THE SCIENCE OF PSYCHOTHERAPY

DECEMBER 2021

EDITORIAL

December heralds year's end and it almost always has some bitter and some sweet reflections. We've had another year of restrictions and expansions. For some it has been like Dr Doolittle's Pushmi-Pullyu, whereas for others it has been a time of release and expansion into new and surprising realms. Opportunity is a strange beast, especially when it also presents itself cloaked in disadvantage. For Matt and myself, December brings the great news that our book is set for release in February/March 2022 and presales – with a fabulous 25% discount from Norton. We'll have links in the magazine, but it seems timely to release the first of a series of articles that explore the content of the book and what we have learnt since submitting the manuscript. We start with a discussion of our proposed Person-Responsive Approach.

This approach is reflected in every article, which is very exciting to see because I feel that the shift is naturally emerging as an evolutionary development of the person-centered approach within the principles of Humanism. We are fortunate to have two book chapters from Norton releases. Both are in the form of case study and reflection which engages us with the author's and the client's therapeutic experience. Beatriz Sheldon and Albert Sheldon share the second chapter of their book, *Complex Integration of Multiple Brain Systems* (Norton, December, 2021). They take us into the detail of Ann and her struggle with "baby blues", which is a very serious issue for new mothers. Pauline Boss shares a chapter that sheds a light on the central idea in her book, *The Myth of Closure* (Norton, December, 2021).

It is with enormous delight that I can present an article from one of the grand people of psychotherapy, Rubin Battino. Now in his eighties, I got to know Rubin at the Milton Erickson Foundation conferences and our friendship is a great example of the benefit of attending conferences in person. He writes about two therapeutic forms in *Guided Imagery Therapy (GIT) and Mirroring Hands Therapy (MHT) Brief, Secret, and Effective*.

Our Last Word is a feature that conveys an idea, a feeling and a valuable principle. I am grateful to Erin Bullus, who has been on our podcasts and is part of our upcoming documentary on autism, for sharing her thoughts about the culture of autism. Please pay keen attention to what she describes in Therapist "*Cultural Humility*" is a *Crucial Component of Psychotherapy with Autistic Clients*.

And so, we prepare for the rollover from one year to the next as we honor the celestial clock. Time for one more spin around the Sun. What will we create?

RICHARD HILL | EDITOR

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VOLUME 9 ISSUE 12

FEATURE

The Next Evolution in the Practice of Psychotherapy:

The Person-Responsive Approach

Richard Hill

In February/March of 2022, our upcoming book, *The Practitioner's Guide to the Science of Psychotherapy* (W.W. Norton, release Feb/March 2021) will be available around the world. Pre-orders have already begun with a handy discount (see the advertisement). Matthew Dahlitz and I have endeavoured to distil for you, in a single volume, some of the knowledge and experience that we believe is the foundation for the 21st Century Therapist. This is a term that was first expressed to us by John Arden (see his book, *Mind, Brain, Gene*). He generously wrote the Foreword which lays out the case for the idea that a therapist may not be able to know everything, but they need to know more about as much as they can. It is no longer viable to learn a particular methodology and decide which school of therapy will contain you. You will see that the book covers a lot of territory from the biology of the brain and the body to both psychological and pathological issues of mental health. We describe the concept and principles of complex systems and how that is fundamentally important to human experience. We include an insight into genetics and the importance of the genetic diversity in our gut microbiome. But this is a book for therapists and so we ask a group of experts including Reid Wilson and Pat Ogden to share how they work with issues like anxiety, somatics, and the experience of pain and distress.

Based on the ideas expressed in *The Practitioner's Guide to the Science of Psychotherapy* by Richard Hill & Matthew Dahlitz, forthcoming from W. W. Norton, 2022.

One of the chapters we are most pleased about, is the final chapter, Chapter 10, which explores what is new and developing in the sphere of mental health and psychotherapeutic practice. We are grateful to friends and colleagues like Scott Miller and the late Ernest Rossi for sharing their visions. One of the most intriguing developments in psychotherapy (and in many other spheres of professional practice and daily life) is the emerging evolution of the person-centered approach into a person-responsive approach. It is hard to say whether this approach is as innovative as the changes brought about when Carl Rogers presented his concept of a person-centered approach, but we do suggest that there is a demonstrable difference for both therapist and client when therapy is oriented by a client-responsive approach. There is much work to be done to explore the many possibilities this approach might offer and is already offering. Research is in progress on several continents and at least one PhD is working towards a deeper understanding of how this approach could and is incorporated and integrated into therapy and perhaps even into daily life.

This article is about the section in Chapter 10 concerning the client-responsive approach and some of the developing thoughts that have emerged since submitting the manuscript.

INTRODUCTION

"Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped if a definable climate of facilitative psy-

chological attitudes can be provided." (Rogers, 1995, p 115)

Rogers' comment, a fundamental principle of his person-centred approach, heralded a radical shift in how practitioners appreciate and engage with their client's personal resources. Inevitably, ideas evolve over time. The person-responsive approach to psychotherapy is the latest development in this ongoing evolution with the potential to promote another radical shift in how practitioners engage with clients.

The person-responsive approach has emerged from the integration of previous progressive developments to produce an approach that can increase efficacy, reduce resistance and elevate the client's access to their natural resources to produce health and wellbeing (Hill & Rossi, 2017). Adopting a person-responsive approach circumvents the perplexing research results where different therapeutic interventions show no significant difference in outcome (Wampold, 2015). The best therapeutic strategy is achieved by acknowledging the notion that the most appropriate therapeutic direction is not in the therapist's opinion, but in the client's innate messaging (Rossi, 1996). The person-responsive approach amplifies resonance within the client-therapist relationship (therapeutic alliance) because the therapist becomes a facilitator of a co-creative integration of the client's natural capacities and the therapist's expertise and skills. To fully appreciate this complex system, it is important to differentiate the interacting elements. These elements are what might also be described as the ontological components. The component organising principles of the person-responsive approach include (with names of some of the key researchers):

- The person-centred approach (Rogers)
- Utilisation (Erickson)
- Responsiveness (Erickson; Rogers; Rossi; Stiles)
- Natural cycles and rhythms (Kleitman; Rossi)
- Complex systems: self-organisation, feedback and emergent qualities (Rossi; Marks-Tarlow)
- Biopsychosocial informatics (Engel; Rossi)
- Numinosum – wonder and fascination (Otto; Rossi)
- Co-creative improvisation of therapeutic possibilities (Rossi; Hill)
- Sensitive observation (Erickson; Rossi)
- Dynamic curiosity – information-play-meaning triumvirate (Hill)
- That therapeutic modalities are derived from natural, innate human capacities (Rogers; Erickson; Rossi; Hill)

DESCRIPTION OF THE ELEMENTS

Humanism, as a philosophy, can be traced back to the Greeks, emphasising human agency, autonomy and progress (Lieberman, 1978). Humanistic psychology (psychotherapy) is considered by many to begin with Abraham Maslow's paper "A Theory of Human Motivation" in 1943 when he introduced his concept of a hierarchy of needs. The Humanistic Approach acknowledges that humans have free will, an innate need to make themselves better, are motivated to self-actualise, and subjective perception is more important for self-awareness (Maslow, 1968). Maslow described humanistic psychology as the "third force" in psychother-

apy, which had, up to that time, been influenced by the more deterministic "first force" of psychoanalysis (Bruer & Freud, 1893) and the "second force" of behaviourism (Watson, 1913).

The subsequent theories and practices that have emerged have revolutionised psychology and psychotherapy. One of the first and most influential concepts to emerge was the person-centred approach proposed by Carl Rogers (1946; 1959). Person-centred therapy became the foundation for a vast range of therapeutic theories and methods that emerged in the latter half of the 20th century and early 21st century. Modern psychotherapeutic training includes many of these methodologies - gestalt therapy, rational emotive behavioural therapy, cognitive behaviour therapy, emotion focused therapy, solution focused therapy, strategic psychotherapy, positive psychology, family systems therapy, narrative therapy, somatic therapy, and literally hundreds more.

An equally important influence developing humanism in parallel to Rogers was psychiatrist, psychotherapist and hypnotherapist Milton Erickson, renowned for his novel and innovative approaches to therapy. He advocated that the task of the therapist is to shift the "burden of responsibility of effective therapy" back to the client (Erickson, 2010, p.68) because it was the client who possessed the natural resources to resolve their psychological dilemmas. He championed the concept of *utilisation* where the therapist would incorporate into the therapeutic experience whatever the client brought with them, both explicit and implicit.

Ernest Rossi was Milton Erickson's principal student and co-author in the 1970's, responsible for many of the seminal texts of Erickson's work. After Erickson's death in 1980, Rossi continued developing the humanistic approach.

Rossi re-engaged the relevance of human biology and biochemistry as part of our natural resources. He also extended Erickson's ideas of a non-directive approach toward a responsive utilisation of what became available during therapy to co-create a beneficial therapeutic experience. William Stiles (Stiles, et al., 1998) was among those who also examined the value of responsiveness in psychotherapy and the need to change focus from linear patterns to complex systems. "The concept of responsiveness helps show how client characteristics, therapist characteristics, and process components may be important in psychotherapy" (p. 439) was still a bold statement in 1998. Stiles writes the opening chapter in a new book, *The Responsive Psychotherapist* (Watson & Wiseman, 2021). The ideas in this book integrate several elements in this proposal and explore the importance of responsiveness as an element within a psychotherapy method, but not to the degree that responsiveness is a fundamental approach. The vital component that was promoted by Erickson and elevated by Rossi was being genuinely and actively curious, interested and even fascinated in the client and their therapeutic experience. Erickson described intense observation as fundamental to discovering what the client was implicitly conveying. Rossi has described the importance of "creative moments" that can emerge at any time during a session or between sessions.

In my work with Rossi, as his student and co-author, I developed an expanded definition of curiosity as a triumvirate of curiosity for information, curiosity for play and curiosity for meaning (Hill & Rossi, 2017, Hill & Dahlitz, 2022). This triumvirate is distinguished as dynamic curiosity. Our modern tendency to only focus on curiosity for information inclines

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therapists to take on the responsibility to procure information from the client. Even done in a person-centred way, the client can be inclined to talk about what they feel the therapist wants. Curiosity for play elicits information through serendipitous discovery. Our natural curiosity for meaning seeks to find what the information means and how it relates to the self. Meaning triggers the "Aha" moment of insight and self-realisation that generates creative change and development.

Finally, the person-responsive approach takes the humanistic principle that the client has inner resources one step further. The client's natural resources are advanced from being a capacity for "self-understanding … for altering their self-concepts, basic attitudes, and self-directed behaviour" (Rogers, 1995, p. 115), toward including these capacities as the basis of a natural system that is able to move a person toward wellbeing. It is clear that human beings are innately capable of physical and mental recovery from insult and injury. The person-responsive approach embraces the assumption that all therapeutic modalities have been observed or intuited from our natural human repertoire – our natural capacities are the source of what heals us and ipso facto, the source of information that has produced the panoply of interpersonal healing processes across the social synapse.

The therapist's task is to create opportunities and the appropriate circumstances for the client to be able to express and access what is therapeutically appropriate. Each person will have a uniquely developed natural problem-solving system that will have developed in relations to experience and prior dispositions, including the genotype and the epigenotype, that all contribute to the phenotype we can ob-

serve sitting opposite in the therapy room. The client-responsive therapist notices and then co-creatively responds to the messages and indicators emerging from the client. In 2013, Ernest Rossi explained to a class of therapists, "The power is not in the therapist folks. It's in the client's (as yet) unknown capacity, certainly unknown to both therapist and client" (Rossi, 2013).

In this issue are articles that employ a client-responsive approach, or at least numerous elements of it. These types of therapies are beginning to emerge spontaneously and out of people seeking to fill what seems to be a void in the established therapeutic approaches. This indicates to me that it is time to push forward, beyond what Ernie Rossi called the growing edge and see if we can find the effectiveness of therapy is rooted in the client's natural capacities first and then the therapist's effective and co-creative responsiveness. Are the difficulties that face psychotherapy rooted in the framework of the relationship where the therapist is the conveyor of what is needed? How does therapy change when the therapist is responsive to the information coming from the client in unique and even improvisational forms? I have commented that psychotherapy has largely been the "tail wagging the dog". It will be very interesting to see what happens when our focus changes from, "What therapy will be best to help this client?" to "What therapy, or combinations of therapies, or therapies that I have never seen before, is the client trying to show me, and what can I responsively create with that?"

Milton Erickson said, and I paraphrase, that the most effective therapy is likely to be the one that you have never done before and never do again because that shows it is highly attuned

to that client, their needs and their capacities. I think it is time to examine this radical idea from the 1960's and consider it very seriously for the 21st century therapist.

REFERENCES:

Breuer, J., & Freud, S. (1893). On the psychical mechanism of hysterical phenomena: Preliminary communication, Ch 1 (pp. 1-17), In James Strachey (Ed.) The standard edition of the complete psychological works of Sigmund Freud, Vol II Studies in hysteria. Hogarth Press.

Erickson, M. H. (2010) Burden of responsibility in effective psychotherapy, in Rossi, E. L., Erickson-Klein, R. & Rossi, K. L. Eds. The Collected Works of Milton H Erickson: Opening the Mind, Vol 3, Ch. 7. The Milton H Erickson Foundation Press.

Hill, R., & Rossi, E. L. (2017). The practitioner's guide to Mirroring Hands: A client-responsive therapy that facilitates natural problem-solving and mind-body healing. Crown House Publishing.

Lieberman, S. (1978). Humanism and nonhumanism in greek tragedy and culture. The Bulletin of the American Society of Papyrologists, 15(1/2), 73-84. http://www.jstor.org/stable/24518755

Maslow, A. H. (1943). A theory of human motivation. Psychological Review, 50, 370-96.

Maslow, A. H. (1968). Toward a psychology of being (2nd ed.). D. Van Nostrand.

Otto, R. (1923) The Idea of the Holy: An inquiry into the non-rational factor in the idea of the divine and its relation to the rational. Harvey, J. W. Translator. Oxford University press.

Rogers, C. R. (1946). Significant aspects of client-centered therapy. American Psychologist 1, 415-422.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In (ed.) S. Koch, Psychology: A study of a science. Vol. 3: Formulations of the person and the social context. New York: McGraw Hill.

Rogers, C. R. (1995). A way of being. Houghton Mifflin.

Rossi, E. L. (1996). The symptom path to enlightenment: New dynamics of self-organization in hypnotherapy – an advanced manual for beginners. Palisades Gateway Publishing.

Wampold B. E. (2015). How important are the common factors in psychotherapy? An update. World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 14(3), 270–277. https://doi.org/10.1002/wps.20238

Watson, J. B. (1913). Psychology as the behaviorist views it. Psychological Review, 20, 158–177.

Watson, J. C. & Wiseman, H. (eds) (2021) The Responsive Psychotherapist: Attuning to Clients in the Moment. American Psychological Association

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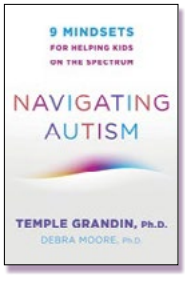

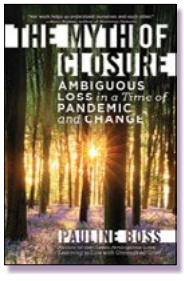

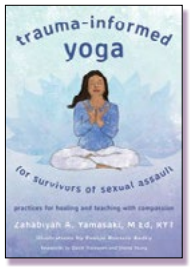

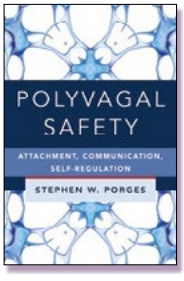

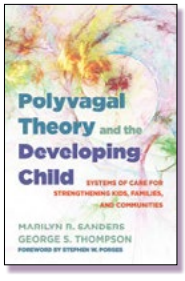

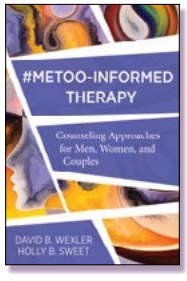

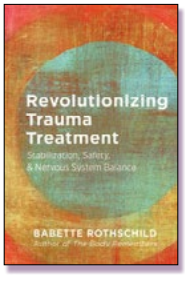

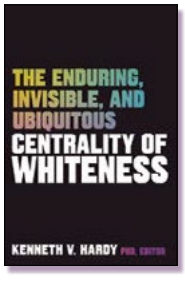

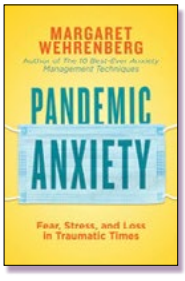

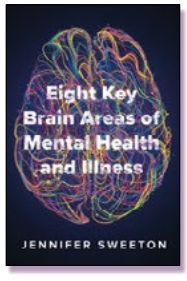

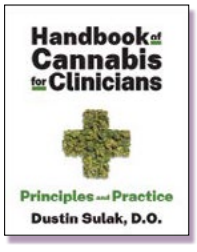

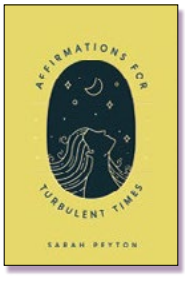

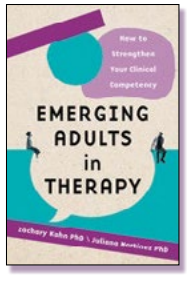

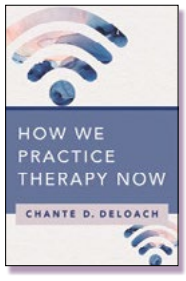

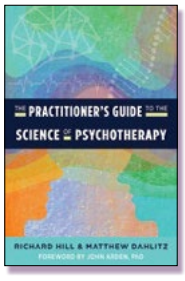

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COMPLEX INTEGRATION OF MULTIPLE BRAIN SYSTEMS IN THERAPY

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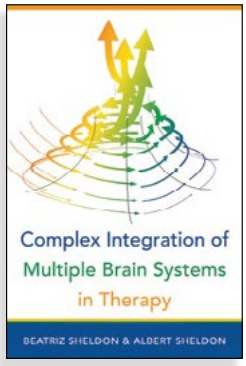

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About the Authors

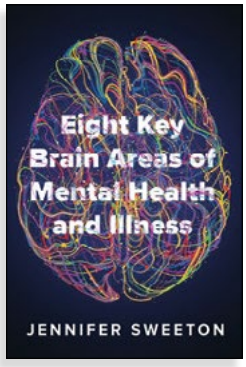
BEATRIZ SHELDON, MEd, has practiced psychotherapy for forty years. She works in Seattle, Washington**. ALBERT SHELDON, MD**, a clinical professor of psychiatry at the University of Washington, Seattle, has been conducting research and teaching psychotherapy for twenty-five years.

ISBN: 978-0-393-71428-9 • **December 2021** • 288 pages • Hardcover • $42.00 **/ $31.50**

EIGHT KEY BRAIN AREAS OF MENTAL HEALTH AND ILLNESS

JENNIFER SWEETON

Bridging the gap between neuroscience and clinical therapy.



"Sweeton distills neuroscience into engaging, comprehensible information for the everyday clinical psychologist, making it significantly easier to incorporate it into our therapeutic work. **I've used this with my toughest trauma clients with measurable success."** –Gricelda Fragoso, PsyD, Clinical Psychologist, Owner of Mind Body Soul Psychology

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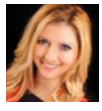
About the Author

JENNIFER SWEETON, PhD, is a clinical psychologist, best-selling author, and internationally recognized expert on trauma, anxiety, and neuroscience. Based in Kansas City, Kansas, she has trained more than 15,000 clinicians in all fifty US states, and in over twenty countries.

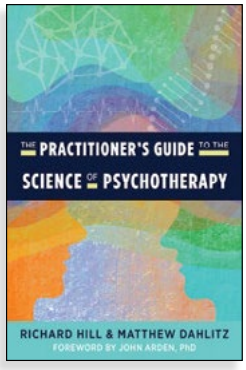


ISBN: 978-0-393-71413-5 • **November 2021** • 264 pages • Paperback • $29.95 **/ $22.46**

THE PRACTITIONER'S GUIDE TO THE SCIENCE OF PSYCHOTHERAPY

RICHARD HILL and MATTHEW DAHLITZ, Foreword by JOHN B. ARDEN

Establishing a new scientifically-validated foundation for current psychotherapeutic practice



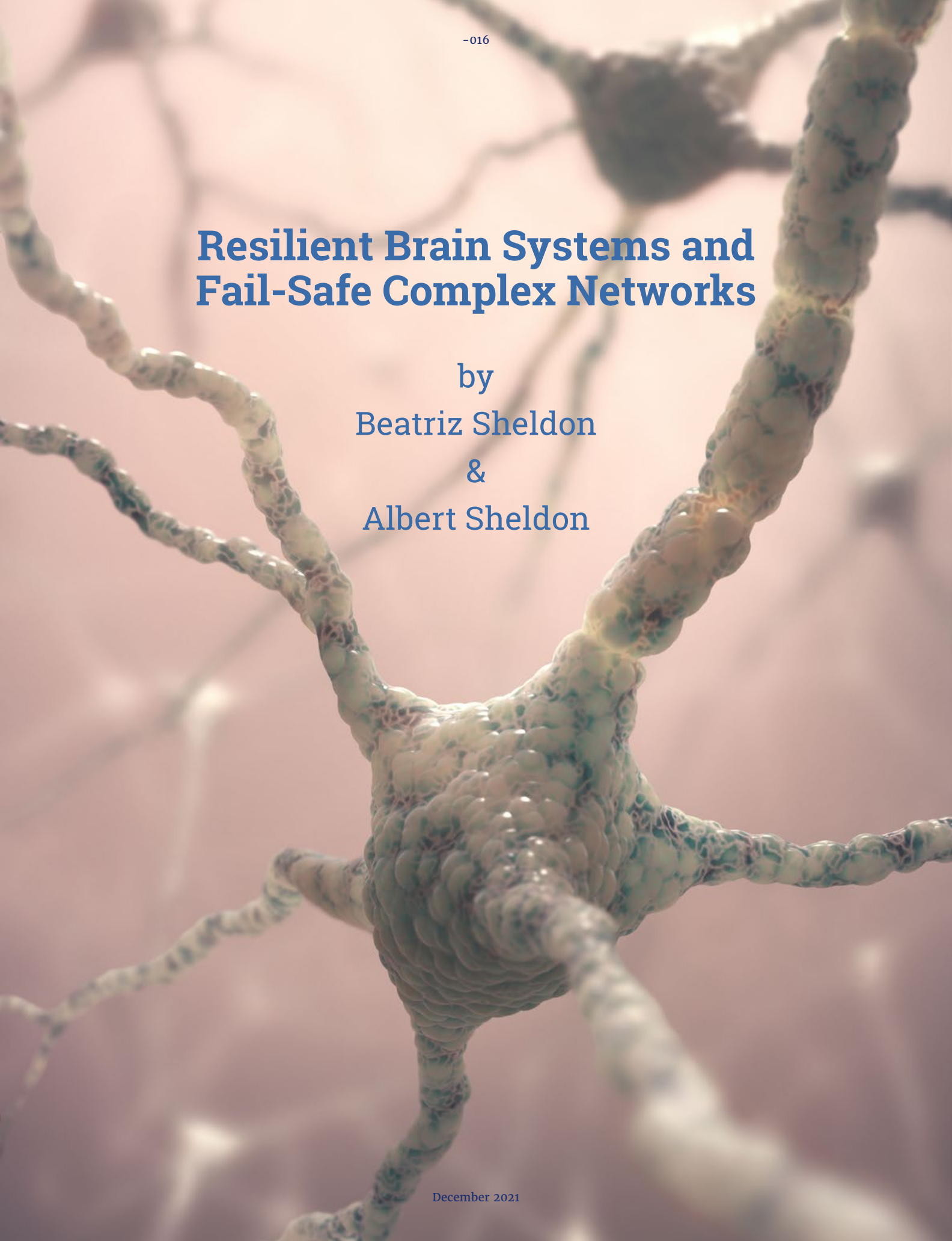
"Hill and Dahlitz tear down the walls that have isolated psychotherapeutic archetypes while reinforcing an integrated scientific foundation for psychotherapy in the twenty-first century and beyond."
–Eric T. Beeson, PhD, Clinical Associate Professor, The Family Institute at Northwestern University

The 21st Century psychotherapist can no longer be constrained by specific schools of practice or limited reservoirs of knowledge. But this new "era of information" needs to be integrated and made manageable for every practitioner. This book helps therapists know more about this new knowledge and how to apply it effectively. From basic neuroscience to body-brain systems and genetic processes, here therapists learn how to become more "response-able" to their clients.

About the Authors

RICHARD HILL is Managing Editor of *The Science of Psychotherapy* magazine. He holds workshops around the world based on his book *Mirroring Hands*, co-authored with Ernest Rossi. **MATTHEW DAHLITZ** is an author, psychotherapist, and Editor-in-Chief of *The Science of Psychotherapy* magazine (which he founded as *The Neuropsychotherapist* in 2013).

ISBN: 978-1-324-01618-2 • **February 2022** • 416 pages • Paperback • $29.95 **/ $22.46**



Resilient Brain Systems and Fail-Safe Complex Networks

by
Beatriz Sheldon
&
Albert Sheldon

December 2021

FEATURE

CASE STUDY: BABY BLUES

Ann first came to therapy after being depressed for a year. She came to Albert for treatment to get off her medications so that she could get pregnant safely. She successfully got off her meds and became pregnant. Her pregnancy and delivery went smoothly. She came back six weeks postpartum for follow-up. During the first few minutes of the session, she described fatigue and difficulty taking care of her infant. She complained that she was unhappy, anxious, and unable to rest even when her baby was asleep. She was troubled that she was withdrawing from her daughter and at times not wanting to take care of her or even play with her. Ann was afraid of developing postpartum depression.

Because this treatment process is primarily experiential rather than verbal or cognitive, the following transcript contains the music, score, and lyrics of the session, so to speak. The "music" refers to the descriptions of the nonverbal body movements, facial expressions, voice tones, and other psychophysiological phenomena that reveal the emotional activations of both participants. The "score" refers to the therapist's inner thoughts and moment-to-moment decision points to promote the ebb and flow of the brain system activations and therapeutic intentions. The therapist's inner observations will help you see through the eyes of the therapist the distinct psychophysiological phenomena that provide evidence of the functioning of the primary- and secondary-level brain systems. The "lyrics" are the unedited words that were spoken in the session.

Please interrupt any effort your brain is making to figure out what is happening in the session. Rather than figuring out what the therapist is doing or what the patient is saying and experiencing, trust your capacities for observing with different lenses and from different vantage points. Use your beginner's mind. Let yourself be moved in our unique way by this therapy session.

The following is an 8-minute vignette from Ann's first session after her baby, Dawn, was born. Albert offers comments about his observations as a therapist.

Excerpt from *Complex Integration of Multiple Brain Systems,* Chapter 2: Resilient Brain Systems and Fail-Safe Complex Networks*,* by Beatriz Sheldon and Albert Sheldon (Norton, December, 2021)

Albert: We can see you are working to care for yourself and care for Dawn.

Ann: It takes work. I feel conflicted all the time!

Albert: Mmm, this is interesting. Are you curious about it?

Ann: I mostly feel sad.

I could see tears beginning to well up in Ann's eyes.

Albert: Ann, what do you see in my eyes right now?

Ann: You are smiling.

Albert: What else?

Ann: You like me?

Albert: Yes! I care for you. I am caring for you.

I saw a puzzled look on Ann's face. She started crying softly. Then she quickly swung her head away with an expression of disgust.

Ann: I feel nausea and want to run away!

Albert: How wonderful that you are being aware of the feelings of nausea and running away. You are aware of these feelings and you are not running away. You are being capable of being aware. Are you curious about that?

Ann: Not really. I just want to run away and hide.

Albert: Curious, isn't it? Any idea of what is bringing up this feeling of nausea at this present moment?

Ann: I don't want you to care for me. I am not a good person.

Albert: What do you see in my eyes?

Ann: You still like me?

Ann looked at me sideways. Her quizzical expression had returned. I raised my arms toward her and opened my hands in a welcoming gesture.

Albert: Together we can care for you in your struggle.

Ann: I feel resistance.

Ann at first nodded her head, then gave me the sideways puzzled look again.

Albert: Good awareness! You are aware of your resistance. Are you curious about it?

Ann: I am beginning to be curious.

Albert: Do you want us to care for you in your struggle?

Ann: It feels bad. I feel wrong to tell you that I want to be cared for.

Ann's expression shifted. She seemed to be stunned by her conflicting feelings. I said nothing, but once again I gave her an affectionate gaze, and I raised and opened my hands toward her.

Ann: This is what happens with my baby. Weird; she loves me and I feel unworthy. I feel bad and I put her down. This a very strange experience. I feel like it is totally natural for a mother to receive the love of her baby.

At first, as she spoke, Ann was sighing and wiping tears from her eyes. Then her voice strengthened, and she became more animated.

Albert: It is interesting, isn't it? There are some aspects of this intense love, this beautiful love, that stir up shame and unworthiness. As if there is something wrong to receive the love of your baby.

It is wonderful. It is out in the open. You know it, and can describe it, so that it does not become an obstacle to loving Dawn—to loving yourself, to allowing yourself to be loved by Dawn.

Do you want to allow yourself to be loved by us, just at this little moment in time?

I placed my hands on my chest in a hugging gesture. Ann sobbed openly. Then I swung my hands to the side, as if to sweep the shame away. Ann sighed in response and turned her face away.

Ann: I feel resistance, like what is the catch? What do you want from me? And then I know it is not true.

Albert: It is irrational, but it is your reality. It is your truth. Things have happened in your development that have created these connections. Unfortunately we cannot erase them, we can just override them.

Ann: Okay, let's override it!

As Ann spoke, her voice again became stronger, and she sat up straighter in the chair. I addressed her emphatically and swept the shame away to her left with my hands. Then I again raised open hands toward her, gave her a warm, open gaze, and leaned slightly forward toward her.

Albert: We are overriding it! The shame is over there, so it does not become an obstacle. It is a very significant discomfort. It does not have to be an obstacle between you and receiving our caring. Together we can care for you in your struggle, and in your desire to receive our caring.

Ann: It feels dangerous and wrong. I feel nausea. I feel resistance.

Albert: And you are overriding those feelings to stay connected. Well done!

Ann: I feel relieved, and hopeful too, that maybe I can actually love my baby.

Albert: It is interesting, isn't it? It is a paradox, but it is true. Do you want to continue receiving our caring?

Ann: Okay, let's do it!

Ann was a stew of conflicting body language. She still had the puzzled look, but she nodded and held our gaze of connection even as she cringed and squirmed. I used an animated voice and continued to show the affectionate expression and the open-hand gesture. She leaned toward me slightly, and gradually turned to face me directly for half a minute before squirming and looking away.

Albert: Well done! It is hard work and you are doing it! You are being capable of staying here receiving my caring. You are being capable.

Ann: That is probably what my depression is really about.

Albert: How do you know that?

Ann: Because it feels the same way. It feels painful. I feel depressed. . . . But it feels like I really want to love her.

Albert: That is great. That is what is underneath your depression: your want, your desire, and your capacity to love and to allow yourself to be loved. It releases pain, but we are facing that.

Ann began to cry again, and her voice was tight. She placed her hand on her heart, and I responded with a hand gesture of release over my torso.

This session was a turning point for Ann. She did not develop postpartum depression. Albert saw her for several more sessions. She was able to release more grief from her past traumas. She developed an increasingly secure attachment with her daughter, and even more importantly, a more secure attachment with herself. When Albert saw her for 10-year follow-up, she remained free of depression. Her daughter was flourishing independently.

BABY BLUES: DEBRIEFING

Ann's story is a case study that illustrates several key aspects of Complex Integration of Multiple Brain Systems (CIMBS) therapy. Be-

low, Beatriz and Albert discuss and analyze a video recording of Ann's session in their characteristic manner. This session with Ann gives a brief example of how CIMBS therapy operates in practice. Beyond that, the analysis below is a deep dive into what it is like to experience a CIMBS session. We wished to demonstrate some of the concepts and principles we outlined in Chapter 1—to paint them red. We look at the brain systems that Albert chose to Activate and how they operated in this particular patient. We also highlight the therapeutic interventions and approaches that Albert used in the session and their effects. In later chapters, we will examine each of these interventions and approaches in greater detail.

We follow the video analysis by answering a couple of typical questions that occur when we show video recordings of therapy sessions in our training courses. After this debriefing, we elaborate on some key CIMBS therapeutic interventions and strategies that emerge from Ann's case study: Activating, Facilitating, Differentiating, and Go the Other Way.

The rest of the chapter is dedicated to defining and developing our concept of resilient brain systems and how they could transform your patient and their therapy. Developing and integrating multiple capabilities can achieve an outcome that releases the self-organizing capacities (Siegel, 1999) of our BrainMind. When multiple resilient brain systems operate together, they create what we call a Fail-Safe Complex Network, which can thrive and survive even in the most adverse of emotional environments. This is the outcome we seek from Complex Integration of Multiple Brain Systems.

BABY BLUES: THE POSTGAME SHOW

Albert: As soon as the session began, I could see that Ann was overwhelmed with conflicting emotions. She was clearly struggling to fully care for her daughter. So for my Initial Directed Activation (Chapter 6), I focused on activating her Care brain system. I said, "We can see you are working to care for yourself and care for Dawn." This assertion explicitly alerted Ann that she possessed adaptive caring capacities, and that they were present right now. I also wanted to establish a positive Therapeutic Attachment Relationship with her through both physical and verbal expressions of caring.

Ann reacted with sadness, and she cried. So I reinforced the activation by smiling, giving her a caring look, and when she recognized it, verbally confirming it. Her reaction was to say, "I feel nausea and want to run away," and to turn her head in disgust.

Beatriz: I can see that Ann's nausea and urge to run away were caused by Shame and Fear, respectively. Those are nonconscious secondary-level brain systems, and they were entangled with Care, a nonconscious primary-level brain system. Those Secondaries were constraining her ability to receive caring from you, as well as to express caring for her daughter. But you didn't explore what those constraints felt like or where they were coming from. Instead, you probed the inner capabilities that could help her cope with the constraints.

You told her, "How wonderful that you are being aware of the feelings of nausea and running away . . . and you are not running away." You helped make her aware of her nausea and avoidance constraints, and that activated her Awareness brain system. And you further pointed out that despite her revulsion, she was not running away. She was seeking help. That was an act of caring—for her daughter, and for herself. So after you Activated her Care system, you connected it to her Awareness system to get them working together. Further Activation of her Care brain system would help her viscerally experience her capabilities rather than trying to explain them to her.

Albert: Yes, and I followed up by asking, "Any idea what is bringing up this feeling of nausea at this present moment?" I did that to Activate her Seeking brain system (curiosity) to help her override the overwhelming feelings. After I asked why she was feeling nausea, she said she didn't want me to care for her, that she was not a good person. She was revealing an absence of self-worth that surprised me. And when I showed her again that I cared for her and invited her to share in that caring, she said, "I feel resistance."

I replied, "Good awareness! . . . Are you curious about it?" And she said, "I am beginning to be curious." This was a great opportunity now to connect her Awareness and Seeking brain systems after both had been activated. And it seemed that her Fear system was starting to calm down a bit. She was beginning to be able to explore her difficulties rather than being overwhelmed and avoiding them.

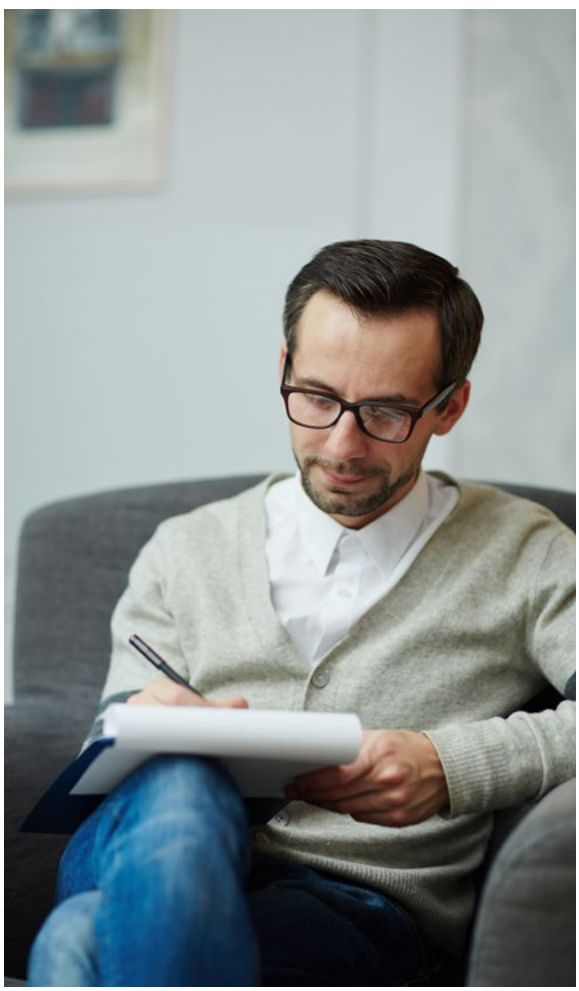
Beatriz: Yes, I can see that at that point, Ann was no longer being as overwhelmed by the caring feelings coming her way. She was not moving her head away with an expression of disgust. She was actually looking at you sideways, which was good. It meant that her constraints were less dominant. The emotional energy was shifting from protection and avoidance to approach and discovery.

Albert: The next step was very important. When I said, "Together we can care for you in your struggle," I followed up with, "Do you want us to care for you in your struggle?" When Ann's emotional energy shifted towards more openness, I saw an opportunity. By asking whether she was willing to join me in caring, I activated two more brain systems: the Motivational (want) and Authority (choice) brain systems. And I explicitly used the word "us," to take advantage of the positive Therapeutic Attachment Relationship I had been developing with her. Developing explicit collaboration is particularly important with this level of emotional activation and constraints. I embodied the attachment relationship with my silence and the look of caring in my eyes.

Beatriz: I can see that this became a turning point in the session. Ann repeated how it felt bad to be cared for, and to feel the love of her baby. But then she said, "This a very strange experience. I feel like it is totally natural for a mother to

receive the love of her baby." And as she said this, her voice grew louder and more animated. She was entering a state of disequilibrium and novelty, in which transpiring changes can take place. Ann was actually experiencing her inner entanglement. When she heard herself say, "My baby loves me and I feel unworthy," she consciously realized how her Shame was conflicting with her Care. Just for this moment, her entanglement was being differentiated.

Albert: I wanted to reinforce Ann's conscious Awareness of this differentiation process. So I said, "It is interesting, isn't it? . . .This intense love, this beautiful love stirs up shame. As if there is something wrong to receive the love of your baby." I made a hugging gesture, and Ann started crying freely.



Beatriz: It looks like all these activations reduced the constraints on her Grief brain system and she was able to release her tears. This was an important release for her. Probably she was experiencing grief over her inability to receive her baby's love, along with some grief from the past that we don't know about. We could speculate that her grief comes from feeling unworthy of care. You spotlighted her grief for her, you connected her Grief and Awareness, when you said, "It is wonderful. It is out in the open." In cases like Ann's, we also need to activate the Care and Connection brain systems again and again so that they develop strength and become resilient brain systems.

Albert: Yes, and that is why I continued by saying, "Do you want to allow yourself to be loved by us, just at this little moment in time?" She said she still felt resistance, and I saw her look away again, but she also said she recognized the contradictory nature of her desire to love and be loved, yet feeling blocked. That was a valuable awareness, and I validated it verbally. "It is irrational, but it is your reality. It is your truth. Things have happened in your development that have created these connections." Then it was time again to Go the Other Way. I told her, "Unfortunately we cannot

erase [these conflicts], we can just override them."

Beatriz: That was great! I could see Ann sit up straighter and speak more firmly as she asserted, "Let's override it!" These were significant psychophysiological shifts telling us that her Authority and Assertive brain systems were being activated. She was in a state of novelty and discovery. It is vital for our patients to have these kinds of new adaptive experiences in order to change the brain.

Albert: I wanted to support those brain system activations, so I made the arm gesture of sweeping the conflicts to the side, and I declared to her, "We are overriding it!" Then I made caring gestures with my eyes and my arms, and told her, "It does not have to be a barrier between you and receiving our caring." Not surprisingly, she reported that she felt the nausea and resistance all over again.

Beatriz: Yes, the resistances came back, as expected. But I could see that she was nodding and keeping the eye connection, even as she squirmed, cringed, and looked puzzled. She was successfully overriding those resistances. The drives of the Care, Connection, and Assertive (primary-level) brain systems were activated, and they were overcoming the Shame and Fear (secondary-level) brain systems that were inhibiting those drives. She was in a moment of struggle. This was the perfect moment to Go the Other Way to help her to see her capabilities at this moment in time rather than exploring the "dangerous or wrong" feelings.

Albert: At this point I thought the best thing to do was just to keep reinforcing the shifts that she was experiencing. I said, "You are overriding those feelings to stay connected. Well done!" I was very encouraged when she replied, "I feel relieved, and hopeful too, that maybe I can actually love my baby." I asked her whether she wanted to keep receiving caring. She fidgeted, but she also shifted her body slightly towards me, looked me straight in the eye, and said, "Okay, let's do it!" Then she squirmed and looked away again. I continued, "Well done, it is hard work and you are doing it! . . . You are being capable."

Beatriz: What you did really helped Ann start to build the resilience of her Care and Connection brain systems and to continue Differentiating her Care and Connection brain systems from her Shame and Fear brain systems. I can see that her struggle is mostly visceral and only partly conscious. You kept your focus on creating an experience for her rather than just giving her explanations or descriptions.

Albert: There was one more round of emotions in this session. Ann's voice tightened again. She cried and put her hand on her heart, and she said, "I feel depressed. . . . But it feels like I really want to love her." I reflected back to her that she had it right: "That is great. That is what is underneath your depression: your want, your desire, and your capacity to love and to allow yourself to be

loved. It releases pain, but we are facing that."

Beatriz: I can sees that this was a visceral breakthrough for her. For just this moment, she was able to stand up to the Shame and Fear that kept her from bonding with her infant and placed her on the verge of a postpartum depression. She was releasing pain and grief from some implicit emotional learning. She was having a complex experience.

BABY BLUES: QUESTIONS AND ANSWERS

Ann's story has been very useful for us to present as a CIMBS case study to our colleagues. When we first showed this session to a child psychiatrist, for example, she was immediately excited. She likened this session to heart surgery, in which one operation (session) can save the life of an infant from great suffering. This child psychiatrist went further by saying, "In one session you stopped the possible development of postpartum depression and helped the mom to develop a secure attachment relationship with her baby. This changed the developmental trajectory of this child and future generations by stopping the intergenerational attachment dysfunction."

When we have presented Ann's case in our training sessions, it has stimulated many interesting questions, such as the following:

Question: Were you surprised by Ann's resistance to attaching to her infant?

Albert: Yes, I was quite surprised. She was very excited and well prepared to become a mother. The strength of her resistance in the face of her powerful maternal attachment drive was most surprising of all. I will never look at postpartum depression as only a function of hormonal

imbalances, anxiety, and sleep deprivation again. Her feeling unworthy and resistant to her daughter's love helps me understand the intergenerational transmission of depression and insecure attachments.

Question: How do you make sense of Ann's feelings of shame, grief, and danger in relationship to being cared for by Albert? [We suggest that you stop reading for a second and ponder your own answer before you read ahead.]

Beatriz: That was quite an array of emotional resistances, wasn't it? We can all see how it was easier for her to give in to the resistance rather than to stand up to those feelings of grief, shame, and fear. There are a number of explanations for her resistances from a brain systems perspective. The simplest answer is that her Shame brain system was entangled with her Care brain system. In other words, when she started feeling cared for, Shame was triggered (as well as nausea) and the experience "felt wrong" (guilt). That does not explain her feelings of pain or danger, though. We could speculate that the pain came from her Grief brain system. Her grief may be the result of her own feelings of insecurity and/or loss of attachments. The fear could be the result of feelings of abandonment from her own infancy. What is important to see here is that Ann is feeling the constraints from three distinct brain systems: Shame, Fear, and Grief. These facts can help us understand how difficult it is to change those implicit emotional learnings.

Question: How come you did not address her crying, her sadness directly?

Albert: I felt the tears were a mix of emotions: tears of intimacy and connection with the therapist, tears at feeling understood and acknowledged, and tears of grief from previous losses. The fact that she was experiencing the grief was healing, because crying is a healing process. It helps to release grief.

Beatriz: Albert very much paid attention to the crying, but he did not try to make sense of it. He sustained the care and connection, and that is what released the grief. Stopping to analyze or explain grief often stops the visceral release. We believe that helping the release of the grief is very beneficial. It is likely that some of the sources of these tears are from deeper nonconscious experiences. Sustaining the care and connection is a way to keep strengthening those capacities so that the healing tears can be released. Albert is trusting her capacity and her spontaneous self-organization (Siegel, 1999, p. 214).

Albert met with Ann to obtain her permission to print the transcript above. She was moved to tears by reading and reflecting on the session. She was inspired and pleased to revisit her experiences, so Albert asked her to write down her thoughts. These are Ann's exact written words after reviewing the transcript from the session after her baby was born:

"I was honored when Dr. Sheldon asked if he could include one of my therapy sessions in his book. When I read the document transcribing key portions of that session, tears filled my eyes. I felt immense gratitude for the very special growth that occurred in that session: from feeling blocked and unable to connect on a deep heartfelt level with my newborn baby daughter, to feeling freed to love her and care for her deeply as her mother. It seemed remarkable that I could clear such a seemingly complex block in just one therapy session. Dr. Sheldon and I spent several moments sharing this sense of gratitude reflecting on that past session, because what else could be more impactful than a mother being able to love her child completely, unconditionally, and without old trauma getting in the way? Sitting in our chairs several feet apart, but close enough to make eye contact, our feet both firmly grounded, hands on our legs, sitting and sharing space in a sort of silence that I had grown very accustomed to in therapy with Dr. Sheldon. After several moments, a deeper wisdom surfaced, and I realized that although this session seemed miraculous and one of a kind, it was in fact, not at all. There was a much deeper context that had set the framework within which this 'leap' could be made in my psyche. I told Dr. Sheldon this really wasn't an isolated phenomenon. It was the painstaking practice we had done together in therapy prior to this session, which consisted of session after session untangling my feeling of shame from all my other feelings, creating new healthier neural pathways to replace the old trauma pathways, and growing my self-worth. All the practice we had previously done with shame and my self-worth had given me a set of tools I was familiar with, so when life presented this new situation where shame and unworthiness were triggered, I was able to process it and overcome the trigger.

What made this session remarkable, was when I overcame the trigger of shame and unworthiness, I was able to connect with and integrate into my life unconditional love for my new baby. At the time of this session, I had just given birth to my first baby, so everything in my body, mind and spirit were primed toward protecting, caring for, keeping alive, and nurturing my newborn baby. You can imagine how surprising and perplexed I felt when the old feelings of shame and unworthiness had surfaced, causing me to feel so uncomfortable with my baby needing me and loving me! I felt profoundly unworthy of her love—the shame was acute. Even now while writing this, I can sense the feeling of shame in my body like a hand pressing hard against my chest, a stone dropping in my stomach, and hands tight around my neck restricting my voice. But something new and wonderful happened in this session, that shined a very bright light and helped me move out of sorrow to—unconditional love for my baby. Deep within my being, something very maternal overpowered that force of shame. My baby was much more important than the grip shame had on me and the stories it told me about myself. It didn't matter if I felt unworthy; what mattered was being her mom and giving her everything she needed to flourish. The light of love was so bright, that the darkness of shame could not exist with it in the same moment, or at least was greatly minimized for the moment. When that pure, selfless love came into my being and I connected with it, my heart opened and shame released its hold. I was free to love my new baby, and free to allow my new baby to love me. Becoming a parent truly propelled my own personal healing, and I would often return to this unconditional love for my children in my recovery as time went on to redirect myself out of depression."

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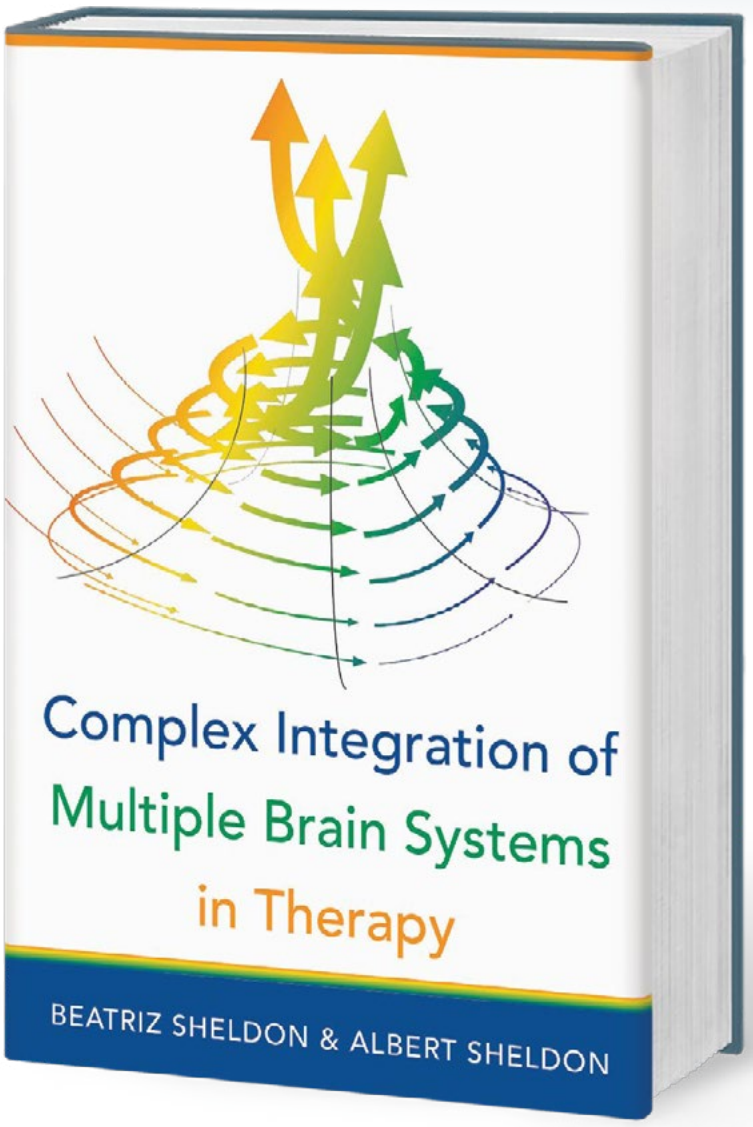

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The Myth of Closure

by Pauline Boss

December 2021

FEATURE

Death ends a life, not a relationship.

—Mitch Albom, Tuesdays with Morrie

As the pandemic raged on, losses of all kinds were piling up for people. The barber down the street, a family man, lost his business; a prominent restaurateur lost his restaurant; and dozens of smaller eateries and shops have shut their doors. The term "closure" was heard routinely as the pandemic closed many small businesses, many forever. While the term fits for describing businesses that close their doors, closure does not fit the experience of losing someone we love.

In the popular vernacular, closure is unfortunately used to describe the ending of the grief that comes after loss. The assumption is that you'll be "over it," done with your sorrow once you have closure. Not true. When Mitch Albom writes about death not ending a relationship, he knows that his visits with Morrie every Tuesday formed a bond that continues even after death. There is no closure, nor does there need to be.

As a family therapist, I worked primarily with people suffering from unexpected and traumatic losses, most of them full of ambiguity. What I learned is that even with the most extreme cases of loss, having no closure does not have to be devastating.

Sarah was a traumatized 19-year-old woman who was the survivor of a horrific small plane crash that killed her father and brother and left her mother with third-degree burns. It's been over a decade now since we ended our therapy work together. She completed her bachelor's degree with honors, married, had two children, then finished her master's degree, and moved with her husband and children across the country to work as a marriage and family therapist.

An excerpt from *The Myth of Closure* by Pauline Boss (Norton, December, 2021)

On the tenth anniversary of her losses, she wrote to me:

> When I lost Dad and Zachary, the pain and suffering from the experience forced me to stare at the closed door. I couldn't believe what had happened; there were still conflicts between my father and me, and the disbelief that my brother was gone was too overwhelming. . . . However, as the ten-year anniversary approaches, I am grateful that the energy that flows between us continues, not on a physical level, but now as a highly emotional and spiritual experience. These relationships have actually continued to evolve, especially with my father. Forgiveness has occurred between my father and me and acceptance that my brother was killed at such a young age happened. Forgiveness and acceptance. These two acts have expanded my heart in ways that I could not possibly imagine. I now have the ability to empathize with others who are suffering and genuinely be in the moment with them. People ask, "Have you found closure in their deaths?" Honestly, no. However, I have accepted what was—what has happened, and what will be. Because in the end, I actually have NO control over other people's destinies, but I can continue to accept and grow in mine.

And then there is Donna. Her loss was, and still is, more ambiguous. In 2007, her husband vanished at sea. He has not been seen since, nor was any debris from his red sailboat found. Donna has struggled deeply with the ambiguity of this loss and now, 14 years later, is enjoying her life in a new way. She moved back to her hometown, a city in the Midwest, and returned to her early talent of writing poetry. She also wrote about closure and the hurt it causes: "People wanted to call me a 'widow' right after he disappeared. . . . They would say, 'Oh, Donna, just call yourself a widow. It will make your life easier and no one will know the difference . . . ' " , except, she said, she would know the difference. It is not unusual for others to want closure more than the person experiencing the loss.

Donna continued, "To call myself a widow was diminishing my life experience. It was another way of tucking away what happened under the cultural veneer of a closure word." Later she wrote:

> People are often so uncomfortable being in the room with loss. With strangers, I am very careful not to mention the word "disappeared," for all sorts of reasons, including not wanting to see their discomfort about my missing husband or go into the world of voyeurism with them. Alzheimer's is handled a bit easier, I think, because of its frequency now, but even so, there is a "hush" in the room when it is discussed, as though if we talk in a hush about this loss of a living person, it might be less horrible. It might not happen to us.

It was from people like Donna and Sarah that I learned again and again that closure is a myth. I saw repeatedly that keeping loved ones present in one's heart and mind, even after they have disappeared or died, helps one to hold the loss and its grief without seeking an absolute

ending. Yes, they accept the loss as real and, at the same time, move forward with new hopes. They take a risk to change and do not wait for things to go back to the way they were. Instead of seeking closure, they find ways to hold the ambiguity and live with it.

For Sarah, while referring to her father and brother as "a part of my soul that will remain for eternity," her story gradually changed over the years from one of immense trauma and loss to one of higher purpose—raising her own children now in a healthier environment than she experienced and honoring her deceased father, who always wanted her to go to college, by becoming a licensed family therapist who can help others.

Donna found meaning in more artistic ways, becoming an accomplished poet, making friends in the arts community, and becoming a wise and compassionate head of her extended family. Neither Donna nor Sarah believes today that closure is possible or essential. They are both at peace with a "continuing bond." Donna may wish for more certainty, but that has not stopped her from living life in all of its fullness.

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While closure is a frequently used term, what does it mean? Sociologist Nancy Berns analyzed the term and found that there was no agreed-upon answer among the people who use it. In her study, closure was described as:

> justice, peace, healing, acceptance, forgiveness, moving on, resolution, answered questions, or revenge. And how are you supposed to find this closure? People try to find closure by planting trees, acquiring memorial tattoos, forgiving murderers, watching killers die, talking to offenders, writing letters, burning letters, burning wedding dresses, burying wedding rings, casting spells, taking trips to Hawaii, buying expensive pet urns, committing suicide, talking to dead people, reviewing autopsies, and planning funerals.
>
> And she tells us this is just a partial list.

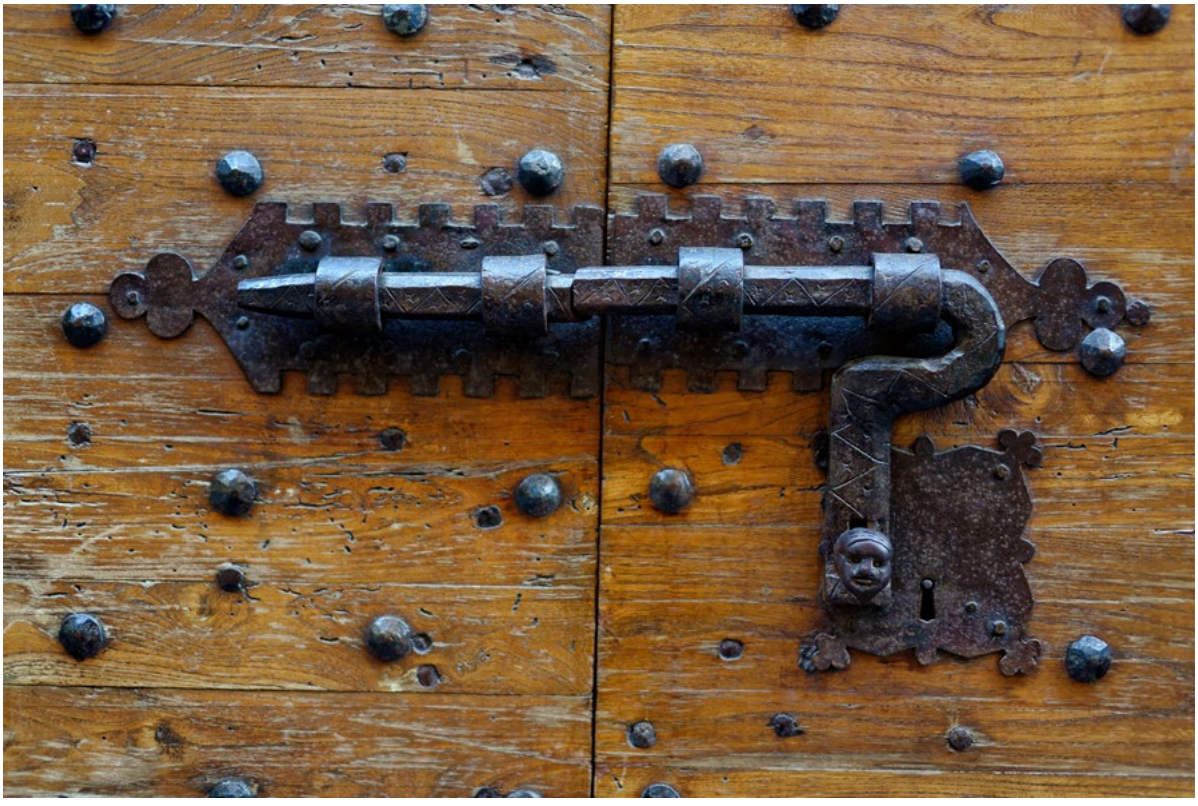
My definition of closure, however, focuses on the meaning of the word itself. In relation to loss, closure means termination, finality, something finished. It implies a clear and absolute ending. However, many people don't want such total, absolute termination of a relationship. As

referred to earlier, Mitch Albom wrote, "Death ends a life, not a relationship." I add that while divorce ends a marriage, it does not always have to end a friendship and coparenting.

When I was in graduate school in Madison, family therapist Carl Whitaker angered some of us in his seminar when he blithely said, "You can never get divorced." I had just gotten divorced, and that was not what I wanted to hear. I wanted closure and thought the divorce decree was the end of it. But after some years passed, I noticed my empathy for my ex-husband had grown. I now knew what Whitaker meant. Once there has been an attachment, even a legal divorce might not end the relationship. Still today, I think kindly of that husband of my youth when I see his good looks and athleticism in both of my children.

In the end, the cost of seeking closure is that it's impossible and thus saps our energy and distracts us from seeing other coping options that could lead to more emotional growth and resilience. The benefits of not seeking closure are many: First, it allows us to savor or resist the parts of ourselves that others have influenced, positively or negatively; second, giving up on closure increases our tolerance for ambiguity and thus makes us more resilient for future experiences of loss; third, without needing closure, we can feel more rooted in this world because we now see more than just ourselves in it. We are genetically part of those who have gone before us—and thus part of the human species. With continuity instead of closure, we are not alone.

In my view then, the idea of closure cuts off



these real and symbolic connections and thus often hurts those left behind. Berns said that after giving birth to her stillborn son, people encouraged her to move on from her grief—or assumed she had already done so. This is when she first became wary of the term and also of businesses and politicians who use closure to sell products and agendas. Nevertheless, although it's hurtful, many still use the term. Even the "proof" of an official death certificate may not suffice for what some think of as closure.

For example, with the many killings of Black people still today, families are told they will have closure when the judge sentences the perpetrator to their satisfaction. But this is an illusion. Yes, there is the closure of the trial or the legal case, but there is no closure for the relationship the family lost. While people often say they need justice to have closure, this may be a misnomer, the wrong word. I imagine that what they want—and deserve—is justice, to have the certainty of systemic change so that other families do not have to bear the same pain. Shutting the door on the memory of the person they lost is not their goal.

***

What about the many other losses during this time of loss and change? Will the barber who lost his shop find closure on his losses once the pandemic is over? I doubt that. Will the millions worldwide who lost family members to the virus find closure once the virus is controlled? I

doubt that too and do not encourage anyone to wait for it. Instead, we should search for meaning and purpose in our lives after this horrific time in history.

For me, one of those new meanings is that I now understand more deeply that my Swiss immigrant family on a tenant farm in Wisconsin pulled ourselves up by the bootstraps during the Great Depression more easily because of white privilege. While my family was poor and spoke with heavy accents, I had more opportunities. I also need to educate myself more now about people who still live from paycheck to paycheck. I did that, too, once, but have not paid attention to current numbers. And while I have received many speeding tickets in my day, and sometimes talked back to the police officer, I need to educate myself again about white privilege and the injustices still being perpetrated by police against Black people. In the twilight of my life, this time of pandemic has opened my eyes to the huge disparities in health care, housing, food availability, and opportunities for education, employment, housing, and thus income. My stunted awareness was likely awakened because the pandemic made me slow down enough to see and hear all that was happening.

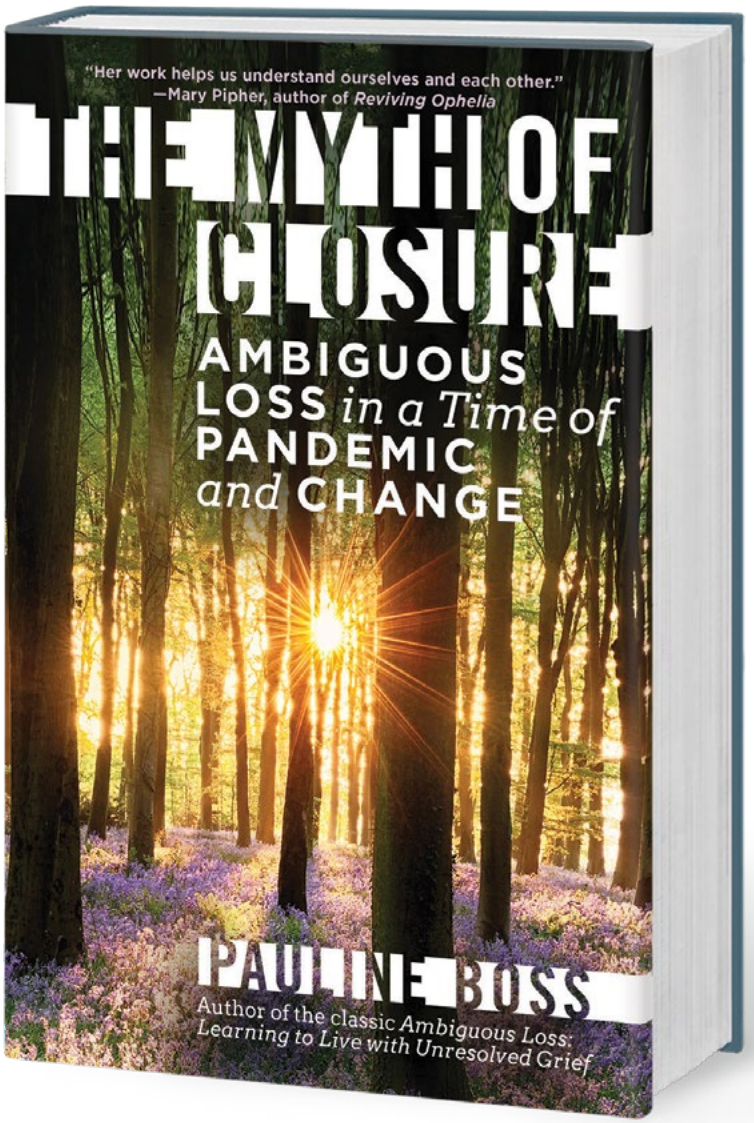
Millions have been sickened by or died from the coronavirus. Rather than seeking closure on this terrible time, let's face the enormity of the losses, grieve, support others who are grieving, and find a way to help bring about systemic change.

To all of you who are grieving someone or

something you loved and lost during this pandemic, may I say this: What you have lost is not the chance for closure, but more likely, the chance to say goodbye, to be with your loved one as they lay dying, to finish unfinished business, to ask for or give forgiveness, to say, "I love you" and to touch your loved one's hand for the last time. It is not closure you need but certainty that your loved one is gone, that they understood why you could not be there to comfort them, that they loved you and forgave you in their last moments of life. Without these things, some doubts may linger for you, but that is the nature of loss. Its ending is never perfect even in the best of times.

Whether our losses are human or material, concrete or ambiguous, we will not forget this plague. At every class reunion, the kids who never had a graduation ceremony will remember the pandemic; health care workers will forever remember the patients they lost; businesspeople will remember the customers and money lost; employees will remember the jobs and income lost; and parents will remember the loss of having their kids learning at home, instead of with others in school, as they always have. Even homes were lost due to deadly hurricanes, floods, and wildfires that came during the pandemic. There will be no closure on this hellish time; it will leave its mark on all of us, and like the Great Depression and World War II, will shape an entire generation.

Coping with loss in pandemic times from Pauline Boss



The COVID-19 pandemic has left many of us haunted by feelings of anxiety, despair, and even anger. In this book, pioneering therapist Pauline Boss, author of *Ambiguous Loss*, identifies and helps us understand these vague feelings of distress as caused by ambiguous loss, losses that remain unclear and hard to pin down, and thus have no closure. Collectively the world is grieving as the pandemic continues to change our everyday lives. This book provides many strategies for coping: encouraging us to increase our tolerance of ambiguity and acknowledging our resilience as we express a normal grief, and still look to the future with hope and possibility.

"[Boss] writes beautifully and with great emotion as she tackles one of our most difficult challenges—how to grow through pain and suffering. Boss is a cultural therapist whose work helps us understand ourselves and each other."

—Mary Pipher, psychologist and author of *Women Rowing North* and *Reviving Ophelia*

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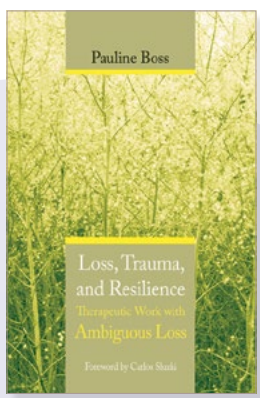
December 2021

Also from Pauline Boss



Loss, Trauma, and Resilience: Therapeutic Work With Ambiguous Loss

Guided Imagery Therapy (GIT)
and
Mirroring Hands Therapy (MHT)

Brief, Secret, and Effective

Rubin Battino, MS

December 2021

FEATURE

INTRODUCTION

There are two therapy models - one old and one an adaption of an old approach - that are brief, secret, and effective. The author has used them for many years yet feels that they are not sufficiently well-known to be in common practice. They are both simple three- or four-step approaches. Since most readers will not know what is meant by "secret therapy," it is described in this introductory section.

In his 2020 book Battino (pp. 115-116) writes about the "Yenta Syndrome." This is a Yiddish term, and it generally refers to a person who is an insatiable gossip. Psychoanalysis, which dominated the twentieth century, required almost incredible amounts of information about the client's past, especially their childhood. (Many years ago, I was "in analysis" for about six years. It was apparently the case that many patients even made-up things to tell their analyst. I did.) Since this is relevant in what I call "secret therapy," two questions come to mind: (1) how much information do you really need to guide a client to the changes that are realistic and helpful and desirable; and (2) is it possible to provide such guidance with *only knowing* that they are currently troubled and hurting and seeking ways out of being stuck? The answer is "Yes," to both. Two excellent approaches are GIT and MHT.

(Both GIT and MHT are applications of Mary Goulding's opening question for a client, "What are you willing to change today?" Note: this is a marvelous opening query for any therapy session.)

THE GIT MODEL

Guided imagery has been around for a long time and started with the work of the Simontons (Simonton, et al., 1980) who used it to help cancer patients. (My own book on the subject was published in 2000.) In my adaptation of using this approach to therapy I need just four bits of information:

1. *A brief statement of what troubles the client.* (I consistently avoid the word "problem." My clients have things that *bother* or *trouble* or *concern* them.)
2. *Relaxation* - Do they have a preferred method of relaxing or meditating, and what is it?
3. *Safe Haven* - Do they have a special safe and secure place that they can go to within their mind that is real or imaginary? If yes, ask for a brief description of that place.
4. *Healing Entity* - What or who do they feel will help them through this troubled time and into their future?

Please note that the client supplies all of the information needed to realistically help them through their current difficulties. *They know* what changes are possible in their lives. There is no easy way for the therapist to know enough about the client to find ways of guiding them or making practical suggestions in the first (and maybe only session) that you are with them. So, in the GIT method *the client tells you* exactly what will help them! Your job, then, is to basically tell them all of this back in a detailed and suggestive manner. That is, you *guide* them through their own change process. Since a major strength of using hypnosis is that it is generally understood that people are more open to suggestions when they are in trance state, the delivery of steps 2-4 are generally via hypnosis. (The delivery can also be made in other styles as in simply telling stories.)

Some examples of items 2-4 are:

1. *Paying attention to breathing is the most common method used.*
2. *Safe Haven* - Common places are: being at the beach or in a forest or near a stream or some place in nature, or places at home like a bedroom or a garden.
3. *Healing Entity* - Religious people have chosen God or Jesus or Hashem or the Holy Spirit, a healing presence, healing hands, or a healing light. (Many other healing entities have been chosen that are unique to a particular client.)

In part 3 you feed back to your client details about their safe haven so that it becomes reified. In part 4, the "Healing Entity" is described as being near and even in physical contact with the client. Via this connection, the Healing Entity somehow (the word "somehow" is magical since the client chooses how this is done) transmits knowledge and skills and whatever is needed to attain the realistic changes that the client (in their own mind) needs. In summary, the effectiveness of GIT to achieve their desired changes and goals is that *they are telling you* exactly what will bring this about for them. [Thus, in essence, the therapist is not bound by or needs to use any "named" therapy!]

GIT and MHT (see next section) are the simplest model I can think of for doing brief and effective therapy. Other approaches (to my mind) just require too much time and information and steps and sessions. Rather than present a case study or two here, you are referred to the many case studies with commentary in (Battino, 2020). Give the GIT model a go, i.e., "git" with it!

The MHT Model

I first learned about the MHT (moving or mirroring hands) approach at an Erickson congress where it was presented by Brian Lippincott (a colleague of Ernest L. Rossi who had developed the method). Lippincott reported on using this approach on a study he did with PTSD veterans. Details on the MHT approach can be found in three of Rossi's books (Rossi & Cheek, 1988, p. 39; Rossi, 1996, p. 194; Hill & Rossi, 2017, pp. 62-67). There are three steps to this approach and all you need to know is that the client has come to you for help. The following is just paraphrased and slightly modified from the Rossi and Cheek citation above whose heading is, "Moving hands accessing of creative resources.":

1. *Readiness signal for inner work.* "Place your hands comfortably in front of your chest about six to eight inches apart. Close your eyes or look off into the distance. Imagine that there is some kind of force between those hands. If you are ready to begin therapeutic work, will you find your hands somehow moving closer just by themselves to signal yes? (If there is another issue that you need to explore first, will you find your hands somehow moving further apart? In that case a question will come you in your mind that we can deal with. [Note: this rarely happens.])
2. *Accessing and resolving concerns.* "As your mind accesses and explores the relevant and important memories about these concerns, will you find one of your arms drifting slowly down until it finally settles on your leg? This will be a complete and satisfactory inner review of those concerns." [Note: In my experience both arms drifting down sequentially have always occurred.] "And now, your other arm will begin drifting down all by itself as your mind explores many realistic therapeutic possibilities for resolving those concerns. When your mind has found at least three satisfactory practical actions, that other arm will come to rest.

3. *Ratifying resolving your concerns*. "And now, will you find your head nodding yes all by itself to verify that you will select one or more of these practical ways of helping yourself? When you know that this is the case, will you find yourself taking a deep breath or two, blinking your eyes, and stretching a bit? Thank You.

The MHT model first gets the client's agreement to work on a difficulty of their choice (the therapist does not need to know what this is!). Then the client explores relevant factors about this, and knowing those factors selects several realistic ways for resolving the original concern. The final and third step has the client agreeing to appropriately resolve what it is they came to see you about! I cannot think of a simpler way to access and utilize what the client knows about him/herself to guide them to changing behaviors. In essence you are guiding clients to discover ways of helping themselves. (Please note that Hill and Rossi's book contains much additional useful material related to MHT than has been presented in this short essay. For example, Chapter 13, entitled "Personal Access to Your Growing Edge," describes solo and personal uses of mirroring.)

Commentary - In this brief essay two rapid and effective methods are described where a client's own resources are tapped to provide them with effective and rapid change. Why not give them a go?

Bio – Rubin Battino, MS, has a private practice in Yellow Springs, Ohio. He is an Adjunct Professor for the Department of Human Services at Wright State University, and has over twenty five years of experience as a facilitator of a support group for people who have life-challenging diseases and for caregivers. He is a Fellow of the National Council for Hypnotherapy (UK), and also a Fellow of two chemistry societies.

References

Battino. R. (2020). *Using guided imagery and hypnosis in brief therapy and palliative care*. Routledge.

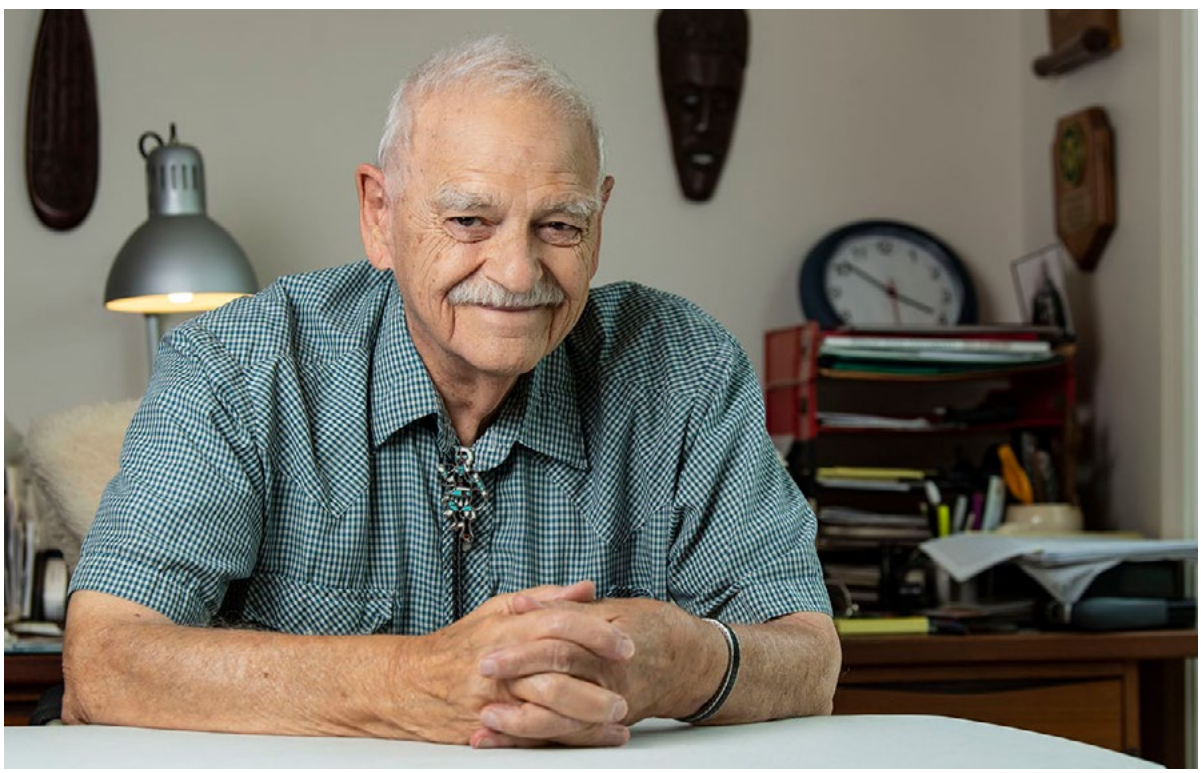
Battino, R. (2000). *Guided imagery and other approaches to healing*. Crown House Publishing.

Simonton, O.C., Simonton, S. & Creighton, J. (1980). *Getting well again*. Bantam Books.

Hill, R. & Rossi. E.L. (2017). *The practitioner's guide to mirroring hands*. Crown House Publishing.

Rossi, E.L. (1996). *The symptom path to enlightenment*. (Ed. K.L. Rossi). Palisades Gateway Publishing.

Rossi, E.L. & Cheek, D.L. (1988). *Mind-body therapy. Methods of ideodynamic healing in hypnosis.* W.W. Norton.



Therapist *Cultural Humility* is a Crucial Component of Psychotherapy with Autistic Clients

By
Erin Bulluss

December 2021

LAST WORD

"Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations"

(Tervalon & Murray-Garcia, 1998, p.117)

The Oxford Dictionary defines *culture as* the ideas, customs, and social behaviour of a particular people or society. The pervasive, neurodevelopmental nature of autism means that it fundamentally impacts the way we think (Murray, Lesser, & Lawson, 2005), our customs (Bulluss & Sesterka, 2020), and way of socialising (Morrison et al., 2020; Crompton et al., 2020), creating a culture in its own right - *Autistic Culture.* While Autistic Culture is a phenomenon that is often discussed within the Autistic community, it rarely makes it into academic or clinical discussion. Instead, the pathologizing lens of the medical model has led to autism being seen as a bundle of deficits to be fixed, rather than as a defined population of people with divergent ideas, customs, and social behaviour, resulting in Autistic Culture being overlooked in conversations about the importance of cultural competency and humility for various groups of people.

Cultural competency refers to learning about a culture that we are not a part of ourselves - gathering information to build awareness and understanding of the elements of the culture that differ from our own so as to be more culturally sensitive in our interactions, and especially in the provision of psychotherapy. The history of psychotherapy for Autistic people is not one brimming with cultural competence and sensitivity, but rather one of attempting to teach Autistic people to behave in ways that fit the dominant culture. Fortunately, this is slowly shifting, and psychotherapists are increasingly working from an autism-affirming psychotherapeutic paradigm, which centres "cultural competence" at the heart of the approach. There are a range of easily accessible resources to learn about Autistic Culture, including resources created by Autistic people that explore their lived experience, and resources created by Autistic psychotherapists to explore the junction between lived and professional experience. Social media has allowed a range of Autistic voices to have a platform. Psychotherapists simply need to seek them out and listen with an open mind.

Further, a truly autism-affirming psychotherapeutic approach recognises that we cannot possibly ever be entirely competent when it comes to working with a culture that we are not part of ourselves, and thus also includes cultural humility as a fundamental and ongoing practice in the provision of autism-affirming psychotherapy. In this context, cultural humility is a lifelong commitment to self-reflection and self-critique (Tervalon & Murray-Garcia, 1998), while seeking to learn from Autistic peo-

ple rather than taking an expert stance. Cultural humility includes acknowledging and addressing any underlying assumptions that are held as a result of being part of the dominant non-autistic culture, and frequently asking oneself during psychotherapeutic sessions, "what assumptions am I making?" rather than letting privilege render the assumptions invisible.

> "... people in a majority or socially supported position, no matter how well-meaning, are often so protected in their assumptions about the world that they do not even know they are making assumptions." (Hope, 2019, p.17)

When it comes to working with Autistic clients, assumptions can be very well camouflaged as they are tied tightly to socio-cultural norms and the core assumptions our society holds about how to connect, how to read emotion on someone's face, and what body language means. A fundamental part of understanding Autistic Culture is understanding that the very way we process the world differs at a neurological level and this difference in processing is not changeable, curable, or wrong. Seeking to understand each individual client's way of experiencing themselves, others, and the world, including regularly checking in about the internal experiences the client is having rather than assuming based on their body language and facial expressions, is essential to providing psychotherapy to Autistic clients. In fact, Wampold (2015) highlights *cultural adaptation* as one of the five common factors in effective therapy, along with *alliance* and *empathy*, which are all enhanced through the practice of cultural

humility and eroded where cultural humility is lacking.

As such, it is our professional and ethical responsibility to listen to the Autistic community, to Autistic health professionals, to Autistic researchers, and - above all - to listen to our Autistic clients as an integral part of best practice of psychotherapy.

Biography

Erin Bullus, PhD Erin is a director on the board of *Reframing Autism*, an organisation that aims to nurture Autistic identity and culture, while celebrating diversity in all its forms. She co-authors a Psychology Today blog called Insights about Autism which aims to provide information from the perspective of late-diagnosed autistic professionals. She also shares autism positive articles about research and clinical practice on the Facebook page, Autistic Wellbeing Consultancy.

References

Bulluss, E. K., & Sesterka, A. (2020, November). The Potential Perils of Christmas: An Autistic perspective. *Psychology Today. Retrieved from* https://www.psychologytoday.com/us/blog/insights-about-autism/202011/the-potential-perils-christmas-autistic-perspective

Crompton, C. J. et al. (2020). Autistic peer-to-peer information transfer is highly effective, *Autism, 24*(7), 1704-1712.

Hope, S. (2019). *Person-Centred Counselling for Trans and Gender Diverse People: A practical guide.* Jessica Kingsley Publishers.

Morrison, K. E. et al. (2020). Outcomes of real-world social interaction for autistic adults paired with autistic compared to typically developing partners, *Autism*, 24(5), 1067-1080.

Murray, D., Lesser, M., & Lawson, W. (2005). Attention, monotropism and the diagnostic criteria for autism, *Autism*, 9(2), 139–156

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry,14(3), 270-277.*

Tervalon, M. & Murray-Garcia, J. (1998). Cultural Humility Versus Cultural Competence: A critical distinction in defining physician training outcomes in multicultural education, *Journal of Healthcare for the Poor and Underserved*, 9(2), 117-125.

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