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Recent Developments in Theories and Practices

Edited by Kenjiro Fukao

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Meet the editor

Kenjiro Fukao, MD, Ph.D., graduated from the School of Medicine, Kyoto University, Japan, with a major in psychiatry. He specialized in psychiatric epileptology, working at the National Epilepsy Center, Japan; University Hospital of Zürich, Switzerland; and Kyoto University Hospital. He obtained a Ph.D. with research in the magnetoencephalographic study of patients with epileptic psychosis. Presently, Dr. Fukao is a professor in the Department of Psychology, Faculty of Human Sciences, Tezukayama Gakuin University, Japan.

Contents

Preface

In the modern world in which human life is becoming more complicated and diverse, the demand for counseling and psychotherapy is growing. Rapid developments in both academic and institutional aspects of the field are occurring worldwide.

This volume presents some examples of recent advances in theories and practices of psychotherapy.

Section 1, "Theoretical Innovations," includes three chapters that address theoretical aspects of psychotherapy. Chapter 1, "A Plea for Mixed Methods Research in the Field of Counseling", highlights the need for mixed methods research in mental health counseling. The author presents and discusses three projects in this area. Chapter 2, "True Happiness as a Shortcut to Mental Health: A New Theory of Psychopathology and Psychotherapy Based on Aristotle's Ethics and Evolutionary Science", presents a novel theory founded on a conceptual synthesis of the classical ethics of Aristotle and contemporary views of evolutionary psychology. Chapter 3, "General Three-Component Structural-Dynamic Theory of Psychotherapy and Its Implementation in Method of Positive-Dialog Psychotherapy", presents a new comprehensive theory based on an analysis of archaic therapeutic systems and historical/cultural aspects of psychotherapy and its clinical application.

Section 2, "New Attempts of Practice," includes three chapters describing practical attempts with various ideas. Chapter 4, "Including Religion in Rational-Emotive Behavior Counseling", explains the resemblance between rational emotive behavior therapy and traditional religious doctrines and exemplifies its usefulness by presenting a case of borderline personality disorder with religious inclination. Chapter 5, "Mindfulness-Based Stress Reduction as a Culturally Relevant Treatment for Racial or Ethnic Minorities", reappraises mindfulness-based stress reduction from the viewpoint of adaptability and accessibility for people of racial and ethnic minorities. Chapter 6, "Psychotherapy in Nature: Exploring an Alternative Psychotherapeutic Framework to Address the Limitations of Working in Traditional Settings in Order to Move with the Times", describes the limitations of traditional psychotherapy, which usually takes place in an office or clinic, and proposes psychotherapy in outdoor settings as an alternative.

Section 3, "Practices under the COVID-19 Pandemic", includes two chapters, both dealing with psychological practices in African states under the current pandemic of COVID-19. Chapter 7, "A Scoping Analysis of the Psychosocial and Health Implications of Covid-19 Comorbidity-Related Complications in the African States: Recent Developments in Counseling and Therapeutic Options", presents and analyzes mental health problems of people living in African states under the pandemic and proposes effective psychological policies. Chapter 8, "Volunteer Counseling Services in the Context of COVID-19: Compromises and Challenges", reports the actual status of volunteer counseling services in African states amidst the pandemic, exemplifying some narratives of clients and therapists.

The editor believes that these chapters will provide readers with fresh ideas and instructive references for the theorization and practice of counseling and psychotherapy.

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Section 1

Theoretical Innovations

Chapter 1

A Plea for Mixed Methods Research in the Field of Counseling

Dirk Rohr

Abstract

We need more research in counseling if we want to strengthen counseling as a profession and if we want to implement counseling in mental health systems. Thus, the research should be multiple dimensional. This chapter is a plea for mixed-methods research (MMR) designs in the field of counseling. Even if MMR is very elaborate, it is worth doing. By way of example, I would like to briefly outline three of my projects, using MMR. The first one is a mixed methods research study on the video-based counseling method Marte Meo. The second project is one concerning genograms. Genograms are an integral part of therapy and counseling. The third MMR project is an elaborate research project which we carry out on behalf of the "Deutsche Gesellschaft für Beratung", the German National Association for Counseling (Member of the European Association for Counseling, EAC, and the International Association for Counseling, IAC) to develop a German qualifications framework for Counseling—in the context of the European Qualifications Framework (EQF). Finally, I refer to Guetterman et al. who provide some empirical evidence for researchers who wish to take full advantage of mixed methods to address pressing clinical and public health issues.

Keywords: counseling, mixed methods research, mental health research, triangulation, convergent designs, exploratory sequential designs, explanatory sequential designs

1. Introduction

Mixed methods research (MMR) is defined as the collection, analysis, and integration of both quantitative data (e.g., RCT outcome) and qualitative data (e.g., observations, semi-structured interviews) to provide a more comprehensive understanding of a research problem than might be obtained through quantitative or qualitative research alone [1, 2]. Relevant strategies for the use of mixed methods in health services research include adding qualitative interviews to follow up on the outcomes of intervention trials, gathering both quantitative and qualitative data to assess patient reactions to a program implemented in a community health setting, or using qualitative data to describe or explain the mechanism of a study correlating behavioral and social factors to specific health [3]. We want to find out if this is important in the field of counseling.

2. What is mixed methods research (MMR)?

I want to start this chapter with the "Classification", the "five purposes for mixing in mixed-methods research":

1. Triangulation seeks convergence, corroboration, and correspondence of results in different ways.

2. Complementarity seeks elaboration, enhancement, illustration, and clarification of the results from one method with the results from the other method.

3. Development seeks to use the results from one method to help develop or inform the other method, where interpretation includes sampling and implementation, as well as measurement decisions.

4. Initiation seeks the discovery of paradox and contradiction, new perspectives of frameworks, and the recasting of questions or results from one method with questions or results from the other method.

5. Expansion seeks to extend the breadth and range of inquiry by using different methods for different inquiry components [4, 5].

Next to the five purposes MMR has five essential characteristics: (1) the collection and analysis of both quantitative and qualitative data, (2) the use of rigorous procedures in conducting quantitative and qualitative research, (3) the integration of the findings, (4) the use of mixed method designs and (5) the use of a conceptual framework [6]. By "Integration", we mean integrating quantitative and qualitative research through our research teams, philosophies, research process, and research methods.

A mixed methods research project provides more insight than qualitative or quantitative data alone by greater mining data depth. The different perspectives from linking enable the databases to "talk" to each other. We can compare the two database results and follow up quantitative results with qualitative data collection.

2.1 Core designs

There are three different core designs: convergent design, explanatory sequential design, and exploratory sequential design. A plan's importance is: identifying a theoretical framework, writing a mixed methods question, and writing a mixed method study aim, composing the study using a writing structure that matches the design, developing a joint display for integration, identifying the methodological/validity issues in design, drawing a diagram of configuration, identifying the type of mixed methods design and creating a title for the project.

The convergent design qualitative interviews, analysis, quantitative survey, and analysis stand alone in the first phase. Then they are merged and an interpretation follows. You should choose a convergent design when your mixed method project intends to compare results, develop broader products, validate data, and build cases. It can be helpful when you need rapid data collection. It is also beneficial when you have equal emphasis on both quantitative and qualitative data (**Figure 1**).

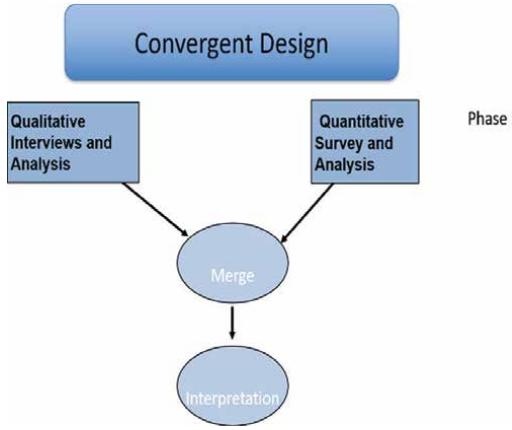

Figure 1.
The convergent design [6].

The explanatory sequential design has three phases. In the first phase, the quantitative survey and analysis of the qualitative interviews and comments will be explained in the second phase. In the third, an interpretation follows (**Figure 2**).

The explanatory sequential design starts with collecting quantitative data through a cross-sectional web-based survey, which delivers numeric data. It follows an analysis of the data through data screening, providing descriptive statistics and factor loadings. In the case selection, an interview protocol will be developed, participant dorm will be selected and interviewed.

The collection of qualitative data happens through documents and telephone interviews. It makes up the text and image data. Lastly, the qualitative data analysis follows a cross-thematic study and delivers a cross-thematic matrix and a visual model of multiple case analyses.

You should choose an explanatory sequential design when your mixed method project intends to explain surprising, contradictory, outlier results or results that do not match theory or form groups/cases for further analysis. Other reasons could be when you have time to conduct your study in phases or emphasize starting a project from a quantitative perspective.

The third core design is the exploratory sequential design.

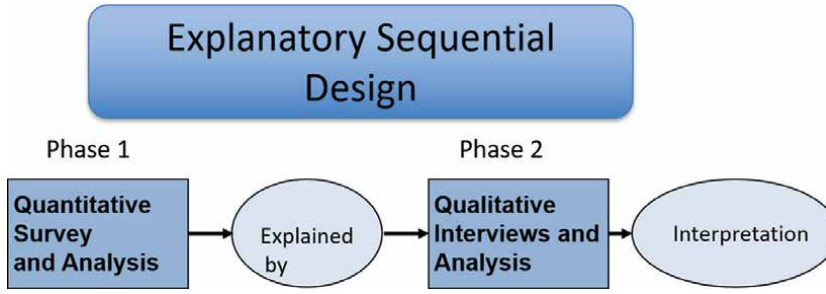

Figure 2.
The explanatory sequential design [6].

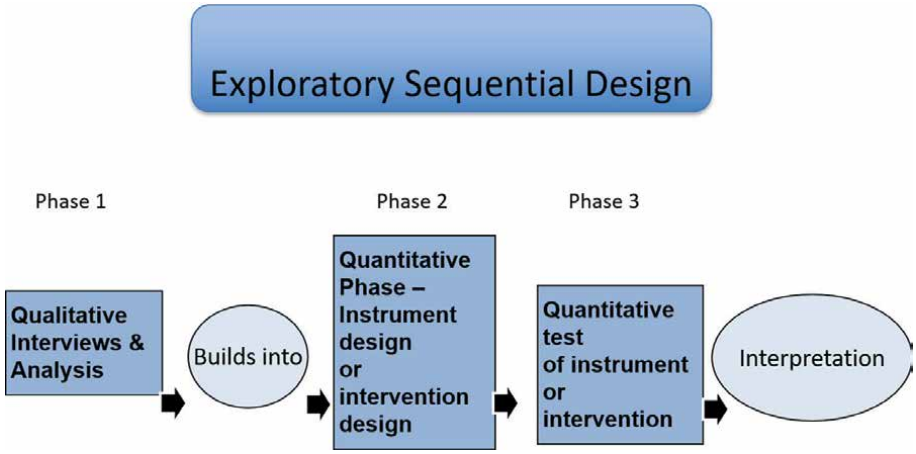

Figure 3.
Exploratory sequential design [6].

As illustrated in **Figure 3** this design has three phases. In the first phase, interviews, observations, and other qualitative methods are conducted and analyses are made. The analysis of qualitative data leads to the development of a quantitative device.

The second phase is the quantitative phase, which includes an instrument design or intervention design. Then follows a quantitative test of an instrument or intervention in phase 3, which leads to an interpretation. "We can first explore qualitatively, and then test out the ideas quantitatively" [6]. Afterward, quantitative data will be collected and analyzed and an interpretation follows.

An exploratory sequential design should be chosen when your mixed methods project intends to build and test an intervention, instrument, survey, app or website, or new variables. Other reasons could be when you emphasize starting your project qualitatively or when you have time to collect in phases over time.

Lastly, a short comment about complex designs. Typically, complex applications are used when researchers have multiple research phases, multiyear research projects, large funded projects, multiple researchers, or the inclusion of mixed methods core designs within different phases of research [7].

3. Three examples of mixed methods research

3.1 Mixed methods research in our Marte Meo project

Marte Meo[1] is a video-based counseling method founded by Maria Aarts in the Netherlands and is now in worldwide use [8]. Marte Meo has been adopted and put into practice by a large and diverse network of trained and certified counselors worldwide.

With the help of a model of beneficial interaction behavior, Marte Meo aims to support personal development. In this respect, it stands in tradition with the

[1] I thank my mentor Charles Deutsch, Harvard University, the Marte Meo Research Group, Kathrin Meiners and Sophia Nettersheim. (This chapter is an excerpt from Rohr et al. 2020).

humanistic approach. It was founded with the aim of reducing symptomatology. However, we found that in practice, more Marte Meo counselors aim for personal growth. The focus is on relationships that exhibit "complementarity". This is mostly given in a dyad relationship, where one person is responsible, supports, cares educates, etc. (e.g., parents, educators, teachers, careers), and another person needs this support (e.g., infant, child, adolescent, sick, disabled, dementia sufferer [8, 9].

In our research, we choose an integrated exploratory sequential design [6], which seems to be best suited to our purposes. It enabled us to discover in detail how a selected group of experts and parents applied for the Marte Meo program, and we then tested out the ideas culled from that process quantitatively with a large convenience sample.

The exploratory sequential design of the Marte Meo project has five phases as illustrated in **Figure 4**. A systematic literature review is carried out in the first phase, which builds into qualitative interviews and analysis in the second phase. The third phase builds an analysis of videotaped observations. A fourth quantitative phase with an online survey follows and in the last step, the fifth phase follows an interpretation.

The staged qualitative research consisted of designing, conducting, and analyzing semi-structured interviews with parents and Marte Meo Counselors and then using that analysis to inform the design, the conduct, and analysis of videotaped observations of everyday situations for example in day-care centers to examine the process and effects of Marte Meo interaction elements on children.

Combining these qualitative analyses then became the basis for developing an online questionnaire that could enable us to collect quantitative data on the current use of Marte Meo in practice by experts. As a result of this design, four phases of analysis will be carried out: after the two qualitative phases, after the quantitative phase, and during the integration phase, which will connect the data strands and expand the initial qualitative exploratory results.

With the aim of obtaining more meaningful results on the application of Marte Meo in counseling and therapy, it would be desirable to collect an international and generally more heterogeneous sample that includes various groups of people (clients, other affected persons, or experts in other methods, etc.).

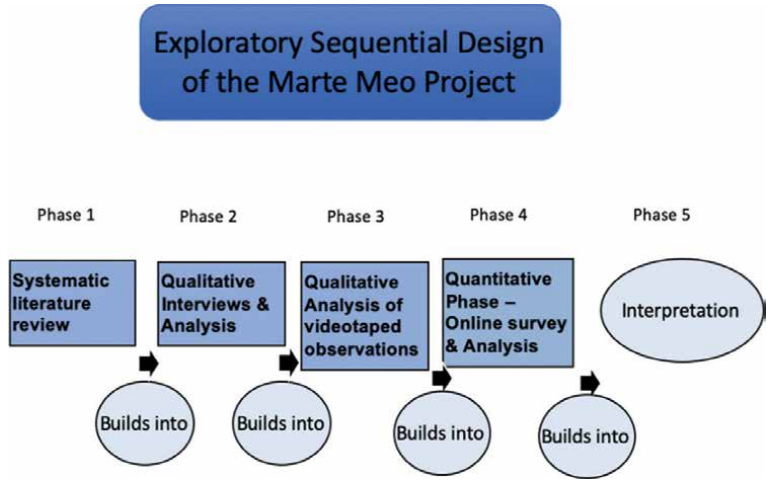

Figure 4.
Exploratory sequential Design of the Marte Meo Project.

In response to the question "What further development does the method need?", the experts' statements strongly pointed to the desire for a scientific foundation for the Marte Meo method. The respondents hoped that increased scientific research on the effectiveness of the method in various fields of application would lead to greater acceptance and consequently to the method being financed by public bodies. The fitting of the effect factors according to Grawe [10] to the basic principles of Marte Meo suggests further follow-up studies are needed to make statements about the effectiveness of Marte Meo. For example, it would be interesting to correlate the experts' self-declarations of the benefits of Marte Meo with objective behavioral data of the clients and to secure them by means of inference statistics. A concrete criterion for this could be the increased rate of observable Marte Meo elements (beneficial interaction) applied visibly and audibly in video recordings over several counseling sessions [11]. Marte Meo seems to fit different approaches. Possible moderators for the effectiveness of Marte Meo could therefore be the experience, knowledge, or skills of the expert. More than one-fifth of respondents stated that they had children themselves. This factor, too, could be a moderator for the effect of the Marte Meo consultancy services used. Overall, although Marte Meo is often used in combination with other methods in a wide variety of contexts, there seems to be little research on the effect of combined use. Here, it would be interesting to get context-specific information about which combinations of methods are effective for which concerns and contexts.

At the time of research, no study could be found that describes the current status of the nationwide application of Marte Meo in practice, counseling and therapy. The results indicate a high degree of diversity in the use of Marte Meo with a high overall satisfaction among experts. Almost one-third of Marte Meo usage takes place in everyday teaching, followed by counseling, exchange with colleagues, teaching, supervision, and therapy. Marte Meo is often combined with the systemic approach, among other things, because it is flexible enough and allows the experts a lot of leeway in their approach, depending on their individual personalities.

The results of the work show that Marte Meo is perceived as beneficial by its implementers. The experts reported more joy and success in their work. In particular, in the pedagogical context, the daily, resource-oriented "Marte Meo view", which has been sharpened by the training, seems to be essential, as it allows for an awareness of the needs of the interaction partners and the beneficial interaction elements. Moreover, for some respondents, the use of Marte Meo seems not to be limited to professional practice but is expressed in a general humanistic attitude towards interpersonal relationships of all kinds.

Regarding various application contexts and concrete advisory procedures, well-founded insights into the benefits and effectiveness of Marte Meo could be found in the future, thus ensuring increasing quality assurance or control and the institutional establishment of the method. In order to consider the diversity in the application of Marte Meo, future research can make use of the results of the qualitative and quantitative studies and derive specific questions. It was discussed that a potential benefit of Marte Meo could be based on the fact that central premises or principles of Marte Meo can be applied to the four impact factors according to Grawe [10]. Thus, in order to advance the application of Marte Meo in the future, scientific studies on this point seem promising.

There are still questions about how competently Marte Meo is performed in practice; that is, how much is supervision prescribed so that there is more reason to infer fidelity to the method than with most other interventions. If fidelity is not something that the Marte Meo process itself effectively ensures (especially when

it is integrated into other methods that are part of the systemic approach), then implementation studies should be built into outcome/impact studies, so that one can distinguish whether objective results vary depending on the level of fidelity of different practitioners. Implementation studies utilizing the Consolidated Framework for Implementation Research (CFIR) might be highly worthwhile.

In our reflections, our decision to utilize an exploratory sequential design was a useful one. In particular, the enhancements of including the systematic literature research (phase 1) and two different qualitative methods (interviews (phase 2) and observations (phase 3) seemed to be a good choice—and might be a recommendation for other similar research projects.

3.2 Mixed methods research in our genograms project

The second project is one concerning genograms. Genograms are an integral part of therapy and counseling (**Figure 5**).

The study investigated the meaning and functions of genograms in the professional practice of counselors.

The article of Rohr et al. [12] presents partial results of the research project InGeno, in which—on the basis of the "actual" use of genograms to be researched—a user-friendly software for genogram creation is being developed. 108 counselors participated in the quantitative online questionnaire study. The data were analyzed descriptively and summarized together with the qualitative results of Rohr's [13] preliminary study. The results show: Genograms are of central importance for those counselors who use them in their counseling practice: they are an integral part of their counseling work, are used in a variety of counseling situations together with the clients, and are further used and processed throughout the counseling process. In this context, genogram work fulfills a variety of functions, such as gaining information about the clients, recognizing transgenerational patterns and relationship dynamics, strengthening the identity of the clients, and uncovering their resources. The advantages and disadvantages of standardization and creativity are discussed.

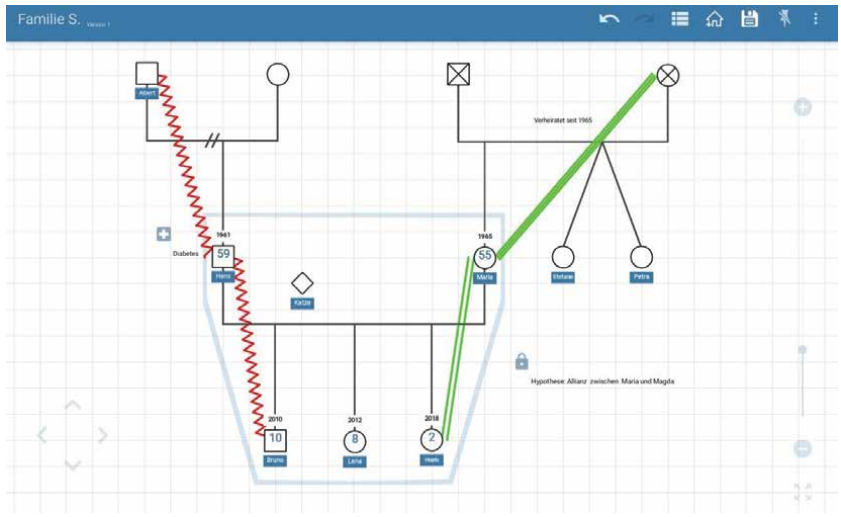

Figure 5.
Example genogram created with the InGeno app.

Overall, the present study confirmed and extended the results of Rohr [13] to a large extent.

"Genograms are visualizations of the bio-psycho-social situation of the family and enable clients to recognize patterns of behavior—and thus to get to know themselves better" [13]. They consist of objective data (analogous to the family tree) and subjective meanings. "The task in genogram work in the context of counseling and therapy is to work out the structures of the social matrix (the social field)." Further, Hildenbrand [14], a pioneer in the use of genograms in German-speaking countries, writes: "Instead, I separate between the given and the given-up in human action [15] and find the actor in the distance between the two: The latter becomes an actor by making the given into the given up, i.e., by shaping his or her life".

The article does not describe normatively and ideally how genograms 'should' be created. There is no single case study described, as this would not be helpful for our research questions. Our questions are discussed based on an elaborate research design. Based on the results we describe in this article descriptively: How do experienced counselors and therapists actually work with genograms, what advantages and disadvantages, limits, and possibilities (modes of action) do they find?

The questionnaire used here was created, among other things, based on the evaluation of twenty qualitative expert interviews. It is part of the interdisciplinary research project "InGeno". A research team from the Department of counseling Research at the University of Cologne is developing a software (app) to create genograms with Computer Science Professor Dr. Mario Winter, B.Sc. Sven Kullack from the Cologne University of Applied Sciences (**Figure 6**) [13, 15].

Based on a systematic literature review [16] our project provides a comprehensive overview of genograms' current research literature. In addition to a detailed account of developed extensions of the standard genogram for specific target groups and counseling settings, research findings on the utility of genograms in training and supervision and the need for discussing psychometric testing of genograms. The presented systematic literature review method aims to invite researchers to "underpin"

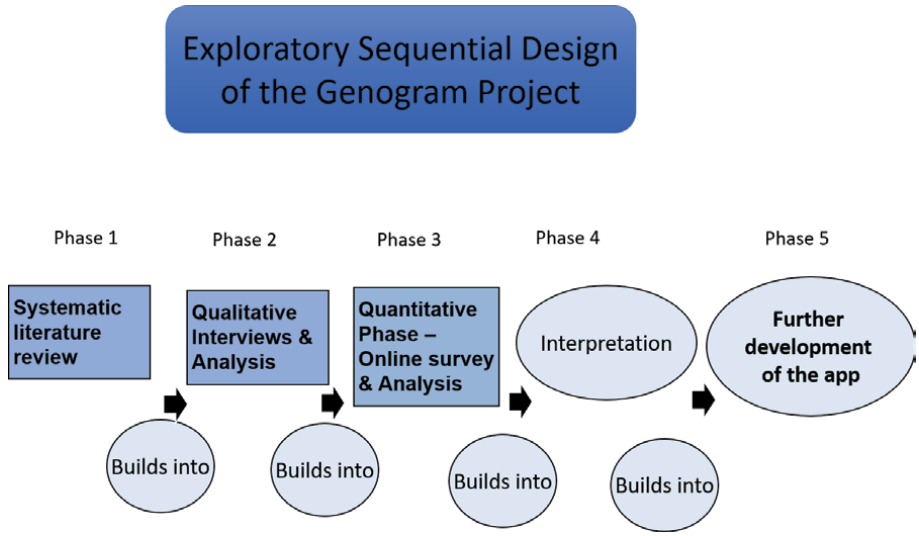

Figure 6.
Exploratory sequential design of the Genogram Project.

their future counseling and therapy research with this approach. In this case, it will inspire counselors and therapists to test different extensions of genogram work depending on the target group and setting in practice.

The systematic literature search done on 05/09/2018 returned 348 hits. Thirty publications from other sources supplemented these. After removing duplicates, we checked the remaining 277 publications for thematic fit based on the titles or abstracts. Here, 112 publications were excluded as they did not fit in terms of content or were not available in English, German, or Spanish. The remaining 165 publications were checked for their suitability in the full text. In this step, a further sixty publications were excluded because they did not contribute to the genograms' role in counseling practice.

The date of publication was not an exclusion criterion; also included were publications before 1990. A total of 105 publications were included in the systematic literature review and were analyzed concerning their empirical content.

Against the background of the quantitative results presented in this article, the systematic literature research [12], and the preceding qualitative interviews with experts the question of the significance and function of genograms in counseling practice can be answered as follows: For those counselors who use genograms in their counseling practice, they are of central importance and an integral part of the counseling process. They are very likely to be used in a large number of counseling situations, whereby most of the time this is done together with the clients. The genogram work is not a one-time activity, but the genogram is used and processed again and again during the counseling process. This leads to the conclusion that for many counselors the genogram fulfills the function of a common thread that runs through the counseling process and can be referred to again and again. The willingness to supplement central and well-known basic functions with further elements that make sense for individual counseling practice is great so that a great heterogeneity in the presentation of the genograms is to be expected. The goals of genogram work are to gain information about the clients, to recognize transgenerational patterns and relationship dynamics, to strengthen the clients' identity—or their own appreciative understanding—and to uncover their resources. According to this, the genogram fulfills a variety of important functions in the counseling process—as well as within training and supervision: almost all respondents experienced the creation of their own genogram as very or mostly helpful.

The counseling and therapeutic work with genograms are very diverse. This is evident from both the systematic literature review (Phase 1) presented in the previous article [12] as well as from the results presented in this article. This is followed by open, fundamental questions: Are we even talking about the same "thing" when we use the term genogram—or genogram work? Bruno Hildenbrand [14] propagates to call "genogram work" only what aims at case reconstruction based on objective data. This could be called an extreme pole of answers to the question: "How are genograms used?"

For us, genograms are semi-standardized "visualizations of the family's bio-psycho-social situation and enable clients* to recognize patterns of behavior—and thus to get to know themselves better" [13]; "semi-standardized" because it became clear in the study presented that the use of the symbols proposed by McGoldrick et al. [17] varied significantly in practice. Despite the advantages of standardization, e.g., the majority use of one and the same software, we believe that the focus should be on the common process of genogram use—and not on the genogram as a means of pure information retrieval.

Maybe the question of standardization or creativity is not relevant for individual counselors and therapists, but undoubtedly for the "scientific community": If professional communication is to be done or if genograms are integrated into therapy applications, standardization is helpful for transparent communication. And if this communication will be digital in the near future (keyword "digital file"), a digitalization of genograms (beyond photos of paper-and-pencil drawings) will be necessary. And yet working with genograms is always an idiographic procedure, i.e., case-oriented, not standard, and developing or progressing from hour to hour. Especially "relationship lines" with double or jagged lines are not "set in stone" from a constructivist-systemic understanding, should not be the basis for "hard diagnostics" (said Tom Levold in the second phase of our project, the qualitative data collection). They are perspectives, circular, they may be experienced quite differently after a few weeks and serve only as hypotheses.

3.3 European qualifications framework (EQF) for lifelong learning—a current MMR project in Germany

In conclusion, this chapter presents an outlook on an elaborate research project which I have started on behalf of the DGfB, the German National Association for Counseling (member of EAC and IAC). Together with Marc Weinhardt (Universität Trier), Cornelia Maier-Gutheil (Evangelische Hochschule Darmstadt), Tim Stanik (Hochschule der Bundesagentur für Arbeit, Schwerin) and Marc Höcker (Universität zu Köln und Universität Mainz) I work on the development of a German qualifications framework for Counseling—in the context of the European Qualifications Framework (EQF).

It is a particular challenge due to the specific conditions in non-formal learning. It requires a well-considered, staged, and explorative approach because it is impossible to fall back on already established procedures for the allocation and reference competencies of the DQR (The German Qualifications Framework) from other fields. The DQR is a mixture of Mixed Methods Program Evaluation Design and Mixed Methods Participatory Design.

In a first step, a multi method approach triangulates a systematic literature review with a quantitative expert survey.

Here, the competencies and competence facets defined in the academic discourse and the competencies and competence facets depicted in counseling curricula are recorded to secure and further explore these in a Delphi study with one hundred experts' participation. The experts were selected in close consultation with the client to adequately reflect the counseling landscape's diversity and consider a cross-school perspective.

The Delphi study (100 experts will fill in the questionnaire) aims to check and supplement the literature review results and weighting concerning the Qualifications Framework for Counseling. It is to ensure that a methodically supported and intersubjectively comprehensible consensus is found within the member associations.

At the same time, we will analyze procedures and instruments for competence assessment, examinations, and certification procedures of the DGfB member associations with regard to their outcome and competence orientation in order to systematize their adaptation possibilities for the project context. Evaluating both partial studies' results (qualification framework for counseling and synopsis of competence assessment procedures). In the course of qualitative group discussions with representatives of the DGfB member associations, proposals for certification criteria and practices

will be derived and, in the course of the project, acceptance for the project results will be created in the DGfB member associations. The entire application's orientation follows a research concept oriented towards impact factors. It is thus natively

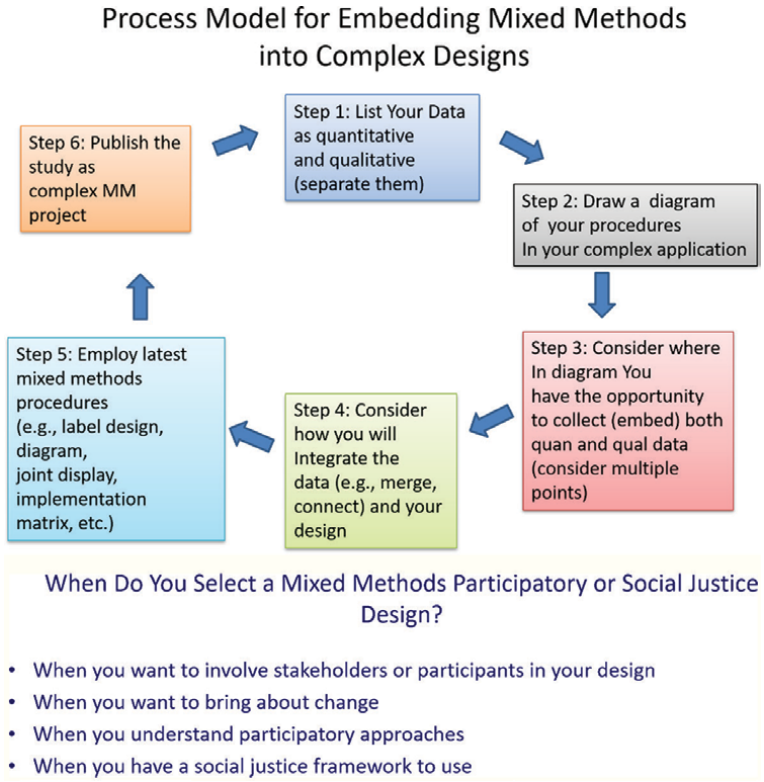

Figure 7.
Process model embedding mixed methods into complex designs [6].

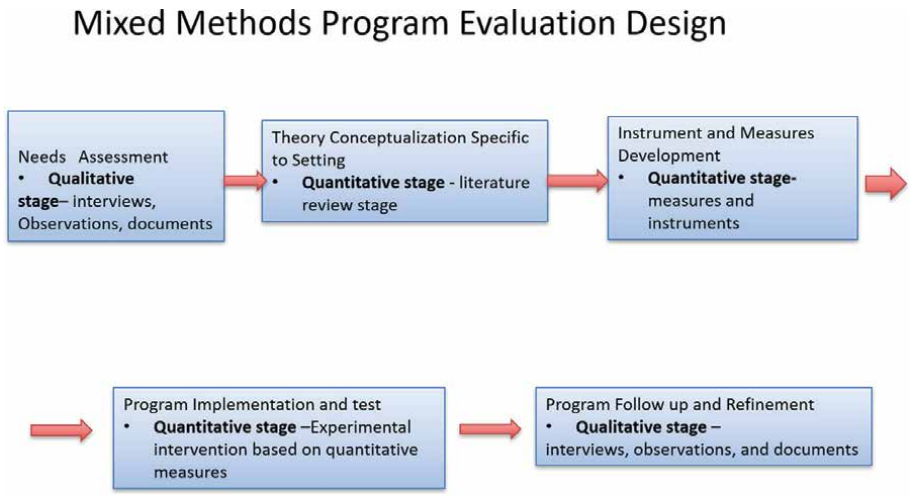

Figure 8.
Mixed methods program evaluation design [6].

connectable to competence-oriented discourses and aims at theoretical and empirical modeling of successful counseling actions.

This project is a so-called complex design—an intersection of core designs with complex applications (see **Figure 7**).

They are used when researchers have multiple research phases, multiyear research projects, large funded projects, multiple researchers, and inclusion of mixed methods core designs within different phases of research [6]. In this case, it is a mix of a "Mixed Methods Program Evaluation Design" (see **Figure 8**) and a "Mixed Methods Participatory Design" which is used when you want to involve stakeholders or participants in your design, when you want to bring about change and when you understand participatory approaches [6].

4. Conclusion

In general, this article can be understood as a plea for mixed methods research. We agree with Teddlie and Tashakkori [18]: "We believe that divergent thought will always be a part of MMR (...), but that it is now time for greater convergence on some basic characteristics and principles" and with Symonds and Gorard [19]: "Death of mixed methods?: Or the rebirth of research as a craft". Considering the limitations of the quantitative and qualitative paradigms and current definitions of mixed methods, we advocate the development of a research community where 'all methods have a role, and a key place in the full research cycle from the generation of ideas to the rigorous testing of theories for amelioration' and do not believe in "oppositional components of paradigms" [20].

This text is a "plea for mixed methods research in the field of counseling" by explaining three empirical examples. Timothy C. Guetterman did a meta-analysis together with my mentor Charles Deutsch from the Harvard School of Public Health and other colleagues [3]. Their goal was to understand how reviewers evaluate mixed methods research by analyzing reviewer comments for grant applications that were submitted primarily to the National Institutes of Health. They asked Mixed Methods Research Training Program (MMRTP) health sciences researchers and consultants to send them summary comments on their mixed methods grant applications and received 40 summary comments on funded (40%) and unfunded (60%) mixed methods grant applications [3]. They conducted a document analysis with a coding rubric based on NIH Best Practices for Mixed Methods Research in the Health Sciences and allowed inductive codes to emerge. Reviewers positively evaluated mixed methods applications that demonstrated coherence between goals and research design elements, detailed methods, plans for integrating mixed methods, and use of theoretical models. Reviewers identified weaknesses in mixed methods applications that lacked methodological detail or rationale, had a high participant load, and did not delineate investor roles. Successful mixed methods applications convey assumptions behind the methods chosen to achieve specific goals and clearly describe the procedures to be followed. Investigators planning to use mixed methods should remember that reviewers are looking for both points of view [3].

Mixed methods approaches are well suited to achieving the goals of health and implementation research. Nonetheless, applicants should be careful to explain the proposed methods based on underlying assumptions so that referees trained in the former methods from disciplines such as epidemiology and statistics will be able to

understand the connection between the specific goals and the mixed methods. The reviewers pay attention to details about the samples, the plans for data collection and analysis, and the data integration procedures. Applicants should anticipate and dispel the concerns of the evaluators about possible disadvantages of mixed methods in terms of participants, time and resource expenditure, and generalizability of results [3]. The study of Guetterman et al. provides some empirical evidence for researchers keen to take full advantage of mixed methods to address pressing clinical and health care issues [3]. Therefore, it fits perfectly into this "plea for mixed methods research in the field of counseling".

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References

[1] Schubert F-C, Rohr D, Zwicker-Pelzer R. Beratung: Grundlagen–Konzepte – Anwendungsfelder. Wiesbaden: Springer; 2019. DOI: 10.1007/978-3-658-20844-8

[2] Bager-Charleson S, McBeath A. Enjoying Research in Counselling and Psychotherapy: Qualitative, Quantitative and Mixed-methods Research. 2020. DOI: 10.1007/978-3-030-55127-8

[3] Guetterman TC, Fetters MD, Creswell JW. Integrating quantitative and qualitative results in health science mixed methods research through joint displays. Annals of Family Medicine. 2015;**13**(6):554-561. DOI: 10.1370/afm.1865. PMID: 26553895; PMCID: PMC4639381

[4] Greene JC, Caracelli VJF, Graham W. Toward a conceptual framework for mixed-method evaluation designs. Educational Evaluation and Policy Analysis. 1989;**11**(3):255-74. DOI: 10.2307/1163620

[5] Greene JC. Mixed Methods in Social Inquiry. San Francisco, CA: Jossey-Bass; 2007. pp. 1-37

[6] Cresswell JW, Deutsch C. Applying core and complex designs. Webinar, MMRTP. May 5, 2017

[7] Nastasi BK, Hitchcock J, Sarkar S, Burkholder G, Varjas K, Jayasena A. Mixed methods in intervention research: Theory to adaptation. Journal of Mixed Methods Research; 2007;**1**(2):164-182. DOI:10.1177/1558689806298181

[8] Aarts M. Marte Meo basic manual. Revised. 2nd ed. Aarts Production; 2008

[9] Bünder P. Enhancing development of children at risk and their parents by video counselling according to the marte meo method. Praxis der Kinderpsychologie und Kinderpsychiatrie. 2011;**60**(5): 333-350

[10] Grawe K. Grundriss einer allgemeinen Psychotherapie. Psychotherapeut. 1995;**40**(3):130-145

[11] Bünder P. Entwicklungsförderung von Risikokindern und ihren Eltern mit Hilfe von Videoberatung nach der Marte-Meo-Methode [Enhancing development of children at risk and their parents by video counselling according to the Marte Meo method]. Praxis Der Kinderpsychologie Und Kinderpsychiatrie; 2011;**60**(5):333-350. DOI: 13109/ prkk.2011.60.5.333

[12] Rohr D, Spath K, Aschermann E. Genogramme in Beratung und Therapie: Übersicht über die aktuelle Forschung. In: Zeitschrift Familiendynamik – Systemische Praxis und Forschung 1/2022. Stuttgart: Klett-Cotta;

[13] Rohr D. Über die Arbeit mit Genogrammen: Auswertung von ExpertInneninterviews zur Genogrammerstellung. Heidelberg: Carl-Auer Verlag; 2022 (angenommen). 2017

[14] Hildenbrand B. Genogrammarbeit für Fortgeschrittene. Vom Vorgegebenen zum Aufgegebenen. Heidelberg: Carl-Auer-Verlag; 2018

[15] Rohr D, Winter M, Kullack S, Schulz T, Lütters T, Geldermann N. Forschendes Lernen im interdisziplinären Teamteaching – Eigenverantwortliches, kooperatives und problembasiertes Lernen am Beispiel der Entwicklung einer Software für Genogrammarbeiten. In: Berendt B, editor. Neues Handbuch Hochschullehre. Berlin: Raabe; 2015

[16] Cooper HM. Research synthesis and meta-analysis: A step-by-step approach. In: Applied Social Research Methods Series. 5th ed. Vol. 2. SAGE: Los Angeles, London, New Delhi, Singapore, Washington DC; 2017

[17] McGoldrick G, Gerson R, Petry S. Genogramme in der Familienberatung. Verlag Hans Huber: Bern; 2009

[18] Teddlie C, Tashakkori A. Foundations of Mixed Methods Research. Los Angeles: Sage; 2009

[19] Symonds J, Gorard S. The Death of Mixed Methods: Research Labels and their Casualties. 2009

[20] Gage N. The paradigm wars and their aftermath: A historical sketch of research on teaching since 1989. In Hammersley M, editor. Educational Research and Evidence- based Practice. London: Sage; 2007. pp. 151-166

Chapter 2

True Happiness as a Shortcut to Mental Health: A New Theory of Psychopathology and Psychotherapy Based on Aristotle's Ethics and Evolutionary Science

Flavio Osmo, Maryana Madeira Borri and Marina Falcão

Abstract

In this chapter, we propose that pathologies can be understood as chronic excess or lack of emotions, which in essence, in our view, refer to the presence of "vicious" or frequent lack of evaluations about reality; which would generally occur due to the absence of wisdom or rationality. We also suggest that true happiness, to be experienced consistently, depends on putting into practice knowledge that reflects reality reasonably. In this sense, we hypothesize that the essence of pathologies is associated with the absence of a level of knowledge that reflects reality reasonably well or recurrent failures to act based on this knowledge, that is, lack of the habit of acting rationally; and that the understanding and pursuit of true happiness, in turn, can serve as a shortcut to exit the psychopathological condition, as (1) it provides greater engagement in the therapeutic process, as it would be the kind of pleasure that every human being ultimately seeks; and (2) because the pursuit of true happiness leads us to be more and more successful in our interactions with reality, feeling appropriate emotions for each context, instead of feeling, or not feeling, certain emotions chronically.

Keywords: happiness, virtues, aristotle, evolutionary science, psychopathology

1. Introduction

There is a long debate about what happiness is, which started in Ancient Greece, especially with Aristotle, and that has not yet been resolved. The only consensus that seems to have been established around this theme refers to something that this philosopher had already stated: that happiness is what every human being ultimately seeks [1, 2]. But this is still little, as it still does not capture the essence of the phenomenon. In our understanding, there is a fundamental reason for the stagnation of knowledge on this topic: a lack of interest by psychologists in understanding Aristotle's works in-depth, in which he already offers "good tips" about what happiness is, which can be taken as starting points for identifying what this phenomenon is in essence. In this

work, we then use these "tips" to suggest, with the help of evolutionary science, what true happiness is and then offer a rationale for how pursuing it can generate positive effects on mental health. To achieve this goal, however, we must first provide certain understandings, also with the help of Aristotle and evolutionary science, that serve as a basis to comprehend what true happiness seems to be.

2. Basic categorizations pathways and basic emotions

In a recently published article [3], the main author of this work, argued that humans and other animals share not only categorical thinking, but also certain types of categorization ("what is something?"; "what end to seek?"; "by what means?"; "was there success in accomplishing the end?"), which would be aligned in a mat of categorizations, constituting what he called the basic evaluation process [4]. He hypothesized that within this evaluation process there are five options for basic categorizations pathways (BCP), namely: "identification of patterns in the novelty"; "acquisition of the benefit", "promotion of the good of the other"; "elimination of the threat"; and "escape the threat". Therefore, the basic evaluation process would follow a certain path depending on the type of categorization "what is something?" performed ("a novelty", "a benefit", "an ally (or potential ally) in difficulty", "a threat that can be eliminated", or "a threat that cannot be eliminated").

Table 1 [5] exposes this idea, highlighting the basic categorizations that our minds ultimately perform[1]; and also what is their usefulness, that is, what adaptive advantage they are able to offer that justified having been mental practices selected by evolution.

Osmo [3] also defended the idea that if the mental architecture of humans is composed of ancestral structures such as BCPs, it is then possible to locate BCP as being at the root of innumerable subjective phenomena of our species, such as emotions. He argued that each BCPs were established as a function of achieving a certain basic end (goal), since it is only with the attainment of such an end that one can come into contact with consequences linked to continuing to survive in hostile conditions. With this in mind, and also from the idea that in the last stage of the BCPs occurs the categorization responsible for evaluating whether or not there was a success in reaching an end, Osmo proposed that emotions can be understood as psychophysiological reactions selected by evolution, mainly because: (1) they directly increase the chances of reaching an end; and (2) increase the chances of realizing whether or not there was a success in achieving an end, which indirectly increases the chances of achieving a basic end next time. In this sense, he suggested that there are two types of emotions, those selected because of "1", which he called emotions of trajectory; and those selected because of "2", which he called emotions of result [7, 8].

The central idea is that at the root of every emotion there is evaluative thinking [9, 10], and that: (1) the evaluative thinking behind the emotions of trajectory are categorizations related to " what end to seek?"; and (2) the evaluative thinking behind the

[1] Humans have a cognitive power that allows them to make more specific categorizations compared to other animals. However, while they may be more accurate, in the end, both our categorizations and theirs seem to "end up" in the same place. By this we mean that, in essential terms, our minds always carry out basic categorizations (for example, "this is a benefit"; "this is a threat"), which are those that proved to be fundamental for survival in the ancestral past [6].

Types of BCPs.	**First categorization: "what is something?"**	**Second categorization: "what end to seek?"**	**Third categorization: "by what means?"**	**Fourth categorization: "was there success in accomplishing the end?"**	**The evolutionary reason for the emergence of the BCP.**
BCP 1: identification of patterns in the novelty.	Something is a novelty.	Seek the end of identification of patterns in the novelty.	By means of investigation.	Whether or not there was a success in the identification of patterns in the novelty.	Identification of relevant "novelties" of the environment, especially if it is a threat or benefit.
BCP 2: acquisition of the benefit.	Something is a benefit.	Seek the end of acquisition the benefit.	By means of "go and try to get it".	Whether or not there was a success in the acquisition of the benefit.	Enjoyment of beneficial things, like food and shelter.
BCP 3.1: escape the threat.	Something is a threat that cannot be eliminated.	Seek the end of escaping the threat (and the primary end of harm avoidance).	By means of "runaway".	Whether or not there was a success in escaping the threat.	Avoidance of harm that a threat that cannot be eliminated can cause.
BCP 3.2: elimination of the threat.	Something is a threat that can be eliminated.	Seek the end of elimination of the threat (and the primary end of harm avoidance).	By means of "attack".	Whether or not there was a success in eliminating the threat.	Avoidance of harm that a threat that can be eliminated can cause .
BCP 4: promoting the good of other.	Something is an ally (or potential ally) in difficulty.	Seek the end of promoting the good of other.	By means of "help".	Whether or not there was a success in promoting the good of other.	Acquisition or maintenance of the benefit of reciprocity. This is then an "appendix" pathway of BCP 2, as it exists in function of the acquisition of a specific benefit.

Table 1.
Basic categorizations pathways (BCPs).

emotions of the result are categorizations related to "was there success in accomplishing the end?" Thus, the categorizations present in the basic evaluation process would be at the root of basic emotions.

Curiosity, which would be an emotion of trajectory, for example, would come from the categorization that "we must seek the end of identification of patterns in a novelty"; and joy, which is an emotion of result, would come from the categorization that "there was success in achieving this end".

Therefore, and considering the existence of five different BCPs, Osmo [3] suggested that there would be five basic trajectory emotions, namely:

1. Curiosity: the emotion that arises in response to the categorization that we must seek the end of "identification of patterns in the novelty", and which is capable of providing an increase in the chances of achieving this end.

2. Craving: the emotion that arises in response to the categorization that we must seek the end of "acquisition of the benefit", and that it is capable of providing an increase in the chances of achieving this end.

3. Fear: the emotion that arises in response to the categorization that we must seek the end of "escape the threat", and that it is capable of providing an increase in the chances of achieving this end.

4. Anger: the emotion that arises in response to the categorization that we must seek the end of "elimination of the threat", and that it is capable of providing an increase in the chances of achieving this end.

5. Compassion: the emotion that arises in response to the categorization that we must seek the end of "promoting the good of the other", and that it is capable of providing an increase in the chances of achieving this end.

In addition, based on the notion that there are only two possibilities with regard to the result of an action, the success or failure in achieving an end, Osmo [3] also argued that there are, then, two basic emotions of result:

1. Joy: responsible for signaling success in achieving the end, encouraging the use of the same means in the future, and also encouraging the interruption of action in view of the fact that the goal has already been reached.

2. Sadness: responsible for signaling failure in achieving the end, encouraging the use of other means in the future, and also encouraging the interruption of the action as it has already proved inadequate for achieving the end ("making room" for the manifestation of a new line of action).

3. The peculiar human nature

Osmo [3], however, considers that the perspective presented in the previous topic is only the foundation for understanding human action because its focus is on what is common between humans and other animals. Thus, in order for us to understand all kinds of human actions, he suggested that it is necessary to add to these perspective elements that are particular to humans.

We are known for being "sapiens" and rational, and not for nothing, as we actually have two capacities that other animals don't have: (1) that of understanding more and more about reality, beyond the dimension of perception [11–13] (theories acquisition); and (2) that of making choices based on our why theories (rational choices). Regarding "2", it is worth noting that this capacity implies being able to understand why we are seeking an end and by certain means; that is, to understand why an end is more worth pursuing and why certain means are the best to be employed in a particular situation. In this kind of reasoning, the person accesses his or her network of theories about reality to analyze the consequences that the choices of ends and means can generate, and then establish what is best to pursue and in what ways [14].

In this view, the exercise of rationality means, in essence, supervision, followed by acceptance or review of the line of action dictated by the first BCP activated in a given context (or conscious activation of a BCP when the situation was initially seen by him or her as neutral); which is based on the personal network of theories [3]. This process allows, for example, the person to resist a piece of the pie (activation of BCP 2), because he or she understands that health is superior to the pleasure of eating something that, although tasty, can be harmful. In this case, the person acted out of fear of some peril (activation of BCP 3.1), diabetes, for example, and so had to use self-control to resist the craving of eating the pie. Thus, what happened, in this case, was the person being aware of their first inclination, which is the first BCP activated in a given.

An alternative option would be the person, for having the habit of prioritizing health, seeing, beforehand, the pie as an evil, and, with that, not feeling crave to eat it. In this case, in which the person only needs to accept, and not review, the first activated BCP, based on what he or she believes to be right, there would be what Aristotle called harmony between the rational and appetitive parts of the soul [1].

In fundamental terms, this harmony seems to occur with the consolidation of new inductive heuristics in the BCP, these in line with the person's current worldview, due to the experience of advantageous consequences from its use over time, in various situations. It is important to note that, based on the perspective presented, this harmony occurs between the theories of the person and, specifically, the first emotion of trajectory evoked; that is, the first categorization "what end to seek" (e.g., end of acquiring the benefit "health") [3].

In this line, Osmo suggested that, while the person still experiences the conflict between his or her worldview and the first categorization "what end to seek?" he or she needs to use principles (self-rules or meta-heuristics) that offer support for decision-making in the direction in line with his or her worldview, which is a different direction to which this first categorization and the emotion of trajectory (that emerges from it) point. So, roughly speaking, the person needs to adopt some principle that helps him or her deal with the emotion that is in disarray with the best of his or her knowledge and supports the task of reviewing the "what end to seek?" categorization.

In the case of inadequate activation of BCP 3.1 and experience of fear, this principle can be something like "I need to choose the best end in spite of being afraid". In this way, Osmo concluded that behind the task of reviewing each basic end there is the adoption and internalization of principles that enable the management of basic trajectory emotions. With regard to BCPs, this management has to do with reevaluating the categorizations made (or lack of categorization, in case of viewing something as neutral) with the help of principles; something that only humans would be able to do.

4. Virtues

The aforementioned notion, in fact, reflects what Aristotle argued about moral virtues. According to him, moral virtues are principles that are internalized in the soul of the person, which are responsible for making possible the choice for the best end [1]. Furthermore, it is evident in his writings that he understands that each moral virtue exists to make it possible the management of an emotion [15]. The moral virtues would then be rules that we establish for ourselves (that is, self-rules) and that we learn to follow, leading us to acquire the ability to reason better when we feel

an emotion that drives us towards a goal; or even when we don't feel the emotion we think we should feel. Thus, the possession of a moral virtue means the possession of the ability to put into practice a self-rule capable of making us reason well (based on the knowledge we have so far), in situations of the domain of a trajectory emotion [3].

It is worth noting that the relationship between moral virtues and emotions implies that if we know, which are the basic emotions of this type, we will know which are the basic moral virtues. As we talked about earlier, our view is that there are five basic emotions that have this property, that of driving us (five emotions of trajectory). Thus, the five basic moral virtues that seem to exist are: (1) Courage, to deal with fear or lack of fear; (2) Moderation, to deal with craving or lack of craving; (3) Mildness, to deal with anger or lack of anger; (4) Useful curiosity, to deal with curiosity or lack of curiosity; and (5) Generosity or Love (and self-generosity or self-love), to deal with compassion or lack of compassion (which includes self-compassion) [3, 5].

Aristotle also defended the existence of virtues related to good reasoning itself, the intellectual virtues [1], such as: (1) Wisdom, a set of theories that an individual has, and that reflect reality reasonably well; (2) Discernment, ability to identify, based on wisdom, the best goal, the best means, and whether there was even success or failure in achieving the end; (3) Prudence, ability to choose the end and means established by discernment, based on wisdom; (4) Facility in the apprehension of universals, ability to apprehend difficult causes, making use of existing knowledge, which implies an easiness in reaching new knowledge and in developing the virtue of wisdom; and (5) Understanding, ability to identify, based on wisdom, what is relevant to take into account in a particular context [1].

Thus, we see that moral virtue is responsible for calling reasoning, which starts with a good grasp of the particulars of the situation (understanding) and continues with the determination of the best end and means (discernment, making use of wisdom). Then, the actual decision-making takes place, regarding the end to be pursued and the means to be employed; this on the basis of the options that discernment has established as being the best. Making such decisions means putting into practice the virtue of prudence. And finally, there is again the performance of discernment, based on wisdom, to carry out a good assessment of whether or not there was a success in reaching the end. It is still possible to have the ability to learn difficult causes acting after all this process, especially in case of perceptions of unexpected success or failure, which prompt us to investigate why things went right or wrong; what refers to the attempt to apprehend new universals, new theories [3, 5].

5. Vices

Aristotle suggested that there are moral and intellectual virtues, as we speak. Moral virtues would be abilities to follow self-rules that lead us to put intellectual virtues into practice, so that, in a particular situation, we can deal well with our emotions of the trajectory (or lack of them) and make choices based on the knowledge we have so far. Not practicing a moral virtue can cause us to fail to act rationally (especially if we are under the influence of emotion of trajectory), that is, it can cause us to fall into some vice. Thus, for each basic emotion of trajectory, there must be a specific vice. In fact, Aristotle said that there are two types of addiction related to an emotion, that of excess and that of lack [1].

Starting with the extreme of excess, it would occur, for example, when someone criticizes a belief we have and, almost without thinking, under the influence of anger,

we go on the attack. In essence, what happened, in our view, was that we interpreted criticism as a threat that could be eliminated, perhaps a threat of domination, which made it settle in our minds that we must pursue the goal of eliminating this threat; and then, almost without thinking, we set out to try to eliminate it.

We did not seek, therefore, to review this objective based on our knowledge, which could have occurred if we had followed a rule such as "I must choose the best objective in the presence or absence of anger" and therefore practiced the moral virtue of mildness, which could even serve to simply confirm that it was appropriate to feel anger in the context (which would lead us to confirm that the best thing to do was, in fact, to "eliminate" the criticism).

People who tend to resolve things impulsively, following an emotion almost blindly, demonstrate the possession of vice related to excess. In the case of anger, the vice of irascibility, which would be nothing more than letting flow an ancestral inclination that is well established in our personality: the inclination that directs us towards the elimination of threats. Note that if anger is not the emotion we believe is appropriate for the context, the "wrong" emotion we experience (anger) is of the "emotion of trajectory" type, and "accepting" it means acting in a wrong direction. Here, therefore, one "sins" by action, and not by omission.

In the case of vice related to lack of emotion, we see that this can happen in two ways: (1) feeling an emotion of result when we actually believe we should feel another emotion; such as, feeling joy when we've just noticed that our best friend has lost money on the stock market. In this case, the person may believe that what was actually right was to feel compassion, but instead felt joy; which may denote the nurturing of some level of competition for status with the friend, so that seeing his or her downfall meant realizing success in being better than him or her, causing this person to feel joy. Note that as the emotion experienced here was joy, an emotion of result, which does not generate an impulse, the person did not fall into the error of going in an inappropriate direction, but into the error of not acting, that is, "sinned" by omission.

The other way (2), which also makes one fall into the error of omission, is when the person does not feel any emotion, believing he or she should feel an emotion of trajectory. Bringing up the same example above, the person may have remained indifferent to the fact that the friend had lost money. This denotes the perception of what happened as something neutral, thus not leading to an assessment capable of making the person feel an emotion. If the person in question really believes that "okay, it's a part of life to lose money, and that it's even a learning experience", then it is understandable that he or she has perceived what happened as neutral, not feeling any emotion (i.e., rational evaluation from the point of view of the person); but if this person believes that, at that moment, the right thing to do was to offer a few words of comfort to the friend, for example, then he or she should think that compassion was the right emotion to feel. Note that if the person realizes this, he or she may revise their previous assessment, feel compassion to some extent, and thereby want to act in the direction of providing emotional comfort to the friend (thus avoiding falling into the error of omission, in case the person has actually decided to act in this direction) [5].

In both cases, of excess and lack, not experiencing the emotion appropriate to the context may represent not following self-rule capable of calling reasoning, which in the case of the last example could be something like "I need to choose the best objective in the presence or absence of compassion", which may mean not putting into practice the moral virtue of love. This, in turn, means not behaving in a way peculiar

to humans, acting almost exclusively on the basis of what we perceive, without considering the knowledge we already have about reality.

Note that if there are five basic emotions that drive us toward something, and two vices for each emotion, then there must be ten vices, namely [5]:

- Vices related to fear
  - Excess: the person "blindly accepts" the emotion of fear (cowardice).
  - Lack: the person "blindly accepts" another emotion (trajectory or result); instead of the emotion of fear (which, according to his or her knowledge, would be the right emotion to feel) (temerity).
  - Lack: the person does not pay attention to the details of the situation which, if perceived and evaluated based on what the person already knows, would make him or her feel the emotion of fear (temerity).
- Vices related to anger
  - Excess: the person "blindly accepts" the emotion of anger (irascibility).
  - Lack: the person "blindly accepts" another emotion (trajectory or result); instead of the emotion of anger (which, according to his or her knowledge, would be the right emotion to feel) (passivity).
  - Lack: the person does not pay attention to the details of the situation which, if perceived and evaluated based on what the person already knows, would make him or her feel the emotion of anger (passivity).
- Vices related to craving
  - Excess: the person "blindly accepts" the emotion of craving (licentiousness).
  - Lack: the person "blindly accepts" another emotion (trajectory or result); instead of the emotion of craving (which, according to his or her knowledge, would be the right emotion to feel) (rigidity).
  - Lack: the person does not pay attention to the details of the situation which, if perceived and evaluated based on what the person already knows, would make him or her feel the emotion of craving (rigidity).
- Vices related to compassion
  - Excess: the person "blindly accepts" the emotion of compassion ("soft hearted").
  - Lack: the person "blindly accepts" another emotion (trajectory or result); instead of the emotion of compassion (which, according to his or her knowledge, would be the right emotion to feel) (indifference).
  - Lack: the person does not pay attention to the details of the situation which, if perceived and evaluated based on what the person already knows, would make him or her feel the emotion of compassion (indifference).

- Vices related to curiosity
    - Excess: the person "blindly accepts" the emotion of curiosity (investigation without criteria
    - Lack: the person "blindly accepts" another emotion (trajectory or result); instead of the emotion of curiosity (which, according to his or her knowledge, would be the right emotion to feel) (closed to novelties).
    - Lack: the person does not pay attention to the details of the situation which, if perceived and evaluated based on what the person already knows, would make him or her feel the emotion of curiosity (closed to novelties).

6. The true happiness

Aristotle gives us good tips on what happiness is, we just need to connect the dots and add a dash of evolutionary psychology. He said that of all animals only humans are capable of experiencing happiness [1], and that happiness is what we all ultimately seek [1]. Furthermore, he also said that to achieve happiness one must use reason (and the virtues) [1]; and that happiness is a kind of pleasure [1].

Well, what pleasure can only human beings feel? It must depend on the awareness that we are agents in the world, that is, on the notion that our actions themselves cause things. With that, we then discard the pleasures of sex, drinking, eating, among others. These are what Aristotle calls the pleasures of the senses [1], which are those that depend only on sensory contact with something to be experienced; this kind of pleasure, other animals are also capable of feeling. And we also discard the pleasure of the most rudimentary joy that comes when we see success in reaching a goal; which can be anything from getting a fruit on the tree, to gaining status, resources, or identifying patterns in something we see as new in the environment, for example. This kind of pleasure other animals can also experience [16]; what changes between us and them is that we are able to set more specific goals, and with that, feel joy with more specific things.

We already know a little bit about what happiness is not, but what we want is to know exactly what it is. The key to this is Aristotle's assertion that to feel it, it is necessary to employ rationality; which means that happiness is a reward for the use of reason. Based on this notion, and making use of the evolutionary approach, we can say that happiness is then a pleasure selected by evolution for stimulating us to act rationally, which is the way of acting that puts us at an advantage in the fight for survival in relation to other animals; and in relation to other humans as well.

But then, what is happiness? We can only think of a type of pleasure that meets all these requirements: that would be precisely the pleasure that arises when we feel proud of the result of our rational actions [17], which is when we look to a recent or distant past and feel proud of what we have done through thoughtful choices; it can be something simple, like being proud of having managed to fix a shower, or more complex, like writing a best-seller. Another pertinent example is feeling proud of having reached a conclusion through the "reasoning" action itself, being proud of a "eureka!" (actually, this has to do with being proud of any conclusion itself, which we perceive to be the result of good reasoning).

Happiness would then be a specific type of joy, which arises when we perceive the result of rational action as being good when we realize that we have performed good works of reason [1, 18, 19].

Note, however, that we do not experience this pleasure when we see the outcome as bad, even though we are aware that we have done our best. A soccer player who looks at the angle of the goal, makes the movement the way he or she trained, but sees the ball passing close to the crossbar, is unlikely to be proud of his or her action (this player would have to make a mental effort to feel this). Certainly, such a kind of pleasure other animals cannot feel. And, in fact, for us to feel it, we really need to employ reason. We are only proud of a result if we realize that it was the result of choices we made based on the knowledge we had so far, that is, rational decisions. A painter who is proud of the result of his work only feels this because he or she realizes that it was the result of good decisions regarding which color combinations to use, for example; a knowledge this painter already had, and used it to support his or her choices about how to paint the picture.

There is, however, a small inconvenience to happiness: although it seems to be the pleasure we all ultimately seek, we cannot experience it if we seek it directly. This is because, if, at the moment we make a rational choice, we are focused not on the immediate objective in question, but on the pleasure, we will obtain in achieving it, we will not engage in the action to the point of being able to produce an expected result [20]. A soccer player who, at the time of shooting at goal, instead of focusing on hitting the angle, is focusing on the happiness he or she will feel if he hits it, he or she will not be able to produce the expected result, and thus will not feel happiness; unless this player gets lucky this time and manages, even without focusing on the angle, to hit it. However, that would be an exception, and what we want is the frequent experience of happiness. This implies that, although happiness is probably, by nature, fixed at the top of the hierarchy of values of every human being, it is important to place just below it the value of acting rationally, since it is through the achievement of this goal that it is possible to experience happiness. Thus, for practical purposes, it is worth considering the objective of acting rationally as our greatest goal, and happiness as the prize that comes whenever achieving this goal brings good results [21] (good results from the perspective of the individual).

It is worth noting that having "acting rationally" as our ultimate goal implies experiencing sadness whenever we fail to achieve this goal. In fact, a specific kind of sadness that we call regret that only humans can feel because it depends on the consciousness of agency. However, as we said, the emotion of sadness is a pain that serves the function of stimulating us to act differently in the future (also in order to avoid experiencing it again, in the case of humans). Thus, as we are not born with the habit of acting based on the knowledge we have so far, the pain of regret for having failed to act rationally serves the function of putting us in the direction of acquiring this habit [20].

However, it is also worth noting that having "act rationally" as our goal, achieving it can provide a reduction in the intensity of the pain of regrets. This is because we are led to conclude that, despite having generated a bad result, we acted based on the knowledge we had so far, that is, we did the best we could. In this case, regret would not cease to exist, but it directs our perception to what really matters: the fact that our knowledge was insufficient to promote a better result; and thus influences us to increase our level of wisdom [5].

Before moving forward, we would like to highlight that there are two types of emotions that depend on agency awareness, but which we see as not being very useful

for the development of virtues, and therefore, to the ever more frequent experience of happiness: self-blame and shame. We believe that such types of emotions are not very useful because what we want with the experience of a negative emotion that depends on agency awareness is not that it leads us to attack the "I" of the past (as is the case with self-blame, that leads to the experience of anger), or running away from a negative evaluation that the other may be making about us (as is the case with shame, which leads to the experience of fear) [19, 22, 23]; but to lead us, especially to lamentation; to repent for not having acted according to what we knew, or for not having the necessary knowledge to have acted better, so that we can become wiser and more adept at acting rationally, in order to do better in a similar situation in the future[2] [5].

7. About the relationship between life purpose and more intense happiness

In Aristotelian philosophy, every human being has a responsibility as a species, a general life mission, so to speak: to make his rational potential a reality, in order to consolidate the habit of acting rationally (which occurs with the practice of virtues), which represents being in a state of "good functioning"; functioning according to the type of being we are. The reward for this endeavor is to experience the pleasure of being proud of the result of rational choices on a regular basis [24, 25]. However, common experience shows us that this pleasure can vary in intensity. The pleasure a writer feels at the moment he realizes, he has managed to fix a shower is certainly not the same as when he sees his work finished, or even a paragraph [26]. But why is that?

We are beings naturally interested in "whys", and among the "whys" we are interested in is knowing why we exist, what is the purpose of being here. Saying that we are here to fulfill our natural responsibility to act rationally is not enough for us as an answer [27], as we want to know not only why the human species exists, but also why we, as individuals, exist; that is, we want to know what is our specific function, our individual responsibility, in the whole, that we believe to be inserted [19, 28, 29] (and here it doesn't matter the size of this whole, it can be from the microgroup "you and your child" to the entire planet, for example). Thus, it is once we find an answer to this question (regardless of whether it is objectively true), which generally involves understanding our own specific interests and abilities (which includes understanding our specific moral virtues), that we started, then, to recognize what our responsibility would be, our specific role in the whole that we believe to be inserted. As a result, we can acquire the notion that we have something to do in this world that no one else is capable of; that we have a mission, which, it is worth noting, can vary in "size" (it can range from caring for a child to preparing a treatise on human nature, for example) [30]. And from there, when we take responsibility for a specific mission, we come to feel the kind of pleasure that the writer of our example experienced: a more intense pride in the result of rational choices; more intense because it is a result that indicates that we are fulfilling, to some extent, our mission; it means that we are managing to fulfill the "why" of our individual existence.

Finally, it is worth noting that, as we have the ability to be proud also with regard to a macro set of results and actions, we can also feel a more intense type of pride if we see that this set of results and actions represents the successful realization of our life purpose. Bringing again the writer's example, he will feel happiness of the most

[2] It is possible to note that from our perspective, all emotions that depend on agency awareness are derived from basic emotions, including happiness, which we consider to be a type of joy.

intense kind when, after publishing his works, he looks at them together and assesses that his specific mission, or a good part of it, has been fulfilled [5].

8. Psychopathologies in an evolutionary perspective

In this work, we are assuming that the human mind is a product of evolution [4, 31]. As a result, we are offering a perspective grounded in the theory of natural selection, which is the theory that best explains "how other animals function" (at least for now); and if we didn't land by parachute on this planet, it is certainly the theory that best explains how we function too, and how we should function, given our peculiar nature [32]. In this way, holding firm to such perspective, we understand that a better understanding of the pathologies that plague humanity can be achieved if we first look at them in their rudimentary form, that is, how they are manifested in other animals; for then, based on this first notion, to analyze how they are amplified in us due to specificities of our nature. This implies looking at pathologies based on the notion of the role of BCPs, and our ability to elaborate theories and act on them. We are not going to offer a canonical list of psychopathologies, but just three of them, as an example, to show how it is possible to understand psychopathologies in the direction we are proposing.

8.1 Depression: psychopathology most related to the emotion of sadness

The perception that there was a failure to achieve a goal, as we said, generates sadness, the emotion that seems to have a role in encouraging the use of other means in the future It turns out that when a non-human animal is faced with a threat that it categorizes as "not possible to be eliminated", and tries, unsuccessfully, to achieve the goal of escaping the threat by successively employing one or more forms of "runaway", this animal may simply end up giving up on escaping the threat, accepting that it is "imprisoned", which in practice means accepting that there is nothing to do; in other words, that the failure is consummated, which would lead the animal to a chronic experience of sadness [33, 34]. This, in our view, would be the rudimentary form of what we know in humans as depression.

However, in the case of humans, such sadness would be amplified by the ability we have to realize that there is really no way out of an unwanted condition, that we are trapped in it: the notion that we are not capable of causing a better future for us, which has to do with what we call hopelessness [6, 33]. This is the case, for example, of a relationship termination, in which the person who has been "abandoned" is afraid of being alone, believing that he or she is not able to find another partner (a possibly false theory), which would likely make this person to behave in the direction of proceeding with countless attempts at reconquest, which, in essence, are attempts to avoid the threat of losing the relation of reciprocity (stage of grief known as "bargaining"). However, there may come a point, after unsuccessful attempts to avoid such a threat, that the person ends up giving up trying, which represents reaching the stage of grief known as depression [35].

It is worth noting that, within the perspective that we are offering, the vulnerability of a person to go into a depressive state is directly related to: (1) although the person has the wisdom to understand that he or she is not facing "a threat that cannot to be eliminated", even so almost thoughtlessly accepts this assessment (and the others that follow), acting in accordance with them (lack of rationality); and (2) the person does not have the wisdom to understand that he or she is not facing a "threat that cannot be

eliminated" (because of having false theories), and, at the same time, does not have the wisdom as to how to accomplish the goal of elimination of the threat (if that person has this wisdom, he or she could eliminate such a threat, even if it is not objectively a threat) (lack of wisdom).

8.2 Anxiety: psychopathology most related to the emotion of fear

In the animal kingdom there seem to be two types of contexts in which the emotion of fear becomes something chronic: (1) when an environment is in fact hostile, as in the case of being in a place full of predators; and (2) when, in the case of animals that live in groups, the individual is perceived by others as being of lower status (usually because of being defeated in fights), which makes it more difficult for this individual to have access to resources, such as food and sexual partner, especially because of being frequently attacked by other members also interested in such resources. In addition, a low-status individual tends to receive less protection from predator attacks [24]. This implies that those at the bottom of a dominance hierarchy actually end up in a hostile environment, similar to being in a place full of predators. We see that in these two cases, there is a chronic classification that "something is a threat that cannot be eliminated", and with it the chronic experience of fear, which we can classify as the rudimentary version of anxiety [36]. It is worth mentioning that, in the case of anxiety, unlike depression, the individual sees escape routes and can follow them in order to achieve the objective of escaping the threat [33].

In the case of humans, anxiety can be amplified by our ability to construct or accept theories that reality is far more threatening than it actually is, which causes us to engage in the frequent practice of mislabeling something as "a threat that cannot be eliminated", and that, therefore, we must seek to escape from it. Some examples of this are internalizing theories that: (1) all people, including close friends, will harm us if given the opportunity to do so (type of theory that supports the establishment of social anxiety disorder) [37, 38]; and (2) if we do not perform such a procedure, like knocking twice on the wood, something bad will happen to us or our family members (the kind of theory that supports the establishment of obsessive-compulsive disorders) [39].

Again, it is worth noting that, within the perspective we are offering, a person's vulnerability to go into a state of anxiety is directly related to : (1) although the person has the wisdom to understand that he or she is not facing "a threat that cannot to be eliminated", even so almost thoughtlessly accepts this assessment (and the others that follow), acting in accordance with them (lack of rationality); and (2) the person does not have the wisdom to understand that he or she is not facing a "threat that cannot be eliminated" (lack of wisdom).

8.3 Food addiction: psychopathology more related to the emotion of craving

Luckily for other animals, so to speak, there is, due to the competition for resources necessary for survival, a shortage of highly palatable foods for their species; so it is not common for us to observe food addiction in its rudimentary form in non-human animals. However, experiments show us that they can develop this pathology [40], which, in our view, refers to the chronic categorization that "something is a benefit", which leads to the chronic experience of the emotion of craving.

In the case of humans, such pathology is possible to be frequent because we are able to generate an environment permeated by highly palatable food; but still, that

would not be the cause, just the removal of a barrier. It is possible for two people to enter a candy store, and only one of them feels tempted to buy sweets in quantity, which may be the case for someone with food addiction (if this is not just a one-off behavior, aiming, for example, at a celebration or relaxation) [41]. Such pathology can be amplified in us because we can make or accept probably false theories and live on the basis of them; for example: (1) that the best way to alleviate emotional pain is to eat tasty foods, or even that (2) we came to this world to enjoy life, and such enjoyment boils down to experiencing the pleasures of the senses (possibly believing that this is happiness) [5].

Once again, we can note that the vulnerability, now to food addiction, is due to lack of wisdom, in case the person does not know that eating a certain tasty food with a high frequency is likely to cause serious damage to his or her health; or lack of rationality, in case the person has this knowledge, but still almost without thinking accepts the categorizations that he or she is facing a benefit (and those that follow, especially the one that "suggests" that he or she should "seek the acquisition of this benefit").

9. The essence of human psychopathologies

It is possible to see that, from our perspective, human psychopathologies (at least those that do not have a physical cause, such as damage to some region of the brain) can be better understood as phenomena specifically caused either by lack of wisdom or lack of rationality. Making a parallel with the cognitive therapeutic approach, we can consider that the possession of false core beliefs, such as those of the unlovable dimension (e.g., "I will always be rejected when my flaws are perceived") [38, 42], means lack of wisdom if such beliefs refer to the person's most advanced knowledge of the matter; so, it is worth emphasizing, acting on that knowledge would not be irrational from that individual's point of view. However, this rationality can lead this person to a condition of psychopathology because he or she is acting based on false knowledge.

On the other hand, if such a person, despite having internalized false beliefs (probably arising from childhood experiences), but managed to reach true conclusions, such as that their "defects" are tolerable (he or she is not a serial killer, for example), this person, then, in this matter, possesses wisdom. However, the person can still fail to make decisions based on conclusions that better reflect reality, and then it would be the lack of rationality that would lead him or her to develop a condition of psychopathology.

Another thing that can be seen, with the help of the relational emphasis that we gave in the previous topic, is that human psychopathologies are related to emotions, that is, the chronic experience of emotion means being in a psychopathological condition. Of course, unless reality doesn't actually call for evaluating things in the same direction almost always, like when we are in a hostile environment and categorizing things as a "threat that cannot be eliminated" should be highly frequent (and with that, the experience of fear), for example. By this we mean that as the stimuli, in objective terms, must be of the most varied types, categorizing them almost always in the same way (or treating them almost always as neutral) probably means being in a psychopathological condition. The chronic experience of joy or indifference when

facing friends in difficult situations, for example, rarely feeling compassion for them, is related to what we know as psychopathy[3] [43].

The point we want to reach is that, in our view, the chronic excess or lack in experiencing each of the seven emotions represents being in a psychopathological state (i.e., vices of lack and excess, paralleling what we talked about earlier), which in essence, as we said, means that we are chronically evaluating things in some direction, or treating them almost always as neutral[4] [1, 44]; and this, in turn, bringing out the main idea of our perspective, has to do with either a lack of wisdom or rationality. Bringing up the example of psychopathy, a person diagnosed with this psychopathology may be in such a condition for actually believing that "his or her good does not depend on the good of others" and acting consistently in accordance with this knowledge, that is, acting rationally but on the basis of false knowledge (which denotes lack of wisdom); or the person may be in this condition because they are unable to act consistently based on a notion that he or she already has (and that reflects reality reasonably well), such as that "his or her good depends, to a large extent, on the good of others" (which denotes lack of rationality).

10. How the pursuit of true happiness can lead to mental health?

From the notion that at the root of human pathologies there is probably a lack of wisdom or rationality, we can conclude, then, that the acquisition of more and more knowledge that reflects reality reasonably well (which represents developing the virtue of wisdom), and the acquisition of the habit of acting based on the knowledge that one has so far (which represents developing moral and other intellectual virtues) should provide a way out of a psychopathological condition and maintenance of mental health [19]. However, informing that the practice of virtues should lead to overcoming psychopathologies, and providing guidance on how to practice them daily, may not be enough for a patient to feel motivated to engage in this therapeutic process. This is because the human being does not seem to be naturally motivated to reach a state of absence of psychic pain simply, what the ancients used to call ataraxia [19]; but rather to achieve and feel happiness [1]. Thus, we understand that clarifying what happiness is (and that the practice of virtues is necessary to achieve it) is essential to "touch the nature" of the patient in order to awaken in him or her the motivation to practice the virtues.

We must not forget that our self-conscious questioning nature makes us want to know why we exist and that greater happiness can be experienced when we realize

[3] A person who feels joy at the loss of a friend in a game, in which they are competing, or who evaluates a difficulty a friend is going through as a good thing (because it can help him or her grow with the experience), could hardly be considered a psychopath. As we said, psychopathy has to do with the chronic experience of joy or indifference in contexts in which a friend is perceived to be in a situation of difficulty, and not with occasional joy or indifference in a context of this type.

[4] Based on this notion, it might be a good idea to divide the Diagnostic and Statistical Manual of Mental Disorders (DSM) into seven large dimensions, related to the 7 basic emotions that we suggest exist, in order to consider the chronic excess and lack in each of them as being psychopathologies, which is equivalent to vices; and that, in general, it represents recurrent failures to act in the peculiar human way, according to Aristotelian philosophy.

that we are succeeding in fulfilling the mission we believe we have [5]. Based on such notions, we can understand that we can make the patient more motivated to practice the virtues through the clarifications that: (1) there is more intense happiness to be experienced, and (2) that it can be experienced from the moment we discover and take responsibility for our life mission. Regarding "2", it is noteworthy that its motivational power depends on the discovery of a mission that the person really sees purpose in fulfilling, which depends on a high reflective effort, especially with regard to personal interests, skills and problems of the world.

As a suggestion, we see that it is possible for a person to find his or her life mission through a reflexive effort to answer at least three questions:

1. What would you agree to do for free for the rest of your life?

2. In this task, you would be employing your best qualities (i.e., virtues)?

3. Does the world need what you're willing to deliver? In other words, can what you will be delivering make the world, to some extent, a better place?

It is important to mention that the engagement in the process also occurs because of the experience of happiness that the patient experiences with each rational decision that he or she perceives to have taken and that generated a good result. By the way, the increasingly frequent experience of this type of pleasure on the part of the patient may indicate that he or she is doing well in the treatment (as Aristotle would say, is doing well in having a good life according to the type of being we are); so that analyzing this data and presenting it, in case it is positive, can also contribute to the engagement in the therapeutic process of practicing the virtues with a focus on experiencing happiness.

It is noteworthy that, in parallel, the engagement in this therapeutic process should provide the overcoming of false beliefs, such as those linked to the notions of unlovability and incompetence, because with the practice of virtues, the individual is exposed to facts that contradict such beliefs, which can, little by little, lead to the expansion of his or her level of wisdom, from the replacement of false beliefs by others that reflect reality better. In the case of incompetence, for example, if the individual focuses on putting the virtues into action, he or she can see that not only is there a solution for almost everything but also that he or she is totally capable of finding them.

Finally, it is worth bringing to the therapeutic scenario three important notions linked to the objective of experiencing happiness, with increasing frequency, throughout life, that refers to the notions we talked about earlier, about emotions that only humans are capable of feeling:

1. That regret, while uncomfortable, is welcome when it prompts us to reflect on whether we made a mistake because we didn't know enough to have done better (which prompts us to want to know more) or because we failed to act on what we already knew (which encourages us to acquire the habit of acting rationally) [1, 5, 20].

2. That self-blame and shame are not very useful for the development of virtues [45] and for the frequent experience of happiness, as they do not encourage us to review our mistakes, but rather to, respectively, attack the self of the past or flee from negative evaluations of others [5].

Although emotions that depend on agency awareness are not in themselves defining psychopathologies (at least, not yet), they are present in a variety of psychopathological conditions. In the case of grief, for example, the anger phase can refer to self-directed anger, in which the person chronically blames him or herself because this person sees him or herself as the cause of the loss of the ally [35]. Therefore, we see that clarifying the nature of such emotions and how they relate to the greater goal of feeling happiness can help the patient to reflect on whether or not it is appropriate to feel them in certain contexts, and thus help him with the task of consciously reviewing or accepting them (i.e., helping him with the practice of the virtues), which, in parallel, helps the patient to avoid feeling these emotions chronically.

11. Conclusion

The acquisition of the notion of what true happiness is (and the most intense of it) makes the person understand what he or she actually ultimately seeks: the pleasure of a kind of pride that arises when he or she perceives himself or herself as causing good consequences through rational choices, as we have argued; and this, both in the short term and in the long term as a whole (which represents having a life permeated by happiness; a happy life). Such understanding is a key part for the patient to discover where he or she should direct his efforts; which, in a world full of possibilities, represents finding the best path, the shortcut out of a psychopathological condition, and feeling the desire to go through it. However, it is not enough just to find such a shortcut and want to take it, it is also necessary to know how to walk on it; which, as we said, happens through the practice of virtues. Such practice represents each step on this path, which is capable of generating happiness in the recent past, if we see that we have just generated a good result, and even in a more distant past, when, after a set of steps, we look back and see that we have left traces of good results along the way, as a result of our choices.

In this work, we have argued that the pursuit of happiness represents a shortcut to mental health. First, because we see that such pursuit represents walking the path that by nature we all want to travel, so the level of engagement we would have on this journey would be greater than on any other, also because we will be reinforced throughout it due to the experience of pleasure with every rational decision that we perceive to have taken that generated a good result; pleasure that evolution "rewards" us for acting in line with our peculiar nature, as we said. And secondly, because the pursuit of happiness leads us to be increasingly successful in our interactions with reality, since in this pursuit we acquire more and more knowledge about reality and get into the habit of acting on what we know so far, which, in essence, refers to making categorizations that reflect reality reasonably well (increasingly better, as our knowledge evolves), which, in turn, as we said, makes it possible to feel emotions appropriate to the contexts, in objective terms, instead of feeling emotions chronically.

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References

[1] Aristóteles. Ética a Nicômaco. Bini E, Translator. São Paulo: Edipro; 2018

[2] Seligman MEP. Flourish: A Visionary New Understanding of Happiness and Well-Being. New York: Free Press; 2011

[3] Osmo F. Basic evaluation process and some associated phenomena, such as emotions and reactive defense of beliefs. Integrative Psychological and Behavioral Science. 2021:299. DOI: 10.1007/s12124-021-09667-z. Available from: https://link.springer.com/article/10.1007/s12124-021-09667-z#citeas

[4] Pinker S. Como a mente funciona. Motta LT, Translator. São Paulo: Companhia das Letras; 2001

[5] Osmo F, Borri MM. Educação das virtudes através dos mitos gregos: Ajude nossas crianças e jovens a realizarem seu potencial racional. Salvador: Escola das Virtudes; 2021

[6] Abramson LY, Metalsky GI, Alloy LB. Hopelessness: A theory-based subtype of depression. Psychological Review. 1989;**96**:358-372

[7] Aquino T. Onze lições sobre a virtude: Comentário ao segundo livro da ética de Aristóteles. Tondinelli E, Translator. Campinas: Ecclesiae; 2014

[8] Gopnik A. Explanation as orgasm and the drive for causal knowledge: The function, evolution, and phenomenology of the theory formation system. In: Keil FC, Wilson RA, editors. Explanation and Cognition. Cambridge: MIT Press; 2000

[9] Lazarus RS. Thoughts on the relations between emotion and cognition. American Psychologist. 1982;**37**(9):1019

[10] Oatley K, Johnson-Laird PN. Cognitive approaches to emotions. Trends in Cognitive Sciences. 2014;**18**(3):134-140

[11] Penn DC, Holyoak KJ, Povinelli DJ. Darwin's mistake: Explaining the discontinuity between human and nonhuman minds. Behavioral and Brain Sciences. 2008;**31**(2):109-130

[12] Povinelli D. Folk Physics for Apes: The Chimpanzee's Theory of How the World Works. Oxford University Press; 2000

[13] Povinelli DJ, Dunphy-Lelii S. Do chimpanzees seek explanations? Preliminary comparative investigations. Canadian Journal of Experimental Psychology/Revue Canadienne de Psychologie Expérimentale. 2001;**55**(2):185-193

[14] Boyle M. Essentially rational animals. In: Abel G, Conant J, editors. Rethinking Epistemology. Berlin: de Gruyter; 2012

[15] Aristóteles. Ética a Eudemo. Bini E, Translator. Edipro; 2015

[16] MacIntyre A. Dependent Rational Animals: Why Human Beings Need the Virtues. Chicago: Open Court; 1999

[17] Hutchinson DS. Ética. In: Barnes J, editor. Aristóteles. Machado RHP, Translator. Aparecida: Ideias & Letras; 2009

[18] Aurélio M. Meditações. Pires Vieira A, Translator. São Paulo: Montecristo Editora; 2019

[19] Nussbaum MC. The Therapy of Desire: Theory and Practice in Hellenistic Ethics. Princeton: Princeton University Press; 1994

[20] Jimenez M. Aristotle on "steering the young by pleasure and pain". The Journal of Speculative Philosophy. 2015;**29**(2):137-164

[21] Sherman N. The Fabric of Character: Aristotle's Theory of Virtue. New York: Oxford University Press; 1989

[22] Herdt JA. Guilt and shame in the development of virtue. In: Annas J, Narvaez D, Snow NE, editors. Developing the Virtues: Integrating Perspectives. New York: Oxford University Press; 2016. pp. 224-234

[23] Kuppens P, Van Mechelen I. Interactional appraisal models for the anger appraisals of threatened self-esteem, other-blame, and frustration. Cognition and Emotion. 2007;**21**(1):56-77

[24] Fowers BJ. The Evolution of Ethics: Human Sociality and the Emergence of Ethical Mindedness. London: Palgrave Macmillan; 2015. p. 153, 286

[25] MacIntyre A. Depois da virtude: Um estudo em teoria moral. Bauru: EDUSC; 2001

[26] Seneca LA. Cartas a Lucílio. Segurado e Campos JA, Translator. Lisboa: Fundação Calouste Gulbenkian; 1991

[27] Kristjánsson K. Flourishing as the aim of education: Towards an extended, "enchanted" Aristotelian account. Oxford Review of Education. 2016;**42**(6):707-720

[28] Damon W. The Path to Purpose: How Young People find Their Calling in Life. London: Free Press; 2008

[29] Maslow AH. Motivation and Personality. New York: Harper & Row; 1954

[30] Frankl VE. Em busca de sentido: Um psicólogo no campo de concentração. Schlupp WO, Aveline CC, Translators. São Leopoldo: Sinodal; 1987

[31] Cosmides L, Tooby J. Evolutionary Psychology: A Primer. Santa Barbara: Center for Evolutionary Psychology, University of California; 1997 http://cogweb.ucla.edu/EP/EP-primer.html

[32] Foot P. Natural Goodness. Oxford, England: Oxford University Press; 2001. p. 15,16, 24, 32

[33] Gilbert P, Allan S. The role of defeat and entrapment (arrested flight) in depression: An exploration of an evolutionary view. Psychological Medicine. 1998;**28**(3):585-598

[34] Seligman MEP. Learned helplessness. Annual Review of Medicine. 1972;**23**(1):407-412

[35] Kübler-Ross E, Kessler D. On grief & Grieving: Finding the Meaning of Grief through the Five Stages of Loss. New York: Scribner; 2014

[36] Peterson JB. 12 regras para a vida: Um antídoto para o caos. Gassul A, Translator. Rio de Janeiro: Alta Books; 2018. p. 54

[37] Fetzner MG, Teale Sapach MJ, Mulvogue M, Carleton RN. "It's not just about being judged": Interpersonal distrust uniquely contributes to social anxiety. Journal of Experimental Psychopathology. 2016;**7**(1):31-40

[38] Osmo F, Duran V, Wenzel A, de Oliveira IR, Nepomuceno S, Madeira M, et al. The negative core beliefs inventory: Development and psychometric properties. Journal of Cognitive Psychotherapy. 2018;**32**(1):67-84

[39] Del Giudice M. Evolutionary Psychopathology: A Unified Approach. New York: Oxford University Press; 2018

[40] de Jong JW, Vanderschuren LJ, Adan RA. Towards an Animal Model of Food Addiction. Obesity Facts. 2012;**5**(2):180-195

[41] Davis C. Compulsive overeating as an addictive behavior: Overlap between food addiction and binge eating disorder. Current Obesity Reports. 2013;**2**(2):171-178

[42] Beck JS. Cognitive Therapy for Challenging Problems: What to do When the Basics Don't Work. New York, NY: Guilford Press; 2005

[43] Lee SA, Gibbons JA. The Dark Triad and compassion: Psychopathy and narcissism's unique connections to observed suffering. Personality and Individual Differences. 2017;**116**:336-342

[44] Cloninger CR. A systematic method for clinical description and classification of personality variants: A proposal. Archives of General Psychiatry. 1987;**44**(6):573-588

[45] Miller CB. Moral Character: An Empirical Theory. Oxford: Oxford University Press; 2013

Chapter 3

General Three-Component Structural-Dynamic Theory of Psychotherapy and Its Implementation in Method of Positive-Dialog Psychotherapy

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Abstract

On the base of analysis of psychotherapeutic practice, archaic therapeutic systems and basic methods of psychotherapy the author formulates the general three-component structural-dynamic theory of psychotherapy, describes its components, formulates the connecting scrip's concept for psychotherapy. The description of sociopsychological component of psychotherapy is based on "models of the disease and therapy" of the mass consciousness, its structure and dynamics. The psychological component includes the learning and intrapsychic subcomponents. The intrapsychic subcomponents contain the mechanisms of reactivation and the formation of the personal system of psychological adaptation. The biological component of psychotherapy is discussed from the perspective of mechanisms of learning, readaptation and neurogenesis. The method of positive-dialog psychotherapy (PDP) of anxiety disorders is based on the above theory of psychotherapy and describes the process of psychotherapy as a multidimensional staged dialog between the psychotherapist and the patient. PDP is realized as a serial resolution of the patient's systemic request for psychotherapy, which presents a set of consistently manifested, resolving stage requests of the patient (reflects in reverse order the history and biopsychosocial mechanisms of the formation of the disorder). PDP includes the method of universal hypnotherapy, which demonstrates mindfulness effect, and is effective in evidence-based research.

Keywords: three-component structural-dynamic theory of psychotherapy, social-psychologic, psychologic, biologic components, mass consciousness, the system of psychological adaptation of the personality, positive psychology, biologic readaptation mechanisms, positive-dialog psychotherapy, anxiety disorders, universal hypnotherapy

1. Introduction

Twenty years ago, the idea of superiority of cognitive behavioral therapy (CBT) was dominated in the evidence-based approach. The exponential growth in evidence-based research on psychotherapy had fundamentally changed the situation. Modern meta-analyses and systematic reviews indicate a lack of benefits in the effectiveness of various CBT techniques, psychodynamic therapy, and supportive psychotherapy for a wide range of posttraumatic, anxiety, and depressive disorders. Researchers note only the traditionally wide representation of the CBT methods, but do not indicate their therapeutic advantage, stating the reliable effectiveness of different psychotherapies [1–4]. The effect sizes for CBT, psychodynamic therapy, relaxation training, non-directive therapy, self-evaluating therapy, mindfulness meditation, psychodynamic and metacognitive therapies, anxiety management training for generalized anxiety disorder (GAD) ranged from moderate to high ($r = 0.76$).

The distinct and comparable effectiveness of a wide range of psychotherapy methods stimulates researchers to explore the general, universal mechanisms of psychotherapy. In recent years, evidence-based studies of psychotherapy have gone beyond the standard for assessing effectiveness, switching to the study of the psychologic and neuronal mechanisms of psychotherapy. The number of studies of psychotherapy psychologic and neuronal (f-MRI-, s-MRI-based) mechanisms over the past decade has increased five times—for psychometric, and more than 10 times—for neuronal methods. Based on f-MRI-, s-MRI-based studies of the neuronal mechanisms, different psychotherapy methods have shown the involvement of brain areas responsible for self-awareness, self-regulation, regulation of attention, self-perception, semantic processes [5, 6].

Widespread methods of psychotherapy have a limited (40–100 years) life cycle: formation, development, maturity, decline, and loss of relevance. The methods of psychotherapy are grouped into psychotherapeutic approaches that are more historically stable in comparison with separate methods. The methods of psychotherapy, which became the basis for the formation of psychotherapeutic approaches, as a rule, live longer than others. Orthodox psychoanalysis [7–13] and A. Beck's cognitive therapy [14–16] can serve as canonical illustrations. The historicity of the psychotherapeutic methods presupposes their involvement in the historical process, conditioned by social changes, while within the psychotherapy the personified narrative of its methods development dominates (one of the examples is the relatively recent history of Ericksonian hypnosis [17–19]).

Any developed and demanded method of psychotherapy creates and maintains hermeneutic semantic structure, explaining a person, disorder, and therapy. The problem is that psychotherapeutic hermeneutics of the methods are not consistent (for example, for psychodynamic and behavioral therapy), which does not affect the comparable clinical effectiveness of the methods.

The data of evidence-based studies of psychotherapy, the aspect of its historicity, comparison of the interpretative constructs of separate methods potentiate the search for common, universal mechanisms of psychotherapy, and their direct use in psychotherapeutic practice. Based on the above logic, in the late 1990s and early 2000s, the author elaborated the three-component, structural-dynamic theory of psychotherapy, which in the 2010s turned into the basis for development of the positive-dialog psychotherapy (PDP) method that underwent an evidence-based assessment, highlighting predictors of its efficiency.

2. General three-component structural-dynamic theory of psychotherapy

Since human life is carried out on social, psychological, biological levels, then effective clinical psychotherapy will inevitably be systematically implemented at the same sociocultural, psychological, and biological levels. Therefore, the explanation of the general theoretical approach to psychotherapy will be based on a systemic analysis on the sociopsychological (cultural), psychological, and biological levels [20, 21].

2.1 Sociopsychological component of psychotherapy

The ethnocultural context, undoubtedly, is accepted by modern psychotherapy as traditional therapeutic practices, which partly are incorporated into modern therapies (an example of mindfulness meditation [22–25]). Nevertheless, the interaction of society, culture, and psychotherapy methods, in which psychotherapy in any society develops in response to current social dynamics and requests, does not become a significant area of the research in psychotherapy. However, if the conditionality of psychotherapy by society exists, then it should manifest since the first steps of social life development, being realized in archaic forms of therapy.

2.2 The analysis of archaic forms of therapy

2.2.1 Siberian shamanism and shamanic therapy

Shamanism is a traditional religiosity worldview of the indigenous ethnic groups of Siberia [5–9], which exists from the Neolithic era. It is founded on faith in spirits and the existence of special intermediaries between the world of people and the worlds of spirits—shamans, who are elected by spirits and endowing with special abilities.

The shaman's universe consists of three worlds: the "upper"—skiey, the "middle"—earthly, and the "lower"—underground. People inhabit the "middle" world, the spirits—"upper" and "lower." The shaman possesses the helper spirits, which supports him in guarding his relatives from the life troubles. The shamanic ability is inherited, the transformation into a shaman occurs as a result of the "shamanic disease" [26–29]. Shamans divided due to their supernatural capabilities into great and medium ones [26, 27]. Great shamans can visit all three worlds and possess the entire shamanistic practice arsenal. Medium shamans can visit only the middle and lower worlds. Siberian Yakuts divide the shamans into good and evil. Evil shamans—"eduns" are able to bring both benefit and harm, "eat" the "kut" (life force) of a person. The strength of the shaman is determined by the amount of helper spirits. The great shaman has helper spirits from all three worlds. Medium shamans have helper spirits from the middle and lower world.

The main reason of illness in Siberian shamanism is the abduction of the patient's "kut" by spirits of the upper or lower world [26–29]. Less often, an evil spirit infuses a person. The treatment's goal consists in returning of the stolen "kut" or in expelling an evil spirit. The basic component of shaman's therapeutic practice is the ritual of "kamlanie" [26–30], which consists of (1) divination and (2) therapeutic "kamlanie" ritual. The divination's aim presents "causal," "pathogenetic" diagnostics that includes: identification of the disease typology (mental, somatic); determination of its cause (abduction of "kut" by the spirit, or the introduction of an evil spirit);

identification of "pathogenic" spirit's "personality" and "domicile." The "kamlanie" is night ritual, its duration is varied from several hours to several nights. The venue is the patient's home. The patient, his relatives, and fellow villagers are becoming ritual member. During the "kamlanie," shaman, striking a tambourine with a mallet, moves around the patient, dances, declares his own poetic improvisations on traditional themes. The script of " kamlanie" includes gathering the shaman's helper spirits, diagnostics of disease, demonstration of the shaman's supernatural abilities, communication with pathogenic spirits aimed at restoring the patient's health, stating the results of ritual, and dismission of the helper spirits. Conducting the "kamlanie" shaman keeps in touch with the patient and the audience for potentiation of the ritual effectiveness, demonstrates his supernatural abilities (flying, sinking into the ground, bloodlessly inflicting wounds on himself, etc.). It is considered that during "kamlanie" shaman develops controlled trance keeping full contact with the audience [27]. In case of abduction of the patient's "kut" by spirits, the shaman travels to the upper or lower worlds during the "kamlanie" and, if successful, takes away, redeems the "kut" from the abductor, leaving them something in exchange, and returns the "kut" to the patient [26–29]. The details of the ritual journey are described by the shaman in his chant to all participants, who react vividly to what is happening, often becoming trance witnesses of the shaman's journey and support him.

The results of "kamlanie" are distributed in the range from patient's recovery, temporary improvement, to lack of effect, and worsening of the condition. The absence of a sufficient effect indicates the need for repeated "kamlanie" by the same shaman, or addressing to another, more experienced and powerful [27, 28].

2.2.2 Therapeutic ritual of primitive farmers

As an example of therapeutic ritual of primitive farmers, let us analyze the Ndembu (Africa) isoma ritual described by V. Turner, the goal of which is to cure women infertility [31]. Infertility is caused by too strong connection of a married woman with the "male side," for which a deceased relative of a woman on the maternal side harms her fertility. He goes to the headwaters of the river flowing near the matrilineal village and utters a spell—"chisaku," which awakens the "shadow" of isoma, who comes to a victim in a dream in the guise of the spirit of Mwenga, whose clothes bind and block female fertility.

Ritual divination precedes the treatment. The isoma treatment contains: finding by the healers the burrows of a rat near the river where the isoma spell was pronounced; instillation of "medicines," with the utterance of a spell; digging of "hot" and "cold" sacred pits connected by a tunnel, clearing the ritual space around; giving a woman a white chicken—a symbol of fertility, wetting spouses with "medicines"; passage of spouses from the "hot" pit to the "cold" pit through the tunnel; drinking beer by participants, sprinkling of spouses with "medicines"; decapitation of the red rooster—the destruction of "chisaku"; re-sprinkling of spouses with "medicines"; singing ritual songs of life cycle by adherents.

2.2.3 Ritual therapy of Russian peasants in 17–19 centuries

The worldview of the Russian peasantry of that historical period has a religious and magical basis [32, 33]. The Orthodox Christian shell is saturated with the pagan, ritual-magical content. The World consists of Heaven with Paradise, Earth,

underground Hell. The world is ruled by the Lord God, the Lord of Hell is the Devil, Man lives on Earth. The world is full of supernatural forces of Good and Evil, good and evil spirits associated with the forces of Paradise and Hell. The Earth is inhabited by pagan spirits of nature, polarized between Good and Evil, or ambivalent. At the same time, earthly life presents the subject of the natural factors influences.

A person is able to directly appeal to God, angels, saints; however, without priests, part of the necessary rites is impossible. A person can directly appeal to the forces of Evil, but this interaction is improved due to intermediaries—witches and sorcerers. Influence on supernatural powers is carried out in the form of prayers, verbal ritual magic, subject-ritual magic. The diseases' reasons are divided into natural and supernatural [33]. Natural reasons of illness: colds, physical overstrain. A cold is caused by general feeling of cold, it includes: rheumatism, fever, typhoid, erysipelas, pulmonary diseases. Physical overstrain generates such diseases as "navel disruption" (diseases of the musculoskeletal system, gastrointestinal disorders). The pathological process develops from outside to inside, if it penetrates deeply, a person will die. Therefore, it is necessary to move the disease out. Dissemination to inside occurs with blood flow; therefore, "bad" and "stagnant" blood must be "released."

Supernatural diseases can be sent by God, as a punishment for sins, sometimes as a teaching. Fighting such diseases is useless. More often, diseases are sent by pagan spirits (leshiy, kikimora) or by the Devil. The Devil is the father of all diseases, diseases sent by the Devil are the most difficult to treat. Diseases can be caused by people mediating the influence of evil spirits (spoilage, evil eye, fright) [32–35]. Evil eye can be sent by healers, sorcerers, witches [36]. Evil eye can be temporary, or permanent, until death. The incurable Evil eye can be removed by the sorcerer who sent it or by a stronger sorcerer.

A wide range of people are involved in magical, spell-ritual therapy: sorcerers, and witches, medicine men, holy elders, clergymen [32–35]. Sorcerers and witches are intermediaries between man and evil spirits, the Devil. The magical action of the sorcerer and witch on man and nature is based on rituals and spells. Sorcerers and witches are capable of sending evil eye, triggering disease on people and livestock, causing adverse weather events. At the same time, they can treat diseases, especially those sent by them; however, this treatment, being effective, uses devilish power. The medicine men mainly serve as intermediaries between man and God, although in some cases they cooperate with evil spirits. Through spells and prayers, they have the ability to heal people and animals and send diseases. The healing function of the clergyman is based on exorcism [33]. The holy elders, having a constant connection with the divine world, are able to realize direct and indirect (through prayers, rituals) harmonizing and healing effects on people. In the treatment by witchcraft and prayer, the therapeutic ritual uses spells—special formulaic texts.

Spells are generated by myths, being myth's abbreviations, applications [37]. The general scheme of the spell and the myth: action—change (new state)—action, taking into account the achieved new state—the desired result. The spell formula has a complex semantic structure, is saturated with mythological and ritual symbolism, but is opaque, hidden from the healer and the patient [37]. For both the spell presents the mandatory formula that includes set of sacred magic symbols, listing them in the prescribed sequence provides the desired result.

If treatment is unsuccessful, its intensity should be increased. If the treatment with an appeal to God does not help, it is radicalized by an appeal to the Devil, an evil spirit (through an intermediary sorcerer).

2.2.4 The patterns of historical dynamics of therapeutic rituals

The effectiveness of all considered archaic therapeutic rituals is due to: the way of life in a certain historical era; correspondence of magical action to the way of life at the given stage of social development; the presence in the mass consciousness, culture of the community of the initial knowledge about rituals and their action. For each historical era, magical action presents an analogue of life-sustaining activity. For collector and hunter societies, the most universal way of activity was the territorial movement, because only it could lead to the goal of obtaining food and maintaining life. In a primitive agricultural society, life became handmade, manual labor—manual manipulations with objects provided life. With the advent of developed social institutions, the oral and written speech of the rulers, the carrier of verbal-symbolic action, began to play a decisive role in people's life and therapeutic rituals.

The magical action in its historical development passed through analogic stages, manifesting in: the magic of movement in territorial space—flight of a shaman to the upper and lower worlds; manual-subject magic—rites of primitive farmers; verbal-symbolic magic spells. Such distinction is partly relative, since any magic is symbolic and already in the magical actions of the shaman all three types of magic are present as elements, but, nevertheless, their predominant representation in each case is different. The degree of participation of social group in the transition from shamanistic and agricultural therapeutic rituals to spells decreases, the magical effect from public becomes more and more individual.

The magical therapeutic ritual's historical transformation, especially in the transition to spells, is accompanied by significant reduction, simplification of the ritual to a rather short verbal formula. The symbolism of therapeutic rituals during their historical transformation also changes significantly. The semantic content of the symbols of the ritual with the historical simplification of the form becomes more ambiguous, due to the absorption of the main symbolic constructs of previous rituals. Ritual symbolism develops from primary, concrete subject to secondary, universal, abstract-symbolic, replacing the multiple primary symbols of a given method of magical action with a basic symbol expressing the essence of such magical actions. In the process of historical development, ritual symbolism becomes increasingly incomprehensible to the performer and user of the ritual, which is most typical for spells.

The most important condition for the effectiveness of magical therapeutic rituals is the knowledge by all members of the community of the mythology of the world order, the nature of the disease and "therapist," the scenario and, the possible outcomes of the ritual. It is obvious that ritual mythology is localized in the mass consciousness of the community, its culture.

2.3 Comparative analysis of some modern psychotherapeutic systems

Modern psychotherapy is represented by a great number of methods, grouped into three main approaches: psychodynamic, cognitive-behavioral, existential; the aggregate analysis of which in a single chapter is impossible. Therefore, in an extremely formal way, the iconic methods of Western psychotherapy (classical psychoanalysis, object relations therapy, cognitive therapy) and the Russian method of personality-oriented psychotherapy will be analyzed.

2.3.1 Psychoanalytic approach

2.3.1.1 Classical psychoanalysis of S. Freud

According to the mature Freud [7–13], the model of personality is represented by three components: Id (unconsciously biological, reduced to energy of libido), Ego (core of personality, constantly matching the requirements of Reality, Id, and Super-ego), Super-ego (social, formed in childhood on the basis of the Oedipus or Electra complexes and subsequently unchanged). The Id presents main motivational sphere, the Ego is its interpreter. Sexual libidinal and genital functions are separated. The libido in its development goes through the oral, anal-sadistic, genital stages, forming the Oedipus complex (the period of the son's heightened attachment to the mother, with hostility to the father) or the Electra complex (the period of the daughter's heightened attachment to the father, with the hostility to the mother). In addition to the libido, the Id includes the death instinct (Thanatos)—the desire for self-destruction, expressed in acts of hetero- and auto-aggression, the existence of the individual is a compromise between them. Personal anxiety is caused by pressure on the Ego of Reality, Id, Super-ego. The Ego is saved from the emerging stress through the mechanisms of psychological defenses.

Neurosis is the consequence of an unsuccessful defense process, the result of a weakening of the Ego's strength due to the pressure of the Id and the dissipation of energy to counter this pressure, or neurosis is a conflict between the Super-ego and the Ego. The roots of neurosis are in early childhood. The goal of psychoanalytic therapy is to resolve the neurotic conflict, i.e., strengthening the Ego, its independence from the Super-ego, changing its organization, and expanding the field of perception with the possibility of a more complete mastering of Id.

Classical psychoanalysis includes the steps of: material production, analysis, working alliance. The main methods of material production are: free associations, transfer, resistance. Analysis of the patient's material includes: confrontation, clarification, interpretation, study. The working alliance implies a rational relationship between the patient and the analyst, which makes the process of psychotherapy goal-oriented. Essential methods of psychoanalysis are also: the "rule of abstinence" and "the analyst as a mirror." The "rule of abstinence" is based on the patient's suffering in the process of analysis, and the suffering must reach such an extent that it becomes effective in work. The term "analyst as a mirror" implies a behavior in which the analyst remains "dark," impenetrable to the patient, but not cold-heartless.

2.3.1.2 Object relations therapy

The development of psychoanalytic theory led to the formation of the theory and therapy of object relations [38–40], the distinguishing feature of which is the shift in emphasis from instinct to relationship. In order to understand an individual, it is necessary to understand his self-representations, ideas about objects and object relations. This inevitably leads to an understanding of the individual's early relationships with the person who provided the main care for him. The individual, on the basis of early experiences, forms patterns, stereotypes that subsequently affect perception, thinking, feeling, and establishing relationships. Disturbance of the object relations of the developing Ego will determine the roots of all psychopathological conditions [41]. The main problem is the defect of the environment or the lack of sufficiently

good maternal care. Therapy of object relations is built as a replacement therapy. It involves replacing bad objects with good ones. Its objective is to give the patient relationships in which the "frozen parts" of his Self would have gained the opportunity to develop, in which the impaired development would be restored, making it possible for the patient to reborn. The intervention requires a good relationship between the psychoanalyst and the patient. Therapy uses "good" personal relationships to eliminate the harm from early "bad" relationships [38]. Regression and transference analysis presents important components of the intervention. The psychoanalyst, with some delay, corrects that which initially failed to make the "insufficiently good" mother [38].

2.3.2 Cognitive therapy

A. Beck's cognitive therapy [14–16] explores the idea that the words and thoughts of people are of great importance. Along with conscious thoughts, unconscious, automatic thoughts are arising. Automatic thoughts consist of ideas that other people consider irrational (however, they seem quite reasonable to the person), as well as the rules and laws, according to which the person judges behavior actions and strategies. These rules can lead to non-adaptive actions. People react to events interpreting them depending on their influence on individual's Self. The result of the interpretations generates various emotions. Interpretations containing a distortion of reality lead to emotional disorders, which are disorders of thinking. Disturbed thinking includes personalization of events, polarizing thoughts, applying rules in an unconditional manner.

Cognitive therapy aims to weaken emotional disorders by correcting false interpretations of reality and erroneous judgments. The therapist and patient establish a cooperative relationship with attention to solving problems, rather than correcting personal defects.

A. Beck with colleagues and followers has developed effective approaches to the treatment of depressive, anxiety, phobic, personality disorders.

2.3.3 Russian methods of personality-oriented psychotherapy

V. M. Myasishchev, the founder of personality-oriented psychotherapy, [20, 42], defined personality as a social formation, a system of relations with people, forming in ontogenesis, in the given sociohistorical and economic, everyday conditions. Relations present a conscious, empirical-selective psychological connection of a person with various aspects of life, expressed in his actions, reactions, experiences. Relationships are characterized by: level of activity, the interrelations of rational and irrational, conscious and unconscious, stability and instability. From the psychology of relations' standpoint, neurosis is a psychogenic, caused by conflicts neuropsychic disorder based on the disturbance of personality-significant relationships. The goals and objectives of personality-oriented therapy [20, 42, 43] are: the study of personality, the specifics of the patient's relationship system; the study of etiopathogenetic mechanisms of the onset and preservation of a neurotic state; the achievement of patient awareness of the cause-effect relationship of a relationship system and disease; help the patient in a reasonable resolution of a situation; change in the patient's relationship with behavior correction. The applied methods of psychotherapy are individual and group, using the mechanisms of group dynamics.

2.3.4 Comparison of the described methods of psychotherapy

Preceding analysis of the methods of archaic magical therapy revealed several important points. Let us emphasize two: (1) the conditionality of the form and context of magical action and therapy by actual social life and ideology; (2) at the next step in the development magic ritual introjects and retains in a symbolic form, the previous magical action. The question arises, are these points of magical therapeutic rituals' development persist in the field of modern psychotherapy? The answer is positive.

Thus, the early basic psychoanalytic construct of the irrationality of mental life, according to E. Fromm [44–47], is secondary and reflects the idea of irrationality that prevailed in the West on the eve of World War I. It also seems logical that therapy of object relations and cognitive therapy, which emerged in the era of the successful post-war reconstruction of Western Europe in the 1950s on the basis of the Marshall Plan, implement therapy as a positive, rational reconstruction of the psyche, distorted in the early period of development, based on corrective cooperation. Russian personality-oriented therapy in its interpretation of personality is based on the definition of K. Marx (a person is a set of social relations) [48], which became part of the ideology of the Soviet period.

All of the above methods of therapy should be accepted by the patient on the base of understanding, causing his confidence in their efficacy, when patient correlates the therapeutic information with own model of the world and disease.

It should be recognized that orthodox psychoanalysis had a profound impact not only on the development of all subsequent psychotherapy, introducing its own positive or negative introjects (including the examples given earlier), but also became a component of Western culture and mass consciousness. In general, psychotherapy, as well as magic therapy, appears to be a secondary phenomenon in relation to social life, worldview, mass consciousness, historically changing after the changes in the latter. The relative simplicity and integrity of social life, worldview, mass consciousness of the times of magic therapy generate its universalism, the limited set of concepts and means, fully incorporated into social life and culture. And, on the contrary, the complexity and differentiation of modern social life, worldview, and mass consciousness give rise to sufficient isolation, specificity of concepts and means of psychotherapy, creating the impression of its self-sufficiency.

Modern methods of psychotherapy are dualistic, have a well-defined theoretical basis and set of techniques, developing in response to an actual, but less conscious social, cultural requests.

2.4 Mass consciousness, "model of disease and therapy"

So, the analysis showed that psychotherapy in its historical development follows social life, changing in mass consciousness [21, 49, 50].

2.4.1 "Model of disease and therapy"

Seeking medical help for various diseases, the patient already has initial common ideas about the presence and characteristics of diseases, about how he will be provided with medical care on the base of his own experience of diseases and certain general cultural knowledge and norms. In the most general form, the provision of medical care is understood as step-by-step sequential: "examination," "diagnostics," "treatment."

Certain knowledge about diseases, their severity, outcomes, sequence, types, and forms of medical care are acquired by a person both directly, through the experience of diseases and their treatment, and indirectly, through the experience of other people's illnesses, accumulated, transformed from the surrounding sociocultural environment, social networks.

The author considers that people's ideas about the causes of diseases and their treatment are not accidental and form a complex system that can be defined as a "Model of Illness and Therapy" (MDT), the repository of which is the mass, everyday consciousness [21, 49–51]. "Model of a disease" is people's set of the most generalized, averaged knowledge, ideas, opinions about diseases, their types, causes, treatment types, and outcomes. The "Model of the Disease" is inextricably linked with the "Model of Therapy"—a set of generalized, middling knowledge, judgments, opinions, and ideas about methods of treatment, their effectiveness, mechanisms.

The MDT—the medical component of mass consciousness is practically unexplored, while its study is of considerable interest not only for psychotherapy, ore therapeutic disciplines in general, but, undoubtedly, for sociology, social psychology too. The MDT of mass consciousness is a component of the "Model of the World" (MW) of mass consciousness, which represents a systematic description of the world and man. From the standpoint of psychotherapy, one should single out in the MW of mass consciousness such a component as "Model of the problem and its solution."

In typical cases, in the process of treatment of diseases, medical measures do not go beyond the traditional, stage-by-stage "Examination," "Diagnostics," and "Therapy" of MDT; therefore, the patient's acceptance of the treatment is in line with his expectations. Modern methods of psychotherapy are probably the least traditional from the standpoint of the actual MDT and therefore must use the means to maintain social attractiveness and effectiveness. Traditional, generally accepted methods of psychotherapy (psychoanalysis, cognitive-behavioral therapy) have already been assimilated by the MDT of the Western mass consciousness. New psychotherapy methods that have developed their own techniques are not included in the MDT of mass consciousness and need to be explained to patients. Therefore, all relatively new methods of psychotherapy at the beginning of work with a patient include the presentation of a connecting script of subsequent therapy, with description of goals, objectives, normative roles, procedures, and expected results. Such a connecting script can be presented in a structured form at the beginning of therapy, or it will be clarified during therapy, at its beginning.

Thus, the development of modern psychotherapy, as well as the historical dynamics of archaic forms of therapy, is determined by uniform laws.

1. The conceptual foundations of the current psychotherapeutic system are in accordance with its contemporary MDT of mass consciousness. The relative discrepancies between the psychotherapeutic system and the model of illness and therapy are overcome with the help of a "Connecting Script" that allows to overcome the differences existing between them.

2. The development of psychotherapy and the dynamics of the MDT represent a single dialectical process with a system of direct and feedback connections, in which the historical, socially determined dynamics of mass consciousness and the MDT determine the development of psychotherapy, while the theoretical foundations of the psychotherapeutic system, which formulated and proposed

the solution of urgent existential problems, are included in the social ideology, penetrating into the mass consciousness.

3. The process of historical development of the mass consciousness MDT and psychotherapy has a qualitative integrity, continuity and is based on the accumulation, specific "conservation" of the previous traditional social models of decision. This is illustrated by the pseudo-spontaneous restoration of the semantic structure of the rites of passage [21] in modern group psychotherapy, using the ritual cliché, crystallized millennia earlier for solving of similar problems.

2.5 Structure, variants of dynamics and historical development of the model of disease and therapy of mass consciousness

The author became interested in the nature of psychotherapy after the archaization of his patients' attitudes toward his psychotherapy. For explanation, the hypothesis of archaization of mass consciousness was proposed as a result of a social deadlock developing in the life of the late USSR on the eve of the 1990s [21, 49–51]. In those years in Russia happened a boom in extrasensory healing, newspapers talked about magicians, A. Kashpirovsky, A. Chumak, D. Davitashvili consistently became TV stars, replacing each other. The author, observing breathtaking events, became interested in the possibility of an experimental study of the initial representations of people about diseases and their therapy (MDT) and the search for signs of archaization of these representations in: 1) an experimentally created deadlock situation; 2) persons involved in training in psychic therapy. Such a study was implemented, its results are described below.

2.5.1 The experimental method "Model of Disease and Therapy"

The method "Model of Disease and Therapy" was developed by the author for study of human representations about the effectiveness of various types of diseases treatment. The method is based on the principle of rank grid method of D. Bannister [52]. The rank grid presents a matrix filled in during the survey, which includes elements and constructs. Elements are groups of objects from a specific area that are reasonably related. Constructs are bipolar-scaled features that relate to the area characterized by the elements.

Our test uses the possible outcomes of different treatments as seven elements [21, 49]: (1) treatment is useless; (2) treatment brings minor temporary improvement; (3) treatment brings clear temporary relief; (4) treatment leads to gradual significant improvement in the condition; (5) treatment leads to gradual recovery; (6) treatment leads to rapid full recovery; (7) treatment leads to sudden full recovery.

The constructs were described by the language of the average patient. The 14 constructs describe various types of treatment, from traditional magical, attributed to "traditional medicine," to conventional in medicine, and finally, high-tech: (1) treatment of a person with extraordinary abilities in recognizing and treating diseases, for example, a psychic who has the ability to sense the biofield and use it for therapeutic effects; (2) treatment by an experienced chiropractor; (3) treatment by an experienced healer, treating with special herbs, potions, spells; (4) treatment by a qualified psychotherapist (hypnosis, autogenous training, group psychotherapy, other types of psychotherapy); (5) treatment with medical massage; (6) treatment by a qualified acupuncturist; (7) treatment with medical tinctures, potions, drops,

prescribed by a doctor; (8) treatment with pills, prescribed by a doctor; (9) treatment with subcutaneous, intramuscular injections, prescribed by a doctor; (10) treatment with intravenous injections, droppers, prescribed by a doctor; (11) treatment with electrical procedures (such as electrophoresis); (12) treatment with balneological agents (baths, mud); (13) treatment by surgical means (operations); (14) treatment with modern technical means (laser, radioactive substances, ultrasound, and others).

The procedure of psychological research was as follows. All seven elements and the first construct are presented to the subject. The subject is asked to indicate the element (treatment result) that most fully characterizes the given construct (type of therapy). The indicated element is removed from, and the subject is again asked to indicate the element (treatment result), most completely, of the remaining, characterizing this construct (type of therapy). The procedure is repeated until the last element remains. When all seven elements are ranked by one construct, construct 2 is presented, its ranking procedure is carried out, similar to the ranking of construct 1. After the ranking is completed by seven elements of all 14 constructs, a 7 × 14 element ranking matrix is obtained.

Modern man has not only a general representation about medicine, but also distinguishes between its individual areas: diseases in general, therapy, surgery, oncology, infections, etc. Therefore, the method provides, on the base of goal setting of a concrete study, the assessment of representations about a specific field of medicine by highlighting the testing theme that is demonstrated to the subject in the testing cycle, when working with constructs and elements.

The ranking results are entered in the protocol form (with a 7 × 14 matrix). Constructs are columns, elements are rows. To assess the group results, the indicator of the sum of the scores of the relationships for each construct of the individual matrix, proposed by D. Bannister, was used; it characterizes the general variance explained by this construct. For each pair of rankings of individual matrix, using Spearman's rank correlation coefficient, the scores of the relationship (p2 × 100) are calculated, which are then summed up for each construct without taking into account the sign. The sums of the scores of the relationships of the 14 constructs of the tested selected groups were subsequently subjected to the standard procedure of factor analysis by the method of principal components.

2.5.2 Experimental psychological study of the structure and dynamics of the model of disease and therapy

2.5.2.1 The objectives of the study

1. Revealing the archaization of representations about diseases and their therapy in adult subjects in a situation of an experimental impasse.

2. Comparison of the archaization of representations about diseases and their therapy in adult subjects in an experimental situation with the archaization of representations of diseases and their therapy in adult subjects who reacted to a social dead-end situation.

To achieve the first goal in 1989 (3 years after the Chernobyl disaster), 60 workers of the factory in the city of Mozyr (70 km from the Chernobyl nuclear power station),

during a preventive medical examination, on condition of voluntary informed consent, twice, with an interval of 5 minutes, were tested according to the MDT method; the theme of the first study is "Diseases in general," the theme of the second study is "Diseases caused by radiation." The author suggested that the second theme would actualize the experimental impasse and cause archaization of representations about diseases and their therapy. To achieve the second goal in 1990, during the period of active disintegration processes in the USSR, accompanied by a sharp increase in interest in psychic healing, 106 students at the "school of psychics" in the Ufa city, during a medical examination, on the basis of voluntary informed consent, a single test was carried out on the MDT method; research theme was "Diseases in general." The author suggested that persons studying extrasensory healing during the collapse of the USSR had already, and most sharply, reacted to the social dead-end situation and would initially demonstrate archaization of representations about diseases and their therapy.

The study design for both groups included MDT testing method: for the Mozyr group—twice, with an interval of 5 minutes, using the first theme "Diseases in General" and the second—"Diseases caused by radiation"; for Ufa group once using the theme "Diseases in General."

2.5.2.2 Materials and methods

The Mozyr group consisted of 60 subjects, 37 women (62%), 23 men (38%), aged from 27 to 52 years (average age 38.5 ± 5.2 years). The Ufa group included 106 subjects, 68 women (64%), 38 men (36%), aged from 22 to 55 years (average age 43.4 ± 6.7 years). In the study, according to the design, the MDT method was applied, the themes "Diseases in General" and "Diseases caused by radiation" were used.

Statistical processing was performed using the Statistica 6.0 software. The sums of the scores of the relationships of Mozyr and Ufa groups were applied in factor analysis by the method of principal components.

2.5.2.3 Results of research

The results of factor analysis of the MDT testing for the Mozyr group data are presented in **Tables 1** and **2**, and the analogous data for Ufa group in **Table 3**. The names of the factors were given on the basis of a generalized interpretation of the totality of the variables included in them. The definition "External" methods of therapy characterize the methods of therapy that act through the surface of the body, the skin. The definition "Internal" therapy refers to therapies that act primarily through the mouth or ears.

The factor matrix for evaluating the therapy of "disease in general" is presented in **Table 1** and consists of six factors (the variables of which are given in decreasing order of significance). The first factor—"Conservative Therapeutic Methods of Treatment" includes: treatment with pills, injections, electrotherapy, treatment with droppers, tinctures, balneological treatment, treatment with modern technical means. The second factor—radical therapeutic methods of treatment includes: surgical treatment, treatment with modern technical means. The third factor is formed by traditional medical methods of manual treatment: acupuncture, medical massage. The fourth factor presents the methods of therapeutic mental influence:

Factor	Factor name	Variables and their meanings
F1	Conservative therapy	Tablets (0.83), Injections (0.81), Electrotherapy (0.76), Droppers (0.76), Tinctures (0.68), 0, Balneotherapy (0.67), Modern technical therapy (0.57)
F2	Radical therapy	Surgery (0.79), Modern technical therapy (0.57)
F3	Traditional therapy	Acupuncture (0.79), Massage (0.56)
F4	Methods of therapeutic mental influence	Psychotherapy (0.87), Psychic Treatment (0.59)
F5	—	Chiropractor Treatment (0.94)
F6	—	Healer's Treatment (0.91)
Number of subjects	60	
Dispersion	86%	

Table 1.
Mozyr factorial matrix of scores for the relationship of assessing the effectiveness of therapy for "diseases in general".

Factor	Factor name	Variables and their meanings
F1	"External" Methods of Therapy	Acupuncture (0.91), Massage (0.69), Electrotherapy (0.61), Balneotherapy (0.60), Modern technical therapy (0.56), Chiropractor treatment (0.94)
F2	"Internal" Methods of Therapy	Droppers (0.79), Psychotherapy (0.71), Injection (0.71), Tablets (0.71),
F3		Tinctures (0.87)
F4		Healer's Therapy (0.83)
F5		Psychic Treatment (0.92)
F6		Surgery (0.91)
Number of subjects	60	
Dispersion	88%	

Table 2.
Mozyr factorial matrix of scores for the relationship of evaluating the effectiveness of therapy for diseases associated with radiation.

psychotherapy, psychic treatment. Factors 5 and 6 include single variables: treatment of the chiropractor and the healer.

The factor matrix for evaluating the therapy of "radiation-related diseases" by the Mozyr group is shown in **Table 2** and consists of six factors (the variables of which are given in decreasing order of significance).

The first factor of "External" methods of therapy includes: acupuncture, massage, electrotherapy, balneological treatment, treatment with modern technical means, chiropractor treatment. The second factor of "Internal" methods of therapy includes: treatment with droppers, psychotherapy, treatment with injections, pills. Factors from the third to the sixth include, single variables: treatment with tinctures, treatment of a medicine man, treatment of a psychic, surgical treatment.

The survey of students of the school of psychics was carried out during the boom of psychic healing in the spring of 1990. The factor matrix of scores for the relationship of evaluating the effectiveness of therapy of the "disease in general" by the students of the school of psychics is given in **Table 3** and consists of six factors (the variables are arranged in decreasing order of significance).

The first factor of Traditional magical methods of treatment includes: Healer's treatment, Acupuncture, Psychotherapy, Chiropractor treatment. The second factor of medical methods of "internal" treatment includes: treatment with injections, droppers, tinctures, tablets. The third factor presents medical methods of "external" treatment, including: electrotherapy, balneotherapy, medical massage. Factors from three to six include single variables: Modern technical therapy, Surgery, Psychic treatment.

2.5.2.4 Modern and archaic models of disease and therapy on the base of test results: Discussion

The first Mozyr factor matrix, which includes the subject's assessments of supposed effectiveness of the treatment of "disease in general," characterizes the MDT, which classifies various methods of therapy according to their presence in real life and adequately evaluates their significance: the dominance of conservative therapeutic methods, the important role of surgery and other modern technical methods, sufficient relevance, the proximity of traditional medical methods of acupuncture and massage. Psychotherapy, extrasensory therapy, chiropractor treatment, and a healer are combined, which justifiably gives grounds to define them as "Methods of therapeutic mental influence."

The second Mozyr factor matrix, obtained during the examination of the same subjects, at the same time, but representing an extremely significant, threatening for those living in the Chernobyl zone, an assessment of the effectiveness of treatment of "diseases caused by radiation" (requiring essentially the same structure of medical care), is qualitatively different. The subjects unexpectedly divided the therapy methods based on the bipolar trait "external" and "internal". Moderately significant in the previous "model of disease and therapy" and the most ancient of all traditional medical

Factor	Factor name	Variables and their meanings
F1	Magic therapy	Healer's treatment (0.76), Acupuncture (0.72), Psychotherapy (0.68), Chiropractor treatment (0.63)
F2	"Internal" Methods of Therapy	Injections (0.78), Droppers (0.74), Tinctures (0.59), Tablets (0.57)
F3	"External" Methods of Therapy	Electrotherapy (0.82), Balneotherapy (0.75), Massage (0.62)
F4	—	Modern technical therapy (0.73)
F5	—	Surgery (0.78)
F6		Psychic Treatment (0.83)
Number of subjects	106	
Dispersion	81%	

Table 3.
Ufa factorial matrix of scores for the relationship of assessing the effectiveness of therapy for "disease in general" by students of the school of psychics.

methods of treatment—acupuncture and massage, are assessed in the second survey as the most significant, leading the first factor of this matrix, which also includes the treatment of the chiropractor, while the indicator of surgical treatment, which headed the second factor of the first matrix, becomes the least significant. The MDT, actualized by the conditions of an experimental deadlock, loses its connection with the modern therapeutic reality and demonstrates different, archaic structure and content.

The factorial matrix for evaluating the effectiveness of treatment of "diseases in general" by students of the school of psychics is close to the Mozyr matrix of "diseases caused by radiation" and is also distant from modern therapeutic reality, since it highlights "internal" and "external" methods of treatment, reduces the importance of surgery. But, in contrast to the compared one, in this model the most significant are traditional methods of treatment (acupuncture, psychotherapy, chiropractor treatment), which acquire a magical coloring due to the leadership of the healer therapy in this group. It is interesting that the indicator of psychic treatment is highlighted by the students in the last factor of the matrix and, having a high significance (0.83), is separated from all other methods of treatment. This is due to the fact that extrasensory perception was understood by teachers and students as a fundamentally new, scientific, developing, if not refuting modern medicine, method of diagnosis, and therapy. The last factorial matrix reflects the most archaized MDT, which is acquiring a frankly magical coloring.

The division of therapy methods into "external" and "internal," revealed in two archaized factor matrices, is, in author's opinion, related to archaic MDT. This circumstance prompts the search for similar classifications of therapeutic techniques in traditional systems of therapy with archaic roots, which inevitably preserved, systematized, developed the provisions of the MDT of mass consciousness that corresponded to the period of their formation. The most developed traditional systems of therapy are the Chinese, Tibetan and Arab ones. Indeed, these systems have developed fundamental concepts of the "external" and "internal" causes of diseases (in line with the ideas of the connection between the Universe and humans) about the clinic, diagnostics, "external" and "internal" treatment.

In classical Chinese medicine, the categories of "internal" and "external" are codified in the concept of yin-yang (yin corresponds to "internal" and yang to "external") [53], they develop in the concept of the cycle of interconversions of Wu Xing, are included in dialectics "I Ching "(" Books of Changes ") [54] and are most consistently implemented in the theory and practice of pulse diagnostics and zhen-chiu therapy [53]. In the Tibetan medical science Zhud-shi, the system of medicine is represented in the form of nine trees growing from three roots [55]. Four trees grow from the third root, the first symbolizes food and drink, the second—the way of life, the third—medicinal substances ("Man") taken internally, the fourth symbolizes external methods of treatment, including surgery ("Shad").

Avicenna, who reflected in the "Canon of Medicine" [56] the achievements of Arab-Persian medicine at the end of the first millennium, subdivided, referring to Galen, all diseases into external and internal, distinguishing three types of therapy: regimen and nutrition; drug administration ("internal" treatment); hand action ("external" treatment).

Thus, the similarity of two factorial matrices showing archaized MDT is a natural phenomenon based on the actualization of previous "models" accumulated, "conserved" in the mass consciousness in the course of the historical development of MDT. It should be noted that the first archaic factor matrix was obtained during a psychological examination and reflects the experimentally determined, individual

regressive dynamics of the previously relevant modern MBT when the subject is placed in a situation that is insoluble from the standpoint of this model. The factor matrix of the psychics school students revealed the "background," actual at the time of the survey, the most archaic of the three MDTs, obtained for persons who have a short interest in psychic therapy (4–6 months) and, for the most part, who had not previously thought about it. It can be reasonably assumed that this archaized MDT is a consequence of the regressive dynamics of the modern model under the influence of not an individual, but a socially conditioned cause, which in its meaning is close to an insoluble disease situation.

If we assume that the first, background factorial matrix of the Mozyr series reflects the modern MBT, the second—reflects the previous MBT; and the factorial matrix of students of the school of psychics reveals the most archaic of the three MBTs of mass consciousness; then the data structure of the models can be represented as follows.

1. Modern multicomponent MDT consists of blocks: (1) conservative therapy; (2) radical therapy; (3) traditional therapy, introjecting "external" and "internal" methods of treatment of the previous model; (4) therapy by psychic means (psychotherapy).

2. The previous two-component MDT consists of blocks of: (1) "external" methods of traditional therapy; (2) "internal" methods of traditional therapy.

3. The earliest of the compared, three-component-magical MBT consists of blocks: (1) spell-ritual magic therapy; (2) "external" methods of traditional therapy; (3) "internal" methods of traditional therapy.

It is principle that the second and third archaic MDTs were obtained with individual and socially conditioned regressive dynamics of the modern MDT. Consequently, modern MDT in a latent, mediated form contains previous MDT, which is possible only if MDT is a hierarchical, multilevel formation with the property of individual and social progressive historical development and regressive dynamics. So, MDT (both individual and social) is a systemic, hierarchical, multilevel formation, which can be represented as a hierarchical, multilayer "spherical" structure, each layer-level of which corresponds to a certain historical stage in its development. The functioning of such a structure is determined by the activity of the highest, modern layer-level of the MDT. If the upper layer-level of the model of the effectiveness of medical care does not correspond to the individual, it is inactivated, with the transition of systemic functions to the MDT of the lower level. The correspondence of the subordinate levels of the MDT to certain historical epochs is probably not literal, only the most essential, key elements are preserved.

The assimilation by the individual of the MDT of mass consciousness is provided by two mechanisms: "vertical" and "horizontal." The "vertical" mechanism plays a decisive role in the formation of the structure of MDT, starting from the deep levels—at the first stages of socialization of the individual and is functioning in the general context of mastering culture, starting with its most archaized elements: myths, legends, fairy tales, signs, prejudices; in direct and indirect forms. The "horizontal" mechanism determines the detailed development of each individual level of the MDT and is based on the active interaction of the individual with the surrounding reality.

Three variants for the individual dynamics of MDT are possible. The first variant is progressive dynamics of MDT, in which, due to the assimilation by individual from

mass consciousness of modern scientific paradigms of pathogenesis and therapy, with formation of higher level of model, which takes on system-forming functions, integrating and transforming the functions of the underlying layers levels. The second variant is regressive dynamics, with inactivation, due to the ineffectiveness of the treatment of the highest level of MDT and actualization of the underlying phylogenetically and ontogenetically preceding level of the model, which takes on system-forming functions. The third variant—reactivation dynamics, in which due to positive outcome of therapy there occurs a restoration of functioning of the initially "external" level of MBT, deactivated by the previous regressive dynamics.

2.5.2.5 Structure, historical development, and dynamics of mass consciousness model of disease and therapy

Analyzing the structure and dynamics of the MDT, it is necessary to recognize the systemic unity, identity of such models of individual and general mass consciousness. The MDT presents a systemic block in the structure of MW of mass consciousness; therefore, it must preserve the basic principles of its organization. Mass consciousness represents a hierarchical, historically forming multilevel system, whose functioning is determined by the activity of the system-forming "external" level. Mass consciousness, MW as a system, undoubtedly has the progressive, regressive, reactivation dynamics discussed above.

Social tension, crisis from the position of the hierarchical system of mass consciousness can be considered as a discrepancy between the conditions of social life and the standards of the "external" level of the system, which should, according to our model, lead to a regressive dynamic of such a system, with the actualization of the historically previous level of mass consciousness, which takes system-forming functions. The disintegration processes that took place in the former USSR served as a vivid illustration of this provision. The regressive dynamics of the system of mass consciousness during social tension encompasses its highest level as a whole, deactivating all systemic blocks of MW, including MDT. Mass interest in various forms of archaic, magical healing, extrasensory therapy, growing during the intensification of social disintegration, is natural. The first wave of telepsychotherapy by A. Kashpirovsky in 1989 [57, 58] and in the 1990s was swallowed up by a flurry of "non-traditional," "folk healing." [34, 35, 59–64]. The development of such "non-traditional folk healing" during the period of social disintegration of 1988–1991 obeyed a certain pattern and proceeded in the direction of successive actualization: the verbal-symbolic (example of telepsychotherapy by AM Kashpirovsky [57, 58]); manual (A. Chumak [49, 60], D. Davitashvili [61], and many others); extrasensory-trance therapy, with the experience of moving in space (flights to "space," to "planets of the hierarchy," etc., in a trance state) [21]. In 1992–1993, the return of verbal-symbolic, spell-ritual healing (the coming of Maria Stephanie and sorcerers of Russia [21, 49, 50], the resumption of A. Kashpirovsky activities) took place. The noted dynamics of "folk healing" corresponds to the initial regressive dynamics of the magic block of the MDT during the collapse of the USSR, in the reverse order to the historical development of magical action (proceeding from the magic of movement in space to manual-object magic and verbal-symbolic magic), followed by the initial reactivation dynamics of the "model" with a return to verbal-symbolic magic during the initial stabilization of statehood in Russia [21, 49–51].

Based on the analysis of the experimental psychological material, as well as the socially conditioned dynamics of the MDT during the collapse of the USSR, we

propose the following structure [21, 49, 50]. Spherical, hierarchical MDT is represented by three main layers levels.

1. The original, the most ancient, "nuclear" layer level of the MDT is formed by magic therapy, which in turn includes three sublevels: the "deepest", the most ancient sublevel of therapy by magical movement in space; next—manual (manual-manipulative-subject) magic therapy; historically the later, "external" sublevel of verbal-symbolic magical therapy.

2. The second, "intermediate" layer level of the MDT is formed by traditional therapy, which distinguishes the opposing "external" and "internal" methods of therapy.

3. The third, modern, "superficial" layer level of MDT includes conservative therapy, radical therapy, therapy with psychic means.

Moreover, the blocks of conservative and radical therapy of the outer layer-level are genetically related to the layer level of traditional "external" and "internal" therapy, while the block of therapy with psychic means—with the layer level of magic therapy, which is revealed during the regressive dynamics of MDT.

It should be noted that the actualization of archaic MBT happened before in the historical past, preceding and accompanying major social upheavals. So, on the eve of the Great French Revolution, the famous Anton Mesmer treated patients with "animal magnetism," and on the eve of October, the gloomy figure of the "healer" of the court and aristocratic Petersburg Grigori Rasputin had "materialized." ***

The MDT of mass consciousness, relevant in the process of therapy, plays the role of a specific communicative "language" of the patient and the therapist. The correspondence of the representations of the patient and the therapist about the disease and its treatment leads to the establishment of psychotherapeutic contact, with the inclusion of individual psychological and biological mechanisms of psychotherapy. The degree to which the MDT context matches the psychological and biological changes of the patient is fundamentally insignificant.

2.5.3 The mythological nature of mass consciousness and its model of disease and therapy; psychotherapeutic aspect

A comprehensive, experimental-psychological and historical analysis of the MBT of mass consciousness made it possible to: describe its historically formed multilevel structure and socially and personally determined dynamics; when studying the experimental and social regressive dynamics of MDT, to reveal the genetic affinity of superficial and deep structures. However, the momentary experimental regression of the formerly rational "model" transforming into "external–internal" and magical methods of therapy confirms the mythological essence of the modern MDT.

So, MDT is a mythological formation, and its hierarchical structure and dynamics are the structure and dynamics of mythology [21, 49, 50]. Since the MDT presents a systemic part of mass consciousness MW, the last is also a mythological formation. The lives of man and mankind are saturated with mythology.

The system of psychotherapy widespread in a certain society interacts satisfactorily with the actual MBT of mass consciousness. Such interaction is provided by adaptation

of psychotherapy to the current MBT, generation of a connecting script and its subsequent exploitation. Psychotherapy, which qualitatively corresponds to the current MDT, inevitably is functioning as a mythological system. Thus, in a social context, psychotherapeutic systems are essentially mythological systems. The socially conditioned dynamics of MW and MDT generates the development of psychotherapy methods.

2.6 Psychological component of psychotherapy

Clinical psychotherapy is based on therapeutic communication between individuals or a group of individuals. Effective therapeutic communication triggers and maintains in the patient intrapsychic, intrapersonal mechanisms of psychotherapy, which provide the patient with the final result [21, 49, 50].

The intrapsychic mechanisms of psychotherapy are obvious, since without them the therapeutic result is impossible. The obviousness of the latter is combined with the mirror-like pseudo-transparency of the psyche's "black box," in which the involved observer will see the desired content, which often presents a reflection of the applied communicative-interpersonal component of psychotherapy. The real intrapsychic mechanisms of the psychotherapeutic process are hidden "behind the mirror" of the individual's psyche and may, probably, not coincide with the methodical prescriptions.

2.6.1 Psychological communication in psychotherapy

Psychological communication of psychotherapy is characterized by (a) a historically determined communicative style, (b) methodological goal-setting and instruments of therapy, (c) partial spontaneity of interpersonal interaction [21, 49–51, 65].

2.6.1.1 Communicative style of psychotherapy

The concept of communicative styles [65] was formulated by the author in relation to hypnotherapy, in a comparative analysis of directive hypnosis, Ericksonian hypnosis, and the author's method of Universal Hypnotherapy [66].

Communicative styles (of hypnotherapy) are determined by: (a) the approach to the use of the initial representations about the method of psychotherapy (hypnosis) among participants in therapeutic communication, (b) the peculiarities of the implementation of therapeutic communication at the verbal and nonverbal levels, (c) the ratio of the activities of the sides of psychotherapy (hypnotherapy), and (d) application of feedback by the therapist. It has been demonstrated that communicative styles of hypnotherapy are characterized by a natural historical sequence of appearance and development, from the Directive to Ericksonian hypnosis and, further, to Universal Hypnotherapy, since hypnotherapy translates historically relevant communicative styles of active influence of the mass consciousness [65]. Each communicative style has a characteristic profile of opportunities and limitations that work at the sociopsychological and psychological levels.

The concept of communicative style is applicable to any psychotherapy method. So, communicative styles are transferred to psychotherapy from everyday life, the historical dynamics of mass consciousness determines natural changes in therapeutic communication.

2.6.1.2 Methodological goal setting and instruments of psychotherapy

Psychotherapy as a methodology includes the methodological goal setting and methodological instruments [21, 49, 65–67]. The methodological component is determined by: theories underlying the applied methodological approaches to psychotherapy; methodological approaches embodied in specific psychotherapeutic techniques and patterns. Each method of psychotherapy reduces the general understanding of psychotherapy to this component.

2.6.1.3 The spontaneity of interpersonal interaction in psychotherapy

Despite the requirement to adhere to the therapeutic protocol, both sides of the therapeutic process are represented by living people, who inevitably bring an element of unique spontaneity to the methodically regulated process. Therefore, the spontaneous-communicative component characterizes the influence of the individual-personal characteristics of the participants in the psychotherapeutic process (therapist and patient) in their real communicative interaction on the results of psychotherapy. The influence of the psychotherapist's personality and his behavioral style on the results of psychotherapy has been widely studied earlier [21, 49, 68] and therefore is not the subject of our consideration.

2.6.2 The intrapsychic mechanisms of psychotherapy

In the process of clinical psychotherapy, the patient learns and assimilates a lot of new information about himself, disorder, the applied therapy, he manages to therapeutically modify and stabilize the modified state, behavior that provide the final therapeutic result. Psychotherapy undoubtedly uses a variety of learning mechanisms that are an important part of the intrapsychic component of psychotherapy [69–76].

However, the author will highlight other, previously detected intrapsychic mechanisms described as the system of psychological adaptation of the personality [21, 49, 51, 68, 77].

2.6.2.1 Study of the intrapsychic personal system of psychological adaptation

In the 1980s and 1990s, the author investigated the dynamics of the MMPI basic scales before and after identical group hypnotherapy for two samples of patients with various types of Anxiety Disorders [21, 49, 68] (Mixed Anxiety-Depressive disorder, ASD, PTSD along with Dissociative and Somatoform disorders, OCD) (N = 145). Another group represented Anxiety Disorders due to Cerebrovascular disorder (N = 51). The design of the research included: (1) clinical estimation of psychotherapy efficiency; (2) analyses of MMPI data (basic validity and clinical scales) at the beginning and at the end of psychotherapy; (3) statistical analysis (descriptive statistics; means; nonparametric statistics [Wilcoxon matched pairs test] along with factor analysis—principal components method (varimax rotation)). For each clinical group of psychotherapy efficiency, we analyzed within the factor analysis the initial data, final data, and data on dynamics of psychotherapy (received by subtraction of final data from initial data).

Our study revealed two levels of the psychotherapy efficiency: significant improvement of the condition (equivalent of full recovery) with a full and persistent

reduction of clinical disorders, and improvement of conditions with only partial or unstable reduction of clinical disorders [21, 49, 68]. This research has shown that patients, who displayed either significant improvement or improvement of conditions, differ from the very beginning and that there are two types of dynamics, which represent mechanisms of the therapeutic effect and final outcomes of psychotherapy.

2.6.2.2 The model of personal system of psychic adaptation

We attributed positive dynamics of affective symptoms to the restoration of the Personal System of Psychic Adaptation (PSPA), which is the primary mechanism of positive change in cases of efficient psychotherapy for anxiety disorders. With regard to cognitive-behavioral parameters, the therapeutic dynamics were associated with developmental mechanisms of mostly supplementing and rebuilding the Personal System of Psychic Adaptation, which is the primary therapeutic mechanism in cases of efficient psychotherapy for Anxiety Disorders Due to Cerebrovascular Disorder.

In the 1980s, based on our research on outcomes from psychotherapy of anxiety and organic disorders, the author elaborated the model of Personal System of Psychological Adaptation (PSPA) [21, 49, 54, 68, 77]. PSPA is a spontaneously active homeostatic dynamic structure, which forms during ontogenesis and includes a hierarchy of adaptive mechanisms ranging from the earliest, most primitive and typical (similar to Freudian ego-defenses such as Regression, Replacement [78], etc., which are normal for early childhood) to mature, complex, individualized, and personal ones, which can be used as coping mechanisms. Hierarchical PSPA can be visualized as a spherical multilayered model (see **Figure 1**) involving the following components.

1. Concentric structure of levels of the hierarchical organization of adaptation mechanisms that form an expanding sphere around a "center" or the "Self." The highest mature level of hierarchy of multilayer level mechanisms of psychological adaptation has a capability of transforming the interactions between the underlying levels.

PSPA dynamics may express themselves in regressive, reactivating or of progressive, forming transformations.

1. In cases of regressive dynamics (where there is relative inactivation of the highest, mature level of mechanisms of psychological adaptation) the underlying levels, ontogenetically antecedent to it, become primarily active and assume the role of regulatory functions overriding more advanced functions; this results in reorganization of the system of radial and spherical connections, and restoration of emotional and behavioral patterns of the previous stages of PSPA ontogenesis. Regressive dynamics is potentially convertible.

2. Reactivation dynamics became possible after previous PSPA regressive dynamics; it involves restoration of function of initially top level of psychological adaptations and of PSPA "normal functioning," which has been disturbed by its previous regressive dynamics.

3. The formation of PSPA dynamics is possible through development of a higher level, which would overcome insufficiency and defectiveness of previous psychological adaptations of underlying levels.

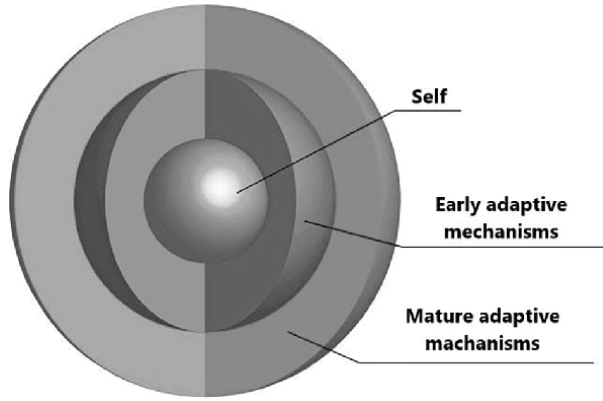

Figure 1.
Personal system of psychic adaptation.

In cases of anxious maladaptation (but not much disintegration), weakening in higher levels of PSPA adaptive mechanisms causes lower levels of adaptive mechanisms to acquire greater behavioral significance. (An example may be the development of dissociative symptoms in persons without a history of dissociative disorders in combat situations).

According to model, psychotherapeutic interventions [21, 49, 54, 68, 77] are especially suitable for cases of anxiety disorders in which there is a potential weakening of the PSPA due to regressive activation of early ontogenic adaptation mechanisms (i.e., dissociative, obsessive disorders) but also to a PSPA deficit, which is due to personality disorders or to organically based brain disorders.

Evidently, mechanisms of effective psychotherapy in cases of reversible psychogenic blocking and organically based PSPA deficit must be different. In instances of regressive dynamics of PSPA, "higher," "normal" levels of psychological adaptation are deactivated psychogenically (or underutilized), in the course of maladaptive functioning, and the goal of psychotherapy is to facilitate their proper functioning again. In the case of deficit, the higher layer level of PSPA, which controls other functions, needs to be developed for the first time and as a result of psychotherapy efficiency, an opportunity for a normal psychic adaptation be formed. So, in psychotherapy of personality and organic disorders, the therapeutic efforts are similar to spontaneous developmental processes leading to formation of the PSPA hierarchy, which means that the patients need to acquire resources allowing for better adaptation.

The results of our empirical research on hypnotherapy outcomes have revealed that dynamics of efficient hypnotherapy with complete improvement in anxiety disorders is consistent with the mechanism of reactivation, and for organic disorders—with a mechanism of PSPA formation; whereas in cases of partial improvement, the psychological dynamics for anxious disorders corresponds to partial PSPA reactivation, and for organic disorders—to incomplete PSPA formation [21, 49, 54, 68, 77].

Consistent with the general resourcefulness model [79–83], our empirically based conclusion is that psychogenic blocking causes underutilization of resources. It also describes two different ways of native personal reintegration, which lead to recovery in cases of anxiety disorder. The first way of recovery, determined as PSPA reactivation, is more effective, simple, and needs fewer resources. The second way, namely PSPA formation, may be less effective and needs expanding acquisition of resources

as PSPA formation requires acquisition through learning of new adaptive skills. In both instances (PSPA reactivation and PSPA formation), in the end the dynamic processes enable individuals to utilize their resourcefulness.

Research reveals the multidimensional nature (both culturally and personally based) of a psychological ability to maintain health and to prevent pathological disorders [79–83]. The mechanism of PSPA Reactivation is close to the Resourcefulness activation of latent personal qualities, while the PSPA Formation mechanism is linked to Resourcefulness as an ability to acquire new skills.

2.7 Biological component of psychotherapy

The patient's participation in psychotherapy changes his consciousness, thinking, behavior on the basis of effective learning [69–76].

Earlier, we formulated the hypothesis that successful psychotherapy should stimulate the process of neurogenesis in patients [84], now this assumption is supported [85]. In our study, it was shown that monopsychotherapy is effective in overcoming the states of anxiety and depression in anxiety disorders [86], which needs positive neurobiological changes.

The author is engaged in research on hypnosis and hypnotherapy [66]; therefore, his analysis of the biological mechanisms of psychotherapy is limited by this method and is applicable in relation to its essential analogues.

2.7.1 Biological component of hypnotherapy

In the 1980s and 1990s, the author conducted research on the biological effect of a hypnotherapy course on the blood system, in relation to its clinical efficacy in anxiety disorders. The obtained clinical and experimental data revealed that hypnotherapy has a distinct, systemic, biological effect on the patient's organism [66]. The following was found.

1. Hypnotherapy activates the systemic (stress-) readaptation processes that are reflected in changes in neurohormonal and neurotransmitter secretions; activities of the immunological system; activation of protein, bilirubin, and cholesterol exchange; etc.

2. Hypnotherapy activates protein metabolism and activity of several enzyme systems of the organism. Hypnotherapy has a positive influence on the metabolism of bilirubin. The activation of cholesterol metabolism, characterized by a significant reduction of its concentration in the blood, has a significant clinical importance. The observed decrease of cholesterol concentration in blood, normalizing its metabolism in the process of hypnotherapy, means the restoration of activity of cell membranes, cells, organs, and tissues, slowing down their aging.

The stressful, readaptive nature of hypnosis limits its therapeutic application, in that excessive intensity of hypnogenic stress may result in the maladaptation. Prolonged hypnotherapy may actually decrease and exhaust adaptable resources of an organism. Of course, the data of hypnotherapy should not be mechanically transferred to all methods of psychotherapy. But there is no reason to exclude the presence of a spectrum of biological mechanisms of psychotherapy associated with learning, neurogenesis, readaptation.

2.8 Discussion. Three-component, structural-dynamic theory of psychotherapy

The performed analysis of sociopsychological, individual-psychological, biological components of psychotherapy allows to proceed to a systematic presentation of the three-component theory of psychotherapy, highlighting its main points [21, 49].

1. The existence of social, psychological, biological components of human nature predetermines the presence of sociopsychological, psychological, biological components of psychotherapy, which determine the patterns and mechanisms of the psychotherapeutic process.

The primary basis of the sociopsychological component of psychotherapy is the MDT, which represents the system block of MW of mass consciousness. The MDT of mass consciousness and an individual, being a historically developing hierarchical system, retains in a latent form previous information and is subject to socially conditioned and individual dynamics in progressive, regressive, reactivation variants.

The psychological component of the psychotherapeutic process is formed by communicative-interpersonal and intrapsychic components. We highlight intrapsychic component of psychotherapy that is described in the context of the PSPA—a spontaneous homeostatic ontogenetically formed hierarchical structure, which includes adaptive mechanisms that are consistently formed from early primitive, typological, to complex individualized, personal, which have regressive, reactivation, progressive dynamics.

The biological component of psychotherapy includes a complex of neurophysiological, organismic mechanisms that ensure the processes of readaptation, successful learning (including neurogenetic ones).

2. The psychotherapeutic process is based on complex psychological interaction and is carried out at two related levels of: sociopsychological, cultural interaction; interpersonal interaction founded on actual communicative style, methodological goal setting, and instruments of therapy, partially spontaneous interpersonal interaction.

Psychotherapeutic interaction at the sociopsychological level uses a connecting script that coordinates the theoretical and methodological tools of psychotherapy with the actual MDT of the patient. The actual MDT of mass consciousness plays the role of the communicational "language" between the patient and the therapist. The psychotherapeutic method may correspond to the actual MDT completely, partially, or differ from it. In the first case, the content of psychotherapy is understood and accepted by the patient initially and completely. In the second and third cases, when the content of psychotherapy does not correspond to the actual MDT, it becomes necessary to reconcile them. In such cases, the methods of psychotherapy, mainly at the beginning of work with the patient, use the connecting script that fills the existing semantic, logical gaps between the applied therapy and MDT. The initial or achieved correspondence between the patient's MDT and the method of psychotherapy leads to the establishment of psychotherapeutic contact and includes individual psychological and biological mechanisms of psychotherapy, initiating the psychotherapeutic process.

3. The complex psychological interaction carried out in the course of the psychotherapeutic process generates and supports the systemic psychological and biological

reactions of the individual to the psychotherapeutic action, including intrapsychic sanogenic mechanisms and a complex of organismic mechanisms (biological, neurophysiological, neurohormonal, etc.). In addition to the obvious mechanisms of effective learning, our study of psychotherapy at the intrapsychic level reveals the mechanisms of reactivation and formation of PSPA of the individual or their combination. We believe that at the biological level, psychotherapy engages mechanisms of stress-readaptive optimization of disturbed biological (and neurobiological) indicators.

2.9 Section conclusion

The three-component theory of psychotherapy focuses on natural phenomena of human life at social, psychological, biological levels. The most significant data are obtained on the phenomenon of mass consciousness, its WM and MDT mythological nature, regressive dynamics in dead-end situations. The author is inspired by the fact that the modern mass consciousness in a latent, indirect, and common form preserves the entire historical totality of cultural ideas about the world and man (from the Stone Age to the present day). And the deepening regressive dynamics of mass consciousness is capable of consistently updating the previous levels of perception of the world, up to the most ancient ones. For the first time, the possibility of regressive dynamics of an individual's ideas about illness and therapy in an experimentally created dead-end situation is shown. In the light of author's research, the phenomenon of mass consciousness contains Jungian "collective unconsciousness."

Psychotherapy presents a secondary phenomenon in relation to the current mass consciousness, everyday culture; therefore, the connecting scenario of psychotherapy becomes its most important means, the effectiveness of which increases in cases of cognizant application by therapist.

Modern psychotherapy is based on psychological communication, in which the therapist, as the architect of the project, together with the patient, builds a therapeutic result. The mechanisms of reactivation and the formation of a PSPA, which are triggered by the patient's psyche autonomously, based on the characteristics of the disorder and the resources of the psyche, which are empirically identified by the author and consistent with a positive psychotherapeutic approach, are fundamental and enrich the understanding of psychotherapy.

The biological mechanisms of psychotherapy are inevitable for its active forms, are universal and based on the mechanisms of fixing positive experience (learning) and readaptation.

3. Method of positive-dialogue psychotherapy

In the 2000s, a similarity between the PSPA model and the resilience/resourcefulness model (Selinski M., Pylowski J.) [79, 82, 83], developed from the position of positive psychology, was revealed. A positive psychotherapeutic approach [79–83] relies on the patient's resources and his positive values, but not on overcoming psychological problems and symptoms. In contrast to the PSPA concept, which implies the neurobiological basis of the system of psychological adaptation of a person, the resilience and resourcefulness model has a philosophical foundation. Psychotherapeutic work in the resilience and resourcefulness model is based on stimulating corresponding mechanisms as positive targets of psychotherapy.

3.1 PDP specifications

Positive-dialog psychotherapy (PDP) was developed by the author in the 2010s as a systemic, integrative, dialogically, procedurally, and causally oriented method of clinical psychotherapy intended for psychotherapy of anxiety, affective, personal, organic (with anxiety symptoms) disorders. PDP is based on the understanding of the psychotherapy process as the communicative staged dialog between therapist and patient using verbal and nonverbal means, carried out at the sociocultural, interpersonal, intrapersonal levels as a system of three dialogs: interpersonal dialog between patient and therapist, intrapersonal dialog of the patient, intrapersonal dialog of the therapist (when the therapist consciously builds such a systemic dialog). PDP includes three stages: diagnostic and psychoeducational with the conclusion of a psychotherapeutic contract (1 session), therapeutic (2–8–10–15 sessions), completion of therapy with an assessment of the results, recommendations (final session).

The psychotherapeutic process in PDP is realized as a sequential resolution of the patient's systemic request for psychotherapy, which is a set of successively manifested, staged patient requests for psychotherapy that are resolved in the course of psychotherapy, which reflects (in reverse order) the history and biopsychosocial mechanisms of the formation of the disorder.

3.2 PDP protocol

PDP is based on the protocol developed by the author [86]. The therapeutic intervention consists of three main components: (1) psychoeducational; (2) causal cognitive-orientated; and (3) hypnotherapeutic.

The psychoeducation component includes a didactic material covering the following information about: (1) anxiety as a normal reaction of mobilization, needed to cope or avoid a dangerous situation; (2) anxiety disorder and the phases of its development for PD and GAD, because of the "swinging" of anxiety reaction by a combination of social, biological, and psychogenic factors; and (3) possibilities of psychotherapeutic treatment of AD based on (a) the resolution of current psychogenic issues, (b) the excluding intoxicating mechanisms (if there are any), (c) the coping with phobic component (if it's present), (d) the general increase of adaptive resources of the organism (through lifestyle rationalization), and (e) the normalization of vegetative regulation by psychotherapy or combination of psychotherapy with pharmacotherapy. The psychoeducational component of PDP is realized during the first therapy session, in an individual or group format.

The causal cognitive-orientated component of PDP has the following objectives: (1) Individual assimilation of the psychoeducational component. (2) Normalization of patient's traumatic experiences during a panic attack (if there are any). (3) Stimulation of patient's coping of anxiety triggers, restrictive behaviors, and phobias. (4) Stimulation of a healthy lifestyle with normalization of vegetative regulation. (5) Development of patient's autonomous understanding and coping with problem situations. (6) Development of skills of positive thinking and attitude. The causal cognitive-orientated component of PDP is used during 2–7 sessions for about 20 min.

The hypnotherapeutic component of PDP uses the method of Universal Hypnotherapy (UH) [66, 67, 87], which contains the following therapeutic interventions: (1) Increase of self-identity and self-integrity. (2) Transformation of patient's projections of his/her psychogenic and somatic-sensorial content. (3) Use of sedative and detachment influences of reproduced colors. (4) Stimulation of detachment of stress experience and

completion of negative states and experiences based on modeling and realization of positive correct behavior. (5) Repeat of the interventions mentioned above (1–4). (6) Creation in hypnotherapy a positive vector semantic space for patient's active therapeutic changes. The UH, done in the second part of a 1-h session of PDP, lasts for 40 min. The frequency of PDP sessions is three times a week; the total number of sessions varies from 8 to 15 (till the stable improvement of patient's state). The UH method has previously been described in detail by the author in chapters of international monographs on positive psychology [67], hypnotherapy and hypnosis [66], psychotherapy [87], which allows, without repeating, to restrict ourselves to a reference to previously published available materials.

The implementation of the PDP, in accordance with the three-component theory of psychotherapy, includes the obligatory use of the connecting script component of psychotherapy involved in the implementation of: a general plan of subsequent psychotherapy; psychoeducational and causal cognitive-orientated components that explain the nature of (anxiety, affective, personality) disorder and the process of subsequent psychotherapy, hypnotherapy. The UH uses hypnotization and hypnotherapy scripts. The hypnotization script is realized before the beginning of hypnotherapy and allows effectively, in the interests of therapy, to transform the initial cultural ideas of the patient about hypnosis, hypnotization, with the achievement of a holistic acceptance by the patient of subsequent hypnotization and hypnotherapy. The patient's assimilation of all psychoeducational material is based on scientific data in the fields of positive psychotherapy and hypnotherapy, but is built on understanding of the mythological nature of mass consciousness, the involvement of the patient's imaginative thinking, and the dialogical form of information presentation. The PDP's deliberate appeal to the mythological side of mass consciousness, shaped into a formal-logical, consistent, scientifically grounded psychoeducational shell, makes the PDP procedurally and clinically effective.

3.3 The results of the controlled study of the PDP effectiveness

In 2010–2015, the author with the coworker [86] conducted a controlled study of the effectiveness of PDP for anxiety disorders. After diagnostic evaluation and completion of all questionnaires, 63 patients were randomly assigned to a treatment group or a waiting-list group. In the treatment group, patients went in therapy immediately and completed the self-report questionnaires at the end of the therapeutic process. Patients on a control waiting-list group were informed about a certain order for the beginning of the therapy and that they had to complete the questionnaires two times (the second time was 3 weeks after the first). The evaluation of psychometric data of the treatment group was carried out 3 weeks before the treatment, just before the start of treatment and at the end of treatment. The control waiting-list group was a control group for itself and for the first group. The study used psychometric and statistical methods accepted in the assessment of the treatment of anxiety disorders. Assuming a similarity of UH to mindfulness-based CBT methods, the study used additional psychometric estimation of UH mindfulness effect. The psychometric assessment used the symptomatic questionnaire SCL-90-R in Russian adaptation of N. Tarabarina [55], its scales: DEP, depression; ANX, anxiety; and GSI, general severity index, a measure of the overall psychological distress. The Spielberger State–Trait Anxiety Inventory (STAI) is a Russian adaptation of Hanin [56]. The following tools were also used: Beck's depression inventory (BDI) [57]; Sheehan Clinical Anxiety Rating Scale (ShARS) [58]; and Five-Factor Mindfulness Questionnaire (FFMQ) [59], its short version. The FFMQ was adapted for Russian-speaking population by the authors.

The Mindful Attention Awareness Scale (MAAS) [60] was adapted to Russian-speaking population by the authors. MMPI (clinical scales) and Resourcefulness for recovery inventory (RRI) [83] were used in the study of predictors of psychotherapy efficacy. The differentiation of the groups of full recovery and partial recovery was carried out using the author's scale of systemic qualitative-quantitative assessment of the psychotherapy effectiveness [49, 86, 88], highlighting four gradations of the improvement degree: (1) significant improvement (full recovery), (2) improvement (partial recovery), (3) slight improvement, (4) lack of improvement. Grades are determined according to the following criteria: (1) the degree of reduction of clinical symptoms, (2) the degree of the patient's conscious control of the current state, (3) the degree of activity in overcoming the disorder, (4) the dynamics of the patient's dependence on the psychotherapist, (5) the stability of psychotherapeutic contact, (6) the patient's own assessment of the degree of improvement.

The results of our controlled study of the effectiveness of PDP were described in the book "Hypnotherapy and Hypnosis" [87]. Therefore, in this chapter, we presented

Scale	**Therapy group n = 52**			**Waiting list control group n = 25**			
	M	**SD**	**d (before-after)**	**M**	**SD**	**d (before-after)**	**d (between the groups)**
SCL-90 DEP							
at baseline	1.66	0.82		1.59	0.81		
at the end of treatment	0.94[1]	0.83	0.87	1.74[2]	0.90	0.18	0.92
SCL-90 ANX							
at baseline	1.85	0.93		1.75	0.89		
at the end of treatment	0.93[1]	0.84	1.04	1.96[2]	1.00	0.22	1.12
SCL-90 GSI							
at baseline	1.29	0.62		1.33	0.58		
at the end of treatment	0.74[1]	0.59	0.89	1.35[2]	0.58	0.03	1.04
STAI-S							
at baseline	37.35	11.11		36.16	11.12		
at the end of treatment	24.81[1]	10.11	1.18	36.00[2]	12.04	0.01	1.01
STAI-T							
at baseline	55.08	9.79		53.72	6.71		
at the end of treatment	48.12[1]	9.27	0.73	55.56[3]	9.90	0.22	0.78
BDI							
at baseline	19.54	10.24		19.80	10.20		
at the end of treatment	9.65[1]	7.41	1.11	19.08[2]	9.87	0.07	1.08
ShARS							
at baseline	48.77	25.47		51.76	22.10		
at the end of treatment	22.04[1]	14.99	1.28	48.40[2]	29.43	0.13	1.13
FFMQ-SF							
at baseline	71.54	9.28		71.68	8.95		
at the end of treatment	80.12[1]	8.06	0.98	70.40[2]	9.99	0.13	1.07

Scale	Therapy group n = 52			Waiting list control group n = 25			
	M	SD	d (before-after)	M	SD	d (before-after)	d (between the groups)
MAAS							
at baseline	3.90	0.72		3.87	0.70		
at the end of treatment	4.35[1]	0.71	0.63	3.82[4]	0.68	0.07	0.76

[1] *$p < 0.0001$ (comparing with the baseline figures).*
[2] *$p \leq 0.0001$ (comparing with therapy group).*
[3] *$p < 0.001$ (comparing with therapy group).*
[4] *$p < 0.002$ (comparing with therapy group).*
SCL-90 DEP, ANX, GSI—depression, anxiety and global severity index of symptom checklist 90; STAI-S—Spielberger anxiety inventory, state anxiety; STAI-T—Spielberger anxiety inventory, trait anxiety; BDI—Beck depression inventory; ShARS—Sheehan Clinical Anxiety Rating Scale; FFMQ-SF—Five-factor mindfulness questionnaire, short version, total score; MAAS—Mindfulness attention awareness scale. MPT group—monopsychotherapy group. PT + PPT group—psychotherapy + psychopharmacotherapy group with later pscyhopharmacotherapy withdrawal.

Table 4.
Treatment effect.

only the final data (**Table 4**) and the results of the comparison of the obtained results with the results of CBT methods based on mindfulness meditation (**Table 5**).

The obtained results allow us to make a number of significant conclusions: (1) PDP is clinically effective for the treatment of PD and GAD, comparing with the wait list control group; (2) According to our data, PDP efficiency is comparable to the efficiency of Mindfulness-based Cognitive Therapy, Mindfulness-based Stress Reduction; (3) Moreover, UH produces a distinct mindfulness effect comparable to that for mindfulness-based CBT techniques.

Data from a controlled study allowed us to search for predictors of PDP efficacy [88]. According to the results of therapy and the systemic criteria of psychotherapy effectiveness, the sample was divided into groups of significant improvement (full recovery) and improvement (partial recovery). Differences in baseline indicators were found in selected groups for the "Health promoting factors" scales of the RRI (the greatest differences in scales: Positive Relationship with HCP- $p < 0.0001$, $d = 1.24$; Self-Responsibility- $p = 0.0002$, $d = 1.19$; Acceptance–$p = 0.001$, $d = 1.13$; Integration–$p < 0.0001$, $d = 1.51$; Minimizes loss–$p = 0.0002$, $d = 1.17$) and scales of the MMPI method (the greatest differences for the masculinity /femininity scale—$p = 0.0002$, $d = 1.1$). Predictors of the effectiveness of psychotherapy have been identified with the help of the discriminant analysis, which appeared to be indicators of the Integration and Positive values of the RRI and the Masculinity/Femininity of the MMPI. Our findings verify actuality of a positive approach in psychotherapy and interrelation between resourcefulness concept and PSPA through the psychotherapy effectiveness systemic criteria.

3.4 Conclusion of the PDP section

The data obtained in a controlled trial indicate a high clinical efficacy of the PDP method, revealing its distinct mindfulness effect. Additionally, a pure final delineation of full recovery and partial recovery groups made it possible to establish their initial difference in a number of psychometric indicators of RRI and MMPI, not only substantiating the concepts of PSPA, resourcefulness, and a positive

Authors	Diagnosis	Intervention	No of subjects	Scales	M1	S1	M2	S2	D-unbiased
Evans S. & co-authors	GAD	MBCT	11	BDI	13.8	7.9	8.82	8.5	0.56
				MAAS	3.68	0.66	4.2	0.58	0.78
Vollestad J. & co-authors	AD	MBSR	31	BDI	17.3	9.3	8.5	9.1	0.93
				SCL-90 GSI	1.3	0.6	0.7	0.7	0.9
				FFMQ	113.8	21.6	128.2	22.3	0.64
Tukaev R., Kuznetsov V.	GAD, PD	PDP (UH)	52	BDI	19.54	10.24	9.65	7.41	1.11
				SCL-90 ANX	1.85	0.93	0.93	0.84	1.04
				SCL-90 GSI	1.29	0.62	0.74	0.59	0.89
				SCL-90 DEP	1.66	0.82	0.94	0.83	0.87
				FFMQ	71.54	9.28	80.12	8.88	0.99
				MAAS	3.9	0.72	4.35	0.71	0.63

Table 5.
The comparison of PDP (UH) MBCT, MBSR efficiency, and mindfulness effect in therapy of anxiety disorders.

psychotherapeutic approach in general, but also localizing the basic mechanisms of psychotherapy in structures and therapeutic dynamics of Self.

4. Chapter conclusion

The chapter context consistently describes the general three-component structural-dynamic theory of psychotherapy, substantiating the historical complementarity of therapies to the current state of the society mass consciousness. The analysis of mass consciousness, its mythological nature, historically formed structure and dynamics is carried out. The study of the application of therapeutic practices allows to form the concept of psychotherapy's connecting script and to describe its practical realization in PDP. On the basis of an empirical study of the psychological component of psychotherapy, the author elaborated the PSPA model, described three variants of its dynamics and psychotherapeutic actualization of mechanisms of PSPA reactivation and the formation. The conceptual affinity of the PSPA model to the concept of resilience/resourcefulness of positive psychology is demonstrated. The brief description of the biological component of psychotherapy is built using mechanisms of learning, readaptation, and probable mechanisms of neurogenesis.

The implementation of the PDP method is based on the methodology of the general three-component structural-dynamic theory of psychotherapy. PDP is realized as a sequential resolution of the patient's systemic request for psychotherapy, it uses the therapeutic protocol, opening a way for evidence-based studies of the effectiveness of PDP for anxiety disorders, searching of predictors of the therapy effectiveness. The results confirm the effectiveness of the given method, comparable to the corresponding effectiveness of modern CBT methods.

In the process of long-term studies, it became clear that the PSPA model, the empirically developed criteria for the psychotherapy effectiveness, and the identified psychometric predictors of the psychotherapeutic effect undeniably address the mechanisms of effective psychotherapy to the psychological structures of the Self and its dynamics. It should be emphasized that comparable results have been obtained in modern neurophysiological studies [5, 6], which indicates the involvement of neuroanatomical zones responsible for self-presentation and semantic processes at various psychotherapies for anxiety and depressive disorders.

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References

[1] Carl E, Sara M, Witcraft SM, Kauffman BY, Gillespie EM, Becker ES, et al. Psychological and pharmacological treatments for generalized anxiety disorder (GAD): A meta-analysis of randomized controlled trials. Cognitive Behaviour Therapy. 2020;**49**(1):1-21

[2] Brooks SJ, Stein DJ. A systematic review of the neural bases of psychotherapy for anxiety and related disorders. Dialogues in Clinical Neuroscience. 2015;**17**(3):261-279

[3] Honyashiki M, Imai H, Hunot V, Caldwell DM, Davies P, Moore THM, et al. Behavioural therapies versus other psychological therapies for depression. Cochrane Database of Systematic Reviews. 2013;(10), 136 p.: CD008696, DOI: 10.1002/14651858.CD008696.pub2

[4] Pompoli A, Furukawa TA, Imai H, Tajika A, E"himiou O., Salanti G. Psychological therapies for panic disorder with or without agoraphobia in adults: A network meta-analysis. Cochrane Database of Systematic Reviews. 2016;(4), 222 p.: CD011004, DOI: 10.1002/14651858.CD011004.pub2

[5] Boccia M, Piccardi L, Guariglia P. The meditative mind: A comprehensive Meta-analysis of MRI studies. BioMed Research International. 2015;**41**:1-11

[6] Messina I, Sambin M, Palmieri A, Viviani R. Neural correlates of psychotherapy in anxiety and depression: A meta-analysis. PLoS One. 2013;**8**(9):e74657. DOI: 10.1371/journal.pone.0074657

[7] Freud S. Lines of Advance in Psycho-Analytic Therapy (1919). Standard ed. Vol. 17. London: Hogarth Press; 1955

[8] Freud S. Beyond the Pleasure Principle (1920). Standard ed. Vol. 18. London: Hogarth Press; 1955

[9] Freud S. Group Psychology and the Analysis of the Ego. Standard ed. Vol. 18. London: The Hogarth Press; 1955

[10] Freud S. The Ego and the Id (1923). Standard ed. Vol. 19. London: Hogarth Press; 1961

[11] Freud S. Introductory Lectures on Psycho-Analysis (1916). Standard ed. Vol. 15. London: Hogarth Press; 1963

[12] Freud S. New Introductory Lectures on Psycho-Analysis (1933). Standard ed. Vol. 22. London: Hogarth Press; 1964

[13] Freud S. Analysis Terminable and Interminable (1937). Standard ed. Vol. 23. London: Hogarth Press; 1964

[14] Beck JS. Cognitive Therapy Basics and beyond. New York: The Guilford Press; 1995

[15] Beck A, Freeman A, Davis DA, Pretzer J, Fleming B, Ottaviani R, et al. Cognitive Therapy of Personality Disorders. 2nd ed. New York: Guilford; 2004

[16] Beck JS. Cognitive Behavior Therapy: Basics and beyond. 2nd ed. New York: Guilford; 2011

[17] Erickson MH. The Collected Papers of Milton H. Erickson on Hypnosis. Vol. I. N.Y: Irvington; 1980. pp. 1-4

[18] Erickson MH, Rossi EL. Hypnotherapy. An Exploratory Casebook. N.Y: Ir-vington Publishers, Inc.; 1979. p. 495

[19] Erickson MH, Rossi EL. Experiencing Hypnosis: Therapeutic Approaches to Altered States. N.Y.: Irvington Publishers, Inc; 1981. p. 374

[20] Karvasarsky BD. Psychotherapy. Moscow: Meditsina Publishing; 1985. p. 298

[21] Tukaev RD. Psychotherapy: Theories, Structures, Mechanisms (2nd Edition, Revised and Enlarged). Moscow: Medical Information Agency Publishing House; 2007. p. 392

[22] Chiesa A, Malinowski P. Mindfulness-based approaches: Are they all the same? Journal of Clinical Psychology. 2011;**67**(4):404-424

[23] Chiesa A, Serretti A. Mindfulness-based stress reduction for stress management in healthy people: A review and meta-analysis. Journal of Alternative and Complementary Medicine. 2009;**15**(5):593-600

[24] Chiesa A. Vipassana meditation: Systematic review of current evidence. Journal of Alternative and Complementary Medicine. 2010;**16**(1):37-46

[25] Fjorback LO, Arendt M, Ornbol E, Fink P, Walach H. Mindfulness-based stress reduction and mindfulness-based cognitive therapy: A systematic review of randomized controlled trials. Acta Psychiatrica Scandinavica. 2011;**124**(2):102-119

[26] Alekseev NA. Shamanism of the Turkish-Speaking Peoples of Siberia (Experience of Areal Comparative Study). Novosibirsk: USSR Academy of Sciences, Siberian Branch, Yakutsk Branch, Institute of Language, Literature and History; 1984. p. 232

[27] Basilov VN. Chosen of Spirits. Moscow: Politizdat Publishing House; 1984. p. 208

[28] Kenin-Lopsan MB. Ritual Practice and Folklore of Tuvan Shamanism. Late 19th - Early 20th Century. Novosibirsk: Nauka Publishing House; 1987. p. 164

[29] Sagalaev AM. Ural-Altai Mythology: Symbol and Archetype. Novosibirsk: Nauka publishing house; 1991. p. 151

[30] Smolyak AV. Shaman: Personality, Functions, Worldview: (Peoples of the Lower Amur). Moscow: Nauka publishing house; 1991. p. 280

[31] Turner V. Betwixt and between: The Liminal Period in Rites de Passage. The Forest of Symbols: Aspects of Ndembu Ritual. Ithaca, NY: Cornell University Press; 1967

[32] Zabylin M. In: Berezin M, editor. Russian People, its Customs, Rituals, Traditions, Superstitions and Poetry. Moscow, Edition of the bookseller M. Berezin; 1880. p. 608

[33] Toren MD. Russian Folk Medicine and Psychotherapy. St. Petersburg., Litera Publishing House; 1996. p. 496

[34] Stepanova NI. 500 Spells of Siberian Healing. Moscow: Ripol-Classic Publishing House; 2000. p. 480

[35] Urengoy V. Treatment of Spoilage. Voronezh: Voronezh Publishing House; 1992. p. 63

[36] Goltsman E. The Evil Eye. A Book about the Customs and Superstitions of the Peoples of the World. Moscow: Prometheus Publishing House; 1990. p. 64

[37] Mythological Dictionary. Soviet Encyclopedia publishing house. Moscow; 1991. p. 736

[38] Fairbairn WRD. Psychoanalytic Studies of the Personality. London: Routledge & Kegan Paul; 1952

[39] Guntrip H. Psychoanalytic Theory, Therapy, and the Self: A Basic Guide to the Human Personality in Freud, Erikson, Klein, Sullivan, Fairbairn, Hartmann, Jacobson, and Winnicott. New York: Basic Books; 1973. p. 224

[40] Winnicott DW. In: Winnicott C, Shepard R, Davis M, editors. Psycho-Analytic Explorations. Cambridge, MA: Harvard University Press; 1989

[41] Fairbairn WRB. An Object-Relations Theory of the Personality. New York: Basic Books; 1954

[42] Myasishchev VN. Personality and Neuroses. Leningrad: Leningrad University Publishing House; 1960. p. 426

[43] Karvasarsky BD. Neuroses. A guide for doctors. Moscow: Medicine Publishing House; 1980. p. 448

[44] Fromm E. Beyond the Chaims of Illusion: Myenconter with Marx and Freud. New York: Simon and Schuster; 1962

[45] Fromm E. The Anatomy of Human Destructiveness. New York: Holt, Rinehart and Winston; 1973

[46] Fromm E. To Have or to be? New York: Harper and Row; 1976

[47] Fromm E. Greatness and Limitations of Freud's Thought. New York: Harper & Row; 1980

[48] Marx K, Engels F. Works. T. 19. Second Edition. M.: Publishing house of political literature; 1961. pp. 376-377

[49] Tukaev RD. Psychotherapy: Structures, Mechanisms. Moscow: Medical Information Agency publishing house; 2003. p. 296

[50] Tukaev R. General theoretical approach to psychotherapy from the practical position: Three-component structural-dynamic theory of psychotherapy. In: Boyd H, editor. In Book: Psychotherapy: Perspectives, Strategies and Challenges. NY: Nova Science Publishers; 2021. pp. 1-54

[51] Tukaev RD. The medical component of mass consciousness. Dynamics in conditions of social tension. In: Materials of all-Union Conference "Sociology of Socio-Political Problems of the Renewal of Socialism: Regional Aspects". Ufa; 1990. pp. 73-74

[52] Fransella F, Bannister D. A Manual for Repertory Grid Technique. 2nd ed. Chichester, UK; Hoboken, NJ: John Wiley & Sons; (2004) [1977]

[53] Luvsan G. Traditional and Modern Aspects of Oriental Reflexology. Moscow: Nauka Publishing House; 1986. p. 576

[54] Shchutsky YK. Chinese Classical Book of Changes. 2nd ed. Moscow: Nauka Publishing House; 1993. p. 606

[55] Badmaev P. In: Zhud-Shi M, editor. Fundamentals of Medical Science in Tibet. Nauka Publishing House; 1991. p. 256

[56] Sina I, Ali A. Canon of Medicine. Selected Sections. Part 1. Moscow: Kommercheskiy vestnik Publishing House; Tashkent: Fan Publishing House; 1994. p. 400

[57] Kashpirovsky AM. Group Non-specific Psychotherapy. Moscow: TEK Ltd; 1993. p. 232

[58] Morgovsky A. Sessions by a. Kashpirovsky. Moscow: Prometheus Publishing House; 1990. p. 47

[59] Borodin V. About Alan Chumak Without Speculation. Medical Newspaper, N 103. 1989

[60] Grimak LP. The Magic of the Biofield. Energy-Informational Treatment. Moscow: Republic Publishing House; 1994. p. 448

[61] Davitashvili D. I Listen to my Hands. Moscow: Physical Culture and Sport Publishing House; 1988. p. 191

[62] Zaitseva V. An Appointment with a... Physicist. Medical Newspaper, No. 18. 1991

[63] Konovalova I. Medicine Grew Out Of Witchcraft. Medical Newspaper, No. 93. 1990

[64] Krasnopolskaya I., Veretennikova I. Order of Sorcerers. Soviet Youth, No. 59. 1990

[65] Tukaev RD. Evolution of hypnotherapy: Methodical aspects. The Bulletin of Psychotherapy. 2020;**76**:7-29

[66] Tukaev RD. Hypnosis; Phenomenon and Clinical Application. Moscow: Medical Information Agency; 2006. p. 448

[67] Tukaev RD. Universal hypnotherapy and resilience – Resourcefulness model. In: Tukaev RD, Selinski MJ, Gow KM, editors. Continuity Versus Creative Response to Challenge: The Primacy of Resilience and Resourcefulness in Life and Therapy. New York: Nova Science Publishers. Inc.; 2011. pp. 451-466

[68] Tukaev R. Research on the effectiveness of the universal hypnotherapy model. In: Selinski MJ, Gow KM, editors. Continuity Versus Creative Response to Challenge: The Primacy of Resilience and Resourcefulness in Life and Therapy. New York: Nova Science Publishers; 2011. pp. 499-520

[69] Grosjean B. From synapse to psychotherapy: The fascinating evolution of neuroscience. American Journal of Psychotherapy. 2005;**59**(3):181-197

[70] Dannehl K, Rief W, Euteneuer F. Effects of cognitive behavioural therapy on verbal learning and memory in major depression: Results of a randomized controlled trial. Clinical Psychology & Psychotherapy. 2019;**26**(3):291-297

[71] Scherf N, Spruit E, Köhler S, Kronenberg G. Avoiding the traps of thought: The relevance of language and rules for acceptance and commitment therapy. Fortschritte der Neurologie-Psychiatrie. 2019;**87**(8):412-420

[72] Minear M, Coane JH, Boland SC, Cooney LH, Albat M. The benefits of retrieval practice depend on item difficulty and intelligence. Journal of Experimental Psychology. Learning, Memory, and Cognition. 2018;**44**(9):1474-1486

[73] Kuei T, Tsai M, McLeod HJ, White RG, Kanter J. Using the primary process emotional-behavioural system to better meet patient needs in psychotherapy. Clinical Psychology & Psychotherapy. 2019;**26**(1):55-73

[74] Boutelle KN, Bouton ME. Implications of learning theory for developing programs to decrease overeating. Appetite. 2015;**93**:62-74

[75] Marić NP, Jašović-Gašić M. Neurons on the couch. Psychiatria Danubina. 2010;**22**(4):484-487

[76] Weersing VR, Weisz JR. Mechanisms of action in youth psychotherapy. Journal of Child Psychology and Psychiatry. 2002;**43**(1):3-29

[77] Tukaev RD. The mechanisms of psychological defense in emotional stress psychotherapy. In: The Eighth all-Union Congress of Neuropathologists, Psychiatrists and Narcologists: Abstracts. Vol. 3. Moscow; 1988. pp. 506-507

[78] Freud A. The ego and the Mechanism of Defense. L.: Hogan Press; 1948. p. 196

[79] Celinski MJ, Pilowsky J. Measuring resilience to psychological outcomes of natural disasters. More questions than answers. In: Gow K, Paton D, editors. The Phoenix of Natural Disasters: Community Resilience. New York: Nova Science Publishers; 2008. pp. 73-86

[80] Antonovsky A. Health, Stress, and Coping. Jossey-Bass Publishers; 1980. p. 255

[81] Wolff AC, Ratner PA. Stress, social support, and sense of coherence. Western Journal of Nursing Research. 1999;**21**(2):182-197

[82] Celinski MJ, Gow KM. Trauma clients: How understanding disintegration can help to reveal resourcefulness of the self. Australian Journal of Clinical and Experimental Hypnosis. 2005;**33**:195-217

[83] Celinski MJ, Allen LM. Resourcefulness as the art of succeeding. In: Selinski MJ, Gow KM, editors. Continuity Versus Creative Response to Challenge: The Primacy of Resilience and Resourcefulness in Life and Therapy. New York: Nova Science Publishers; 2011. pp. 343-358

[84] Tukaev RD. The phenomenon of adult brain neurogenesis in experimental and clinical studies; aspects of etiopathogenesis of mental disorders, psychopharmacotherapy and psychotherapy. Social and Clinical Psychiatry. 2008;**18**(2):96-102

[85] Gorman JM. Combining psychodynamic psychotherapy and pharmacotherapy. Psychodynamic Psychiatry. 2016;**44**(2):183-209

[86] Tukaev RD, Kuznecov VE. Cognitive-oriented psychotherapy for anxiety disorders in a controlled trial. Social and Clinical Psychiatry. 2015;**25**(2):55-64

[87] Tukaev R. In: Mordeniz C, editors. The Integrative Theory of Hypnosis in the Light of Clinical Hypnotherapy. Hypnotherapy and Hypnosis. 2020. pp. 41-72. DOI: 10.5772/intechopen.83045

[88] Tukaev R, Kuznetsov V. Criteria and predictors of eff effectiveness of psychotherapy of anxiety disorders. Psychiatry, Psychotherapy and Clinical Psychology. 2019;**10**(2):291-302

Section 2

New Attempts of Practice

Chapter 4

Including Religion in Rational-Emotive Behavior Counseling

Adrian Opre and Bianca Macavei

Abstract

Cognitive-behavioral therapies (CBT) have been disseminated worldwide. This therapeutic approach is being considered some of the best empirically supported treatments for a large variety of psychological disorders. The core tenet of CBT is to restore mental health and promote psychological well-being by focusing on cognitive dysfunctional patterns that cause emotional distress and maladaptive behaviors. First, a general view of the basic principles and origins of cognitive-behavior therapies constitute the basis on which the chapter is built. Thereafter, a more in-depth discussion on specific forms of CBT, namely cognitive therapy (CT) and rational-emotive behavior therapy (REBT) provides further support for the integration of religion and psychological intervention. Next, a thorough analysis of the theoretical premises of this integration and the ways in which religious beliefs and psychological mechanisms merge in practice is provided. Finally, the REBT conceptualization, techniques, and strategies are illustrated in a practical situation; here, the relationship between religious beliefs and practices on the one hand, and irrational beliefs, dysfunctional emotions, and maladaptive behaviors, on the other hand, is easy to observe. The example provided aptly illustrates the many ways in which REBT can incorporate religious principles, beliefs, and practices; all of them, advocating for the harmonious relationship between Christian values and REBT.

Keywords: cognitive behavior therapy, Christian counseling, religious beliefs and practices, religious clients, case study

1. Introduction

Cognitive-behavioral therapy (CBT) is considered to be the most well-founded in terms of scientific support. It has been widely disseminated worldwide, through numerous training programs, workshops, conferences, and also through a large number of monographs and practical manuals for practitioners in the field of clinical psychology and psychotherapy [1]. The goal of this therapeutic approach is to restore mental health and address a number of issues faced by individuals, by focusing on cognitive dysfunctional patterns that cause emotional distress and dysfunctional behaviors. In a synthetic definition formulated by Amy Wenzel, CBT is considered an active, semi-structured, and time-sensitive psychotherapeutic strategy [2]. Its active character results from the way in which the two actors of the therapeutic act are

involved, the psychotherapist and their client; both prepare for counseling sessions, contribute to the analysis and assessment of the client's condition, and collaborate in the constructive approach to the problems they face. CBT is considered semi-structured, because the therapist, although flexibly positioned in relation to their client's problems, usually prepares for each session a kind of organized scheme to guide the stages of the session, which ensures that the therapeutic process is targeted and effective. Finally, this approach is anchored temporarily/in a time-sensitive manner, in the sense that the clients assume, consciously and with motivation, the proposed therapeutic approach, anticipating that the treatment followed will have an end, that what happens in each session produces a positive development, that this development is noticeable after each session, and that they can implement therapeutic strategies in their daily lives without the need for permanent assistance from the therapist.

Cognitive-behavioral therapy is founded upon three central assumptions, which are as follows:

1. Cognitive activity influences our behavior

2. Cognitive activity can be monitored, but also modified

3. The behavioral changes we target can be achieved through cognitive changes.

The first of these assumptions is, in fact, a brief and up-to-date reformulation of the central thesis of the mediation model, proposed by Michael Mahoney. Since 1974, Mahoney has argued that changes in behavioral therapy necessarily require cognitive mediation. Today, there is an impressive body of empirical evidence indicating that cognitive assessments of life events affect our responses and that changes in the content of these assessments have an indisputable clinical value [3–6].

The second thesis tacitly incorporates the assumption that we can have access to cognitive activity and that our cognitions can be known and evaluated. Undoubtedly, there are enough reasons to believe that our access to our own cognitions is not perfect and that people often report their mental activity based on the likelihood of thoughts occurring rather than their actual occurrence [7]. A corollary of this second assumption is that the assessment of cognitive activity is only a prelude to the changes we can make at this level. In other words, accessing and evaluating one's own cognitions is necessary, but it does not automatically bring about the change we want.

Finally, the third assumption is a direct result of the adoption of the CBT in the model proposed by Mahoney. It explicitly states that the behavioral changes we seek to produce with our clients can only be achieved if we make cognitive changes. Specifically, although CBT theorists accept that a number of external, reinforcing contingencies can influence human behavior without direct cognitive intervention, this does not mean that they are independent and do not involve cognitive changes; moreover, the same changes, as well as others, can be produced by direct intervention on cognitions. To substantiate this assumption thoroughly, cognitive-behavioral researchers have collected a very large volume of experimental evidence.

2. The origins of cognitive-behavioral therapy (CBT)

There were several favorable circumstances that created adequate premises for the development of cognitive-behavioral therapy. Thus, since the 1950s, Hans Eysenck

has published several studies that vehemently criticized one of the prevalent therapeutic approaches of the time, namely, psychoanalytic psychotherapy, proposing behavioral therapy as a more viable alternative. In his challenging attempts, Eysenck argued that the resolution of neuroses does not require a focus on intrapsychic conflicts and that they can be treated completely by a direct approach to the symptoms that portray them [8, 9]. As a result of these warnings and encouragements, in the late 1950s and early 1960s practitioners turned their attention to behavioral therapeutic approaches; these were based on direct behavioral changes, founded upon the two paradigms of learning—classical conditioning, respectively, operant conditioning. However, as interest and involvement in this new commitment grew, it became increasingly clear that a strictly behavioral conceptualization was insufficient for explaining the full spectrum of clinical problems that therapists were facing in their practice. Moreover, there was already evidence that an exclusively behavioral intervention would leave a significant number of issues uncovered, such as the obsessions that are part of obsessive-compulsive disorder, or paranoid ideation [9–11].

A second favorable context was represented by the cognitive revolution, which started in the mid-1950s. Information processing models that began to attract the attention of contemporary psychologists in their attempts to explain psychic life and provide support to artificial intelligence specialists had made a significant contribution to the development of CBT. The new current, which had brought some fresh air to the field of psychology, through its emphasis on cognitive processes, greatly favored the inclusion of the cognitive component in traditional behavioral interventions. In the mid-1970s, a number of academics concerned with the development of therapeutic practice began to draw attention to the importance of the cognitive moment in our actions and propose a model of mediation in this regard. In this way, they explicitly advanced the idea that cognitive processes influence our emotions and behaviors and that cognitive intervention can lead to significant behavioral changes [2]. Once these premises had been accepted, the interest in cognitive-behavioral approaches increased considerably. As a result, a number of new psychotherapeutic approaches based on this new perspective have begun to develop. We mention here some of them: rational-emotive behavior therapy, cognitive therapy, schema-focused cognitive therapy, stress inoculation training, third wave therapies (acceptance and commitment therapy, dialectical behavior therapy, mindfulness therapy). Given the large and ever-increasing number of these new therapeutic guidelines, attempts have also been made to group them based on predefined criteria. Thus, toward the end of the 1980s, Mahoney and Arnkof proposed organizing them into three main categories: a. cognitive restructuring therapies; b. therapies focused on the development of coping strategies; c. problem-solving therapies. Cognitive restructuring therapies are based on the premise that emotional distress is the consequence of maladaptive thoughts. Therefore, clinical interventions aim at examining and replacing dysfunctional thought patterns with their adaptive variants. The second therapeutic category aims to develop a repertoire of skills designed to equip clients for coping with stressful life situations. Finally, the third group of therapies, those focused on problem solving, can be described as a combination of the first two. The latter emphasizes the importance of developing general strategies for the client to deal with a wide range of personal issues, emphasizing the importance of active collaboration between the therapist and their client in the planning of the corrective intervention program [1]. The first category is the most widely used in therapeutic practice, and the best-known paradigms of this family are—rational-emotive behavior therapy (REBT), respectively, cognitive therapy (CT). We will briefly describe each of the two therapeutic approaches, placing more emphasis on REBT, which is also the central object of this chapter.

3. Rational-emotive behavior therapy (REBT)

Chronologically, rational-emotive behavior therapy (REBT) is considered to be the first of the cognitive-behavioral approaches in the category of those that focus, explicitly, on cognitive restructuring. Initially, it was called rational therapy, then rational-emotive therapy, and finally, starting in the 1990s, it became known as the rational-emotive behavior therapy (REBT). The fundamental theoretical and practical principles of REBT were formulated by Albert Ellis, considered the father of REBT and, respectively, the grandfather of cognitive-behavioral therapies. Originally trained in the psychoanalytic school of psychotherapy, after only a few years of therapeutic practice, Albert Ellis began to doubt the quality and effectiveness of this approach. Less and less motivated to continue in the spirit of this school, Ellis successively tested different treatment techniques, most of which involved an active and a directive approach, respectively. The first results of these experiments allowed him to formulate a personal theory on the genesis of emotional disorders, as well as to develop a set of treatment methods. Although ardent proponents of the psychoanalytic paradigm considered the methods proposed by Ellis to be heretical, the advent of behavioral therapy in the 1960s and, above all, the gradual recognition of the fundamental role of cognition in understanding human behavior, led to the acceptance of REBT(at the time called RET) as a viable and credible alternative to classical models of psychotherapy.

The central assumption of this approach is the belief that human cognition (our thoughts) plays a key role in the genesis, maintenance, or modification of the emotional and/or behavioral responses we produce. To make this perspective concrete, Albert Ellis developed the ABC Model of the genesis of emotional responses. The three components of the model are operationalized as follows: A represents the activating element—life events together with our inferences about these events; B refers to the system of personal beliefs (inferences and evaluations) that generate consequences, that is, those that lead to our reactions; C represents the answers that a person produces as a result of the presence of specific beliefs, which can be of a wide variety—emotional (e.g., anxiety), behavioral (e.g., motor agitation), and cognitive (e.g., thoughts of helplessness) [12].

The central objective of REBT therapy is vulnerabilization, namely the elimination of the personal system of irrational (unhealthy) beliefs characterized by exaggeration and rigidity, followed by the adoption of a flexible belief system that promotes/enhances psychological health. In this sense, REBT involves a multidimensional approach that incorporates cognitive, emotional, and behavioral techniques. Of all these, the principal strategy of therapeutic intervention is a logical-empirical method of questioning, challenging, and scientifically disputing the unhealthy thoughts that Albert Ellis called irrational cognitions [13]. Beyond this main healing method, REBT individualizes its intervention strategy using a wide variety of techniques, such as rational-emotive imagery, operant conditioning, modeling, role play, shame attach exercises, thought monitoring, library therapy, and development of various skills and so on [14].

4. Cognitive therapy (CT)

The father of cognitive therapy is Aaron Beck. Like Albert Ellis, Aaron Beck was originally trained in psychoanalysis, but he also became relatively dissatisfied with the conceptualizations that the psychodynamic paradigm offered for various emotional

disorders [3]. For example, in the 1960s, Beck found that a number of cognitive factors frequently associated with depression were systematically ignored in favor of psychoanalytic conceptualizations that accentuated the motivational-affective dyad [1].

The cognitive model proposed by Aaron Beck emphasizes the idea that distorted thinking and unrealistic cognitive assessments can negatively affect our emotions and behaviors. Evaluations are pre-formed (shaped) by mental schemas, that is, cognitive structures that organize and process information taken from the outside. The cognitive patterns of mentally developed people allow/make realistic assessments of life events and lead to functional, healthy emotional experiences. In contrast, individuals who have developed dysfunction are primarily engaged in distorted assessments that lead to emotional dysfunction [5].

The central goal of cognitive therapy is to replace the distorted assessments that clients apply to life events with their realistic and adaptive variants. Cognitive-type therapeutic interventions are based on collaborative psycho-educational approaches and involve the design of specific learning experiences through which clients are guided/prepared:

a. to recognize the relationship between their thoughts and the emotions they experience, respectively, the behaviors attached to them.

b. monitor and control their automatic thoughts;

c. to verify the validity of automatic thinking;

d. to identify and then modify their beliefs, assumptions, or cognitive patterns that favor and support their engagement in psychopathogenic patterns of thinking [15].

5. Integrating religion with REBT

5.1 Theoretical premises of integration

Several reasons (arguments) can be identified that prove the possibility that REBT can be easily and elegantly adapted for the treatment of religious clients. In what follows, we present some of these synthetically [16].

First of all, REBT therapy has proven to be an excellent treatment for religious clients (practitioners) because it is a therapeutic strategy expressly focused on the beliefs of individuals [17–20]. In particular, this approach bears a strong resemblance to the Christian perspective. More specifically, the REBT psychotherapeutic system proves a high convergence with many of the basic principles of the Christian tradition [21–23]. For example, the Christian view that people are all equally worthy and that all sins can be forgiven can serve as admirable support for REBT techniques focused on eliminating the tendency of human beings to appreciate their own worth, respectively, the worth of others. In addition, the position of the Christian Church regarding sin, more exactly, the fact that it condemns sin and not the sinner, is clearly found in the principles of REBT. Moreover, Ellis has explicitly iterated that REBT does not approve of immoral acts, but instead fully accepts the humanity and fallibility of those who commit such acts [24].

The ABC model, already discussed above, with its emphasis on the role of cognitions in the production but also the elimination of emotional-behavioral

dysfunctions, is found in most religious doctrines. In fact, the principles of instilling, maintaining, or changing specific beliefs that are fundamental in most religions, can also be found, carrying equal importance, in the manner in which REBT examines and understands the role played by our cognitions in the genesis of emotional disorders. Furthermore, understanding religious beliefs, both in terms of content and personal quality and worth, is essential for a correct understanding of religion, both as a human phenomenon, and as a determining force in the client's life. Both religious doctrines and REBT theory support and prove the centrality of beliefs in the emotional, behavioral, and cognitive life of the human being [19].

A second convergence between several religious traditions and REBT is their deeply existential and philosophical nature. Therefore, due to the fact that religious systems adhere firmly to the principle of free will, to the benefits and blessings of self-determined involvement in work, but also to the need to change erroneous (dysfunctional) beliefs, we can say with conviction that REBT elegantly meets all these objectives. More specifically, we can argue that religious clients are ideal for philosophical dispute strategies used by REBT therapists, whose major purpose is to change their philosophy of life. In fact, many clients who strongly believe in the strength (power) and usefulness of their religious beliefs are very receptive to the REBT perspective, which states that the deeper a belief is manifested, the more likely it is to manifest itself in the thinking, emotions, and behavior of a person [25].

The third similarity between REBT and the religious perspective concerns the ways in which fundamental principles are expressed. These take the form of behavioral tasks (canons/homework), beliefs, iconographic/pictographic representations, creative musical expressions, etc. In fact, REBT therapists often recommend to their clients that between therapy sessions (face to face or online) they complete/perform various home tasks; most of these topics are behavioral tasks that complement and promote cognitive change processes [26].

Finally, most religious traditions, beliefs, stories, and parables take the form of hymns and represent particular ways of expressing religious worship [27]. It is obvious that combining fundamental religious principles with melodic lines, rhythm and rhyme increases the possibility of making these principles easier to remember at the same time increasing their level of persuasion and emotional relevance [28]. In fact, the transmission of many of the central principles of REBT through therapeutic poems or songs has become a very common practice by therapists.

5.2 Concrete practical ways to integrate REBT with religious beliefs and practices

Considering the arguments regarding the convergences between organized religious systems and REBT theory, it is natural to think of concrete ways in which, at a practical-applied level, there is a possibility of integrating REBT intervention strategies with religious beliefs and practices, in particular, with Christian ones. A primary level of practical integration of the two approaches can be limited to highlighting elements extracted from the religious tradition of the denomination to which the client belongs that are overtly congruent with the specific principles and strategies of REBT intervention.

In fact, all modalities of integration will start by going over and understanding the ABC model that underpins REBT theory and practice. It must be read and interpreted both in the spirit of REBT's central assumption (the emotions and behavioral disorders we experience are the results of our private interpretations and assessments) and of the philosophy behind the client's religious system. For example, when we work with

these clients, rather than threatening or undermining their religious beliefs, through REBT-type interventions we can help them to focus and boost the long-term strength and function of their faith by appealing to several strategies, such as (a) highlighting or reactivating components neglected by the customer [29, 30]; (b) reinterpretation/ reconceptualization of some religious writings in the spirit of REBT; (c) disputation of rigid personal beliefs that overlap and interfere with the authentic religious ones and that can thus generate dysfunctionalities. For example, in the interpretive pattern of the religious client can be identified a series of irrational cognitions that have no basis in the Bible or in the Christian tradition, such as "God does not love me as much when I sin," "Because I am a Christian, God will always guard me against bad things / events that may happen to me," "Because I am a Christian, I should be perfect," "I should condemn and hate myself when I sin because this is the only way I can be saved." All these misinterpretations and misjudgments that religious clients may generate, after being identified, will be the subject of disputes (logical, functional, or empirical), so that they can be made vulnerable and then eliminated.

On the other hand, once the process of disputing erroneous beliefs has begun, the therapist must initiate and offer rational alternatives extracted from religious writings (Bible, Holy Fathers) or the oral religious tradition. Thus, from the very beginning, clients can be offered healthy thinking alternatives, by extracting Bible verses or statements made by credible (holy) religious authorities, that should serve as correct interpretive substitutes which can ensure a healthy and beneficial mental development for the client, from an emotional perspective [18, 31]. Here are some examples of irrational religious thinking: "Let this mind be in you, which was also in Christ Jesus" (Philippians 1,5), "The simple man has faith in every word, but the man of good sense gives thought to his footsteps"(Proverbs 14: 5), "For (man) as he thinks in his heart, so he is"(Proverbs 23: 7).

In the second part of this chapter, for an ecological illustration, we have decided to illustrate the use of the REBT conceptualization, techniques, and strategies in a practical situation. In this section, the relationship between religious beliefs and practices on the one hand, and irrational beliefs, dysfunctional emotions, and maladaptive behaviors, on the other hand, is easy to observe. Several reasons underlie our preference for this particular case:

1. *Religious beliefs and practices play a central role in the client's worldview;*

2. *The client holds very rigid personal) ideas about religious beliefs and practices, that are often formulated irrationally;*

3. *Often the client focuses on some religious tenets while ignoring others;*

4. *The client irrationally demands that people around her share her religious views;*

5. *The client's relationship with God is highly distorted, based on need, punishment, and conditional love, reflecting the relationship she has with her mother;*

6. *The client perceives God's traits and character in a distorted manner, at odds with both the Christian view and the REBT philosophy of unconditional self, other, and life acceptance;*

7. *The client has a distorted sense of responsibility, denying the role of her thinking in the genesis of her dysfunctional emotions, justifying her maladaptive behaviors, yet assuming the cause of her misery to be a deviation from religious norms.*

5.3 Case study—Working with a religious client; Specifics in assessment, case formulation, and treatment

5.3.1 Case history—focusing on the relationship between basic tenets of REBT and the client's religious beliefs

Maria is a 31-year-old woman, single, with no children. Presently, she lives with her brother and his wife to be. She has a high school education and has worked in a beauty parlor since graduation.

Maria comes from a traditional family (i.e., mother, father, and two children). She describes her mother as "perfect housewife and professional." At the same time, her mother believed that the best way to raise a child is to be critical of her/his mistakes and punish them right away. Rewards were considered to be "for the weak" and thus inappropriate for a child's education. Because she worked hard to provide everything for her children, her mother believed they should always be obedient and respectful. Even now, as an adult, Maria says her mother is never wrong, and always knows everything better than anybody else. Maria's father left when the children were young and stopped any relationship with his family. After graduating high school, Maria remained in her mother's house, who instructed her to save money to buy things for her future home. Whenever Maria wanted to go out with some friends, her mother would correct her and force her to save all her income just to buy things. Moreover, even the things she bought for her future house were picked by her mother, regardless of her preferences. As a consequence, Maria did not date or make any friends.

Maria decided to see a mental health professional about 16 months ago. By the time she came to see this therapist, she had already been treated by other mental health professionals (psychologists and psychiatrists), whom she visited successively. At the time of her admission, Maria complained about her unsatisfactory relationships ("I have nobody to love and support me," "My life is a mess," "People around me cannot stand me anymore, although all I do is for their benefit"), her developing panic attacks ("I am so scared not to have another panic attack that I do not dare go to work anymore"), and her lack of pleasure in life ("There is nothing good now. I won't be able to go to work, and that was the only place where I am appreciated").

Maria has always been a person very different from her brother, her friends, and everybody around her. She does not believe she had ever been loved by her mother, whose affection had been constantly seeking since she was a baby. She feels permanently threatened by the prospect of being abandoned by her family and dreads the idea she would one day be forced to live alone. Because she believes her present problems are due to the fact she has a cold, insensitive mother who does not love her (only her brother), she tries to make up for maternal love by searching for surrogate mothers.

In approaching this difficulty during the intervention, the basic tenets of REBT ("You prefer to be loved by your mother, but do not have to have her love") will align with Christian religious tenets ("God loves you always, so you do not need the love of others, although you prefer that.").

For quite a few years now she has been visiting a whole range of churches, believing she could find some priest or believer who could adopt her ("If I cannot be loved by my mother, I will find another one. Nothing can replace the love of a mother and I do not want to remain mutilated like this forever"). For a while, she found a woman (member of a nontraditional religious community) who agreed to "adopt her," because her own daughter lived in another country and was more independent than

she would have wanted. Maria remembers those moments as some of the best of her life. Eventually, one day the real daughter visited her mother; the woman informed Maria that she could not see her for a few days because she took a trip with her real daughter. At this point, Maria was so enraged that she entirely rejected her surrogate mother and told her she was no longer available as a daughter. Although they work together, the relationship between the two was distant ever since.

In approaching this difficulty during the intervention, the basic tenets of REBT ("You prefer to have exclusive love from somebody, but do not have to have that") will align with Christian religious tenets ("God loves you and expects all people to love each other. It is ok she also loves her biological daughter").

Following this episode, Maria joined a few Bible study groups, hoping people in these groups would love her "because they are Christians, and they should." As soon as she realized her colleagues accept her but do not grant her their time exclusively, Maria started looking for someone else. She keeps going weekly to study the Bible because she believes God will be the one to love her forever—if and only if she struggles daily to become a good Christian. Meanwhile, while watching a TV show, she got the telephone number of a woman pretending to get rid of the bad spirits, curses, and malevolent forces residing in people's houses. At this point, Maria was ready to believe her loneliness (she could never have a boyfriend) and lack of attraction was due to her aunt cursing her because she inherited some money from her grandmother. As soon as she called, the woman on the TV asked for a large sum of money for a "counter-spell" to help Maria get rid of the evil spirits. A long period of hope and despair, love and hate followed—either the woman would not be available for months, or she would be pointing to objects in Maria's house, which should be destroyed because the evil spirits resided in them. Although Maria wanted to move away from her parents' house, she could not stand to be alone, so her brother and his fiancée came to live with her. But their relationship, which has always had ups and downs because of Maria's exaggerated need for attention, severely deteriorated when she started destroying the things in the house, in an attempt to remove evil spirits (as indicated by her "spiritual mother"). Just as Maria felt both loves and hate toward her mother, she began feeling love and extreme anger toward her brother. Arguments escalated when Maria threatened to throw the brother in the street because it was her house.

Acceptance and good relationship with one's brother as recommended in Christianity will constitute a point of discussion and cognitive restructuring, focusing the argument on both disputing IB (e.g., "He must support me in everything I do") and reaffirming the Christian values of love and tolerance.

On the other hand, when he and his fiancée decided to move out, Maria was so desperate that she refused to eat, so they decided to stay. Presently, their relationship suffers because Maria believes she has to be perfect ("I must be perfect like my mother") and every criticism from her brother is perceived as a disaster ("He should not say I am fat"). Trying to cope with the situation, she engages in frequent binge-eating episodes, which do not help her lose weight, a consequence that is very detrimental to her self-image: "Nobody will like me like this".

Cognitive restructuring will focus on both the irrational nature of demanding perfection and God's perspective on imperfection as understood in Christianity (Christ died for us when we were imperfect.)—Convergence of religious tenets with REBT principles. Main religious ideas and beliefs are neglected by the client.

Moving into a new house was also a stress factor for Maria; soon after moving in (and before her brother came to live with her) she started fighting with some of her neighbors over different issues, which was sorted out by police intervention.

Although she really hates upsetting other people, Maria equally finds their lack of understanding for her unbearable.

Cognitive restructuring will focus on both the irrational nature of low frustration tolerance and the Christian religious beliefs about forgiveness and tolerance, as well as love for one's neighbors.

The only place where she feels better is her work. Here Maria is appreciated and likes interacting with the clients. The main problems occur here when the customers demand some new, unusual procedure, which Maria perceives as a threat to her image as "perfect professional." Because of this, at times she acts aggressively.

Behavioral intervention will make use of the idea of learning how to react assertively, and the religious strive for bettering yourself in God's eyes.

Recently, these episodes became more frequent and Maria started developing panic attacks related first to her workplace (then to other public places). At about the time she was supposed to go to work, Maria would feel dizzy, choke, have palpitations, lose her balance, and feel like fainting. She began to fear these symptoms and avoid going to work by calling in sick. At the same time, Maria developed feelings of sadness and depression because she believed she might lose her job, which was the only place she felt good. She started to believe the situation was not going to get better in the future, while her inability to control her feelings scared her immensely. For about 3 weeks before she began therapy, she was sad and depressed and had difficulties sleeping and concentrating.

Emotional symptoms—sadness, depression about lack of affection, fear of not being able to control her life, panic over going to work, both love and hate for her mother, surrogate mothers, and her brother, incontrollable anger, guilt.

Cognitive symptoms—believing she must have a mother's affection, believing people around her must be as considerate toward her as she is toward them, believing her recent symptoms mean she is sick and things are going to be even worse, believing she is never going to be like her mother, like her mother wants her to be, thinking she could not stand to be alone, thinking people are bad and unjust toward her (occasionally she believes her neighbors are plotting to throw her out of the building), believing people can put evil spells on her and they would do it for financial benefit, thinking that arguing with and upsetting people around is terrible, being convinced she cannot control her overeating, being convinced she is inadequate and incompetent.

Behavioral symptoms: avoidance of physical effort (when she feels sick), constantly searching for somebody to attach to, binge eating, aggressive behavior.

Physiological symptoms: feeling dizzy, choking, palpitations, loss of balance, and feeling like fainting.

Life philosophy: Maria's life view is organized around religious tenets. Religious beliefs are highly important to Maria, relating to all aspects of her life. She will only accept the authority of leaders or the influence of friends if she is convinced, they are doing God's work. Maria has very rigid ideas and beliefs about what religion represents, which she defends irrationally and demands they are shared by all around her. She will get very excited about a religious group she just learned about, spending the next few weeks or months convinced she found the perfect match for her needs and beliefs. But, as soon as somebody from that group behaves in a way she does not approve of, Maria will reject the group altogether and start looking for a new one, "a real one." Maria prefers the company of people belonging to religious groups that conform to certain rules of behavior and human interaction.

Maria's relationship with God is highly similar to the relationship she has with her mother. She craves love and acceptance she is deeply convinced she cannot obtain

because she is not perfect. She perceives both God and her mother as demanding and punishing and the idea of unconditional love is very hard to understand and accept. As a consequence, all her efforts are devoted to behaving perfectly so can be accepted at last. When her efforts inevitably fail, she becomes angry first at herself, then at her mother and God, followed by a lot of guilt and remorse. In Maria's case, a lot of negative dysfunctional emotions are a direct consequence of perceived disobedience and behaviors that go against her religious beliefs, evaluated irrationally.

Since religion and religious behaviors play such a major role in Maria's life, many of her problems (both emotional and practical) revolve around her religious involvement. Her major life decisions are directly affected by her religious beliefs and the spiritual mentors she reveres at the time (although they change quite often). As such, challenging irrational beliefs, negative automatic thoughts, and maladaptive schemas might mean touching on some religious content Maria is sensitive about (e.g., God's unconditional acceptance vs. His acceptance/punishment predicated on one's behavior/decisions).

Maria exhibits mainly extrinsic religiousness; often using religion in an instrumental way to achieve company, assistance, approval, and status. She experiences joy, purpose, and well-being when her religious group admires her, approves of her behaviors, and takes her advice. For Maria, group approval is also the indicator that God himself approves of her. Quite often, Maria's religiousness conflicts with her goals, relationships, well-being, and social and professional life. Following an idea, she likes or the suggestion of a spiritual leader, Maria would engage in behaviors that irritate her friends, family, and coworkers, which fuel conflicts and distress. These situations occur mostly because of Maria's proclivity for understanding all concepts in black and white, interpreting all gray areas as sinful.

The evaluation revealed a few potential problems with Maria's religiousness:

- Using religion and religious behavior as a means to approach and solve everyday problems and initiate relationships with other people;

- Using religion to explain lack of ability, poor decisions, and maladaptive behaviors by refusing responsibility and blaming mysterious spiritual forces;

- Changing religious groups frequently when people do not respond to her needs according to her expectations and explaining her decisions based on doctrine and belief;

- Obsessing over sin, mistakes, and being rejected by God because of imperfection while holding rigidly to poorly understood concepts.

In conclusion, Maria's religious beliefs are usually formulated in very rigid terms, in an absolutistic and irrational manner. Moreover, she is focused on a small number of beliefs that contradict other major tenets of Christianity. (*For a theoretical discussion, see this chapter "Concrete practical ways to integrate REBT with religious beliefs and practices").*

As a consequence, conflict with other people (including her religious community) occurs frequently, which has a negative impact on her morale and well-being.

Since religion is at the core of Maria's worldview, the conceptualization of her problems and the explanations offered to her will have to take into consideration her sensibilities regarding the subject. Also, the therapeutic objectives will be aimed at improving her ability to live a satisfactory practical and spiritual life.

The major stresses in Maria's life are mostly the lack of friends, social interaction, and isolation. The interactions with her family (i.e., her brother, his fiancé, religious community) are tense and unsatisfactory. Also, her exaggerated need for attention and constant reinforcement makes relating to others much more difficult. A few months ago, Maria was treated for anxiety symptoms with Xanax in an outpatient setting. Maria does not have any medical problems that could influence her psychological functioning or treatment process. Following psychological evaluation, she was diagnosed with panic disorder with agoraphobia, depressive symptoms that do not meet the criteria for an affective disorder, borderline personality disorder as well as some traits of avoidant personality disorder and obsessive-compulsive personality disorder.

5.3.2 Case formulation—integrating the psychological conceptualization and the client's religious beliefs

Stress situations (like moving to a new house, having to face a demanding client, or being confronted by her brother on an important issue, etc.) are those in which the feelings of inadequacy and incompetence develop. Poor anger management abilities and the ensuing prospect of losing the job she liked precipitated the panic attacks. Overwhelmed, Maria began feeling depressed and desperate.

Central beliefs: "I am inadequate," "I cannot be loved," "I am incompetent," and "I cannot stay in control."

Early maladaptive schemas: Emotional deprivation, abandonment, mistrust/abuse, defectiveness/shame, failure, social isolation/alienation, enmeshment/undeveloped self, dependence/incompetence, unrelenting standards/hypercriticalness, insufficient self-control/self/discipline, approval seeking/recognition seeking, punitiveness.

Automatic thoughts: "I will never be as perfect as my mother," "I will never be how my mother wants me to be," "My mother will never love me," "My symptoms mean I am sick and is only going to be worse, and this is awful," "People are bad and unjust", "People can and will put curses on you for financial benefits," "I cannot refrain from eating too much," "Men will not like me this fat," "No matter how much I try I cannot change anything and it is only going to get worse," "Bad spirits came to my house because I am a bad Christian."

Irrational beliefs: Demandingness—"I must have my mother's affection," "People around me must be as considerate toward me as I am toward them," "I must find somebody to love me," "I must have control over myself at all times," "People should be fair," "I must have somebody to love me and help me," "I must be perfect," "I must not sin," "I must be a good Christian."

Low frustration tolerance—"I cannot stand when people criticize me," "I cannot stand to be alone," "I cannot stand when people are angry with me," "I cannot stand the thought that God is angry with me."

Awfulizing—"If I am not perfect, I will not be loved and that is awful," "It is awful to upset people around you," "It is awful to upset God," "It is awful to sin."

Self-downing—"I am an incompetent, ugly and unlovable person," "I am a sinner," "I am not a good Christian."

Other-downing—"People are mean and unjust." "People are not good Christians."

Core religious assumptions:

- believing she must be virtuous to deserve God's love and help;

- believing in good and bad spiritual entities that can interfere with people's lives (physically and spiritually);

- believing people belonging to the religious group she is part of having a moral obligation to help her, accept her, love her and grant her their time and attention;

- being convinced she is entitled to a priest's/pastor's/spiritual leader's love and unconditional support (much like the relationship between parent-child);

- associating sin with immediate punishment and rejection by God.

The typical situations when Maria's beliefs are activated include challenging moments when she is facing activities she has never done before and negative evaluations from the others are possible (like moving to a new house or using new procedures at work). Also, her low frustration tolerance is most evident when people do not grant her the attention and the support, she demands from them. Another difficult situation for Maria is when, after losing her temper, she notices people are upset with her and less willing to interact with her when she experiences guilt and remorse. The possibility of losing her job because of aggressive behavior toward the clients is the main event that precipitated the development of panic attacks. Maria's depression and sadness are mainly connected to her lack of ability to cope with the requirements of healthy human interaction.

While growing up, Maria learned she could always be abandoned by those she loved. Her father left the house when she was very young and made no attempts to restore any relationship with his children. Her mother was herself pretty unstable emotionally and refused to open up to her children, maybe for fear of getting herself hurt. Also, she held the belief a good education is incompatible with expressing affection and was exaggeratedly critical of any mistake her daughter made. Because her brother had better performances in school, he was always the mother's favorite, who repeatedly pointed out how reliable he was as compared to Maria. Also, her grandmother believed the same and acted the same. As a consequence, Maria grew to believe that "They all abandon me because I am not lovable" (acceptance beliefs) and "I am inadequate" (adequacy beliefs). On the other hand, her mother constantly supported the idea of justice over forgiveness. Thus, Maria holds now very strongly the idea that "everybody should treat me fairly and respectfully, because I do the same for them" and "My brother and my mother should help me as I help them" (justice beliefs). At the same time, she hates dependency and believes that "being sick equals being weak and offending others" and that she "should always be in control" (responsibility and control beliefs).

Maria discovered religion on her own, as an adult, being both attracted to and intrigued by the idea of an almighty God that loves and accepts imperfect human beings and was willing to sacrifice his only son for them. While she is very enthusiastic about the idea of unconditional love, Maria is also unable to fully understand and apply this idea to life and human interaction.

As a method of diagnosis, we used interview, observation, and self-monitoring. So far we avoided administering tests or other questionnaires, which she associates with a "formal diagnosis" and therefore something to be ashamed of. Maria is aware of her social difficulties and motivated to change something in her life.

A comprehensive conceptualization—integrating cognitive distortions, selective religious beliefs, and poorly defined religious values to explain emotional and behavioral consequences.

Maria's core beliefs about acceptance and adequacy, justice, control, and responsibility, created in her insecure relationship with her mother and grandmother, are activated mostly in unstructured situations. The various unrealistic demands she has of herself and other people are often unmet and contribute to her poor self-image as inadequate and unlovable. The major lack of social and communication skills (due to prolonged social isolation) contributes negatively to her attempt to integrate socially as an adult. Her low frustration tolerance of the other persons' unjust behavior triggers aggressiveness, which she later regrets; as a consequence, her negative self-image is being reinforced. Panic attacks are mainly related to her catastrophic evaluation of physiological symptoms in terms of weakness and inadequacy. Her lack of ability in properly handling difficult interpersonal interactions leads also to feelings of depression and sadness. In an attempt to cope and adjust, Maria turns to religion, conceptualized mostly as a parallel world where her worldview, expectations, and behaviors are supposed to work. Although she understands relatively well the tenets of Christianity, she arbitrarily selects and rigidly interprets those ideas and guidelines that serve her needs and alleviate her emotional pain. She uses religion in such a utilitarian manner without acknowledging or understanding the underlying problems.

5.3.3 Treatment—integrating the psychological intervention and the client's religious life

Understanding that Maria's worldview is organized around religious beliefs and practices, a main overarching objective of the psychotherapeutic intervention is to determine how her manner of belief impacts her social, relational, and occupational functioning. The truth of Christian ideas and tenets is acknowledged, while the therapist's efforts are directed at pointing out contradictions in Maria's thoughts, attitudes, and beliefs. The main concern is helping Maria articulate a comprehensive and coherent life philosophy that is equally true to Christian values and rational, realistic, and helpful.

The mutually agreed-upon list of problems including—(1) deficient social and communication skills, (2) deficient emotional regulation skills, (3) feelings of depression and guilt, (4) panic attacks and agoraphobic avoidance (mostly related to work), (5) binge eating, (6) socially unacceptable behavior/aggressive behavior (e.g., Throwing her and her brother's things away because they were inhabited by evil spirits), and (7) deficient conflict management skills.

Among the most important treatment goals were—(1) building social and communication skills, (2) building emotion regulation skills, (3) reducing dysfunctional negative emotions (e.g., depression, guilt), (4) reducing panic attacks and agoraphobic avoidance, (5) eliminating binge eating and restructuring the eating behavior, (6) reducing socially unacceptable behavior and developing adaptive behaviors, and (7) building conflict management skills.

In planning Maria's treatment, we have selected treatment packages suitable for her complaints and adjusted the techniques and strategies included to make use of her religious beliefs and practices.

- For panic attacks, we used a treatment package containing: cognitive restructuring techniques (Socratic dialog—pragmatic and empirical disputations) to reduce catastrophic interpretation and evaluation of her physiological symptoms, and a distraction technique to help her manage her distress when in the triggering situation (mostly before going to work). A significant beneficial effect was obtained after the cognitive restructuring of her beliefs that: "Having physical symptoms

meant I am weak", and "I must be perfect, otherwise I cannot stand it". Systematic desensitization was also used to eliminate her agoraphobic avoidance.

- For improving her deficient social and communication skills, we used assertiveness training and social skill training.

- Her binge eating reduced considerably after starting to restructure the LFT (low frustration tolerance). No extra techniques were necessary; some overeating is still present in response to stressful situations. More effort is put into planning her eating habits.

- REBT (cognitive restructuring, rational-emotive imagery, role-play, modeling, and behavioral experiments) was also used to restructure irrational beliefs and other distorted cognitions underlying panic, depression, and guilt and to help her learn unconditional self-acceptance. Also, a broader understanding of emotion regulation strategies was promoted based on the ABC model.

- Behavioral analysis was used to develop an understanding of the causes of maladaptive behaviors and role-play and behavioral experiments help organize adaptive behaviors and build conflict management skills.

The therapeutic relationship was generally good with a few exceptions. First, Maria tried to manipulate the therapist into changing the agenda too often, by presenting different "emergencies" that had to be dealt with. Since this frequently happened at homework checkup time, the therapist decided to address Maria's need for control and decision over the content, duration, and purpose of each task. After some guidelines were established that provided Maria with control over homework, the situation improved.

Several techniques and strategies were used to help achieve the therapeutic objectives.

- Cognitive restructuring—challenging and restructuring maladaptive beliefs—core beliefs, automatic thoughts, and irrational beliefs using Bible verses. For instance, to dispute God's conditional love and acceptance, Maria was asked to meditate on and explain verses like Romans 5:8 "But God commendeth his love toward us, in that, while we were yet sinners, Christ died for us"—pointing out the difference between a sinful behavior and a sinful, unworthy person. Also, when approaching core beliefs like abandonment and emotional deprivation, some verses can help partly cover the unmet childhood need: Romans 8:38–39 "For I am persuaded, that neither death, nor life, nor angels, nor principalities, nor powers, nor things present, nor things to come/Nor height, nor depth, nor any other creature, shall be able to separate us from the love of God, which is in Christ Jesus our Lord (Holy Bible, KJV).

- Behavioral experiments—shame–attacking exercises, in which Maria chose to engage publicly in shameful behavior, were used to (1) expose her to criticism and (2) build tolerance for social rejection. Further discussion about the human value beyond social recognition also revolved around Bible verses. Fasting, as a religious behavior, was used as a means to consolidate frustration tolerance, experience and understand the distress and help control binge eating as a form of coping.

- Prayer and meditation on God's word were employed (1) to help articulate Maria's religious worldview, (2) as a vehicle for remembering and rehearsing useful ways of thinking and behaving, and (3) rehearse and consolidate rational beliefs.

- Rational-emotive imagery was used for changing emotions and coping with distress. Vivid images, including walking and talking with Jesus helped restructure cognitions and rehearse adaptive behaviors. Major distortions in Maria's fantasies were used to identify irrational beliefs (e.g., Jesus would tell me to go away because I am weak"). This technique also helped create detailed scenarios of rational thoughts and adaptive behaviors that Maria was able to rehearse. Some of the early maladaptive schemas were approached by having Maria imagine Jesus responding to her mother's actions when Maria was a baby.

- Modeling and skill training helped in acquiring and using new social and communication skills and managing conflict. Maria observed people she appreciated (e.g., spiritual leaders) handle social interactions and conflict and took notes about their responses. Later on, she took on the role of a teacher for younger people in her prayer group, to demonstrate proper social skills (like Jesus did for us).

All techniques and strategies used were introduced taking into consideration Maria's need to be successful and her difficulties in managing failure. They were initially discussed and demonstrated and rehearsed with the therapist until Maria was confident, she can be successful on her own.

The main obstacle was Maria's resistance to structured homework and a structured approach to therapy. She always preferred to have some control over the strategy used and work in therapy (while supervised and helped by her therapist) and kept coming up with reasons to justify why she could not do the homework. Fragmenting tasks, reducing their difficulty and extent, and reinforcing even the slightest success, combined with carefully selected choices offered to her to validate her need for control helped, but this was an ongoing problem.

The intervention was extended over 40 sessions, once a week for 50 minutes. The main results concern the complete remission of panic attacks and avoidance. Maria is now able to go to work and has not had a panic attack for more than 6 months. Also, she has experienced less and less depression and there is an important reduction in binge eating (although she still overeats). After Maria stopped throwing things away her relationship with her brothers improved significantly, helped by the newly acquired communication skills.

Her religious worldview is more articulated than before and she is able to recognize the instances when her immediate needs take precedence over her relationship with God and over broader religious principles.

On the other hand, she still has quite severe feelings of sadness and depression, low unconditional self-acceptance, and has not succeeded in making new social relations.

In conclusion, in Maria's case, it was vital that the psychological intervention integrated the REBT intervention strategies with her Christian beliefs and practices since Maria's worldview was built around her religious life. This was an organic development given that the REBT's central assumptions and the philosophy behind the client's religious system were already highly compatible. Moreover, it was obvious from the beginning that a lot of religious components were overlooked by our client and many of them were badly distorted and misrepresented. Under these circumstances, it was relatively easy to correct them while

restructuring irrational beliefs. Also, Maria was very responsive to discussing and analyzing religious material; this enabled us to formulate rational alternatives extracted from religious writings, as well as from the oral religious tradition. Maria's case aptly illustrated the many ways in which REBT can incorporate religious beliefs and practices, thus advocating for the harmonious relationship between Christian values and REBT.

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References

[1] Dobson KS, Dozois DJA. Historical and philosophical bases of the cognitive behavioral therapies. In: Dobson KS, editor. Handbook of Cognitive Behavioral Therapies. 3rd ed. New York, NY: Guilford Press; 2010. pp. 3-38

[2] Wenzel A. Innovations in Cognitive Behavioral Therapy. Strategic Interventions for Creative Practice. New York: Routledge/Taylor & Francis Group; 2017

[3] Beck AT, Dozois DJA. Cognitive theory and therapy: Past, present, and future. In: Bloch S, Green SA, Holmes J, editors. Psychiatry: Past, Present, and Prospect. Oxford, UK: Oxford University Press; 2014. pp. 366-382

[4] Dobson KS, Backs-Dermott BJ, Dozois D. Cognitive and cognitive behavioral therapies. In: Snyder CR, Ingram RE, editors. Handbook of Psychological Change: Psychotherapy Processes and Practices for the 21st Century. New York: Wiley; 2000. pp. 409-428

[5] Dozois DJA, Beck AT. Cognitive schemas, beliefs and assumptions. In: Dobson KS, Dozois DJA, editors. Risk Factors in Depression. Oxford, UK: Elsevier/Academic Press; 2008. pp. 121-143

[6] Mahoney MJ. Cognition and Behavior Modification. Cambridge, MA: Ballinger; 1974

[7] Nisbett RE, Wilson TD. Telling more than we can know: Verbal reports on, 1977

[8] Eysenck HJ. Behaviour Therapy and the Neuroses. Oxford, UK: Pergamon Press; 1960

[9] Rachman S. The evolution of cognitive behaviour therapy. In: Clark DM, Fairburn CG, editors. Science and Practice of Cognitive Behaviour Therapy. New York, NY: Oxford University Press; 1997. pp. 3-26

[10] Dobson KS, Dozois DJA. Historical and philosophical bases of the cognitive behavioral therapies. In: Dobson KS, editor. Handbook of Cognitive Behavioral Therapies. 3rd ed. New York, NY: Guilford Press; 2010. pp. 3-38

[11] Rachman S. The evolution of behaviour therapy and cognitive behaviour therapy. Behaviour Research and Therapy. 2015;**64**:1-8

[12] Dryden W. The "ABCs" of REBT I: A preliminary study of errors and confusions in counselling and psychotherapy textbooks. Journal of Rational-Emotive Cognitive Behavior Therapy. 2012;**30**:133-172

[13] Ellis A. The basic clinical theory of rational-emotive therapy. In: Ellis A, Whiteley MM, editors. Theoretical and Empirical Foundations of Rational-emotive Therapy. Monterey, CA: Brooks/Cole; 1979. pp. 33-60

[14] Martin JT. Rational Emotive Behavior Therapy (REBT), Irrational and Rational Beliefs, and the Mental Health of Athletes, Published online, 2016. doi: 10.3389/fpsyg.2016.01423

[15] Kendall PC, Bemis KM. Thought and action in psychotherapy: The cognitive behavioral approaches. In: Mersen M, Kazdin AE, Bellack AS, editors. The Clinical Psychology Handbook. New York, NY: Pergamon Press; 1983. pp. 565-592

[16] Johnson WB. Outcome research and religious mental processes. Psychological Review. 1993;**84**:231-259

[17] Lazarus AA, Ellis A. Can rational emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in god and religion. In: Carlson J, Knaus W, editors. 2014. pp. 269-279

[18] Nielsen SL. Rational-emotive behavior therapy and religion: Don't throw the therapeutic baby out with the holy water! Journal of Psychology and Christianity. 1994;**13**:312-322

[19] Nielsen SL, Ridley CR, Johnson WB. Religiously sensitive rational emotive behavior therapy: Theory, techniques, and brief excerpts from a case. Professional Psychology: Research and Practice. 2000;**31**(1):21-28

[20] Schiffman M. Incorporating Jewish texts with REBT in the treatment of clinical anger. Journal of Rational-Emotive & Cognitive-Behavior Therapy. 2016;**34**:225-239

[21] Johnson WB. Rational-emotive therapy and religiousness: A review. Journal of Rational-Emotive and Cognitive Behavior Therapy, **10**,21-35;1992

[22] Lawrence C. Rational-emotive therapy and the religious client. Journal of Rational-Emotive Therapy. 1987;**5**:13-21

[23] Warnock SDM. Rational-emotive therapy and the Christianclient. Journal of Rational-Emotive and Cognitive-Behavior Therapy. 1989;**7**:263-274

[24] Ellis A. The basic clinical theory of rational-emotive therapy. In: Ellis A, Whiteley MM, editors. Theoretical and Empirical Foundations of Rational-emotive Therapy. Monterey, CA: Brooks/Cole; 1979. pp. 33-60

[25] Walen SR, DiGiuseppe R, Dryden W. A Practitioner's Guide to Rational-emotive Therapy. Second edition. New York: Oxford University Press; 1992

[26] Graham, W. A. (1987). Scripture. In M. Eliade (Ed.), The Encyclopedia of Religion (Vol. 13, pp. 133-145). New York: MacMillan

[27] Ellingson T. Music and religion. In: Eliade M, editor. The Encyclopedia of Religion. Vol. 10. New York: Macmillan; 1987. pp. 163-172

[28] Ellis A. Better, Deeper, and More Enduring Brief Therapy: The Rational Emotive Behavior Therapy Approach. New York: Brunner/Ma-zel; 1996

[29] DiGiuseppe RA, Robin MW, Dryden W. On the compatibility of rational-emotive therapy and Judeo-Christian philosophy: A focus on clinical strategies. Journal of Cognitive Psychotherapy: An International Quarterly. 1990;**4**:355-368

[30] Turner MJ. Rational Emotive Behavior Therapy (REBT), Irrational and Rational Beliefs, and the Mental Health of Athletes. Frontiers in Psychology. 2016;**7**:1423. DOI: 10.3389/fpsyg.2016.01423

[31] Johnson WB. Christian rational-emotive therapy: A treatment protocol. Journal of Psychology and Christianity. 1993;**12**:254-261

Chapter 5

Mindfulness-Based Stress Reduction as a Culturally Relevant Treatment for Racial or Ethnic Minorities

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Abstract

Racial or ethnic minorities (REM) are at a particularly high risk of experiencing mental health conditions. Unlike their White counterparts, social determinants of health (e.g., poverty, racialized violence, or discrimination) exacerbate REM quality of life. REM are less likely than non-Hispanic Whites to seek and receive mental health treatment. Additionally, REM are more likely to experience systemic barriers (e.g., cultural mistrust, stigma, lack of access, and financial barriers), which further complicates their willingness and capacity to seek treatment. While Evidence-Based Treatments (EBTs) are identified as empirically supportive treatments for a range of mental health conditions, there is skepticism about their cultural appropriateness and relevance for REM populations. Clinicians must be culturally competent and use clinical tools (e.g., Multidimensional Model for Developing Cultural Competence) to assist in promoting cultural competence. Likewise, practitioners must be conscientious and knowledgeable about the pitfalls of EBTs when working with REM. Mindfulness-based techniques, such as MBSR, are culturally sensitive and inclusive of historical, social, and cultural ideologies that align with the needs of REM. MBSR has the potential to offer holistic coping given its effectiveness in promoting neurological, physical, and psychological healing.

Keywords: racial or ethnic minorities, mental health, mindfulness-based stress reduction, social determinants of health, systemic barriers to treatment engagement

1. Introduction

Racial or ethnic minorities (REM) in the United States (US) are particularly vulnerable to experiencing mental illness. The US Census Bureau describes the term "race" as people who identify as "White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, or Other Race" and ethnicity as "Hispanic or Latino or "Not Hispanic or Latino." [1]. While REM

report the lowest lifetime risk of mental illness and fewer psychological concerns as compared to non-Hispanic Whites, they are more likely to experience persistent illness [2]. For example, experiences of depression among Blacks and Hispanics are reported as lower than Whites, yet Blacks and Hispanics indicate more persistent symptomatology. In a 2020 screening for most prevalent mental health concerns of Americans (n = 2.6 million), the data reflect notable changes for all people, but particularly, Asian or Pacific Islanders, Black or African Americans, and Native Americans have the highest change in searching for resources and increases in mental health conditions (e.g., depression, anxiety, and suicidal ideation) [3, 4].

Social determinants of health (e.g., health disparities, racial discrimination, racialized violence) exacerbate REM's experiences of mental illness as well as their access to treatment and services [2, 3, 5, 7]. REM are also least likely to access culturally competent care and when they do seek the treatment they are improperly assessed, misdiagnosed, and receive poor care [6–8]. And thus, when REM seek treatment it is essential that counselors are culturally competent and use culturally appropriate interventions. Practitioners are trained and encouraged to utilize evidence-based treatments (EBTs), demonstrated in eliciting therapeutic change in providing care and treatment to their clients [9]. The cultural relevance of EBTs is debated and prescriptive clinical practice is criticized; some practitioners argue for more inclusive and culturally sensitive use of EBTs [10, 11]. Like most EBTs, the efficacy of mindfulness-based interventions has been investigated primarily on White people. Mindfulness-Based Stress Reduction (MBSR) is an evidence-based intervention shown to reduce stress for a few REM groups [12, 13]. A culturally adapted MBSR program has the potential to treat REM suffering from mental health conditions and improve quality of life.

2. Prevalence of mental illness among REM

REM are particularly vulnerable to experiencing mental health conditions. In the year 2020, about 331.4 million people live in the US and the racial or ethnic statistics show a composition where 61.6% identify as White, 18.7% as Hispanic or Latino/a, 12.4% as Black or African American, 10.2% as two or more races, 6% as Asian, 1.1% as American Indian/Alaska Native, and 0.2% as Native Hawaiian/Other Pacific Islander [1]. Though there are more people who identify as White than all REM groups combined, research suggests that REM are at a significantly higher risk of experiencing mental health conditions in part due to the impact of social determinants of health [8, 14].

2.1 Hispanics or Latino/as

The Hispanic or Latino population differs in ethnicity and culture, which makes this population unique. Skin tones vary considerably, and it is not uncommon for non-Hispanic or -Latino/a people to confuse someone of Hispanic descent, as being White American or African American. Because of the significant differences, it is important to understand that while all Hispanics may encounter mental health disparities some groups of Hispanics are affected at even greater rates than others. Overall little difference in the prevalence of mental health disorders exists between Hispanic or Latinos/as and non-Hispanic Whites. One major issue Hispanic children grapple with is suicidality. Hispanic youth are more likely to consider, plan, and attempt suicide than

both Black and White youth [15]. However, when comparing Hispanics born in the US with Hispanics who identify as foreign-born, the data shows that US-born Hispanics experience mental health disorders more frequently [16]. As seen many times in the marginalized populations, Hispanics are not likely to seek therapy due to lack of access, resources, stigma, and discrimination and if they do seek therapy, it is often when their condition is at its worst [17, 18]. Instead of seeking treatment, Hispanics are more likely to adopt unhealthy coping behaviors (e.g., excessive alcohol consumption, poor eating habits, smoking, and illicit drugs), which affect the body negatively and can lead to serious and life-threatening medical conditions [18, 19].

2.2 Black or African Americans

Black or African Americans suffer from mental health conditions at about the same rate as Whites. However, they consistently are misdiagnosed and underexamined due to culturally incompetent practitioners, and thus left untreated [20]. In fact, Black or African Americans are less likely than White Americans to seek counseling or treatment and more likely to struggle including persistent emotional distress with feelings that life requires too much effort, worthlessness, hopelessness, and despair [21]. Furthermore, the report of somatic or physical complaints is common for Black people, as is, often failing to recognize that the underlying cause of their complaints is likely connected to an untreated or undiagnosed mental illness. Like Hispanics, Black or African Americans are not likely to seek treatment and when they do, the condition is severe or in crisis and may require intensive treatment (e.g., hospitalization) [6]. Only one in three Black or African Americans who need mental health treatment will obtain it. Undoubtedly, apprehension to seeking treatments likely influences the prevalence of depression that exists among Black or African Americans. For some, depression is accompanied by suicidal thoughts. As of 2019, the 2nd leading cause of death among Black or African Americans between ages 15 and 24 is suicide. Poverty is a social determinant that exacerbates the prevalence of mental illness and impacts access to treatment. For Black Americans, living below poverty increases the risk of experiencing serious psychological distress at three times a higher rate than when not living in poverty. Lastly, because Black or African Americans are relentless targets of violent crimes, discrimination, and racialized violence, the likelihood of developing a traumatic stress disorder is higher than the general population [21].

2.3 Asians or Asian Americans

Asians are a diverse group that includes many distinct cultures, nationalities, diverse countries of origin, and mental health challenges. Asian Americans and Pacific Islanders comprise about 6.1% of the US population and of that nearly 15% reported experiencing a mental illness in the last year [22]. According to the American Psychological Association, Asian Americans are less prone than White Americans to seek help for any mental health or emotional concerns they experience [23]. Attempting and completing suicide is a prevalent issue within the Asian community and is identified as the 10th leading cause of death for Asian Americans. Women between the ages of 15 and 24 as well as 65 and older have the highest suicides rates across all racial and ethnic groups [24]. Asian Americans reported the increased vulnerability to mental health conditions are due to a range of factors including parental pressure to excel academically, discrimination, cultural attitudes as it relates to mental health care, difficulty with balancing cultures, and difficulty developing

their sense of self while navigating multiple cultures [25]. Social determinants of health that exacerbate mental health conditions include discrimination, prejudice, racialized violence, problems related to immigration, cultural trauma, and model minority myth/stereotypes [22, 26]. Systemic barriers that serve as obstacles to treatment include misdiagnoses or under-diagnosing due to culturally incompetent practitioners, lack of multilingual services in healthcare, poor access to health insurance, and treatment costs [22, 26]. Because talking about mental health concerns are usually considered taboo, it is more likely for Asian American to seek support within their personal network.

2.4 American Indians or Alaskan Natives

Though American Indians and Alaskan Natives only make up 1.3% of the US population, over 19% indicated experiencing a mental health condition in the last year [27]. In fact, they report experiences of psychological distress at a rate of 1.5 times higher than all other racial groups. Historically, American Indians survived systemic trauma, such as forced relocation and family separation, death by way of war, and sickness and death due to exposure to infectious diseases, which likely impacts their mental health as well [28]. American Indians and Alaskan Natives have a substantially higher rate than the other racial or ethnic groups of experiencing post-traumatic stress disorder, suicide, substance use disorder, and attachment disorders [29]. Children and adolescents have the highest rates of suicidality as those between ages 15-19 have double the death rate than non-Hispanic Whites [27]. Furthermore, American Indians and Alaskan Natives use and abuse substances at younger ages and at higher rates than all other racial groups [7]. Major depression episodes and self-reported depression are three times higher than the US population. Additionally, American Indians and Alaskan Natives are still dealing with the consequences of past trauma and current detrimental policies as well as other social determinants, such as high poverty (e.g., 26.6% live in poverty), and other irreversible setbacks [27]. American Indians and Alaskan Natives are also twice as likely to experience unemployment their White counterparts. The cultural mistrust that exists is understandable yet has a negative effect on seeking mental health treatment, which in turn significantly increases the risk of mental illness. Systemic barriers that affect help-seeking include poverty rate, lack of access due to distance and language barriers, and lack of health insurances coverage [29].

2.5 Native Hawaiians and Pacific Islanders

Native Hawaiians and Pacific Islanders are yet another marginalized group that experienced historical trauma and are still coping as well as healing from the effects of the trauma today. The extent of the mental health disparity for this marginalized group is understudied, and thus, the prevalence of mental illness is a work in progress [26]. What is known is 10.1 % of Native Hawaiians and Pacific Islanders reported experiencing psychological distress as compared to 12.7% of non-Hispanic Whites. The leading cause of death between the ages of 15–24 among Native Hawaiians and Pacific Islanders was suicide in 2019 [30, 31]. Social determinants that exacerbate mental illness include multigenerational trauma, discrimination, poverty, housing inequities, and disparities in education and social capital [30, 31]. Like the other racial groups, there are several systemic barriers that exist to serve as an obstacle in receiving mental health treatment. One of the main barriers include the lack of access

to care and health insurance [30]. In fact, Native Hawaiians and Pacific Islanders are three times less likely than non-Hispanic Whites to receive mental health services as well as prescriptions that treat psychological disorders. Although Native Hawaiian and Pacific Islanders do not report serious psychological distress at higher rates than Whites, male Native Hawaiian/Pacific Islanders between the ages of 25–44 report higher rates of death by suicide than White Americans [30].

2.6 Multiracial or mixed race

Multiracial/Mixed Race populations are unique because they are most likely to struggle with identity development and feelings of ostracization, which directly affects their mental health [32, 33]. Adolescents who identify as multiracial or mixed are at a higher risk of suicide, substance use, and depression as compared to adolescents who identify with being in a single race or ethnic category [33, 34]. Additionally, mixed-race adolescents are at a higher risk than White adolescents of having overall poor mental health and to have significantly fewer protective factors [34]. The main social determinants that multiracial or mixed-raced people experience that exacerbates mental health include familial discrimination, racial discrimination, and racial identity invalidation [35].

3. Effects of treatment engagement

Risk factors known to contribute to the prevalence and vulnerability of mental illness within REM communities are vast, and entail coping with significant life events, while simultaneously managing systemic barriers that are unique to their race. Examples of life events experienced by the majority include bereavement, a lack of access due to finances or distance, and poverty, while examples of unique systemic barriers include having minimal or inaccurate knowledge about mental health care, cultural mistrust, cultural attitudes towards mental health care, stigma, and lack of proper assessment and care due to multicultural incompetence, and social determinants (e.g., racial or ethnic discrimination, implicit bias, racialized violence, etc.) [14, 23, 36]. Common cultural barriers are discussed in the next section. As there is diversity among REM, there is also diversity in the risk factors that make these groups vulnerable to mental illness.

3.1 Cultural mistrust

There are a variety of systemic barriers that REM minorities experience when seeking mental health treatment. A few common barriers are cultural mistrust, stigma, lack of access or knowledge of treatment, and financial difficulties [5, 37]. Cultural mistrust, also known as healthy cultural paranoia, refers to an inclination of distrust or skepticism that people of color have about White people when interacting within multiple contexts, such as education, healthcare, business, criminal justice system, etc [38]. The cultural mistrust that exists in communities of color stems from a history of racism, violence, and other social oppressions, which continue to inform US systems (e.g., medicine, education), industries (e.g., healthcare), and policies [38]. Even within the history of medical research, oppression was prevalent, such as the inhumane treatment conducted on REM minorities for the sake of medical advances. The US has a long history of marginalizing Black and Brown people for

experimentation. In the 1840s, Dr. Marion Sims, "the father of gynecology" performed several surgeries on female slaves without anesthesia to better understand the female reproductive system [39].

Several historical studies revealed how the science and medical communities dissected and mutilated Black Americans and other ethnic minorities for decades under the guise of medical treatment and development. The Tuskegee Syphilis Experiment withheld antibiotics and without consent, which allowed the disease to run its course on groups of Black men serving as participants. During the 1970s, the University of Southern California-Los Angeles Medical Center sterilized Puerto Rican women by misinforming and forcing them into participation [39]. As a mechanism of scientific experimentation, REM developed a healthy skepticism about the true motive of White people in Western medicine and the intent of science, which continues to exist today [39]. As a result, REM attitudes toward seeking treatment for physical or mental health problems are informed by distrust, which in turn makes them reluctant to obtain help. As well, as racism and oppression continue to be embedded in US medical science, providers without cultural competence, humility, and sensitivity further marginalize REM through the improper assessment and treatment of REM. "Over 30% of Black people, 20% of Latinx people, and 23% of Indigenous people report avoiding medical care because of experiences of personal discrimination due to their race or ethnicity in health care settings" [40]. The fears of seeking help due to cultural insensitivity are transmitted across generations. Thus, cultural mistrust serves as a direct systemic barrier for REM's decision-making about seeking treatment, which exacerbates mental illness in these communities.

3.2 Stigma

When exploring the multidimensional nature of mental health stigma within communities of color, it is essential to exercise sensitivity and to understand that communicating intimate, familial issues to a stranger can feel like one is crossing cultural boundaries. Mental health stigma refers to derogatory or demeaning attitudes one has about mental illness; it is described as a) personal stigma, b) self-stigma (e.g., internalized attitudes), or c) institutional stigma (e.g., reflected in systemic or mainstream society) [41]. Cognitive processes, stereotypes, affective processes, prejudices, and behavioral processes, or discrimination inform one's experience of stigma as the "stigmatizer" or the "stigmatized" [42]. There are differences in how mental health stigma affects REM and their mental health [42]. Among some Asian Americans, stigma may include upholding the "save face" mentality by not seeking psychological treatment to protect their family's reputation [43]. Stigma may derive from individuals in their own community given the constant flow of misinformation about mental illnesses [41]. In some REM communities, people who choose to seek help may become the object of ridicule in their communities, which can lead to even more reluctance or apprehension to seek treatment [42]. To avoid shame and denial, some Black or African Americans may abuse substances as a means to cope with mental illness instead of seeking help [44]. In order to address the stigma that exists in these communities, there must be increased awareness and easier access to education about mental illness and mental healthcare.

3.3 Lack of access

There is a complex relationship between the utilization of mental health treatment and poverty-stricken neighborhoods [21, 27]. The adverse social conditions in certain

geographic locations contribute to the vulnerability or manifestation of some psychological disorders [45]. As REM are more likely to reside in impoverished neighborhoods, they are more likely to lack accessibility to the education or resources needed to access psychological treatment [45]. Many Native Americans, for example, live in rural or isolated areas that do not offer the needed services, and transportation can be a deterrent to seeking treatment if one does not have a car or needs to spend a long time traveling to receive services [43]. Black or African Americans living in rural areas may believe there are better resources available in larger, more urban cities and may think the resources provided in their rural communities are either of poor quality or nonexistent [46].

3.4 Financial barriers

Financial barriers play a considerable role in people's reluctance to seek therapy. Some individuals are fearful they cannot afford mental health treatment and may never get help. While some REM lack the health insurance coverage necessary to see mental health professionals, others may have health insurance but may reside in a community where the majority of practitioners are self-pay only [47]. Due to a lower percentage of Latino/a with access to health insurance coverage, they are unable to financially afford mental health services [48]. As compared to their White counterparts, Black or African Americans and Latino/as earn lower incomes, receive less education, are least likely to have health insurance coverage, are more likely to be underinsured, and have a higher probability of being involved with the public- or social-service agencies [47]. And thus, each of these systemic barriers has an impact on the capacity to seek and obtain mental health services. These barriers need to be addressed on a systemic scale so that policy and funding can be allocated for the development of a mental health system that is inclusive and representative of all ethnic minorities.

4. Effectiveness of evidence-based treatment

In the US, nationwide health disparities and systemic barriers impede REM access to quality mental health services [49, 50]. REM are less likely to seek and engage in mental health services as compared to their White counterparts [49–51]. Additionally, those who opt to engage in mental health services believe that evidence-based is culturally appropriate, or report dissatisfaction from treatment engagement [49, 51, 52]. Evidence-based practices (EBPs) are defined as the combination of empirical research, clinical expertise, and the lived experiences, values, and identities of participants [9, 11, 53, 54]. Evidence-based treatments (EBTs) refer directly to the clinical interventions, supported by scientific research, that are implemented to promote positive therapeutic outcomes [9, 49, 53, 54]. EBTs are often utilized to treat anxiety disorders, depression, posttraumatic stress, trauma, chronic pain, eating disorders, and other mental health conditions [52, 55–60]. Examples of clinical interventions include Cognitive Behavioral Therapy (CBT), Narrative Exposure Therapy (NET), Eye Movement Desensitization and Reprocessing (EMDR), and Cognitive Processing Therapy (CPT) [52, 56–69].

4.1 Evidence-based treatments

CBT is an empirically supported therapeutic treatment that is guided by the basic principle that exposing, challenging, and reshaping distorted thoughts, modifying behavioral patterns, and managing affective processes can increase positive coping

skills and improve mental health [70]. Research demonstrates the effectiveness of CBT in the treatment of a variety of mental health conditions, to name a few: anxiety, depression, stress, substance use disorders, and chronic pain management with people throughout their lifespan [56, 71].

NET is a short-term, trauma-focused, therapeutic treatment that was originally developed for those experiencing trauma due to exposure to disaster, war, and torture [63, 72]. A significant component of NET is the perception that trauma is not an isolated event but is interwoven into an overlapping network of various traumas that contribute to distorted sensory and cognitive information and can lead to the development of posttraumatic stress [63, 72, 73]. NET assists individuals in processing these traumas through creating a narrative that chronologically maps traumatic events across their lifetime, rather than focusing on a single traumatic event [63, 73]. NET is effective in the treatment of posttraumatic stress disorder (PTSD), anxiety, depression, insomnia, and other trauma-related disorders [72–75].

EMDR is an empirically supported therapeutic intervention that was developed in the late 1980's when researcher, Francine Shapiro, observed that engaging in saccadic eye movements, while recalling traumatic memories, significantly reduced the intensity of anxiety associated with these disturbing thoughts [65, 76]. EMDR is proven to be effective in mitigating the impact of traumatic stress, anxiety, and depression through aiding participants in processing dysfunctional memories and developing more adaptive cognitive processes [52, 66, 76–78].

CPT is an evidence-based cognitive therapy that is commonly utilized to treat PTSD [79]. CPT provides participants with psychoeducation about trauma, stress, and cognitive skill-building to aid in the identification of "stuck points" that form distorted thought processes that contribute to symptoms of posttraumatic stress [79, 80].

4.2 EBTs with REM populations

Despite widespread acceptance in the treatment of trauma and other mental health conditions, EBTs are often critiqued for a lack of cultural relevance [11, 81]. Historically, REM have been underrepresented in the scientific research that informs the efficacy of these interventions [49, 53, 54, 82, 83]. Researchers believe that this underrepresentation compromises the efficacy of these treatments among minority populations, and may negatively influence participant engagement, outcomes, and treatment satisfaction [49, 53]. Researchers investigate and address this disparity through the implementation of culturally competent programmatic modifications to traditional EBTs [52, 60, 79, 84, 85]. And thus, it is essential that practitioners be conscientious of cultural factors that inform REM perceptions of mental illness, the nature of their presenting concerns, and their desire or propensity to seek help; the EBTs that are utilized will not account for or address the nuances these individuals experience.

In one empirical study, researchers modified CBT interventions to be culturally inclusive for Mexican American women struggling with binge eating disorders. Findings suggested the eating habits of Latina women were significantly affected by both the cultural meaning of food and cultural beliefs surrounding help-seeking behaviors [60]. The women were less likely to be motivated by thinness ideals than their White counterparts and were more likely to engage in binge eating behaviors due to food signifying love, community, and other factors of their culture. In other words, the Latinas' experiences were informed by cultural beliefs that implied they should be considerate of others before caring for themselves, which made them less likely to

engage in treatment for their eating disorders [60]. Adaptations for the CBT intervention included guiding participants in navigating culturally specific social interactions about food, assisting participants in navigating culturally relevant healthy food options, and advocating for culturally competent service delivery.

Furthermore, it is necessary to implement cultural modifications to meet the unique needs of specific populations, such as refugee survivors [64]. Another common EBT, NET, is often used with diverse populations, such as refugees who experience trauma by exposure to war, torture, political unrest, anxiety, and depression [63, 64, 74, 75]. In another investigation of the cultural appropriateness of EBTs, NET was empirically examined and modified to address the specific needs of Cambodian survivors. The research adapted a NET intervention to meet the needs of Cambodian survivors of the Khmer Rouge genocide [86]. The adaptation included the implementation of traditional spiritual practices, such as chanting, protection rituals, and the presence of Buddhist monks to supplement the traditional NET intervention format [86]. The participants were responsive to this treatment approach.

4.3 Cultural appropriateness of EBTs

It is common for some investigators to examine the efficacy of traditional EBTs on specific minoritized populations. For example, one study attempted to examine the efficacy of a traditional EMDR intervention with Black or African American clients [52]. Several themes emerged that inform future adaptions to EMDR as an efficacious intervention for Black or African American clients. More specifically, the findings indicated the participants had insufficient psychoeducation on EMDR, which contributed to fear, uncertainty, and feelings of powerlessness regarding participation in the intervention. Additionally, the participants lacked trust and felt they were unable to identify with the White treatment providers who administered the intervention [52]. Combine these findings with Black or African Americans' experience of systemic barriers; not only will they be less likely to seek treatment, but also their mental health conditions will deteriorate. An example of a study where researchers made cultural adjustments to an EMDR intervention to meet the needs of Syrian refugees includes implementing a translation of program materials into the local language, adjusting to a scheduled time (preferred evening schedules), and providing a discreet location for intervention services to decrease the possibility of stigmatization for receiving mental health services [55].

Spanish-speaking Latino populations face unique barriers when treated with EBTs. Shortages of Spanish-speaking clinicians, lack of access to bilingual program material, and limited protocol about culturally appropriate adaptations to EBTs are examples of unique barriers that Spanish-speaking Latino populations experience that can exacerbate their mental health or deter them from seeking help [85]. When seeking to culturally adapt a CPT intervention to meet the needs of Spanish-speaking Latinos managing PTSD, one study found that participants reported a lack of language accessibility of materials, difficulty understanding psychological terms, and poor integration of cultural values in program materials to be challenging [85]. Findings from a similar empirical study identified comparable barriers when adapting a CPT intervention for Native American women diagnosed with Human Immunodeficiency Virus (HIV), PTSD, and who were engaged in high-risk sexual activities [87]. These barriers included difficulty understanding scientific language presented in program materials as well as lack of spiritual and cultural relevance. Another CPT intervention was modified to address the needs of Kurdish trauma survivors living in Iraq [84]. Adaptations to the CPT manual and materials included the removal of American

cultural idioms, reduction of psychological terms, translation of materials into Kurdish language, adjustment of language to create greater accessibility across literacy levels, and implementation of culturally appropriate case examples.

Today, researchers advocate for more culturally competent clinicians and propose cultural modifications to EBTs to help improve outcomes for REM who are participants in these interventions [52, 57]. As well, more REM need to be invited to participate in clinical trials when examining the efficacy of EBTs. Challenging clinicians to be creative in their clinical work, such as using clinical tools like the Multidimensional Model for Developing Cultural Competence (MMDCC) to guide practice can also improve psychological outcomes for REM clients [88]. The components of the MMDCC include cultural awareness, cultural knowledge, cultural knowledge of behavioral health, and cultural skill development and the components examine how these factors intersect at the individual, clinical, and organizational levels. Additionally, adaptations of intervention language are widely accepted as a culturally competent adjustment to EBPs [89]. There is presently no universal protocol for the culturally competent modification of EBTs [57, 89].

5. Mindfulness-based stress reduction

MBSR was originally developed to reduce psychological and emotional stressors experienced by people with chronic health issues [12, 90]. MBSR has been administered to a wide range of populations in different settings, such as hospitals, schools, and prisons [90]. An advantage of MBSR is its format as a group training program that are led by either one or two trained instructors who facilitate group sessions [91, 92]. In order for MBSR to be most effective, instructors should have competency in teaching the program, embody qualities of mindfulness, commit to good practice, and be engaged in the learning process [90].

For participants, a potential benefit of MBSR is the shared experience of addressing various psychosocial stressors in a supportive group setting. Specifically, MBSR is administered as an 8 to 10-week training program intended to reduce stress through the systematic application of mindful-based practices [12, 91, 92]. Groups can range from 10 to 40 participants who meet weekly for a 2.5 hour MBSR training session. Activities for each session often include mindfulness meditation, mindful awareness, yoga, and mindfulness practice for stressful events [12, 92]. As a requirement of MBSR, participants are assigned a 45-minute homework task. These daily homework assignments include practicing different mindful-based exercises learned in each session. Mindfulness is developed through regular and repeated practice, which helps people readily access the techniques during stressful events [92].

5.1 Effectiveness of MBSR

The application of MBSR is an effective non-pharmacological method toward managing stress deriving from chronic physical illnesses (e.g., cancer, diabetes, hypertension, HIV) [93]. In fact, studies found that the practice of MBSR enhances coping skills while being used as an alternative medical treatment for clinical patients [92, 93]. For treatment of physical health conditions, reportedly MBSR decreases patient complaints of sensory pain, physical impairment, and medical symptoms. Furthermore, even non-clinical populations indicate improved quality of life after

participating in MBSR [12, 92]. Overall, empirical findings suggest that MBSR can be utilized as a healthy coping strategy to manage a range of physical ailments.

In terms of mental health treatment, MBSR is found to be an effective approach in reducing symptoms related to anxiety disorders (e.g., generalized anxiety, social anxiety, panic attacks); more specifically, symptoms that relate to worrying and future-oriented cognitions [94, 95]. Furthermore, individuals with anxiety disorders report improvements in transdiagnostic symptoms (e.g., emotion dysregulation, avoidance, cognition) after completing a course of MBSR [94]. These participants indicated that MBSR was a beneficial activity to reduce their anxiety, helped them feel at ease, and gave them the confidence to do more activities. Based on these findings, MBSR is a clinical intervention that can be utilized to guide individuals toward change and acceptance of their anxiety [94].

Although, the clinical efficacy of MBSR extends beyond the treatment of various anxiety disorders and physical ailments. Among both clinical and non-clinical groups, MBSR has been found to be moderately effective at reducing depressive symptoms and psychological distress [12, 92, 96]. Moreover, MBSR is shown to decrease depressive symptoms and slightly improved cognitions among individuals with mild cognitive impairment. These results indicate that MBSR can be used as a supplemental treatment for mild to moderate depressive disorders [96].

Additionally, the effectiveness of MBSR as an alternative treatment for clinical ailments may be attributed to neurological change. In one study, neuroimaging data indicated increased connectivity in the visual and auditory networks of participants who completed an 8-week course of MBSR [97]. Likewise, the increased neurological connectivity was associated with improved attentional focus, sensory processing, and awareness of sensory experiences [97]. Similar neuroimaging studies found increased connectivity in the hippocampal region of participants after completing MBSR [98]. As a result, the findings suggested increased hippocampal connectivity from mindfulness may improve stress resilience and fear extinction (e.g., worry) [98]. And thus, MBSR as a clinical treatment promotes beneficial neurological growth and regeneration, which positively affects physical and mental health outcomes.

5.2 Effectiveness of MBSR for racial and ethnic minorities

The efficacy of MBSR as an EBT for physical and mental health conditions is well documented. However, there is a dearth of research that promotes mindfulness-based interventions as a treatment for REM populations. There are a few studies that demonstrate MBSR as a potential culturally appropriate treatment for a wide range of clinical ailments. For example, Native American, Latinx, and Black communities often uphold values that honor the mind-body and spiritual connection. Mindfulness-based techniques are inclusive of historical, social, and cultural perspectives or ideologies, which align with the needs of REM communities. And thus, the mindfulness-based interventions can promote communal coping (e.g., community or collectively) and healing (e.g., prayer, meditation, other spiritual rituals) [99].

In another example, MBSR can serve to reduce health disparities for Black or African American females experiencing the stress or traumatic stress deriving from sexism and racism [100]. In turn, MBSR can help Black women overcome harmful cultural or racialized stereotypes such as the Superwoman schema and the Strong Black woman script. A recent investigation found that prediabetic Black or African Americans notable decreases in diabetes risk (i.e., lower A1C) after completing an MBSR program [13]. These participants reported increases in spiritual well-being and reductions in perceived

stress, BMI, and fat. These studies indicate that MBSR served as a culturally appropriate treatment for African Americans experiencing psychosocial stressors.

The benefits of mindfulness-based interventions (MBI) such as MBSR and mindfulness-based cognitive therapy (MBCT) have also been examined for REM and age demographics. A recent study found that culturally adapted mindfulness-based interventions for Latinx populations were correlated with improvements in depression, stress, and chronic illness [101]. Similarly, MBSR and MBCT were found to reduce depressive and anxiety symptoms among various Asian communities [102]. After participating in MBSR, low-income older African Americans reported decreased stress, depression, and anger and decreased blood pressure [103, 104]. Findings also indicated that young African Americans with HIV that completed MBSR experienced decreased hostility and improvements in social relationships, academic achievement, and physical health [105]. Thus, there is evidence that mindfulness-based interventions are culturally sensitive and inclusive, which aligns with the needs of REM coping with mental health conditions.

6. Conclusions

REM are at a particularly high risk of experiencing mental health conditions. Social determinants of health, such as poverty, racialized violence, or discrimination exacerbate REM mental health and quality of life. REM are less likely than White people to seek and receive treatment. Furthermore, REM are more likely to experience systemic barriers, such as cultural mistrust, mental health stigma, lack of access, and lack of financial resources, further complicating their willingness and capacity to seek treatment. While EBTs are identified as empirically supportive to treatments for a range of mental health conditions, there is skepticism about their cultural appropriateness and relevance for REM populations. Clinicians must be culturally competent and use clinical tools (e.g., Multidimensional Model for Developing Cultural Competence) to assist in promoting cultural competence. Practitioners must be conscientious and knowledgeable about the pitfalls of EBTs when working with REM. Mindfulness-based techniques, such as MBSR, are culturally sensitive and inclusive of historical, social, and cultural ideologies that align with the needs of REM. MBSR has the potential to offer holistic coping given its effectiveness in promoting neurological, physical, and psychological healing.

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References

[1] United States Census Bureau. Measuring Racial and Ethnic Diversity for the 2020 Census. 2021. Available from: https://www.census.gov/newsroom/blogs/random-samplings/2021/08/measuring-racial-ethnic-diversity-2020-census.html [Accessed: December 2, 2021]

[2] American Psychiatric Association. Mental Health Disparities: Diverse Populations. 2017. Available from: https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts html [Accessed: December 2, 2021]

[3] Mental Health America. 2021 The state of America. 2020. Available from: https://www.mhanational.org/research-reports/2021-state-mental-health-america [Accessed: December 2, 2021]

[4] Mental Health America. How Race Matters: What We Can Learn from Mental Health America's Screening in 2020. [Internet]. 2021. Available from: https://mhanational.org/mental-health-data-2020 [Accessed: December 2, 2021]

[5] Williams T, Walker T, Wyatt W. Conceptualizing racism through a systemic trauma lens: Impacts on Black College students. Journal of Psychotherapy Integration. 2021. Advance online publication. DOI: 10.1037/int0000206

[6] Gregory K. Mental Health Disparities by Race. MI Blues Perspectives. 2021. Available from: https://www.mibluesperspectives.com/2021/07/20/mental-health-disparities-by-race/ [Accessed: December 2, 2021]

[7] Alvidrez J, Snowden L, Kaiser D. The experience of stigma among Black mental health consumers. Journal of Health Care for the Poor & Underserved. 2008;**19**:874-893. DOI: 10.1353/hpu.0.0058

[8] Meyer O, Saw A, Cho Y, Fancher T. Disparities in assessment, treatment, and recommendations for specialty mental health care: Patient reports of medical provider behavior. Health Services Research. 2015;**50**:750-767. DOI: 10.1111/1475-6773.12261

[9] Kazdin A. Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. American Psychologist. 2008;**63**:146-159. DOI: 10.1037/0003-066X.63.3.146

[10] McMurray A. Culturally sensitive evidence-based practice. Collegian. 2004;**11**:14-118. DOI: 10.1016/S1322-7696(08)60469-2

[11] Gone J. Reconciling evidence-based practice and cultural competence in mental health services: Introduction to special issue. Transcultural Psychiatry. 2015;**52**:139-149. DOI: 10.1177/1363461514568239

[12] Khoury B, Sharma M, Rush S, Fournier C. Mindfulness-based stress reduction or healthy individuals: A meta-analysis. Journal of Psychosomatic Research. 2015;**78**:519-528. DOI: 10.1016/j.jpsychores.2015.03.009

[13] Woods-Giscombe C, Gaylord S, Li Y, Brintz C, Bangdiwala S, Buse J, et al. A mixed-methods randomized clinical trial to examine feasibility of a mindfulness-based stress management and diabetes risk reduction intervention for African Americans with prediabetes. Evidence-Based Complementary and Alternative

Medicine. 2019;**2019**:e3962623. DOI: 10.1155/2019/3962623. PMID: 31511777; PMCID: PMC6710811

[14] Fernando S. Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health. London, UK, Basingstoke: Palgrave Macmillan; 2017. p. 209. DOI: 10.1007/978-3-319-62728-1

[15] Zayas L. Forgotten Citizens: Deportation, Children, and the Making of American Exiles and Orphans. New York: Oxford University Press; 2015. p. 269

[16] Alegria M, Canino G, Shrout P, Woo M, Duan N, Vila D, et al. Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. American Journal of Psychiatry. 2008;**165**:359-369. DOI: 10.1176/appi.ajp.2007.07040704

[17] American Psychiatric Association. Mental Health Disparities: Hispanics and Latino: Fact Sheet. 2017. Available from: www.psychiatry.org [Accessed: December 2, 2021]

[18] Cabassa L, Zayas L, Hansen M. Latino adults' access to mental health care. A review of epidemiological studies. Administration & Policy in Mental Health. 2006;**33**:316-330. DOI: 10.1007/s10488-006-0040-8

[19] Torres L, Zaya L, Cabassas L. Diagnostic symptoms, and functional assessments of Hispanic outpatients in community mental health practice. Community Mental Health Journal. 2009;**45**:97-105. DOI: 10.1007/s10597-0089156-5

[20] Perez A, Gamarel K, Berg J, Operario D. Sexual and behavioral health disparities among African American sexual minority men and women. Ethnicity & Health. 2018;**25**:1-12. DOI: 10.1080/13557858.2018.1444149

[21] Office of Minority Mental Health. U.S. Department of Health and Human Services Mental health and African Americans. 2021. Available from: http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24 [Accessed: December 2, 2021]

[22] Mental Health America. Asian American/Pacific Islander Communities and Mental Health. 2021. Available from: https://www.mhanational.org/issues/asian-americanpacific-islander-communities-and-mental-health [Accessed: December 2, 2021]

[23] American Psychological Association. African Americans have Limited Access to Mental and Behavioral Health Care. 2016. Available from: http://www.apa.org/about/gr/issues/minority/access.aspx [Accessed: December 2, 2021]

[24] Centers for Disease Control. Leading Causes of Death—Females—Non-Hispanic Asian or Pacific Islander – United States. 2016. Available from: https://www.cdc.gov/women/lcod/2016/nonhispanic-asian-or-islander/index.htm [Accessed: December 2, 2021]

[25] Spencer M, Chen J, Gee G, Fabian C, Takeuchi D. Discrimination and mental health-related service use in a national study of Asian Americans. American Journal of Public Health. 2010;**100**:2410-2417. DOI: 10.2105/AJPH.2009.176321

[26] American Psychiatric Association. Mental Health Facts for Asian Americans/Pacific Islanders. 2020. Available from: https://www.psychiatry.org/psychiatrists/cultural-competency/education/asian-american-patients [Accessed: December 2, 2021]

[27] Mental Health American. Native and Indigenous Communities and Mental Health. 2021. Available from: https://www.mhanational.org/issues/

native-and-indigenous-communities-and-mental-health [Accessed: December 2, 2021]

[28] Heart M, Chase J, Elkins J, Altschul D. Historical trauma among Indigenous Peoples of the Americas: Concepts, research, and clinical considerations. Journal of Psychoactive Drugs. 2011;**43**:282-290. DOI: 10.1080/02791072.2011.628913

[29] Office of Minority Mental Health: U.S. Department of Health and Human Services Mental Health. Mental and Behavioral Health – American Indians/Alaskan Natives African Americans. 2021. Available from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39 [Accessed: December 2, 2021]

[30] Office of Minority Mental Health: U.S. Department of Health and Human Services Mental Health. Mental and Behavioral Health – Native Hawaiians/Pacific Islanders. 2021. Available from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=172 [Accessed: December 2, 2021]

[31] Liu D, Alameda C. Social determinants of health for Native Hawaiian children and adolescents. Hawaii Medicine. 2011;**70**:9-14

[32] Whaley A, Francis K. Behavioral health in multiracial adolescents: The role of Hispanic/Latino ethnicity. Public Health Reports. 2006;**121**:169-174. DOI: 10.1177/003335490612100211

[33] Udry J, Li R, Hendrickson-Smith J. Health and behavior risks of adolescents with mixed-race identity. American Journal of Public Health. 2003;**93**:1865-1870. DOI: 10.2105/ajph.93.11.1865

[34] Garcia G, Hedwig T, Hanson B, Rivera M, Smith C. The relationship between mixed race/ethnicity, developmental assets, and mental health among youth. Journal of Racial & Ethnic Health Disparities. 2019;**6**:77-85. DOI: 10.1007/s40615-018-0501-2

[35] Franco M, Durkee M, McElroy-Heltzel S. Discrimination comes in layers: Dimensions of discrimination and mental health for multiracial people. Cultural Diversity and Ethnic Minority Psychology. 2021;**27**:343-353. DOI: 10.1037/cdp0000441

[36] Ali N, McLachlan N, Kanwar S, Randhawa G. Pakistani young people's views on barriers to accessing mental health services. International Journal of Culture and Mental Health. 2017;**10**:33-43. DOI: 10.1080/17542863.2016.1248456

[37] Conner K, Copeland V, Grote N, Rosen D, Albert S, McMurray M, et al. Barriers to treatment and culturally endorsed coping strategies among depressed African-American older adults. Aging & Mental Health. 2010;**14**:971-983

[38] Phelps R, Taylor J, Gerad P. Cultural mistrust, ethnic identity, racial identity, and self-esteem among ethnically diverse Black university students. Journal of Counseling & Development. 2001;**71**:209-216. DOI: 10.1002/j.1556-6676.2001.tb01962.x

[39] Owens D. Medical Bondage: Race, Gender, and the Origins of American Gynecology. Athens: University of Georgia Press; 2017. p. 113. DOI: 10.2307/j.ctt1pwt69x

[40] Mensah M, Ogbu-Nwobodo L, Shim R. Racism and mental health equity: History repeating itself. Psychiatric Services. 2021;**72**:1091-1094. DOI: 10.1176/appi.ps.202000755

[41] American Psychiatric Association. Stigma, Prejudice, and Discrimination

Against People with Mental Illness. 2021. Available from: https://www.psychiatry.org/patients-families/stigma-and-discrimination 39 [Accessed: December 2, 2021]

[42] Eylem O, de Wit L, van Straten A, Stebul L, Melissourgaki Z, Danışman G, et al. Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. BMC Public Health. 2020;**20**:879-899. DOI: 10.1186/s12889-020-08964-3

[43] Leong F, Kalibatseva Z. Cross-cultural Barriers to Mental Health Services in the United States. Cerebrum: The Dana Forum on Brain Science. 2011;**2011**:5

[44] Cruz M, Harman S, Pincus A, Post P, Reynolds F. Barriers to care-seeking for depressed African Americans. International Journal of Psychiatry in Medicine. 2008;**38**:71-80. DOI: 10.2190/PM.38.1.g

[45] Chow J, Jaffee K, Swonden L. Racial/Ethnic disparities in the use of mental health services in poverty areas. American Journal of Public Health. 2003;**93**:792-7797. DOI: 10.2105/ajph.93.5.792

[46] Brody G, Heflinger C, Murry V, Suiter S. Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. Journal of Youth Adolescence. 2011;**40**:1118-1131. DOI: 10.1007s10964-010-9627-1

[47] Ashton C, Haidet P, Paterniti D, Collins T, Gordon H, O'Malley K, et al. Racial and ethnic disparities in the use of health services. Journal of General Internal Medicine. 2003;**18**:146-152. DOI: 10.1046/j.1525-1497.2003.20532

[48] Vega W, Lopez S. Priority issues in Latino mental health services research. Mental Health Services Research. 2001;**3**:189-200. DOI: 10.1023/A:1013125030718

[49] Chu J, Leino A. Advancement in the maturing science of cultural adaptations of evidence-based interventions. Journal of Consulting & Clinical Psychology. 2017;**85**:45-57. DOI: 10.1037/ccp0000145

[50] Guerrero E, Marsh J, Khachikian T, Amaro H, Vega W. Disparities in Latino substance use, service use, and treatment: Implications for culturally and evidence-based interventions under health care reform. Drug and Alcohol Dependence. 2013;**133**:805-813. DOI: 10.1016/j.drugalcdep.2013.07.027

[51] Guerrero E, Garner B, Cook B, Kong Y. Does the implementation of evidence-based and culturally competent practices reduce disparities in addiction treatment outcomes? Addictive Behaviors. 2017;**73**:119-123. DOI: 10.1016/j.addbeh.2017.05.006

[52] Lipscomb A, Ashley W. A critical analysis of the utilization of eye movement desensitization and reprocessing (EMDR) psychotherapy with African American clients. Journal of Human Services. 2021;**7**:1-16

[53] Cook S, Schwartz A, Kaslow N. Evidence-based psychotherapy: Advantages and challenges. Neurotherapeutics. 2017;**14**:537-545. DOI: 10.1007/s13311-017-0549-4

[54] Lyon A, Lau A, McCauley E, Vander Stoep A, Chorpita B. A case for modular design: Implications for implementing evidence-based interventions with culturally diverse youth. Professional Psychology: Research & Practice. 2014;**45**:57-66. DOI: 10.1037/a0035301

[55] Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Cuijpers P, et al. EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. European Journal of Psychotraumatology. 2015;**6**:27414. DOI: 10.3402/ejpt.v6.27414

[56] Ehde D, Dillworth T, Turner J. Cognitive-behavioral therapy for individuals with chronic pain: Efficacy, innovations, and directions for research. American Psychologist. 2014;**69**:153-166. DOI: 10.1037/a0035747

[57] EnnisN,ShorerS,Shoval-ZuckermanY, Freedman S, Monson C, Dekel R. Treating posttraumatic stress disorder across cultures: A systematic review of cultural adaptations of trauma-focused cognitive behavioral therapies. Journal of Clinical Psychology. 2020;**76**:587-611. DOI: 10.1002/jclp.22909

[58] Holliday R, Holder N, Williamson M, Surís A. Therapeutic response to cognitive processing therapy in White and Black female veterans with military sexual trauma-related PTSD. Cognitive Behaviour Therapy. 2017;**46**:432-446. DOI: 10.1080/16506073.2017.1312511

[59] Mørkved N, Hartmann K, Aarsheim L, Holen D, Milde A, Bomyea J, et al. A comparison of narrative exposure therapy and prolonged exposure therapy for PTSD. Clinical Psychology Review. 2014;**34**:453-467. DOI: 10.1016/j.cpr.2014.06.005

[60] Shea M, Cachelin F, Uribe L, Striegel R, Thompson D, Wilson G. Cultural adaptation of a cognitive behavior therapy guided self-help program for Mexican American women with binge eating disorders. Journal of Counseling & Development. 2012;**90**:308-318. DOI: 10.1002/j.1556-6676.2012.00039.x

[61] Iverson K, Bauer M, Shipherd J, Pineles S, Harrington E, Resick P. Differential associations between partner violence and physical health symptoms among Caucasian and African American help-seeking women. Psychological Trauma: Theory, Research, Practice, and Policy. 2013;**5**:158-166. DOI: 10.1037/a0025912

[62] Lim J, Choi S, Lee W, Jang J, Moon J, Kim Y, et al. Cognitive-behavioral therapy for patients with chronic pain: Implications of gender differences in empathy. Medicine. 2018;**97**:e10867. DOI: 10.1097/MD.0000000000010867

[63] Gwozdziewycs N. Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. The Permanente Journal. 2013;**17**:72-78. DOI: 10.7812/TPP/12-058

[64] Hijazi A, Lumley M, Ziadni M, Haddad L, Rapport L, Arnetz B. Brief narrative exposure therapy for posttraumatic stress in iraqi refugees: A preliminary randomized clinical trial: narrative exposure therapy for refugees. Journal of Traumatic Stress. 2014;**27**:314-322. DOI: 10.1002/jts.21922

[65] Cuijpers P, van Veen S, Sijbrandij M, Yoder W, Cristea I. Eye movement desensitization and reprocessing for mental health problems: A systematic review and meta-analysis. Cognitive Behaviour Therapy. 2020;**49**:165-180. DOI: 10.1080/16506073.2019.1703801

[66] Shapiro F. The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experience. The Permanente Journal. 2014;**18**:71-77. DOI: 10.7812/TPP/13-098

[67] Asmundson G, Thorisdottir A, Roden-Foreman J, Baird S, Witcraft S, Stein A, et al. A meta-analytic review of cognitive processing therapy for adults with posttraumatic stress disorder. Cognitive Behaviour Therapy. 2019;**48**:1-14. DOI: 10.1080/16506073.2018.1522371

[68] Bernardi J, Dahiya M, Jobson L. Culturally modified cognitive processing therapy for Karen refugees with posttraumatic stress disorder: A pilot study. Clinical Psychology & Psychotherapy. 2019;**26**:531-539. DOI: 10.1002/cpp.2373

[69] Haller M, Norman S, Cummins K, Trim R, Xu X, Cui R, et al. Integrated cognitive behavioral therapy versus cognitive processing therapy for adults with depression, substance use disorder, and trauma. Journal of Substance Abuse Treatment. 2016;**62**:38-48. DOI: 10.1016/j.jsat.2015.11.005

[70] Beck J. Cognitive Behavior Therapy: Basics and Beyond. 3rd ed. New York: The Guildford Press; 2021. p. 401

[71] Iverson K, Gradus J, Resick P, Suvak M, Smith K, Monson C. Cognitive–behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. Journal of Consulting and Clinical Psychology. 2011;**79**:193-202. DOI: 10.1037/a0022512

[72] Siehl S, Robjant K, Crombach A. Systematic review and meta-analyses of the long-term efficacy of narrative exposure therapy for adults, children and perpetrators. Psychotherapy Research. 2021;**31**:695-710. DOI: 10.1080/10503307.2020.1847345

[73] Jongedijk R. Narrative exposure therapy: An evidence-based treatment for multiple and complex trauma. European Journal of Psychotraumatology. 2014;5:1. https://doi.org/10.3402/ejpt.v5.26522

[74] Park J, Park J, Elbert T, Kim S. Effects of narrative exposure therapy on posttraumatic stress disorder, depression, and insomnia in traumatized north Korean refugee youth. Journal of Traumatic Stress. 2020;**33**:353-359. DOI: 10.1002/jts.22492

[75] Raghuraman S, Stuttard N, Hunt N. Evaluating narrative exposure therapy for post-traumatic stress disorder and depression symptoms: A meta-analysis of the evidence base. Clinical Psychology & Psychotherapy. 2021;**28**:1-23. DOI: 10.1002/cpp.2486

[76] Landin-Romero R, Moreno-Alcazar A, Pagani M, Amann B. How Does eye movement desensitization and reprocessing therapy work? A systematic review on suggested mechanisms of action. Frontiers in Psychology. 2018;**9**:1-23. DOI: 10.3389/fpsyg.2018.01395

[77] Behnammoghadam M, Alamdari A, Behnammoghadam A, Darban F. Effect of eye movement desensitization and reprocessing (EMDR) on depression in patients with myocardial infarction (MI). Global Journal of Health Science. 2015;**7**:258-262. DOI: 10.5539/gjhs.v7n6p2

[78] Wallis O, de Vries J. EMDR treatment for anxiety in MS patients: A pilot study. Multiple Sclerosis Journal: Experimental, Translational and Clinical. 2020;**6**:2055217320974388. DOI: 10.1177/2055217320974388

[79] Moring J, Dondanville K, Fina B, Hassija C, Chard K, Monson C, et al. Cognitive processing therapy for posttraumatic stress disorder via telehealth: Practical considerations during the COVID-19 pandemic. Journal

of Traumatic Stress. 2020;**33**:371-379. DOI: 10.1002/jts.22544

[80] Morland L, Mackintosh M., Greene C, Rosen C, Chard K, Resick P, Frueh B. C. Cognitive processing therapy for posttraumatic stress disorder delivered to rural veterans via telemental health: A randomized noninferiority clinical trial. The Journal of Clinical Psychiatry. 2014;**75**:470-476. DOI: doi.org/10.4088/JCP.13m08842

[81] McClendon J, Dean K, Galovski T. Addressing diversity in PTSD treatment: Disparities in treatment engagement and outcome among patients of color. Current Treatment Options in Psychiatry. 2020;**7**:275-290. DOI: 10.1007/s40501-020-00212-0

[82] Arora P, Parr K, Khoo O, Lim K, Coriano V, Baker C. Cultural adaptations to youth mental health interventions: A systematic review. Journal of Child and Family Studies. 2021;**30**:2539-2562. DOI: 10.1007/s10826-021-02058-3

[83] Parra-Cardona J, López-Zerón G, DomenechRodríguezM,Escobar-ChewA, Whitehead M, Sullivan C, et al. A balancing act: Integrating evidence-based knowledge and cultural relevance in a program of prevention parenting research with Latino/a immigrants. Family Process. 2016;**55**:321-337. DOI: 10.1111/famp.12190

[84] Kaysen D, Lindgren K, Zangana G, Murray L, Bass J, Bolton P. Adaptation of cognitive processing therapy for treatment of torture victims: Experience in Kurdistan, Iraq. Psychological Trauma: Theory, Research, Practice, & Policy. 2013;**5**:184-192. DOI: 10.1037/a0026053

[85] Valentine S, Borba C, Dixon L, Vaewsorn A, Guajardo J, Resick P, et al. Cognitive processing therapy for Spanish-speaking Latinos: A formative study of a model-driven cultural adaptation of the manual to enhance implementation in a usual care setting: Adaptation of CPT for Spanish-speaking Latinos. Journal of Clinical Psychology. 2017;**73**:239-256. DOI: 10.1002/jclp.22337

[86] Strasser J, Chhim S, Taing S. Narrative exposure therapy (NET): Culturally sensitive trauma treatment for Khmer rouge survivors. Asian Journal of Psychiatry. 2011;**7**:111-116

[87] Pearson C, Kaysen D, Huh D, Bedard-Gilligan M. Randomized control trial of culturally adapated cognitive processing therapy for PTSD substance misuse and HIV sexual risk behavior for Native American women. AIDS Behavior. 2019;**23**:695-706. DOI: 10.1007/s10461-018-02382-8

[88] Substance Abuse and Mental Health Services Administration. Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series, No. 59 HHS Publication No. (SMA) 14-4849. Rockville, MD. 2014

[89] Huey S, Tilley J, Jones E, Smith C. The contribution of cultural competence to evidence-based care for ethnically diverse populations. Annual Review of Clinical Psychology. 2014;**10**:305-338. DOI: 10.1146/annurev-clinpsy-032813-153729

[90] Crane R, Brewer J, Feldman C, Kabat-Zinn J, Santorelli S, Williams J, et al. What defines mindfulness-based programs? The warp and the weft. Psychological Medicine. 2017;**47**:990-999. DOI: 10.1017/S0033291716003317

[91] Dobkin P, Hickman S, Monshat K. Holding the heart of mindfulness-based stress reduction: Balancing fidelity and

imagination when adapting MBSR. Mindfulness. 2014;**5**:710-718. DOI: 10.1007/s12671-013-0225-7

[92] Grossman P, Niemann L, Schmidt S, Walach H. Mindfulness-based stress reduction and health benefits. Journal of Psychosomatic Research. 2004;**57**:35-43. DOI: DOI. 10.1016/S0022-3999(03)00573-7

[93] Niazi AK, Niazi SK. Mindfulness-based stress reduction: A non-pharmacological approach for chronic illnesses. North American Journal of Medical Sciences. 2011;**3**:20-23. DOI: 10.4297/najms.2011.320

[94] Schanche E, Vøllestad J, Binder P, Hjeltnes A, Dundas I, Nielsen G. Participant experiences of change in mindfulness-based stress reduction for anxiety disorders. International Journal of Qualitative Studies on Health and Well-Being. 2020;**15**:1776094. DOI: 10.1080/17482631.2020.1776094

[95] Wharton E, Kanas N. Mindfulness-based stress reduction for the treatment of anxiety disorders. International Journal of Group Psychotherapy. 2019;**69**:362-372. DOI: 10.1080/00207284.2019.1599289

[96] Marciniak R, Šumec R, Vyhnálek M, Bendíčková K, Lázničková P, Forte G, et al. The effect of mindfulness-based stress reduction (MBSR) on depression, cognition, and immunity in mild cognitive impairment: A pilot feasibility study. Clinical Interventions in Aging. 2020;**15**:1365-1381. DOI: 10.2147/CIA.S249196

[97] Kilpatrick L, Suyenobu B, Smith S, Bueller J, Goodman T, Creswell J, Tillisch K, Mayer E, Naliboff B. Impact of mindfulness-based stress reduction training on intrinsic brain connectivity. Neuroimage. 2011;**56**:290-298. DOI: 10.1016/j.neuroimage.2011.02.034

[98] Sevinc G, Hölzel B, Greenberg J, Gard T, Brunsch V, Hashmi J, et al. Strengthened hippocampal circuits underlie enhanced retrieval of extinguished fear memories following mindfulness training. Biological Psychiatry. 2019;**86**:693-702. DOI: 10.1016/j.biopsych.2019.05.017

[99] Woods-Giscombé C, Black A. Mind-body interventions to reduce risk for health disparities related to stress and strength among African American women: The potential of mindfulness-based stress reduction, loving-kindness, and the NTU Therapeutic Framework. Complementary Health Practice Review. 2010;**15**:115-131. DOI: 10.1177/1533210110386776

[100] Bergen-Cico D, Prouix J. Mindfulness and contemplative practices for diverse cultures. In: Grimes D, Wang Q, Lin H, editors. Empirical Studies of Contemplative Practices. Syracuse, New York, NY: Nova Science Publishers. pp. 145-164

[101] Castellanos R, Yildiz Spinel M, Phan V, Orengo-Aguayo R, Humphreys K, Flory K. A systematic review and meta-analysis of cultural adaptations of mindfulness-based interventions for Hispanic populations. Mindfulness. 2020;**11**:317-332. DOI: 10.1007/s12671-019-01210-x

[102] Thapaliya S, Upadhyaya K, Borschmann R, Kuppili P. Mindfulness based interventions for depression and anxiety in Asian Population: A systematic review. Journal of Psychiatrists' Association of Nepal. 2018;**7**:10-23. DOI: 10.3126/jpan.v7i1.22933

[103] Szanton S, Wenzel J, Connolly A, Piferi R. Examining mindfulness-based

stress reduction: Perceptions from minority older adults residing in a low-income housing facility. BMC Complementary and Alternative Medicine. 2011;**11**:44-50. DOI: 10.1186/1472-6882-11-44

[104] Palta P, Page G, Piferi R, Gill J, Hayat M, Connolly A, et al. Evaluation of a mindfulness-based intervention program to decrease blood pressure in low-income African-American older adults. Journal of Urban Health. 2012;**89**:308-316. DOI: 10.1007/s11524-011-9654-6

[105] Sibinga E, Kerrigan D, Stewart M, Johnson K, Magyari T, Ellen J. Mindfulness-based stress reduction for urban youth. The Journal of Alternative and Complementary Medicine. 2011;**17**:213-218. DOI: 10.1089/acm.2009.0605

Chapter 6

Psychotherapy in Nature: Exploring an Alternative Psychotherapeutic Framework to Address the Limitations of Working in Traditional Settings in Order to Move with the Times

Philippa Williams

Abstract

This paper introduces nature therapy and single session therapy as alternative psychotherapeutic frameworks in addition to more traditional ways of working, offering a modern perspective on evolving societal and individual needs. In particular, the concern for human coping mechanisms and survival in today's fast paced environment dictates a growing need to address conflicts of inner and outer lived experiences, dissociation, and trauma, where traditional settings are failing or inadequate. Ethical considerations and applications for working outside in nature are discussed, as well as limitations for traditional settings. This paper can be used as an introductory guide for practitioners seeking to work therapeutically in nature.

Keywords: nature, ecotherapy, psychotherapeutic, body-mind, trauma

1. Introduction

Traditional room-based psychotherapy has come a long way since the nineteenth century, however, psychodynamic approaches and therapeutic traditions have maintained their place in the psychotherapy field to this day. One of the better-known paradigms that psychotherapy training courses still use as a core element and foundation to their teaching, is humanism, and the work of psychologist, Carl Rogers. In the 1950's Roger's created a person-centred/client-led psychotherapeutic framework that included 'Core Conditions', which he deemed as necessary in order for the psychotherapy to be effective [1]. Decades later, plentiful scientific research has supported this notion, and understandably this framework still forms an important part of many psychotherapy exchanges around the world.

Roger's core conditions of 'empathy, congruence, and unconditional positive regard' form part of the second foundational aspect of a safe and effective

psychotherapy framework, which is the importance and strength of the relationship between therapist and client [1]. Generally speaking, this humanistic approach forms the underpinnings of many newer modality frameworks, and lends itself to being adaptable to other frameworks based on the evidence-based effectiveness of its principles. Furthermore, the neurobiological aspects of humanism are poignant when considering a non-cartesian, embodied approach in nature, which considers the whole of the person as opposed to separating mind and body. For that reason, throughout this chapter, it can be assumed that any nature therapy discussions or examples are being referred to as within the context of a humanistic approach.

Nature therapy shares many aspects of humanism, and at its core is the parallel notion that clients seeking therapy do so in a state of incongruence, thus the therapeutic intervention can restore the client to a state of congruence. Additionally, humanism and nature therapy share important understandings of human existence, not least of all that we are all interconnected to one another, our internal and external environments and their processes, and indeed nature itself. In this chapter we will consider some alternative ways for working with clients outside in nature, within the context of a therapeutic framework.

2. Characteristics of traditional psychotherapy frameworks

Generally, most traditional psychotherapeutic frameworks are based on the following: initial engagement in an assessment or screening with the service to determine whether the service/practitioner is right for them and their struggles; agreeing a set amount of sessions relevant to budget or necessity for improvement, determined at assessment stage, e.g. time-limited (perhaps 6–20 sessions) or open- ended work (as many sessions as required, which may be years); thereafter, client and therapist working within a room-based setting that usually has two comfortable chairs and engaging in talking therapy; on average, meeting once or twice weekly for 50–60 min; in an ideal situation, upon completion of the work, agreeing and planning on working towards a suitable and safe ending session.

It must be acknowledged that there are of course variations to the above, but in general, that is what a traditional framework depicts. Along with the theory briefly mentioned above, the common features of the psychotherapy framework have changed very little since the 1950's, which understandably, in our evolving society, leads us to notice where this framework may not work for certain individuals, groups or presentations today.

One of the most salient research areas of psychotherapy, is the therapeutic relationship and its positive correlation with effectiveness. It has been argued that for this relationship to have a meaningful or positive impact on the therapeutic experience of the client, there must be more than one session. However, it is also evidenced that Roger's core conditions alone impact the effectiveness of psychotherapy. Consequently, it could be suggested that there is a platform for an alternative framework in the form of a single, one-off session, so long as the core conditions are present.

2.1 Single session psychotherapy

Single session therapy (SST) is not a new concept. In Ref. [2] Dryden documents that both Freud and Adler had used a single session approach in the late

1800's and early twentieth century. Over the last two centuries, it could be understood that its use evolved out of a common experience a lot of therapist's encounter; which is that often clients will only ever attend one session. It can be for a number of reasons, but not least of all recognising they are not ready to engage in ongoing therapy sessions. As a consequence, Moshe Talmon published work on the 'effect of the first (and often only) therapeutic encounter' which opened up opportunity to explore how a single session could be used to maximum benefit, whilst also considering the evidence base for distinct features of a psychotherapy framework, such as a pre-assessment session, establishing and utilising the therapeutic alliance, goal setting, therapeutic process, and a safe, pre-planned ending. One of the contraindications of SST is the suitability or effectiveness of a single session for certain presentations, such as PTSD or attachment disorders. That said, there are also benefits that may address downfalls of a traditional framework, understanding that not one size fits all. The most obvious benefit of SST is that it allows the client autonomy to choose as and when they want to engage in a therapeutic encounter; and additionally, an affordable and manageable way of accessing therapy without time or financial constraints. Furthermore, as evidence suggests, SST is effective, despite the assumptions traditional thinkers may purport. That said, it is important to note that SST is not a modality in itself, but more a way of working that can be adapted and used alongside other existing frameworks. As will be discussed further in this chapter, SST lends itself to complimenting a nature therapy framework.

2.2 Nature therapy as an alternative intervention

Nature therapy, also known as ecotherapy or nature assisted psychotherapy, is driven by a social constructivist worldview. It takes the position of understanding that we are not separate to the environment or other systems inside us or around us. For example, our internal biological system is not separate to our neurological system; and we are not separate from the functions of our external work place, families and relationships, or indeed the processes and systems of nature. In understanding that we are not separate from our environment, nature therapy provides the opportunity to explore our relationship with nature, and the meanings that it may have as a parallel to the relationship we have with ourselves.

When referring to nature within this chapter, it will be relating to the outdoors in any form of green space; beach, forest, garden, water, etc. Furthermore, as will be discussed later on, whilst nature is typically found outdoors, working in a nature therapy framework can also include bringing nature indoors, or interacting with it inside, for example: listening to nature sounds; bringing plants/planting inside; working with sand; holding a rock or a leaf in your hand.

Nature therapy can take a wide variety of contexts and approaches, including horticultural and group projects, or sitting on a beach and talking with the therapist. As the area is so broad, for the purpose of this chapter, nature therapy will be referred to in the context of a psychotherapeutic framework, as opposed to social/community experiences or projects, and will include both the outdoor and indoor setting. Furthermore, it is important to note that there are currently no advanced or singular, evidence-based nature psychotherapy frameworks, and so this too, can be thought of like SST, in that it is an approach rather than a modality that can be used and developed alongside existing frameworks.

2.3 Limitations to traditional room-based, talking therapy frameworks

General presentations such as anxiety and depression can be easily and effectively addressed within the therapy room. The therapy room can feel like a safe and containing space to many individuals, couples, families, and groups. That said, even in these instances, depending on age and gender, a barrier to starting this type of therapy may be stigma and managing to engage with the service in the first place. For example, there is plentiful research literature that supports the concept that men, in particular are less likely to engage in traditional room-based psychotherapy, as well as young people, due to societal judgements and pathologizing attitudes that suggest 'you may be mad' or 'weak' if you are having counselling or psychotherapy. Organising and attending an appointment outdoors in nature at the beach, forest, or botanical garden can remove the potential and fundamental challenge of overall and initial engagement relating to stigma, and often presents as less formal and therefore not intimidating and clinical.

In thinking about the types of difficulties clients might face and where room-based settings may not work or indeed be suitable for the client, post-traumatic stress disorder (PTSD) or psychological trauma of any type is a great example. When a person experiences trauma, whether it is a one-off event or prolonged experience, afterwards, it often leaves the body in what we would call a hyper-vigilant state: the brain is telling the nervous system to constantly be ready for oncoming threats, and as such, similar or other environmental cues can trigger the brain into the primal survival response of fight, flight or freeze. In my clinical experience, it is most common that individuals seeking therapy for trauma related difficulties can find being shut in a small room with another person very triggering. By that, I mean their nervous system can perceive that setting as a threat. Often the notion of being trapped inside a room and not being able to 'flee' (flight) when triggered is a barrier for someone of this presentation engaging in this type of therapy at all.

Continuing with the example of PTSD/trauma, we can also discuss the other two responses (fight and freeze) the brain may instruct when triggered, which are not just limited to a trauma survivor, but can be present in a number of different presentations such as autism spectrum disorders (ASD), generalised anxiety, etc.; in fact, any of us, at any moment could experience this during therapeutic processing. In Ref. [3] I describe in more detail the cognitive processes involved, and the nuances of cognitive/top-down therapies versus body/'bottom-up' therapies. When we experience a highly stressful or traumatic event, functioning in several areas of the brain is disrupted. Additionally, part of our brain called Broca's area, responsible for retrieving verbal memory will shut down. Its function is to enhance our survival in a potentially unbearable physical or psychological painful event(s). What this means in relation to talking therapy, is that when we try to recall traumatic memories, Broca's area will shut down in the present moment, leading to the client freezing in the room, unable to speak or move. This can disarm an unexperienced therapist, and re-traumatise the client, leaving both parties in a fairly powerless and hopeless position.

In considering the fight response and the relevance to working with clients in a room-based setting, similar can be said to the previous discussions. When attempting to process past memories, or indeed present experiences, particularly when clients are in a state of hyper-vigilance, there is just as much chance that their brain may respond with a 'fight' response. When shut in a room, this can be dangerous and traumatising for both the client and therapist, not least of all that the room can be a trigger in itself. If the therapist has experienced trauma themselves, and becomes triggered

from a severe anger response, it could be an extremely dangerous situation if neither can escape. Whilst general safety measures are taught during therapy training for managing high risk situations, such as to sit in the chair nearest the door, and have a panic alarm nearby, if the freeze response occurs for the therapist in a highly charged situation, these safeguarding parameters become void.

The limited examples I have provided in this section are enough of an argument to consider the need for alternative settings or modalities, and not least of all in relation to the importance of the type of processing that is required for individuals in many presentation groups. As briefly mentioned above, there are times and situations where an individual is unable to attend sessions in a room, and more specifically, where there is a need for the type of processing to be non-verbal, or 'bottom-up' as opposed to 'top-down'.

Top-down processing can be understood as cognitive-based talking therapy interventions, which rely on functions of memory and attention bias. When considering the information presented above in regards to Broca's area, this form of processing poses a problem and indicates a need for an alternative intervention [3]. Furthermore, in considering other presentations or individuals who might struggle to engage in a talking therapy setting; executive functioning and attention bias are evidenced as key areas that are fundamental for cognitive or talking therapies to work. Consequently, for those with PTSD, ASD or similar presentations, an alternative, effective solution is needed.

2.4 The medical versus biopsychosocial model

When considering our human existence and our own sense of self, we are forced to consider our own world views on whether we feel our minds are separate to our bodies, or whether they are indeed interconnected as one. Cartesian theory suggests that our mind functioning is separate to our body functioning, and importantly to note, fits hand in hand with the medical model, adopted by national health services, medical insurance companies, the pharmaceutical industry, and medical practitioners today. The medical model attempts to locate within the body, individual ailments or disease; also known as pathologising. This way of understanding our human existence leaves little room to consider the environments we exist in, such as family, work, school etc., and the influences these play on our well-being; socioeconomic factors influencing diet, or workplace factors influencing stress for example.

In considering the topic of stress; it is a well-documented concept that stress caused from external environments has a strong relationship with physical ailments and disease. Let us consider I have a headache: I can either take a pain killer (medical model approach) or I can evaluate whether there's something in my environment that is causing this, or perhaps how much water I have had to drink, or how much fresh air or exercise I've had. The latter way of considering the headache would be fitting with the biopsychosocial model, which differs to the medical model by taking into consideration the connection between body and mind, and takes the view that our bodily systems are all interrelated, and in relation(ship) with our external environments.

It can therefore be argued that talking/cognitive/top-down therapies are mostly based on the medical model approach, with exceptions such as sensorimotor and body psychotherapies, which may be conducted in a room-based setting alongside talking therapy. This poses several ethical questions about accessibility, suitability, inclusivity, working with diversity, and highlights the need for alternative interventions or approaches to traditional frameworks. Furthermore, therapists working

within a room-based setting may feel limited to those confines, and, restricted therefore in their interventions in regards to responding to current global issues. Interventions carried out in a room-based setting, may encourage use of techniques, such as issues of anxiety raised about the client's external situation, as being a platform for exploration of past events (e.g., CBT/Psychodynamic), placing the issue inside the individual, thus taking an individualistic, pathologising position, which could potentially be harmful to the client.

2.5 The importance of mind-body connection and bottom-up processing

As humans, we have evolved to move away from using our bodies as sensing tools in regards to primal safety, non-verbal communication, illness, and so on. Over time, we have formed a reliance on language as our primal form of communication; a reliance on cognitive processes to make sense of situations, including physical illness; and become increasingly dissociated and desensitised from our bodies. It is of my opinion that the over-reliance on these cognitive functions forms an extensive part of mental distress/disorders seen today. Take depression for example: clinical depression diagnosis is generally treated with medication and cognitive behavioural talking therapy, and commonly understood by society as being negative, or someone having something wrong with them (pathologising) by experiencing low mood or suicidal thoughts or feelings, thus fitting into the medical model appraisal.

The umbrella term of depression however, can be thought of very differently, as a straightforward, animalistic behaviour that is shared across the mammalian life span. In understanding it in this way, we can consider its purpose as being there to communicate when we need to hibernate, withdraw from our environment, rest, or process a difficult, stressful, or upsetting situation. This perspective would fall into the biopsychosocial model of understanding.

These examples start to paint a picture of how society has been conditioned to desensitise, and dissociate from primal, body-mind functions, and instead, adopted a shaming culture in which pathologising labels are used to diagnose one another. Following that, it is then expected that if you are not functioning in a typical 9–5 job; coping with the kids; your elderly parents; your kid's school projects, and whatever else life throws at you, that there is something wrong with you.

For all the reasons named above, it is glaringly obvious that through human evolution, we have lost touch with our body-mind connection, and in doing so, the essence of our true selves and external environments.

2.6 Human evolution: adjoining the inner and outer worlds

According to Psych Central, 'human beings have been talking about their inner lives and challenges with one another therapeutically for centuries' [4]. Our inner world can be understood as our thoughts, feelings, emotions, beliefs etc., whilst our outer world are external factors making up and relating to our physical existence, such as material objects. It can be slightly more complex than this, as the outer world is also what we display and communicate to others. It has been said that our outer worlds reflect our inner worlds, but this opens up a curious topic for discussion. Does what we feel inside always match what we display to others in our outer world, and does it always align with the situation or setting we are in? For example: Susan's sister is about to have life threatening surgery after a car accident. She is concerned and distressed, but has a presentation to deliver at work in order to secure an important

contract; she is likely to display a professional, jolly, composed, disposition to her work colleagues on the outside, which does not reflect her true, inner world at that time. This process is likely a form of dissociation, which is where the brain has the ability to detach from our feelings and bodily sensations, including distress and physical pain. It is an inherent, primal mechanism which serves to protect us during highly stressful or traumatic events in order to survive.

Today, within our high-pressured culture, there are many situations similar to Susan's where society dictates a set of norms or behaviours that are acceptable to display in public or as part of our outer world. One particular example comes to mind when considering a shared human, inner world experience, which is the feeling and expression of anger. Anger is one of Darwin's six basic emotions which he hypothesises are shared across the human and animal life span [5]. Anger is a core emotion that we all experience as humans. It is another primal, survival response that serves to protect us when we are in danger, and ties in with the notion of fight instead of flight or freeze. Within society, healthy expressions of anger are not acceptable in many settings or situations, and in this case, there would be a need to not display our true, outer world. We are taught very early on as children that expressing anger is not allowed, and that it is bad, as opposed to emotions such as happiness, surprise, etc. Bearing in mind anger also serves as a primal safety mechanism (fight/flight), what do we then learn to do when we are in situations where we feel angry? As children, most of us would've found some form of dissociative mechanism that allowed us to detach from feeling angry, in order to display an incongruent reflection of our inner world to our outer world, which begs the question as to what else we dissociate from, and how normal this has become as part of human evolution.

The importance of living congruently between our inner and outer worlds is not something that is spoken about much outside the psychotherapy industry, nor is it particularly acknowledged, which suggests that incongruence in our lived experience has become a societal norm. My clinical experience both directly with clients, and indirectly through supervising practitioner's work with their clients, shows a salient theme in regards to the societal pressure of holding it all together, and "*keeping up with the 'Jones'*", displaying an incongruent or false outer self. Children in particular, are increasingly suicidal from the emotional overwhelm, and pressure to cope and maintain this perfect image, which ultimately results in switching off the bodily, emotional, felt-sense and over using cognitive processes to try and fake. This leads to dangerous levels of dissociation and is currently creating a crisis that is unmanageable for national health services. As traditional talking therapy frameworks are in crisis, I postulate whether an alternative framework such as SST or indeed nature therapy interventions would be beneficial in attempting to manage this.

2.7 The importance of a congruent, environmental framework for therapy

Speaking very generally and across a broad spectrum of presentations, in my clinical experience, a lot of clients seek therapy due to a form of distress becoming intolerable or unbearable, resulting in difficulty experiencing emotions and the overwhelm these can cause. This can be because of coping strategies developed as a child to survive in the family environment; stress or trauma due to a single or prolonged experience; illness and so on. What I have experienced as a theme shared amongst these clients, are that their inner world experience is not able to align with their outer world, lived-experience; not dissimilar to Roger's theory that clients seek therapy in a state of incongruence, that there is a conflict that they are seeking help to resolve. In

exploring some psychological symptoms that might conceptualise these difficulties further, let us consider an example: Mark is a successful, driven, businessman who plays golf on the weekend with his friends. He is the life and soul of the party, but at home, he is quiet and introverted, and has started drinking a bottle of vodka each night, which is impacting his family/home life. He has contacted the psychotherapy practice to seek help as he is afraid of losing his family due to his drinking. I have given this example as I believe that even without psychotherapeutic training, we can see that there are two lived experiences for Mark, which we might infer as relating to both a congruent inner world reflection (the home experience of drinking etc.) and an incongruent inner world reflection (appearing to function as successful, life and fun of the party). The distress the conflict is causing Mark is what has led him to seek therapy.

Our work with Mark might involve exploring his inner world, and finding out if there is an underlying reason or process that is leading to the conflict between his inner and outer worlds, causing the intolerable distress that leads to the coping strategy of drinking alcohol/numbing, and feeling depressed. Whilst we could go a number of ways and much deeper with Mark's psychological formulation, this section is about exploring the inner and outer worlds of our lived experience, and what that might look like. Mark's example is sadly not uncommon, and is a classic illustration of trying to function in a society that demands a certain level of functioning, including what emotions and feelings are acceptable to show to the outside world. As a result, Mark is left with a distressful, incongruent existence.

2.8 Nature therapy and its applications

Whilst the same could be said for traditional room-based settings in some areas; a core strength of nature therapy is the broad range of settings and activities that can be offered to different groups of people with varying abilities and disabilities; those who are non-verbal and or experience difficulty in speaking, including language differences; and ethnic and socio-economic factors. It has been highlighted in previous discussions in this chapter, that room-based settings pose ethical compromises for inclusivity and working with diversity; nature therapy is able to lend itself to working with a broad range of presentations including trauma/PTSD, ASD etc.

Nature offers a congruent, non-judgmental space for people to recover. These attributes are parallel components to the humanistic conditions that Rogers specifies as necessary for therapy to be effective. In nature, people feel they can be their true selves, and consequently can feel 'at one' or connected to nature, regaining the natural connection to their body, emotions and feelings. This is not only experienced as a relief, but often an opportunity to process and be with feelings that have been avoided or numbed for long periods of time. When combining nature with traditional frameworks of psychotherapy, there is something that is immediately shared in an experiential way between the therapist and client in comparison to a room-based setting. We have all experienced being in or around nature at some point in our lives, and according to existing literature, we will have had at least one positive experience in doing so. It could therefore be suggested that the nature element has a positive influence on the therapeutic relationship, which, as Roger's first postulated; is the core of successful therapeutic encounters. In the same vein, our own relationship with nature encourages something phenomenologically different to emerge, in comparison to what might be experienced in a room-based setting, where, without nature, an incongruent self can still be present. Consequently, nature therapy alongside even an

SST session is likely to be a positive substitute for traditional room-based frameworks when considering this aspect. When combining nature therapy with SST, accessibility in terms of affordability and time commitment, supporting an autonomous, client-led service, are offered.

Allowing a natural space to connect to the body within therapy sessions can lead to processing of feelings, emotions, and memories that are stored in the body. Van der Kolk's extensive research suggests that body processing is required in order to work with trauma, in particular which can lay dormant in the body for years [6]. Additionally, other neuropsychological research has taught us, that rather than pushing away or ignoring and numbing thoughts and feelings, and instead taking time to feel and experience them, actually leads to positive processing and being able to move on and detach from unhealthy patterns [7]. In some cases, solely relying on talking therapy in a room-based setting, can mean that clients are unable to move away from repetitive, intrusive and overwhelming thoughts and feelings, and get stuck on a loop through rumination. We could be the best psychotherapy practitioner in the world, delivering the perfect intervention, however, it is clear that as mankind has evolved, in a lot of cases, we require something more than talent and traditional psychotherapeutic frameworks in order to address complex dissociative and embodied issues.

2.8.1 Benefits of nature therapy

The direct physical and mental health benefits experienced from nature have long been documented in scientific studies, as well as qualitative measures that report client's verbal accounts of their experiences in nature. Since the global pandemic occurred in 2020, salience of people recognising the importance of connecting to nature for their mental as well as physical wellbeing by gravitating to natural spaces, has been well documented. Bringing nature indoors, spending more time in the garden, and travelling to green or outdoor spaces have become increasingly popular as people experience the benefits of nature to their physical and mental wellbeing.

Nature therapy is diverse in its applications, as not only can practitioners work with clients outside in a broad range of settings, such as the beach, forest, countryside, and garden; it is also possible to experience the benefits of nature inside the room. The latter lends itself to ensuring inclusivity and all corners of the population are able to be reached, no matter what their psychographic or demographic. Including nature within the room-based setting can be achieved by bringing natural elements such as sand, plants, and water into the surroundings to create a natural environment inside. These elements can also be used through other senses such as touch (sand or plants), smell (plants with perfume/strong scents), or sound (running water, rain, birds and wildlife sounds). Working in this way offers a platform for mind-body connection, grounding and working in an embodied way, which research literature suggests is necessary, particularly in considering the prevalence of dissociation and internal conflict which can be argued, is causing a lot of mental illness and dis-ease. Once again, nature therapy can lend itself to working well alongside other therapeutic modalities, which offers a broad and diverse way of working with many presentations. Importantly, this means that the issues discussed previously surrounding disconnection to the body, and reliance on cognitive processes as an intervention, can be re-evaluated and combined with a somatic, nature approach.

Working in nature also addresses societal challenges relating to stigma in accessing psychological services. Attending a session in a green space is far more appealing to those with pre-conceived concepts of the negative connotations surrounding

psychotherapy, and consequently makes nature therapy accessible to large demographics of people who may not ordinarily seek help. On an organisational level, this can boost engagement rates for services, and improve service level outcomes. The physical and psychological benefits of spending time in nature have been reported for centuries. There is a large body of research that has documented the following benefits, specifically from engaging in nature assisted psychotherapy [8, 9]:

- Reduced anxiety, stress, and depression
- Increased self-esteem and positive self-image
- Reduced cortisol (stress hormone) levels, which in turn has been shown to reduce physical pain and emotional overwhelm, thus supporting PTSD and borderline personality disorders
- Improved mental as well as physical relaxation, thus supporting anxiety and ADHD presentations
- Increased feelings of 'awe' which is related to gratitude and selflessness: these emotions documented in improving mental states of mind
- Physiological relaxation, which leads to a restorative impact on the parasympathetic nervous system, supporting stress & trauma presentations, borderline personality disorders and more
- Overall, the psychological benefits have a direct impact on the positive function of the immune system, thus improving physical health. It is also documented that nature therapy lowers heart rate

2.8.2 Practical exercises for working with nature therapy

As discussed earlier, there are a multitude of variations for working therapeutically in nature. As this book is directly relating to psychotherapy and counselling, the following exercises are suggested for suitability for that context and framework. Whilst it is important to consider the evidence base for efficacy of any intervention we are delivering; less is known about traditional psychotherapy models being combined with outdoor/nature spaces. That said, there is a growing evidence base for combining the two, and also for enhancing traditional settings by bringing alternative or nature therapies into the room, as well as saliently, by incorporating mindfulness into the session (e.g. Mindfulness based cognitive therapy).

2.8.2.1 Walk and talk

In its most basic form a 'walk and talk' in any green space can be understood as transferring the therapist's skills to the outside environment, and conducting the session as you would inside a room, but instead, walking instead of sitting. Additionally, grounding and mindfulness exercises can be included to ensure the client is having an embodied experience and remains grounded and safe. This exercise can work well for meeting and sitting somewhere outdoors in nature (preferably somewhere that protects the client's confidentiality) and offer another option for those who may find

walking physically challenging. This exercise creates opportunity for an embodied experience and allows authenticity and congruence, encouraging a body-mind connection.

2.8.2.2 Forest bathing

Forest bathing derives from the Japanese practice known as Shinrin-Yoku. It was developed as a practice for physical as well as mental wellbeing. The idea is to immerse yourself in the forest surroundings by using all five senses. Similar to the walk and talk, this exercise offers opportunity for an embodied, mindful experience, encouraging body-mind connection and an authentic encounter. Sessions can include guided meditations and moments of stillness, either sitting or standing.

2.8.2.3 Mindfulness

Most agree that the definition of mindfulness is simply to pay attention to the present moment by using all five senses. In doing so, we can introspectively reconnect to our body and mind moment by moment. This offers clarity, improved cognitive function, and a reconnection between body and mind. It can consequently help to realign a congruent experience between a person's inner and outer world. Simple mindfulness exercises can be to notice the surroundings, and what you can see, hear, touch, smell, or feel. In nature, we can ask the client to notice every step they take, and how it feels when their foot is connected to the earth etc. Being mindful helps to improve mood, and lower anxiety, as well as increase emotion regulation. Mindfulness based cognitive therapy (MBCT) is a powerful tool, and fitting with the concept of combining nature interventions with room-based work. MBCT teaches the client to pay attention to their thoughts, which in turn can positively impact and change unwanted feelings and behaviours.

2.8.2.4 Grounding

Grounding exercises in nature can be as simple as hugging a tree for a few minutes, to walking barefoot (where safe to do so); or planting seeds/plants with bare hands. This direct connection to nature improves the body-mind connection, and this improves the physical and psychological state of a person. Another grounding exercise that is particularly useful when someone is having a panic attack, is to get them to turn their head and body 360 degrees, as slowly as they can, and notice everything that they can see. Some people like to say the things they notice out loud, others in the mind. If a person is highly anxious, and this interrupts a session continuously, grounding exercises can be done as often as needed.

2.8.2.5 Meditation-guided body scan

For a highly stressed, anxious, or dissociated person to have an embodied experience in nature, a powerful exercise to carry out is a body-scan meditation. It is a great exercise for moving a person away from over-reliance on cognitive function and processes, and into their body. To carry this out, the practitioner invites the client to close their eyes, or focus on something still in the distance. Relaxed, long breaths in and out are encouraged, directing the client to breath into the stomach space, as opposed to the chest. The practitioner then leads the client to mindfully notice each and every

part of their body, from head, to arms, to stomach to toes. Throughout this process, it is common for people to struggle with intrusive thoughts, distraction etc. The practitioner must encourage the mindful practice of noticing these thoughts or feelings, and bring the focus back to the body or the breath each time it occurs. At the end of the scan, the practitioner can ask the client what it is like to be inside their body, whether it is the same or different to usual, etc. They then guide the client to bring awareness back into their surroundings by noticing any sounds or sensations they can feel or hear, and to gradually open their eyes. The practitioner can then explore with the client if they noticed anything during the body scan. This exercise can be carried out at the beginning, and repeated by the practitioner or the client as many times as is needed throughout the session if beneficial. Please note that this exercise may not be suitable for highly traumatised individuals, early on in their process, before they have reached a period of stabilisation. This is due to the levels of dissociation being so high, and at this stage of a client's process, leading them into their bodies can be extremely re-traumatising.

2.8.2.6 Mandala creation

The term 'mandala' derives from Sanskrit and translates as 'circle'. It is a creation of geometric patterns, often used to depict elements of the universe, incorporated with Buddhist and Hindu teachings. In the nature therapy context, mandalas can be created as a form of art using natural elements. The client can be directed to collect flowers, leaves, and different natural elements using a variety of textures and colours. To start with, they would create one large circle on the ground with leaves for example, followed by smaller layers inside. This can be delivered as both a mindful and grounding exercise, and the mandala can be used to represent a dream, the client's life, self-image, as an ending exercise to represent their journey of therapy, etc.

2.8.2.7 Bringing nature therapy inside the therapy room

If you would like to create a natural environment inside the therapy room, you can bring in plants, flowers, rocks, sand, water, fish etc. You can ask the client to connect to the nature through meditation, or breathing it in, or indeed to touch or feel the natural elements. Listening to nature sounds can also promote relaxation, and this can be used as a grounding or mindful exercise. Another exercise that doubles as both mindful and grounding, is planting seeds/flowers. This can also be a metaphor for the client's new journey into therapy. Using sand to create art, or simply to feel and notice the texture can be a useful tool to encourage an embodied experience. Asking the client to hold a rock or form of nature, can work in combining a cognitive therapy intervention with nature therapy. Feeding the fish in the tank can open up dialogue for the meanings of care-taking, encourage connection with nature, and thus with self. Exercises observing the fish can also be very beneficial. A mandala can be created on paper using sand, and other natural elements that the therapist can collect prior to the session.

2.9 Ethical considerations for nature therapy

There are a multitude of questions that the basic ethical framework poses, and many referral agents will ask, when considering working with clients in outdoor

spaces. It is crucial to create policies and procedures in order to address these. Below are 10 examples of questions and areas to be thinking about if you would like to work with clients in nature:

1. Will the professional liability insurer cover the work being carried out in an outdoor setting?

2. What will the procedure be for meeting the client on arrival or the time of their session in place of a receptionist and waiting room, and as such how will the boundaries for start and finish times be managed, including clients arriving/leaving at the same time, and a possible comfort break in between sessions for the therapist?

3. Is the client's confidentiality protected when conducting a session in a green space, and if there are compromises, how will the client be fully informed and consent to this?

4. Are there any safety issues pertaining to working outdoors for mental health or physical risk, e.g. do you need to carry out a screening and inform the client of any physical risks, and in doing so ensure there is an appropriate risk assessment in place for the service (refer to Section 2.6 for more information)?

5. Does the client need to be briefed on any suitable clothing attire to wear, e.g. sturdy shoes for walking, a sun or rain hat?

6. Is the therapist first aid trained in case of an emergency/will they carry a first aid kit, and what will the first aid procedure be?

7. What type of lone working safety parameters are in place if this is the case?

8. Will you need extra training in this area to ensure ethical competency of work is upheld? For example, a 'continuing professional development' training on ecotherapy.

9. Will you outline potential risks or confidentiality compromises in a therapeutic contract to ensure the client is fully informed and consenting to the work being outside.

10. Will you conduct all your sessions in the outdoor setting, or some in a room-based environment? For example, would it be a sensible safety measure to conduct a telephone or in-person room based initial assessment/screening to ensure the setting is safe and suitable for the client?

2.9.1 Addressing diversity and inclusion in nature therapy

It could be argued that there is a slight ethical dilemma in defining who can/cannot participate in nature therapy when you are using a client-led model or approach, as ultimately, we aim to offer the client full autonomy over their

decisions regarding how they participate in therapeutic activities. That said, psychotherapeutic frameworks must be based on safety and managing risk, and the importance of creating a boundaried framework for the service, are what fundamentally help to maintain client safety and manage risk, in order to provide a safe space for effective therapy to take place.

The University of Exeter in the UK have created a handbook [10] for services to refer to when working with service users in a range of therapeutic nature settings. They suggest that the following be taken into consideration when going through the referral and or screening stage:

Ref. [10] suggests that the most important element to building trust with service users or referral agents for nature therapy are: honest and accurate information sharing of the site description. It could therefore be suggested that this falls in line with a client-led model due to the transparency and level of openness in information sharing, which fully informs the client/care giver, and allows them to make an autonomous decision on whether they feel the nature therapy is suitable or safe for them. That said, it should also be taken into consideration the vulnerability of each individual client and their capacity to make decisions safely, as well as a person's lack of experience engaging in a nature therapy session, and the therapist's knowledge of this.

Aside to the general areas mentioned in **Table 1**, during the referral process it could be argued that other considerations should be made for socio-economic and ethnicity factors, that may affect a person's desire or reluctancy to engage in nature therapy. Ref. [11] found that the way in which nature is generally used by different ethnic groups can differ significantly, and may therefore impact their overall experience of nature therapy, and consequently its effectiveness. Evidence suggests that there is a correlation between a person's desire for nature and the effectiveness of nature therapy and vice versa. The research found that in some cultures, the association between past generational trauma and hardship can influence cultural and ethnic attitudes towards nature [10, 11]. It may therefore be a criterion to take into consideration at the initial screening, and consideration be taken for whether this type of therapy would be suitable or indeed damaging to the client, or whether this challenge could be positively overcome.

Accessibility to services is a key area for consideration in this topic. When reflecting on socio-economic factors, it is well understood that psychotherapy has long been framed as being for the private sector, or those who can afford the luxury. This may

Age
Weather
Site Description/Type/Terrain
Length/Number of Sessions
Detailed description of what will take place
Clothing & Equipment
Transport Availability
Limited Mobility/Disabilities

Table 1.
Referral screening considerations: information taken from 'Nature on Prescription Handbook' [10].

present as a barrier for engaging in psychotherapy in any setting, and efforts should be made to ensure that the service framework is inclusive and suitable for people from all economic backgrounds, and to think about things like affordability and accessibility if someone does not have transport. Many green spaces are not on main bus routes, and consequently when thinking about the location for the service, this factor should be considered, in order to not exclude certain people who may not own their own transport. It may be that you are able to offer a shuttle or taxi service as part of your service.

2.9.2 Psychological risk factors

Further consideration in the area of screening and procedures for referral in nature settings is imperative, just as with managing the safety and suitability of services, settings and practitioners, in relation to ethical frameworks such as British Association for Counselling and Psychotherapy [12] for room-based settings. Risks for working outside or in nature must be identified as part of this umbrella framework. The below **Table 2** lists some examples of the areas for consideration and identifies some presentations and behaviours that require risk assessments. Although risk assessments do require careful thinking and extra, detailed paperwork, in most cases, they can allow a diverse range of service users access to therapies that they may have been excluded from otherwise, thus supporting an inclusive, client-led framework.

Table 2 illustrates some examples of areas that require careful thinking, planning, and risk assessment, and the list is endless; however, for the purposes of this chapter, limited examples have been provided. Aside to risk assessments and general considerations for direct harm to service users; it is also important to include the practitioner/therapist and any support workers within these processes. Importantly, a lone working policy must be in place, and where necessary, extra support and human resources present/available. Considerations for health and safety for all stakeholders must also be in place, just as with other settings. It goes without saying that in any setting, when working with high-risk clients, regular supervision and self-care are of central importance in any case.

Presentation/ behaviour	**Brief description of identified risks for consideration**	**How might this be managed**
Schizophrenia	Interruption of cognitive function due to auditory/ visual hallucinations which can lead to harm of self/ others/risk of fleeing in outdoor space	Working in smaller spaces such as a fenced garden, ensuring a care or support worker/close relative nearby/present. Ensuring prescriptive medication is being taken as a condition for attendance
Dissociative Identity Disorder	As above, plus risk of anxiety/panic attacks	As above. Agreeing with the client the importance of transparency when experiencing symptoms and identifying red flags for relapse. Not attending sessions when relapsing if risk too great (risk assessment at screening stage to determine this); provisioning support person to attend and share responsibility for safety; contract with the client beforehand that they must disclose at any point during or outside of the session when they are experiencing symptoms ensuring provision for safety measures/alternative plans.

Presentation/ behaviour	Brief description of identified risks for consideration	How might this be managed
Post-Traumatic Stress Disorder	High evidence for correlation with substance/ alcohol dependence, self-harm, anxiety attacks; triggers in open environment and flashbacks could lead to severe distress, self- harm & suicidality	As above, and including in the contract that sessions are dependent on attending when not under the influence of alcohol or drugs.
Self-Harm/ Suicidality	A larger environment, more options for potential ways to harm	Contracting for transparency and full disclosure for self-harming before, during and in between sessions, encouraging client to disclose when the urge occurs during a session in order to safeguard as best as possible. It may be useful to get the client to keep a weekly diary to monitor patterns and identify times of higher risk. Plus, in-depth risk assessment of potential dangers at the site and for the client at screening stage. Possible support workers, considering not lone working; working in smaller, secure area as opposed to remote, open area.
Substance or alcohol dependence	Being under the influence may impair judgement for making rational decisions- risk of harm to self/others	Ensure to agree in the therapeutic contract the safety implications around not being able to work together if the client should arrive at their session under the influence. To encourage transparency of the client to disclose this. To consider alternatives in order to ensure oppression and inclusivity are considered and supportive of a client-led model, by offering an alternative option; for example, an online session/phone call that is recorded.
Referrals from high security forensic services	Potential for cluster B personality disorders and harm to others, particularly where violence has been used in the past. Secluded environment away from human resources.	Depending on each individual, the setting, and whether it is group/individual work, it would be suggested to have plenty of human resources nearby, and support workers who have an existing relationship with the clients and who are trained in physical restraint in case of physical violence. In these cases, confidentiality within the ethical framework should be carefully considered in order to best support each client. It may also be suggested that consideration for the type of nature therapy (e.g., creation/active horticulture in place of mindfulness in a forest) and working in an enclosed setting which is not too remote.

Table 2.
Presentations relating to metal health diagnoses that require risk assessment.

3. Conclusion

Traditional therapeutic frameworks are well documented as being effective and necessary in many contexts and settings. There is however, a growing need to address the incongruent way of being that society has created, along with the disconnect between body and mind. Additionally, as a result of this, the coping strategies and damaging behaviours that have been adopted to manage this unnatural way of surviving, is causing a crisis, and necessitates more than what the traditional frameworks and settings may be able to offer. Aside to this, as discussed, certain presentations are not suitable for traditional settings, and an alternative framework is needed.

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Nature provides a platform for an embodied, grounding experience, which acts as a powerful, multi-dimensional process in comparison to room based talking settings. Furthermore, as has been documented throughout this chapter, evidence suggests that alternative, bottom-up processes are needed in order to address a broader range of presentations. A single session in nature in comparison to several sessions in a room-based setting do not seem to be of equal comparison. Offering SST in nature creates a platform for combining evidence-based strategies, that support a diverse, inclusive, and ethical framework for psychotherapy. This combined approach allows flexibility to address the evolution of society by offering a timely and financially affordable solution.

Conflict of interest

It could be considered a conflict of interest that the author works within a nature therapy setting, and consequently there may be some bias expressed in the writing.

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References

[1] Rogers CR. The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology. 1957;**21**(2):95

[2] Dryden W. Single-Session Therapy: Distinctive Features. London: Routledge; 2019

[3] Williams P. Working with relational trauma: Limbic restructuring through equine-facilitated psychotherapy. In: Equine-Assisted Mental Health for Healing Trauma. New York: Routledge; 2018. pp. 69-83

[4] History of Psychotherapy [Internet]. 2021. Available from: https://psychcentral.com/lib/history-of-psychotherapy [Accessed: December 21, 2005]

[5] Darwin C. The Expression of the Emotions in Man and Animals. Chicago: University of Chicago Press; 2015

[6] Van der Kolk BA. The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. Harvard Review of Psychiatry. 1994;**1**(5):253-265

[7] Kaplan-Solms K, Solms M. Clinical Studies in Neuro-Psychoanalysis: Introduction to a Depth Neuropsychology. New York: Other Press, LLC; 2002

[8] Hansen MM, Jones R, Tocchini K. Shinrin-yoku (forest bathing) and nature therapy: A state-of-the-art review. International Journal of Environmental Research and Public Health. 2017;**14**(8):851

[9] Nature and Canine Assisted Therapies: Benefits [Internet]. 2021. Available from: https://psychotherapyinnature.com/nature-canine-assisted-psychotherapy/ [Accessed January 22, 2002]

[10] A Handbook for Nature on Prescription [Internet]. 2021. Available from: https://www.ecehh.org/wp/wp-content/uploads/2021/05/A-Handbook-for-Nature-on-Prescription-to-Promote-Mental-Health_FINAL.pdf [Accessed: December 21, 2014]

[11] Collier B. Black Absence in Green Spaces [Internet]. 2019. Available from: http://www.bethcollier.co.uk/blackabsence-in-green-spaces [Accessed: January 21, 2003]

[12] Ethical Framework for the Counselling Professions. [Internet]. 2018. Available from: bacp-ethical-framework-for-the-counselling-professions-2018.pdf [Accessed: December 21, 2020]

Section 3

Practices under the COVID-19 Pandemic

Chapter 7

A Scoping Analysis of the Psychosocial and Health Implications of COVID-19 Comorbidity-Related Complications in the African States: Recent Developments in Counseling and Therapeutic Options

Oluwatoyin Olatundun Ilesanmi, Faith Ibitoyosi Ilesanmi, Raouf Hajji and Garba Moussa

Abstract

Since the upsurge of Coronavirus in 2019, the WHO and the US CDC have been detecting and characterizing new variants and providing updates to healthcare workers, the public, and global partners on its spread and effects on patients with noncommunicable diseases and co-morbid ailments. Epidemiology and virologic evidence suggest that COVID-19 and its subsequent deadly variants have been associated with mental and neurological manifestations, including delirium or encephalopathy, agitation, acute cerebrovascular disease, meningoencephalitis, impaired sense of smell or taste, anxiety, depression, and sleep problems. While data on these complications may be available in the global north and south, there is a paucity of literature in most African States. Recent developments in COVID-19-related theories and concepts include ethical principles for clinical, counseling, psycho-therapeutic, and rehabilitation options for special and vulnerable populations, such as pediatric patients, pregnant women, mothers, older people, PLWDs, and other marginalized groups. However, there is no known coordinated and multidisciplinary continuum of clinical, counseling, and psychotherapy COVID-19 care pathways for symptomatic and asymptomatic patients and their families in the African States. Hence, the need for this scoping analysis of existing literature on the psycho-social and health implications of COVID-19 Comorbidity-Related Complications for vulnerable persons in developing societies.

Keywords: COVID-19, COVID-19-related comorbidity, clinical care, counseling, psychotherapy, continuum of care and African states

1. Introduction

1.1 Background

There is no health without mental health. Mental health is important at every stage of life, from childhood and adolescence through adulthood to senescence. However, the upsurge of Coronavirus (COVID-19) as a global burden in 2019 in Wuhan, China, its high mortality rate and attendant stressors, such as lock-downs, self-isolation and quarantines, infection fears, inadequate information, job and financial losses, stigma, and discrimination, among others have contributed significantly to the increase of negative psycho-social and mental health disorders globally. Since the WHO's declaration of the outbreak of coronavirus disease as a Public Health Emergency of International Concern (PHEIC) and a pandemic between 30th January and 11th March 2020, there had held six different International Health Regulations (IHR) Emergency Committee meetings (third to ninth) for COVID-19 in Geneva. The meetings were specifically held on 30 April 2020, 31 July 2020, 29 October 2020, 14 January 2021, 15 April 2021, 14 July 2021, and 22 October 2021. During each of these committee meetings, it was concluded that the pandemic constitutes a major PHEIC.

The physical burden associated with COVID-19 included symptoms such as mild to moderate respiratory illnesses characterized by fever, dry cough, tiredness, difficulty breathing or shortness of breath, and loss of the ability to smell and taste. Between 31st December 2019 and the week 492,021, five out of 316,017 COVID-19-related deaths and 270,327,277 cases have been recorded in line with the applied case definitions and testing strategies of affected countries. The total number of cases recorded in the global community and the EU/EEA are probably an underestimate of the true number of cases and deaths, due to various degrees of under-ascertainment and under-reporting. Between 9th and 16th December 2021, there had been no changes made to the following ECDC variant classification—*the variants of concern (VOCs), variants of interest (VOIs), variants under monitoring, and de-escalated variant*s.

The COVID-19 pandemic has not only disrupted and altered lives in Africa but a surge in depressive cases, public anxieties, worries [1], and increased risk of mental health symptoms and disorders among vulnerable populations, such as unemployed adults, youth, the elderly, and frontline healthcare workers [2]. Its impact in the Democratic Republic of the Congo (DRC) was complicated by the recent Ebola virus disease (EVD) outbreak reported on 8 October 2021, in Butsili Health Area in the Beni Health Zone, North Kivu Province, even though it has been officially declared over on 16 December 2021. In total, eight confirmed and three probable EVD cases, including nine deaths (six among the confirmed cases), were reported since the start of the outbreak (8 October 2021).

Although the WHO and the US CDC have been detecting and characterizing new variants and providing updates to healthcare workers, the public and global partners on the spread and effects of COVID-19 on patients with noncommunicable diseases and co-morbid ailments, Corser [3] posit that the impact of COVID-19 on the mental health of individuals is an unfolding urgent crisis. Additionally, epidemiology and virologic evidence suggest that COVID-19 and its subsequent deadly variants have been associated with mental and neurological manifestations, including delirium or encephalopathy, agitation, acute cerebrovascular disease (including ischaemic and hemorrhagic stroke), meningoencephalitis, impaired sense of smell or taste, anxiety, depression, and sleep problems. WHO [4] found that out of 775 adults, studied in the United States, 55% believed that COVID-19 had dangerous effects on their mental

health, while 71% felt agitated about the negative impacts of isolation on their mental health. Pappa, Ntella, Giannakas, Giannakoulis, Papoutsi, and Katsaounou [5] also associated personality changes consistent with depression with COVID-19-induced encephalopathy. Zhang and Ma [6] reported that symptoms of depression, anxiety, fear, stress, and insomnia, increased during the pandemic.

1.2 Variants of COVID-19

Toward the end of 2020, the emergence of specific variants of the COVID-19 pandemic that constitute a greater significant risk to global public health led to the listing of specific Variants of Interest (VOIs) and Variants of Concern (VOCs). This classification aided the prioritization of global health monitoring, research, and ongoing response to the pandemic. According to the SIG Variant classification scheme, the following are the four main classes of SARS-CoV-2 variants (see **Table 1**).

a. **The Variant being monitored (VBM):**

   i. **SARS-CoV-2 lineage—B.1.1.7**: According to the European Centre for Disease Control and Prevention [7], this variant originally detected in the United Kingdom (UK) is defined by multiple spike-protein mutations (deletion 69–70, deletion 144, N501Y, A570D, D614G, P681H, T716I, S982A, D1118H) present as well as mutations in other genomic regions. It is significantly more transmissible than previously circulating variants with an estimated potential to increase the reproductive number (R) by 0.4 or greater with estimated increased transmissibility of up to 70%. This poses a challenge to the monitoring of the spread of the virus at the population level to assess the effectiveness of containment strategies—including vaccination. Vaccine inequity leaves most African countries helpless in the wake of more deadly variants.

   ii. The alpha, gamma, and beta variants continue to be monitored but are spreading at much lower levels in the U.S.

b. **The variant of interest (VOI)**–Currently, no SARS-CoV-2 variants are designated as VOI

c. **The variant of Concern (VOC)**: Currently designated variants of concern (VOCs) + are:

   i. **Delta (B.1.617.2 and AY lineages)**: The Delta variant of COVID-19 is highly contagious and still dominant worldwide. It has been labeled a variant of concern by WHO because of its increased transmissibility and increased ability to cause a severe form of the disease. The greatest risk of transmission is among unvaccinated people. People who are fully vaccinated can get vaccine breakthrough infections and spread the virus to others

   ii. **Omicron (B.1.1.529 and BA lineages)**: The eCDC classified a SARS-CoV-2 variant belonging to Pango lineage B.1.1.529 as a variant of concern (VOC) on 26 November 2021, due to concerns regarding immune escape and its potentially increased transmissibility. The WHO also classified this variant as a VOC and assigned it the label Omicron. As of 16 December 2021,

The WHO's label of COVID-19 Variants	Pango lineage•	GISAID clade	Next strain clade	Additional amino acid changes monitored d°	Earliest documented samples	Date of designation
Alpha	B.1.1.7	GRY	20I (V1)	+S:484 K + S:452R	The United Kingdom, Sep-2020	18-Dec-2020
Beta	B.1.351	GH/501Y. V2	20H (V2)	+S: L18F	South Africa, May-2020	18-Dec-2020
Gamma	P.1	GR/501Y. V3	20 J (V3)	+S:681H	Brazil, Nov-2020	11-Jan-2021
Delta	B.1.617.2	G/478 K.V1	21A, 21I, 21 J + S:417 N	+S:484 K	India, Oct-2020	VOI: 4-Apr-2021 VOC: 11-May-2021
Omicron*	B.1.1.529	GRA 21 K, 21 L 21 M	+R346K	Multiple countries, Nov-2021	VUM: 24-Nov-2021	VOC: 26-Nov-2021

Source: *WHO: Tracking SARS-CoV-2 variants. Available at https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/*

Table 1.
Variants of COVID-19.

overall, there were 15,778 confirmed cases of Omicron VOC (an increase of 13,608 cases since the last report on 9 December 2021) reported globally by 85 countries. The number of countries reporting cases with the SARS-CoV-2 Omicron VOC continues to increase globally. Africa has detected 8,982,687 cases; the five countries reporting the most cases are South Africa (3167497), Morocco (951482), Tunisia (719662), Libya (378105), and Ethiopia (373115). Africa has had 224,869 deaths with most deaths occurring in the following five countries—South Africa (90137), Tunisia (25437), Egypt (21060), Morocco (14796), and Ethiopia (6829).

d. **The variant of high consequence (VOHC)n:** Currently, no SARS-CoV-2 variants are designated as VOHC

All variants of COVID-19 can cause severe disease or death. While data on these complications may be available in the global north and south, there is a paucity of literature in most African States.

1.3 Rationale

The upsurge of Coronavirus as a global pandemic and its attendant gender-related socio-economic problems have sparked up depression, sadism, suicidal ideation, and all manner of psychiatric ailments across the globe. The pandemic that claims millions of lives both recorded and unrecorded deaths created a new wave of mental ill-health and vicarious trauma even for clinicians attending to COVID-19 patients.

The prevalence of these illnesses and traumatic experiences among clinicians and significant persons attending to the sick or those who have lost loved ones to the pandemic is yet to be determined. The policy strategies deployed for containing the spread of the pandemic increased unemployment, financial insecurity, and poverty. It also had grave impacts on mental health by increasing social isolation and loneliness that have been strongly associated with anxiety, depression, self-harm, suicide attempts, and emotional problems across the lifespan. The effect of social (or physical) distancing measures affects mental health within a syndemics approach through interacting socio-demographic forces (eg, aging, rising inequality) and health conditions (eg, chronic diseases and obesity) that yield resultant comorbidities.

More so, the World Health Organization in its new Mental Health Atlas report identified the growing need for mental health support and a worldwide failure to provide people with the mental health services needed during the COVID-19 pandemic. In a policy brief on COVID-19, the United Nations also mandated the need to provide high-quality data on the psychological impacts of the COVID-19 pandemic [8].

1.4 Purpose of study

The purpose of this study is to examine the psychosocial and health implications of COVID-19 Comorbidity-Related Complications among selected vulnerable groups in the African States, identify which sub-groups are most vulnerable to psychological distress, identify the risk and protective factors associated with this population's mental health, and to highlight recent developments in counseling and therapeutic options.

1.5 Objectives of study

The study contributes to informing where mental health interventions, together with organizational and systemic efforts to support this population's mental health could be focussed in an effort to support psychological well-being.

1.6 Research questions

a. What are the COVID-19-related mental health theories?

b. Are there existing policies or plans for managing mental health issues associated with COVID-19 in Africa?

c. What is the prevalence of the mental health consequences of COVID-19 containment measures, socio-demographic forces, and other health conditions for vulnerable groups?

d. How can the mental health consequences of the COVID-19 containment measures, socio-demographic forces, and other health conditions among vulnerable groups be mitigated in Africa?

e. What are the basic psychosocial counseling principles for COVID-19 positive patients and other significant persons?

2. Methodology

2.1 Research design

To address the stated research questions and objectives, the study adopts a desk review of the literature. The desk review of literature includes scoping existing online records, scientific articles, and reports published in English on the pandemic, related comorbidities, and mental health between 2000 and 2021. All scientific articles were obtained from the online database, while country and continent-specific reports and preprint articles were abstracted using google scholar.

3. Results

Question 1: what are the COVID-19-related mental health theories?

According to WHO [9], mental health is a state of well-being during which the individual realizes his or her own abilities, has the capacity to cope with the normal stresses of life, works productively and fruitfully, and makes meaningful contributions to his or her community. In other words, mental health is not just the absence of mental illness, but the presence of well-being. Cohan and Cole [10] and Ilesanmi and Eboiyehi [11] asserted that disasters have complex, multi-faceted, and long-lasting mental health implications for the people who experience them and vicarious trauma effects on their caregivers. Maths, Nirmala, Moirangthem, and Kumar [12] reported that the prevalence of mental health problems in populations affected by disasters was two to three times higher than that of the general population.

Sturgeon [13] posits that the determinants of mental health and well-being during the pandemic are both psychological and social factors. The psychological factors encompass emotions (e.g., anger, guilt, and grief), thought processes (e.g., hopelessnesses, helplessness associated with the pandemic), beliefs (e.g., about the outbreak, its attribution, and those affected by it), and so on. The social factors entail access to family and community networks during the COVID-19 quarantine, economic factors, stigma and discrimination, cultural practices, and so on. Both psychological and social factors interact with each other to influence the mental health and well-being of individuals during the pandemic.

Consequently, the general theoretical mental health assumption related to COVID-19 and its associated comorbidities as well as the containment measures (quarantine) is that undue distress, a sense of loss, and impairment to social and occupational functioning can stem from losing direct social contacts, loved ones, employment, sources of income, educational opportunities, recreation, freedoms, and social supports. This can be worsened by the gripping fears and anxieties of its morbidity, mortality, and efficacy of high transmission. These anxieties include constant fears of getting infected and passing the infection to friends, families, and coworkers, as well as fear of survival when infected. The development of this mental stress is an emergency needing mental health response. Nearly 20 months into the global health crisis, the pandemic fatigue worsened by the resurgence of more deadly variants is contributing to and creating risks of mental distress of losing jobs, keeping families safe, or the sweeping uncertainty of the future.

Gallagher and Wetherell [14] classified the mental health implications of COVID-19 and its associated comorbidities as peritraumatic stress occurring during or immediately following infection. Biello [15] highlighted the following characteristics of pre-trauma in the current global pandemic scenario as including:

a. **Lack of predictability**: This entails the disruption of daily routines as a direct consequence of the pandemic.

b. **Immobilization**: This refers to the containment measures, such as physical distancing, limited mobility, and quarantine at home.

c. **Loss of social connection**: This refers to the sudden and unnatural interruption in social connectivity and physical engagement, resulting in the sudden disruption of the very nature of human interactions.

d. **Numbing out:** Numbing out is a protective reaction that prevents emotional overload. Excessive numbing out can result in the loss of agency and sense of control over individual actions and choices. It entails being aware of oneself, feelings, and emotional discomfort. Non-realization of these feelings and emotional discomforts can result in automatic outbursts of anger, fear, or irritation.

e. **Loss of time perception or dyschronometria**: This infers distortion of an individual sense of time perception. It is a condition of cerebellar dysfunction in which an individual cannot accurately estimate the amount of time that has passed as a result of shock from the traumatic situation. It is an overwhelming loss of sense of time, tracks of events, and differences in each and every moment.

f. **Loss of safety**: The high rate of COVID-19-related deaths and the associated violence experienced by many during the total lockdown has resulted in the loss of physical sense of safety, social safety, job loss, and loss of social connection.

g. **Loss of meaning for life**: The psychotherapists need to assist patients to gain meaning for life out of the current adversity and find their roles and purpose through existential safety and satiation of basic needs such as food, safe shelter, and jobs, as well as on the psychological mind.

Question 2: are there existing policies or plans for managing mental health issues associated with COVID-19 in Africa?

Since Africa recorded its first COVID-19 case in Egypt on 14 February 2020, a significant number of countries have reported cases in capital cities and multiple provinces. As of 2020, out of the WHO's 194-Member States, only 51% had mental health policies or plans that are in line with international and regional human rights instruments. More so, only 52% met the target relating to mental health promotion and prevention programs, and these are way short of the 80% target. The only 2020 target met was a reduction in the rate of suicide by 10%, but even then, only 35 countries had a stand-alone prevention strategy, policy, or plan.

In compliance with the WHO's Mental Health Policy Action Plan (2013–2020) that aimed at preventing mental disorders; providing care; enhancing recovery; promoting mental well-being and human rights, as well as reducing the mortality, morbidity, and disability of persons with mental disorders, the following are the existing MHP in African nations:

a. **Kenya:**

   i. **Mental Health Preparedness and Action Framework (MHPAF):** This is the MHP framework in Kenya prior to the pandemic. The MHPAF provided a useful schema for evaluating and guiding the mental health response during the COVID-19 pandemic, its implementation remains a major challenge for the poorly resourced mental health system. Kenya currently has no formal mental health response plan for its COVID-19 response. The nation majorly had an unmet need for psychological first aid.

   ii. **Mental Health Surveillance System**: Kenya also lacked a mental health surveillance system, thereby limiting its ability to design evidence-based interventions [16].

b. **South Africa:** South Africa's mental health laws promote a community-oriented approach

c. **Ghana:** The mental health aspect of the pandemic is yet to receive the desired policy attention in Ghana. Although the nation has a Mental Health Act, established Mental Health NGOs, and Increased media attention on mental health care [17], its mental health system has been neglected for far too long while there are doubts about how the system can respond to the mental health aspect of COVID-19 [18]. Like other African nations, the mental health system in Ghana is, generally, a neglected area in the health care system due to years of underinvestment and it still is amidst the COVID-19 pandemic [19]. There is, therefore, an urgent

need for mental health policymakers and policies to alleviate the potential threat of the pandemic to the mental health of Ghanaians

d. **Cameroon:**

i. **Cameroon Crisis Response Plan 2021–2022:** This plan provides tailored lifesaving assistance and protection, complemented by efforts to build community-based approaches for the attainment of durable solutions, seeking to prevent forced displacement and favor reintegration by addressing the drivers of crises, supporting mechanisms of conflict management and reduction, and building resilience in communities

e. **Nigeria:**

i. **The Lunacy Act of 1958**: The nation's mental health system is still governed by the Lunacy Act of 1958, which dates back to Nigeria's colonial era. Although stigmatization and mental health are among the greatest challenges to the national response to COVID-19, Nigeria is yet to prioritize its policy reform for mental health infrastructure.

ii. **National Policy on Mental Health Device Delivery 2013**: This policy emphasizes the development of community-based services for persons with mental health conditions, but its implementation is very limited across the nation.

iii. **The Mental Health and Substance Abuse Bill - 2019**: Since the return of democratic governance in Nigeria, no civilian administration has enacted a law focusing on protecting mental health except for the 9th National Assembly that is currently reviewing the Mental Health and Substance Abuse Bill – 2019, which aims at strengthening the capacity and regulatory environment for those who experience mental health distress in the wake of COVID-19.

iv. **National Budget**: Nigeria has no clearly defined budget allocation for mental health in its national health budget, while there is inequality in the distribution of mental health services and available resources.

Question 3: what are the prevalence of the mental health consequences of COVID-19 containment measures, socio-demographic forces, and other health conditions for vulnerable groups?

The mental health impact of disasters usually outlasts their physical impact, thus indicating that the elevated mental health impacts of COVID-19 will continue well beyond the outbreak of the pandemic. The vicarious trauma of the pandemic on clinicians and other health care providers during outbreaks may last up to three years after an outbreak. According to Carfì, Bernabei, and Landi [20], reports from viral outbreaks in earlier centuries, including the deadly "Spanish Flu" pandemic of 1918–1920, describe an increased incidence of neuropsychiatric symptoms such as insomnia, anxiety, depression, mania, psychosis, and suicidality. They also claimed that the full impact of COVID-19 on mental health may be known for several years, but it is likely to be significant—and potentially chronic in some patients globally.

However, Panchal et al. [21] noted that about four in 10 adults had symptoms of anxiety or depressive disorder prior to the onset of the pandemic between January

to June 2019 in the U.S. The Mental Health America (MHA) [22] reported surging rates of depression, anxiety, and other mental health problems because of COVID-19 among the people accessing their online mental health screening services. MHA observed a slight increase in the demand for mental health care between January and April 2020, a sharp spike around May and June of the same year. The MHA report also noted that screenings for anxiety (406%) and depression (457%) in June 2020 were greater than those in January. There was also a spike in the percentage of people diagnosed as "at-risk" for psychosis during the onset of the lockdown and self-isolation in May 2020. This continued to rise in June to more than four times the number in January. A six-fold increase was noted for those considering suicide or self-harm. The MHA [22] observation was confirmed by A KFF Health Tracking Poll in the US around July 2020 to 2021 on the mental health impacts of COVID-19 among adults that showed difficulty sleeping (36%), eating (32%), increases in alcohol consumption or substance use (12%), and worsening chronic conditions (12%), due to worry and stress over the coronavirus.

These have been worsened by the enforcement of the containment measures, including restriction of movements and self-isolation procedures, which led to increasingly negative and poor mental health outcomes. For many, this has been compounded by job loss and loss of income. In the US, more than half of young adults (ages 18–24) captured by the KFF study reported symptoms of anxiety and/or depressive disorder (56%). While the majority of these had suicidal thoughts (26% vs. 11%) during the pandemic, there were further concerns around poor mental health and well-being for children and their parents, particularly mothers, as many experienced challenges with school closures and lack of childcare. Panchal, Kamal, Orgera, Cox, Garfield, Hamel, and Chidambaram [21] claimed that women with children are more likely to report symptoms of anxiety and/or depressive disorder than men with children (49% vs. 40%).

Panchal et al. [21] further reported that Non-Hispanic Black adults (48%) and Hispanic or Latino adults (46%) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41%) resulting from the pandemic in the US. They also reported that some of the mental health-related challenges experienced by many essential workers include a greater risk of contracting the coronavirus, symptoms of anxiety or depressive disorder (42% vs. 30%), starting or increasing substance use (25% vs. 11%), and suicidal thoughts (22% vs. 8%) than other workers during the pandemic compared to nonessential workers.

MHA [22] posited that the social consequences of the pandemic, rather than the threats of sickness or death, are the major causes of stress among persons using the screening tools. Factors identified as the major cause of depression and anxiety (73%), past trauma (46%), or relationship problems (44%) were loneliness and isolation among girls/women between 11 to 25 years of age.

In the UK, a British Medical Association survey conducted during the pandemic showed that 45% of UK doctors suffered depression, anxiety, stress, burnout, or other mental health conditions relating to, or made worse by, the COVID-19 crisis [23].

In India, the socio-economic and mental health of marginalized communities were disproportionately impacted by the pandemic [24]. Balaji and Patel [25] observed mental health difficulties among women, children, young people, sexual minorities, and people with pre-existing mental health conditions and substance use disorders. In spite of this information, Duggal et al. [26] claimed that there exists a lack of empirical data on the mental health impact of the pandemic on marginalized communities and their needs in India. In a meta-analysis of 31 studies conducted in China,

Deng et al. [27] reported that the prevalence of depression among persons diagnosed with COVID-19 was 45%, anxiety was 47%, and sleep disturbances were 34%. Also, the Chinese, Singaporean and Australian governments have identified the psychological side effects of COVID-19 and the long-term impacts of isolation which could cause more harm than the pandemic itself [28–30].

Zeroing in on the African States, the experience of the disease, breakdown of social support, loss of loved ones, and stigmatization could trigger short-term mental health problems among affected persons and their families, while factors such as economic losses (job and income losses) can potentially trigger long-term mental health problems. Some of the COVID-19-related fears, worries, and anxieties may be borne out of lack of knowledge, rumors, and misinformation, while its associated mental health care has become one of the most neglected areas of health. Frissa and Dessalegn [31] predicted that the impact on mental health will be immense in sub-Saharan Africa due to their weak health care systems. They also hinted that patients with COVID-19 and other illnesses along with significant persons around them consistently experienced post-traumatic stress disorders, anxiety, depression, and insomnia. They further reported that the uptake of mental health care services is generally low in the region while individuals in some communities rely solely on social resources. This was further compounded by poor digital literacy, low smartphone penetration, limited internet connection, and weak expertise in online mental health service delivery even among clinicians and psychotherapists. While the majority of those who need mental health care do not have access to services, receive little or no treatment at all.

The COVID-19-related mental health treatment gap is thus higher in African nations. Consequently, the need to protect individual socio-cultural coping and resilience mechanisms is very critical in the continent, most especially the sub-Saharan African region.

The MTL status of some of the African states shows that:

a. **Cameroon:** Cameroonians are vulnerable to mental health problems related to COVID-19 due to the challenges of a weak healthcare system, inadequate mental health workforce, insufficient financing to pay for health care, lack of access to mental health medications, and stigmatization which continues to prevent individuals from seeking mental health care [32].

b. **Ghana**: There was an increase in boredom and anxiety symptomatology during the COVID-19 pandemic and a decrease in well-being among Ghanaians [33].

c. **Kenya:** the effect of the COVID-19 pandemic in Kenya has been felt by children and young people due to prolonged school closures and loss of learning. There have been more calls for help to deal with psycho-social issues since the pandemic began [34].

d. **Nigeria:** Nigeria is ranked 197 out of 201 countries in terms of the quality health system, and is one of the poorest countries among Africans [35]. Prior to 2019, Bloomberg [36] ranked Nigeria as the most stressful country to live in the world, based on multiple factors in the living environment. An estimate from the Federal Ministry of Health reveals that about 20–30% of the population suffers from mental health challenges, such as anxiety, depression, psychosis, substance use disorders, mental disorders in pregnancy and childbirth, childhood psychological/developmental disorders, and suicide among others [37].

Although numerous factors contribute to elevated stress among people, such as heavy workloads, lack of physical or psychological safety, moral conflicts, and workplace-related bullying or lack of social support [2]. These were exacerbated during the pandemic with a wide range of emotions, including uncomfortable feelings such as shame, sadness, anger, frustration, or any other emotional painful feelings. These were worsened during the pandemic (around 2019, 2020, and 2021) and also worsened the existing insecurity, herdsmen attacks, and Boko-Haram violent insurgencies across the nation. High incidence of job loss, domestic violence, rape, battering, sexual assaults, and brutal killings of innocent girls during the lockdown further stressed the mental health stability of individual Nigerians beyond the limit.

Consequently, the pandemic has heightened individual vulnerability to financial insecurity, unemployment, and fear, which have been identified as risk factors for poor mental health among Nigerians [2]. The pandemic amplified existing vulnerabilities, inequalities, societal divides, fragility, instability, and threats to social cohesion and peace processes [38]. Currently, a lot of Nigerians are facing psychological distress that can lead to burnout, depression, anxiety disorders, sleep disorders, and other illnesses due to the absence of protective factors, such as employment, educational engagement, physical exercise, and access to health services during the lockdown [38].

In spite of the fact that mental health challenges are huge across the nation, Nigeria has no clearly defined mental health-related allocated budget. The allocation for health in the entire 2016 National Budget was only 3.65% out of which about 3.3% was barely earmarked for mental health and more than 90% of this amount went to institution-based services provided through eight stand-alone mental hospitals [39].

Another major challenge is the lack of a social welfare package for addressing the mental health needs of the socially marginalized and neglected groups in Nigeria, most especially women, children, the elderly, the homeless, and the very poor. These groups of people are vulnerable to different risk factors associated with mental disorders and also exhibit poor health help-seeking behavior [39]. More than 70% of these categories of patients with mental health problems/disorders in Nigeria seek unorthodox interventions before orthodox care [39].

a. **South Africa**: The mental health of South Africans was significantly impacted by the COVID-19 pandemic, especially as a result of a previous history of mental health surges. Mental health issues such as anxiety disorders, post-traumatic stress disorder, loneliness, phobias, mood disorders, and obsessive–compulsive disorders were common issues in the South-African population [40].

b. **Tanzania:** In Tanzania, anxiety disorders and fear were rampant among the younger population. The economic issues coupled with the pandemic exacerbated the anxiety states of most people. Among youths, the lack of enrollment in school led to frustration and a feeling of isolation [41]. The uncertainty about the future also affected the mental state of people. Moreover, the diversity of conflicting reports about the pandemic increased fear and anxiety levels [42].

c. **Uganda:** In Uganda, like most African countries, mental healthcare was already weak before the epidemic. Which was then worsened by the pandemic [43]. Giebel, Ivan, Burger & Ddumba [44], West, Ddaaki, Nakyanjo, Isabirye, Nakubulwa, Nalugoda & Kennedy [45], and Akena, Kiguba, Muhwezi, Kwesiga, Kigozi, Nakasujja &

Lukwata [46] reported increased psychological distress and onset of common mental disorders (CMD), such as major depressive disorders (MDD), generalized anxiety disorders (GAD), post-traumatic stress disorders (PTSD) and substance misuse disorders (SUD), among Ugandaians living with HIV, older adults (aged 60+) and health workers during the COVID-19 pandemics. Lemuel (2021) specifically observed a high incidence of anxiety among respondents with a primary and secondary level of education compared with those with no formal education and a tertiary level of education after the onset of the pandemic.

Question 4: how can the mental health consequences of the COVID-19 containment measures, socio-demographic forces, and other health conditions among vulnerable groups be mitigated in Africa?

a. **Vulnerability to mental health impact of COVID-19:**

Vulnerability to the negative psychological impact of the current pandemic varies among different populations across the continent. In post-apartheid South Africa, for instance, even though mental health services have been decentralized and integrated into primary health care, there still remain service gaps within and between provinces, especially in the rural areas [47] According to Jaguga and Kwobah [48], even though preventive and medical actions are critical to the containment of the pandemic, emergency psychological crisis interventions (EPCI) are required for the mitigations of the mental health consequences of the pandemic among affected populations by and other vulnerable groups such as pediatric patients, pregnant women, mothers, older people, PLWDs, other marginalized groups with suspected or confirmed cases and frontline workers. The direct EPCI may be utilized for COVID-19 patients, while the indirect EPCI is employed for their relatives, caregivers, and health care professionals. Forms of Emergency Psychological Crisis Interventions (EPCI) could entail both digital and preventive virtual mental health services aimed at addressing scale and limiting the exposure of patients to COVID-19 at health facilities. Psychological counseling, digital mental health education, and communication materials may be delivered for those in need and shared through Facebook, Twitter, Whatsapp, and other commonly used social media platforms.

There is also the need to proactively identify high-risk groups early on and provide them with targeted interventions. This may be done through research and deployment of artificial intelligence to proactively identify posts on social media from people who are in crisis and likely to commit suicide. Such vulnerable persons may be reached through different types of virtual psychotherapeutic mechanisms, including video-conferencing, the conduct of cognitive-behavioral and mindfulness-based smartphone therapies, and chess-edutainment [49, 50]. Most African nations, especially Nigeria, Ghana, South Africa, and Kenya, already have a telecommunications density exceeding 100%, which serves as a veritable tool for the implementation of mobile psycho-therapeutic care and services. Existing digital psycho-therapeutic clinical care across Africa include Wazi in Kenya, PsyndUp in Nigeria, MindIT in Ghana, and the MEGA project in South Africa and Zambia. There could also be the provision of several mental health hotlines and online therapy services for COVID-19 pandemic emotionally distressed people.

The following vulnerable groups within the larger population in all African nations are particularly needing EPCI and support:

i. **Male and female Persons Living with Disabilities**: Psychosocial first aid (PFA) is necessary for people living with disability in periods of crisis, such as the COVID-19 pandemic. This will reduce anxiety levels and feelings of uncertainty [51].

ii. **Male and female Survivors of** COVID-**19**: An intervention for adaptation post survival is necessary to prevent segregation and promote social interaction among survivors of the pandemic [6].

iii. **Relatives of COVID positive patients:** The family members of the COVID positive patients will require an awareness briefing, correct scientific knowledge, and psychosocial first aid in the form of emotional and mental support in a culturally appropriate manner.

iv. **Health Care Workers (HCWs), nurses, first responders, and other frontline workers:** Both Health and social care workers (HSCWs) have carried a heavy burden during the COVID-19 crisis and, in the challenge to control the virus, have directly faced its consequences. This group may be at risk of experiencing worsening MH during an outbreak, hence supporting their psychological well-being should continue to be a priority [52]. The psychological well-being and resilience of Health and social care workers (HSCWs), nurses, first responders, and other frontline workers in close contact with COVID-19 patients need to be enhanced and preserved by ensuring shorter workdays, provision of protective gear, and adequate training in infection control.

b. **Mitigating strategies in Africa—cameroon and Uganda**

To mitigate the mental health consequences of COVID-19 in Cameroon among these vulnerable groups, including those living in the hard to reach rural communities, the government (Cameroon's Ministry of Public Health) in collaboration with WHO and the Red Cross initiated the following strategic actions:

a. An assessment of the psychological care during the COVID-19 response.

b. **Developed the National Mental Health Strategy:** This sets the framework for improvements in psychological care.

c. **Development of other handy and reliable support documents** on psychological first aid, confidentiality, and stress management guidelines and procedures for the mental health of children and adolescents, simplified guide on mental health care and mental illness care algorithms, for health workers when deciding on best interventions.

d. **Establishment of a Data Management Tool**: This has been continuously used since 2020 to generate data on the psychological impacts of COVID-19 and interventions deployed in the nation.

e. **Establishment of a Psychological Care Team**: The National Public Health Emergency Operation Centre established this team and recruited 27 psychologists and 36 nurses across the country. The Centre further conducted the

WHO-sponsored training tagged "**mental health and psychosocial support during the pandemic**" for the newly employed staff, 1500 psychological care specialists, health workers of other specializations, 300 social workers, 120 investigators, and 30 journalists.

f. **Creation of Public Awareness and Enlightenment**: The empowered journalists who participated in the WHO's sponsored training on mental health and psychosocial support during the pandemic created and translated mental health communication into simple and compelling posters, picture boxes, and leaflets for public awareness and enlightenment campaigns on mental health support, including those living in remote areas.

g. **Launch of a toll-free helpline for psychological care**: This was an initiative of the Cameroonian government in partnership with WHO and the Red Cross.

h. **Funding support** to a local NGO to provide psychosocial support to victims of physical violence perpetrated by armed groups in the southwest part of Cameroon.

i. Provision of remote medical and psychological support to vulnerable communities, including older people and those with comorbidities: This was provided in partnership with the German Agency for International Cooperation and iDocta Africa

j. The UN Population Fund and Uni-Psy et Bien-Être have also set up psychological support for pregnant and breastfeeding women including their families, as well as caregivers.

k. Engagement of key stakeholders in the reduction of the mental health impact of COVID-19 among different populations

The strategies adopted in Uganda include:

i. **Home Visits**: Kola, Kohrt, Hanlon, Naslund, Sikander, Balaji and Patel [53] reported that home visits for patients with severe mental illness were ongoing in Uganda amid the pandemic.

ii. **Family Group Intervention**: This entails the involvement and training of parents to support community health workers in the delivery of "Family Group Intervention" to children with disruptive behaviors during the pandemic. The training intervention strengthens the capacities of family members, caregivers, and children. It also provided opportunities for them to communicate in safe settings with other families who have shared experiences.

Question 5: what are the basic psychosocial counseling principles for COVID-19 positive patients and other significant persons?

The psychosocial counseling principles for understanding and addressing the mental health needs of individuals who are awaiting results of COVID-19 tests confirmed COVID-19 individuals, health care workers working in COVID isolation hospitals and their family members from a nonjudgmental and empathic attitude include:

a. **Psycho-education on Safety, health, and hygiene**: This should be objectively and truthfully explained to patients and their caregivers. It should include information about the disease and epidemic situation, time for recovery, quarantine stay facilities, and available treatment process.

b. **Anticipatory Anxieties and Coping skill enhancement**: The psychotherapists will need to encourage patients to develop a sense of Calmness by reducing immediate distress and motivating them to rehearse their minds and practice effective coping mechanisms and stress inoculation techniques such as exercising, virtual socializing, performing pleasurable activities, actively seeking emotional support, positive reframing of the situation, using humor and practicing religious prayers.

c. **Stabilization and Hope Building**: Stabilization and hope building will help vulnerable populations to overcome an intense fear of dying, feeling of helplessness, anxiety, and fear. It will also improve their health-seeking behavior. Individuals exhibiting such concerns need to consult a psychotherapist who will assist in validating their fear of dying, feeling of helplessness, anxiety, and fear. The therapist will also assist in normalizing their worries, and further assist in developing healthy strategies for addressing the problem and generating a sense of realistic hope.

d. **Addressing Adjustment issues, Self-and collective efficacy**: To deal with the emergent psychological problems of people involved in the COVID-19 epidemic, a crisis intervention model that impacts self-efficacy is necessary [54].

e. **Recovery and Connectedness**: To reduce the psychological impact of being isolated, the psychotherapists will encourage the patients to strengthen their physical health, create new routines, virtually connect to their loved ones, limit information consumption on COVID-19 online, accept the uncertainty of the situation by focusing on what is within their control and doing as best as they can to handle the situation

Psychotherapeutic approaches that could be deployed for COVID-19 affected persons are approaches in response to disasters, including psychological debriefing, psychological first aid, cognitive-behavioral approaches, crisis intervention, screening and triage models, problem-solving interventions, rumor control, and conflict mitigation [55].

Clinical, counseling, psychotherapeutic and rehabilitation options for special and vulnerable populations, such as pediatric patients, pregnant women, mothers, older people, PLWDs, and other marginalized groups with suspected or confirmed cases, as well as reporting and grief counseling of COVID-19-related death. However, there is also no known coordinated and multidisciplinary continuum of clinical, counseling, and psychotherapy COVID-19 care pathways for symptomatic and asymptomatic patients and their families in the African States. Hence, there was a need for this study that attempts to run a scoping analysis of existing literature on the psychosocial and health implications of COVID-19 Comorbidity-Related Complications for vulnerable persons in developing societies.

4. Conclusion

The short- and long-term mental health implications of the COVID-19 pandemic are far-reaching for clinicians and the significant persons or survivors, especially among those at risk of new or exacerbated psychological illness and those facing barriers to accessing care.

Although the global community is in the vaccination phase against COVID-19, however, many people are refusing to be vaccinated due to fear or uncertainty, and the need for vaccinated people to continue taking existing precautions to mitigate the outbreak. Thereby compounding the psychological and mental health distress of the pandemic. It may also result in an increase in alcohol consumption, drug dependency and abuse, deaths due to suicide, and despair. It is, therefore, important for policymakers to continue to discuss further actions to alleviate the burdens of the COVID-19 pandemic.

5. Recommendations

Globally, the mental health status of vulnerable persons and clinicians has become more acute during the COVID-19 pandemic, while the targets for effective leadership and governance for mental health, provision of mental health services in community-based settings, mental health promotion and prevention, and strengthening of information systems, are far from being attained.

The following are recommendations on organizational measures, policies, and systemic changes needed to address the challenges of prevention, treatment, and education of Africans going forwards on their mental health:

a. Preventive and treatment interventions for mental health symptoms;

b. **Innovative Intervention for Mental Health**: These should be novel and universal interventions that are mechanistically based on experimental and social sciences for issues, such as loneliness;

c. Arts-based and Life-skills Therapeutic Interventions and Recreational activities, such as outdoor exercises.

d. **Mental Health Bill:** This is a policy measure currently needed in Nigeria and other African Nations. The Mental Health Bill will promote and protect the rights of persons with mental health conditions and persons with intellectual, psychosocial, or cognitive disabilities. It will also make provisions for the enhancement and regulation of Mental Health Services.

e. Need for the prevention of mental disorders and prioritization of mental health as a public health concern;

f. Need for the attainment of universal access to mental care;

g. Increase in mental health funding through direct budgetary allocation and integration of mental health into primary care;

h. There is an increasing need to accelerate the scale-up of investment in mental health and to scale up the quality of mental health services that are aligned with COVID-19 pandemic-related needs.

i. African nations need a documented mental health policy to tackle the menace in the country noting that the prevalence is one in four individuals. The policy should be formulated to cover a long period of about 5–10 years. It should be an initiative of the government and, the higher the level of government involvement, the higher its chances of success. The policy document will provide a framework and also give priority to the treatment. It will help to develop mental health services in a coordinated and systematic manner. It will help to identify key stakeholders and allow different stakeholders to reach an agreement. People with mental health disorders need equity and should not be discriminated against on the basis of their mental illnesses.

j. Mental health services should be integrated into other health care services at all levels instead of stand-alone facilities.

k. There is an urgent need for local governments to invest more in Primary Healthcare Centres (PHCs) as the entry point of other health care systems.

l. There is also the need to fund young psychiatry practitioners' interest in research geared toward the development and advancement of mental health delivery in Nigeria.

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References

[1] Lin C-Y. Social reaction toward the 2019 novel coronavirus (COVID-19). Social Health and Behaviour. 2020;**3**(1):1. DOI: 10.4103/shb.shb_11_20

[2] Onyeji E. Three in Ten Nigerians Suffer from Mental Disorders – Official. Nigeria: Premium Times Nigeria; 2018. Available from: https://www.premiumtimesng.com/health/health-news/295794-three-in-ten-nigerians-suffer-from-mental-disorders-official.html Accessed January 13, 2022

[3] Nigeria: COVID-19 - Dealing with the Post-Pandemic Mental Health Crisis. Available from: *allAfrica.com*. https://allafrica.com/stories/202005220569.html. Published May 22, 2020 [Accessed January 13, 2022]

[4] Mental Health and COVID-19. Available from: https://www.who.int/teams/mental-health-and-substance-use/mental-health-and-covid-19 [Accessed January 13, 2022]

[5] Papoutsi E, Giannakoulis VG, Ntella V, Pappa S, Katsaounou P. Global burden of COVID-19 pandemic on healthcare workers. ERJ Open Research. 2020;**6**(2):00195-02020. DOI: 10.1183/23120541.00195-2020

[6] Zhang Y, Ma ZF. Impact of the COVID-19 pandemic on mental health and quality of life among local residents in Liaoning Province, China: A cross-sectional study. International Journal of Environmental Research and Public Health. 2020;**17**(7):2381. DOI: 10.3390/ijerph17072381

[7] Threat Assessment Brief: Rapid increase of a SARS-CoV-2 variant with multiple spike protein mutations observed in the United Kingdom. European Centre for Disease Prevention and Control. Solna Municipality, Sweden 2020. Available from: https://www.ecdc.europa.eu/en/publications-data/threat-assessment-brief-rapid-increase-sars-cov-2-variant-united-kingdom. Published December 20, 2020 [Accessed January 13, 2022]

[8] Policy Brief: COVID-19 and the Need for Action on Mental Health (13 May 2020). New York City: World ReliefWeb; 2020 Accessed January 13, 2022

[9] Digital health and COVID-19. Bulletin of the World Health Organisation. 2020;**98**(11):731-732. DOI: 10.2471/blt.20.021120

[10] Cohan CL, Cole SW. Life course transitions and natural disaster: Marriage, birth, and divorce following hurricane Hugo. Journal of Family Psychology. 2002;**16**(1):14-25. DOI: 10.1037/0893-3200.16.1.14

[11] Ilesanmi OO, Eboiyehi FA. Sexual violence and vicarious trauma: A case study. Gender and Behaviour. 2012;**10**(1):4443-4469. eISSN: 1596-9231

[12] Math SB, Nirmala MC, Moirangthem S, Kumar NC. Disaster management: Mental health perspective. Indian Journal of Psychological Medicine. 2015;**37**(3):261-271. DOI: 10.4103/0253-7176.162915

[13] Sturgeon S. Promoting mental health as an essential aspect of health promotion. Health Promotion International. 2006;**21**(suppl_1):36-41. DOI: 10.1093/heapro/dal049

[14] Gallagher S, Wetherell MA. Risk of depression in family caregivers: unintended consequence of COVID-19.

BJPsych Open. 2020;**6**(6):e119. DOI: 10.1192/bjo.2020.99

[15] Biello P. Lifelines: How COVID-19 Creates "Pre-Traumatic Conditions" in the Brain. New Hampshire. Available from: https://www.nhpr.org/nh-news/2020-05-04/lifelines-how-covid-19-creates-pre-traumatic-conditions-in-the-brain. Published May 4, 2020: New Hampshire Public Radio; 2020 Accessed January 13, 2022

[16] Ransing R, Ramalho R, Orsolini L, et al. Can COVID-19 related mental health issues be measured? Brain, Behaviour, and Immunity. 2020;**88**:32-34. DOI: 10.1016/j.bbi.2020.05.049

[17] Yaro PB, Asampong E, Tabong PT-N, et al. Stakeholders' perspectives about the impact of training and sensitization of traditional and spiritual healers on mental health and illness: A qualitative evaluation in Ghana. International Journal of Social Psychiatry. 2020;**66**(5):476-484. DOI: 10.1177/0020764020918284

[18] Taquet M, Luciano SR, Geddes JJ. In: Harrison P, editor. Bidirectional Associations between COVID-19 and Psychiatric Disorder: A Study of 62,354 COVID-19 Cases. Spring Harbor, NY: Cold Spring Harbor Laboratory; 2020. DOI: 10.1101/2020.08.14.20175190 Accessed January 13, 2022

[19] Asekere G, Arko AB. The politics of mental health amidst COVID-19 in Ghana. African Journal of Social Sciences Education. 2021;**1**(1):92-113

[20] Carfì A, Bernabei R, Landi F. Persistent symptoms in patients after acute COVID-19. Journal of the American Medical Association. 2020;**324**(6):603. DOI: 10.1001/jama.2020.12603

[21] Panchal N, Kamal R, Orgera K, et al. The Implications of COVID-19 for Mental Health and Substance Use. San Francisco, California, United States Available from: https://www.rcorp-ta.org/sites/default/files/2020-07/The%20Implications%20of%20COVID-19%20for%20Mental%20Health%20and%20Substance%20Use%20_%20KFF.pdf: KFF; 2020

[22] AJN. Mental Health Effects of COVID-19. AJN, American Journal of Nursing. 2020;**120**(11):15. DOI: 10.1097/01.naj.0000721880.79285.04

[23] National Institute for Health Research. Mental Health and COVID-19. UK: National Institute for Health Research; 2020. DOI: 10.3310/collection_40756 Accessed January 17, 2022

[24] Rehman U, Shahnawaz MG, Khan NH, et al. Depression, anxiety and stress among Indians in times of Covid-19 lockdown. Community Mental Health Journal. 2020;**57**(1):42-48. DOI: 10.1007/s10597-020-00664-x

[25] Patel V, Balaji M. How has COVID-19 Impacted Mental Health in India? India: India Development Review; 2020. Available from: https://idronline.org/mental-health-and-covid-19-in-india/. Published July 29, 2020 Accessed January 17, 2022

[26] Duggal C, Ray S, Konantambigi R, Kothari A. The nowhere people: Lived experiences of migrant workers during Covid-19 in India. Current Psychology. 2021;**1**:1-10. DOI: 10.1007/s12144-021-02220-6

[27] Deng J, Zhou F, Hou W, et al. The prevalence of depression, anxiety, and sleep disturbances in COVID-19 patients: A meta-analysis. Annals of the New York Academy of Sciences. 2020;**1486**(1): 90-111. DOI: 10.1111/nyas.14506

[28] Auto H. Fear and Panic Can do More Harm than the Coronavirus, says PM Lee

Hsien Loong. Singapore. Available from: https://www.straitstimes.com/singapore/fear-and-panic-can-do-more-harm-than-the-coronavirus-says-pm-lee-hsien-loong. Published February 8, 2020: The Straits Times; 2020 Accessed January 17, 2022

[29] Public Health Agency of Canada. National Case Definition: Coronavirus disease (COVID-19). Canada. Available from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html: Public Health Agency of Canada; Accessed January 17, 2022

[30] Ma F, Lyu X. China national report on COVID-19 pandemic and the role of social work. China Journal of Social Work. 2021;**14**(2):80-99. DOI: 10.1080/17525098.2021.1872840

[31] Frissa S, Dessalegn BS. The Mental Health Impact of the COVID-19 Pandemic: Implications for Sub-Saharan Africa. Charlottesville, Virginia, United States: Center for Open Science; 2020. DOI: 10.31219/osf.io/yq9kn Accessed January 17, 2022

[32] Kar SK, Yasir Arafat SM, Kabir R, Sharma P, Saxena SK. Coping with mental health challenges during COVID-19. In: Medical Virology: From Pathogenesis to Disease Control. Singapore: Singapore; 2020. pp. 199-213. DOI: 10.1007/978-981-15-4814-7_16 Accessed January 17, 2022

[33] Boateng GO, Doku DT, Enyan NIE, et al. Prevalence and changes in boredom, anxiety and well-being among Ghanaians during the COVID-19 pandemic: A population-based study. BMC Public Health. 2021;**21**(1):1-13. DOI: 10.1186/s12889-021-10998-0

[34] UNICEF. Impact of COVID-19 on Poor Mental Health in Children and Young People 'Tip of the Iceberg'. New York, New York, United States. Available from: https://www.unicef.org/kenya/press-releases/impact-covid-19-poor-mental-health-children-and-young-people-tip-iceberg-unicef: UNICEF; Accessed January 17, 2022

[35] Guardian Nigeria. Expert Seeks Policies for Improved Health Care Services. Nigeria Available from: https://guardian.ng/news/expert-seeks-policies-for-improved-health-care-services/. Published October 31, 2021: Guardian Nigeria; Accessed January 17, 2022

[36] Bloomberg. Are you a Robot? Manhattan, New York. Available from: https://www.bloomberg.com/graphics/best-and-worst/#most-stressed-out-countries: Bloomberg; Accessed January 17, 2022

[37] Suleiman D. Mental health disorders in Nigeria: A highly neglected disease. Annals of Nigerian Medicine. 2016;**10**(2):47. DOI: 10.4103/0331-3131.206214

[38] Vanguard News. COVID-19 Stressing Nigerians' Mental Health Stability Beyond Limit — Owoeye. Lagos, Nigeria: Vanguard News; 2021. Available from: https://www.vanguardngr.com/2021/11/covid-19-stressing-nigerians-mental-health-stability-beyond-limit. Published November 2, 2021 Accessed January 17, 2022

[39] Abdulmalik J, Olayiwola S, Docrat S, Lund C, Chisholm D, Gureje O. Sustainable financing mechanisms for strengthening mental health systems in Nigeria. International Journal of Mental Health Systems. 2019;**13**(1):1-15. DOI: 10.1186/s13033-019-0293-8

[40] Nguse S, Wassenaar D. Mental health and COVID-19 in South Africa. South Africa Journal of Psychology. 2021;**51**(2):304-313. DOI: 10.1177/00812463211001543

[41] University at Buffalo. Issue 16: COVID-19 and Impacts on Mental Health, Violence, and Adolescent Vulnerability in Rural Tanzania. Buffalo, NY: University at Buffalo; 2021. Available from: http://www.buffalo.edu/globalhealthequity/Resources/policy-briefs/issue-16--covid-19-impacts-on-mental-health-violence-and-adolescent-vulnerability-in-rural-tanzania.html Accessed January 17, 2022

[42] ODI. "I am not at peace"': Covid-19 Impacts on Mental Health of Adolescents in Tanzania. ODI: Think Change. London: ODI; 2021. Available from: https://odi.org/en/publications/covid-19-impacts-on-mental-health-of-adolescents-in-tanzania/ Accessed January 17, 2022

[43] The Independent. COVID-19 Impacts Mental Health. Uganda: The Independent; 2021. Available from: https://www.independent.co.ug/covid-19-impacts-mental-health/. Published June 14, 2021 Accessed January 17, 2022

[44] Giebel C, Ivan B, Burger P, Ddumba I. Impact of COVID-19 public health restrictions on older people in Uganda: Hunger is really one of those problems brought by this COVID. International Psychogeriatrics. 2020;**1**: 1-8. DOI: 10.1017/s1041610220004081

[45] West NS, Ddaalki W, Nakyanjo N, et al. A double stress: The mental health impacts of the COVID-19 pandemic among people living with HIV in Rakai, Uganda. AIDS and Behavior. 2021;**26**(1):261-265. DOI: 10.1007/s10461-021-03379-6

[46] Akena D, Kiguba R, Muhwezi WW, et al. The effectiveness of a psycho-education intervention on mental health literacy in communities affected by the COVID-19 pandemic—a cluster randomized trial of 24 villages in central Uganda—a research protocol. Trials. 2021;**22**(1):1-7. DOI: 10.1186/s13063-021-05391-6

[47] Petersen I, Lund C, Bhana A, Flisher AJ. A task shifting approach to primary mental health care for adults in South Africa: Human resource requirements and costs for rural settings. Health Policy and Planning. 2011;**27**(1): 42-51. DOI: 10.1093/heapol/czr012

[48] Jaguga F, Kwobah E. Mental health response to the COVID-19 pandemic in Kenya: A review. International Journal of Mental Health Systems. 2020;**14**(1):1-6. DOI: 10.1186/s13033-020-00400-8

[49] Adepoju P. Africa turns to telemedicine to close mental health gap. The Lancet Digital Health. 2020;**2**(11):e571-e572. DOI: 10.1016/s2589-7500(20)30252-1

[50] Smith AC, Thomas E, Snoswell CL, et al. Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19). Journal of Telemedicine and Telecare. 2020;**26**(5):309-313. DOI: 10.1177/1357633x20916567

[51] Hudcova B. Psychosocial First Aid for People with Disabilities in Crisis Situations – The Role of a Special Education Teacher. In: NORDSCI Conference Proceedings Book 1. Vol. 1. Orpington, Greater London: Saima Consult Ltd; 2018. DOI: 10.32008/nordsci2018/b1/v1/17 Accessed January 17, 2022

[52] Maunder R, Lancee W, Balderson K, et al. Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. Emerging Infectious Diseases. 2006;**12**(12):1924-1932. DOI: 10.3201/eid1212.060584

[53] Kola L, Kohrt BA, Hanlon C, et al. COVID-19 mental health impact and

responses in low-income and middle-income countries: reimagining global mental health. The Lancet Psychiatry. 2021;**8**(6):535-550. DOI: 10.1016/s2215-0366(21)00025-0

[54] Zhang J, Wu W, Zhao X, Zhang W. Recommended psychological crisis intervention response to the 2019 novel coronavirus pneumonia outbreak in China: A model of West China hospital. Precision Clinical Medicine. 2020;**3**(1): 3-8. DOI: 10.1093/pcmedi/pbaa006

[55] Halpern J, Vermeulen K. Disaster Mental Health Interventions. New York: Routledge; 2017. DOI: 10.4324/9781315623825 Accessed January 17, 2022

Chapter 8

Volunteer Counseling Services in the Context of COVID-19: Compromises and Challenges

Amir Kabunga, Chika Eze and Mandu Selepe

Abstract

The outbreak of COVID-19 necessitated professional trained psychologists to offer voluntary services leading to online paradigm of counseling intervention. This chapter presents the challenges and compromises some counselors encountered when they assisted individuals who were either infected or affected by COVID-19. The chapter also presented the narratives collected from social media, personal experiences of the authors and communications with their colleagues from Nigeria, South Africa and Uganda. It was realized that counselors faced challenges such as lack of experience, poor internet availability, threatened clients' perceived privacy and data security and financial implications. Based on the challenges and compromises, the authors recommended counseling regulatory bodies within African countries should generate operative policies to guide provision of e-counseling services. It was also recommended that e-counseling be integrated into its curriculum in order to adequately prepare the student counselors to be effective and efficient e-counselors. The chapter recommended that policy makers of counseling bodies liaison with network providers in alliance with government to negotiate a sustainable service provision, which ought to facilitate telepsychology. The chapter concluded that the COVID-19 counselors are charged with the responsibility of integrating traditional counseling approaches with telepsychology in order to provide relevant services to the clients who need their services.

Keywords: challenges, compromises, counselors, COVID-19, telepsychology

1. Introduction

COVID-19 pandemic is a public health crisis [1], which brings with it one of the greatest mental health shock of the twenty-first century ravaging countries with high death rate. Its infection is chiefly manifested through rapid spread and harmful respiratory consequences. The statistics of infection is rapidly growing across nations associated with its ever increasing death toll despite the infection prevention controlled (IPC) strategies that have been adhered to, such as wearing of face mask, social distancing and washing of hands. Reports indicate that United States, India, Brazil, Russia, Peru and Colombia are the most hit with largest confirmed cases [1], however Africa is no exception. In all ramifications, COVID-19 is compounding global health

crisis with a major economic and financial crisis that is threatening to set in motion severe mental crisis that will burden the society for years to come.

Historically, records show that infectious diseases are correlated with psychological distress and mental health issues like depression, post-traumatic stress disorder, substance use disorder, domestic violence and child abuse [2]. Besides, quarantined individuals as in the case of COVID-19 are susceptible to present severe anxiety disorder and cognitive distress including depression, panic attack, anxiety and suicidal ideation [3].

Across the globe people are experiencing untold apprehension regarding the possibility of being infected, losing jobs and having children out of school. The prolonged existence of such trepidation is an antecedent of mental ill health. It is in this regard that this paper explores the challenges and compromises some counselors encounter when they are assisting individuals who were either infected or affected by COVID-19. These counselors are based in Nigeria, South Africa and Uganda. The exploration is largely based on data gathered through social media and personal experiences of the authors including email communications with their colleagues. Based on these narratives and its thematic analysis this paper makes recommendation that ought to be of interest to counseling policy makers regarding the provision of services in the context of COVID-19 pandemic and beyond.

2. Certainties versus uncertainties surrounding COVID-19

COVID-19 has a package of mixed sentiment for almost everyone ranging from the fear of being infected to how long the virus would exist in the world including the possibility of advancing a vaccine to curb the risk of infection [4]. Majority of the world's populace are perplexed that COVID-19 is not going away soon, hence the anticipation is that everyone has to grapple with the likelihood of being a direct victim coupled with the fact that it is changing the world's economic, educational, political, socio-religious spaces [5]. Majority of the people are having a desert experience reflected in the reality that whilst some have resources such as food, water, electricity, others have nothing including the fact that some can work from home yet many cannot. To a large extent no one can really predict the level of post-traumatic stress disorder (PTSD) that would arise from the experiences of COVID-19 [6]. The restriction on movement though it has eased off a bit without much downward shift in the rate of infection, is constraining nearly all Nations of the world to still keep their boarders closed. The threatening reality is, would life ever return to its normalcy. Hence it is not an exaggeration to say that COVID-19 is holding the world to a spell-bound changing paradigm of trade-online, school-online, worship-online and counseling-online and everything online all the way. The question is what kind of implication does this change in paradigm pose to people's sense of living? It is in this bid that professional trained psychologists/counselors alongside other health practitioners who provide essential services for wellness of life are risking their own lives to stand out there ensuring that physical, mental and social among many other form of wellbeing is maintained.

3. The imperative of voluntary counseling

Epistemologically, every counseling session comes to birth on the premise that everyone needs therapeutic assistance in order to grapple with life's stressors. Accordingly, counselors ought to wait for clients to knock on their doors requesting

for help, which requires the establishment of due protocol such as booking appointment, negotiating time/place for the meeting, duration and fees among other things [7]. However, the leverage of life stressors associated with COVID-19 has necessitated that counselors move out of their work comfort zones to offer help to the populace who are traumatized irrespective of the professional demands of having client's referral among others. The overwhelming demand for help has led professional trained psychologists/counselors to stretch their boundaries to offer voluntary services. Literally, counseling psychologists have to put on the tag reading 'we are here to help' and this slogan needed to be frequently repeated. This concept is what the paper presents as voluntary counseling. Hence, the notion of providing voluntary counseling with or without pay, face-to-face interaction leading to online paradigm of counseling intervention has become a reality.

Volunteering could refer to the inclusiveness of having all hands on deck including untrained and trained professionals. This form of intervention has proved to be challenging in some African countries, particularly in South Africa where psychological services are highly regulated. As a result, most registered counselors were more cautious when offering this form of intervention, so that they do not violate ethics and regulation of the Health Professions Council of Psychology (HPCSA). As such they waited until HPCSA has published the guideline on telehealth and telepsychology that most of practitioners and organizations such as the *Gift of the Givers* were more willing to volunteer psychological services telephonically. But this is different for other nations where the regulation of practice is much relaxed such as in Nigeria and Uganda.

4. COVID-19 and challenges of online counseling

The safety requirement of social distancing and lockdown in the context of COVID-19 has forcefully defied the norm of face-to-face counseling services in favor of online. Although online counseling pre-existed COVID-19 but it is still in its infancy and psychologists/counselors were in the process of navigating its full canons and operative modalities. According to Nwachukwu and colleagues [8] online counseling is a viable alternative source of help when traditional psychotherapy is not accessible, therefore counselors could resort to different forms of online such as internet counseling, e-mail counseling, web counseling, e-therapy, tele-therapy and/or cyber-therapy [7]. However, it is important to note that online counseling is challenging and requires additional training for the traditional professional counselor [7]. In addition, it has cost implication as it involves the use of ICT related components which is not easily available to all counselors/clients particularly in developing countries [8]. Hence some of the frustration could reflect in poor power supply, limited service and lack of competence. Other challenges reflect in the risk of confidentiality and safety of the client's data as storage system for online data could easily be violated by service providers despite the fact that some stored information could become corrupted, thus become inaccessible. Besides, online counseling consumers ought to have access to technology [9], and as well be proficient with online communication which include the ability to express feelings and ideas in text format. As such some scholars argue that online counseling should not replace traditional therapy but rather be used when necessary bearing in mind that not all cases can be handled via e-counseling [8]. Nonetheless, online counseling is convenient and offers the client remote access to therapy and the counselor's physical absence reduces or even eliminates the client's initial shame or need to "save face" while presenting a problem [10].

5. Presentation of narratives and analysis: African counselors' experiences

This section presents the narratives collected from social media, personal experiences of the authors and communications with their colleagues across African nations, particularly from Nigeria, South Africa and Uganda. The narratives are presented in themes.

6. The Nigerian narratives

The index case of COVID-19 in Nigeria was reported on March 27, 2020 and at present the infection rate has risen to a total of 55,632 confirmed cases, 43,610 recovered cases with a total death of 1070. In responding to the pandemic health professionals took the bold step of being in the frontline battling to attend to the infected in order to slow down the curve of infection whilst trained psychologists work alongside with them assisting the populace to manage the associated distress arising from the crisis. In this context, a free telepsychological service team had been constituted to provide free tele-psychological (e-counseling) services to the needy members of the public in a bid to assist them manage the present and aftermath effect of the pandemic on mental health [11]. Hence, the professional psychologists offer volunteer services despite the challenges and compromises they encounter. Some of the Nigerian counselors' experiences are presented using three themes as follows: Lack of experience versus poor internet availability, clients' perceived privacy versus data security and professional demand versus client's satisfaction.

6.1 Lack of experience versus poor internet availability

Some of the Nigerian counselors' narratives reflect instances of lack of experiences of handling online counseling particularly in the context of COVID-19 wherein social distancing completely deter face-to-face interaction. For some of these counselors, interacting solely online is overwhelming and they grapple with the best skill for assisting the clients to manage their mental health. Some of the counselors expressed that identifying severe depressive symptoms like suicide ideation is often challenging. Hence, the counselors are faced with the dilemma of either breaking the protocol of social distancing to reach out to clients who may be in dire need of their physical presence. Based on personal communication a counselor narrated her predicament as follows:

> *I am having a session with a client who was sobbing, saying life seems meaningless, therefore, not worth living anymore as her husband lost his job due to company staff scale down in the face of COVID-19 pandemic, no food in the house, and suddenly she screams I feel like killing myself and the phone line goes off. I am frustrated trying to call back but she doesn't pick... I wish I could do more.*

In this narrative the counselor is not only frustrated but stretches his/her resources to reach out to the client by calling back. Hence, it can be argued that counselors are challenged to compromise their resources whilst offering online counseling to clients in the face of COVID-19 despite the temptation of wanting to break the lockdown/social distancing protocol, another argument reflecting the idea of the emotional cost involved should be added as follows: Besides, it is important to note the emotional cost that the counsellor encounters based on the experiences of the frustration. The

counsellor could easily experience burn-out should s/he continue to experience frequent frustration. In addition, some other counselors emphasized that online counseling is always interfered with due to poor network connection. In this regard, one counselor via email communication expressed:

> *The reality is that online counseling could be irritating due to frequency of on and off network connection. One is never sure that the session would begin and end smoothly; you are starting all over and over again! Often times the coherent flow of the session and understanding of the issue the client presents is impacted upon due to too many frequent beginnings...*

Explicitly, this counselor states that fluctuation of network services impact on the smooth flow of online counseling session. What this means is that more time is likely spent, which by extension means spending more resources on data in order to stay tuned in, and the question is how would the counselor and counselee sustain such expenditure? Equally, the experience of poor internet availability is affirmed by counselors who expressed that failure in power supply is one of the major causes. In this view, one counselor reported:

> *Some of the difficulties experienced within this COVID-19 online counseling is the mere fact that clients do not have frequent access to electricity to charge their phones besides the resources to buy the data. Worst still some do not even have phones that possess internet accessories...*

Basically, the above narratives indicate that there are a number of challenges that counselors encounter ranging from lack of skills to poor internet connectivity, which need to be addressed in order to find a better way of providing online counseling. What is emerging is that online counseling cannot possibly replace traditional face-to-face [12]. Hence, negotiations are needed to integrate the two in order to withstand the stress of the time such as COVID-19 pandemic.

6.2 Clients' perceived privacy versus data security

Some counselors emphasized that although online counseling has facilitated client's perceived privacy in the sense that majority of their clients have made in-depth disclosure of themselves which they may not naturally do within face-to-face counseling they are still worried about the clients' data security. In this line some of them narrated that they struggle to save data from being violated by service provider including safe guarding them from getting corrupt. In this context, one counselor in a radio interview said:

> *So far I am happy with the progress my clients are making particularly as many of them are able to share freely their stories more than when I have face-to-face session with them. It seems they are more eager to talk under the mask of telephone conversation; needing less prompting but I am worried about the level of confidentiality as some of the conversations could easily be accessed by service providers...*

This counselor expressed that clients seems to be more open to sharing their stories over the phone in comparison to face-to-face conversation. For this counselor, this is a plus but he is worried about the security of the data. His major concern is

focused on the maintenance of confidentiality of which he is not alone as another counselor reiterated:

> *Some of my clients have expressed that they are sharing spaces with either their family such as spouse, children and/or parents when talking on the phone. In such situation there is no privacy! In fact some maintain that they live in a very communal setting where everybody over hears everyone's conversation.*

In this counselor's narrative, the mismatch status quo is clear; it is the counselor's concern over security of data and client's attitude towards interference from others due to cultural orientation. Thus, what is the best practice counselors should adapt in order to bring their clientele to the same level where they are? This question relates directly to the next challenges regarding the clients' satisfaction and professional demand.

6.3 Professional demand versus client's satisfaction

Some of the counselors in their narrative claimed that online provision of services impact on some of the professional demand such as ethics of informed consent as many clients are not aware of such requirement. Therefore, they sometimes act like the counselor is wasting their time and data bundle by following the fundamental rudiments such as introducing yourself, your qualifications, specific approach, if you are a registered counselor including establishing which online facility the client prefers. Accordingly, one counselor presents the challenge she encounters in view of informed consent expressing that clients always seem to be in a hurry to get it over and done with (Abuja Local Chapter of Counseling Association Meeting, July 2020). In affirmation another counselor via email communication stated:

> *One of the biggest challenges is that many clients feel you are wasting time whenever you start enlightening them about what is anticipated to happen during your session together. Sometimes you hear them sigh over the phone reflecting their displeasure and unfortunately the online inhibit observation of body language, so one cannot tell what exactly is going on in the mind of the client.*

Therefore, the challenges according to this counselor's narrative reflect the struggles counselors encounter in order to maintain professional ethics whilst sustaining clients' satisfaction. These are two parallel lines which if care is not taken might be compromised. However, another counselor emphasized that because she wants to satisfy the clients, she would always bend some of the professional demands in order to make the clients happier. As such she would allow the client to go straight on and pour out their narratives amidst tears as their experiences are stressful reflecting fear of contracting the virus, losing job, having children stay home all the time including the reality that a victim died in their neighborhood but they could not condole with the family among many others.

7. South African narratives

As a result of the global outbreak of COVID-19, most people in South Africa struggled with the "new normal". It is under this "new normal" that citizens were expected to change their ways of life. The adjustment process affected the economies, corporate spaces, education system, religion and families. At the personal level, the

pandemic and the process of adjustment triggered in most people, the onset of mental disorders, such as anxiety and depression [3]. The rise in these disorders suggested that the psychological services were needed, to maintain the mental health for the citizens.

During lockdown, citizens who were presenting with symptoms of mental illnesses became more frustrated because the public health care centres were only accessible for the severe and emergency cases. To help the public, mental health practitioners who run their private practices offered their volunteering services to the citizens who were affected by both COVID-19 and gender based violence. Their counseling services were offered through direct telephone or through *WhatsApp* calls. In the process of executing their volunteering services, these counselors experienced several challenges as cited below:

7.1 Telepsychology

Most of the mental health practitioners (registered counselors/psychologists) in South Africa were trained to use the traditional methods of counseling such as face-to-face counseling. When COVID-19 hit the shores of South Africa, the first challenge was to find a new counseling mode and platform that would not expose the clients/counselors to COVID-19 since the traditional methods were not safe. It is in this regard that telepsychology was recommended as the safest method in this era. As an unfamiliar method, some of the counselors and psychologists were not confident in using it:

> *Honestly, I did not know how to do counseling online. I am used to see the clients face-to face. At first I was afraid that I am gonna do it wrong, but once you pick up the phone, the conversation just flow. I can even pick the emotions on the other side. Practice makes perfect.*

At first, the practitioners were not confident in using this mode since they did not have the formal training in it. Again, the practitioners were concerned that without such training, they are likely to violate HPCSA ethics rules and regulations. As such one counselor countered: *"I feel good when I do something I master. This one was just new. You learn as you go. The problem is that as you learn, you don't want your practicing licence to be revoked".* These concerns were genuine. For instance, according to the HPCSA form 223, the health practitioner is expected to obtain an informed consent before the commencement of the counseling session. Under normal circumstances, a consent form is discussed with the client and signed by both parties. When using telepsychology, the concern was mainly on how the practitioner would obtain such consent. Initially, this uncertainty led most of the practitioners to be uncomfortable in volunteering their health care services. Another counselor affirmed:

> *At first it was frustrating because we had no document to sign. A phone just rings and the person start narrating his or her problems. I resorted to verbal informed consent, but I had to read up on HPCSA and the APA guidelines to ensure that I do it right.*

Even though it was frustrating at first, counselors had to navigate their way through, to ensure that they do not deny the public of these vital services, yet at the same time they ensured that they do not violate the HPCSA ethics.

In addition, another issue that was raised concerning telepsychology was confidentiality. According to HPCSA form 223, in offering psychological services, the

practitioner is expected to maintain confidentiality. However, it is during this time that the practitioners experienced an ethical dilemma on how to handle confidentiality in telepsychology since the information of the session could still be accessed by the network providers of both users. Most of these practitioners are still uncomfortable with this intervention approach since private information might not necessarily be private. As such one counselor stated:

> *You see, one thing that might lead us into trouble when using this method is confidentiality. Do you know that the workers at those networks can still access our recordings? What if the spouse is working in one of the networks, s/he might access the file and listen to the whole conversation. I don't trust phones. The phone can still be hacked and the information can be accessed. I don't think I will do forensic work online. I am still afraid.*

Although there is no total security of information when one uses this mode, in the meantime, to mitigate this risk, most of the practitioners resorted to informing the clients about this limitation before the commencement of the first session. The challenge with this form of mitigation is that it is likely to limit the client from sharing their most private issues with the practitioner.

7.2 Challenges during the intervention process

When they started with the intervention, some of the practitioners did not anticipate that the cases would be overwhelming. Immediately when their telephone numbers were broadcasted over the local radio stations, the practitioners were overwhelmed by many calls which were outside the scope of the mental health practitioner expertise. For example some counselors expressed:

> *One client called me about food parcels. She said that she did not get her food parcels for three months. I encouraged her to go to the local social worker.*

> *...this woman called me and asked about the procedures of divorce. She said she does not have enough money to pay the lawyer. Her husband was cheating on her for a long time and now she wants divorce. She received counseling in the hospital in the past. This time she just wanted to start with the process of divorce...*

The influx of calls from the citizens was an indication that most people indeed needed help, not only related to COVID-19 but covering a wide range of issues. To narrow this influx of calls, the public were encouraged to contact the practitioners on matters related to mental health.

As they continued to offer their volunteering services to the public, one other challenge was that there was no uniformity in recording of the statistics. Since this volunteering was unplanned, it was not coordinated. Instead, different templates were used to record the cases. In as much as psychological intervention was provided, statistics is also important for designing future intervention strategies based on the current findings as a baseline. With such gaps, it would be a challenge to improve the services and for future intervention.

Another challenge that was brought forth was the issue of boundaries. Since the practitioners availed their personal contact numbers to the public, it was challenging at first because some individuals would sometimes phone the counselor at odd times even

though the public have been informed of the counselor's available times. Giving out personal numbers to the public led to enmeshed boundaries. To resolve this problem, practitioners had to find ways to re-create boundaries. To this effect, one counselor said:

> *Once I realised that some called me late at night when I am sleeping, I decided to switch off the phone because it is a business phone. For my family I use the other one.*

Despite all these challenges, it seems practitioners perceived them as a learning curve that contributed to their professional growth.

7.3 Financial implication

When they started volunteering, it was anticipated that the time spent with the general public might affect the businesses of counselors negatively since most of them are self-employed. However, the counselors reported that they scheduled times for their daily work and for volunteering differently in order to control interference. Even though their businesses were not affected, a concern related to costs was raised. It was reported that some of the members of the public called the practitioner using less credit and during the session, they requested to be called back once their credit is depleted:

> *They will call you knowing that they don't have enough airtime. When their airtime is finished, they send you "please call me". You find yourself calling them back with your own money. When you call them back, their conversation becomes lengthy. You end up being frustrated.*

To ensure that their volunteering do not affect their finances, some of the practitioners stated that they informed the clients that they are liable for their phone bill. For instance, it was clarified that if the call breaks, the client would call again when s/he has enough credit. Alternatively, they were sent a message to contact the toll-free numbers for the non-governmental organizations that are providing counseling services too.

Even though their volunteering compromised their time and money in some instances, to some extent the process has enabled them to be innovative in trying to meet the needs of their clients using telepsychology. Despite the compromises and challenges, volunteer counseling appears to have also brought fulfillment as one counselor expressed: *"Even though I was not paid, at least I helped other people".* It appears as if it is this fulfillment and inner peace that made the practitioners to turn a blind eye to these challenges and continue to assist the people. In as much as it was fulfilling, it is recommended that these practitioners should not overwork themselves, to avoid compassion fatigue, which might eventually be registered as another challenge.

8. The Ugandan narratives

On March 21, 2020, Uganda confirmed the first case of COVID-19. This unfortunate information resulted to restrictive measures including country-wide lockdown of sectors except those providing essential goods and services [13]. This has been accompanied with mental problems including stress, depression, anxiety and others. Mental health services were notably on demand during the pandemic owing to the rise in mental health issues, child abuse and gender- based violence [14]. Cognizant of the repercussions of the virus on the mental health, the Ministry of Health (MoH)

invited and recruited volunteer health professionals in response to the National fight against COVID-19. Some of these volunteer counselors provide face-to-face counseling services while others have resorted to telepsychology. Volunteer counselors have been surprised at how effective telepsychology can be of help amidst the pandemic. One of the counselors said:

> *Previously, we did not think that providing counseling services over the telephone would have much impact. Now, we have learnt that distance should not be a barrier to helping individuals, even if they come from remote communities.*

The use of telepsychology helps connect mental health professionals to underserved clients. The client and counselor can engage in service while maintaining social and physical distance. People are encouraged to call or send messages to the mental health professionals. However, there are noticeable challenges and compromises on the side of mental health workers who volunteered their services. These challenges and compromises are categorized into three themes as presented below.

8.1 Limited skills to use telepsychology and internet connectivity issues

The term telepsychology refers to using internet and communication technologies. In the context of COVID-19 this means access to internet is access to counseling services. However, counselors and clients had issues related to internet subscription. Some of the telepsychology channels and information platforms leveraged on third party operators including Facebook, WhatsApp and others are costly. The extra charges incurred on Over the Top (OTT) tax affected the use of telepsychology platform and mental health information access for the population [15]. Besides, many counselors did not have adequate training in the use of modern technology. Other counselors complained of poor network connectivity and consistent power blackout. In this context, the counselors believe that there is need for national guideline grounded with respect to local context. One counselor had this to say:

> *Telepsychology innovation has the capacity to reduce the mental health costs and enable access to better quality mental healthcare. However, loss of internet connectivity and unreliable power supply impede its application.*

In developing countries like Uganda, many people are offline because either they cannot afford smartphones or costs involved and hence unable to access the service. Internet access plays an important role in providing mental health services. Additionally, internet connection is not always stable. One counselor put it better:

> *A dropped connection may not be a big problem between a counselor and a client. It could lead to possible client misunderstanding and mismanagement.*

Counselors are able to offer counseling through modern technology to clients who had psychological and emotional challenges. However, some counselors believe that many other clients are unable to transit to telepsychology despite the fact that they are in need of professional support. One counselor said:

> *Clients without the means from the equipment such as lack of smartphones are largely affected by the inability for me to provide face-to-face services. Those with*

psychological problems are unable to access psychological care at all. Sadly others are reluctant to adapt to the "new normal".

8.2 Verbal versus nonverbal communication in counseling

Non-verbal communication is established through gestures, postural positions, eye contact, voice tone and nodding. The volunteer counselors believe that failure to observe the nonverbal communication was a serious challenge to them using telepsychology. The counselor may wish to match the client's posture with verbal communication for congruence or incongruence. The counselors believe that something is lost due to virtual distance between the clients and counselors. One counselor tells her experience with respect to non-verbal cues:

I volunteered to provide counseling service to a married couple who hit a rough patch in their lives. As counselor I listened attentively to both the wife and husband as they narrated their alternative views of their marital problems. The wife is willing to tell me how unhappy she is, she feels the husband is cheating on her and considering quitting marriage. On the side of the husband everything is okay and the wife is simply paranoid. That's all the husband said through the session that took 60 min. The challenge is that I am unable to assess the nonverbal behaviours of the couple when working remotely which would tell more to the story if all of us were together in the same counseling room. There are things that are much harder to notice and attend to virtually.

Counselors believe that when sitting with clients, they often use their own body language and positioning to help clients feel more comfortable during moments of silence or when struggling with difficult emotions. However, this strategy is difficult to deploy with telepsychology sessions. One counselor said. The outbreak of COVID-19 therefore has had a deep impact on the way counselors communicate with clients given the need to maintain isolation and social distancing. However, both of these have been compromised in the COVID-19 experiences. A counselor narrative expounded on this challenge:

...not having cues from the audience makes it difficult for counselors to know if the clients are engaged. As a counselor I rely on non-verbal communication to proffer care to my clients: head nodding, smiling, focussed eye contact. The absence of these elements makes it difficult to help my clients.

8.3 Privacy and confidentiality

The rapid emergency of digital technology used by counselors to deliver services during COVID-19 is characterized by issues related with privacy and confidentiality. The counselors acknowledged that there are no national guidelines for secure management of individual's electronic information and services placing personal private data at risk. Other individuals might have access to private and confidential conversation. Even stored data could be accessed by unauthorized companies or people. Therefore there are significant privacy and confidential risks in telepsychology systems that can greatly impact the clients' and counselors' levels of trust and relationship and use of the technology [16]. A client who wants privacy, getting a safe place in crowded house to do a 60 min telepsychology session is quite challenging. A counselor shared his experience:

> *Some clients might worry about privacy and there is reluctance among clients to have these modern technologies that affects counseling sessions. Clients may be more confortable having such sessions while face-to-face with the counselors.*

Another counselor shared her experience:

> *There is a probability for other people to overhear sessions especially because these sessions took place in homes, in our sitting rooms or small compounds hence risking confidentiality.*

Another counselor reported:

> *Besides malfunctioning internet connection and other technological issues, one of the biggest barriers for social distance counseling in maintaining a client's privacy especially if the clients want to talk about the person is nearby. An emotional husband could not tell the entire story concerning her wife whom he considered a source of the problem.*

Some clients found it difficult to be able to speak in private. Their children, wives or husbands were home and it was difficult to have an hour-long or so conversation without being interrupted. It is a challenge for counselors to address difficult issues when family members are around or nearby. The spread of the virus and social distancing measures are changing the way counselors work across the scope of the field. In the transition from face-to-face to telepsychology, new ethical challenges are emerging. With family members including children, roommates and partners spending more time at home, it can be difficult to maintain the confidential space which is key to therapeutic relationship.

9. Recommendations

In the context of COVID-19, telepsychology has become a reality facilitating the ease of providing online counseling within the challenges of safety protocols. Therefore, this paper recommends that counseling regulatory bodies within African countries (particularly in Nigeria and Uganda) should generate operative policies to guide provision of e-counseling services. Such policies should expand on the training needs of counselors, ethical issues of confidentialities, relationship boundaries, and informed consent among many others as the counselor's narratives presented in the paper emphasized. No doubt such policies will highly offer immensurable support to counselors who otherwise may continue to grope in the dark for want of guiding procedures to follow, except for South Africa where there is seemingly an already existing policy.

It is anticipated that the policy document should influence the higher education training program to appreciate the need to make a paradigm shift towards integrating the canons of e-counseling into its curriculum in order to adequately prepare the student counselors to be effective and efficient e-counselors. This would also mean that concurrent workshops in terms of in-service-training ought to be offered to the already trained professional counselors in order to boost their efficiency of telepsychology skills. Again the onus falls on regulation bodies to ensure that such policies are inaugurated and practiced.

In view of the poor internet connectivity that majority of the counselors raised, the paper recommends that policy makers of counseling bodies liaison with network

providers in alliance with government to negotiate a sustainable service provision, which ought to facilitate telepsychology. Such negotiations ought to include confidentiality and the cost of data tariff, bringing it to affordable rate. In this way, counselors will be attracted to integrate traditional counseling approaches with e-counseling in order to continue to be relevant to the populace that needs their services.

10. Conclusion

With the outbreak of COVID-19 pandemic, telepsychology swiftly became the sole option for many people in need of mental health services; hence counselors are compelled to embrace the paradigm shift. Although there are multiple challenges associated with telepsychology but such are not insurmountable. Consequently, the COVID-19 counselors are charged with the responsibility of integrating traditional counseling approaches with telepsychology in order to provide relevant services to the clients who need their services.

Conflict of interest

The authors declare no conflict of interest.

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References

[1] Amir K. COVID-19 and its related stigma: A qualitative study among survivors in Kampala, Uganda. Stigma and Health. 2021

[2] Bao Y, Sun Y, Meng S, Shi J, Lu L. 2019-nCoV epidemic: Address mental health care to empower society. The Lancet. 2020;**395**:e37-e38

[3] Salari N, Hosseinian-Far A, Jalali R, Vaisi-Raygani A, Rasoulpoor S, Mohammadi M, et al. Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. Globalization and Health. 2020;**16**:1-11

[4] Samuel J, Rahman M, Ali G, Samuel Y, Pelaez A. Feeling like it is time to reopen now? COVID-19 new normal scenarios based on reopening sentiment analytics. arXiv preprint. arXiv:2005.10961. 2020

[5] Walsh F. Loss and resilience in the time of COVID-19: Meaning making, hope, and transcendence. Family Process. 2020;**59**:898-911

[6] Boyraz G, Legros DN. Coronavirus disease (COVID-19) and traumatic stress: Probable risk factors and correlates of posttraumatic stress disorder. Journal of Loss and Trauma. 2020;**25**:503-522

[7] A. P. Association. Neurodevelopmental Disorders: DSM-5® Selections. American Psychiatric Pub; 2015

[8] Nwachukwu LC, Nwazue DI. The dawn of e-counseling in Nigeria: Issues and challenges. International Journal of Academic Research in Business and Social Sciences. 2014;**4**:374

[9] Haberstroh S. Strategies and resources for conducting online counseling. Journal of Professional Counseling: Practice, Theory & Research. 2009;**37**:1-20

[10] Speyer C, Zack J. Online counselling: Beyond the pros and cons. Psychologica. 2003;**23**:11-14

[11] Petersen MW, Dantoft TM, Jensen JS, Pedersen HF, Frostholm L, Benros ME, et al. The impact of the Covid-19 pandemic on mental and physical health in Denmark—a longitudinal population-based study before and during the first wave. BMC Public Health. 2021;**21**:1-10

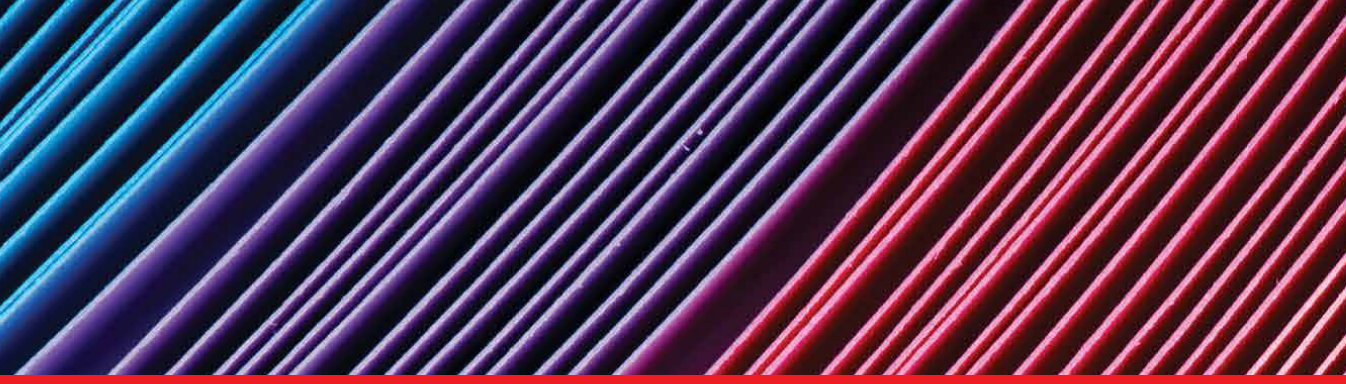
[12] Baker KD, Ray M. Online counseling: The good, the bad, and possibilities. Counseling Quarterly. 2011;**24**(4):341-346

[13] Lakuma PC, Sunday N, Sserunjogi B, Kahunde R, Munyambonera EF. How has the COVID-19 Pandemic impacted Ugandan businesses? Results from a business climate survey. 2020

[14] Kamulegeya LH, Bwanika JM, Musinguzi D, Bakibinga P. Continuity of health service delivery during the COVID-19 pandemic: The role of digital health technologies in Uganda. The Pan African Medical Journal. 2020;**35**:43

[15] Kakungulu-Mayambala R, Rukundo S. Implications of Uganda's new social media tax. East African Journal of Peace & Human Rights. 2018;**24**:2

[16] Hall JL, McGraw D. For telehealth to succeed, privacy and security risks must be identified and addressed. Health Affairs. 2014;**33**(2):216-221. DOI:10.1377/hlthaff.2013.0997



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While the demand for counseling and psychotherapy is increasing in this ever-growing and ever-complicating world, traditional theories and methods are becoming less useful because of the rapid change in people's lifestyles due to technological developments and because of an increase in clients with various ethnic and cultural backgrounds. This volume provides helpful and instructive information on counseling and psychotherapy, including discussions of theoretical innovations and proposals for new practices that transcend ethnic/cultural differences. It also includes chapters addressing the status of counseling services in African states under the COVID-19 pandemic.

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