syndromal and characterological presenting issues. I believe that client resistance is all too often a secondary problem that counsellors and psychotherapists need to embrace fully and comprehensively in their approach to therapy and their overall treatment plan. Once the transference phenomenon is denied its 'clandestine' quality and brought to the attention of the client, only then, I believe, can this potentiate the invitation for a mindful discussion in treatment on negotiating the conflict between change and familiarity. This is our responsibility as therapists. However, the issue of change is always the responsibility of the client.

Clive Rooney

Clive Rooney is a corporate psychotherapist, wellness coach and site lead for Spectrum Mental Health, coordinating individual and group well-being for agents working for Accenture. Clive worked as a psychotherapist in CIPC (Counselling in Primary Care), SHIP (Self Harm Intervention Programme) and in the Bereavement Counselling Service for Traumatic Deaths (HSE). He holds BA and BSc degrees in Marketing, Psychology, and Counselling & Psychotherapy and a higher graduate diploma in psychoanalysis and an MA in Cognitive Behavioural Therapy. Clive has experience working clinically in the HSE mental health services with adults and adolescents presenting with a range of symptomatic and personality disturbances. He can be contacted by e-mail at cliverooney@yahoo.co.uk or by phone on 085 1859 154.

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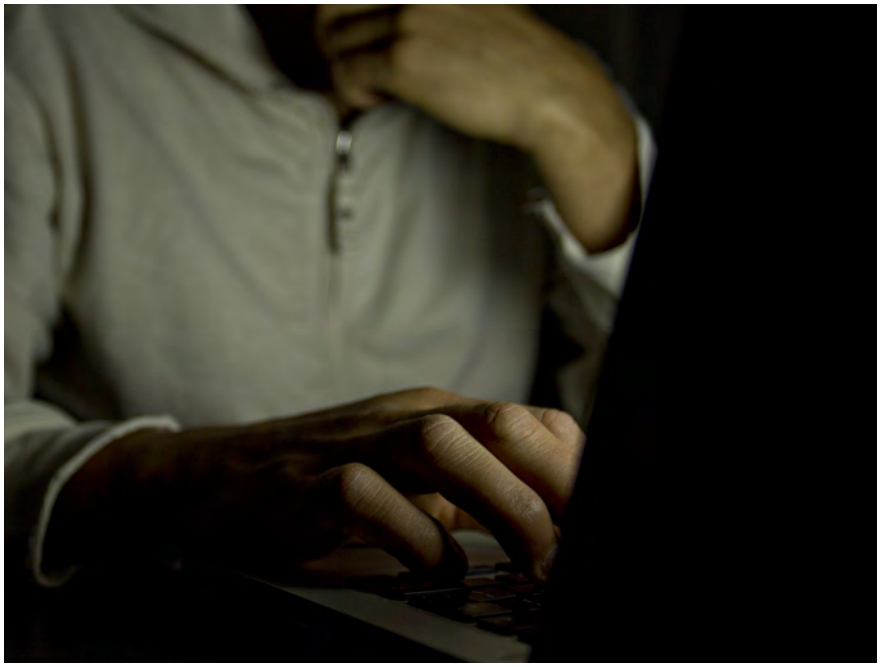
Academic Article

How Relevant is Some Knowledge of Neuroscience for Those Working to Help Sex Addicts Recover?

By Dr. Marion Mensing



Many psychotherapists doubt that effective therapy needs neuroscience, but the damaging impact of early contact to internet pornography on the complex brain system cannot leave us cold

Introduction

It may be helpful to bring to mind, where there has been repeated failure in addressing and changing addictive behaviour, that the brain is not like a computer, that it is not purposely constructed from scratch with one central control unit, but that it has evolved over time – module after module. The central control unit, clients and therapists often are aiming at, does not seem to be in control in the least – if it exists at all. Hence, a better understanding of the human nervous system could be beneficial, also for therapists working to help sex addicts recover.

The first section of this article is an attempt to shine some light on the neuroscience underlying addiction in general. The focus will be on the habitual aspects of addiction, the reward system in the brain, the role of dopamine, the regulating role of the cortex, and the influence of childhood experiences on the capacity of the cortex to regulate. In the second section I will gather up some particularities of the neuroscience underlying sex addiction. A crucial factor is the sexual arousal system in the brain and the strong impact, intense consumption of internet pornography has on sexual functioning in men. Another relevant aspect is the brain development during adolescence and how it is impaired by early contact to pornography leading to quite harmful consequences. The third section elaborates on the relevance of neuroscience for sex addiction therapy and finally, the conclusion will bring all findings to a close.

Neuroscience Underlying Addiction in General

Lewis (2016) puts it very poignantly that the statement 'addiction changes the brain' in itself is rather insignificant because *any* new experience – depending on its novelty, attractivity or enchantment – has the potential to change the brain and with-it – also depending on the frequency of repetition – the potential to condense those changes into a habit. However, what makes addiction different from many other behavioural habits – according to Lewis (2016) – is that it involves thinking and

feeling, including the intense feeling of desire that grows into a compulsive focus on one goal superseding all other goals. "It's no accident that addiction and love look pretty much the same in a brain scan" (Lewis, 2016, p.181). Wood (2019) presents a similar view, emphasising that addiction shows relevant characteristics of a habit, whilst acknowledging that addiction and habit require different levels of mental commitment; a pure habit does not require a lot of conscious awareness, as it uses implicit memory whereas addiction also takes over the conscious thinking. Brain scans have shown that with the repetition of certain activities, a shift occurs from the initially activated areas of the *cortex* – the outer layer of the brain which in evolutionary terms is the newest part of the brain – to the activation of inner brain areas more closely connected to the mammalian brain or *limbic system*, i.e., the *striatum* at the base of the fore brain. This shift seems to be associated with less cognitive involvement during habit forming (Patterson and Knowlton, 2018).

According to Woods (2019) habits are (1) context-depended, they need (2) repetition and (3) reward, and the reward needs to be unexpected to stimulate the release of dopamine in the midbrain, which facilitates the transmission of information along certain neural pathways. Dopamine instructs neural areas that are involved in the selection of behaviour to favour a certain action when sensory areas sense the same context again.

Dopamine is released when something pleasurable is anticipated or experienced; it creates desire and is fuelled by endorphins that increase the liking of something by influencing the opiate receptors in the brain, reducing pain and boosting pleasure (Afford, 2020). With each repetition of the pleasurable behaviour, the neural pathways linking the reward networks in the midbrain to the *frontal lobes* – the frontal cortex – become stronger (Lewis, 2013). Over time, neural pathways can become overwhelmed by the high levels of dopamine and the dopamine receptors try to compensate by becoming less sensitive, leading to a need of more and more stimuli to create the same response as before and also making all other things with more modest rewards appear less and less attractive (Afford, 2020). Pleasure cannot be achieved anymore through the behaviour, but withdrawal from it would result in the collapse of dopamine and high levels of stress with high cortisol secretion depleting dopamine even further (Afford, 2020). The striatum, the subcortical region at the base of the forebrain responsible for the control of habits and for impulsive joyful behaviour, cannot function without dopamine; reduced dopamine activity here is associated with depression which seems to be a regular companion of addiction (Korb, 2015).

As a way to cope, neural connections consequently emerged within the unconscious memory to distort reality and reduce anxiety and fear differently

(Cozolino, 2017)

Flores (2004) sees addicts as rarely being able to develop and maintain healthy relationships or regulate their emotions; for him, addiction is an attachment disorder caused by early attachment issues or childhood trauma. The cortex has also the important role of regulating emotions, impulses and behaviours. In this role, the cortex draws on neural networks shaped by supportive experiences through early attachment relationships that helped to increase successively the tolerance for stress (Cozolino, 2017). If such a support was missing in early childhood the cortex has only limited capacity to regulate. As a way to cope, neural connections consequently emerged within the unconscious memory to distort reality and reduce anxiety and fear differently. These coping strategies easily lead to some kind of addiction or other psychological problems (Cozolino, 2017).

McGilchrist (2018) detects the regulating capacity of the cortex mainly in the right hemisphere and sees underactivity in the right frontal lobe as symptomatic for addiction. This view is supported by Camprodon, Martínez-Raga et al. (2007) who found that high frequency transcranial magnetic stimulation to the right frontal cortex reduced craving in cocaine addicts.

Hall (2019) mentions three specifics of sex addiction: (1) Access to porn and online sex has become easy, even for young teenagers, (2) sex addiction can be kept as a secret for a long time and (3) sex addiction is the most damaging addiction for relationships.

Particular Aspects of Neuroscience Underlying Sex Addiction

One important aspect of neuroscience underlying sex addiction – in particular porn

addiction – is the male sexual response in the brain. The *hypothalamus* in the limbic system plays a crucial role in facilitating erections; it gets its pro-erection information from the reward system in the brain, receiving exciting or inhibiting information from other limbic structures or from the frontal lobes (Park, Wilson et al., 2016). Park, Wilson et al. (2016) suspect internet pornography of having the potential to change these circuits in the brain that rule desire and erection and causing the significant increase in sexual difficulties – i.e., erectile dysfunction, delayed ejaculation, low sexual satisfaction, and reduced libido in partnered sex – especially in young men. The brain is assumed to become hyper-reactive to the excitatory glutamate feed from the limbic system, caused by high-speed sexual streaming videos with endless options of climbing from one novel scene to the next, free and widely accessible on so-called 'tube sites'. The resulting over-consumption likely prompting the brain to downregulate the reward system with the consequence of an increased insensitivity to 'normal' sexual rewards (Park, Wilson et al., 2016).

This problematic development is aggravated, firstly, by the fact that the adolescent brains are much more sensitive to positive rewards of all kinds of stimuli (Doremus-Fitzwater et al., 2010). Secondly, the age of first contact to internet porn significantly dropped. Nearly 50 % of college age men reported in a 2014 study to have been exposed to internet porn *before age 13* versus 14 % in 2008 (Sun, Bridges et al., 2016). The most sensitive time for conditioning sexual arousal is adolescence, and the younger the age of initial exposure to particular films the stronger the preference for it over natural partnered sex later in life (Park, Wilson et al. 2016). A younger age of onset in the use of adult pornography also increases the likelihood of a progression to *deviant pornography*, e.g. child pornography (Seigfried-Spellar & Rogers, 2013).

> *Just the message that brains can change is good news and many would prefer now to see addiction as a deeply ingrained habit rather than an illness or a genetical curse*
>
> *(Lewis, 2016)*

The phases of brain development during childhood and adolescence move from the bottom to the top and from the back to the front; i.e., the brain fully connects the regulating frontal lobes at last (Siegel, 2012). Brain scans reveal that frontal lobe connectivity is delayed until age 20 or older, which means that not every young adult aged 18-24 is already fully capable of seeing the 'bigger picture', especially when attachment and developmental issues also play a role (Jensen & Nutt, 2015; Siegel, 2015). Teenage brains are more formable than adult brains, unfortunately also in a negative way, i.e., by addictions (Jensen & Nutt, 2015). The destructive impact of sex addiction on forming and maintaining significant relationships can lead to isolation and loneliness, thus exacerbating the risks of depression and consequently, there is a higher risk of suicide (Hall, 2019).

Now, I shall expand further on the question whether a knowledge of neuroscience can contribute something to the clinical work with sex addiction, that was not already provided through clinical research and experience in a different way.

How Relevant Is Knowledge About Neuroscience for Those Working to Help Sex Addicts Recover?

A lesson can be drawn from the past, that uncritical embracing of every 'discovery' in neuroscience can lead therapy astray: In the late 1990s neuroscientists came to the conclusion that addiction was indeed a brain disease; brain scans were used to display the addicted brain as evidence for this hypothesis (Satel & Lilienfeld, 2015). This became a dominant view in addiction treatment although an earlier study with Vietnam veterans proved the falsity of this hypothesis: Only 5% of the American soldiers who became addicted to heroin in the Vietnam war relapsed within 10 months after return to the U.S. and 12 % relapsed briefly within three years after return, which shows the importance of context in addiction and disproves the disease concept (Satel & Lilienfeld, 2015; Wood, 2019). Of course, the proponents of the brain-disease paradigm also see its benefit in the public view for dissolving the stigma of a weak character. However, for many clients struggling with addiction, just the message that brains can change is good news and many would prefer now to see addiction as a deeply ingrained habit rather than an illness or a genetical curse (Lewis, 2016).

Basic knowledge about the laterization of the brain could be relevant for therapy in general: The left hemisphere of the

cortex is important for focus, logical thinking, language and attention to detail, while the right hemisphere has a more holistic view and is more intuitive, more connected to the mammalian brain, to body sensations, unprocessed emotions and the so-called felt sense of internal awareness in the body (Afford, 2020). McGilchrist (2009) attributes passivity, a certain stickiness, denial, being set in one's ways, a relative inability to support new ways of looking at things to the left hemisphere of the cortex, whereas the right hemisphere would be more associated with independence and motivation. An important implication for therapy would be to engage the right hemisphere and its primary connections to the subcortex and the body, e.g. through paying attention to the bodily feelings and sensations in the present moment. The task of the left hemisphere then is to force aspects of the background or the implicit into consciousness – through the link with the right hemisphere – and bring clarity about them (Afford, 2020). As the neuroscientist Eagleman (2016) puts it, consciousness developed during evolution in the human brain, because it must have had some advantage at some stage. However, he sees consciousness merely as comparable to a newspaper. When the headline is available to read, the activities have already been done and can only be interpreted. Oddly, the interpreter in the brain – as the reader of the newspaper – takes credit for the headline as its own thought and pretends to be the origin of it. Eagleman (2016) does not see a conscious executive control function but rather an interpreter function in the left hemisphere of the cortex.

Even if neuroscience only validates what is already known through clinical research and experience, a validation through a different branch of science is always beneficial and welcome

This is supported by the experiments of Gazzaniga and Ledoux in 1978 with epilepsy patients who had their two brain-hemispheres disconnected in a surgery. The left hemisphere had command over speech and the right hand, the mute right hemisphere could communicate with the left hand (Eagleman, 2016). A picture of a chicken claw was flashed to the left hemisphere and a picture of a snow shovel to the right hemisphere. Then, when the patient was shown both pictures and asked to point to the picture that was seen before, the right hand pointed to the chicken claw and the left hand to the snow shovel, instantly followed by a verbal explanation quickly made up by the left hemisphere (Gazzaniga, 2012). In another experiment the command 'Walk' was shown only to the right hemisphere and when the person walked and was asked for the reason to walk away, the left hemisphere explained that it wanted to get something to drink (Gazzaniga, 2012).

Eagleman's thesis about the lack of control in the conscious mind would imply that a more systemic approach to the whole inner world would be adequate in therapy. If nothing else, the brain is a complex organic system that has – according to Mitchell (2009) – no central control, but is self-organising, similar to an ant colony where the group as a whole becomes an organism with group intelligence without any commander.

This emphasises the importance of right-hemisphere activation in addiction therapy, as the right hemisphere is more connected to the whole brain-body system. The right hemisphere has a role also in the synchronisation of eye-movements (McGilchrist, 2019) which supports the usefulness of Eye Movement Desensitization and Reprocessing (EMDR) in this context.

Only due to modern brain imaging it is known in what succession different brain regions are connected to one another in childhood and adolescence, and that the frontal lobes are connected at last (Jensen and Nutt, 2015). This has implications for therapy when the group of young clients presenting with porn addiction becomes increasingly significant.

Another important aspect in therapy is the re-sensitisation of the sexual response in the brain after the desensitisation through porn; the technique of mindful masturbation, e.g., could help to create new neural connections in the sexual response/reward system that are more connected to the sense of touch (Hall, 2019).

Even if neuroscience only validates what is already known through clinical research and experience, a validation through a different branch of science is always beneficial and welcome. More importantly, with neuroscience, a *non-pathologizing* way of explaining sex addiction and therapy to clients emerges. Therapy is about understanding and processing the underlying issues by activating the right hemisphere. It is about learning how to break deeply ingrained habits through change of

context and building in friction – e.g., porn blockers – but also about developing positive and rewarding habits.

Conclusion

Looking at processes in the brain can provide comprehensible reasoning that addiction may be rather an extreme habit than a disease and how it is often accompanied by depression. Childhood experiences and attachment issues play a role in inadequate neural connections to the cortex, making impulse regulation difficult and manifesting unhelpful coping strategies in the unconscious memory.

The unlimited availability of pornography – sometimes already from a very young age – has extremely damaging impacts, because of the way pornography changes the circuits in the brain ruling arousal and erection. The rapidly decreasing age of onset for first contact with pornography is a reason for concern, also because the brain is formable so precisely in childhood and adolescence. Harmful consequences comprise erectile dysfunction, delayed ejaculation, low sexual satisfaction, reduced libido in partnered sex, higher progression to deviant pornography, difficulties in developing and maintaining relationships, depression and suicide.

In addiction therapy, overreliance on every finding in neuroscience should give way to collaboration and critical dialogue between the two disciplines. Knowledge about the different roles of the right and the left hemisphere of the cortex may provide better understanding of what works in therapy. Neuroimaging brought the learning that adolescent brains are not like adult brains and require different therapeutic approaches – and adolescence can last much longer than age 18. Finding techniques and tools to help re-sensitise the sexual response in the brain by connecting it more to the sense of touch is another implication.

In summary, a knowledge of the neuroscience underlying addiction in general and sexual addiction in particular, is becoming increasingly important for those working to help sex addicts recover – even if it is only a way to explain and validate what is already known in therapy; it can be an explanation that is more acceptable for the client.

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FLORESCENCE

The Therapeutic Encounter

By Anna McGrath

I hear you from the depth of me
As we make contact psychologically
We are not robots
Inherently I know
Your need for healing, your need to grow
From genuine empathy I am aware
It reaches out to me, in centred space, and I meet you there
I deeply regard the presence I am seeing
I respect your individuality, the uniqueness of your being
You are accepted
I feel your pain but I can't take it with me on my journey
It is not mine to take
Still I am beside you as you hurt
From self-destructive conditions of worth
And we just are
Sharing this encounter
I need no reward
You have my unconditional positive regard
I am open and you are free to be you
As I see the world from your point of view
I too have hurt, but that is my domain
Your experience is yours and will not be regarded
as the same
And you will not be judged
In this relationship you are free to grow
Without disapproval, or criticism, or reprimands
There are existential realities, but the choice is always
in your hands

The texture of your story weaves a tapestry of your life
And through our dialogue you see the picture for yourself
The intricacies of the woven threads
It is a masterpiece
And it becomes clearer, the richness of your pain
Catharsis
And in the silence of knowing you weep
Tears of release entrenched with meaning
Person to person we do not speak
And in this precious space, you focus and we just know
Through the process something has changed because
you could let go
I am not a director in this play
But new pathways are opening and you begin
to see your own way
Coming to terms with angst and fear
We are each of us alone but there is a connection here
I meet you with empathic understanding
as a therapist should
And I communicate this to you
You have been understood
As you begin to trust in your validity
A chrysalis softens its rigidity
You value 'the self' that is authentically you
And I have shed tears because I was being real too
And the emerging butterfly self-actualised and flew

It has to be

By Eugene Doherty

It has to be this way,
The text, the wrench, the sorrow, the free,

It has to be this way,
The flee,
The plea,

It has to happen to me,
For you to see this happened to me,
The push,
The rush,

The door to settle the score,
Hands full of odd socks and jocks,
Bags full,
Car full,

Head and shoulders,
Man, you're bigger than me,

Did it have to be this way,
Now I see,
You're part of me.

You And I

By John Edward Basil Keenaghan

I sit, listen and observe
To all you say and do
I take it all in
To try and understand you

I try not to judge or doubt
To empathise if I can
I sit with you in hope
To try to lend a hand

You talk and tell your story
To express how you feel
You cry laugh and gaze
To see what is revealed

You then may pause awhile
To let it all sink in
You reflect, repeat and relive
To question, lose or win

We then meet together
Without a word being said
To wander through this journey
For a while we are wed

We gently come to realise
That ease has just begun
It may take a little longer
Until your song is sung.
But you are singing.

The Ring

By Tim Walsh

We visited that rath in another time
The sun came gently

On this island the wind got only a look in
The rain fell unaccompanied by wild forces

And those who had lived here
Left energy

In endings
Beginnings yearn out little messages

In beginnings
Endings

Thoughts Unbidden

By Niamh Jackson

…thoughts locked away in some back room of the mind
Till time and everyday ignoring
Made them all but forgotten

Still, one year in a season of good fortune
Softened by the warmth and softness of a late spring air
And now
Set free of the callouses that doored them away
They surge
Unwelcome… Yet… familiar in their musty coats
And a-partnered with a cocktail of emotion

Here they come: storming like labourers
Across the master's carpet
Muddy and uncouth,
The like of which no one would willingly abed with
Untempered and unchained
Wreaking havoc and clamouring for attention.

They will not be silenced, no!
Monsieur Thought and Madam Feeling
And they insist upon my notice: more indeed, my Very Presence
Here…

And here I sit; and in the moment Now we have some meeting
Here they trample and they clamour until I have heard each word, each moan
Here, I hold discreet communion
Entertain them throughout all their discourse until dawn.

…Strange it is
Their clamour heralds in the silence,
a Peace so long my soul has waited for
That these mine enemies became Dear Friends
With patience Each One holding there
The key, that … dreaded… key

To lance my wounds and cleanse my soul
To bind my wounds and… Make me whole.

In To Me See

By Debbie Byrne

Are you sinking, well then let go.
You have to surrender if you want to grow.
You think you have the answers but the truth is, you don't know.
You want to be seen but are you willing to show.

You know you are strong but you want to be held.
Risk reaching out what if your request is dispelled.
Then you retreat, go back into your shell.
It wise to say nothing but there are times you're compelled.
So much to say, it's often misspelled
Try hard to explain, not understood you rebel.
Say it once second time yelled.

Your thinking conflicted, your heart broke in two.
Know what you want but what will you do?
Try to explain, come stand in my shoe.
Relationships questioned everything's under review.
Can things be salvaged or have you outgrew
The haters, the preachers the spiritual guru.
Are you prepared to be the outcast if you let go of your crew.

Or can you do nothing, just sit in the pain.
Stay with your body, don't engage with your brain.
Slow it right down, get off the fast lane.
Feel the sensations, the aches the migraine.
Can you let me sit with you without feeling the shame.
I can't take the pain away
My names not cocaine.
I don't have the answers, I won't try to explain.
But I'm open to seeing you, as I've often felt the same.

*THE PROCESS OF FLOWERING OR DEVELOPING RICHLY AND FULLY

Research Paper

A Silent Cry

By Cheryl Murphy

This article is a qualitative exploration of the lived experiences of clients who disclose self-harming behaviours to their therapist

Introduction

Persons engaging in Non-Suicidal Self-Injury (NSSI) may be slow in asking for help, often because of a perceived stigma attached to the engagement of such behaviours. The National Suicide Research Foundation (NSRF) released statistics for presentations to hospital for 2018, for self-harm in Ireland, stating 12,588 cases were reported. With an increase of 8% of admissions since 2014 (NSRF, 2019) there is a compelling argument for therapists to be equipped with the knowledge and training to support individuals presenting with self-harming behaviours.

There seems, however, to be a gap in research, in relation to client's experiences when they disclose self-harm, in a therapeutic setting. Understanding client's perspectives may provide richer, more robust feedback to help educate therapists in working more effectively with clients who self-harm. As a practicing therapist, reflecting on the number of adult clients disclosing NSSI, makes me question if the statistics are a true reflection of the number of individuals engaging in NSSI, as these are solely focused on hospital admissions.

Review of Literature

Self-harm is an intentional act of damaging one's own body tissue, regardless of suicidal resolve (Saraff & Pepper, 2014; Burke et al., 2018). Self-injury can be seen in a variety of behaviours involving cutting, inflicting burns, self-hitting, hair pulling, excessive skin picking and interfering with wound healing (Sheedy et al., 2019). Given the identifiable behaviours associated with self-harm, it is understandable one may confuse NSSI with suicidal attempts. However, NSSI is usually embarked upon in the absence of suicidal resolve (Whitlock et al., 2015). What it does indicate however, is the intensity of the core anguish that, if left unattended, can cause unforeseen levels of dangerous self-injury or indeed mortality (Whitlock et al., 2015).

Research indicates self-harm is used to cope and regulate dysregulated emotional states (Shallcross, 2013; Wester & McKibben, 2016). NSSI is employed to induce physical pain to distract from psychological pain, or to diminish an experienced sense of numbness (Lloyd et al., 2018).

NSSI and Suicide

Self-harm is a universal public health concern linked to psychological suffering, and while distinct from suicide, it can indicate a higher risk of suicidal ideation or completion (Gardner et al., 2020; Ferrey, et al., 2016). Research indicates conflicting opinions of the relationship between NSSI and suicide. Duarte et al. (2020) argue NSSI should be considered a protective act, in contradiction to suicidal tendencies (Nock, 2009; Castellvi et al., 2017). Nock (2009) and Castellvi et al. (2017) specify that permitting the act of harmful compulsions into a confined area, helps individuals construct an impression of having self-control over fatality. Moreover, Nock (2009) and Duarte et al. (2020) say NSSI is employed to diminish suicidal ideation, which suggests there is no clear link between NSSI and intentionally completing suicide.

Disclosing NSSI

The secretive nature of self-harm is evidenced in 40-60% of university students never revealing their NSSI (Gayfer, 2020). The social stigma attached to NSSI may contribute to reluctance in disclosure (Gayfer, 2020). Socially stigmatised acts tend to induce feelings of shame and rejection, coupled with anxieties around judgement (Corrigan & Rao, 2012; Gayfer, 2020). Despite the high rates of NSSI, individuals who self-harm are habitually disinclined to reach out to support services or helping organisations (Burke et al., 2018).

Persons who engage in NSSI tend to exhibit poorer competencies in communication (Nock, 2009). This is attributed to the absence of emotive language or, possibly, alexithymia (Cerutti, et al., 2014). Alexithymia is a personality trait with inability to regulate and communicate feelings in a typically adaptive way, and difficulties in deciphering and describing emotions. This leads to the limited probability of these individuals seeking help (Burke et al., 2018; Yilmaz, 2019).

The historical propensity in conducting research with psychiatric populations has led to a distorted empirical evidence base by constructing countless assumptions. These assumptions hold inadequate weight of NSSI in the broader population (Long et al., 2016) As a Humanistic Integrative therapist I question the validity of such studies (Skegg et al., 2004; Jacobson et al., 2008) in overemphasising self-harm as a product of a "disorder", leading to missed opportunities to explore NSSI thoroughly, in the wider population.

Treatment Planning

Evidence suggests some helping professions may find the treatment of NSSI difficult. The National Collaborating Centre for Mental Health UK (2012) (NCCMH) highlight that therapeutic engagement is vital for impacted individuals. However, there is uncertainty about the effectiveness of psychosocial interventions. The main interventions employed are Cognitive Behavioural Therapy (CBT) or Behavioural Therapy (BT) (Shallcross, 2013). These therapeutic orientations require client self-motivation and desire to change behaviour. Therapists may assume clients want to stop self-injuring, however, Shallcross (2013) indicates many are reluctant to stop believing this coping mechanism works. Hence, the sole use of CBT techniques may be ineffective. Additionally, asking clients to cease self-injuring can cause isolation and prevent them from verbalising future instances (Shallcross, 2013).

About this Study

This research explored the experiences of clients who had disclosed self-harming behaviours to their therapists. The objectives for this research were for clients:

- To verbalise their experiences of disclosing their self-harming behaviours to their therapist.
- To explore the different ways that therapists responded to their disclosure.
- To define the impact of the therapist's response on them, and thereafter the therapeutic relationship.
- To describe what were helpful and less helpful behaviours in the therapist.

Methodology

Interpretative Phenomenological Analysis (IPA) was employed to explore, in detail, how clients perceived their experiences in therapy. Phenomenological in nature, the essence of IPA aspires to understand and portray the experiences of individuals as they contend with, live and engage in given circumstances (Smith & Osborne, 2003).

Due to the COVID-19 pandemic, access to participants was through a designated online self-harm support group, where participants self-selected. The participants consisted of six females and two males, aged 22 to 33 with a mean age of 26.8 years, who had disclosed self-harm to their therapist. Table. 1 "*Participant Demographics*" below displays the population sample.

Procedures for Data Collection and Data Analysis

Participants were requested to complete a semi-structured questionnaire with closed and open-ended questions. SurveyMonkey

Table 1: *Participant Demographics*

Name	Gender	Age
Kelly	Female	23
Nina	Female	33
Diane	Female	29
Finch	Male	27
Phoenix	Female	30
Roxy	Female	28
Paul	Male	22
Ellie	Female	23

**Participants were invited to provide a pseudonym to protect their identity and adhere to research ethics.*

was used as a data-collecting tool. All respondents were provided with an information sheet and were required to sign a consent form.

Ethical Considerations

As you can see from the "Participant Demographics" table, confidentiality was adhered to. It was imperative that participants be protected from harm. Inevitably there was a risk factor in participating in this study. Due to the sensitive nature of the topic, participants who believed they were lacking in support, and/or processing deep emotional work were requested not to take part.

Findings and Discussion

The findings impart the respondents lived experiences of disclosing self-harm to their therapists. Key themes that arose are presented through the narrative of the participants, with their words displayed in italics. The analysis elicited the metaphor of a Jack-in-the-Box and the painting Fig 1. *Jack-in-the-box* (painting created by author) symbolises the secretive nature of NSSI and the unspoken complex emotions attached to self-harming behaviours. The hands represent the therapists holding capacity and the vulnerability of the client in this.

Imagine Jack, squashed down and hiding in inside the safety of his box. Jack knows he is going to reveal himself, but he can't see what awaits him. Jack is frightened, fearful and feeling alone. He is worried that in sharing his deep secret he will be made "feel like a monster" (Roxy). Jack wonders how he will express himself and if he has the words to match his emotions, which he struggles in deciphering. He is concerned how his therapist will react and is uncertain if they will understand. When Jack springs out and is seen, how will the therapist respond? Will the therapist's response frighten Jack back into hiding in his box, or will he feel safety in the holding of his therapist?

Figure 1: *Jack-in-the-Box*

A Reflection of Clients' Lived Experiences

The overarching themes that arose were; visibility and invisibility, power and disempowerment, and feelings prior, during and after disclosure. Each of these themes inter-linked to form sub-themes:

- the positive and negative consequences of being seen/unseen
- effects of the quality of the therapeutic relationship and responses
- the perceived lack of understanding of self-harm, by therapists
- the importance of a trusting safe space

"…it was my darkest secret" (Kelly)-Unseen

Consistent with previous research (Wester & McKibben, 2016; Abrams & Gordon, 2003), the findings depicted the secretive nature of self-harm, with participants expressing reluctance in disclosing and difficulty in verbalising their self-harm. Kelly had borne her "secret" for "a long time", conveying self-protection in building "walls around" her "determined nobody would knock through them". Nina experienced a profound "struggle with putting words" to her emotions and "didn't really understand" what triggered her self-injury. Diane felt ready to disclose however, she had to "write it down, as it was too difficult to verbalise". This indicates alexithymia might be part of some respondents' presentation. Considering trauma in childhood is typically common in individuals

with alexithymia, a trauma informed approach would be useful when working with this client base. Hence, longer term therapies, rather than solution focused therapies may be more effective.

Before disclosing, Finch told of his "fear" of being put "under lock and key" or "being put on medication". The therapist's reaction determined whether the participants continued hiding their NSSI, or alternatively whether they actively investigated healthier coping strategies, coupled with exploring the origins of their self-harming behaviours. Respondents indicated that a supportive environment, feeling "validated" (Phoenix) and "reassured" (Diane) by their therapist, encouraged exploration of various aspects of their NSSI. Kelly conveyed a sense of ease and being "comforted in the care" shown, where Ellie felt "safe to talk" about her self-harm when there was a sense of "trust" (Finch, Nina). Respondents reflected on how this deepened the therapeutic bond.

"For the first time I felt I wasn't alone." (Nina) -Seen

When respondents felt seen as a whole, they felt connected. Therapy was regarded most valuable when therapists recognised NSSI "doesn't define" the client (Kelly, Nina, Diane). Promoting client autonomy and a willingness to listen, suggests an approach to working with NSSI that is based on co-creating an effective therapeutic relationship, rather than techniques. To achieve this, practitioners need to appreciate the unique meaning the individual attributes to their NSSI, with Finch expressing "it's important for therapists to have a broad knowledge of the reasons a person may self-harm." When therapists journeyed alongside their client, this reinforced a sense of solidification and solidarity in the therapeutic relationship. Ellie felt "we were in this together" which helped her reduce her self-injurying. Long et al. (2016) suggest that therapists are more supportive when they are prepared to accept self-harm as a meaningful attempt to manage distress, rather than pathologise it as a psychological abnormality.

This research evidenced that barriers to disclosing were interpersonal, due to fear of the therapists' response, rather than an intrapsychic conflict

"…brushed under the carpet" (Roxy)

Respondents felt invisibility in visibility when their therapist response was unproductive. They revealed the complexities they experienced after disclosing NSSI, and how unconstructive responses stimulated further invisibility of their NSSI. Not being met, or adequately supported would lead clients to deny their reality. Kelly felt her therapist "just didn't get it" and Roxy would put "on a mask" and/or withdraw from therapy. A direct challenge from Kelly's therapist to stop self-harming, subjected her to feeling "ashamed and guilty" when she relapsed, preventing her in disclosing future incidents. Wester and McKibben (2016), propose that individuals engaging in NSSI to manage their stresses often turn to maladaptive coping tactics, namely self-reproach, substance abuse and denial. When clients feel shamed, they can internalise a skewed view of self-hatred, believing they are immoral or fundamentally flawed (Garisch et al., 2017). Therapists need to be attuned to and actively help in managing shame with this client base.

This research evidenced that barriers to disclosing were interpersonal, due to fear of the therapists' response, rather than an intrapsychic conflict. This research reflects the conclusions of previous research that social stigma was present (Lloyd et al., 2018). This theme relates to participants' perspectives on strategies to therapy, which emphasises cessation of self-harm. Additionally, when self-harm was minimised, respondents felt it was "brushed under the carpet" (Roxy), and they would regress into their secretive ways.

"…things didn't seem as daunting" (Nina)

In order to encourage the clients to own their own power, therapists should consider the needs of their clients rather than their own assumptions of what is favourable. Participants' felt that exploring the geneses of their behaviour was helpful in activating their own power, helping Nina in "figuring out what had caused" her "to begin hurting" herself. Nina felt able to tell her therapist when she relapsed as "he didn't ever tell" her to "just stop." Finch expressed the strength in the relationship with his therapist, whom he "trusted entirely," enabling Finch to take his own power, and consider "various strategies to stop" his "habits."

Considering trust in the therapeutic relationship, the focus typically rests on the client trusting the therapist. However, respondents highlighted the fact that reciprocal trust provided them with a sense of empowerment. Furthermore, Nina felt valued when her therapist regarded her as "a capable person" and not as someone who "needed to be fixed." As self-harm tends to be a repetitive act (Bennardi et al., 2016), therapists need to anticipate the possibility of relapse. Discussing this possibility with clients is important in the early stages of therapy.

"…too broken to be fixed" (Ellie)
Disempowerment
Evidence of disempowerment was displayed by Kelly's therapist asking her not to cut in-between sessions. When participants felt exposed unwillingly, they felt disempowered with Ellie adding she felt her therapist was not "equipped with the knowledge and training" needed to work with persons who self-harm. When respondents (Paul) felt a "shocked" reaction from therapists, they were left with a sense of no one understands. Roxy was left feeling "horrified" and "made out to be a monster," on top of not having the "choice" of self-disclosure. Paul also said that he felt "angry" that he "had to tell someone." It seems removing clients' choice and coercing a premature disclosure takes away their power. Ellie was referred to another therapist, leaving her feeling that she was "weird, too much of a problem and too broken to be fixed." This compounded Ellie's feelings of helplessness and ultimately "escalated the cutting."

"…you're not alone" (Diane)
Support
All respondents communicated the importance of hearing from their therapist that they were not alone. Most respondents expressed the need to consider what had led them to self-harming behaviours and wanted their therapist to help them "find the trigger" (Roxy). Participants said they would like therapists to say that self-harm does not define them; it is only part of who they are (Kelly, Diane & Nina). Respondents also felt the use of phenomenological questions was helpful.

"it's just for attention" (Diane)
Unsupportive Interventions
Throughout the participants responses there were consistent commonalities on what proved the most unhelpful. Roxy and Phoenix felt hearing self-harm was a "cry for help or doing it for attention" was unsupportive. It is also contradictory to the secretive nature of NSSI that respondents had expressed. Linking self-harm to suicidal tendencies was another unhelpful intervention. This would indicate the participants viewed self-harm and suicidal ideation as separate entities. This is important information for therapists to understand while working with and assessing clients who present with NSSI. While both are distinct in their intent, it is also essential that practitioners do assess how they may interrelate as there is an increased risk of unintentional suicide (Garisch et al., 2017), particularly where substance abuse is present.

Linking self-harm to suicidal tendencies was another unhelpful intervention

The Importance of the Therapeutic Relationship
There is little empirical evidence about treatment of NSSI however, studies (Levitt et al., 2006; McAndrew & Warne, 2014; Garisch et al., 2017) illustrate that clients place importance on the therapeutic qualities of the therapist. They suggest the relationship is a key factor in facilitating change which was evident in the present study. In line with previous studies (Long et al., 2016), most participants expressed the importance of making sense of their experiences with self-injury. Furthermore, Garisch et al. (2017) state that by validating your client's "experiences as understandable within the context of their experience" (p. 101), encourages the probability of disclosure and promotes self-acceptance.

This would suggest a humanistic approach would be more beneficial then the traditionally employed approaches of Cognitive Behavioural Therapy (CBT) and Behavioural Therapy (BT). Scholl, Ray and Brady-Amoon (2013) propose that a humanistic approach is deeply relational, with relational depth being a state of profound connection and contact, co-created between two people (Mearns & Cooper, 2005). The humanistic approach to therapy encapsulates the essence of the relationship being at the core of healing. I believe we are *fellow travellers* (Yalom, 2010) with our clients, and moreover including them in research, allows them to have their voices heard, thus empowering them and enlightening us as therapists.

Ultimately, this research shows the importance of hearing the voices of clients and listening to their lived experiences. This offers the prospective of a more enriched therapeutic experience. Based on the literature and the voices of the respondents in this research, Table 2: *"Hearing the Clients Voice"* is offered to provide guidance, derived directly from individuals engaging in NSSI, and offers some resources for therapists, health practitioners and others working in the field of mental health. Offered alongside are alternatives that may be helpful. Included in the table are the voices of respondents, and what they have expressed as being important to hear from therapists. Having this knowledge may assist us as therapists in building a supportive and and trusting relationship with our clients who struggle with their silent cry.

The Use of Safety Contracts
Evidenced in this study, there were negative consequences when clients were asked to refrain from self-injury. Washburn et al., (2012)

suggest that safety contracts or contracts agreeing not to engage in NSSI have no empirical support (Lewis, 2007; Garisch et al., 2017) and may be counterproductive, leaving the client feeling isolated and misunderstood. Garisch et al., (2017) suggest contracts are more likely to be used to ease practitioners' anxieties rather than generating therapeutic change. Special attention is advised with regards to introducing 'no harm contracts' with consideration given to what purpose it is serving, and whose needs are being met.

Table 2: *Hearing the Clients Voices*

What NOT to Say- The Clients Voice	Suggested Alternatives- The Therapists Voice	What Respondents' Felt would be Important to Hear
Will you not cut before we meet? (Nina)	What would it be like for you if you did self-injure before we met again? Do you imagine you could share that with me?	I don't expect you to just stop but I am concerned for your safety so what can we do to manage your cutting in a safe way? What do you think may help? (Kelly)
Why would you hurt yourself? (Kelly)	How is it for you to tell me you hurt yourself?	Thank you for telling me that, I'm proud of your honesty. (Finch)
Can I see your cuts? (Kelly)	Are you taking care of your cuts/burns? Opening a discussion around risk of sepsis	Do they need medical attention? (Ellie) If they ask to see your cuts maybe explain why, I thought she didn't believe me. It also felt too exposing. (Nina)
Do you feel ashamed? (Kelly)	I'm noticing... (Body language, facial expressions etc.) What's happening for you right now?	Your self-harm does not define you; you are still you. (Diane)
You know self-harm is linked to suicide? (Nina)	Do you ever have suicidal thoughts?	It's ok that it happened you had a bad moment and couldn't talk to anyone. (Paul)
Do you think it does any good? (Finch)	What is it like for you when you self-injure?	How can I help you? (Diane)
Why do you do it? (Paul)	Do you know what triggers your need to self-injure? Is it typically impulsive or compulsive?	How can I help ease that pain you are feeling? (Phoenix)
Do you enjoy it? (Finch)	When you self-injure, what need does it serve?	It is just your way of trying to cope (Ellie)
Why didn't you tell someone? (Nina)	Is this the first time you've spoken about it?	Thank you for being brave enough to tell me this and I will support you. (Nina) You don't need to be alone in this. (Kelly) I am here for you. (Kelly)

Limitations

As a Humanistic Integrative Therapist, I feel this research would have benefitted more with the use of interviews. As it was conducted online with the use of a questionnaire, there was no opportunity to probe for elaboration or clarification, which may have yielded more fruitful insights and a greater depth of understanding.

Conclusion

This research represents a preliminary step toward developing an in-depth understanding of clients' lived experiences in disclosing NSSI in therapy. The therapeutic relationship is a significant factor in fostering clients' autonomy and empowerment. Respondents perceived therapy to be helpful when therapists were prepared to work with underlying issues, exploring the geneses of their behaviours, rather than focusing on the cessation of self-harm. Practitioners need to look past the behaviour, connect with the client, and facilitate the necessary therapeutic requirements for cultivating a soothing reconnection with self, and others.

Cheryl Murphy

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Academic Article

A Simulated Interview with Carl Jung: Part 3 – General Views About Psychotherapy

By James C. Overholser, Ph.D., ABPP

Introduction

Throughout his career, Carl Jung remained active in both scholarly writing and the provision of psychotherapy sessions. Jung broke with Freud's style of therapy, and instead recommended face-to-face discussions. Jung also confronted important issues related to the therapeutic relationship and relying on an idiographic approach to therapy. Laced throughout his writings, Jung explained the value of treating each client as a unique individual, and the importance of an equal relationship between therapist and client.

Jung was the first to recommend that every psychotherapist should first receive their own psychoanalysis, in order to cleanse their psyche and better prepare them for managing the struggles of their clients. Finally, Jung's writings retain relevance for several current issues including evidence-based treatments, published therapy manuals, and psychotropic medications. Assorted issues about psychotherapy process and psychotherapy training are addressed using a simulated interview between Carl Gustav Jung (CGJ) and James C. Overholser (JCO).

JCO: Nice to see you again. Where should we get started?-

CGJ: "I hardly know what to say to you tonight. I have talked so much" (Jung in McGuire & Hull, 1977, p. 95).

JCO: Can we begin with your view that all psychotherapists should undergo their own analysis?

CGJ: "Yes, certainly" (Jung in Evans, 1964, p. 82). "Every doctor should submit to a training analysis before interesting himself in the unconscious of his patients" (Jung, 1954, p. 115). "Anybody who intends to practice psychotherapy should first submit to a training analysis" (Jung, 1954, p. 177).

JCO: Why is this training analysis so important?

CGJ: "Even analysts are not absolutely perfect, and it can happen that they are occasionally unconscious in certain respects. Therefore long ago I stipulated that analysts ought to be analyzed themselves" (Jung, 1968b, p. 157).

JCO: How does a training analysis help someone to become a better therapist?

CGJ: "Who can enlighten others if he is still in the dark about himself?" (Jung, 1954, p. 73). "It is something like a surgical operation on the psyche" (Jung, 1954, p. 62). "Surgery and obstetrics have long been aware that it is not enough simply to wash the patient - the doctor himself must have clean hands" (Jung, 1954, p. 18). "What the doctor fails to see in himself he either will not see at all, or will see grossly exaggerated, in his patient ... Just as one rightly expects the surgeon's hands to be free from infection, so one ought to insist with special emphasis that the

psychotherapist be prepared at all times to exercise adequate self-criticism" (Jung, 1954, p. 115).

JCO: Aside from their own analysis, how can we best train the next generation of therapists?

CGJ: "Experience, not books, is what leads to understanding" (Jung, 1968a, p. 483). "Neither our modern medical training nor academic psychology and philosophy can equip the doctor with the necessary education, or with the means, to deal effectively and understandingly with the often very urgent demands of his psychotherapeutic practice" (Jung, 1954, pp. 82-83). "The analyst must go on learning endlessly, and never forget that each new case brings new problems to light" (Jung, 1954, p. 116).

JCO: Most graduate programs today place a heavy reliance on coursework.

CGJ: "Yes, they are exceedingly didactic" (Jung, in Evans, 1964, p. 89). "Well, that's a very great problem" (Jung in McGuire & Hull, 1977, p. 267).

JCO: Graduate coursework provides strong training in psychological theories.

CGJ: "Theories are to be avoided, except as mere auxiliaries" (Jung, 1954, p. 88). "I say to the young psychotherapist: Learn the best, know the best - and then forget everything when you face the patient. Nobody becomes a good surgeon merely by learning the textbooks off by heart. The danger today is that the whole of reality is simply replaced by words. This will lead to a terrible lack of instinct" (Jung, 1960, p. 98). "Even the most experienced psychotherapist will ... come to realize that there are very many things indeed of which his academic knowledge never dreamed. Each new case that requires thorough treatment is pioneer work" (Jung, 1954, p. 178).

JCO: So, to be effective, the psychotherapist remains active in the field?

CGJ: "Oh, yes, most definitely" (Jung in McGuire & Hull, 1977, p. 206). "I have learned much from my own practice" (Jung, 1954, p. 255). "In my therapeutic practice of nearly thirty years, I have met with a fair number of failures which made a far deeper impression on me than my success ... The psychotherapist learns little of nothing from his successes ... but failures are priceless experiences because they not only open the way to a better truth but force us to modify our views and methods" (Jung, 1954, p. 38). "I always learn the most from difficult cases" (Jung, 1939, p. 1011).

JCO: But I have seen many novice therapists do a fine job. What's the danger?

CGJ: "The danger for the beginner is great, as he will be inclined to suggest or to give advice" (Jung, 1961, p. 200). "Advice may occasionally do some good, but advice is about as characteristic of modern psychotherapy as bandaging of modern surgery" (Jung, 1954, p. 21).

JCO: Why is a bit of advice so bad; the therapist is *the expert* in the room?

CGJ: "If I wish to treat another individual psychologically at all, I must for better or worse give up all pretensions to superior knowledge, all authority and desire to influence" (Jung, 1954, p. 5). "When one begins as a young doctor, one's head is still full of clinical pictures and diagnoses. In the course of the years .... one is struck by the enormous diversity of human individuals .... squeezed into the straightjacket of a diagnosis only by force" (Jung in Stein, 1982, p. 157). "Diagnosis is a highly irrelevant affair, ... nothing is gained by it" (Jung, 1954, p. 86). "Much too often people have a pathetic cock-sureness, which then leads them into nothing but foolishness. It is better to be uncertain because one thereby becomes more humble and more modest" (Jung in Jakobi, 1943, p. 379). "I do not know which is more difficult: to accumulate a wide knowledge or to renounce one's professional authority and anonymity" (Jung, 1954, p. 18).

JCO: Would you say your style of therapy is aligned with Freud's psychoanalysis?

CGJ: "Not at all" (Jung in Evans, 1964, p. 106). "I prefer to call my own approach 'analytical psychology'" (Jung, 1954, p. 53). "I reject the idea of putting the patient upon a sofa and sitting behind him. I put my patients in front of me and I talk to them as one natural human being to another" (Jung, 1968b, p. 155). "Analysis is a dialogue demanding two partners. Analyst and patient sit facing one another, eye to eye; the doctor has something to say, but so has the patient" (Jung, 1963, p. 134). "The relation between doctor and patient remains a personal one within the impersonal framework of professional treatment" (Jung, 1954, p. 71).

JCO: Do you think the Socratic method provides a useful exploratory framework for psychotherapy?

CGJ: "In more than one respect it may be compared with the Socratic method, though it must be said that analysis penetrates to far greater depths" (Jung, 1953, p. 24). "Any complicated treatment is an individual dialectical process, in which the doctor, as a person, participates just as much as the patient … particularly in regard to the 'rapport' or relationship of mutual confidence, on which the therapeutic success ultimately depends" (Jung, 1954, p. 116).

JCO: Some of my clients directly ask for my advice about what they should do.

CGJ: "I do not know what to say to the patient when he asks me 'What do you advise? What shall I do?" (Jung, 1954, p. 42). "Nothing is achieved by telling, persuading, admonishing, giving good advice" (Jung, 1958, p. 55). "Things are not quite so simple as that" (Jung, 1953, p. 27).

JCO: So, you prohibit all advice?

CGJ: "Of course not" (Jung in Evans, 1964, p. 104). "There are of course innumerable obstacles that can be overcome with good advice and a little moral support" (Jung, 1953, p. 159). "Good advice' is often a doubtful remedy, but generally not dangerous because it has so little effect" (Jung, 1954, p. 173 footnote 20). "The simplest cases are those who just want sound common sense and good advice. With luck they can be disposed of in a single consultation" (Jung, 1954, p. 19**).**

JCO: Instead of advice, you try to avoid directing the client?

CGJ: "Oh, yes; most definitely" (Jung in McGuire & Hull, 1977, p. 206). "I gave up hypnotic treatment … because I did not want to impose my will on others" (Jung, 1964b, p. 58).

JCO: Why is it a problem to direct the client?

CGJ: "The doctor should … avoid influencing the patient in the direction of his own philosophical, social, and political bent" (Jung, 1954, p. 26). "No one develops his personality because somebody tells him that it would be useful or advisable to do so" (Jung in Storr, 1983, p. 197).

JCO: If you avoid imposing your view, how do you help clients to change?

CGJ: "Psychoanalysis … is a catharsis of a special kind, something like the maieutics of Socrates, the 'art of the midwife'" (Jung, 1953, p. 260). "Just as a mother awaits her child with longing and yet brings it into the world only with effort and pain, so a new creative content, despite the willingness of the conscious mind, can remain for a long time in the unconscious" (Jung, 1969, p. 11 footnote 19).

JCO: This sounds like Socrates' metaphor of himself serving as something of a midwife to help deliver the ideas from another person's mind.

CGJ: "In general I can see that you are right" (Jung in McGuire, 1974, p. 25). "The analyst must observe carefully what the patient says … without attempting to force his own opinions upon the patient" (Jung, 1915a, p. 245). "We must renounce all preconceived opinions … and try to discover what things mean to the patient" (Jung, 1954, p. 157). "The psychotherapist will therefore take pains to ask questions about matters that seem to have nothing to do with the actual illness … the more he widely casts his net of questions the more likely he is to succeed in catching the complex nature of the case" (Jung, 1954, p. 85). "One has to be exceedingly careful not to impose one's own will and conviction on the patient. We have to give him a certain amount of freedom" (Jung, 1955, p. 131).

JCO: So, you view psychotherapy as a collaborative process?

CGJ: "Of course" (Jung, 1955, p. 84). "The therapist is no longer the agent of treatment but a fellow participant in a process of individual development … No longer is he the superior wise man, judge, and counsellor; he is a fellow participant who finds himself involved in the dialectical process just as deeply as the so-called patient" (Jung, 1954, p. 8).

JCO: What if a client makes mistakes and poor decisions?

CGJ: "We have to let the patient and his impulses take the lead, even if the path seems a wrong one. Error is just as important a condition of life's progress as truth" (Jung, 1961, p. 200). "The patient should reach his own view of things" (Jung, 1963, p. 138). "He discovers that his own unique personality has value, that he has been accepted for what he is, and that he has it in him to adapt himself to the demands of life" (Jung, 1954, p. 137).

JCO: And therapy is based on the supportive relationship between therapist and client?

CGJ: "Oh, yes; absolutely" (Jung, in McGuire & Hull, 1977, p. 259). "The greatest healing factor in psychotherapy is the doctor's personality" (Jung in Stein, 1982,

p. 49). "The touchstone of every analysis ... is always the person-to-person relationship" (Jung, 1954, p. 137). "The important thing is not the neurosis, but the man who has the neurosis" (Jung, 1954, p. 83).

JCO: Is it important for the therapist to avoid personal self-disclosures?

CGJ: "I don't think so" (Jung in McGuire & Hull, 1977, p. 425). "The relation between doctor and patient remains a personal one within the impersonal framework of professional treatment ... The personalities of doctor and patient are often infinitely more important for the outcome of the treatment than what the doctor says and thinks ... for two personalities to meet is like mixing two different chemical substances; if there is any combination at all, both are transformed ... the patient has a reciprocal influence on the doctor" (Jung, 1954, p. 71).

JCO: Do you agree with the value of providing unconditional acceptance to clients?

CGJ: "Yes, certainly" (Jung in Evans, 1964, p. 82). "We cannot change anything until we accept it ... If the doctor wishes to help a human being he must be able to accept him as he is" (Jung, 1970, p. 339).

JCO: It seems like your approach would take many sessions.

CGJ: "I content myself with a maximum of four consultations a week ... I then generally reduce them to one or two hours a week, for the patient must learn to go his own way" (Jung, 1954, p. 20).

JCO: Today most clients are only seen once a week for a few months.

CGJ: "This is a mistake" (Jung, in McGuire & Hull, 1977, p. 302). "Most neuroses are misdevelopments that have been built up over many years, and these cannot be remedied by a short and intensive process" (Jung, 1954, p. 24).

JCO: What are your thoughts on the current push for evidence-based practice?

CGJ: "In what way? The question is a bit vague" (Jung in McGuire & Hull, 1977, p. 263).

JCO: Let me try again. Does the scientific research support your treatment?

CGJ: "While science opened the door to enormous quantities of knowledge, it provided genuine insights very sparingly" (Jung, 1963, p. 99).

JCO: But research helps to document what works and what doesn't work.

CGJ: "There is no doubt that causalism and empiricism are prevailing powers in the scientific culture of today" (Jung, 1915b, p. 397). "I am an empiricist and adhere to the phenomenological standpoint. I trust that it does not collide with the principles of scientific empiricism if one occasionally makes certain reflections which go beyond a mere accumulation and classification of experience" (Jung, 1938, pp. 1-2). "Science is not, indeed, a perfect instrument ... Scientific method must serve; it errs when it supplies a throne" (Jung, 1962, p. 82).

JCO: Psychology research at most universities relies on college students as subjects.

CGJ: "The findings of laboratory psychology are, for all practical purposes, often so remarkably unenlightening and devoid of interest" (Jung, 1958, p. 35).

JCO: So, you feel that much of psychology research is junk?

CGJ: "You are right, but you should not say such things" (Jung, 1968b, p. 65).

JCO: But shouldn't we aim for an integration of research and clinical practice?

CGJ: "You are quite right" (Jung in McGuire, 1974, p. 170). "My time has always been divided. Either I dealt with patients, or I did research work" (Jung in McGuire & Hull, 1977, p. 166). "A psychology that satisfies the intellect alone can never be practical" (Jung, 1953, p. 117).

JCO: I know many academics who have published important studies from research conducted on college campuses.

CGJ: "My point of view is ... that of a practicing psychologist whose task it is to find the quickest road through the chaotic muddle of complicated psychic states. This view must be very different from that of the psychologist who can study an isolated psychic process at his leisure, in the quiet of his laboratory. The difference is roughly that between a surgeon and an histologist" (Jung, 1969, p. 140). "Academic psychology is scared of this risk and prefers to avoid complex situations by asking ever simpler questions" (Jung, in Storr, 1983, p. 372). "The experimental psychology of today ... tries to isolate the very simplest and most elementary processes which border on physiology, and studies them in

isolation ... Therefore anyone who wants to know the human psyche will learn next to nothing from experimental psychology" (Jung, 1953, p. 244).

JCO: But there have been many rigorous studies conducted on college students.

CGJ: "I must warn against all such frivolous undertakings ... It is really high time academic psychologists came down to earth and wanted to hear about the human psyche as it really is and not merely about laboratory experiments" (Jung, 1969, p. 279). "Psychology ceases to be a tranquil pursuit for the scientist in his laboratory and becomes an active part of the adventure of real life. Target practice on a shooting range is far from the battlefield; ... this is why no textbook can teach psychology; one learns only by actual experience" (Jung, 1964b, p. 91).

JCO: Today, there is a heavy emphasis on the structure provided by published treatment manuals.

CGJ: "Is it becoming a problem today?" (Jung, 1940, p. 62).

JCO: Well, it has become common practice.

CGJ: "Therapy is different in every case.... I treat every patient as individually as possible" (Jung, 1963, p. 130). "Each patient is a new problem for the doctor, and he will only be cured of his neurosis if you help him to find his individual way to the solution of his conflicts" (Jung, 1968b, p. 204). "I learned to adapt my methods to the needs of the individual patient, rather than to commit myself to general theoretical considerations ... 60 years of practical experience has taught me to consider each case as a new one" (Jung, 1964b, pp. 65-66). "I may allow myself only one criterion for the result of my labours: Does it work?" (Jung, 1954, p. 43).

JCO: But don't you rely on general principles to guide your therapy?

CGJ: "On no, not at all" (Jung in McGuire & Hull, 1977, p. 426). "The patient is there to be treated and not to verify a theory" (Jung, 1954, p. 115). "In practical psychology there are no universally valid recipes and rules. There are only individual cases with the most heterogeneous needs and demands" (Jung, 1954, p. 71). "The deeper his understanding penetrates, the more the general principles lose their meaning" (Jung, 1958, p. 36). "Psychology does not consist of medical rules of thumb" (Jung, 1939, p. 1011). "In psychotherapy it seems to me positively advisable for the doctor not to have too fixed an aim ... The shoe that fits one person pinches another" (Jung, 1954, p. 41).

JCO: Do you believe that treatment requires a change of attitude?

CGJ: "Yes, you can put it like that" (Jung, 1955, p. 28). "When you think in a certain way you may feel considerably better" (Jung in McGuire & Hull, 1977, p. 438). "We know well enough that an imaginary pain is often far more painful than a so-called real one" (Jung, 1964a, p. 15). "If a neurosis should have no other cause at all than imagination, it would none the less, be a very real thing" (Jung, 1938, p. 11).

JCO: So, neurosis derives from a person's imagination and attitudes?

CGJ: "A neurosis or any other mental conflict depends far more upon the personal attitude of the patient, than upon his infantile history. No matter what the influences are that disturbed your youth, you have to put up with them and you do it by means of a certain attitude. It is the attitude that is of decisive importance" (Jung, 1930, p. 350). "There is hardly any neurotic case that does not like to dwell upon the evils of the past and to wallow in self-commiserating memories" (Jung, 1930, p. 350). "There are no insoluble problems ... Through this widening of his view the insoluble problem lost its urgency ... What, on a lower level, had led to the wildest conflicts and to panicky outbursts of emotion, viewed from the higher level of personality, now seemed like a storm in the valley seen from a high mountain-top" (Jung, 1962, p. 91). "It is not that something different is seen, but that one sees differently" (Jung, 1964a, p. 17). "Riches never brought supreme happiness to anybody, nor is poverty a reason for melancholia" (Jung, 1954, p. 18).

JCO: These ideas seem aligned with Cognitive Therapy.

CGJ: "I do not understand" (Jung in Storr, 1983, p. 174).

JCO: Sorry. These ideas sound like most emotional problems derive from bad attitudes.

CGJ: "That is true" (Jung, 1955, p. 48). "Neurosis is made every day by the wrong attitude the individual has, but that wrong attitude is a historical fact and needs to be explained historically by things that have happened in the past ... The wrong attitude can have originated ... long ago, but it wouldn't exist today any more if there were not immediate causes and immediate purposes to keep it alive" (Jung in McGuire & Hull, 1977, p. 317). "There are, indeed, not a few

people who are well aware that they possess a sort of inner critic or judge who immediately comments on everything they say or do?" (Jung, 1969, p. 83).

JCO: As a psychotherapist with medical training, what do you think about biological factors and the importance of brain functions?

CGJ: "This is a profound and very ticklish question" (Jung in McGuire & Hull, 1977, p. 108). "The connection with the brain does not in itself prove that the psyche is an epiphenomenon, a secondary function causally dependent on biochemical processes ... The structure and physiology of the brain furnish no explanation of the psychic process. The psyche has a peculiar nature which cannot be reduced to anything else" (Jung, 1958, pp. 32-33). "Free psychology ... from the prejudice that the psyche is ... a mere epiphenomenon of a biochemical process in the brain" (Jung in Storr, 1983, p. 370). "The treatment of neurosis ... goes far beyond purely medical considerations ... medical knowledge alone cannot hope to do justice" (Jung in Storr, 1983, p. 255).

JCO: But many researchers today focus on biological factors in mental illness.

CGJ: "The distinction between mind and body is an artificial dichotomy" (Jung, 1933, p. 85). "This overrating of the somatic factor in psychiatry is one of the basic reasons why psychopathology has made no advances ... The dogma that 'mental diseases are diseases of the brain" is a hangover from the materialism of the 1870's" (Jung, 1969, p. 279). "We cannot allow a psychology based on biology simply to cut the throat of a psychology of the ego" (Jung in Meier, 2001, p. 189). "Unfortunately, my time doesn't allow me to go here into more details" (Jung, 1915b, p. 397).

JCO: But psychotropic medications have become a huge business today.

CGJ: "This is not surprising" (Jung, 1958, p. 45). "Modern psychotherapy ... assumes somewhat the humble role of individual charity work versus the big organizations and institutions" (Jung, 1930, p. 348). "The real causes of neuroses are psychological" (Jung, 1938, p. 10).

JCO: I see our time is up. Thank you for your time, and the useful ideas you have shared throughout your career.

CGJ: "Many thanks for your ever wonderfully stimulating conversation" (Jung in Meier, 2001, p. 83). "I hope I have managed to make myself clear" (Jung in Meier, 2001, p. 63).

Jim Overholser

Jim Overholser is a professor of psychology at Case Western Reserve University, Cleveland, Ohio, and is a licensed clinical psychologist who provides outpatient psychotherapy through a local charity clinic. Dr. Overholser conducts research on depression and suicide risk through a local VA Medical Centre and the County Medical Examiner's Office.

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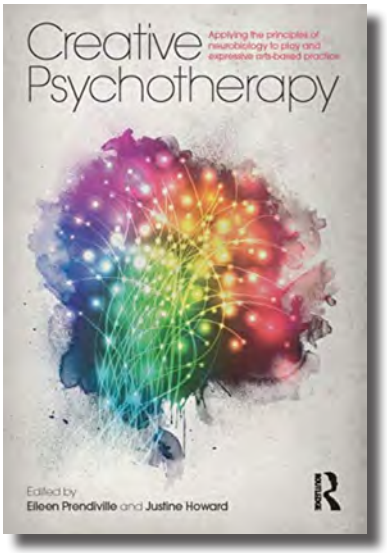
Book Review

Title:	*Creative Psychotherapy: Applying the Principles of Neurobiology to Play and Expressive Arts-Based Practice (1st ed.)*
Authors:	*Eileen Prendiville & Justine Howard*
Published:	*2016, Routledge*
ISBN:	*ISBN-13: 978-1138900929*
Price:	*£29.99*
Reviewed by:	*Fina Wurm*

Imagine working with a selectively mute teenage client for over 30 weeks. How would you approach these sessions and what would you do to engage the client in the healing process? Having read Creative Psychotherapy, edited by Eileen Prendiville and Justine Howard, I have gained valuable ideas as to how I could approach this scenario, especially, as this client is but one of the many vignettes included in the book.



This text provides a theoretical rationale for the implementation of creative interventions at a neurodevelopmentally appropriate level across the lifespan for those who have suffered trauma. Topics discussed include neurobiology and creative interventions, namely rhythm, movement, play, sand tray, narrative and art. Each chapter is penned by a specialist in that field and includes three vignettes, a summary of key points and a list of references.

There is an emphasis on play therapy throughout the book, which I found interesting having already studied music and art therapy. However, for those without any creative training, it is worth noting this prevailing paradigm so the reader can make an informed decision on the relevance of the text for them, based on what modality they wish to learn the most about.

The text highlights the opportunities creative interventions can offer to those who have suffered trauma with reference to neurosequential development as informed by the Neurosequential Model of Therapeutics (NMT), an approach to working with traumatised children based on neurodevelopmentally-informed principles (Perry, 2009).

The variety of techniques used in NMT-informed therapy, for clients of vastly varying demographics, highlights the flexibility and versatility of NMT. However, it also highlights the lack of standardisation and clearly defined treatment protocol in NMT.

Throughout the text, I noted the scarcity of critique of NMT, and the fervent support of the approach by all the authors. For an approach that was first introduced twenty years ago, it is truly surprising that there is a lack of evidence to support its use, with only two empirical studies to date showing inconclusive results regarding its efficacy (Barfield et al., 2012a; Barfield et al., 2012b). While NMT is challenging to research given that it is an approach rather than a specific treatment, it is far from impossible to do. I concur with Dr. Catherine Caplis (2014) as she states, "it is important to determine if NMT is a valid and useful mode of treatment for traumatized children, comparable to, or more effective than, others on the The National Child Traumatic Stress Network (NCTSN) list" (p. 102). Acknowledgment by the authors of NMT's deficits would have strengthened their theoretical rationale and I encourage readers to take a critical stance to NMT until supporting evidence matches its current popularity.

Additionally, I noted that conclusions drawn by the authors regarding the efficacy of creative interventions for children were made with little critique of the information they reference. This is worth noting, as in a meta-analysis of 56 studies examining creative interventions for traumatised children, authors Van Westrhenen and Fritz (2014) conclude that data from these studies are not sufficiently "convincing to falsify any theoretical claims" due to methodological weaknesses (p. 7). In my opinion, the authors argument that the arts are effective in psychotherapy for traumatised children would have been stronger had they noted the need for future research of a higher standard to support their ideas.

The theoretical rationale for the use of creative interventions in psychotherapy discussed in this book is thought-provoking and many of the vignettes have stayed with me long after reading the book. Critical evaluation would have improved the text in my opinion, nevertheless, the text has merit and I would recommend it to anyone with an interest in the application of the arts in psychotherapy.

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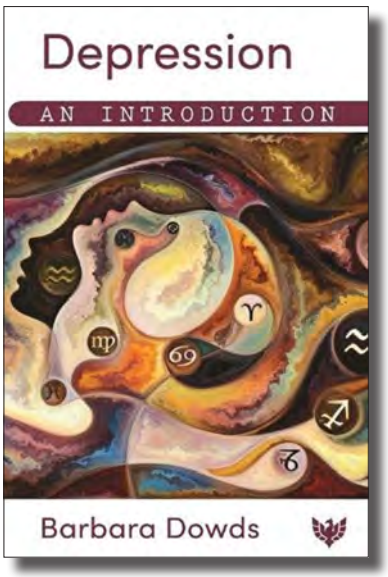
Book Review

Title:	*Depression AN INTRODUCTION*
Author:	*Barbara Dowds*
Published:	*2021, Phoenix Publishing House Ltd*
ISBN:	*ISBN-13: 978-1912691791*
Price:	*€18.23*
Reviewed by:	*Pauline Macey, MIACP*

This timely book is not just a convincing and comprehensively positive answer to the author's own question in the preface, as to whether we need another book on depression; it is a creative synthesis of extensive up-to-date thinking and research on the complexity of this subject. It flows easily and seamlessly between the worlds of science and psychotherapy; continuously reminding us of how they influence each other and particularly how recent developments and research in neuroscience, the ANS and the Polyvagal system have made a crucial contribution to both the theory and practice of psychotherapy. They are also presenting us with essential knowledge and newly evolved perspectives on both the different causes and presentation of depression, and on its many different symptoms and frequently accompanying disorders. Dowds' own familiarity with the world of science is rooted in her background as a lecturer in molecular biology (before developing a career as an author, psychotherapist, supervisor and lecturer in psychotherapy). Roz Carroll expresses in the forward, that the real achievement of this book "is to bring so much knowledge into a clear discussion without over-simplifying the issues". It also builds on and integrates many of the themes and concepts which form the content of her previous publications.



Written in an immediate and deeply engaging style, in eight relatively short, richly informative chapters; each page contains the seeds of numerous ideas that are analyzed in depth, while at the same time given space to germinate, blossom and integrate with related concepts as the book unfolds.

The early chapters focus on the different facets of depression, its' roots and origins (frequently in adverse childhood experiences and insecure Attachment). While understood as a single malady up to recently, it is now evident that it has "multiple aetiologies"(p xiii) or diverse causes. These include; trauma, abuse, stress, loss, social exclusion, infection, stroke, inflammation and genetic predisposition. The focus on depression as an immediate and common experience that is on the increase (while being hard to work with), marks this book out as essential reading not just for therapists and trainees, but for anyone interested in deepening and expanding their knowledge and awareness of the impact of depression, its evolution and manifestation within the context of contemporary society.

The concept of a biopsychosocial model acts as a consistent backdrop that supports the interweaving of key elements of depression; including genetic predisposition, insecure attachment, adverse childhood experiences and the impact of the social setting in which these take place and interact with each other. It also sets the stage for the idea of a two-stage trajectory, where the later development of depression in adolescence and adulthood is frequently triggered by "stress, bereavement, loss of agency (helplessness) or abandonment", often mirroring earlier wounds (p 4).

Structured in two parts; the first part (chapters one to four) explores the incidence, causes and consequences of depression and the second part (chapters five to eight) focuses on psychotherapy: mobilization and meaning. This two-fold structure, allows the author to simultaneously explore key themes in rigorous detail (particularly in the first half) and then to further develop and interweave these themes and aspects throughout the book – particularly in the second half.

The key points in the second half of the book concern the particular difficulties and challenges specific to working with depression in therapy. One of these is helping the client understand that the depression often has a meaning that can be uncovered – the material of chapter five. The other is that depression isn't just low mood; it is stuck mood. This is associated with rigid beliefs that must be challenged, (chapter six) for example by using 'parts work', body work or integrating experiential creative modalities to suit particular client issues. The final chapters illustrate the working practice of many of the ideas introduced in the earlier part of the book, with a range of carefully chosen case material and clinical studies, generously shared from the author's own practice.

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