Comprehensive Assessment Essay

Fielding Graduate University: Ph.D. in Clinical Psychology
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A Defense of Existential Phenomenologically Informed Clinical Psychology

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The collapse of possibility in theory, diagnosis, and protocol

Thank you for your careful reading of the latest revision to my comprehensive essay, and for your challenges to the perspective that I have represented in both drafts. Our stimulating dialogue has clarified and reinforced my theoretical and clinical perspective in several important respects. Your insistence upon a commitment to *some* specific clinical method has been particularly illuminating for me, since I have struggled for years with Will Kouw's unshakeable refusal to endorse or identify with any particular method. In fact, this is a central tenet of the venerable tradition that he teaches and advocates, and which I am hopeful that Sandy Drob will carry forward at Fielding in his own style (Boss, 1963; Heidegger, 1962; Husserl, 1954; Jaspers, 1971; Merleau-Ponty, 1962; Spinelli, 1989; Thévenaz, 1962). For a long time I took Will's vigorous renunciation of theory and method as a metaphor or a puzzle of some kind, which it is not. Although he takes methodical action all the time, he insists that he has no idea what he will do in advance of any human encounter; psychotherapeutic or otherwise. He usually refuses even to speculate about what he would do under this circumstance or that because he regards it as a distraction or worse. What he actually *does* in each of his individual or group encounters, which can certainly be thought of as intervention or treatment, literally just occurs to him. Of course, Will has a predisposition to act on good ideas that just occur to him rather than on bad ones, and he has great confidence in his ability to distinguish between them as they arise. He does not regard this as an unfortunate disability but rather as the condition that he cultivates, and which he has persuasively recommended to me and a few others in the small but dedicated EPICP community at Fielding.

This posture demands a principled and active distance from all presupposition, especially including psychological theory, diagnosis, and clinical protocol. I can understand how this stance might easily be mistaken for a disregard or disparagement of the very things which constitute the scholarship of clinical psychology, which it is definitely not. Since my objective for this essay remains the honest representation of my comprehensive professional perspective, I

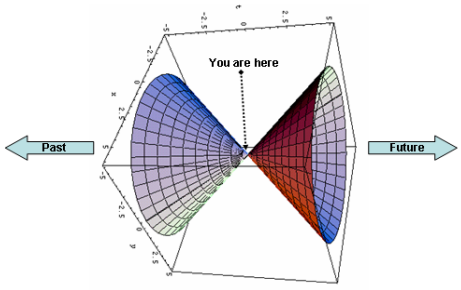
must insist upon this posture for myself even though it appears likely that it will result in an expensive and inconvenient extension of my academic career at Fielding, and in the indignity of a remediation hearing at the conclusion of an otherwise excellent academic record. I do not believe that I have misunderstood Will Kouw in this important respect and I have been entirely persuaded to his view, which you have indicated is unacceptable to you. This direct clash in explicit assertions among Fielding faculty about what is essential versus what is unacceptable is disconcerting but really, I suppose, no different than the social and psychological contradictions that we encounter in the normal course of even the most orderly clinical practice and, indeed, in the normal course of events in the world.

It may be that you and I are irreconcilable on this ground, so I will shift my frame of reference from comprehensive to anecdotal in an attempt to satisfy you of my appreciation for theory and technique within their appropriate domain, and for the ongoing process of empirical research and systematic protocol development where that is appropriate to the delivery system. My frame of reference for these purposes must be regarded as anecdotal in light of the cultivated skepticism about comprehensive theories of human being which Existential Phenomenologically Informed Clinical Psychology demands, and which I endorse and defend in these comprehensive essays. I therefore draw no global conclusions from the case discussions which follow and they should not be taken as a declaration of my intentions for future psychotherapeutic encounters, each of which will be informed by unpredictable circumstances and by my ongoing scholarship, discourse, research, and practice.

Before turning to case discussion I will briefly address your question (3d) about my understanding of "*surrender to a theoretical perspective*" because that idea is so central to the distinction between the *natural* and *phenomenological* attitudes that I have been striving to represent. Undoubtedly the word "surrender" can be taken in a pejorative sense (as can the word "rubric") but it does capture the more-or-less voluntary collapse of possibility (freedom) that is inherent in all theory, diagnosis, and protocol. I have drawn this metaphor from a

commonplace technical characterization of quantum mechanical events, which are fundamentally probabilistic, as the *collapse of a wave function* (or of a state vector) (Gell-Mann, 1994). The wave function represents the full range of possible future states that are open to every particle at every instant, given their present state and environment. When one of those possibilities is realized, the wave function is said to have *collapsed* into a single actualized reality, not unlike the unfolding of a human life in progress.

Processes in which some *specific and essential* collapse of possibilities is a principle function are pervasive throughout the neurological, sensory, perceptual, and cognitive hierarchies (Douglas *et al.*, 1993). At the bottom of the hierarchy are simple structures like retinal ganglia which discriminate among elementary environmental possibilities such as point luminance and contrast, and which are followed in the course of subsequent sensory analysis by a cascade of (usually) winner-take-all discriminations (Cooper & Reilly, 1995; Levine, 2000). The phenomenology of binocular rivalry illustrates this process particularly clearly at the lofty level of gestalt visual representation, where two distinct images presented simultaneously to opposing eyes result in the alternating visual perception of either one clear image or the other, rather than of superimposed or otherwise combined images (Blake, 1989). Pulp fiction detectives, scientists, sudoku puzzle devotees, mathematicians, philosophers, and clinical psychologists all employ similar but far more complex discriminative mechanisms in the service of actionable information, ranging from those which are implemented directly in wetware to those which are entirely formal and abstract (Kosslyn & Koenig, 1992). The utility of discriminant mechanisms near the bottom of the sensory/cognitive hierarchy (e.g. elementary visual discriminations) have been established by the test of survival in the course of evolutionary history (Cosmides & Tooby, 1995). The objective reality and character of such fundamental discriminations (their truth, if you like) is difficult to challenge except from the most esoteric



philosophical perspective, but the habits and mechanisms of discrimination also extend to the loftiest and most abstract metaphysical questions (e.g. the meaning of life or of psychopathological diagnosis), the ontological status and utility of which are unclear (Jaspers, 1955).

The relevance of this abstraction to the clinical realities of the psychotherapeutic encounter hinge upon the question of whether clinical theory and diagnosis represent the clarification of a persistent objective reality, as does the accurate demarcation of object boundaries in the visual field, or whether they tend to suppress valid alternative interpretations (insights) by the imposition of what may fairly be characterized as stereotype; albeit systematically articulated stereotype which may be entirely accurate in its particulars (Spinelli, 1989). It is in this sense that EPICP is systematically skeptical about *all* theory, diagnosis, and established protocol, and it is in this sense that I have previously characterized all of the major traditions of psychological theory and clinical method as tending *inherently* toward stereotype. I have found the practical reality of recourse to diagnostic categories like many of those in the DSM to be highly misleading and distinctly limiting *when they are applied to individuals human beings rather than to generalized theoretical models*, where I regard them as indispensable. I recognize a relatively clear distinction between organic pathology and personal idiosyncrasy, and I place the former in the realm of medicine and psychiatry rather than in the realm of clinical psychology, as Thomas Szasz has famously suggested (Szasz, 1974). Even in the wake of substantial study and reflection I do not pretend to clearly understand the proper categories of psychiatry and I do not attempt to practice it. That is an entirely different line of work for which I am not qualified. I believe that there is a fundamental confusion of medicine with psychology embedded in the categories of the DSM, which can be either illuminating or constrictive, depending upon how literally they are taken (Luhrmann, 2000). I am opposed to prescription privileges for clinical psychologists, although I practice and recommend judicious psychiatric referral.

In the course of my 5 years at Fielding, and of my concurrent clinical engagements, I have experimented with several different psychotherapeutic techniques, under excellent supervision in most cases, and my reflections upon these experiences have prompted Will Kouw to observe my "*ubiquitous experience of discord between what you experienced as the implementor of theoretically formatted procedures and protocols, and the lively interpersonal dynamics of being-with another person whose human aspects had to be virtually ignored in the service of being theoretically 'correct' (Kouw, 2006).*" Yes, that's it exactly! It is not that I devalue or reject the insights and instrumental capabilities that parochial psychological theories, diagnostic language, and established protocol offer, but rather that I have come to recognize the need to emphasize proactive vigilance (as I am doing here) in order to balance the convenience, the reassurance, the institutional pressure, and the genuine necessity for diagnostic stereotype and methodical intervention in certain circumstances (Jaspers, 1963).

In this light, to proclaim allegiance to any specific treatment method would amount to the application of an unwarranted stereotype toward subtle and complex human beings who I have not yet even met. To answer your demand that I stipulate in advance how I would approach a hypothetical future client in terms of the DSM categories that you have enumerated in your feedback section #1, would be to step consciously upon the slippery slope of systematic presupposition (stereotype) to which Will has finally succeeded in drawing my attention. Even the assumption that these diagnostic categories had been appropriately assigned on the basis of their own internal criteria would not determine which aspects of our shared experience we should address, or how we should proceed together in the course of our psychotherapeutic encounter. Clearly this posture is incompatible with most managed care institutions and healthcare delivery systems, which properly attempt to manage the cost, efficiency, and utility of psychotherapy on an industrial model. This observation lies at the root of my earlier comment, upon which you asked me to elaborate in your most recent feedback (3f), that "*existential-phenomenological clinicians must be selective about their employment*". In my own case, I

expect to have the flexibility to exercise such selectivity in my forthcoming practice as a clinical psychologist, for which I am thankful. I understand that this is a big problem for others, and it is undoubtedly one of the main reasons that EPICP is not defended more often as a clinical perspective.

It is not that my years of academic and clinical training at Fielding have been wasted but rather, having mastered the curriculum, that their influence upon my behavior in therapeutic encounter becomes automatic. There is no need to preserve or enshrine particular elements of my experience, faith, and judgment in personal or institutional doctrine. This is not an incidental assertion or an attempt to dodge your examination of my qualification as a professional clinical psychologist, but rather *it is the central tenet of the EPICP perspective*, which I continue to defend. An attempt to justify EPICP as a clinical approach on the basis of empirical research would be a fool's errand because EPICP rests instead upon the philosophical reasoning and the theoretically informed 1st person reflection of expert clinical practitioners much better qualified than me (Kouw, 2001-2006). I have followed their reasoning to some depth and have been persuaded to their perspective. I will try to demonstrate in the case discussions which follow that this reflects no disrespect or disregard for the scientific method, for the results of empirical research, or for any particular clinical discipline. It was in my reading of Karl Jaspers that I finally found the natural reconciliation of my own deep reverence for scientific principles with their practical limitations in the world we know only by means of our phenomenological experience as human beings, despite our pretensions of objectivity (Jaspers, 1955, 1971). The expression of my clinical perspective can be properly represented only as anecdote, and in the present revision I will try to satisfy you of my intellectual and clinical competence by means of case discussion, as you have requested. But first I shall try to represent my clinical method in general.

My global clinical schema and universal treatment protocol

In the course of my Fielding experience I have come to embrace the theoretical and clinical perspectives I have articulated these comprehensive essays. Taken together, they inform both my academic and my clinical posture. As a practical matter, each may absorb my attention and enlist my loyalty to a greater or lesser extent at any particular moment. To the extent that I am so absorbed, then I regard myself as being *in* that mode, or even *captured by* that mode, which may or may not be a good thing depending upon circumstances. Each client and situation calls for some unpredictable balance of understanding, discourse, guidance, inspiration, commitment, and action. I now strive to bracket my presuppositions about each client, and to restrain my own interpretation and intervention significantly, in order to expand the space of possibilities in which we engage one another. Diagnosis and intervention arise more or less spontaneously in the course of our clinical dialogue, partly because psychotherapeutic expectations are explicit in the nature of the clinical relationship, partly because it is my general intention to take some action that will benefit my client, and partly in the light of that cluster of clinical theories and techniques which I have described in an earlier draft of this essay under the title of *Cognitive Analytic Existentialism*.

I have already confessed my clinical infidelity to the ideals that I have represented as EPICP although, to an extent at least, this is *exactly* the point of the phenomenological attitude. The clinical approach that follows is my own and I do not attribute it to anyone else, although I do claim that it is consistent with the principles of EPICP. I must also acknowledge once again that the model that I am describing does not fit into the contemporary managed care system, and that it requires a clinical environment which can at least tolerate the sort of therapeutic relationship that EPICP calls for. I have had the luxury of this sort of environment for the past three years at my internship site and I will continue to enjoy this luxury in private practice following my graduation. I understand how far EPICP stands outside the mainstream of

contemporary psychotherapy, and I am grateful for the personal circumstances which permit me this latitude.

The phenomenological attitude and epoché in the consulting room

The essence of the phenomenological clinical attitude is to permit each perspective that I embrace to develop, if you will, its own independent and idiosyncratic understanding of my client and our situation together; *in parallel and without dominating my consciousness, attention, or* judgment (Bugental, 1992; Spinelli, 1989). When I am able to achieve this attitude in session there is a part of my awareness always standing back from, and often restraining, whatever particular mode of interpretation or action I might be given over to. This detachment permits a greater attention to the holistic synthesis that is my consciousness, *including* any theoretical analysis or method that I might choose to employ (Thompson *et al.*, 1999). For me this is the starting point and foundation of every therapeutic encounter. Particulars emerge from it naturally.

In my initial encounters with each new client it is my intention to be as passive and receptive as possible to whatever he or she offers to me, at every level. In particular, I do not want to succumb to the stereotype of any diagnosis that my client might arrive with. The only stimulus that I want to offer at the beginning is something like "*Tell me your life*." In my experience almost everyone is prepared to do this spontaneously over the span of a few hours or a few sessions. Most people can produce a 20 minute version as well. The objects and instruments of therapy and self-actualization are inherent in such stories (Rogers, 1959). While they are being told I strive to maintain the posture of inconclusive detachment that I have attempted to describe above. I know that I will, shortly and inevitably, embrace *some* interpretation of my client and her situation, and I will begin to formulate various intentions. Restraint in doing so broadens my field of vision (Jaspers, 1971).

But the detachment and holistic attunement of the phenomenological attitude *does nothing*. Any interpretation, response, or intervention must be rooted in some theory or model, whether

explicit or implicit. Embedded in the therapeutic discourse is an ongoing negotiation about our joint and respective intentions in working together (Berne, 1961, 1972; Berne *et al.*, 1996). Clients may come to the therapeutic encounter with clear intentions or not. Presenting complaints often reveal themselves as superficial in the light of a broader and deeper exploration, which may be therapeutic in its own right. At some point I begin to relinquish myself to the formulation of therapeutic intentions, and I seek to engage my client in this process. Eventually we agree to work toward something and we submit ourselves to some theory of action in the hope that it will carry us in the intended direction.

To the extent that the therapeutic process can be serialized, it is while we are engaged in the pursuit of an objective that we must submit ourselves to some method. At this point the appropriate intervention really does just occur to me, for which I still insist no apology is required. ***In my perspective, and in the perspective of the venerable tradition that Will Kouw represents and teaches at Fielding, the alternative is quite simply to have had some intervention in mind before it was clear that it was appropriate (Kouw, 2001-2006, 2006).*** The appropriate intervention does not occur to me out of thin air, but out of the context of my entire professional and personal development. The CBT triad of depression provides a framework for action in its own domain (Alford & Beck, 1997; Leahy, 2001; Persons, 1989; Teasdale *et al.*, 1995), as do the empty chair of Gestalt or the psychodynamic interpretation (Lifschitz, 1993). The intention calls forth the tool and the immediate human engagement between my client and me calls forth the intention. Submission to treatment protocol does not breach the phenomenological clinical attitude unless I get lost in it. The awareness that I reserve for detached observation stands above the theory and above the action. Protocol is informative only to the extent that it fits the situation at hand, and that is a judgment that I must *always* reserve.

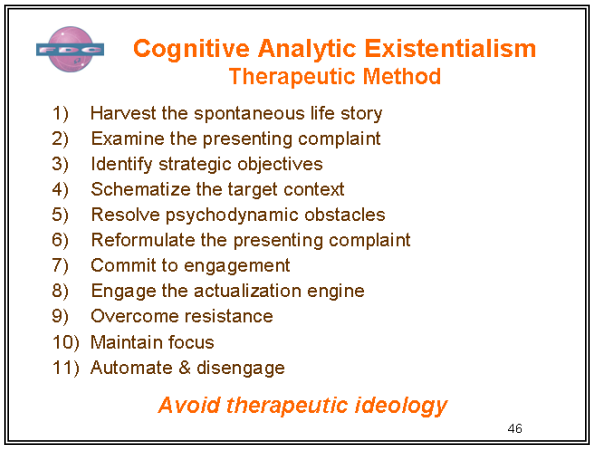
What do you want to change about yourself today?

If I were not defending my identification with EPICP I would be taking the perspective of Transaction Analysis & Redecision Therapy (Berne, 1961, 1964), which I successfully defended in my PIE. I have completed the TART clinical track at Fielding, so I am a card carrying transaction analyst, but I now regard the theory and technique of that discipline as subordinate to my phenomenological orientation, as I do the aspects of psychoanalysis, behaviorism, and humanism that I have discussed above.

One pearl of wisdom that I have taken from TART is the standard opening of each therapeutic exchange: "*What would you like to change about yourself today?*" The question cuts straight to the intervention, and it asserts that it is within the power of the client to change at will. I love this question, but I don't use it anymore because it begs a diagnosis and a treatment plan too explicitly. No matter, this exchange is ongoing throughout the clinical encounter in one form or another; it is what empowers and guides both parties to it.

My universal therapeutic protocol

Always reserving the superordinate detachment of the phenomenological attitude, there *is* a general protocol that reflects important elements of my therapeutic approach. This protocol appears in slide #46 in the overheads that I used several years ago for a presentation that was part of my assessment in *Theories of Personality & Psychotherapy*, which was attached to the last revision of this essay. I still like it.



1. **Elicit and harvest the life story**: At the start of each clinical relationship I try to remain as passive as I can, so that I can be receptive to what the client actual brings to our encounter. In most cases this means that I ask sometime like "*tell me your life story*". This is the only point in our relationship where my own participation is fairly well separated from that of my client.

2. **Examine the presenting complaints**: At some point in the telling of the life story, and sometimes as the starting point, most clients have some sort of statement about why they have come. This is a starting point for discourse. Although I try to take whatever the client presents at face value, I also strive to "horizontalize" this presentation in order to avoid assigning inordinate weight to it. After all, it sometimes happens that the client's initial rationalization for counseling turns out to be a red herring, or at least not quite on the mark in the light of further exploration.

3. **Negotiate tentative objectives**: Once both of us appear to have some reasonable comfort that we share a level of common understanding about what we are doing there together, an exploration/negotiation begins regarding what we might like to do about it.

4. **Schematize the therapeutic context**: I have already confessed that I cannot (or do not yet choose to) maintain my distance from diagnosis for long, as EPICP recommends. At some early point I begin to formulate an interpretation of what is going on in my relationship with my client, and in her life in particular. Although I do not usually create a graphic representation of my interpretation, I might as well.

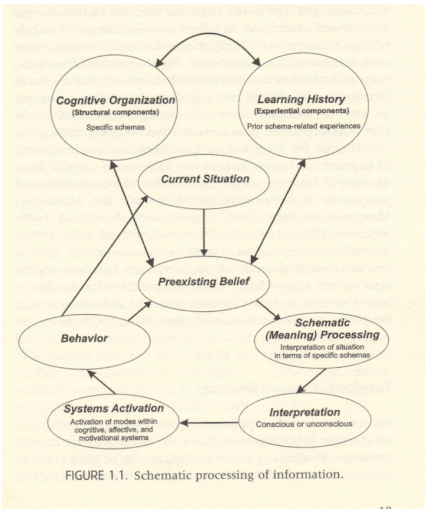


FIGURE 1.1. Schematic processing of information.

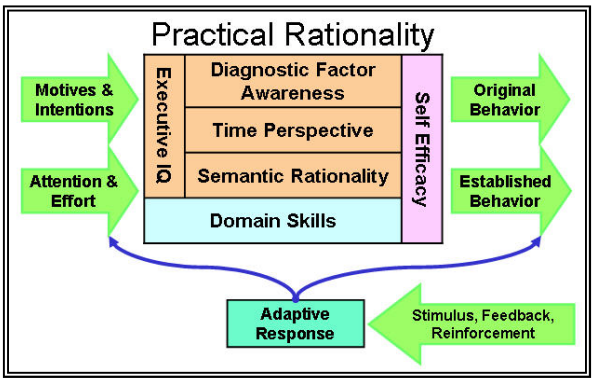
5. **Resolve psychodynamic obstacles**: People do not always say what they mean, they do not always know what they mean, and they embrace meanings that are contradictory. It is necessary to interpret. I have referred to the catalog of

psychodynamic transformations that both psychoanalysis and cognitive behaviorism have formalized, and then there is always intentional deception. There is always a delicate balance between interpretation and attention to what the client is actually saying.

6. **Reformulate the presenting complaints**: As the shared context of the therapeutic partners is expanded and refined in discourse, the client's situation often appears in a different light than at our initial encounter. There is always a delicate balance between the definition and persistence that is sometimes necessary in order to achieve significant results, and the detachment from this that is necessary in order to avoid red herrings and other counterproductive attachments or protocol.

7. **Commit to engagement**: Another pearl of wisdom that I have taken from TART is the emphasis on the therapeutic contract. The therapeutic partners have some understanding with each other about what they are doing together. This not only authorizes me to meddle in the life of my client, but it establishes the extent to which the client is responsible for making any changes that she might embrace. To the extent that a client is unaware of her power to *change what she chooses to change about herself* <u>*today*</u>, the therapeutic contract may itself empower her.

8. **Enable and engage the actualization process**: As I have indicated, I believe that a generalized actualization process, which I take to identical with practical rationality, can be represented as a procedure. For present purposes I can only offer this cartoon representation of what a procedural model of practical rationality (or actualization, if you like) might look like. This is the subject of my dissertation and my ongoing research program.



9. **Overcome resistance**

10. **Maintain focus**

11. **Habituate the actualization process**

12. **Disengage**

Two clinical venues: partner violence intervention and HIV^{+} counseling

Beyond the weeks of clinical training in EPICP and in Transaction Analysis and Redecision Therapy (TART) that I have undertaken at Fielding residential events, my clinical experience to date has been in two quite different venues that I have pursued continuously and in parallel over the past 5 years. The first venue began as my clinical practicum working with an agency that is dedicated to court mandated group intervention for partner violence offenders. In most jurisdictions this is a heavily regulated environment in which many aspects of treatment are stipulated, sometimes directly within the criminal code. The second venue began as my clinical internship, counseling the mostly gay male clients of an HIV+ services agency in an exceptionally flexible and open clinical environment. I have continued to work in both venues following the completion of my Fielding program requirements and I expect to remain involved in both areas indefinitely, in parallel with the development of my private practice. Between these two environments I have been fortunate to have engaged in a variety of clinical encounters which have called in some cases for a heavy reliance upon theory and empirical research, and in other cases for my most diligent effort at atheoretical detachment in the phenomenological attitude. I hope that the discussion of case material that follows will give you a flavor for my developing clinical style and for the practical application of the principles I have articulated in these comprehensive essays. At any rate I believe that they will provide a reasonably accurate picture of my recent clinical behavior, which I claim is the best that you can ask for.

Intimate partner violence intervention

My engagement with the partner violence intervention system has represented much more to me than a clinical training opportunity and a vehicle for the satisfaction of certain Fielding program requirements. About 600,000 distressed families a year fall under the influence of a vast distributed organization (American Psychological Association., 1996) that presently incorporates little in the way of outcome evaluation or systematic enhancement of treatment efficacy (Babcock *et al.*, 2004; Jackson, 2003). This system represents the most significant opportunity that I can identify to make a contribution both on the large scale, by means of systemic change in the national intervention system, and on the small scale through direct encounter with abusive men as well as with the clinicians, programs administrators, and politicians who have so much influence upon them.

Since the completion of my clinical practicum in partner violence group treatment I have continued to work in the field with 9 different programs in 3 states. I have led more than 1,000 two-hour treatment sessions in California and I have co-facilitated treatment groups with about 25 different facilitators from a variety of backgrounds and orientation. I have established a lively correspondence with some of the leading academic researchers in this field, and I have made presentations with some of them at the annual Family Violence and Sexual Assault Institute conference in San Diego. I have also established an ongoing dialogue (sometimes reluctantly on their part) with several domestic violence court judges, prosecutors, probation departments, and treatment program providers around the country. I have integrated my focus on partner violence deeply into my Fielding curriculum by fulfilling the requirements of the Violence Prevention track and the erstwhile Group Dynamics specialization, by dedicating my research practicum to the development of a plan for ongoing empirical research and partner violence treatment program development in California counties (now entirely absent), and by my selection of dissertation research topic.

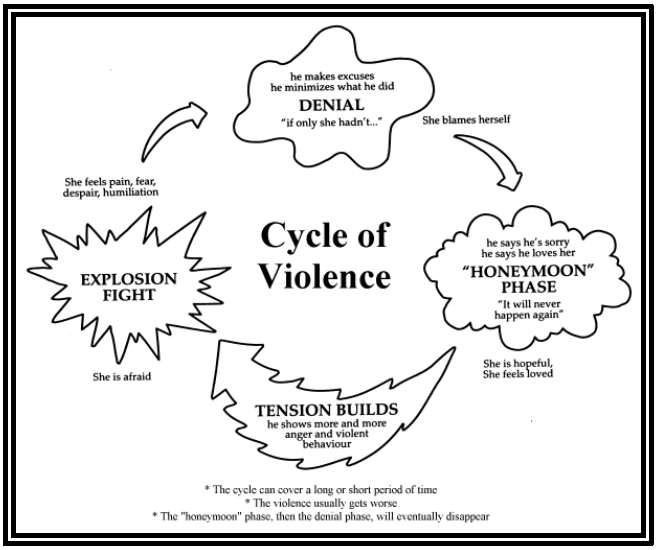
Individual clinical engagement and social action research

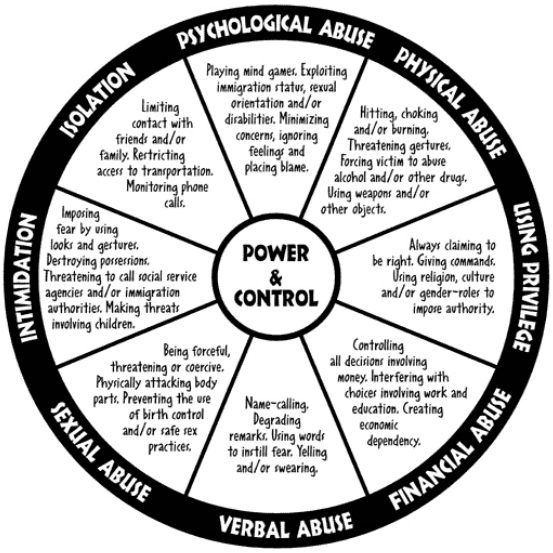
My engagement with partner violence intervention has taken two very different aspects over the past 5 years. I am engaged locally as a clinician with a small number of individual offenders in my own groups (although I am between engagements at the moment), and I am also engaged more globally as a proponent of social action research in the inspirational tradition of Kurt Lewin (Lewin, 1951; Lewin & Gold, 1999). The influence of my clinical experience upon the theoretical 5-factor model of practical rationality that I will discuss briefly cannot be clearly distinguished from the reverse effect, which is as it should be. The clinical and theoretical significance that I have invested in this model goes far beyond what has yet been demonstrated empirically, and the nature of the relationships that are suggested in my schematic figure are not only unsubstantiated in some cases, but they are not all even clearly defined. These gaps constitute my theoretical and research agenda in the field, a starting point for which is my dissertation topic of *Time Perspective and Impulsivity among Partner Violence Offenders*. But in the social action aspect of my engagement with the partner violence intervention system it is the *process* of systematic evaluation and protocol refinement that I proselytize rather than my own current theoretical preoccupation with practical rationality as the operational equivalent of self-actualization, which I will discuss briefly below.

In many jurisdictions it is stipulated that the treatment modality for partner violence must by "*psychoeducational*", which is intended to proscribe any treatment approach that focuses on psychological factors that could be interpreted as an excuse for morally and legally unacceptable behavior, or on aspects of interpersonal conflict for which the victim might be assigned some responsibility, or "victim blaming" (Gondolf, 2002; Healey, 1998). There is strong institutional pressure in most jurisdictions to emphasize psychoeducational content that illustrates the systematic oppression of women by men on the patriarchal model of feminist theory (Austin & Dankwort, 1998). This treatment approach is usually presented under the rubric

of *Cognitive Behavioral Therapy*, which is broadly understood within the partner violence intervention community to be psychoeducational in character.

The dominant schematic representations of the central elements in the standard approach, which is based upon what is known as *the Duluth model (Adams, 1988; Dutton, 1994; Hansen et al., 1996; Harway, 1997)*, are usually depicted along the lines of the following two figures:

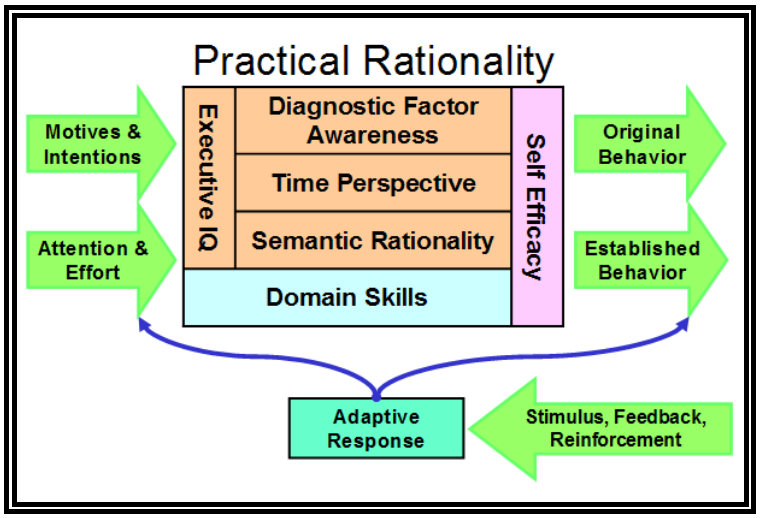




Although this model undoubtedly captures some important elements of the context in which intimate partner violence takes place I remain skeptical about the efficacy of the standard protocol, which enjoys nearly universally adherence in jurisdictions across the country (RJ Gelles, 2000; R Gelles *et al.*, 1997). Indeed, the limited outcome research that has been conducted to date indicates only a very modest treatment effect beyond the effect of arrest alone (Babcock et al., 2004; Jackson, 2003). I suspect that this is due to the fact that the standard treatment approach tends to exacerbate rather than mitigate the defensive posture in which most offenders enter into treatment, and also to the fact that the emphasis of the standard model is on the continual reinforcement of sanctions against undesirable attitudes and behavior rather than on the development of constructive new skills.

Practical rationality as self-actualization: the confluence of Maslow and Bandura

In response to the environmental factors that I have outlined above, I have formulated my own model of a 5-factor construct that I regard as an operational model of practical rationality *in general*, for which my current schematic illustration follows[1]:



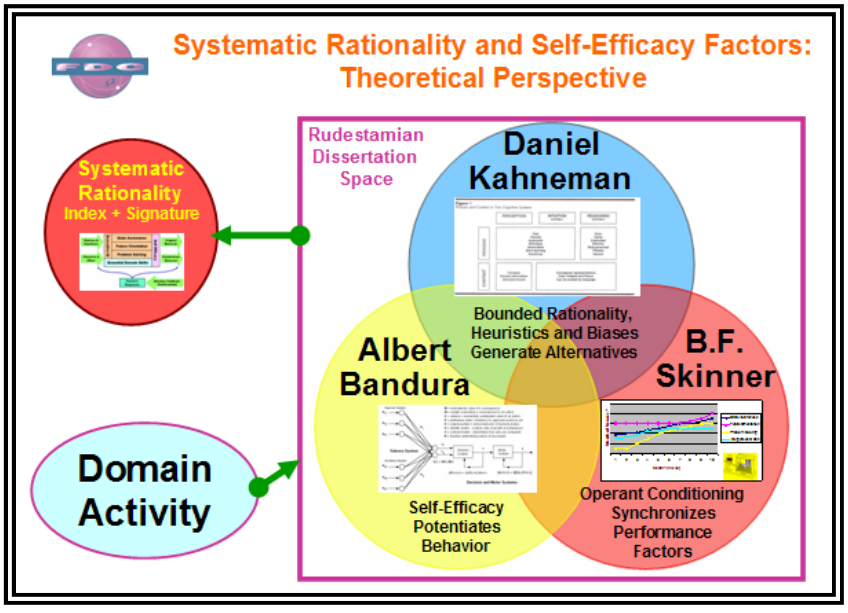
It appears to drive Kjell Rudestam slightly crazy when I make statements like this, but I quite seriously regard this model as an attempt to operationalize the humanist construct of self-actualization. I was raised in an environment where the term "*self-actualization*" was commonplace, if rather vague. My established professional expertise lies in the field of information systems, which sits on the porch of artificial intelligence, among the founders of which was Herbert Simon (H. A. Simon, 1996), to whom I also credit an important role in the foundation of modern cognitive psychology (H. Simon & Newell, 1959; H. A. Simon, 1947; H. A. Simon, 1957; H. A. Simon & Thaler, 1986), among the distinguished heirs of whom I number Albert Bandura, to whom you have referred repeatedly in your feedback. So we were already cousins when I arrived at Fielding 5 years ago.

To date, my reading of Bandura has been limited to *Aggression: a social learning analysis (Bandura, 1973), Social foundations of thought and action: a social cognitive theory*

[1] Executive IQ, depicted in this figure, is an aggregate construct that is constituted by Diagnostic Factor Awareness, Time Perspective, and Semantic Rationality rather than an independent factor in it own right.

(Bandura, 1986), and *Self-efficacy: the exercise of control (Bandura, 1997)*. I have been strongly influenced by Bandura's exploration of social modeling, metacognitive and behavioral self-regulation, and by his elegant deconstruction of the persistent behavior patterns that have frequently been mistaken for innate drives. But Bandura's most significant impact on my thinking has been his clarification of the manner in which perceived self-efficacy potentiates not only overt behavior in a given domain, but also the crucial engagement in cognitive modeling, which mediates the development of new expertise in relevant domains. The construct of self-efficacy figures prominently among the 5 principle factors in my model of practical rationality, represented in my schematic figure as a *gatekeeper* to the expression of heuristic goal seeking behavior. In the course of their detailed exploration of the many idiosyncratic biases and heuristic shortcuts to which people normal resort in the course of what Herbert Simon called "bounded rationality", Albert Bandura, Daniel Kahneman, and their colleague Amos Tversky have encouraged my pursuit of an operational understanding of self-actualization (Kahneman *et al.*, 1982), and its relationship to the etiology and treatment of intimate partner violence (fDutton, 1985).

As I began to formulate this model at the foundation of my dissertation research several years ago, I presented the following graphic to my dissertation committee as an overview of my preliminary thinking in terms of Kjell Rudestam's famous Venn diagram of the overlapping theoretical areas that are necessary for a good Fielding dissertation, which I designated as *Rudstamean Dissertation Space*.



Although I have narrowed and refined the focus of my dissertation topic considerably since I first presented this overhead to my dissertation committee more than 3 years ago, I hope it is evident that I am deeply sensitive to Bandura's remarkable contributions. The detailed analysis of various contributions from cognitive psychology and systems theory to a robust understanding of problem solving, which I attached as an appendix to my last revision of this comprehensive essay, should underscore this appreciation and the footwork from which it is derived.

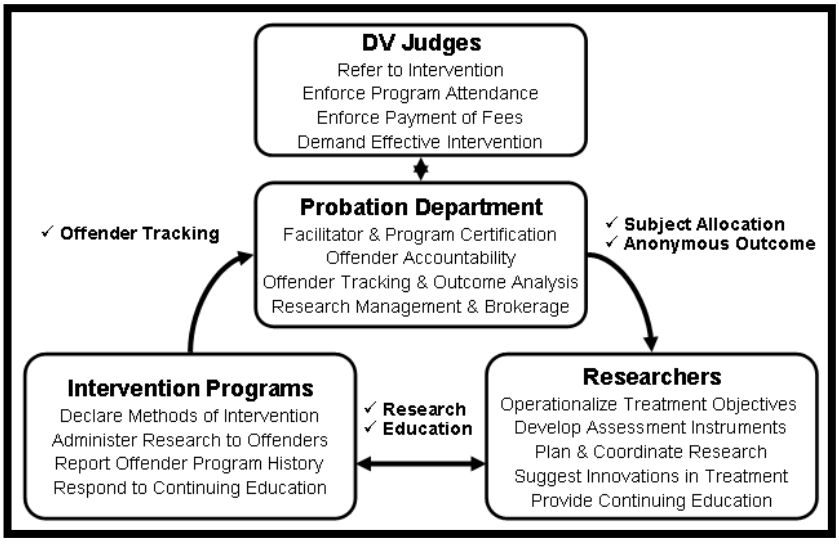
I believe that the general process of self actualization can be usefully conceived as the practical habit of heuristic goal seeking, enabled by a sense of self-efficacy, activated by the recognition of challenging circumstances, and constituted *at least* by the factors that are enumerated in my model of practical rationality. My essential interpretation of much intimate partner violence is as a poor solution to problems of interpersonal relationship, and that better solutions would result from a systematic search for them by means of a generalized procedure like the one I have illustrated in my schema for practical rationality. This is certainly the intention behind the nearly universal emphasis, in partner violence intervention programs, on a procedure which has been unfortunately labeled "*Time Out*" (Geffner, 2002). This is unfortunate because, while it is undoubtedly a useful procedure, most of the men under treatment in these programs, and their intimate partners who are asked to participate in it with them, have already been exposed to this term in the context of preschool behavior management, which association undoubtedly diminishes its effectiveness in adult populations.

I suspect that an increased emphasis on the elements of this model of practical rationality might have the potential to enhance the effectiveness of IPV treatment in a manner that can be framed as an incremental or enhanced aspect of treatment protocol, which does not directly challenge the dominant ideological model of IPV etiology and treatment. The model is framed in a terms which lend themselves to systematic empirical research and, if they are

validated in that process, to ongoing protocol development. I believe that such a program can be carried out within the existing intervention system without the need for additional funding. Additional funding will not be forthcoming and, in my experience, the lack of it constitutes the most common justification (excuse) for inaction among both clinicians and academics.

This is indeed a tall order for academic research that is not thoroughly grounded in the institutions that actually deliver direct treatment services, but the effect of social action research goes far deeper than the production of useful results when it succeeds in engaging these institutions and the reflective attention of their clinical personnel. When the clinicians who are directly engaged with offenders identify with an ongoing process of inquiry, reflection, experiment, outcome evaluation, and refinement of technique, they will become more effective as a result of that engagement; regardless of specific experimental findings or insights (Beck, 2000; Lewin, 1951; Lewin & Gold, 1999).

This conviction is central to my engagement in both the clinical and systemic aspects of partner violence intervention. In this case, progress in the field must be tied to particular theories and protocols, even while the ongoing process of systematic research ensures that *every* theory and protocol will be eventually transcended. The polemic that is an expression of my engagement with the social system of partner violence intervention cannot be separated from the theoretical expression that informs my clinical practice and guides my dissertation research, or from my personal experience of being with these particular men in these very special circumstances, or from the course of my academic discourse at Fielding. It is all one cloth.



Clinical encounters around themes of sexual orientation and HIV+ status

The other major aspect of my clinical experience over the last three years has been working with HIV+ clients of the non-profit service agency where I completed my clinical internship almost 2 years ago. Almost all of these clients are gay men, some of whom are newly diagnosed and some of whom have known their HIV status for many years. The charter of the mental health staff at this agency is to help these men accommodate the social and psychological consequences of their medical condition. Counseling services, both in groups and individually, are provided by 3 doctoral interns under the excellent supervision of several veteran clinical psychologists who have worked with this population for many years.

No particular psychotherapeutic technique is stipulated by the agency or by the clinical supervisors, none of whom identify with any particular psychotherapeutic discipline. Although I did not originally select this internship site on that basis, this posture on the part of my supervisors has further reinforced the explicit resistance to theoretical and methodological commitment that Will Kouw has stressed in the context of EPICP. In this environment I have been free to work with each client in whatever manner seemed appropriate, in regular consultation with my supervisors, of course. During my full time internship I worked with 15-20 clients at a time and since its completion I have continued to work with 6 or 7 clients one long day a week, usually in weekly sessions for which I allow 2 hours on my schedule. Most of my sessions last about 90 minutes.

I originally approached this environment with an expectation that the predominant theme in counseling would revolve around the terminal disease that my clients had contracted. To be frank, I was also preoccupied with concerns about how I would fare working with a gay population, having had little direct involvement with the gay community to that point. So I did my homework and acquainted myself with the literature on the agency bookshelves regarding HIV/Aids as well as sexual orientation, the gay experience, and the impact of these issues in

psychotherapy. I therefore began my internship with a fairly clear schematic concept of the clinical environment and of the clients with whom I would be working.

I was not surprised to find that the conversation in my early encounters revolved largely around these issues. Over the course of my first few months in this environment I developed a fairly consistent style of working with clients, which included an exploration of each client's HIV^+ diagnosis and status, lifestyle habits, medication compliance, as well as their understanding of the disease and what it meant to them; particularly regarding their expectations for the future and their attitude toward death. At the time I began my internship I had recently completed the Transaction Analysis and Redecision Therapy (TART) clinical training track at Fielding and successfully defended that theoretical perspective in my PIE. I felt as though I had mastered the principles of TART and I tried to adopt the style of encounter that it recommends. One of the central techniques of TART is the standard opening to each therapeutic session: "*What would you like to change about yourself today?*" (Berne, 1961) The question cuts straight to a focus on action and it asserts that it is within the power of the client to change herself at will, both of which are themes to which I was and am strongly attracted. The mechanics of TART fit nicely with the themes around which most of my clinical encounters revolved.

I began to recognize the "*ubiquitous experience of discord"* that Will has commented on in group supervision when I realized that I was not getting the same type of feedback from my clients regarding their sexual activities as were the other interns. I realized that my established clinical protocol was serving me to deflect this uncomfortable material. At first I regarded this specifically as an instrument of my counter-transference in the face of uncomfortable material and I took pains to remain especially receptive to it. Of course, I began to find that many of my clients placed a great deal of emphasis on issues surrounding their sexuality, and a much greater proportion of my clinical discourse began to revolve around these. I rapidly became comfortable with this type of material and I incorporated it into my regular clinical protocol, even as I began to suspect that by doing so I was creating another self-fulfilling prophecy. Under the

growing influence of Will Kouw and in the light of my own recognition of the way in which I had inadvertently used protocol to exclude important material, I noticed that my clients were trying to emphasize many other themes beside those that I had in mind. They were not all preoccupied with death, with the consequences of their disease, *or* with their sexuality. Each of my clients was drawn to a unique combination of themes, and the more receptive I became to the emphases that they lent to our discourse the further afield I felt from any generic interpretation of our encounter or what we were doing together. I began to notice that when I was preoccupied with this reality I felt adrift, uncomfortable, and unprofessional, but that when I abandoned myself to each encounter the salient issues that spontaneously emerged made compelling sense and indicated some clear course of clinical action. I began to notice, in a tangible way, that my interpretations and my intentions had an inevitable effect on the clinical discourse and that, on reflection and in the light of supervision, restraint in surrendering to them *always* improved the quality of my understanding and the effectiveness of my interaction. With Will's encouragement I began to see this less as a sign of academic lassitude and more as a positive method in its own right; the central element of which is, not ironically as it turns out, a resistance to method itself. Diagnosis and protocol are inevitable and there is no need to guard against their neglect; the greater danger may lay in the collapse of possibility which they inevitably entail.

Kelly: CBT for depression by the book

Terry presented at our first encounter visibly distraught and complaining of what she repeatedly referred to as a paralyzing depression. She told me that she could not bear to leave her house and that her visit with me was the first time she had been out in several weeks. She said that her HIV^+ status required a medical prescription for marijuana, which she filled by cultivation in her home. She said that her plants were her only real source of comfort. Terry said that most of the time she could not even get out of bed and that she felt hopeless about the future. Terry said that she had been repeatedly diagnosed with major depression (her term) in

the past. She kept asking me if I could help her and I answered in various formulations that were all intended to convey: *Yes, of course you can help yourself in whatever way you choose if you choose to actually work with me*. Although she paid them some lip service, Terry ignored these assurances and insisted upon reiterating and demonstrating her irremediable misery.

We continued in this vein for the better part of three sessions before Terry finally asked me to write prescriptions for several psychotropic drugs that would make her feel better, which she specified in detail. When Terry discovered that I did not have script privileges she appeared ready to wrap up our therapeutic relationship then and there, so I asked her if the depression was real or simply a device to get the prescriptions. *Of course* the depression was real, that was why she needed the medication. I gave her a referral to a clinic where she could get the prescriptions that she wanted free of charge if their psychiatrist thought they were appropriate. I told her that I did not think the medication alone would give her the relief she was seeking and I invited her to start again with me the following week on an *authentic* exploration of her life situation and a search for opportunities to improve it.

Although Terry immediately obtained the prescriptions that she sought from the free clinic, her isolation and depression persisted and she became genuinely engaged in our exploration of her situation and perspectives. We spoke explicitly about the cognitive triad of depression and its correlates in her life. Terry continued to work with me for about 6 more weekly sessions, at which point she told me that she would be moving to another city and would not be able to work with me any more. In our last meeting I attempted to consolidate the small amount of work that we had done together and I gave her a copy of *Feeling Good: The new mood therapy* (Burns, 1980) as well as a copy of its companion workbook. Terry called me out of the blue 6 months later and told me that the book and I had entirely changed her life. She said she had lost 30 pounds, taken a job, found a boyfriend who was also HIV^+, and entirely abandoned her dependence on prescription drugs.

Perhaps Terry was simply in a manic episode when she called me or perhaps she had really made fundamental changes in her life strategy. I wonder where our discourse would have taken us if Terry had stayed to work with me for months or years. My treatment plan for Terry had been to lead her toward the recognition of her ability to choose her own course of action, if not necessarily her own feelings. I would have encouraged her to identify and commit to new ends that mattered to her, and urged her to take comfortable but tangible steps toward them. These activities should have led her naturally out of her house and hopefully toward a lessened dependence upon medications. If she had taken on their general pattern she could have taken this much farther. I will never know because Terry moved away and all I have is that unexpected phone call from her 6 months later. As far as I can tell, the CBT protocol embodied in the book that I gave her enabled all of this in Terry. I certainly was not responsible for what she seems to have done, but I participated in it with her just a bit.

Thomas and Dylan

Dylan began our first session with a declaration to the effect that he was no longer gay, and that his life now revolved around a Christian group of men dedicated to overcoming their former homosexuality. He was emphatic about this and he immediately countered whatever mild expression I uttered to the effect that it might not necessarily be such a bad thing to be gay after all. Dylan stuttered occasionally, which I took to be in connection with emotionally laden subjects. He alternated between long emphatic statements about “how a responsible person should behave” and rapt attention to pretty much anything that I said.

Dylan had been HIV^+ for 12 years when I first met with him and he reported that he had never been sick or required the medication that is almost universally required to keep that condition in check. When I asked him to tell me his life story he launched immediately into a comprehensive autobiography that he delivered over the course of about 3 hours without pause (I had the afternoon free). There were lots of men in and out of Dylan’s life, but none of them was his father. His twin brother had apparently escaped the effects of the pre-natal alcohol

poisoning to which Dylan attributed, as he put it, whatever it was that was different about him. Dylan and his 4 younger siblings were raised “like coyotes”, essentially without adult supervision, and he worked full time from the age of 13, buying his own school clothes and sometimes food. When Dylan was 16 the authorities removed him from their home along with his siblings, who were placed in foster homes. Dylan and his brother were essentially released on their own recognizance into the world, although their mother had sold the family home and disappeared, never to be heard from again. Dylan graduated from high school and attended a school of cosmetology, following which he has worked hard and continuously as a hair stylist for over 30 years, except for the 4 years that he was on tour around North America, the Caribbean, and Europe as a Rod Stewart impersonator. I have no doubt that Dylan was fantastic in this role.

While on tour, Dylan encountered a woman who was apparently a fake-rock-star groupie, who married him on the spot and had two children on the road with him before the show suddenly shut down and he was returned to the streets of his home town; destitute, unemployed, and bewildered. His wife divorced him and took both children to live with her in another part of the state. Over the course of the intervening 17 years his ex-wife has periodically delivered both children to live with Dylan for periods ranging from a few months to a year, appearing at some unpredictable moment to retrieve them. The few simple rules of proper behavior that Dylan reiterates with such great fervor and practices include hard work, healthy nutrition, and unflagging dedication to his children when they are with him. These rules have served Dylan pretty well. He often brings me healthy snacks and insists that I eat them during our session.

It was some time before I could formulate any coherent theory at all about the nature of my clinical encounter with Dylan, or its proper objectives. In our first session, when Dylan had violently renounced his gay past, I was comforted by the certainty of a solid diagnosis and a clear treatment objective. I did not happen to cast these in terms of DSM code 302.85 (Gender

Identity Disorder in Adolescents or Adults), but I might as well have done. For several weeks I engaged Dylan in a very direct discussion of the assertions he had made about his sexual identity and what he meant by them. He was clearly delighted with this entire discussion and he defended his positions with dogmatic arguments that I took to be slogans of the church group with which he was involved. It gradually dawned on me that Dylan did not appear to be genuinely invested in the question of his gender identity at all, nor did he seem to be really invested in the church group to which he avowed such zealous dedication.

As I reflected upon this observation Dylan informed me that his 14-year-old son, Thomas, was flying down to live with him 2 weeks hence; permanently. He said that he was glad that he was no longer gay and that he could prove it in court, which he said he was planning to do when his ex-wife tried to take his son away from him again. I realized immediately that the whole issue of Dylan's sexuality and his involvement with the church group was a huge red herring to which I had devoted so much of my attention, and that the important issues revolved around his relationship with his children and his ex-wife. I saw Dylan several times during the following week and we discussed many aspects of his son's coming visit, including his enrollment in school, the acquisition of his health records, how to set limits on staying out at night, homework, how to represent his participation in the church group and his sexuality to his children, telephone contact with the mother, etc. Dylan asked me to talk to the junior high school that Thomas would be attending on his behalf, and also to speak to his mother; both of which I did. His mother was a well-spoken, intelligent woman who told me that she was the director of special education for a California county; influencing young lives. She sounded very reasonable and expressed her satisfaction at my close involvement with Dylan and Thomas. I was confident that this would be a good experience for everyone involved and I was resolved to do what I could to facilitate this result.

Thomas spent about 3 months living with his father, during which time I saw Dylan at least twice a week. I saw Thomas as well, with his father and separately, both in my office and

on informal outings around the community. Thomas was doing well in his new school and both of them appeared to be doing well together when suddenly his mother appeared and took him home without explanation, to which Thomas apparently consented in order to avoid a conflict between his parents. In my only subsequent meeting over the following six months it was clear that Dylan was severely depressed. He moved out of his apartment quite suddenly and I lost track of him entirely.

About six months later Dylan simply arrived for our regular Tuesday afternoon session and sat in his usual chair as though there had been no break in our regular weekly sessions. For about a year we continued our weekly sessions and we addressed a number of significant themes with very rewarding effect. Dylan very much enjoyed what I am sure he regarded as the psychotherapy game that I liked to play and I am quite sure that, from Dylan's perspective, the themes we worked with were secondary to our relationship itself. It became apparent that Dylan was genuinely attached to his participation in the church men's group but that he was uncomfortable with the anti-gay rhetoric that was central to it. On one occasion I suggested that Dylan might want to experiment with other groups that did not have this slant, and at our next session he announced that he had joined the bible study group at a neighborhood protestant church and "*told them the whole story*" during his first visit. I had envisaged something more tentative and gradual, but apparently this group essentially adopted Dylan on the spot and he has been attending church events and group meetings several times a week for over a year at this point. We also worked out a regular telephone contact schedule with Dylan's children and I believe that our regular discussion of his relationships with them has resulted in the greater confidence that he reports in dealing with them.

This past week the mother has called to say that Thomas wants to come live with Dylan again, permanently again. I am grateful for the ground that we have already covered and I hope that I can provide more effective support in this important undertaking than I was able to provide last time. Dylan stands on somewhat more solid ground than formerly.

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Joe Ferguson

From: Melissa Timmons [mtimmons@fielding.edu]
Sent: Tuesday, May 23, 2006 5:31 PM
To: Joe Ferguson; Joseph G. Ferguson
Cc: Nolan Penn; Kjell Rudestam; Nancy Leffert; Katie Davis; Elaine Tagles; Melissa Timmons
Subject: No Pass Grade/Comprehensive Essays (Joe Ferguson) PSY

Importance: High

Categories: Fielding

May 23, 2006

Dear Joe,

I have received the response from the Comprehensive Committee regarding the results of your Comprehensive Assessment. Regretfully, they did not pass you on your assessment.

At this time your comps readers have read and evaluated your original assessment and two revisions. You have now received a No Pass grade. This means that your faculty advisor and Associate Dean will be in contact with you to discuss a remediation plan which will consist of targeting the specific skills and/or deficiencies that have prevented you from passing the assessment by this point. Subsequently, you will be given a new comps date with a new pair of readers and the opportunity to submit a revised comprehensive assessment to them. The No Pass grade will not appear on your transcript and there is no penalty for re-doing the assessment. However, the receipt of a final No Pass grade from a second set of readers will be taken as a Fail grade on the Comprehensive Assessment and may result in withdrawal from the Psychology Program.

We wish you well on your remediation plan and your subsequent comps performance.

Sincerely,

Melissa Timmons
Academic Resources Administrative Assistant

Cc: Nolan Penn, Kjell Rudestam, Nancy Leffert, Katie Davis, Elaine Tagles, Melissa Timmons

Comments:

Comments of Exam # 776—Second Revision

Although you stated clearly that you anticipated the following outcome, we regret to inform you that your third version of your comprehensive examination is a No Pass. As in the previous two versions, you did not completely or adequately answer the questions that are necessary to form the core of the assessment. Again, you did not provide the empirical evidence or a compelling theoretical rationale to support the position that you articulated. Your therapeutic approach appeared overly spontaneous and ignored the collective or consensual knowledge that has been developed in psychology over the past century. Your presentation showed a lack of identity with and an absence of awareness of the profession's and the public's expectations of a clinical

psychologist. Asserting that you work with a select population that does not require this knowledge and skill does not absolve you from demonstrating that knowledge and skill in the comprehensive examination of clinical psychology. You stated that your model requires a specific environment and will not fit a managed care environment, but you did not elaborate the impact such a restriction would have on the type or treatment of various clinical clients. Consistent with this concern, you did not adequately deal with issues pertaining to culture, social class, or race, which are critical aspects of the assignment. We want to make emphatically clear that our response is not an evaluation of Dr. Kouw's EPICP theory, but of your attempt to adequately address the issues of the comprehensive examination that have been delineated herein and in our previous feedback.

You asserted that you "do not understand the proper categories of psychiatry" and demonstrated that lack of understanding by suggesting possible diagnoses (e.g., manic, gender identify disorder) in your clinical presentation when no basis for either diagnosis was provided. Again, you did not explain how your approach conceptualizes various clinical disorders, such as bipolar disorder, schizophrenia, ADHD, etc., and how those specific conceptualizations would influence treatment. To state that your intervention "really does just occur to me" is inadequate. The problem in the logic of your approach is perhaps best illustrated in the case of Dylan, in which you also appear to have inaccurately suggested the diagnosis of gender identity disorder. Your treatment approach lacked coherency and seemed to lurch about without much logic or connection to existing "best practices." Indeed, it is the strong desire to not attend to "best practices" that is most troubling here and throughout your examination.

A grade of No Pass will require a remediation plan, which Melissa Timmons will elaborate for you. We would recommend that areas necessary for remediation are knowledge of the basic areas of psychology; knowledge and understanding of the different psychological disorders and theoretical and empirical support for various interventions; knowledge of multicultural issues essential for the ethical and appropriate practice of clinical psychology; accurate and current information about theories you choose to critique; knowledge of the limitations of your own theoretical orientation and therapeutic interventions; and the ability to demonstrate your competence in clinical conceptualizations and treatment decisions.