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# PSYCHOTHERAPY & COUNSELLING TODAY

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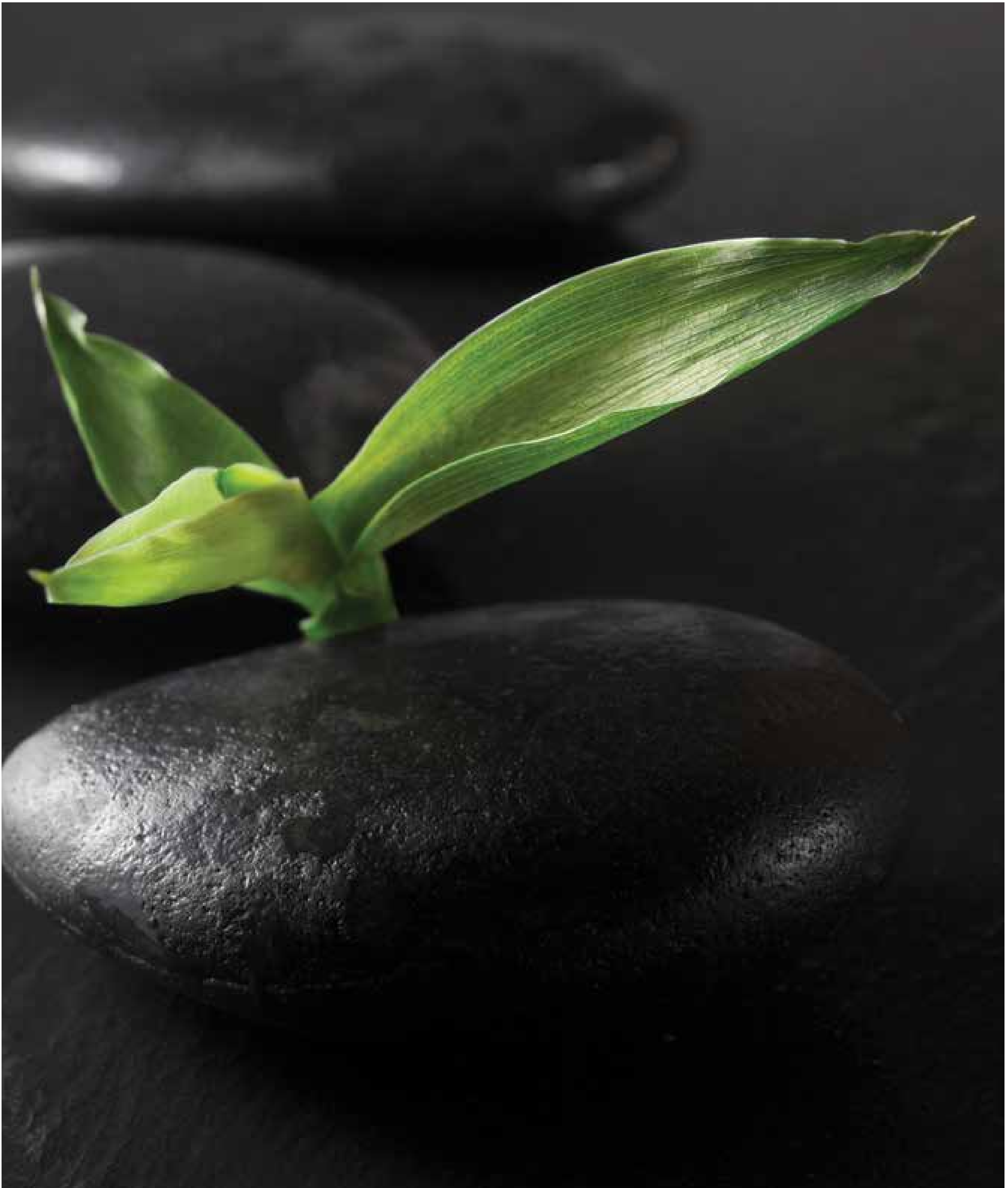

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Dr Paul Gibney is a psychotherapist, a family therapist, organisational consultant and a psychotherapy theorist. Since 1988, Paul has conducted a full-time private practice in psychotherapy, couples therapy, family therapy and professional supervision.

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*"Just brilliant, thank you! It's wonderful to listen to an approach to therapeutic practice, rather than strategies for specific presentations." Kath K.*

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# FROM THE PRESIDENT

DR DI STOW
President

In the last six months I have spoken to hundreds of PACFA members and stakeholders. It has been an interesting and challenging time, happening as parts of Australia simultaneously implemented lockdowns which restricted movement for public safety and impacted on community mental health. The twin messages of these conversations have been clear: Australians need help and PACFA members are ready to do so.

Yet demand for counsellors and psychotherapists has not been at a level expected in the 'greatest mental health challenge to face Australia'. For passionate counsellors and psychotherapists with high level qualifications and substantial expertise this is disappointing and demoralising. I feel for our members and their confusion when faced with daily media coverage of demand for psychologists.

It is difficult to reconcile these pieces of disparate information but we must. There is no point to rehashing the how and whys. Instead, we must go forward and demonstrate in the clearest possible way why counsellors and psychotherapists are an essential part of any efforts to support the mental health of the Australian community.

Respondents to our 2020 workforce study (published in PACJA) reported that:

- 33% are located outside metropolitan capital cities making them an essential tool in any efforts to support rural, regional and remote communities which have specific and substantial mental health struggles.
- 27% reported working with young people who face particular challenges in the current Covid-affected environment.
- 67% have postgraduate qualifications and specialised training in areas ranging from grief and loss to addressing trauma.
- 54% work part-time and 27% would like to have increased hours of clinical work.

This last point is in an important one. Australia's healthcare sector has not been immune to the structural shift to a casualised workforce. Counsellors now commonly operate as independent contractors across a range of employers as well as private practice. Whilst societally efficient this is a stressful way to manage generating income and leaves individuals to pay the price of flexibility. Just like other parts of the Australian workforce, our members deserve sustainable and fair payment for their skills and expertise.

Fortunately, the growing interest and awareness of the needs of people with mental health issues does provide a range of opportunities for our membership although these may look different from the past. The National Disability Insurance Scheme assists hundreds of thousands of

Australians with a wide range of support needs which can be provided within the scope of practice of counsellors.

Workcover in Queensland, New South Wales (and soon Victoria) now fund counselling to support recovery. Primary Health Networks are increasingly aware of the need to utilise a wider workforce than they have traditionally. Private health insurers continue to slowly add counselling to their rebated services.

Many of these roles involve working as part of a multi-disciplinary team with doctors, psychologists, and other allied health professionals. PACFA members are well placed for these responsibilities due to our rigorous membership requirements. PACFA members must have a relevant undergraduate or postgraduate qualification and substantial hours of experience to become a Certified Practising Counsellor, Registered Clinical Counsellor or Registered Clinical Psychotherapist. Our clarity around these requirements is highly regarded by our stakeholders who can have confidence in the skills of our workforce.

Crucially PACFA does not accredit diploma courses, courses provided 100% online, or courses of less than 18 months because these courses cannot provide the consistently high standards of workforce that the Australian community deserves, and the variability of these courses damages the good name of the counselling workforce.

Professional advocacy is never easy. Many professions find the government disinterested and unresponsive despite their best efforts. I believe that, like most people, the government does its best to grapple with complex matters and vested interests. Changing thoughts, and behaviour, is never easy.

This is a complex time, and who better to address its complexity than people who are well trained in the depth and breadth of the human condition.

## Make the most of your PACFA membership in 2022

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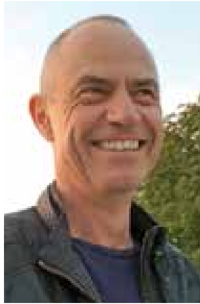
- Take advantage of our weekly jobs email
- Access affordable insurance cover with free advice through Insurance House.

* Individual eligibility criteria apply.

**Thank you for supporting your fellow members. For more information see your monthly enewsletter or go to pacfa.org.au**

# THE LOSS OF A MENTOR

STEPHEN ANDREW
Editor



The loss of a mentor is often accompanied by a particular type of grief. This loss can carry a pain that can cause one to feel disoriented in the world, cowered perhaps, by challenges that were previously embraced, and can leave one bruised by an anxious uncertainty about the future. When Professor Bernie Neville died earlier this year, I felt all of these things.

Bernie was a central player in the education of psychotherapists in Australia. He was instrumental in setting up the Bachelor of Education (Counselling) at La Trobe University, which for many years was considered to be Australia's preeminent, humanistically-focussed psychology degree. The spirit and pedagogy of this course later became the core of La Trobe's much-loved Masters of Counselling, one of the first professional psychotherapy training courses in Australia.

These were determinedly pluralistic programs which sought to educate as much as train, encouraging creativity, critical thinking, and the application of a practical, holistic, experiential learning model. As a teacher, Bernie embodied the qualities of these courses. I had the privilege to experience both these programs, firstly as a student and later as an academic.

I also had the honour to get to know and work with Bernie. He was a progressive thinker as well as an old school academic. He read, he thought, he pondered, discussed, argued, inquired, imagined, formulated and wrote. He had little time for what are now sometimes considered the markers of 'quality' education.

He lectured without notes, PowerPoints or lesson plans. He wasn't interested in KPIs. Bernie emanated a slightly dishevelled wisdom. He really knew his stuff and absolutely loved what he taught, and this, more than anything else, captivated and inspired his students.

Raymond Gaita's description of his German teacher could have been said about Bernie:

> As a human being he wanted, and as a teacher felt obliged, to share what he loved with his students, hoping that they would find it worthy of their love and that it would nourish in them a love of the world, as it had in him. (Gaita, 2012, p. 764)

In an ever-changing, sometimes unsteady world, a mentor offers deep stability. At times, I would turn directly to Bernie with a problem or a question. Sometimes he'd give me a direct, no-nonsense reply. Often, though, in true Rogerian fashion, he'd respond with a curious question, trusting that I, as the inquirer, already knew my own answer. This meant that I'd often use Bernie's mentorship *in absentia*, without asking him anything directly, simply imagining his response.

When I supervise counsellors, or speak with clients about work-related matters, I am struck repeatedly by the absence of mentors in their lives. Mentors are like map makers who offer direction that is sometimes comforting, sometimes challenging. These are the wise voices who can see beyond the

Photo: Marian Kroell

presenting concern and situate the issue in a broader, systemic frame. They can hold and dispense the human gold that is wisdom.

The fast-paced fluidity of modern work life leaves little time for reflection or long-term planning. Work colleagues arrive, stay awhile and then move on quickly, taking whatever workplace history and knowledge they have gleaned with them. This comes with the cost of the regular reinventing of the wheels of the work place. Our corporate addiction to restructuring is a symptom of this organisational disorientation. This absence of elders, of an occupational lineage, is linked to an increased level of 'accountability', a disconnection from mission, and a loss of long-term purpose. All this can lead to increased anxiety and an ironic fall in productivity. Mentors fly a bit higher than the rest of us enabling them, in a very real sense, to see into the future. With Bernie's passing, I lament our general lack of interest in what good mentorship can offer.

While Bernie Neville is gone, his writings remain. In this edition of *Psychotherapy & Counselling Today,* we lead off with an extract from his book *The Life of Things: Therapy & the Soul of the World* (Neville, 2013). This book weaves together Bernie's deep knowledge of therapists like Rogers and Jung, and philosophers like Whitehead and Gebser, with topics like psychotherapy, the Greek gods and ecopsychology.

Bernie loved a question. They were his fields of play and a place for imagination to flourish. Here are three questions that meant a lot to him: Is learning simply a manifestation of what is there already, or can it be truly creative? (Neville, 2005, p. 31). What is your relationship with nature? What would psychology look like if we took the planet seriously?

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# IMAGINING THERAPY

Here is an excerpt from Bernie Neville's book, *The Life of Things: Therapy and the Soul of the World*. We are publishing this, the opening chapter, in two parts across this and the next edition of *Psychotherapy & Counselling Today.*

Bernie Neville

Photo: Sergio Capuzzimati

Alfred North Whitehead argued that: "Every philosophy is tinged with the colouring of some secret imaginative background, which never emerges explicitly into its train of reasoning" (Whitehead, 1927, p. 7). We can say much the same about counselling theory and practice. Though the theory may be set out in persuasively rational terms, it is the imaginative background which gives it its resonance. We can see the image of the machine behind cognitive behavioural therapy and the hydraulics of psychoanalysis. We can detect the Hero's journey in narrative therapy and the scientific experimentation with life in personal construct therapy. We find Carl Jung caught between an academically credible, mechanistic image of energy exchange and his unfashionable sense of an ensouled universe. In Reichian and many other body therapies we find not a machine-like individual in a machine-like universe, but an organism subsisting on the life-energy of the universe.

In the following discussion of Carl Rogers and client-centred therapy, my interest is in a particular kind of complexity I find in his ideas. I do not find in Rogers a single 'secret imaginative background' shaping a rationally coherent theory. There are paradoxes and contradictions inherent in the person-centred approach, paradoxes and contradictions that I believe should be acknowledged rather than explained away.

Jung's notion of archetype provides a framework for my reflections. The notion of archetype is central to Jung's psychology, and archetypal psychology has become a useful tool for cultural analysis as well as an approach to individual therapy. Jung was intrigued by the recurring patterns he found in his clients' behaviour and imaginings, patterns which could not readily be understood in terms of learning. He found collective behaviour to be patterned in similar ways. Those of us who take Jung seriously would argue that the concept of archetype is one of the most important ideas to have emerged in the twentieth century, an idea with enormous implications for the way we think about ourselves.

In his writing, Jung swings through a number of variations on the notion of archetype. He sometimes wrote as though archetypes are pre-existent, as though they are eternally there, outside of our time and space, existing independently of our consciousness, manifesting themselves in various ways in individual behaviour and human history. At times he was careful to point out the distinction between the archetypes as such and the archetypal images through which we become aware of them. At times he seemed most interested in their physical manifestation, in instinct or pathology. At times he described them as our archaic heritage – a "living system of reactions and aptitudes that determine the individual's life in invisible ways" (Jung, 1979, CW 8, para. 339). He argued that "they can only be explained by assuming them to be deposits of the constantly repeated experiences of humanity" (Jung, 1979, CW 7, para. 109). At other times he emphasized that they were not inherited habits, or even inherited ideas, but inherited *possibilities* of ideas and behaviour. All our ways of perceiving, thinking, feeling, valuing and behaving are shaped by particular possibilities. Our ancestors saw these patterns as representing primal energies, which they personified as gods.

More recently, archetypal psychologists like Michael Conforti have argued that it makes most sense to think of archetypes as fields which predate the existence of matter, and out of which matter and form emerge. Others, like Anthony Stevens and John Haule, suggest that the archetypal patterns in human behaviour are the result of evolutionary adaptation, noting that Jung himself had moments of Darwinian insight:

> This whole psychic organism… preserves elements that connect it with the invertebrates and ultimately with the protozoa. Theoretically, it should be possible to 'peel' the collective unconscious, layer by layer, until we come to the psychology of the worm, and even of the amoeba. (Jung, 1979, CW 8, para. 322)

If we see these two ideas as contradictory it may say less about the nature of archetype than it does about the nature of our thinking. What is important here is the notion that the universe we live in is patterned in specific ways, and that these patterns can be detected even in apparently trivial aspects of human experience.

James Hillman, the central contemporary figure in the school of thought known as archetypal psychology, does not make Jung's distinction between the archetype per se and the archetypal image, nor his distinction between the personal and collective aspects of the unconscious, so that for him every image is an archetypal image, and these archetypal images structure all our experience and behaviour. For Hillman, the proper work of psychology is *seeing through* our personal and collective experience to the archetypal images which shape them.

Hillman's argument takes him inevitably into a multi-perspectivist understanding of reality. As a framework for his multi-perspectivism he takes the gods of the Greco-Roman pantheon. Each of the

gods personifies a 'mode of apprehension' (Jung's term), which gives distinct and observable shape to our encounter with the world. This is distinct but not discrete, for the archetypal patterns interpenetrate in ways which are represented by the relationships (familial and erotic) between the gods. The Greek pantheon is chosen because its images are embedded in European culture – even in the culture of positivist science. Hillman (1975) suggests that if we want to understand ourselves we should see through our behaviour all the way to the god image and the god-story in which it is embedded. And we need to experience these god stories the way our ancestors did, not just as interesting stories which we hear and remember and tell to our children, but as grand narratives within which we live our lives.

Jean Gebser argued that we will find five distinct 'structures of consciousness' manifested in culture. First, there is the basic 'archaic' structure which experiences the world with little or no awareness. Second, there is the 'magic consciousness' which emerged with the first humans and experiences a world of 'vegetative entwinement' in which everything is connected. Third, there is the 'mythical structure' through which we live our lives embedded in particular tribal narratives which give them meaning. Fourth, we have a 'mental' consciousness which enables us to think, objectively and rationally, as individuals. Finally, the 'integral' structure of consciousness – a structure which integrates all the others – enables us to experience the universe transparently. Archetypes shape our experience through all of these structures: in our body; through health and disease; in our instincts; in our behaviour; in our emotions; in our values; in our ideas.

If we accept the notion that all human behaviour is archetypally constellated, we might expect to be able to *see through* any philosophical system or political ideology to the images that give it its form. This should apply no less to the theories and methodologies of psychotherapy than to the grand narratives of our culture. Each therapy will be a manifestation of a mode of apprehension, a value system, a form of energy, a notion of truth and a vision of the good life which can be personified in a god – or in more than one god. In a world where truth has been increasingly relativized, counselling theory and technique is less likely than before to be constrained to a single perspective on what it means to be human, and may hold various perspectives and values in creative tension.

Jung brought us the notion of 'inflation', a condition in which the individual is taken over by a complex, or a nation or culture is taken over by a particular archetypal energy. We may find inflations of all kinds in our professions, and in the personalities of those who profess them. Taking the lead from Hillman, we can attempt to see through the theory and practice of therapy, and find the energy and perspectives of the Greco-Roman deities. When we look at therapists and the professional sub-culture within which they exercise their skills we may find both the wisdom which comes with embracing the perspective of a particular god, and the pathology which comes with excessive worship – when the therapist is inflated by the energy of one god at the expense of all the others.

The Greek pantheon provides us with a language for talking about a wide range of distinct philosophies, value systems, energies, feeling states, habits of behaviour and communication styles as they can be observed in the counselling profession and the counsellor–client interaction. It is a language which is not dominated by a single philosophy or theory but welcomes contradictory perspectives. The gods are many, and if we follow the advice of the ancient Greeks we will be careful not to neglect any of them – and not to get too carried away in worshipping any single one of them.

## Many gods, many therapies

The first of the Greek gods is Zeus. Zeus is the father of the gods, the patriarchy personified, generally benevolent but ready to punish if annoyed. He is sometimes grouped with the older, pre-Olympian gods – Uranus, Kronos, Saturn – as the Senex, the old man, the image both of autocratic power and of ancient and unchanging wisdom. He is the image of transcendent divinity which we have inherited from the three great religious traditions of the ancient Middle East.

When the Senex is supreme in a society, therapy as we understand it has no place. Political or religious authority tells people how to live and that is the end of it. Where patriarchal power is breaking down, the Senex counsellor may take the client, as Freud did, from a state of hysterical desperation to the state of 'ordinary unhappiness' that comes with adjustment to the strictures of society. It has been argued that, regardless of the intentions or ideology of the therapist, the political function of therapy is to soften dissent and to divert challenge to an oppressive political system. There are plenty of Senex counsellors still around, even in a society where patriarchal power is no longer assumed to rule by absolute right. They have unambiguous notions of right and wrong, and their mode of counselling is to advise their clients how they should live. There are many clients who seek only this from their counsellors.

Zeus–Senex is not actually the first and oldest of the gods who inhabited the Greek peninsula. When the Hellenic tribes (known to us as the Greeks) first arrived there in the second millennium BCE they found that the indigenous inhabitants worshipped the Earth as the Great Mother who gave them life (without the assistance of any male gods) and took them back into herself when their time was up. She had a lot of different, local names, as though there were multiple mother-goddesses. The Greeks incorporated her into their religious system in a number of ways. The identified all the local goddesses with Zeus' consort and Queen Hera (a name which simply means 'lady'). They invented stories about Zeus seducing or marrying the local goddesses and having children by them. They made Gaia (the Earth) the grandmother of Zeus and his five siblings. Gaia holds a place in the classical Greek religious system rather as an impersonal force than as a superhuman being with a personality of her own like the Olympian gods. She is, however, personified in her different aspects in the different female gods of the pantheon. Demeter, Athena, Aphrodite, Artemis and Hera are different, and limited, manifestations of the Great Mother, as are various nymphs, Titans and mythical mortals.

Hera, queen of the Olympian gods, is the archetypal image of marriage, family, social bonds and social roles. Her authority supports that of Zeus. A therapy grounded in such values will be socially conservative, based on notions of social rights, obligations and duties, and the maintenance of proper roles. Hera has no problem with giving advice, and her advice is likely to focus on the need to adjust to society's demands. Systems approaches to therapy come out of a Hera perspective, and it is no coincidence that they provide family therapy with its orthodoxy.

Demeter is the mother. A therapy which functions by providing the kind of support and nourishment which encourages growth in the client belongs to Demeter. So does the therapy which controls by giving and withdrawing affection, and the therapy which develops emotional dependence.

Apollo is the god of clarity, reason and understanding. He has been powerfully present in some therapies, notably psychoanalysis, logotherapy and cognitive therapy, which are shaped in different ways by the notion that human beings have a basic urge to understand, to find meaning, and that change in behaviour tends to follow more or less inevitably on the insights gained through therapy. It should be noted that Apollo is notoriously inept in his relationships.

Artemis is the goddess of the moon, sisterhood, and untouched nature. She is most obviously present in radical feminist therapies, for she has no interest in giving men power or pleasure. She cares for the new-born and fragile, and sees the good life as one lived in harmony with nature and its rhythms. Like Demeter she is a manifestation of the original Great Mother, Gaia. She is the personification of wild nature, in contrast to Demeter, who personifies the nurturing earth. By contrast, Athena is the goddess who accommodates the feminine to the patriarchal world. She is the warrior goddess, the goddess of common sense, the goddess of expertise and professionalism, of civilization, of normality. She is, significantly, goddess of democracy. We find her in therapies based on the sharing of power between therapist and client, and in therapies whose aim is the sharing of understandings and the solving of problems rather than the sharing of feelings and the building of relationships. Feelings and relationships are not of much interest to her.

Ares, god of war, might not seem to have much of a contribution to make to therapy, but we can find him present in confrontative therapies and in the confrontational style of therapists from many persuasions. We find him wherever the counsellor challenges the client to fight. We find him in a somewhat domesticated form in assertiveness training. Ares is not terribly smart, and prefers the simplistic solution, but he is passionate and certainly knows how to stimulate action.

Hephaistos, the craftsman, forms the perspective of the counsellor who sees counselling essentially as a craft. In Greek myth, Hephaistos is the only god who does any work. He is the god who convinces us that the creation of something beautiful is worth long hours of hard and intensely focused work, slaving over the forge. He is wedded to Beauty (Aphrodite) but in spite of his obsession with her, and the toil and pain of his crafting, he never manages to please her.

Aphrodite has many aspects. She is most commonly worshipped under the aspect of sexual attractiveness, but she is also the goddess of spiritual beauty. In any case, under one aspect or another, she is the driving force behind much of what we do in counselling as anywhere else. Leaving aside the psychoanalytic notions of transference and projection, and leaving aside the all too frequent cases of sexual exploitation, it is arguable that therapy often works by way of seduction, so that the attractiveness of a therapist's personality or the attractiveness of a therapist's view of life makes a powerful contribution to the client's healing.

Photo: Guille Pozzi

For the Aphrodite-driven therapist, counselling is an aesthetic activity – an art rather than a science or a craft.

The son of Aphrodite is Eros, the god of relationship, who is central to most humanistic conceptions of therapy. Eros has his own truth, that healing occurs through the coming together of therapist and client in a relationship which is truly mutual and truly caring. For Eros, the key ingredient of successful therapy is love.

Dionysos is the god of 'the flow', of fertility, growth, impulse, and spontaneity, of spiritual ecstasy and emotional freedom. Dionysos is fervently worshipped by psychodramatists, and by different species of expressive therapists. As the divine child, the god of death and resurrection, he is worshipped also by rebirthers and holotropic therapists. Our society, no less than that of Greece, has a tendency to regard his activities as subversive of good order and morality. No less than the Greeks we pay a heavy price when we ignore him.

Hestia is the quiet goddess, the goddess of the hearth, of the home, of focus and 'centring'. Therapies which work through meditative introspection, such as psychosynthesis and experiential focusing, carry her power. She is responsible for the healing which comes simply through being still. She is the sense of safe containment in a therapeutic encounter.

Classical psychoanalysis and classical behaviourism, grounded as they are in the mechanistic and positivistic assumptions of nineteenth century science, point to the myth of Prometheus, the ancient hero who stole fire from heaven and taught men how to use it to gain control of the world and free themselves from the power of the gods. The Promethean fantasy of ego-driven emancipation through technology also shapes such diverse therapies as neurolinguistic programming, biofeedback and biomedical psychiatry.

And so on. Each archetype is manifested in its particular perspective on the world, its peculiar system of values, its own pathology, its own vision, its own methodology, and the particular energy which drives it. Each god has their own truth and their own morality. Reality is not single and simple, but multiple and complex.

Yet even this statement about the nature of reality is archetypally constellated. When we look at the world and see not the one truth but relative and local truths, when we see not facts but images, when we acknowledge the paradoxical and the irrational, we are taking a particular archetypal perspective – the perspective of Hermes.
I suggest that Hermes is the god of a postmodern consciousness and provides the energy and the vision of both Jungian and Rogerian therapy.
The Greeks worshipped him as the god of travellers, the god of exchange, the god of information, the god of flexibility, the god of transformation. He is the god who insists that all the gods must be worshipped.

## Person-centred pluralism

When I first encountered the work of Rogers in the late sixties, what most impressed me was his focus on relationship. As a teacher I suspected that my ability to teach my students effectively was somehow related to the quality of my relationships with them. The Beatles were still singing 'All You Need Is Love'. Hippies in San Francisco were apparently wearing flowers in their hair. Dialogue and encounter were entering the vocabulary of many teachers. Rogers gave me a language to talk about this in a legitimately psychological manner, and to share my excitement with colleagues who were making the same discoveries.

Another notion which made a big impression on me was the notion of process. Reading *On Becoming a Person* (1961) confirmed me in my sense that what really mattered in teaching was the immediacy of what was happening. I accepted the obvious truth of Rogers' assertion that the information that children pick up in their schooling is far less important than the processes by which they pick it up, that what matters is that they learn to adapt creatively to the future, rather than learn to repeat the past.

I was also impressed by his insistence that power be shifted from teacher to student, his confidence that students are perfectly able to decide what was good for them, and his conviction that their teachers should respect this ability and desist from telling them what to learn and what to do. I enthusiastically embraced the notion of 'facilitation'. It became obvious to me that my prime function as a teacher was to develop and maintain an emotional and intellectual climate which was both nurturing and challenging, in which my students would be encouraged to initiate and take responsibility for their own learning. As a young teacher with countercultural tendencies, I saw education in terms of growth, freedom, dialogue, sharing, discovery, relationship, nurturance and creativity.

When I now try to look at all of this archetypally I find the language of relationship clearly pointing to the god Eros, the god of love and of the creativity which springs from relatedness. The language of growth, freedom and new beginnings points to Dionysos, the god of fertility, of impulse and spontaneity. The language of nurturance points to Demeter, the mother. The language of process, dialogue and discovery points to Hermes, while the language of power-sharing, co-operation and problem-solving points to Athena.

When I left the classroom in 1970 to do my PhD, I found that there were other gods involved in client-centred therapy and student-centred teaching. I read what Rogers had to say about the organisation of personality in *Client-Centered Therapy* (1951) and in his 1959 paper 'A Theory of Therapy, Personality and Interpersonal Relationships'. I noted his respectful acknowledgement of the perceptual theory of Snygg and Combs, and read *Individual Behavior* (1959) with great excitement. I came to understand behaviour as the rational response of the organism to the world as perceived. I became persuaded that the essence of therapy and education (from the client's and student's point of view) is the search for clarity; the unending endeavour to construct a meaningful world out of one's experience. This is the work that the therapeutic conditions make possible. When my colleagues tried to trivialize the client-centred approach by locating it in a fantasy of touchy-feely countercultural cosiness and put scorn on the notion that empathic understanding is an essential component of effective teaching, I argued that empathy is essentially a cognitive operation, that it involves entering another's world in order to know how the other perceives and understands – not in order to share the other's feelings. I took both therapy and education to be concerned with an expansion of consciousness which enables greater freedom of action. This perspective on the person-centred approach was clearly that of Apollo, the sun god, the god of clarity and rationality, the god of understanding.

Working on my PhD at a graduate school which was at the time avowedly empirical in orientation, I was attempting to 'operationalize' Rogerian therapeutic conditions, in order to develop testable hypotheses related to educational outcomes. When I came across Robert Carkhuff's *Helping and Human Relations*, which had been published in 1969, it was just what I needed. I was soon immersed in a self-consciously tough-minded fantasy of levels of functioning, personal effectiveness, the development of human resources and, above all, of training and skilling. It is apparent to me now that Carkhuff's vision of highly effective people training less effective people in the skills of effective living belonged, as did his operationalism, his evangelical fervour and his focus on human resources, to the fantasy of Prometheus, the heroic liberator, the technologist.

The work of Carkhuff, Charles Truax and their associates was taken up by Gerard Egan, and still has an enormous impact in the field of counsellor training. However, I believe there has been a shift from Carkhuff's Promethean vision of interpersonal skilling as a way of emancipation to a notion of interpersonal skills as marketable commodities. This is, in part, a criticism of 'Eganism', but the phenomenon is much more broadly based than that. I find that there are many people and organisations willing and able to pay me to teach them (or at least their employees) 'interpersonal skills' and 'negotiation skills', and I find empathy, positive regard and congruence being bought and sold by people whose language comes from Rogers but whose commitment to a person-centred philosophy is doubtful.

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*In the second part of Bernie Neville's exploration of the gods in therapy, he focuses on the importance, the strengths and the weaknesses of Hermes energy in the counselling process. He concludes by commenting on the necessary recognition of a pluralism of practice in psychotherapy.*

*Bernie's book,* The Life of Things, *is published by PCCS Books, Monmouth, UK. Special thanks to Sam Taylor and the good folk at PCCS for permission to reprint this chapter.*

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# THINKING, PHILOSOPHY AND PSYCHOTHERAPY

Tra-ill Dowie*

Photo: Giam Marco

The practice of philosophy and various branches of what may be termed psychological practice have long existed in a strange and abiding tension. Philosophy as a practice was originally concerned with how to live a good life and respond to the complexities of human living. These concerns have in many ways left professional philosophy and have found themselves in the domain of psychological practice. This paper explores the ways in which philosophy and various modes of psychological practice exist in a mutually informative register.

* I would like to thank Dr Josh Comyn for his help in reading and supporting this piece.

## Introduction

*The most thought-provoking thing in our thought-provoking time is that we are still not thinking.*

-Heidegger

When attending to complex thinking tasks such as those that are employed in various modes of psychological practice, it is a simple yet pivotal insight that errors in foundational thinking always eventually become manifest at a clinical level. This is because conceptual and philosophical problems are always already present in the clinical arena. Consequently, philosophical thinking forms the substratum of clinical practice, and is therefore the fundamental organising dimension of clinical work. This is why psychotherapy as a discipline, and psychotherapists as individuals, shun such thinking at great peril.

Philosophical modes of thinking are already present in a myriad of ways in every clinical presentation. The most obvious question every clinician must begin with is 'Why is this client attending this clinic to see me?'

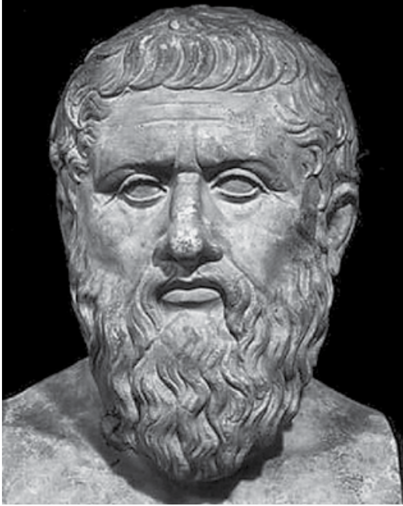
Therapists are always already making explicit, but more likely, implicit knowledge claims. These knowledge claims include having the knowledge and ability to facilitate a process called psychotherapy (whatever that may mean). This process called psychotherapy is purported to assist persons suffering (whatever that may be). Another way of rendering this is to see that in this situation one is making knowledge claims about human suffering, human change, and the technical skills required to administer one's particular mode of practice to achieve the goals of a particular mode of therapy. These goals one is trained in. These approaches to psychotherapy all come with latent assumptions about persons, minds, change and healing. The assumptions of this pre-reflective state often operate perfectly as long as the process of therapy continues in the prescribed and predictable contours of a specific model, but these concepts become much more problematic and important when a patient is not responding to treatment in an expected or predictable manner (as often occurs). In this situation where the 'expected' collapses, the therapist finds themselves off the map, where the 'natural attitude' established by a model of practice collapses, and in so doing the therapist and patient find themselves without a clear means to move forward. This state of deracination renders the territory of the mind and the 'other' mysterious as understanding always occurs within a certain epistemological register. It is at this juncture that a clear understanding of the what, why and how of the clinical endeavour is required. Without the meta-perspective afforded by philosophical thinking, the result can be a state of clinical lostness.

It important to realise that psychotherapy does not represent categories of 'natural kinds' rather all models of psychotherapy, are simply attempts to make sense of human suffering and healing in the life of the mind, through the production of metaphors. Some models, like some therapists however are more philosophically sound than others in terms of the coherence of the worldviews they generate and imply for practice. The task of philosophy in psychotherapy is myriad. It seeks to help the clinician establish a sound and coherent world-view for practice, yet it also seeks to help the clinician understand what and how they practice as well as develop the critical meta-cognitive abilities required for clear and detailed thinking.

The practice of philosophy and various branches of what may be termed psychological practice[1] have long existed in a strange and abiding tension. Philosophy as a practice within the Western tradition was originally concerned with how to live the good life and thereby respond to the complexities of human living and suffering. These concerns have in many ways left professional philosophy and have found themselves in the domain of psychological practice. Yet there is all too often a sense that philosophy has nothing to say to psychological practice and vice versa[2]. I think this is fundamentally wrong. It is my contention that these respective traditions have much to contribute to each other. This paper sets out to explore the contributions which philosophy and philosophical thinking have to offer psychological practices through an examination of philosophy and psychotherapy undertaken in the spirit of philosophical enquiry.

1. By 'psychological-practice' I am referring to the distinct, yet connected, domains of clinically orientated practice that focus on the workings of what is referred to as the mind, the mental, psyche or the psychological. This includes practices such as clinical psychology, psychotherapy, psychiatry, psychoanalysis, social work, counselling and mental health.

2. This is an anomaly as the history of psychotherapy has long connections to philosophy. Many of the early progenitors of psychotherapy (including Freud) were deeply educated in classical and European philosophy. Nietzsche, for example, is well documented as a source of inspiration and influence on early psychoanalysis. A number of branches of CBT owe more than a passing debt to stoic philosophy, and existential psychotherapy is in many ways the relational enactment of existential philosophy.



# "The unexamined life is not worth living"

- Plato

## What is philosophy?

*Wonder is the only beginning of philosophy.*

-Socrates

The word 'philosophy' means 'lover of wisdom' when translated from the original ancient Greek, φιλοσοφία. To trace an etymology is not to offer a definition, however. Philosophy, then, may be understood as an attempt to examine and understand life and reality, primarily but not exclusively by using reason, evidence and argument. Philosophy involves two basic activities: the search for wisdom and critique.[3] In this sense philosophy is focused on a relatively small set of questions with many answers. In simple terms, philosophical training is a declaration of war against stupidity. This is the first marker and intersection between psychological practice and philosophy, namely that the practice of philosophy supports the general themes of meta-cognitive and reflective functioning which have been established as central to the practice of psychotherapy.

To adopt a philosophical stance is to practice paying attention to assumptions, which constitute, what in phenomenology might be termed, our 'natural attitude'. This includes natural attitudes that develop within philosophy, about philosophy. It is this pressing concern with natural attitudes that makes the practice of philosophy curiously self-referential: philosophy is unique as a discipline for its own definition is a concern of its own practice. There are no mathematical proofs of the nature of mathematics. The question of the nature of mathematics is a question that lies beyond the practice of mathematics itself (in the realm of philosophical enquiry) (Badiou, 2010). As with mathematics, so with physics: physicists do not interrogate the discipline of physics through the use physics itself. When a physicist asks these types of questions about physics, they are very often engaging in philosophical enquiry.

As can be seen from the previous examples, when one comes to enquire into the nature of an intellectual discipline or domain of enquiry, this enquiry is often unavoidably undertaken in an philosophical manner. Despite this, philosophical practice has a varied history in psychological practice, particularly psychotherapy and counselling. In recent years the intersection between philosophy and psychiatry has experienced resurgence, led mainly by Oxford University Press' International Perspectives in Philosophy and Psychiatry series. Yet psychotherapy seems to still wrestle with understanding the role of philosophy in helping it define itself and support clinical practice by sound thinking.

Philosophy is the discipline, *par excellence*, of thinking about thinking. It is the practice, to paraphrase Plato, of examining one's life in order to make it worth living. Philosophy is in all its branches, a systematic process of contemplation that recognises that the act of contemplation is of value in and of itself, independent of the solutions that may be the result of such contemplation.

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3. The notion of critique dates back to the foundations of philosophy. Socrates was in fact put to death for critiquing those in power within Athenian society. Socrates charge was that he was guilty of corrupting the youth and worshipping false gods. The notion of the critique follows on as a constant theme in philosophy. Kant's critiques are a foundation of most philosophical training. The notion of critique is exemplified in various schools of philosophy, but perhaps most notably in the development of critical theory. According to one of the founders of critical theory in the Frankfurt school tradition, Max Horkhemier. Critique should explain 1) what is wrong with current social reality, 2) identify the actors to change it, 3) provide both clear norms for criticism and practical goals for social transformation.

## Branches of philosophy

*Whereof one cannot speak, thereof one must be silent.*

-Wittgenstein

There are numerous branches or specialiations within the discipline of philosophy that are concerned with particular questions. These questions offer an excellent orientation to what philosophy is concerned with, but they also offer a structure for an inquiry into the possible intersection between philosophy and psychological practice. The discipline of philosophy may be schematised as in Figure 1.

These specialist questions of philosophy can be tailored to address certain first principles of psychotherapeutic thinking and practice and arriving at questions of ethics, politics and pragmatics.

1. What is?
2. What is the nature of mind?
3. What is the nature of self?
4. What is psychotherapy?
5. What is healing?
6. How might these questions affect psychotherapy?
7. What and how can we know?
8. How do questions concerning how and what we can know affect psychotherapy?
9. What are legitimate ways of knowing in psychotherapy?
10. What is the nature of time?
11. What is the nature of inter-subjective experience?
12. How ought we to practice psychotherapy?
13. What is right in psychotherapy?
14. What are our obligations in psychotherapy?
15. How might we respond to suffering?
16. What is the nature of power in psychotherapy?
17. Who is psychotherapy in service of?

As a general rule we might say that questions 12–16 are competently addressed by psychotherapy, while most therapy practice and training is very limited in how the other twelve questions are integrated into both clinical practice and the psychotherapeutic training environment. In the spirit of these questions which psychotherapy has tended to overlook, I propose to demonstrate how philosophy can shape various axioms within psychotherapy, and to pursue the implications of this within the domain of psychotherapy. I begin by presenting a brief and non-exhaustive problematisation of first principles in psychotherapy, namely 'What is?' (ontology) and 'What and how can things be known in psychotherapy?' (epistemology)[4].

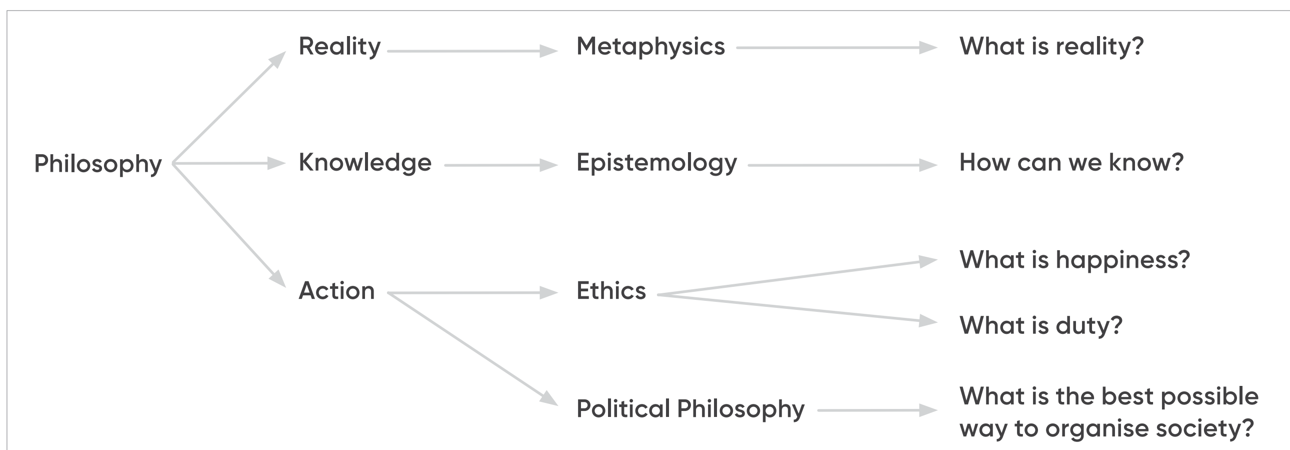
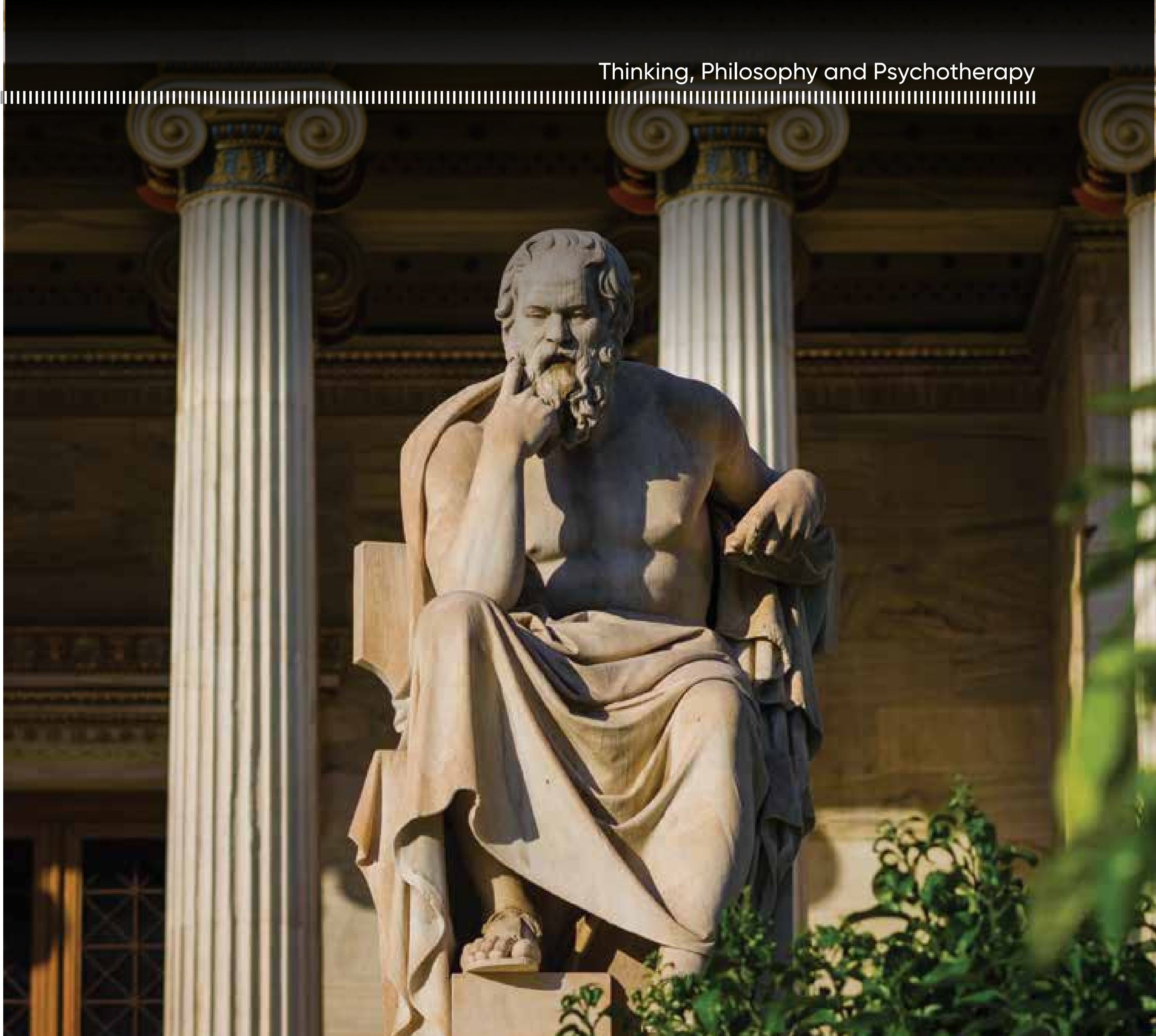



Figure 1: Branches and Questions of Philosophy

4. Ontology is a philosophical term which is derived from the Greek word for being, it is a branch metaphysics that concerns itself with questions of 'what exists'. Epistemology is a term derived from Greek. It is the branch of philosophy that addresses theory of knowledge. "Its central questions include the origin of knowledge; the place of experience in generating knowledge, and the place of reason in doing so; the relationship between knowledge and certainty… the changing forms of knowledge that arise from new conceptualizations of the world. All of these issues link with other central concerns of philosophy, such as the nature of truth and the nature of experience and meaning". (Blackburn, 1996 p.123)



## First principles, assumptions and problems of practice

*All resistance is a rupture with what is. And every rupture begins, for those engaged in it, through a rupture with oneself.*

– Alain Badiou

Every psychotherapy implies certain assumptions of about what is and what and how things can be known. In this sense psychotherapy is always involved with a series of metaphysical assumptions that are seldom acknowledged or addressed. In short, every theory attempts to give an account of what the philosopher Wilfred Sellers (1962) saw as the aim of philosophy: "to understand how things in the broadest possible sense of the term hang together in the broadest possible sense of the term" (p. 35). Psychological practices also need to offer such an account in order to develop a coherent theory of practice. In other words, psychotherapy must examine the taken-for-granted, axiomatic views about how things have hung together if this discipline is to fulfil its essential purpose: to give an accurate account of human mental life for the purpose of offering some type of utility to human living.

These axioms, whether made explicit or carried along implicitly in the practice of psychotherapy, are crucial, for they dictate what and how research is practised, what and how theories are generated and, by extension, what constitutes practice. One example of an axiom of contemporary psychotherapy is the subscription to different kinds of substance ontology that are governed by scientism, reductionism and the philosophical monism known as reductive materialism[5].

5. These all are epistemologically problematic as they display excessive belief in the power of scientific knowledge and techniques.

The reductive materialist view is that matter is the fundamental substance in nature, and accounts for the universe in its entirety—including human consciousness and experience. These modes of thinking are, I believe, largely inadequate in the ontologies, and thus too, in the epistemologies they propose.

The notion of a reductive materialism, and the reductionist linear logic values that underpin it, can most acutely be observed in psychological practice through the solution that is normally offered for the mind-body problem—that the mind is brain, and that the self is merely matter. In such a view, any sense of transcendence is abolished and replaced by a reductive materialism that offers an utterly deficient account of what it means to be human. Such a view sees matter as merely matter: hollow, empty and mechanical. As Charles Hampden-Turner (1970) states, "what … science has done is banish human purpose from its universe of discourse." (p. 12).

This view has developed as the dominant discourse of psychological practice out of the continuation of nineteenth-century physical sciences and has for a number of complex reasons become an almost unquestionable bastion of contemporary intellectual life. (One need only think of Freud's early 'Project for a Scientific Psychology' to see how clearly this has cut to the centre of psychotherapy.) Buoyed by technological advancement, these views have infused themselves not just within psychological practice, but also within modern society, and now are offered as an almost incontestable discourse for explaining human life and the world we live in. I believe this is both erroneous and foolhardy. What is problematic about this dominant discourse of scientistic reductive materialism is that as a metaphysical position it carries with it an ontology and an epistemology that are wholly unsatisfying when seeking to define and describe the world, or more accurately human beings' immediate access to the world. Merleau-Ponty (2004) reminds us that:

> The question is whether science does, or even could, present us with a picture of the world which is complete, self-sufficient and somehow closed in upon itself, such that there could no longer be any meaningful questions outside this picture. It is not a matter of denying or limiting the extent of scientific knowledge, but rather of establishing whether it is entitled to deny or rule out as illusory all forms of inquiry that do not start from measurements and comparisons and, by connecting particular causes with particular consequences that end up laws such as those of classical physics (pp. 42–43).

This is a point further supported by Gregory Bateson (1979) when he states: 'every schoolboy [sic] ought to know that logic is precisely unable to deal with recursive circuits without generating paradox and that quantities are precisely not the stuff of complex communicating systems' (p. 30). What is missing in such reductive materialism is a more integrated and nuanced account of the nature and structure of the world—an ontology that radically rethinks the issues of materialism and, therefore, the notions of immanence and transcendence. Such a radical rethinking must strive to integrate multiple ways of knowing, cutting a line between scientism and obscurantism, to fashion an ontological stance that can revitalise materiality, a materiality that possesses immanent capacities for transcendence.

This small problematisation highlights my simple assertion that all practice is built on assumptions about what is, and that we must explore and understand these assumptions about how the world hangs together if we wish to develop a coherent view of the self, the other and the world. This is perhaps best highlighted in psychotherapy by the assumptions psychotherapists harbour towards the concept of the mind.

## What is the mind?

> *The energy of the mind is the essence of life*
>
> - Aristotle

One of the most profound and obvious questions that we need to investigate in psychotherapy is the question of minds. Many people may think that psychotherapy tells us a lot about what a mind is and what a mind does, yet, while psychotherapy works with and upon the mind, psychotherapy training rarely exposes students to an enquiry concerning the nature of the mind. What then is a mind?

The concept of mind within psychological practice lacks a universally agreed definition. It appears that psychological practices have yet to seriously integrate interdisciplinary research from areas such as philosophy of mind, cognitive science, neuroscience and eastern spiritual practices to develop a coherent view of mind, but instead rely upon unexamined reductive materialist accounts of mind or poorly conceived metaphors and folk psychologies. The notion of mind implied in any clinical model already delimits the scope of what and how practice occurs. Below is my working definition of mind; while this may seem overly

detailed at first glance to some readers, it is important to note that the human mind is the most complex informal system that we know of. Thus while simple accounts are popular, they by definition are always going to be incomplete or even completely wrong when addressing complexity. The small definition below that I offer is an attempt to develop a cohesive understanding of the interface between the theory and clinical practice, yet in this context I am offering it as a provocation to therapists to think about their assumptions about minds and how those assumptions are implicated in practice:

> Mind is an embodied relational negentropic process, which is energetic and informatic in nature. Mind is preserved against entropy by its organisational characteristics, thus the mind is temporal in the sense that the informatic qualities of mind are propagated forward in time. Mind is ecological in its features in the sense that it is characterized by feedback loops and inter-connected non-linear processes and patterns of hetarchies and hierarchies. A mind also possesses expressive, regulatory and generative features. In this sense the mind demonstrates autopoietic qualities and is enactive. In this sense, life and mind become processes where the characteristics of life may be defined simplistically as the self-organisation of energy, and mind may be then framed as the self-organisation of information. This organisational process in humans has features which are stable in organisation which are termed stages and non-stable processes which are termed states. Both states and stages exhibit unique energetic and informatics qualities. With complexity of energetic-informatic organisation and significant coherence, mind develops as well as emerges from structures of biology in an embodied context and situatedness. Mind thus has properties which can act in both a top-down and bottom-up manner, as well as inside to outside, and outside to inside manner. The mind is not epiphenomenal, rather the mind is central to many living beings and there are many kinds of minds with varying complexities, sufficiently complex and cohered minds form a process pattern or coherence termed a self which produces subjective phenomenal experience" (Dowie, 2018).

One important implication in addressing the theme of the mind, that term used to designate the usual and particular focus of the practice of psychotherapy, is that we run head long into the age old question of quantity and quality, which, in psychological practice, often takes the form of minds versus brains. Sometimes the term 'mind' is used as a synonym for 'brain'. Yet philosophically, often this terminological slippage is a means for smuggling in a series of philosophical assumptions and using these assumptions as evidence for argumentation. In philosophical parlance, this is called 'begging the question'.[6] To address this head-on: quantities are by definition measurable, and therefore, calculable. Yet it does not follow from either logical necessity or common-sense that all things in the universe are quantities. Rather there are features of the world that are best understood as qualities. And in psychotherapy, things such as the therapeutic relationship should be understood as matters concerning quality not of quantity. In this sense, psychotherapy is a pragmatic manifestation of what in philosophy of mind is referred to as 'the easy problem' and 'the hard problem' of consciousness.[7]

## Clinical thinking

> *Diagnosis is not the end, but the beginning of practice*
>
> - Martin H. Fischer

Another key and obvious area to explore in psychotherapy, given our statements about how the world hangs together, is: how do we think clinically in a consistent and accurate manner? We need to remember that, as Bateson (1979) reminds us, we can only get away with faulty epistemologies for a while—or as the philosopher Cornel West often quips, the chickens come home to roost. That is: faulty thinking is never escaped, rather the consequences of faulty thinking are merely delayed. Thus concern with thinking elaborated in this essay touches upon extremely practical domains of psychotherapy, those of relational exchange and clinical thinking (otherwise known as 'case conceptualisation' or 'formulation').

The issue of case conceptualisation or formulation is a critical matter in psychological practice. The ability to conceptualise refers merely to the psychological practitioner's ability to think about the particular problem presented to them by the person who has sought their help and expertise, and to connect this problem to the broader disciplinary knowledge in the form of theory, research, evidence and clinical experience. One must conceptualise otherwise one cannot treat effectively. Thus, a case formulation is a

6. The notion of begging the question is an informal fallacy. First proposed by Aristole in *'De Sophisticis Elenchis'*. Begging the question is one of the original thirteen fallacies outlined in philosophy.
7. See: Chalmers, D. (2007). *The hard problem of consciousness*. The Blackwell Companion to Consciousness, 225–235.

conceptual scheme that seeks to make clinical sense of the information gathered regarding a case, and is the key to formulating a treatment plan through the development of a clear conceptual rationale. The formulation/conceptualisation contains three essential elements: information, explanation, and the development of a treatment that follows from the explanation in a casually linked manner. A clearly articulated case formulation permits communication with one's clients, supervisors, team members and case managers concerning the client's presenting problems. Conceptualisation is a key to competency in the area of psychological practice.

Case formulation or conceptualisation is, therefore, the extended thinking process that categorical diagnosis all too often fails to achieve. Formulation/conceptualisation is essentially the thinking about, and sense-making practice of, clinical data. It seeks to address many basic functions. These normally include:

1. describing 'the person'
2. specifying 'the presenting issues'
3. forming a hypothesis or hypotheses
4. prioritising a hypothesis
5. integrating multiple hypotheses
6. inferring treatment (synthesis and integration of theories to match data)
7. treatment methodology (logic of treatment)
8. revising the integrated hypothesis and, therefore, the treatment, for utility and accuracy.

Stated differently, the overall purpose of formulation then is to increase insight into the subjectivity of the client, since the value of objective data pales in value when compared to first person subjective understanding. Thus, formulation is an attempt to explain and understand persons. This may be summarised by the clinical question 'Why is this person presenting at this time in this way?'

In describing case formulation as a mode of thinking, the critical concept is the term 'thinking' itself. Thus, in revising the ontological foundations of psychological practice, it becomes evident that clinical thought is the first arena that must undergo radical revision. Most contemporary clinical thinking is in practice referred to as 'clinical reasoning'. The notion of 'reason' is, in turn, directly connected to formal practices of logic. Such reasoning is dominated by modes of abductive and inductive reasoning, or what may be called calculative thinking. Such thinking has unquestionable utility in practice, but it is just as surely incomplete. I contend that such reasoning must give way to a broader, more totalising mode of thinking when seeking to develop a psychological practice emerging from a redefined ontology. This notion of a redefined clinical reasoning begins with the question, paraphrasing Heidegger, 'What is called clinical thinking?'

When asking the question 'What is called clinical thinking?' it is useful to pick up on a Heideggerian wordplay whereby 'What is called thinking?'[8] can also be read as 'What calls for thinking?' In this sense the question we might ask is, 'What calls for clinical thinking?' In asking such a question it becomes clear that the categorisation of a patient in relation to a diagnostic framework does not call for thinking, but rather amounts to a failure to think at all: a pathetic calculative checklist of behaviours that attempts to categorise human experience. Such 'thinking' is thoughtless in its complete misapprehension of the lived experience of a person who may be the recipient of such a diagnosis.

Should these common practices in the organisation of clinical data continue to displace a deeper contemplative mode of thinking, or might there be a dual mode of thinking required for clinical practice? This begins to uncover the true concern with what is normally called clinical reasoning. In the very deepest sense, such reasoning is a calculative rationality that asks questions and, *ipso facto*, is always directed at answers and, therefore, ends. But such thinking remains thoughtless with reference to the nature of what is being calculated. To calculate human subjective life is to calculate the incalculable, as the mind is not something that can be weighed upon a scale. Thus, by definition, such calculations distort that which it sought to calculate in the first place. In this sense, the so-called thinking process of clinical reasoning is merely cognitive and linear, and as such, inadequate as a mode of thinking derived from a living, chiasmatic, ontology that connects the upper cortical processes of cognitive thinking to affective, sensate and environmental levels of human experience. To generate such a connected, hermeneutic mode of thinking—one that is a gathering together of the thinker and about the 'object' of the thinker's thought—requires what Heidegger would have referred to as meditative or contemplative thinking, designated by a gathering

8. The focus here is not merely to define, but to show the way to, such thinking. In German the phrase 'Was denken?' can be read in a variety of ways; the notion can refer to 'being called' or 'named' but can also mean 'to call for', and then there are terms like 'aufrufen', which refers to 'being called upon' or 'summoned'.

and dwelling upon without end. Heiddeger's term for this is *gelassenheit*[9]: an orientation in thinking of letting be. In this sense, calculative thinking for Heidegger pertains to *feldweg*, a 'path to a field'—a kind of end-focused thinking. This contrasts with contemplative thinking, or *holzweg*, which is a 'path that leads nowhere'.

Thus, true thinking, deep thinking, is a task that is characterised by a series of unending hermeneutic loops. According to Heidegger (1971), 'ways of thinking hold within them that mysterious quality that we can walk them forward and backward and that indeed only the way back will lead forward' (p. 12).

Thus I contend that the simplest answer to the question, 'What is clinical thinking?', is that it is a totalised gathering of thinking in all its forms, which include the thinking modes of the scientist, the scholar, and critically, the thinker and therapist.

Our concern is that psychological-practices have begun to exclusively constellate around scientistic thinking, with platitudes like 'scientist–practitioner' and 'evidence-based' becoming catch cries for validity. A scientific mode of thinking is needed in a clinical setting. The basic scientific notion of information as the reduction of uncertainty is pragmatically helpful in practice, but the mode of scientific thinking often being utilised in this context is only a science of the simple or perhaps the complicated. I contend that a mode of psychological practice that attends to the space between the simple and the random is needed—a psychological practice that attends to the complex. Thus, thinking about a mess as complex as human lived experience requires not just scientistic reasoning, but also a contemplative mode of thinking for adequate understanding.

Such contemplation is a practice of thinking not as means towards certain ends but as process. This answer also stands for 'What calls for clinical thinking?' in the sense that it is the totality of the inter-subjective life-world that requires more thought, and in being more thoughtful it calls forth this kind of thinking. For what is imperative in thinking in this manner is the switch from mere calculation to a dwelling upon. Thus the question, 'Why is this person presenting at this time in this way?' is treated not as a question requiring answers and calculation alone, but more like a *koan* to be dwelled upon, knowing full well it is never answerable in a complete sense. 'Why is this person presenting at this time in this way?' is thus, in a very real sense, a question of cosmic proportions. A formulation that is emerges from a redefined ontology requires a redefinition of how the act of clinical thinking itself is conducted. This reorientation of formulation is the death knell for all forms of merely calculative practice exemplified by manualised treatment processes.

## Conclusion

In line 38a of Plato's *Apology*, Socrates famously states that "the unexamined life is not worth living" (Plato, 1997). This line simultaneously sums up the practice of both psychotherapy and philosophy. Both practices are built upon self-reflection and self-knowledge. Philosophy has a much to teach psychotherapy about what constitutes clear thinking about itself as a discipline, as well as offering wisdom on the age old problems of living. However, psychotherapy, in its turn, has much to teach philosophy about the affective life of *anthropos* and the nature and role of relationship.

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9. The term 'gelassenheit' originates in the mysticism of Meister Eckhart. See Heidegger's 'Conversation on a Country Path' in his *Discourse on Thinking* published in English first in 1966. In this text, Heidegger explores the notion of a 'will-less thinking' in the form of a dialogue between a scientist, a scholar and a teacher. During the dialogue, the scientist represents thinking in a calculative and deductive manner, much like many psychological practitioners today. The scholar represents an academic history of metaphysics and knowledge and the teacher represents the Heideggerian idea of the 'thinker', as opposed to the philosopher or scientist, who contemplates.

# 'ALL ANIMALS ARE EQUAL BUT SOME ARE MORE EQUAL THAN OTHERS': A discussion of guild capture of psychotherapy and the cost

Richard Lakeman

Photo: Nikola Mirkovic

In 2021 the Australian Government announced the largest planned increase in investment in mental health services in the history of the Commonwealth. In the 'Prevention, Compassion, Care', National Mental Health and Suicide Prevention Plan (Commonwealth of Australia., 2021), 'psychotherapy' is not mentioned, or funded (although 'treatment' is mentioned 14 times). Over half of committed expenditure is to extend existing initiatives in which the clinical work will primarily be provided through a small number of guilds at different rates of remuneration for the same work under the Medicare Benefits Schedule (MBS) scheme, *Better Access*. Meanwhile, the majority of Australians are unable to access a proper subsidised dose of the right therapy at the right time from the most qualified person (often trained in psychotherapy). This paper discusses how professional guilds have appropriated 'treatment' as their own and how treatments provided by professional groups have become over-valued and unaffordable to those most in need. The call for action is for those most qualified to provide psychotherapy to clients most in need be enabled to access a subsidy through the MBS.

Richard Lakeman

In George Orwell's book, *Animal Farm,* the government proclams that; "All animals are equal, but some animals are more equal than others". This was a satirical comment about the hypocrisy of governments that proclaim the equality of the citizenry but confer power and privileges to a small elite. This is an apt metaphor for the treatment of psychotherapy and psychotherapists by Australian governments.

Since the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM III)* which cemented medical hegemony over all matters to do with mental health (Lakeman & Cutcliffe, 2016), there have been few champions of psychotherapy within medicine or indeed from any other regulated profession in Australia. The rolling mental health crisis in Australia is framed by medicine, and it is medical doctors who prescribe 'treatment'. The treatment for most mental health problems is psychotherapy. Those most qualified and experienced in the provision of psychotherapy are excluded from being able to provide subsidised services under the MBS scheme, *Better Access*. Eligibility to do so has become a de-facto credential signalling competence in providing psychotherapy.

Even the traditional, conservative clinical practice guide for mood disorders produced by the Australian & New Zealand *Journal of Psychiatry* (Malhi et al., 2021, p. 42) concedes that there are many meta-analyses which conclude that there are no significant differences in the benefits of antidepressants compared to 'psychological treatment' of major depression. They go further by mandating lifestyle interventions and 'psychological interventions' for every person with depression. This foundational 'treatment' is rarely offered in tertiary services. I have been involved in numerous 'complex case reviews' where an individual has been receiving expensive frequent, lengthy and often unhelpful hospital care, and there is consensus that long term psychotherapy is the treatment of choice. However, never in my experience have tertiary services offered the treatment or even underwritten the cost of therapy (often a fraction of the cost of a hospital stay). There may, of course, be outstanding local examples of tertiary services offering therapeutic programmes or individual therapy. However, by and large if one attends hospital or the emergency department it is very unlikely one will receive treatment for those problems if treatment is psychotherapy.

Australia's answer to the provision of subsidised psychotherapy is *Better Access* which is mediated through a 'mental health plan' constructed by a general practitioner (GP) (a doctor in a tertiary service cannot make a referral although private psychiatrists can). In 2019-2020 the writing and review of mental health plans cost the taxpayer $281.5 million in subsidies (Australian Government., 2021). A further consequence of the medical framing of mental health issues and gatekeeping subsidised psychotherapeutic services is the over-valuing of medication. Australia consistently rates as one of the highest consumers of psychotropic medications in the world. Australians filled close to 14 million prescriptions for the nine most commonly prescribed antidepressants in 2019–2020 at a cost of $227 million Department of Health, 2021b).

In the last Federal Budget, Australia committed $200 million to provide transcranial magnetic stimulation (TMS) to those with treatment-resistant depression (Department of Health, 2021a). TMS has an effect size of approximately 0.39 (Sonmez et al., 2019). Even those who have taken a very critical review of the literature (often confining examination to randomised controlled trials) (Cuijpers et al., 2020; Cuijpers et al., 2010) find that psychotherapy has close to twice the effect size of TMS. However, how many people in Australia who have 'treatment-resistant depression' have ever had the experience of psychotherapy unsullied by a first parse as a medical problem and followed by prescription of drugs? Treatment resistance is defined as not responding to drugs (Malhi et al., 2021), not a poor response to psychotherapy. Drugs also have a lesser effect size than psychotherapy for conditions such as depression (Hengartner & Plöderl, 2018).

Our medico-centric system has not delivered improvements in the nation's mental health, despite increasing access to 'treatments'. Indeed, Australia has more years lived with disability (YLD) due to depression than any other country in our region (WHO, 2017, p. 23).

Medicine has firmly established itself as the arbiter of what counts as mental illness, as well as the gatekeeper and prescriber of treatment. In Australia whichever guilds participate in *Better Access* effectively controls psychotherapy. *Better Access* was established in 2006 with a view to providing 'focused psychological strategies' to those with mild to moderate problems. These strategies include CBT, problem-solving and more recently, eye movement desensitisation and reprogramming (EMDR). Costs have grown to close to $15 million per week in subsidies and while it has increased access to psychotherapy, critics note that it has not made any discernible difference to the overall mental health or wellbeing of the nation (Jorm, 2018). All eligible providers (GPs with specific training, psychologists, occupational therapists and social workers) apparently do the same thing, although there are different rates of remuneration for different guilds, (Australian Government, 2021).

There is no rationale for this disparity or an explanation why GPs can provide this service with 20 hours training, or how an undergraduate preparation focused on issues such as hand splinting, child protection or psychometric testing qualifies someone to provide psychotherapy. Some groups such as social workers may even qualify with a two year Masters degree. Why are these groups privileged to access subsidies to provide therapy? The disparity in rebates might be explained by concerted lobbying. For example, a prominent psychologist suggested the then subsidy of $124.50 (now $151.05) was "pathetic" and out of step with the reported average charge per 50 minute hour of $260 (Sapwell, 2019).

*Better Access* has been disastrous for mental health nurses (MHN) who opted instead for a now-defunct programme called the Mental Health Nurse Incentive programme where skilled nurse psychotherapists (myself included) often provided medium to long-term psychotherapy for those at risk of hospitalisation (Lakeman et al., 2020). In this survey of MHN psychotherapists, 86% of nurses had postgraduate qualifications specific to psychotherapy (in addition to graduate diplommas or equivalent in mental health nursing) and 95% had worked for over 10 years in the mental health field and had hundreds of hours of training in psychotherapy hospitalisation (Lakeman et al., 2020). Regardless of the skills, education or experience, MHNs (or anyone not belonging to the four guilds) cannot provide a subsidised service under *Better Access*.

Since the establishment of *Better Access* the number of psychologists in Australia has grown exponentially, and they now exceed nurses working in mental health and psychiatrists combined. The income of psychologists has also tracked steadily upward. Psychologists claim 94% of *Better Access* and took home over $525 million in subsidies in 2019–2020. Therein lies another problem. In the spirit of the MBS, providers can and do charge more than the subsidy. Given that the Government's response to the escalating mental health crisis associated with COVID-19 was to double the number of sessions of *Better Access* (and allow video consultations) whilst not increasing supply of practitioners, if the public wants 'focused psychological strategies' then they often must pay quite substantial gap fees and wait a long time (Rosenberg & Hickie, 2019). Meanwhile, groups who are highly skilled in providing sophisticated psychotherapy receive no rebate and often cannot compete in a market where a subsidy is expected, making them less able to assist those who are most in need and unable to pay.

There has for many years been a capped alternative to *Better Access* which was designed for a higher tier of service users who were unable to access *Better Access*. This programme, called Access to Allied Psychological Services (ATAPs),

had a higher rate of remuneration, allowed for a larger number of sessions and crucially was able to employ people who had skills in psychotherapy with at-risk groups (rather than simply specify eligibility as membership of a guild). This programme was devolved to the Primary Health Networks to commission services for people who by and large cannot access *Better Access* because they cannot afford the gap fee charged by health professionals. The rate of pay (because a fee cannot be charged on top) was more than *Better Access*. Generally, ATAPs providers are also providers of *Better Access* and often the minimum rate charged for therapy is whatever the current rate of ATAPs is (usually $135~$150 per session). If people cannot afford the *Better Access* 'gap' then a GP can refer to the clinician by name under ATAPs. Other providers (including those not eligible for *Better Access*) are often unable to enter the programme.

If this doesn't make it hard enough for competent psychotherapists to ply their craft in this anticompetitive and nepotistic environment, eligibility to *Better Access* is the benchmark for other psychotherapy MBS item numbers, most notably those to treat eating disorders. What the public perhaps doesn't understand (and neither do most politicians) is that the $1.4 billion of extra funding announced in the federal budget to largely provide more headspace centres and adult equivalent services (Department of Health, 2021a) relies on quasi-private practitioners who have eligibility to provide *Better Access*.

Sadly, in Australia, psychotherapy has been conflated with psychology and is rapidly losing a workforce of psychotherapists who cannot compete in a marketplace where their patients cannot receive a subsidised service (Hurley et al., 2020). In Australia, the dominant discourse around 'stepped care' is about the right dose of psychology and medicine (Anderson et al., 2020), whereas in Europe, the discourse is around the right dose of psychotherapy at the right time, and the conversation is with psychotherapists who are recognised as specialists (Maehder et al., 2020). Perhaps it is time to learn from the guilds, regulate psychotherapy, and strongly assert that the provision of psychotherapy is a specialist skillset and that people are best prepared to practice this craft by substantial training and supervision in psychotherapy not necessarily membership of particular guilds. The public deserves to get the right dose of the right therapy by the right therapist at the right time and for all appropriately trained practitioners in this craft to be considered and treated as equal.

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# CONTEMPLATIONS ON THE TEACHING OF HEALING AND THE HEALING OF TEACHING: Participation in a humanistic counselling classroom

Viviane Golan

*There is no such thing as a neutral education process. Education either functions as an instrument which is used to facilitate integration of the younger generation into the logic of the present system and bring about conformity or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world.*

(Shaull, in Freire, 2006, p. 34)

Viviane Golan

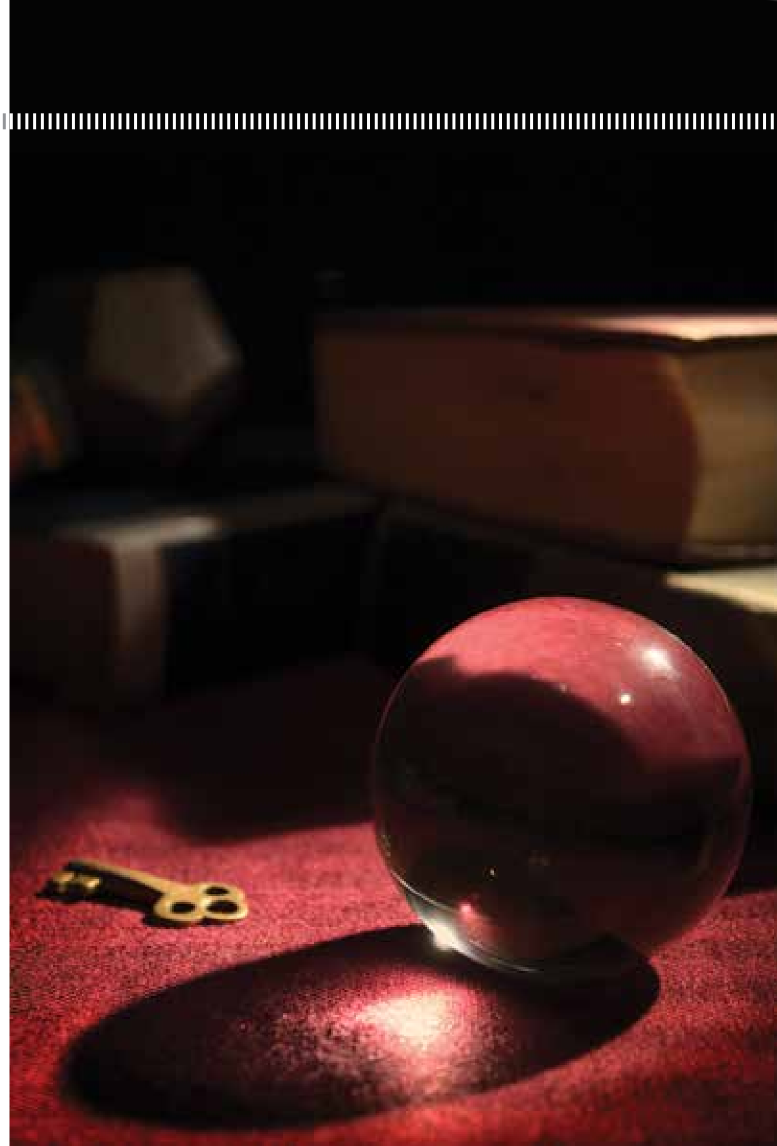
Photo: Michael Dziedzic

To teach in an environment of transformation and wholeness one is required to simultaneously participate, facilitate and witness. Transformation is the process by which one is irrevocably altered from the inside out. It is an internal revolution and not just a modification of the exterior. Wholeness may involve two seemingly paradoxical felt meanings that come together to form far more than the sum of their parts. One is a sense of coherence and belonging to self, earth, cosmos and spirit, in short; to life itself. The other, simultaneously is a sense of sincere and unique differentiation, of being a very individual and precious expression of such life (Hart, 2001; Miller, 2006). Many of the students drawn to learn the counselling or psychology professions appear to come for their own healing whether they articulate it or not. Many drawn to the teaching professions seem to come for their own learning whether it is acknowledged or not. One could think of healing and learning as involving similar processes. Both involve a transmutation of the interior of the person, an alchemical journey inward toward greater wholeness that can involve a parallel process between student and teacher or client and counsellor if the experience is to be authentic and true. I am, of course, not writing of more superficial forms of learning or healing that are more about the addition of further material to the psyche while leaving what is already there intact and unquestioned. Transformation and its goal; an ever more inclusive wholeness, is about the deeper forms of these processes where the interior is, at the very least, questioned and at the most, profoundly challenged and changed; "the very point of personhood: the process of constant renewal." (Moore, 2004, p. 47). Thus real learning can be painful, confronting, delicate, joyful, freeing and humbling.

Such a transformational quest occurs through making the acquaintance of both conscious and unconscious processes at work, in a way that leads to insight and, more importantly, ethic and meaning; factors that cannot arise from a solely rational approach (Romanyshyn, 2007, 2010). Such a quest includes the person of the teacher and of the counsellor. We are what we practice and are not separate from those that we work with, our own selves or this earth and cosmos. Participation, in this context, is about the all of our selves and requires tenderness and honouring that they may tentatively come forth.

True participation cannot be enforced or demanded. True participation involves the giving of oneself to the moment, to the room, whether it be wholeheartedly, with fear and trepidation or resistance. Participation may be lovingly invited, and a loving invite always containing the acceptance of a decline of the offer. To participate is to give of oneself, the greatest gift, and does not tend to occur under obligation or worse. True participation is of far more than on offering of intellect.

It involves one's being which has the capacity to articulate wisdoms and truths not consciously known until they escape one's mouth or pen. Old models of teaching assume an obligation of participation and begrudge it when it does not occur, a recipe for both resentful students and teachers. Inherent in a more transformative model is the knowledge that it is not possible to prescribe one's own learning journey, let alone that of another. Participation occurs in its own good time and place.

Participation requires playfulness. It is a dance of reaching out and receding, waiting, grabbing the moment, hide and seek, all best played with an air of amusement. No game is fun when played too hard, too seriously or with a need to prove oneself. Lightness brings out the best in us and renders participation an easier prospect. Learning is a daunting task. Humour smoothes the humbling and awkward journey from unaware ignorance to aware ignorance to awareness. It is an infinite cyclical process.

In some classes, as people reconnect with feelings in the body, there appears to be enormous reticence, resistance and fear, sometimes parading as boredom, usually motivated by a profound knowing that becoming more whole and connected with oneself will send ripples, initially small but building to seismic proportions, into one's life. Often, amongst the students, there is the subtle awareness that much of the structure of their lives is directly related to the compartmentalisations in their heads. A subsequent, initially unspoken, understanding then arises that external aspects of their lives may collapse as the internal structures creating and holding them begin to dissolve under the weight of the desire to become more whole and alive. And so we tread slowly, intently resting in the body, gently acknowledging the feelings, quietly sharing the thoughts, hesitantly questioning certain premises, and speaking softly lest the rest of the world hear our doubts and fears. The room, at these times, is often pervaded by a sense of guilt or disloyalty, as long held beliefs, tacit agreements and intergenerational and cultural inheritances are hesitantly unpacked and revealed. Sometimes students feel that they betray themselves by letting their pain be voiced. Others feel that their pain betrays them, voicing itself without their conscious consent. At times like these, there is a quiet yet shattering encounter going on between long held and even culturally rewarded allegiances and the longing to be whole and real, unedited and self-loved.

Learning might best be exemplified through the notion of connection rather than acquisition. When we connect to something, we know it although we may not cognitively understand it, and we also may come to love it. The necessary skills develop organically and the knowledge required is illuminated by the thing itself. We feel the matter in the inner recesses of our organs and within our bones. This learning can be transformative. Connection requires participation, the participation of the self where commitment and detachment are paradoxically simultaneous (Bolen, 1984). It occurs in the here and now even when the subject matter being considered arises from the past. It is as relevant for the sciences as the humanities. Palmer (1999) calls it recovering the sacred. He writes of the Nobel prize winning scientist Barbara McClintock who worked with ears of corn and learned to think and feel like them in the process of her investigations. Keller wrote of McClintock that, in her relations with ears of corn, she practised "love that allows for intimacy without the annihilation of difference." (p. 164). True connection respects the mystery of the other and of oneself and, in so doing, involves both strength and vulnerability.

Participation is not about how often students attend class, verbally contributes or reads assigned texts. One can do all of that and still be going through the motions. In fact, most educational institutions reward this sort of superficial engagement. True participation is with one's being and leads to direct experience. Direct experience is when the arrow hits its mark, when one's question is specifically answered even if it was still hovering below consciousness. Direct experience is when the learner and the learning become one. Such learnings happen in the core of our being and have ramifications for other times and places. They are hard to speak of and even harder to assess. Talking about something mostly requires us to disengage from it. Hence direct experience is hard to talk about and so we become wiser if not cleverer. Towards the end of a subject, students often report that they feel they have learned a great deal yet can't quite remember what and have few notes to show for class after class where we sat on the edge of our seats sharing discoveries of soulful proportions. Where the learning becomes more evident is in the clear and tangible positive changes in students' lives, their relationships and their attitude to learning.

They often find themselves communicating better with others, accepting themselves more, making peace with past pains and having more empathy and respect for that which is around them, both human and non-human. Such learnings dramatically increase their capacity to be present, congruent, accepting and accurately reflective in their counselling practice (Rogers. 1957, 1980). The power of direct experience is that it changes one from the inside out and therefore changes everything. Nothing is untouched which is what makes such learning both brutal and loving.

Often I struggle with the curriculum. The depth and feeling at which I place myself as teacher and the superficiality and rationality of the curriculum appear at great odds with each other. Curriculum is important and I am accountable for conveying it to the students in a meaningful way. However, sometimes it has not been developed from a transformative, holistic or loving perspective. Often, demands of auditors, time frames, expectations of consistency and the commonsense approach of forging future workers compliant with an atomistic world view take precedence over learning. And so I offer the curriculum to spirit, to consciousness, to a wiser, greater force than my own, to bring resonance between it and a more integral truth, to bring it into the service of a broader good than institutional requirements and work ready skills and theories. I have learned to trust that the curriculum always returns in ways I never would have thought of, ways that allow for and instigate learning and healing. Over the years, and for each group of students, the curriculum is handed back quite differently, in ways that specifically and pertinently resonate with that group so that although the syllabus is always covered, one would sometimes barely recognise that it was the same subject being taught.

The word 'participation' is often individualistically loaded, carrying the assumption that it is I, of my own free will, that participates. This is one level of participation but there are many others where the indistinct dance of destiny and choice play their parts in a growth, simultaneously, of both human and cosmic proportions. At times it seems to me that it is very much a student's or group's need that has called forth a degree of clarity or insight that I would not have otherwise felt and expressed. The frequency in the room seems to change. I feel myself transported from an I-It way of being, a subject-object mode of distant and partial communication, to an I-Thou mode of direct and essential contact (Buber, 1970).

This can lead to an I-Am fundamentality where no longer are there two or more individuals relating but the one organism, recreating itself anew in that moment. Growth is inevitable. We participate with or without our own volition. Those I-Am moments may be terrifying but they also declare a truth that I cannot deny; a spiritual identity that excludes nothing (Bache, 2000).

We live in a constructive, participatory, postmodern era. Many may resist, and many parts of those that are willing may resist, but even if one goes by the modernist belief that science knows best, this is a consensus now hard to avoid. Despite the best of intentions to maintain the rational and linear status quo, quantum physics has exploded the notions of order, control and predictability (Goswami, 1993). A deconstruction is occurring; the shattering of the old, egoic world view. Any shattering of the ego, that part of us that would claim authorship of a life lived through us (Balsekar, 1999; Liquorman, 2000, 2009), brings with it a sense of nihilism. A void opens up and at first there is nothing to replace the sense of forged certainty and false mastery. It must be so. To fill the crevasse too soon would simply produce more of the same, under the facade of a different form. The human psyche must lick its wounds and grieve its losses. Nihilism, despondency, depression; these can be signs of profound change that take time to evolve to notions of possibility and potential.

At this point concepts of chaos and complexity arrive to let us know that there is order below the random surface but it is not of our making. This is the nature of the cosmos and of all living things. Exquisite formations lie within the turbulence of our lives but they are not of our design. Autopoietic, self-evolving, dissipative structures reach levels of turmoil and confusion and then find new multidimensional, ordered states of being, surpassing anything that human intelligence can muster, let alone imagine (Prigogine & Stengers, 1985). The classroom too is a complex system where the whole is greater than the sum of its parts and is highly sensitive to initial conditions or minor fluctuations. Parts interact nonlinearly to produce emergent behaviours not seen in the individual components of the system. There is a continual, irreversible, participatory, constructive process taking place, a dynamism that builds on itself.

Participation can also hide a deeper non-participation. In all these years of striving, no matter how productive, there have also been acts of avoidance, of compensation; a non-participation with that part of me that feels itself soiled and abandoned. As human, I must claim and love this unlovable part lest I fear it forever. As counsellor and teacher, I must own and know this untouchable part, lest I project it onto others that I may then come to their aid as healer, undermining their wholeness while becoming further defended from my own. Participation would have me attend to my inner absence, that I may come to behold the fullness in the room, the fullness in my students and clients and the fullness that belies my own internal barrenness. Simultaneously, the supposed fullness of identity that has formed as compensation and cover dissipates as I participate with rather than against myself. Sometimes becoming peaceful feels more like a loss than a gain, more of an acquiescence than an accomplishment. Such capitulation may be part of the evolving ego's uncommon struggle with its own dominance and privilege in service to a form of participation that involves more of us than we may consciously know (Bernstein, 2005).

Participation is a pathless land. One cannot put a foot wrong (Tzu, 1990). It is a form of creativity, a leap from the known into the unknown, incorporating the quantum modalities of communication and inspiration alongside the classical modalities of information and perspiration. Both modalities are needed for idea to take form. "The ego has to act – but under the guidance of an aspect of the self that it knows not." (Goswami, 1993, p. 228). Individuality is a wondrous thing and even more so because it stems from a kaleidoscopic, unified whole. Our individual personalities may worship the cult of separation but our souls hunger for a greater connection that is.

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# THE "GREAT DIVIDE" AND A NEED FOR CAUTION IN PSYCHOTHERAPY

George Wills

In this paper, there is an argument made that in a world that is increasingly naïve in its divisiveness, we in the field of psychotherapy are not immune from such naiveté. Therapeutic binaries such as that between thinking and feeling and brief and long-term therapy are identified and analysed. An effort is made to identify what it is that each of us as therapists have in common and to highlight ways in which we can maximise our usefulness.

George Wills

Photo: Johnathon Arthursson

We live in a world in which there is fear and uncertainty. This is not to presume that fear and uncertainty have not existed at earlier times, but present-day instant media cause us to feel the universal nature of the fear more strongly. I presume, as do many others, that the impact of the Covid 19 virus has made this situation more stark. We are living at a time when the relative security of wealthy nations can no longer be taken for granted and the fear that is engendered has highlighted binaries as we struggle to respond. One such is so-called black versus white. According to Joseph Stiglitz (2012), his native US is no longer home to the American Dream, but instead to a "Great Divide". There is disturbance expressed at the fact, for example, that one-fifth of America's children live in poverty; the average wage of male high-school leavers has declined by 12 per cent in the past 25 years, while the pay of CEOs has swelled from 30 times the average worker's wage to 300 times.

The "Me Too" movement has increased the leverage within Western societies to no longer ignore the dominance of women by men whose last vestiges reside in their mindlessness as they assert power in relation to women. This occurs in homes, businesses, and politics, but its core is hard wired; that 'power over' is a primary motivation in human relationships while compassion and empathic understanding are not. Fortunately, although 100 years in the making, there seems to be greater hope than ever that this situation is seeing a reverse. One can only hope that the gender divide, as well as the natural varieties of sexual expression, can to be acknowledged instead of being subjected to forms of polarising prejudice.

The analysis provided by Thomas Picketty (2014) has begun to provide a substantial amount of evidence in support of the thesis that rising inequality is hard-wired into capitalism. Those favoured with social connections and economic skill in a capitalist environment, can accumulate power and wealth while condemning those without such skills or interest to relative powerlessness. This used to be true of the stark class differences in Europe that preceded the First World War but is now, ironically, greatest in the United States. One of the key drivers of such difference is the relational advantage provided by friendship and family networks in Western societies. Trump's America is an extreme example. Monarchist societies have and continue to be longstanding maintainers of advantageous difference. Let us remember that modern China has a capitalist culture, notwithstanding its totalitarian governance.

What these observations have in common is that some form of human advancement is needed. Advancement, at present, however, is contingent mainly on economic freedom so that human creativity is primarily associated with material development and comfort. Advancement in areas such as community, family and friendship circles is being neglected. I know from over fifty years experience as a therapist, that development attached to economic advancement is rarely what is of concern to my clients. Instead, they struggle with ways they might better experience peace of mind and find a sense of personal purpose.

People who turn up in the rooms of a therapist are often accused of there being something wrong with them or that they are inferior in some way. My own conviction is that they are people who have a capacity to experience the subtleties of a lived life and are finding that there is little in it that is nourishing. I find repeatedly that clients thank me for attending to their expression and find it helpful because they are so unused to receiving it or doing the same for themselves. Instead, they are inclined to repeat personal attacks that they've learned since birth and which are reinforced by society through personal contacts or through media in which there are normative expressions about right living and other forms of right behaviour or right thought.

When people feel overwhelmed, the toughest thing is for them is to see ways forward and it is this sense of overwhelm that mostly accounts for limited foresight.

To explore the claims that I am making I want to focus on my work with couples. I see the difficulties presented by each person in the relationship as sharply underlining the difficulties that each has in being faithful to their own ways of being because of fears about failing to live up to the expectations of the other. The problems faced by the couple are a microcosm of those that each of us face in the broader canvas of our lives.

When a couple comes to see me, it does not take long for me to feel a degree of anxiety arising within from pressure being applied to me. I am recalling initial sessions with a couple with whom I have been working for four years. In discussing this, I also want to point out that change takes time; and present-day pressure to name objectives, list methods and conclude time needed to create change is symptomatic of Piketty's (2012) view that inequality is hard-wired into capitalism. Since capitalism is based on the steps I have just identified, there is an assumption that change too is able to be engineered.

I am here to say that efforts by therapists to "engineer" anything with clients is counter-productive unless the client understands and accepts the role of being engineered. My own experience is that when I meet clients and they realise that I am not on about assessing them and bringing out a set of tools to change them, they express sighs of relief and understand that I am there to help them experientially to understand themselves and to make choices within their own lives.

Anyway, I return to my account of the clients to whom I was referring at the start of my last paragraph. I recall an early session in which the woman looked at me with a conspiratorial eye and began to describe the limitations of her partner and of the changes needed for him to contribute to the recovery of their relationship. She made expressions that implied that we two were professionals when it comes to understanding the human condition and that, together, we will be able to work it out. I am also presuming that her sense of professional equality arose from particularly important work she had done with a woman therapist over 15 years.

I also remember the first time I met her partner. Somewhere during the course of that session, my sense was that he felt okay enough about being with me to talk about the difficulties they were having, but wanted to impress on me that he was not there to be changed into any preconceived version of what he was expected to be.

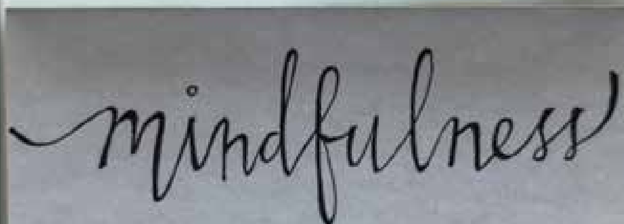


Photo: Lesly Juarez

As time has passed, it was revealed that each of them has plenty of reason to be self-protecting in the ways I have just described and it is equally true that there have been eminent reasons for each to be reserved and to desire personal independence and self-contained control. Today, I learned that the man's mother was brought up not to burden anyone and this meant that she had to manage anything problematic by herself. Consequently, she is quiet and self-maintaining most of the time except when she reckons that someone else is invading her space and being careless with her. She will then lay down the law. His father is a benevolent sort of man with a high level of sociability and is charming enough to avoid conflict. When my client was a boy, he spent a lot of time alone and he developed a lot of anxiety and fear about direct physical conflict and has retained specific bodily sensations that come on when conflict is present, (trembling, weaknesses). He then physically removes himself. The belief he has, based on these family dynamics, is that if someone erupts there is trust that the other will take it on board and be responsive. This means that the next time they are present to each other, there is nothing left over about the eruption, so they can "get on". He is conscious that his avoidant behaviour fires his partner up because it leaves her feeling invalidated and unloved. He says, though, that his experience of her is that when she expresses disappointment and he tells her that he understands, she tells him, in return, that he doesn't. These early learnings exist at the present moment as he struggles to acknowledge that his partner is someone on whom he can rely when necessary, but she also has tendencies that make it hard for him, or anyone, to know that she experiences love and a longing to be taken seriously by the other.

Both clients are about 50 years old. She is unhealthily overweight and suffers from a profound experience of being unworthy to the point that she frequently feels that she does not exist. Anything that her partner does or says to reinforce this experience causes her initially to plead for understanding, but when he self-justifies, she becomes enraged and yells at him. The back and forth of these behaviours reinforces alienation leading them to feel hopeless about desirable change coming about. I need also to point out that the woman has had awful experiences of sexual abuse, beginning at the hands of her parents when she was a baby. She has every reason to trust no one, including me.

Therapists are as equally prone as clients to think in unhelpful binaries. The first therapist binary to which I wish to attend is that of thinking and feeling. Since the early behavioural work of Skinner, there has been an emphasis on thinking and behaviour. Skinner was even vainglorious enough to insist that feeling was irrelevant to his work (Skinner, 1983). Since then, behaviourists have acknowledged that human feeling might be relevant yet much of their treatments proceed as if feeling is problematic, something to be controlled than anything more. My experience with clients is that feeling is the direct route to organic understanding that imbues conceptual understanding with validity. It is this validity that changes behaviour. (Wills, 2018).

The approach to understanding that first emphasised feeling and intuition is found in the work of Carl Jung. He noted that affects were the lifeblood of the psyche. I am afraid that I don't know enough of Jung's work to have a process understanding of how he worked but I do know that the encouragement of the subtleties of client affective and somatic experiences were central to assisting clients to develop the fullness of their personality, a process he named individuation. This notion of individuation is central to my intentions in working with clients. Regarding the couple to whom I have referred, I think that their potential was interfered with early on. For the man, it was from being left alone by overwhelmed parents and for the woman, both of her parents' narcissistic preoccupations meant that their lives and work were primary; any efforts by my client to express her individuality to them were immediately appropriated and the validity of her experience questioned. Consequently, when she experiences her partner as placing more importance on self-justification than on her immediate expression, she becomes split and angry.

In recent times, I think that each of them has become clearer that my intention when offering therapy is to understand as deeply as I can, moment by moment, and reflect this back. Where there is acknowledgement by the client, I simply continue to find out more and when there is no acknowledgment, I affirm that and continue to find out more. When working, I also look carefully for signs of emotion arising. Given that we are all brought up to see feeling as a sign of weakness, clients often quickly go on to say the next thing. I usually intervene and say "Hey, wait a second, you seemed to be feeling something. Let me know what's going on". Sometimes I will not be so direct, but I do not forget, especially if the expression arises again.

What I have discovered in the processes just described, is the challenge of being as empty as I can whilst on the other side of the relationship. I've been a Zen practitioner since 1963 and have learned from Zen that suffering arises from egoic attachment, that such attachment is virtually never-ending and that the only way to deal with it is to remain in the here-and-now as best one can. For this reason, I hope that when eventually I am dying, I will notice fear, return to the present moment, and remain curious until the next evasion takes place.[1] All of this, to me, is also a reflection of the work of Carl Rogers (1942). From him I have learned the power of disinterest[2] in what the client says. The client expresses, I listen as deeply as I can and reflect it back. Moreno et al. (1932) referred to this as "mirroring".

The second binary I have in mind is the tension around the use of assessment. Assessment is a big thing in psychological therapies. Official assessments are in a constant process of change and reasonably can be argued to have begun in 1921 when the American Psychiatric Association was set up and the first Diagnostic and Statistical Manual of Mental Disorders (DSM) was published. What has been laudable about the intention and effort is establishing a systematic way of describing the existence and frequency of psychological disorders, to differentially classify and to provide definitional frameworks for treatments. I have always been suspicious of this last criterion, however. My suspicions have been aroused because of what I see as an overgeneralisation from the precise definition of physical disorders within medicine and their treatments. In this latter, effective treatments rely on precise understandings of disorders. With psychiatric "disorders" however, conditions that do not require specific biomedical interventions have varieties of psychological "treatments" prescribed as if the treatments match the descriptions and are specifically effective. Since this has not been proved to be the case, (see Messer and Wampold [2006] and, Beutler et al. [2012]), there is a need for we who work in the therapeutic fields to be modest about the claims we make.

1. After sitting in meditation, I have been taught to say: "Caught in a self-centred dream, only suffering. Holding to self-centred thoughts, exactly the dream. Each moment, life as it is the only teacher. Being just this moment, compassion's way".

2. Forgive my excess caution. It is important to me that "disinterest" is not taken to be the absence of interest; it means that one's personal investment in the content of what is being reflected, is absent.

In my view, psychological treatments that are most specific, such as cognitive and behavioural ones, and those based on specific methodologies, such as eye movement desensitisation and re-processing (EMDR), are described as specific and brief to be in accordance with expectations that are embedded in descriptions in the DSMs. The expectations, in turn come from the growing requests of governments for mechanistic understandings of human psychological disorders to reduce the costs of medical treatments. To succumb to these pressures is to ignore the likelihood that psychological conditions that arise over many years cannot be significantly modified using short-term therapies because they are not basically mechanistic in nature.

The third problematic binary relevant to our work is efforts we make with our clients to present a professional façade to them over being immediate or present to the other. There are many subtle ways in which we can avoid being ordinarily human when we relate to others, including our clients. Fundamentally, such avoidance occurs when we are reserved. Being reserved is to keep something to ourselves that could be deepening in our relationship with the other if expressed. As therapists, we usually have learned a substantial amount of theoretical material in the field of psychology and this theoretical understanding can cause us to distance ourselves from the objects of this understanding.

When, for example, the therapist is oriented more toward assessment than to encouraging development and change in clients, clients can emerge from consultations feeling personally minimised and unable to make use of what the therapist has to say. What are likely causes of these processes? When Stanford psychiatrist, Richard Almond (2011) was conducting a review of the work of Freud, he highlighted the scientistic language used by translators of Freud's writing, particularly that of Strachey (1934). He concluded that Freud's descriptions of "Little Hans" were misinterpreted by Strachey and were better understood as: "the child's experience, attachments, and internal models are complex, fluid and multi-faceted" (Freud, 1909). Such language presents an open and flexible way Freud was thinking about the boy's consciousness and is contrary to subsequent inferences that have been made about the relatively rigid structures that have been attributed to him. Principle among these structures is Freud's theory of attachment. Freud pointed out that it is a two-way process, but to my view, much of the professional reserve of therapists is attributable to efforts to understand client transference while avoiding the same processes going on in the therapist. The fact is that transference will go on and the therapist's responsibility is to be open to understanding both sorts of transference but always at the service of the work of clients.

What, then, do we do to manage some of these binaries? What, then, do we do to manage some of these binaries? Primarily, my answer is to avoid splitting processes within ourselves. We are socialised creatures as are all of life's animals. Socialisation permits us to avoid being left out of our tribes, and vulnerable to destruction. Consequently, there is a potential for social disorder if we place too high a value on discovering the ways in which each of us is unique. Nonetheless, the whole of humanist-existential literature contains argument about the virtues of becoming true to your being and this, notwithstanding the fear that is engendered in those who would prefer to maintain present order, into eternity. Within humanist-existential thought is the assumption that the more we live a life we have been socialised to, the less we know about ourselves and the more likely we are to act out of unconsciousness.

Nonetheless, the word "liberal(ism)" is being bandied about nowadays as if it is a form of defection from social order, and the word "traitor" was used by some, in recent demonstrations against the Victorian Premier Daniel Andrews, for the efforts of his administration to act on scientifically-based advice about the Covid virus. Many commentators have been of the view that these tensions in Australia are but a minor form of those that emerged in the United States with the election of Donald Trump, his subsequent loss of office, and efforts being made by many Republican supporters to have him, or his views, re-elected so that what is "safe" for the country can once more be established. This is a struggle that has been of long-duration there (Bennet, 2007), and is symptomatic of the enactment of a social binary between personal freedom and government control. In America, personal freedom includes having the right to carry weapons such as an AK 47, in public places.

When Martin Buber (1937) wrote of relationships, he posited a primary distinction between circumstances in which the other is primarily an "it" to the subject, and circumstances in which the other is primarily a "thou". His point was that while instrumentalism can be necessary for reflecting, designing and executing plans, it is a mistake if it is brought to bear on relationships where there is a hope for each opening up to the other – opening up without design and with a desire for greater intimacy. As a theist, Buber had humankind's relationship to God in mind when writing in this way. In effect, the "I-thou" relationship was contiguous with one's efforts to encounter God. In fact, the word "encounter" was used by Buber to underline the quality of relating that is contained in the "I-thou" relationship. Subsequently, in the two or three decades following the late 1950s, there

emerged in the Western world a hunger for this type of relating that was the basis of so-called “encounter groups”.

I mentioned earlier about a recent paper of mine (Wills, 2018) in which I engaged in a qualitative analysis of the work of an Australian colleague who was demonstrating the use of CBT with a client who had become so scared of life that he was being accused of being a bully in his place of work. I was extremely impressed with the quality of the work of the therapist who provided the so-called “CBT” treatment. My approval arose from the subtlety, respect, and congruence that he displayed virtually throughout the session, that is, until he explicitly began to advise thinking and behavioural revisions to his client. When this happened there was sufficient evidence, according to my qualitative analysis, of a retreat in both parties to cognitive explanations for the client’s sense of worthlessness.

My conclusion was that the deterioration in the value of the work was entirely attributable to the imperatives embedded in the therapist’s task of demonstrating the CBT method. What is more, what I observed was entirely consistent with the work of Wampold & Imel (2015) when they presented evidence of the lack of any superiority among different ways of conducting therapy. My view is that their conclusions arose from the extremely high probability that it was the quality of the working relationship among therapists and clients among those different methods that explains outcome, not the theoretically preferred explanations. I realise that, at this point, I might be accused of making the same mistake; that is to reify a theory. My defence against such an accusation, is that since difference of theoretical model is not able to explain outcome quality, the only viable alternative is about working relationship quality and such quality is about subtle processes. It would be as useless to think of such qualities as a theory as it would be to develop theories about Bach’s creativeness – possible, but unrelated to the creativity.

The quality of working relationship was formally identified many years ago by Carl Rogers (1942) and has been extended and differentiated by people like Greenberg and Safran (1987), Greenberg (2002), Elliott et al. (2004), Egan & Reese (2018). I do remain suspicious of the operational differentiation offered by them, however. My fear, as I hope is now obvious, is that scientistic minds might well become more interested in the differential effects of the variables they identify than in the overall quality of the working relationship. I want to argue that they have provided us with a gift when they find names to enlighten us about the nature of an optimal working relationship but I want to caution any person learning about approaches such as theirs against forgetting their abilities to be present, real, respectful and understanding when they are working.

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# THE USE OF TELEPRACTICE IN THE FAMILY AND RELATIONSHIP SERVICES SECTOR

Anagha Joshi, Nicole Paterson, Trina Hinkley, Nerida Joss

The use of telepractice as a service delivery method has increased in Australia since the start of the COVID-19 pandemic. This paper reviews the evidence for telepractice as a service delivery method in the family and relationship services sector. It describes the acceptability of telepractice as a service delivery option for both clients and practitioners, the enablers and barriers to uptake and implementation, and the current evidence on client outcomes. Evidence-informed implications of implementing telepractice for practice in this sector are also presented at the end of the paper.

Note: This is an edited and truncated version of this paper. The full publication can be accessed via the Australian Institute of Family Studies (AIFS) website. https://aifs.gov.au/cfca/publications/use-telepractice-family-and-relationship-services-sector. We would like to thank AIFS and the authors of this paper for permission to republish it here.

## Key messages

- Telepractice can be a satisfactory form of service delivery for clients and practitioners, when personal preferences and client circumstances are considered.
- Key enablers of telepractice include ensuring that service providers are sufficiently skilled in the use of virtual service delivery and that clients and organisations have access to, and the skills to use, the necessary technological resources.
- Key barriers to using telepractice include difficulties engaging clients, digital inequities and privacy risks, practitioner resistance and an organisational environment that is not set up to support telepractice.
- The benefits of telepractice compared to face-to-face services include improved access to services for certain populations and it can provide practitioners with insights into family life through video-conferencing technology.
- There is limited material comparing client outcomes from telepractice with client outcomes from face-to-face delivery.
- Some evidence suggests that telepractice may suit certain service areas (e.g. mental health related early intervention compared to other family and relationship services).

## Introduction

As the COVID-19 pandemic began in 2020, many child, family and social services across Australia transitioned to online/telephone service delivery due to mandated physical distancing restrictions affecting traditional face-to-face service delivery. At the same time, services providing family and relationship support (such as child and family services, mental health and family law services) experienced a surge in demand due to an increase in family violence, unemployment, poor mental health, and financial hardship (Bowden & Johnson, 2020; Crime Statistics Agency, 2020).

The family and relationship services sector in Australia includes a variety of family and child related services. Those services aim to strengthen family relationships, prevent breakdown, support families through change, and ensure the wellbeing and safety of children, through prevention and early intervention strategies. The family and relationship services sector also includes services provided under the Australian Government's 'Families and Children' Activity such as Family Law Services, Communities for Children (place-based) services, Children and Parenting and Adult Specialist Support.

Historically, the family and relationship services sector has under-used technology in service delivery compared to the medical and health care sectors (Lee, Flint, & McIntosh, 2017). Similar to these sectors, the family and relationship sector often works face-to-face with clients on a one-on-one (or one family to one practitioner) basis, providing tailored, evidence-based interventions that target specific or multiple needs (e.g. counselling, parenting interventions, early intervention for child development delays). The use of technology in medicine and health care has a relatively robust evidence base, with multiple large-scale reviews finding positive patient experiences associated with the use of telepractice (e.g. satisfaction with health outcomes, avoiding travel, having access to their preferred modality of service delivery and low cost) (Dods et al., 2012; Orlando, Beard, & Kumar, 2019). However, for the family and relationship service sector, evidence on the effectiveness, benefits or risks of telepractice as a service delivery model is not as clear. Family and relationship services operate differently to health and medical services; therefore, evidence from these sectors is not directly transferable.

## What is telepractice?

Telepractice refers to the use of telecommunications technology – including voice calls, video conferencing or teleconferencing – to assess, triage and provide therapeutic and other supports to clients, enabling clients and service providers to meet despite being in different physical locations. Several terms are commonly used to describe this form of service delivery including telehealth and

telemedicine. Telepractice provides a broad definition that encompasses services outside the health sector, including early intervention services, education and therapeutic or social services (Akemoglu, Muharib, & Meadan, 2020).

As Australia shifts into 'Covid-normal', services and their clients are adjusting to new ways of providing and accessing services, including the increased use of telepractice as a service delivery model. At the same time, traditional face-to-face models are being challenged on their ability to reach different types of clients with specific needs for the services they are accessing. Unlike the health and medical sector, the evidence on the effectiveness, benefits and risks of telepractice as a service delivery model is still emerging in the family and relationship services sector. For this reason, this paper will focus on telepractice services outside of health and medicine in an effort to capture evidence specific to the family and relationship sector.

This paper answers the research question: *What evidence is there on the use of telepractice in family and relationship services?* It describes the acceptability of telepractice as a service delivery method for practitioners and clients, implementation considerations and client outcomes. The paper also highlights key considerations for practice managers regarding the implementation or integration of telepractice into routine service delivery.

## Methodology

A scoping review was undertaken due to the broad nature of the research question and the relatively small amount of evidence on the topic. This review methodology is also rapid and allows for consultation and engagement with key stakeholders to review findings. The methodology used in this review was informed by Arksey and O'Malley (2005) and the *Joanna Briggs Institute's Manual for Evidence Synthesis* (Peters et al., 2020). CFCA would like to acknowledge Family and Relationship Services Australia's (FRSA) contribution to shaping the research question for this paper.

Literature was searched across three types of publications: academic journals, online grey literature and reference lists of included publications. The database literature search identified 1,777 publications. Twelve publications were added from the grey literature search and a further six from reference lists. Of those 1,795 publications, 30 publications were selected for review based on the inclusion and exclusion criteria.

## What does the evidence tell us?

### Acceptability of telepractice as a delivery method

'Acceptability' was described in the publications in this review as the level of satisfaction for the use of telepractice as an alternative service delivery method to face-to-face services. Across the publications reviewed, telepractice was found to be satisfactory for clients across several areas including intimate partner violence prevention (Anderson et al., 2019), early intervention parent counselling (Owen, 2020), family counselling for treatment of challenging behaviour (Schieltz & Wacker, 2020) and domestic violence and sexual assault therapy (Gray et al., 2015; Steinmetz & Gray, 2017). Primary research investigating telepractice satisfaction in clients undergoing couple/family therapy (Burgoyne & Cohn, 2020) and parents receiving training to support their children with challenging behaviour (Ruppert, 2016) also found that telepractice was acceptable to these groups. Parents indicate a preference for a hybrid model, incorporating both telepractice and face-to-face service delivery, according to a literature review on technology assisted parental interventions and primary qualitative research on parental counselling (Hall & Bierman, 2015; Owen, 2020).

However, telepractice acceptance may be dependent on client characteristics such as income level and comfort in using technology. For example, one literature review showed that parents with higher incomes were more receptive to the delivery of interventions online (Hall & Bierman, 2015). While further research is required on why this is the case, the review indicated that it could be due to lower-income parents having limited access to technology and less comfort with using technology (Hall & Bierman, 2015).

The evidence suggests that practitioners find telepractice less acceptable as a service delivery model compared with face-to-face due to concerns regarding privacy and limitations in developing client rapport. For example, practitioners have described how the loss of visual cues affected communication and rapport with their clients (Pfitzner, Fitz-Gibbon, McGowan, & True, 2020). Practitioners seem to be more accepting of technology when provided with organisational support, online communication training, and through using techniques to protect client privacy; for example, by using headphones during consultations (Ghiara, 2020; Lee et al., 2017; Wrape & McGinn, 2019).

## Implementing telepractice

### Enablers to telepractice

- Acceptance, access and authorising environment for telepractice

  Organisations and clients need access to the necessary digital resources to deliver and receive telepractice. Appropriate hardware with built-in or external audio-visual capabilities (e.g. laptop, computer, tablet, smartphone) aid with telepractice. A consistent, high-speed internet connection is also essential to facilitate telepractice service delivery for providers and clients. Where clients do not have access to appropriate equipment, one research paper suggests organisations provide equipment to facilitate service delivery and minimise digital inequity and access limitations (Gurwitch, Salem, Nelson, & Comer, 2020). Having access to technology support (such as a dedicated IT team) can allow for the smoother delivery of services (Pfitzner et al., 2020; Sourdin & Zeleznikow, 2020).

- Competencies to deliver telepractice

  The confidence, skill and adaptability of practitioners support the successful implementation of telepractice. Opportunities to practice using virtual service delivery methods helps to improve practitioner confidence in using the technology (Owen, 2020). Interactive peer meetings and training on video conferencing can help to increase practitioner skills (Owen, 2020). Several publications highlighted that upskilling practitioners in the use of technology facilitates telepractice (Cole, Pickard, & Stredler-Brown, 2019; Early Childhood Intervention Australia, 2020; Ghiara, 2020; Hall & Bierman, 2015; Owen, 2020; Ruppert, 2016). Supporting practitioners to understand the logistics (e.g. the technology required such as secure platforms for service delivery) and benefits of telepractice is also considered useful (Cole et al., 2019). Ensuring clients were prepared before beginning telepractice also aided delivery; for example, letting the client know what a session will entail so they can be prepared with resources (e.g. toys for a child during the session). Practitioner flexibility when planning a session was identified as an enabler; for example, working with the client to ensure a suitable intervention format (e.g. multiple shorter appointments might be preferred) (Schieltz & Wacker, 2020).

- Flexibility to accommodate client preferences

  Understanding and working with a client's resources (e.g. digital resources and private space) to meet their needs and goals is another enabler of telepractice. A recent guideline produced by Early Childhood Intervention Australia, and in a recent report from the UK, recommends an initial face-to-face session to build rapport with the client and make sure they are comfortable, prior to using telepractice (Early Childhood Intervention Australia, 2020; Ghiara, 2020). Additionally, allowing clients to choose their preferred method of service delivery may facilitate better engagement (e.g. a hybrid approach with both in-person and telepractice appointments (Burgoyne & Cohn, 2020; Early Childhood Intervention Australia, 2020; Hall & Bierman, 2015; Owen, 2020).

- Other enablers

  Establishing a back-up plan for technology failures can improve telepractice and ensure a more consistent service delivery for clients. For instance, if the internet connection fails, delivery can continue on the phone (Steinmetz & Gray, 2017). Other enablers identified include being innovative by providing visual aids to assist client engagement and to cater to all levels of literacy (Hall & Bierman, 2015; Lee et al., 2017) and practical tips such as keeping the web layout for online platforms similar to paper forms (Lee et al., 2017).

## Barriers to telepractice

Barriers are the challenges to accessing, implementing or successfully using telepractice in family and relationship services.

### Limits to digital technology and technical ability

Concerns over inequitable digital access, also known as the 'digital divide', 'digital equity' and 'digital poverty', were articulated across the publications in this review. Unequal digital access can impact clients who cannot afford the required equipment or technology, such as high-speed internet. Certain population groups may have more difficulty accessing telepractice services; for example, older adults who might be less familiar or comfortable with using technology (Emezue, 2020). Unreliable functionality of technology (e.g. poor internet connection, video freezing) is frequently reported in the literature as a barrier to telepractice (Cole et al., 2019; Early Childhood Intervention Australia, 2020; Emezue, 2020; Kohlhoff, Wallace, Morgan, Maiuolo, & Turnell, 2019; Sourdin & Zeleznikow, 2020; Steinmetz & Gray, 2017).

### Attitudinal barriers from practitioners or service providers

Practitioners' attitudes towards telepractice can pose a barrier to virtual service delivery. Research showed that when practitioners had reservations about the capacity of telepractice to deliver client outcomes, or assumed their clients would prefer traditional face-to-face models of service delivery, telepractice was less likely to be offered (Cole et al., 2019; Lee et al., 2017). Practitioners were reluctant to use telepractice when working with clients who had complex needs (Wrape & McGinn, 2019). Similarly, telepractice was not considered by the practitioner if the practitioner believed there was no organisational support (Owen, 2020).

### Risks to client engagement and rapport

Another barrier that practitioners delivering telepractice identified was the potential communication risk it poses to client engagement (Ruppert, 2016). Difficulty engaging clients could occur from the outset if there was significant investment required on the client's behalf to set up the technology (e.g. needing to download software or learn a new platform) (Anderson et al., 2019). Practitioners were also concerned about the difficulty in building rapport with families or children over telepractice, with the loss of non-verbal cues and limited ability to establish trust (Burgoyne & Cohn, 2020; Sourdin & Zeleznikow, 2020). Practitioners expressed difficulty in being able to accurately assess clients or convey empathy via technology, which may be particularly problematic when working with clients from culturally or linguistically diverse backgrounds (Pfitzner et al., 2020).

### Concerns about privacy and inappropriate telepractice environments

Concerns about privacy were also frequently identified. If unaddressed, this could create a significant barrier to telepractice, posing potential risks to professional codes of ethics and duty of care to clients (Lee et al., 2017; Rogers, 2020). Platforms used for telepractice need to be secure in terms of client confidentiality and data storage (Doss, Feinberg, Rothman, Roddy, & Comer, 2018; Early Childhood Intervention Australia, 2020; Emezue, 2020). Practitioners and clients may not have an appropriate space at home, without distractions, to participate in telepractice (Burgoyne & Cohn, 2020; Owen, 2020).

One publication highlights how practitioners have minimum control over the treatment space when using telepractice, which poses potential safety risks if a child elopes from the treatment space (Kohlhoff et al., 2019). Privacy risks are magnified for victims of family and domestic violence, who require a private and safe space away from perpetrators to receive support from specialist services. Telepractice may also inadvertently provide perpetrators with an additional avenue to abuse their victims; for example, through digital tracking and impersonation, online stalking and surveillance (Emezue, 2020).

## Perceived benefits of telepractice

Several publications in the review described how telepractice has been beneficial for clients and practitioners or described how telepractice is perceived to be beneficial for service delivery. Clients and practitioners in the family and relationship services sector appreciate the greater flexibility and convenience that telepractice provides. Benefits include parents' attendance at appointments while caring for young children, reduced coordination efforts required to organise child care and reduced travel time to attend clinics (Kohlhoff et al., 2019; Pfitzner et al., 2020).

The evidence suggests that telepractice is perceived to improve access to services, particularly for:

- remotely located families who do not have access to local practitioners or find it difficult to travel long distances (Anderson et al., 2019; Burgoyne & Cohn, 2020; Cole et al., 2019; Comer et al., 2017; Gray et al., 2015; Kohlhoff et al., 2019; Steinmetz & Gray, 2017)
- clients with a disability or who are housebound (Burgoyne & Cohn, 2020; Hall & Bierman, 2015)
- clients undergoing domestic violence screening through providing visual aids online and reducing literacy burden (Lee et al., 2017)
- clients with complex circumstances, through greater ease of access to multiple professionals from different locations through group video conferencing (Early Childhood Intervention Australia, 2020; Pfitzner et al., 2020).

Telepractice can provide personalised and consistent connections with families; for example, by connecting family members who are physically separated (Wrape & McGinn, 2019) or providing continuity in care if a client moves location (Burgoyne & Cohn, 2020; Owen, 2020).

Practitioners can obtain unique and valuable insights into a family's life, interactions and environment through telepractice. Practitioners can observe parenting skills in the context of the family's life and provide tailored support (e.g. by understanding what toys are available at home) (Kohlhoff et al., 2019). In early interventions for children, telepractice allows parents to 'take the lead' in their interaction with their child during the session, because the practitioner is not physically present (Early Childhood Intervention Australia, 2020). Telepractice may also facilitate sessions during non-traditional hours, giving access to important daily routines (e.g. mealtimes) and providing insight into family functioning (Cole et al., 2019).

Telepractice may be less intimidating and less stigmatising, compared to face-to-face service delivery, for clients obtaining certain services, such as mental health services (Comer et al., 2017; Doss et al., 2018; Wrape & McGinn, 2019). This could be a valuable consideration for services operating in regional and rural locations, where client anonymity is more difficult to protect. Clients at an Australian domestic violence men's service reported that using a telephone was less intimidating than face-to-face delivery (Pfitzner et al., 2020).

Additionally, in a literature review on domestic and intimate partner violence, some survivors preferred tech-enabled interventions and online guided support because of the confidentiality it provided (Emezue, 2020).

## Client outcomes from telepractice

The review showed that there was limited evidence on client outcomes for telepractice in the sector (few studies or poor-quality evidence). Five evidence reviews, including one systematic review, and one report reviewed the evidence that compared client outcomes from telepractice to face-to-face service delivery (Anderson et al., 2019; Caldwell, Bischoff, Derrig-Palumbo, & Liebert, 2017; Hall & Bierman, 2015; Lee et al., 2017; Martin et al., 2020; Schieltz & Wacker, 2020). Comparisons between telepractice and face-to-face services were evaluated in programs focused on intimate partner violence (Anderson et al., 2019), early interventions for children and young people across a range of areas including education, physical and mental health, substance misuse and so on (Martin et al., 2020), parenting (Hall & Bierman, 2015), couple/family therapy (Caldwell et al., 2017), parenting and child mental health (Lee et al., 2017) and functional assessment/function-based therapy (Schieltz & Wacker, 2020).

No reviews found telepractice produced better client outcomes than face-to-face delivery. The remaining evidence showed varying degrees and inconsistent levels of effectiveness between the two delivery methods. Two literature reviews and one rapid review suggest that when compared, client outcomes from interventions delivered via telepractice were poorer or equivalent to those delivered face-to-face (Lee et al., 2017; Martin et al., 2020; Schieltz & Wacker, 2020). There was some evidence to suggest that telepractice can produce comparable outcomes to face-to-face delivery for clients receiving mental health treatment (Lee et al., 2017) or mental health early intervention (Martin et al., 2020). Limited evidence exists for two specific services producing equivalent outcomes: early intervention programs targeting risky sexual behaviour or teenage pregnancy (Martin et al., 2020) and functional assessment/function-based therapy (Schieltz & Wacker, 2020). Some evidence suggests early intervention programs targeting substance use via telepractice may produce worse outcomes than traditional face-to-face service delivery (Martin et al., 2020).

Recent primary research studies suggest telepractice may be more effective compared to face-to-face delivery with specific interventions. An online family problem-solving therapy for adolescent dysfunction (Kurowski et al., 2020) and internet-delivered parent-child interaction therapy (Comer et al., 2017; Kohlhoff et al., 2019) showed better self-reported outcomes, improved child behaviour and symptoms compared to face-to-face delivery. This could be because the target group for the first study were adolescents, who may be more amenable to telepractice techniques due to their familiarity with online resources (Kurowski et al., 2020). In the second study, parents were able to participate in the parent-child interaction therapy in their natural home environment, which may be more effective than in an office environment (Comer et al., 2017). These interventions were highly specific; therefore, findings may be less applicable to other areas of practice, target groups or contexts. Some aspects of program delivery may need to be modified when using telepractice and only some programs may be suited to this type of delivery. However, the evidence is not yet clear and caution is required when using these findings in practice.

## Technology requirements

Digital access and technology requirements for telepractice are key factors influencing the effectiveness of delivery for both practitioners and clients. Evidence shows that organisations and clients need access to the appropriate technology, internet and devices for telepractice to be considered viable (Pfitzner et al., 2020). Practice managers may need to consider the organisation's scope to supply these resources to clients who have limited access to technology (Gurwitch et al., 2020). This may be more challenging in certain circumstances; for example, telepractice in remote communities may be restricted by a lack of availability of high-speed internet (Cole et al., 2019; Thomas, Barraket, Rennie, Ewing, & MacDonald, 2020). In this review, specific guidelines on what technology requirements are needed to facilitate telepractice in the family and relationship sector were not found. When implementing telepractice, it may be helpful to consider published guidelines from other sectors for information on how to support clients using technology and minimum requirements for technology set-up and use.

## Conclusion

This paper reviewed the evidence on telepractice as an alternative or complementary option to face-to-face service delivery in the family and relationship service sector. Research on telepractice for the family and relationship service sector is emerging, especially in response to the Covid-19 pandemic in 2020. According to this review, telepractice can be an acceptable mode of service delivery for clients but suitability to telepractice must be assessed based on individual context. There are several potential disadvantages to telepractice including privacy concerns, access, affordability and ease of use for certain user groups. To support practitioners, services may need to invest in developing the technological skills of practitioners and their understanding of the benefits of its use.

At present, there is limited evidence comparing the impact of service delivery via telepractice on client outcomes compared to face-to-face service delivery (not enough studies/poor quality) and there were no evidence reviews included in this review suggesting that telepractice produces better outcomes for clients compared to face-to-face service delivery. While the evidence is limited, there is some evidence to show that certain family and relationship services, such as mental health related services, may be more amenable to telepractice than others. Further research and evaluation would allow for improved insights into client outcomes.

Telepractice may provide unique benefits to the family and relationships service sector, including gaining insights into family life in the home. It may also improve access to services for clients, provide greater flexibility for clients and practitioners, and can be less stigmatising in certain family and relationship services such as family and domestic violence services. Telepractice provides benefits that work well as an addition to, and not a necessarily replacement of, face-to-face consultations. As the family and relationship services sector continues to adapt to changing circumstances as it moves into 'Covid-normal', telepractice may be a required part of the mix of service delivery methods in order to stay nimble and respond to client needs. This paper provides a starting point to understand the evidence in this space.

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Photo: Priscella du Preez

# THE INSIDE STORY OF ATTACHMENT: What can Internal Family Systems Therapy offer?

David Eckel

David Eckel

How many of us have seen our own challenges with connection and relationships in our clients and their stories? And how many of us have felt the sharp pang of embarrassment when these relational challenges unexpectedly emerge between the client and ourselves? Throughout the course of my career as a mental health social worker, attachment theory has intermittently helped me understand and navigate these challenges... up to a point. The commonly understood four categories of attachment (secure, anxious, avoidant, disorganised) have assisted me in case conceptualisation again, up to a point.

In my moments of presumption and hubris when I think I've figured out a client's attachment style and proceed with the work, I'm inevitably confronted by the client in the same or following session inhabiting another, clearly different attachment style. I have also noticed that I may shift my way of connecting with a client(s) depending on their different attachment styles. This common occurrence has challenged my longstanding, 'lite' understanding of attachment as the four, fixed rudimentary categories.

There are alternate ways of understanding attachment that could more comprehensively embrace the real-world complexity of connecting with others. David Wallin, a prominent attachment commentator and clinical psychologist eloquently speaks to this therapeutic conundrum:

> That most people have a multiplicity or "layering" of states of mind partly explains the paradox that as therapy moves along and we presumably know the patient better, we often feel less clear about exactly who the patient is – or, at any rate, that clarity is no longer reducible to a single classification (Wallin, 2007, p.97).

These layered states of mind could also refer to 'parts' in Internal Family Systems (IFS) Therapy. I first became interested in IFS as part of my efforts to upskill in the area of trauma. It appeared to me to offer a simple yet elegant model to understand oneself and others that incorporates elements of mindfulness and mentalisation, as well as provide a compassionate way to process trauma. IFS is a therapy about different parts of our psyche, and the way in which we connect or attach to these parts. My personal experience as a client engaging in IFS has consistently been one filled with self-compassion and acceptance, profundity and power, and a sense of increased connectedness both internally and externally.

What might the Internal Family Systems model (IFS) be able to offer attachment theory, and vice versa? During IFS training two years ago, an impassioned discussion took place about how the IFS model considered that a secure attachment in childhood was not required for an adult to possess the qualities and capacities of secure attachment. It was not until I felt the heat of this discussion, did I consider that there could be something to be gained for both attachment theory and the IFS model to meet and learn from each other.

Internal Family Systems is a psychotherapeutic model about multiplicity of the mind. It is a promising psychotherapeutic treatment for clients who have insecure styles of attaching to others. In this article it is hypothesised that IFS can be considered an attachment-based therapy that sufficiently addresses and embraces the complexity, contradictions and breadth of present-day attachment theory, research and therapeutic practice. This premise is explored by highlighting and questioning the links and similarities, and points of divergence and controversy between IFS and attachment theory.

## Reaching inwards to the Self with IFS

A psychotherapy about parts of an individual's personality is not new. IFS has emerged from a lineage of psychotherapies focused on parts, such as Gestalt Therapy, Ego-State Therapy and Schema Therapy (Falconer & Schwartz, 2017). However, the way in which these parts are related to, and the 'who' with whom they relate and attach to is distinctive and highly consequential in IFS.

IFS was conceived and cultivated by Richard Schwartz in the United States during the 1980s (Schwartz & Sweezy, 2020). Schwartz began to recognise that particular parts harnessed specific functions in a client's external world, and that often they would exhibit internal relational patterns with other parts that mirrored relational dynamics that transpired in families (Falconer & Schwartz, 2017; Grabowski, 2017). When an IFS therapist facilitates an internal conversation between the client and a part that is activated or up for exploration, it is common that other concerned parts step in to prevent this from happening. By asking other parts that tended to obstruct the client dialoguing with the selected target part to step aside, Schwartz discovered a persona or aspect of the client that seemed to hold similar qualities for every client he applied this intervention to (Goulding & Schwartz, 2002; Schwartz, 2013a). When parts that hated, were irritated, or were fearful of the target part stepped aside, Schwartz witnessed the client relate from a mindful distance to the target part with some semblance of compassion, curiosity, love, kindness and calmness (Earley, 2009; Schwartz, 2004). Schwartz named this aspect of the client the Self, and has since articulated that Self is one of the salient defining features of IFS (Falconer & Schwartz, 2017; Schwartz, 2004; Schwartz & Sweezy, 2020).

Photo: Ari Spada

The IFS understanding of Self is of a compassionate state of consciousness at the core of an individual's multiplicity, which differs from the colloquial understanding of 'self' as a whole, unitary person (Falconer & Schwartz, 2017, McConnell, 2020).

The combination of several existing key theoretical stances underlies IFS theory and practice. These key concepts include systems theory, and multiplicity of the mind – viewing the individual as a system of parts (Cahill, 2015; Goulding & Schwartz, 2002; Hsieh, 2015). This standpoint challenges the prevailing view in Western culture that an individual is comprised of a singular mind (Falconer & Schwartz, 2017). IFS subscribes to the multiplicity of the mind paradigm, seeing an individual containing multiple 'parts', or indeed 'little people' inside of them (Earley, 2009). Parts that are referred to as manager or firefighter parts may play a protective role in the client's life, whilst others that are referred to as exiles may hold, what IFS calls 'burdens', from traumatic or painful past experiences (Makidon, 2014). This internal ecology of parts is considered a system in the IFS model, broadly similar to how a system is viewed in family therapy, with individual parts relating and co-ordinating with each other and/or Self in a particular way or pattern (Schwartz & Sweezy, 2020). As previously mentioned, aside from parts working in an internal system, the radical and elemental defining feature of IFS is the notion of the Self. Self is the core essence or spirit within an individual, that has been undamaged since birth, and is viewed as the natural leader of the parts in a person's system (van der Kolk, 2014).

Schwartz recounts unwittingly encountering the Self in individuals in the early development of the model – a presence and demeanour was revealed that possessed the qualities of being calm and caring, from which clients related to parts, whether they be critical managers, reactive firefighters, or overwhelmed exiled parts (Schwartz, 2004). Schwartz began to define the Self by listing the qualities he repeatedly and consistently observed, which he eventually formulated as the 8's of Self– compassion, curiosity, calm, confidence, clarity, creativity, connectedness and courage (Anderson et al., 2017; Falconer & Schwartz, 2017; Schwartz, 2001). These C words did not exclusively define Self, but rather acted as a template from which to begin to recognise Self, given that clients also experienced Self amongst other qualities as present, collaborative, wise, joyful and grateful (Anderson et al., 2017; Schwartz, 2001).

Schwartz noted that once clients were able to access the energy of Self, as therapist, he was required to do very little, with the Self rising as principal therapist and natural leader in the process of relating to, and healing parts (Schwartz, 2013b).

The phenomenon by which parts 'step back' to reveal a previously occluded Self is termed 'unblending' in IFS (Krause, Rosenberg & Sweezy, 2017). When an individual is of the mindset that a part is all of them and they are unable to achieve a mindful distance from a particular part, IFS perceives that the part has 'blended' with the client and Self is difficult to access (Anderson et al., 2017).

With Schwartz discovering that Self was present in the most traumatised and attachment-deprived clients, he postulated that Self was present in everyone, from birth, and remained undamaged throughout the life course, only to be blocked and hidden by other parts intent on enacting their strategies or role, or having their emotional pain recognised. (Falconer & Schwartz, 2017; Herbine-Blank, Kerpelman & Sweezy, 2016; Schwartz & Sweezy, 2020). The discovery and subsequent pivotal position of Self in IFS has become its primary treatment goal. "The goal of IFS therapy is to help clients become Self-led, which means that their parts feel loved by the Self and trust the Self's leadership." (Schwartz & Sweezy, 2020, p.23). In the domain of psychotherapy, Self has also been referenced and known in different forms with Jung referring to it as active imagination, whilst Carl Rogers described the actualising tendency and self-actualised individual who could be autonomous, open and present to experience (Kirschenbaum & Henderson, 1990; McLeod, 2013). Rogers asserted that clients had the resources they required already residing within them–a view consonant with IFS (Falconer & Schwartz, 2017; Kirschenbaum & Henderson, 1990). Schwartz openly acknowledges other spiritual and psychotherapeutic ways of knowing Self. However, he contends that unlike spiritual traditions that require often years of practice to reach Self, he has discovered a faster and more direct way with IFS (Schwartz, 2001, Schwartz & Sweezy, 2020). Despite citing manifestations of the Self in religious traditions and psychotherapy, no explicit empirical evidence exists at present to support Schwartz's specific premise of Self.

The IFS view of Self is a radical departure from how self is understood in the context of attachment theory. Alan Sroufe, clinical psychologist, professor, and eminent attachment researcher states–"...self is an outgrowth of the dyadic organization that preceded it." (Sroufe, 2000, p.67). The self Sroufe refers to is the individual human being and their singular, mono-mind. The dyadic organisation he mentions is the infant-caregiver attachment relationship. Sroufe essentially proposes that our sense of self emerges and is created from our attachments with others (Sroufe, 2000). IFS proposes that Self emerges when parts 'unblend', and that Self has been ever-present (Schwartz & Sweezy, 2020). Attachment has commonly been viewed as a 'cradle to grave' phenomena, however Mikulincer and Shaver (2018) contend that attachment bonds can be experienced beyond the grave through the memory of a dead person, or with God or other deities, who act as attachment figures serving as imagined and symbolic sources of security for surviving individuals. This beyond-the-grave view of attachment affiliates itself with Schwartz's view of the Self being connected beyond the intrapersonal and interpersonal to something more expansive. "The sparks of the eternal flame that had dispersed into people and into parts are uncovered and reunited...people feel integrated, as if they belong in the universe, as if they've come home." (Falconer & Schwartz, 2017, p.270). The beyond-the-grave view of attachment in regards to attaching to spiritual deities or the deceased also ties in with what are known as 'Guides' in IFS. Guides are defined as, "...benevolent spirits or energies that are external or non-native to one's system of parts...to help, guide and protect." (Glass, 2017, p. 153).

## Reaching outwards to others with attachment theory

These expansive perspectives on attachment and self were not in view at the birth of attachment theory. Indeed, attachment theory has been one of the most influential psychological constructs of the past 50 years, and as a body of knowledge, it continues to grow and evolve (Howe, 2009, 2011). There now exists a multiplicity of understandings of attachment, in addition to varying definitions and views of attachment theory and associated assessments and clinical practices. John Bowlby, the originator of attachment theory saw it as "...a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance...", in humans (Bowlby, 1977a, p.201). In essence, Bowlby's initial and nascent presentations of attachment theory were an amalgamation and reformation of the ideologies of Freud and Darwin (Schore, 2000). Since its original inception and presentation, attachment theory has been viewed not only as a reformation of evolutionary and psychoanalytic ideas, but also

as a theory of cognitive representation, and as a theory of emotion regulation (Bowlby, 1977a, Howe, 2011, Mikulincer & Shaver, 2018, Schore & Schore, 2008, Schore, 2017, Waters & Roisman, 2019).

Bowlby put forward the idea that through the repeated interlacing of attachment behaviours from an infant converging with a particular response by the caregiver, a representational model of the self and other is constructed, as is a representational model of relationship between self and other (Ainsworth, 1989; Bowlby, 1977b; Mikulincer & Shaver, 2018). These cognitive constructions are referred to as internal working models in attachment theory (Waters & Roisman, 2019). If caregivers provide consistent and sensitive care in early life, then a more secure internal working model of self and other, and a secure attachment style should generally emerge. Greatly impacted by early caregivers, these models are templates comprised of thoughts, feelings, memories and corresponding behaviours that are automatically referenced in subsequent relationships with attachment figures throughout the life course (Ainsworth, 1989; Bowlby, 1977b; Mikulincer & Shaver, 2018; Waters & Roisman, 2019). In this sense, they can be employed as stable, predictive templates, or relational maps involving expectations of self and others in new relationships, and therefore in their utilisation tend to re-create past relational experiences and patterns in current relational contexts.

The idea that internal working models are constructed early in life from repeated interactions between infant and primary caregiver, and that they vary according to how stable and consistent the quality of care received from the caregiver was pursued and extended by a colleague of Bowlby's– Mary Ainsworth (Brown & Elliott, 2016; Howe, 2011). Through her observational studies of caregivers and infants, first in Uganda, then in Baltimore, Ainsworth proposed the idea of the secure base.

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A secure base is developed when a caregiver affords availability, protection and consistent responsiveness, so the infant can alternate between engaging in periods of exploration with the external environment, and returning to the 'secure base' of the caregiver for security and comfort. Emerging initially from her Ugandan observations, Ainsworth began to delineate different patterns of attachment, famously then investigated through her now renowned and highly influential Strange Situation Experiment. "The assessment procedure consists of classification according to the pattern of behavior shown in the strange situation, particularly in the episodes of reunion after separation." (Ainsworth, 1979, p. 932). According to how the infant responded in the experimental procedure from when the parent left and then returned to reunite with the infant after a short period of time, Ainsworth initially identified eight different patterns or classifications of attachment behaviour exhibited in these infants, before concentrating on three main patterns. Group A infants were classified as having an insecure avoidant attachment, Group B infants were noted to be secure in their attachment, whilst Group C were observed to enact an insecure anxious and ambivalent attachment (Ainsworth, 1979; Mikulincer & Shaver, 2018).

For those viewed as having an avoidant attachment, attachment figures in their life have thought to have been inattentive, angry or rejecting, encouraging of autonomy, emotionally suppressed and self-reliant, even for some being abusive or hostile toward efforts for closeness. For those viewed as having an anxious attachment, attachment figures may have been inconsistent, mis-attuned and unreliable caregivers, overly intrusive or protective, or given messages of the care-seeker's incapability or weakness (Mikulincer & Shaver, 2018; Poole Heller, 2019; Wallin, 2007). The coalescence of these interactions and the care-seeker's doubts or rejection of proximity-seeking impacts on their attachment system by means of either hyperactivating or deactivating this system.

The concept of hyperactivation and deactivation was first introduced by Cassidy and Kobak (1988). It was then been expanded upon by Mikulincer and Shaver over the next two decades (Mikulincer & Shaver, 2018). It is hypothesised that anxiously attached adults engage in hyperactivating attachment strategies (akin to fight responses and upregulation), whilst avoidantly attached adults engage in deactivating attachment strategies (akin to flight and immobilisation responses and downregulation) when encountering a threat (Daly & Mallinckrodt, 2009; Mikulincer, Shaver & Berant, 2013; Poole Heller, 2019; Zalaznik, Weiss & Huppert, 2019). Threats are perceived by anxiously attached adults as larger and potentially catastrophic, whilst for avoidant individuals, threats are minimised, distanced or denied in order not to activate proximity-seeking behaviours (Daly & Mallinckrodt, 2009; Mikulincer & Shaver, 2018).

Though attachment research has flourished over the past three decades, the application of attachment theory in psychotherapy initially lagged behind other areas of development and research regarding attachment (Eagle, 2006, Slade & Holmes, 2019). Although Bowlby was a psychiatrist and psychoanalyst, his pioneering work, alongside that of Ainsworth, subsequently picked up by scholars and researchers, initially veered toward deepening our conceptual understanding of attachment, rather than focusing on how insecure attachment could be treated through psychotherapy (Burke, Danquah & Berry, 2016). Many therapies are informed by attachment theory and these could be referred to as attachment-informed therapies. Some therapies can also be referred to as attachment-based therapies. Attachment-based therapies specifically seek to utilise tenets of attachment theory in order to generate a shift in the client toward attachment security. This explicit shift toward attachment repair and security forms one of the key identifying and defining aspects of these therapies (Burke, Danquah & Berry, 2016; Obegi & Berant, 2009).

## When attachment theory meets with IFS

IFS could be considered an attachment-based therapy through its notion of Self-Leadership which seeks to create attachment repair and security. IFS also embraces and addresses the present-day complexities, conundrums and contradictions regarding attachment theory. Just as IFS employs an 8Cs model for understanding Self, an 8Cs model of understanding the multiplicity of attachment theory is proposed here through the following key areas: complexity, context, change, calibration, cause, combinations, connections, and corrections.

Table 1. The 8Cs of Attachment

| | |
|---|---|
| **Complexity** | Individuals possess multiple attachment styles. |
| **Context** | A particular attachment style comes to the fore in a particular relational context. |
| **Change** | Attachment styles can change in response to life events. |
| **Calibration** | There are numerous ways of classifying and assessing adult attachment which attests to the complexity of attachment. |
| **Cause** | Biological, transgenerational, broader societal systems, as well as mental illness can influence and impact attachment. |
| **Combinations** | Therapeutic process and outcome are influenced by the combination of a therapist's and client's attachment styles. |
| **Connections** | Therapy helps the client in making more secure connections with themselves, the therapist and others in the external world. |
| **Corrections** | Therapy can provide corrective attachment experiences whether imaginal and internal, or though the therapeutic relationship. |

These 8Cs act like a summation and union of research and current knowledge about attachment. How might IFS address these 8Cs?

### Complexity

The notion that we only have one attachment style may still prevail, however, research suggests that adults commonly possess multiple attachment orientations (Girme, Agnew, VanderDrift, Harvey, Rholes & Simpson, 2018; Mikulincer & Shaver, 2018; Sibley & Overall, 2010; Wallin, 2007). These may be arranged internally in a hierarchical fashion with a global attachment predisposition positioned at the top and akin to a trait, moulded through repeated interactions with the primary attachment figure. Underneath this global attachment predisposition sit other relational attachment maps. These may be a mix of secure and insecure styles (Doherty & Feeney, 2004; Fraley & Roisman, 2019; Girme et al., 2018; Sibley & Overall, 2010). The multiplicity of the mind model of IFS could accommodate the numerous, fluid attachment styles within the one individual. Different parts within an individual can have different attachment styles. The IFS model is also capable of understanding and accepting contradictory attachments within an individual with the concept of opposing or polarised parts.

### Context

Different attachment maps according to specific relational contexts are thought to be held concurrently within the individual. An individual can form an attachment to a variety of attachment figures ranging from parents and partners, friends, peers, co-workers, extending to therapists, pets, spiritual deities and deceased loved ones (Doherty & Feeney, 2004; Girme et al., 2018; Mikulincer & Shaver, 2018). IFS sees that different parts are activated in different contexts, including relational contexts. This view can help explain a client who has a history of secure attachment with friends and a history of anxious/ambivalent or avoidant attachment in intimate relationships. Additionally, IFS views that both attachment wounding and hyperactivating and deactivating strategies occurred or were adopted in different times periods in different relational contexts or domains.

### Change

Context-specific attachment maps can change or modify over time, as a result of the impact of specific life events, with at least 40% of the population undergoing modifications and changes to their global attachment orientation over the life course (Chopik, Edelstein & Grimm, 2017; Scharfe & Cole, 2006). Factors that impact on the change from attachment security to insecurity include negative life events such as divorce, depression, poverty, abuse, loss of parents or family member, and environmental stress. Additionally, contexts that facilitate lowered stress, increased positive affect and emotional openness, adaptive coping and overall wellbeing have been shown to prompt a change from insecurity to security in adulthood (McConnell & Moss, 2011). The IFS model could flexibly accommodate the ways in which an adult's attachment maps can change over time through the identification of new parts, or existing parts with new roles, or in the case of exiles, neo-exiles (parts that are exiled to sustained a current relationship). IFS may create change and attachment repair through unburdening exiles. Secure attachment could be attained internally through Self-Leadership.

### Calibration

Models of classifying attachment include categorical models and continuous dimensional models of attachment (Mikulincer & Shaver, 2018). Diverse methods of assessing an adult's attachment style/s exist that may erroneously issue an outcome for one's internal working model as "worked" rather than "working" (Bakermans-Kranenburg & van IJzendoorn, 2009; Baldoni, Minghetti, Craparo, Facondini, Cena & Schimmenti, 2018). Methods for assessing adult attachment include interview-based approaches and self-report measures. An adult's unconscious cognitive representations of attachment are captured in interview-based approaches, whilst an adult's conscious cognitive representations are captured in self-report measures (Brown & Elliott, 2016; Mikulincer & Shaver, 2018). The assessment results from each type of approach have shown very weak convergence and correlation (Baldoni et al., 2018; Fortuna & Roisman, 2008; Mayseless & Scharf, 2007). The range and variance of models and methods for understanding attachment suggest the recondite complexity of attachment. IFS may measure a person's secure attachment through the unburdening of exiles, the propensity for care between Self and parts, the degree of Self-Leadership within a person's internal system, and the degree of Self-Leadership a person holds in the external world. Through the IFS techniques of in-sight (the client directly dialoguing with the part), and direct access (the therapist directly communicating to the client's target part), conscious and unconscious appraisals of attachments and attachment strategies can be revealed alongside explicit and implicit memories of attachment.

### Cause

Attachment foundations begin in utero via factors including a mother's levels of cortisol, depression, and the functioning of her hypothalamic-pituitary-adrenal axis contributing to the foetus' development of the amygdala and hypothalamus (Antonucci, Taurisano, Coppola & Cassibba, 2018; Chambers, 2017). Some studies indicate that a mother's attachment security can predict their infant's attachment security by up to 75% (Antonucci et al., 2018; Chambers, 2017). The relationship between insecure attachment and mental illness may most likely be bi-directional and non-linear as the attachment system interacts with other systems including the biological system, the family system and a broader societal system (Brown & Elliott, 2016; Mikulincer & Shaver, 2018). IFS is non-pathologizing and is not interested in discerning scientifically if mental illness causes insecure attachment or vice-versa. IFS possibly interprets the generational transmission of attachment styles as legacy burdens. These are burdens imposed by particular cultures or ethnic groups, or passed down through family generations (Schwartz & Sweezy, 2020; Sinko, 2017). IFS believes that the burden is not the part, and aims to transform the part, rather than extinguish or do away with it, by helping the part release or discharge its burden (Geib, 2017). Once unburdened, exiles are thought to return to their naturally occurring state of playfulness, spontaneity, unself-conscious joy and openness (Anderson et al., 2017). IFS may aim to heal attachment injuries and mental illness through its promotion of Self-Leadership and unburdening of parts. IFS believes that the individual has the resources for a secure attachment already inside of them in the form of Self.

### Combinations

A therapist's unconscious attachment history can often times be evoked when combined with, and in response to, the client's unconscious attachment re-enactments of internal working models. The therapeutic relationship has often been seen as the vehicle for change by many in the attachment field,

therefore it is important for both client and therapist to reflect on their attachment system (Wallin, 2010). Therapists may internally experience frustration, anger and rancour when working with anxiously attached clients. In contrast, therapists may internally experience frustration, boredom, discouragement and inadequacy when working with avoidantly attached clients (Daly & Mallinckrodt, 2009). Secure therapists may demonstrate higher reflective functioning, curiosity and support for client autonomy. Anxiously attached therapists may fail to encourage client autonomy, lose boundaries with clients and feel discouraged if the client does not forge a strong emotional connection. Avoidantly attached therapists may provide less empathic reflections, reduced sensitivity and in-depth interventions (Mikulincer & Shaver, 2018; Talia, Muzi, Lingiardi & Tuabner, 2018). IFS openly acknowledges that the therapist's own parts (potentially conceptualised as attachment styles), will be evoked in their work with clients, and strongly advises therapists to work on increasing their awareness of these parts, openly acknowledge them in session if appropriate, and take them to supervision and therapy (Schwartz & Sweezy, 2020).

When we encounter a problem in therapy, it means that a part is probably interfering – but we don't know whose part it is: the client's or ours. IFS therapists practise being aware of and helping their own parts. We either help our parts to relax and trust our Self in the moment, or, when that's not happening despite our best efforts, we acknowledge to the client that a part is interfering and apologize, and work with our part later (Schwartz & Sweezy, 2020, p.89).

### Connections

Both attachment-informed and attachment-based therapies utilise the therapeutic relationship as a vehicle for reflection and change (Geller & Farber, 2015; Gold, 2011; Levy & Johnson, 2018a; Obegi & Berant, 2009; Slade & Holmes, 2019). Client's internal working models, formed from past connections and problematic in present connections, are identified, assessed and re-evaluated in light of the current connection with the therapist who becomes a secure base and safe haven for the client (Borelli & David, 2004; Eagle, 2006; Mallinckrodt, 2010; Teyber & McClure Teyber, 2014). Although IFS is an attachment-based therapy, there is less focus on the therapeutic relationship as the vehicle of healing and change than other attachment-based therapies. The primary focus of IFS is on building the relationship (a secure attachment), between the client's Self and their parts. Attachment-informed and attachment-based therapies aspire to deepen the client's connection to themselves through a focus on non-verbal communication, mindfulness and mentalisation (Brown & Elliott, 2016; Fitzgerald, 2014; Fonagy, Luyten & Strathearn, 2011; Burke et al., 2016; Siegel, 2012; Wallin, 2007). The therapeutic process of IFS combines three skills associated with secure attachment–emotion regulation, mindfulness and mentalisation (Brown & Elliott, 2016; Mikulincer & Shaver, 2018; Wallin, 2007. Attributing feelings to parts leads to better emotion regulation (Chen, Chen & Yang, 2019). Both mindfulness and mentalisation are enhanced by drawing awareness to the presentation and perspectives of parts (Bockler, Herrmann, Trautwein, Holmes & Singer, 2017, Falconer & Schwartz, 2017). Additionally, IFS embraces three strata of attachment for clients to forge connections with - the Internal (Self with parts), the External (Self/parts with other people and their parts), and the Eternal (Guides, the Collective Self, deceased attachments and spiritual deities).

### Corrections

Attachment-based therapies seek to provide restorative, correcting experiences for the client's attachment injuries. This is achieved through reflective process comments of the here-and-now, and 'limited reparenting' provided by the therapist. Additionally, a corrective attachment experience is constructed by pairing a maladaptive emotional state with an adaptive one–referred to as a mismatch. This takes place through guided imagery with imagining ideal parents, the client's adult self, or the therapist providing attachment repair and security in scenes of early attachment injury (Armstrong, 2019; Bateman & Fonagy, 2013; Gillath & Karantzas, 2019; Johnson, 2019; Lipton & Fosha, 2011; Young, Klosko & Weishaar, 2003; Teyber & McClure Teyber, 2014). In IFS, limitless reparenting by Self seeks to provide an ongoing corrective attachment experience in and of itself. This ongoing repair and correction may be achieved by means of access to, and presence of, the therapist and/or the client's Self, alongside the adoption of the attitude that all parts are welcome. Repeated access to Self may be a way of increasing attachment security. The mismatch of pairing the compassion from Self with the attachment wound/burden of the exile may provide a new, internal secure attachment experience which positively impacts and updates a client's internal working model.

## Hope moving closer

IFS more than sufficiently attends to, and enfolds the proposed 8Cs of attachment theory and associated therapeutic practice. Therefore, it could be considered an attachment-based therapy. The fabric of both attachment theory and IFS is partly comprised of systems theory, an inherent and driving curiosity from their originators regarding relationship and connection, and the long shadow cast by the fathers of both Bowlby and Schwartz. Both had fathers who were medical doctors and who strongly directed their sons to pursue careers in medicine (Kanter, 2007; Schwartz & Sweeny, 2020). Neither son was fully engrossed by natural sciences, anatomy and medicine and instead, veered their attention toward psychology, psychiatry and therapy, both achieving recognition and prominence for their significant contributions to these fields. Relational distance, yet strong pressure to achieve characterised the impact of both fathers on their sons' trajectories (Mikulincer & Shaver, 2018; Schwartz & Sweeny, 2020; van Dijken, 1998) The development of IFS and attachment theory highlight that both bodies of knowledge did not arrive purely from a professional context, but were influenced by personal attachment experiences. Bowlby sought to grasp and understand external, tangible attachments, whereas Schwartz sought to attune to and explain internal, intangible attachments, and subsequently spiritual attachments. IFS invites individuals to flexibly traverse all three levels of potential attachment – internal (parts), external (people), and eternal (guides, gods and those already gone).

Significant points of departure and questions also arise from the meeting of attachment theory and IFS. The two most discordant issues involve the notion of Self as an attachment figure and therefore the source of attachment repair, and the lack of current empirical evidence to align with this idea of Self. Secondly, the IFS assertion that our original caregivers/parents have no impact on Self and that the qualities of Self are inherent and undamaged, as opposed to being developed in safe, attuned, early experiences of caretaking, confronts the prevailing opposite view held by attachment theory (Falconer & Schwartz, 2017). Finally, the partisan dispute concerning co-regulation and dependence on other humans, versus regulation and care by Self as a person's primary caretaker, leaves little room for a more expansive and all-embracing outlook of a continuous migration between the internal, external and eternal worlds of attachment (Dana, 2018; Levine & Heller, 2011; Schwartz & Sweeny, 2020).

Despite these questions and contentions, the nexus of IFS and attachment theory gives hope. Recent attachment research demonstrates that the dance of distance and closeness is not cemented into a singular, doomed and permanent category, and that we indeed hold multiple attachment styles… which can change. These new theoretical ideas infuse hope into attachment theory. IFS also provides hope in that it offers a bold, internal therapeutic approach to heal and transform those of our parts that defend, struggle with, or are burdened by insecure, external attachment experiences. The union of latest theoretical understandings from attachment theory and the courageous therapeutic approach of IFS have offered hope to me both professionally and personally for transformation and growth. When combined, a new 'what', and a new 'how' of connection is perhaps a vaccine of hope. The result of this union could help us recreate, and recover internally and externally, inside and outside of the counselling room, from the growing partisanship, individualism, and disconnectedness of the world.

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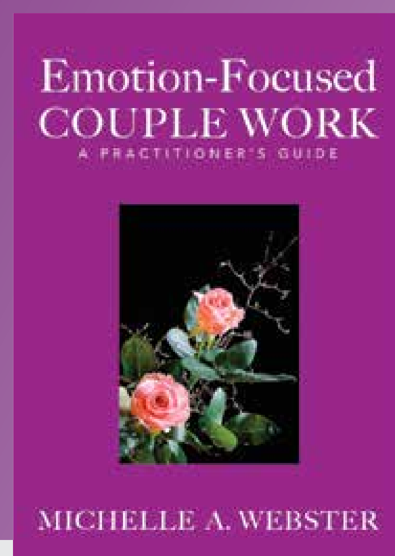


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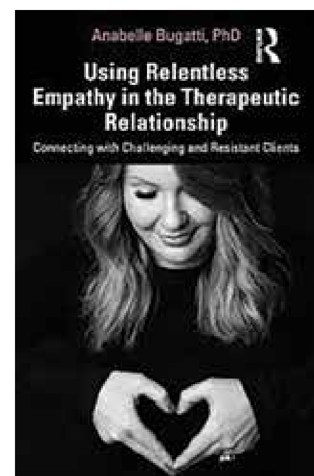
# Using Relentless Empathy in the Therapeutic Relationship:

## Connecting with Challenging and Resistant Clients

By Anabelle Bugatti

Review by Karolina Krysinska




Anabelle Bugatti's book "Using Relentless Empathy in the Therapeutic Relationship" aims to be a handy resource for psychotherapists and counsellors, who may be struggling in their work with challenging and resistant clients. The book is based on the concepts of the emotion focused therapy (EFT) and attachment science. EFT is a humanistic approach to psychotherapy formulated in the 1980s, which considers emotion and emotional regulation to be key organising agents in both the experience of an individual and in their significant relationships.

Before presenting the book content in more detail, it will be good to briefly define the two key terms: "relentless empathy" and "difficult clients". "Relentless empathy", a concept based on Roger's "unconditional positive regard", refers to "never stopping to have empathy for our client, no matter how challenging or difficult they may seem". "Difficult clients" are clients, who are more challenging to work with than others, as they resist the help therapy offers or challenge their psychotherapist's level of skills or personal beliefs.

The book consists of seven chapters. The first two chapters set the scene for applying relentless empathy in the therapeutic relationship. The first chapter presents the science of attachment, including the neurobiological basis of attachment, secure and insecure attachment, and myths about attachment. The second chapter introduces the concept of relentless empathy, first by defining what is empathy and then by discussing barriers to empathy. Chapters that follow show applications of relentless empathy to psychotherapy with four categories of "difficult clients": resistant clients, personality disordered clients (in particular narcissistic and borderline personality disordered clients), addicted clients, and angry or hostile clients. The final, seventh chapter looks at personal and professional applications of relentless empathy when interacting with the so-called "difficult people" in everyday life, including authority figures and work colleagues.

The book has several important features. The EFT and attachment science lens is consistently applied throughout the text, providing a solid clinical and scientific basis for the work. The author frequently provides references to seminal texts in EFT and expresses her deep appreciation of one of the founders of this approach to psychotherapy: Dr. Susan Johnson. This can be seen as a strength of the book, in particular appreciated by psychotherapists familiar with EFT. On the other hand, a reader who is new to this particular type of psychotherapy, as is the case with the reviewer, may need time to understand the principles and applications of EFT and wonder how to practice "relentless empathy" in their own clinical work, which is different from the EFT paradigm.

Examples and vignettes from the author's psychotherapy practice show advanced clinical applications of the proposed approach in working with individual clients and with couples. The author strongly opposes using labels, such as clinical diagnoses of personality disorders, when working with clients who challenge the psychotherapist. Instead, Bugatti proposes a deeper attachment-based understanding of interpersonal difficulties facing clients and their clinicians.

An endearing feature of the book is starting each chapter with a quote, including excerpts from the works of Henry David Thoreau, Gabor Maté, and George Eliot. These quotes add depth to the discussion and show the universal applications of topics and concepts covered in the book. Further, each chapter concludes with a series of "questions to consider", such as the reader's own attachment history, their understanding of empathy, and personal beliefs about personality disorders and addiction. These questions make the book more interactive and invite the reader to reflect on their own life, beliefs, and clinical practice.

In the final section on directions for relentless empathy, Bugatti reminds the reader that relentless empathy "means being able to understand what's at work in human behaviour when people do behave in hurtful ways, and being open to making space for more than one side of the story without it feeling like a threat". This is the core message of the book, which indeed allows the reader to gain a deeper understanding of how attachment science can be applied in a clinical setting when working with clients who challenge our beliefs and our skills.

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