SELECTED COUNSELLING INTERVENTIONS

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SPECIFIC COUNSELLING INTERVENTIONS

FOUR DIFFERENT DISORDERS VIEWED THROUGH DIFFERENT SETS OF LENSES
“A metaphor for dealing with clients with BPD involves clients perceiving themselves as balanced precariously atop the apex of a mountain. They are at the mercy of every stray breeze and drop of rain. All of their energy and concentration is spent on maintaining their balance. If they lose their balance, they fall to their deaths, or experience severe injuries. There is no room on the mountaintop for others, so they suffer alone. They grasp at straws in the attempt to avoid damage and destruction. Expanding this metaphor for treatment, counsellors help clients build decks on the mountain so that clients can keep their balance more easily. The deck implies development of stable bases so that the clients' energy may be directed toward other life activities.” (Freeman, 2004, 458)

ETIOLOGY AND SYMPTOMATOLOGY

The above quote clearly implies clients with BPD hold distorted views of the self, the world, and their future. These distortions are rooted in their ‘schema’ that evolves through the process of adaptation (interaction of assimilation and accommodation). Early schema will be maintained if the client has not found a reason to alter them; it is only when the schema are not perceived to be of value that clients alter or modify their present circumstances. Schema are amoral and must be seen as adaptive or maladaptive, judged by the present quality of fit with the client's life.

The more active the schema, the greater the effect on daily behavior: the more credible the source of the schema, the more powerful and difficult it will be to modify. In addition, the earlier in life a schema is acquired, the harder it is to modify. “Schema acquired during the sensorimotor stage of development will be nonverbal, concrete, and amorphous. Schema acquired during older ages may be far more amenable to change because there are visual and verbal elements.” (Layden et al., 1993)

People with this disorder can often be bright and intelligent, and appear warm, friendly and competent and can maintain this appearance for a number of years until their defense structure crumbles, usually around a stressful situation like the breakup of a romantic relationship or the death of a parent. Symptoms include: inappropriate and intense anger or rage with temper tantrums, constant brooding and resentment, feelings of deprivation, and a loss of control or fear of loss of control over angry feelings. Identity
disturbances may result with confusion and uncertainty about self-identity, sexuality, life goals and values, career choices, friendships. There is a gnawing, deep-seated feeling that one is flawed, defective, damaged or bad in some way, with a tendency to go to extremes in thinking, feeling or behavior.

**COUNSELLING INTERVENTIONS FOR BPD**

CBT proponents (Beck et al., 1990; Freeman et al., 1990; Lineham, 1993) concur that interventions should be: (a) active and directive, (b) problem-focused and solution oriented, (c) collaborative and finally, (d) structured and educational. In addition, Freeman & Fusco (2004) state modifying schema can include: (a) reconstruction / construction, (b) modification, (c) reinterpretation and (d) camouflage. Re-interpretation and camouflage are choices usually made by the client *ex therapeuo*. Modification and reinterpretation are far more likely choices in working with the client.

Effective treatment requires a client’s movement in the direction of less distorted views of themselves and the world. The counsellor must expect and address the increasing anxiety as therapy progresses, as increased anxiety indicates the client is likely perceiving a loss of safety. It is essential to pay careful attention to the style, content, timing, and volume of the client's statements. The client's metaphors, language, and images should be used in session, as much as possible, as metaphors may be far less threatening. It is important to anchor the patient's actions and feelings in the present and, as much as possible, make self-destructive behavior unrewarding. Acting-out behaviors should be dismissed. Clarifications and interpretations should be focused in the here-and-now, with a connection between thinking and feeling. Confrontation, although intended to be firm and clear, is to be done tactfully, often including reference to the client's healthier intentions.

More recently, Smucker (2004) describes a technique of imagery re-scripting for BPD:

“That therapy involves identifying negative images and then rewriting the image so that it has a more positive ending or outcome... These include using imagery for an assessment of the client’s views of the world and experience; modifying self-defeating interpretations; helping the client re-enact a past experience and reconstruct the image; rehearsing an adaptive image;
empowering the "child as metaphor" with the knowledge, reason, and compassion of the adult; focusing on an image that provokes the emotion (use a graded approach); and supporting feared memories. In all cases, the therapy should move slowly and build security images so the client can approach the feared image.”

LIMITATIONS OF COUNSELLING INTERVENTIONS MENTIONED

When schema are questioned, challenged, or threatened, anxiety or survival-related danger will result. Counsellors treating clients with BPD must be aware that, when challenged, clients will shift into security modes and may enter defensive modes that may include fight, flight, or freeze. The movement from one therapist to another, the splitting often described with clients with BPD, the avoidance of affect, the aggressive expression of emotion, or the physical threats and self-injurious behavior are all manifestations of safety-seeking. Clients will strive for maintenance of the status quo which may equate with their goal of safety and survival.

Regardless what counselling therapy offered, frequently clients may find they are incapable of change or fear change because their concept of safety may be compromised. In order to make a change, clients must be helped to maintain the motivation for change. Sensitivity, hyperreactivity, and poor problem solving of clients with BPD makes them extremely vulnerable to crises. Therapy will be ineffective unless the patient makes the statement "I'm willing to try to be different."
“What is known about DID is that it is a developmental disorder. If an individual is traumatized in early childhood and the experience is so overwhelming that she is unable to process it, the child may dissociate to survive. DID results when the dissociation becomes severe enough to allow the child to compartmentalize parts of herself from consciousness [splitting] and experience them as separate parts [alters] from the core [host] self.” (Haddock, 2001, 28) [brackets mine]

“DID is due to traumatic experiences... too horrendous to contemplate, so the victim forces them into the dark recesses of inner psychic space, where they nevertheless chafe the unknowing ego, eventually splitting into fragments that later manifest themselves as alternate personalities.” (Loftus, 2000, 32)

**ETIOLOGY AND SYMPTOMATOLOGY**

From these descriptions, DID can be viewed as a disorder involving the separation of mental processes that are normally integrated. It has been described as an autohypnotic disorder, a skill, an altered state of consciousness, a neurobiological phenomenon, and a means of resolving psychological conflict (Putnam, 1989). Haddock (2001, 101) generalizes DID in her statement, “the process of dissociation is about banishing the unacceptable from the consciousness.”

Predisposing factors relevant to DID include: (a) a propensity for hypnosis; (b) temperament, (c) biological or genetic predisposition, and (d) neurological structure changes following prolonged trauma.(Comstock, 2000, 155). One hypothesis is that DID occurs when the amygdala overfunctions and the hippocampus underfunctions (van der Kolk et al., 1997) *see the reference in the biblio of Freisen’s paper* Waller and Ross (1997) reported that pathological dissociation appears to have no heritability whatsoever, whereas non-pathological dissociation or psychological absorption evidently has a substantial genetic component. *See HJ Irwin’s electronic paper*

Dissociation is seen not an illness, but a very adaptive coping method; an adaptation in the face of severe trauma. Persons suffering DID have usually experienced powerful others as malevolent and capricious. For example, early parental abuse causes disrupted attachment patterns, leaving DID sufferers “experiencing themselves as helpless and unlovable, and their caretakers as dangerous, or abandoning.” (Bowman, 2000, 126)
The process of dissociation interferes with normal memory processes, thus shielding the trauma victim from re-experiencing the event through the persistence of intrusive thoughts (Friesen, 2000, 146). Therefore, dissociation serves as a defense against pain, fear, helplessness, and panic, providing a welcome feeling of detachment from a terrifying physical reality and the emotions associated with it. This sense of detachment includes depersonalization, derealization, numbing of responsiveness and other alterations in perception and memory. (Koopman, Classen, & Spiegel, 1996, p. 52) see Kreidler et al. electronic paper

And so the dissociated parts or “alters” (ego states) can be thought of as protectors; some may function to soothe younger parts and others may house valuable information about the abuse event. Typically, this “splitting” of the psyche into alters occurs in situations where the trauma is severe and long lasting. Numerous researchers (Coons, 1994; Williams, 1994; Lonie, 1993; Ross et al., 1991; Chu & Dill, 1990; Coons, Bowman, Pellow, & Schneider, 1989; Terr, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986; Bliss, 1980) have cited direct correlations between severe or prolonged childhood trauma and DID, including prevalent incidents of sexual abuse and incest. see Comstock’s article, p. 155

The continuation of this defensive mechanism, in order to ward off re-experiencing the feelings associated with the traumatic event, may result in a reduced capacity for feeling, thinking, remembering, or even being -- which Haddock (2001, 47, 48) describes as “numbing”. Symptoms of flashbacks, nightmares, and intrusive thoughts are the result of the ego's attempt to facilitate integration of the feelings with the physical experience. Suicide ideation and actual attempts are quite common among DID clients, especially when they perceive their suffering as overwhelming or endless. (Bowman, 2000, 128) Lack of personal safety seems to trigger these impulses and other self-injurious behaviours.

Symptoms of dissociation in early childhood are somewhat different than those of adulthood and include: (a) amnestic periods and/or trance-like states, (b) marked changes in behaviour and functioning, (c) impulsivity, (d) lying, and (e) age-inappropriate sexuality (Putnam, 1993). see Carrion & Steiner’s electronic paper
COUNSELLING INTERVENTIONS FOR DID

Haddock (2000, 77, 87) writes:

“Dissociation can be difficult to diagnose because DID clients often enter therapy in a state of crisis. Stabilization and creating a psychological and physical safety for a client is more important than diagnosis. There are two possible long terms goals of therapy. One is to fuse the alters [integration] so that they cease to exist as separate parts... an equally viable goal is that of co-consciousness, with each part working in cooperation with the others, much like members of a family might operate if they hope to live in any kind of harmony.” [brackets mine]

Psychodynamic therapy is often employed in the treatment of DID, however, cognitive and Adlerian approaches are also well suited for the treatment of this disorder. Psychodynamics has proven to be particularly helpful as it: (a) interprets what the client shares, (b) assist the client to work through the transference relationship, and (c) helps to bring disowned parts of the self into awareness. Often Object Relations is introduced as the initial focus in most treatments would be on the mother/infant relationship. In DID therapy, exploring these internalized images, leads to a more unified sense of Self.

Many therapists incorporate cognitive work (CT) into their sessions with DID clients. CT teaches concrete skills that can be practiced outside the therapeutic environment, helping the client take responsibility for their lives and feelings, rather than externalizing and remaining a victim even after the danger has passed. Cognitive work takes a psychoeducational approach to help clients understand the connection among thoughts, feelings and behaviours. It also challenges a client’s distorted or irrational thinking and beliefs formed during trauma.

Adler believed that the healthiest people are the ones who are able to look beyond their own suffering to see and respond to others in empathetic ways. To Adlerian therapists, it is imperative that “alters” or multiple personalities learn to cooperate if healing is to occur; to ultimately attain mutual respect among internal parts. Cooperation, although difficult to maintain, can only be developed over time through therapeutic modeling within the therapeutic relationship itself.

LIMITATIONS OF COUNSELLING INTERVENTIONS MENTIONED

Frequently, counsellors have found that certain clients do not make the progress in psychodynamics they could make. Many get worse, some much worse, and the
dropout rate is high. Although helpful, it does not tend to bring closure to the wounds uncovered through processing memories. According to Friesen (2000, 146) and Haddock (2001, 114), the major pitfall of psychodynamics is the possibility of moving into trauma work before adequately addressing safety and stabilization. In addition, the remote stance and non-disclosure could be problematic in working with younger “alters” who might perceive the therapist’s behaviour as uncaring or even abusive.

Cognition tends to rely more on theory and less on relationship. Vital to the therapeutic relationship is the creation of a secure space that allows the DID client to feel secure within the context of relationship. Assuming a directive or authoritarian manner will only serve to undermine such a relationship. Haddocks (2001, 117) quoting Watkins mentions “nurturance and resonance as being helpful in facilitating positive outcomes with child ego states.” Cognitive therapy fails to approach the child alters at their level of reasoning.

Adlerian therapy values cooperation and egalitarianism to the detriment of setting appropriate boundaries in therapy. Furthermore, stressing the concept of individual wholeness refuses to acknowledge the client’s experience of having internal parts. This may force the issue of premature integration, which may not be in the client’s best interest. “The basic rule is this”, says Friesen (2000, 148), “healing, conflict resolution and spiritual recovery should precede integration. In some cases clients choose not to integrate... do not make integration the goal of treatment.”
PART THREE --FEMALE SEXUAL DESIRE DISORDER (FSDD)

“FSDD is often accompanied by decreased sexual desire and/or inhibited orgasm. As many as a third of happily-married women may experience some difficulty in maintaining sexual excitement. Many causal factors may be involved in sexual dysfunction in general, including physical illness, medication side effects, hormonal factors, depression, anxiety and poor relationships with sexual partners. Possible psychological factors include obsessive self-observation, performance anxiety, guilt about sexuality, marital discord, and anger at ones partner, fear of pregnancy or fear of orgasm.” (Kaplan, 1995)

ETIOLOGY AND SYMPTOMATOLOGY

Loss of desire for sexual activity is the commonest presenting female sexual dysfunction and often the hardest to treat. Whether this loss of sexual desire should be seen as abnormal or simply as a variation of normal has long been debated. Much of the literature available on female loss of desire considers sexuality for women from various viewpoints and worldviews. In the DSM-IV (1994, 541), FSDD is described in terms of “persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity.” As very little is known about normative desire levels, it becomes unclear where to separate normal variation from “disorder.” Thus, a great deal rests on the subjective and probably highly variable evaluation of the clinician and the level of “marked distress or interpersonal difficulty” the woman expresses about her sexual desire level. (Heiman, 2001, 447)

The DSM-IV delineates two subtypes of desire disorders, namely FSDD or female sexual desire disorder (sometimes called inhibited sexual excitement or hypoactive sexual desire disorder) and SAD or sexual aversion disorder. Women with FSDD can have good sexual functioning. They simply will not initiate sexual contact. Those who do not desire sexual activity can operate quite well sexually once engaged in the sexual encounter. Touch around the clitoris and genital area facilitates neurological pathways, producing good arousal, good lubrication, and on to orgasm.

Suspected etiological factors might include a woman’s age, age differences between partners in relationship, social class, the duration of the sexual problem, hormonal condition, relationship duration, affairs during the current relationship, STD’s, present life situations, number of children, strength of religious beliefs, and any current psychiatric disorder. (Heiman, 2002, 448) Women in the USA aged 24-25 showed FSDD rates (rounded) of 29-32% and 50-59-year-old women reported rates of 30-37% (Laumann et al., 1994). Certain medical conditions induced by stress, fatigue and anxiety are known to negatively affect sexual desire; with each successive sexual encounter becoming more difficult or less desirable than the last. For example, when a woman becomes overly anxious about
sex, it can cause her to have sex less often with her partner or not actively seek sexual partners at all. This can make her even more anxious, so that she anticipates her own unresponsiveness each time she’s about to have sex.

Most Christian counselors take a more simplistic view toward sexual desire in women, as is advocated by Clinton & Oschlaeger (2002, 504-5), suggesting sexual desire is directly related to “finding the energy for sex” in a hectic lifestyle and claiming that “women’s sexual desire is strongly influenced by their body image and menstrual cycle” and “with women, it may not be a sexual-desire disorder but simply fatigue or distractions.” In any case, as my wife suffers this disorder, I can’t simply write it off to being overly distracted or fatigued.

**COUNSELLING INTERVENTIONS**

Sexuality is a complex process, coordinated by the neurologic, vascular and endocrine systems. Individually, sexuality incorporates family, societal and religious beliefs, and is altered with aging, health status and personal experience. In addition, sexual activity incorporates interpersonal relationships, each partner bringing unique attitudes, needs and responses into the coupling. A breakdown in any of these areas may lead to sexual dysfunction. As such, our counseling interventions need to be a diverse as sexuality is complex. Heiman (2002, 450) writes that most research indicates an integrated approach to medical and psychological treatments is optimal:

> “…to prescribe any treatment and ignore the fact that human sexuality is infused with individual meaning is to invite further interference with sexual functioning. In the enthusiasm for new physiologic approaches, there has been a tendency to overlook or dismiss evidence for psychologic treatments.”

Tiefer (2001, 93) takes a totally different tack, suggesting that many medical and psychological professionals have adopted a social constructionist view of sexual experience that avoided any universal blueprint for successful or normal sexual experience:

> “Women suffer … incomplete health care (limited access to abortion and poor insurance coverage for contraception); greater social pressure to marry and frequent trading of sex for socioeconomic advantages; greater burdens in homecare, child care, and eldercare that limit energy for sex and other pursuits of the self; limits in nonmarital sexual opportunities because of dangers to reputation and the threat of sexual violence; and loss of personal sexual power as a result of child sexual abuse, poor self-esteem, depression, and other problems not uncommon in women’s lives. We believe that a fundamental barrier to understanding women’s sexuality is the medical classification scheme in current use, developed by the American Psychiatric Association (APA) for its Diagnostic and Statistical Manual of Disorders (DSM-IV, 1994). These “dysfunctions” are disturbances in an assumed universal physiological sexual response pattern (“normal function”)
originally described by Masters and Johnson in the 1960s. This universal pattern begins, in theory, with sexual drive, and proceeds sequentially through the stages of desire, arousal, and orgasm. We propose a new and more useful classification of women’s sexual problems, one that gives appropriate priority to individual distress and inhibition arising within a broader framework of cultural and relational factors. We challenge the cultural assumptions embedded in the DSM and ... call for research and services driven not by commercial interests, but by women’s own needs and sexual realities.”

Tiefer and Heiman (2002) see Heiman’s paper Psychological treatment for FSD both agree that to prescribe any treatment and ignore the fact that human sexuality is infused with individual meaning is to invite further interference with sexual functioning. In the enthusiasm for new physiologic approaches such as those prescribed in the DSM-IV, there has been a tendency to overlook or dismiss evidence for psychological treatments.

A coaching model outlined by Clinton & Oshlaeger (2002, 506-12) seems to link with Heimen & Meston’s (1998) research investigating therapies for female sexual dysfunction. All the treatment approaches investigated had several common ingredients: “(a) a detailed history that assesses physical, psychosocial, and interpersonal factors, (b) brief (5-20 session) solution-focused treatment, (c) a theoretical basis of CBT, sometimes with accompanying, though untested, systemic or psychodynamic interpretations, (d) home prescriptions, and (e) a view of sex as a legitimate symptom rather than only as a sign of other issues or pathology.” see Heiman 2002 paper

LIMITATIONS OF COUNSELLING INTERVENTIONS MENTIONED

Phillips (2000, 131) suggests women with disorders of desire are difficult to treat. Occasionally, decreased desire in patients is secondary to boredom with sexual routines. No medical treatment is available specific to patients with disorders of desire. If no underlying medical or hormonal etiology is discovered, Phillips suggests individual or couple counselling may be helpful.

McCabe’s (2001, 259-60) research suggests the effectiveness of cognitive behavioural interventions in treating lack of sexual desire, considered to be the most difficult of all the sexual dysfunctions to treat, is largely unknown. However, McCabe points out that many of his study subjects had sexual dysfunctions that were long-term
and well entrenched and, thus, a 50% success rate resulting from a relatively brief ten
session intervention can be seen as encouraging. The results of his current study have
demonstrated that “after therapy, there were no significant changes in frequency of
intercourse or other types of sexual activity or general feelings about the relationship.
However, after therapy, subjects had more positive attitudes toward sex, were more likely
to perceive sex as being more enjoyable, and less likely to see themselves as a sexual
failure.”
“Where children experience their primary caregiver as available and appropriately accessible and responsive to their needs, they gradually develop a secure representational schemata or internal working model of relationships that confirms others as trustworthy and as sources of comfort. In contrast, the development of insecure attachment is related to an internal working model that accurately reflects disrupted or deviant care giving. Insecure anxious attachment is typified by ambivalence ... while the insecure avoidant type involves distancing and a blockage in the capacity to make deep relationships.” (Bowlby, 1969, xii-xiv)

**ETIOLOGY AND SYMPTOMATOLOGY**

Reactive Attachment Disorder (RAD) of Infancy and Early Childhood is best explained using attachment theory: “early relationship experience with the primary caregiver leads eventually to generalized expectations about self, others and the world” (Harms & McDermott, 2003, 33). It’s etiology springs from Bowlby's internal working model (1973), a representative model of internalization highly compatible with Piaget's theory (1954) of representation sharing similarities to object relation's description of internalized self and object representations. Attachment was conceptualized as an intense and enduring bond biologically rooted in the function of protection from danger (Bowlby, 1969).

Bowlby contended that infants and their parents are biologically hard-wired to forge close emotional bonds with each other and that these attachments serve important emotional regulatory functions. On the basis of repeated experiences, the infant learns what to expect from the parent. The rules governing these expectations are internalized along with mental representations and guide a person's thoughts, feelings, and behavior in subsequent close relationships. The Self evolves and consolidates in development through the dimensions of intimacy made available through attachment experiences. Creating the capacity for attachment is crucial because it reactivates the developmental course toward Self and Self-with-other consolidation.

The DSM-IV delineates two subtypes of RAD, the *inhibited* type and the *disinhibited* type. The DSM-IV states these two patterns of disordered attachment “appear to be very uncommon”; however Reber (1996) suggests this disorder is fairly
common, citing a study that claims 1 million children with RAD live in New York City alone. Estimated prevalence rates extrapolated from maltreatment research indicate that approximately 1% of all children may have RAD (Richters & Volkmar, 1994).

The disinhibited (or indiscriminate) subtype is characterized by social promiscuity; marked by a lack of selectivity in choosing those from whom to seek comfort, support and nurturance, resulting in a peculiar “overfriendliness” with relatively unfamiliar adults that has been labelled "indiscriminate sociability." A child diagnosed with RAD-disinhibited type may be “overtly charming, telling strangers that they love them, asking them to come home with him or her. Destruction of property is common, as are hoarding or gorging of food, refusal to make eye contact with others, stealing, and lying (Parker & Forrest, 1993; Reber, 1996). They may engage in ‘crazy lying,’ which is lying for no apparent reason. Cruelty to animals and to other people is frequent and often fatal to the victim, as in arson, another common manifestation (Parker & Forrest, 1993; Rayfield, 1990; Reber, 1996). Other features not identified in the current DSM-IV diagnostic criteria of RAD (but that appear to be shared by most of these children) include lack of empathy, poor impulse control, and lack the ability to engage in cause-and-effect thinking and are commonly described as lacking a conscience, for they do not seem able to experience remorse or sincere regret for their actions.” (Reber, 1996). see Hall & Geher’s paper for Reber, Rayfield, Parker & Forrest references

The inhibited subtype, observed to a much greater degree in the first several years of life, were noted most when “cases of physical abuse, sexual abuse and neglect were documented.” (Egeland & Sroufe, 1981, 46) Characterized by a persistent failure to initiate and respond to social interactions in a developmentally appropriate manner, evident is a resistance to comfort along with a mixed pattern of approach and avoidance behaviors.

Evidence of RAD expressed during infancy (from 6 to 12 months) include weak crying responses and/or tactile defensiveness. Infants at-risk for RAD appear to display either marked stiffness (described as "stiff as a board") or limp posturing. Other indicators include a poor sucking response or little eye contact, as well as no reciprocal smile response and indifference to others. (Wilson, 2001, 42)
COUNSELLING INTERVENTIONS FOR ADULT RAD CLIENTS

Wilson (2001, 50) says numerous therapies have been developed to reach the child with attachment disorders and have met with varying success. Many divergent therapeutic views exist; so I shall restrict my discussion of intervention strategies to adult psychotherapeutic techniques, which seem successful for treating adult RAD cases. Wilson, quoting Randolph & Myeroff (1998) explains:

“...therapies for those suffering from RAD have similar goals: developing self-control and self-identity, understanding natural consequences, and reinforcing reciprocity and nurturing. The Attachment Center...uses an integrated multidisciplinary approach. The 2-week intervention revolves around four key techniques: cognitive re-structuring, re-parenting, psychodramas, and trauma resolution.”

Attachment theory has important implications in this age and culture wherein people strive for independence, autonomy, and self-sufficiency but all too often at the cost of alienation from self and others. Autonomy is purchased at the price of alienation and the absence of mutuality in their relationships. To the extent that childhood abuse or trauma has caused an adult client to fear or distrust relationships, Kahn (1997), Karen (1998) and others believe the development of relationship with the counselor both activates these beliefs, feelings, and provides “a new model of what close relationship can be and provide the persuasion and support needed to attempt something new.” Hillman (1996), Schnarch (1999) and Norton (2003) all argue that we are less childlike victims of parenting than cognitive adults recovering from past abuses. In Schnarch’s terms, attachments have “reduced adults to infants and reduced infants to a frail ghost of their resilience.” If this is so, Harms & McDermott (2003) argue counsellors should remain optimistic by shifting the site for intervention for RAD clients more to the “here-and-now” using psychodynamic, cognitive and narrative approaches:

“...there is however a more optimistic view for those who have experienced earlier attachment disturbances. There should be a stronger emphasis on the importance of current states of relationships than with past experiences. The therapeutic relationship with its elements of transference and counter-transference becomes the site for intervention and offers new models of [adult] attachment. A secure and containing therapeutic relationship is purported to provide the opportunity to form new, secure attachments.”

Norton (2003) quoting Ricks (1985) echo this belief; “… the primacy of transference… opens opportunities to transform interactions around what was
experienced in the immediate counselor/client relationship… from those experienced in earlier relationships.”

**LIMITATIONS OF COUNSELLING INTERVENTIONS MENTIONED**

The symptoms of attachment disorder can confuse many counsellors and, as a result, RAD often goes *undiagnosed* thereby negating appropriate intervention. These symptoms include low self-esteem, lack of self-control, anti-social attitudes and behaviours, aggression and violence, and among other things, a lack of ability to trust, show affection, or develop intimacy (Levy & Orlans, 1998). *see Sheperis et al. paper for citation* RAD behaviors can also be *misdiagnosed* as a conduct disorder, oppositional-defiant disorder, or attention deficit hyperactivity disorder; it is important to distinguish attachment disturbances from these other disorders to ensure “no harm” ethics. (Reber, 1996)

Clients with RAD have less empathy and engage in more self-monitoring activities. Therefore, these clients may consciously attempt to present themselves in a socially desirable manner rather than an accurate manner in transference. Because of this significant tendency to engage in (perhaps) conscious self-monitoring behaviour, these individuals pose unique problems for counsellors. They can be ingeniously manipulative, fooling professionals who assume that cooperative behaviour is sincere, while in fact, it is devious and controlling.

Physically, RAD clients may experience body distortion (Levy & Orlans, 1998). This distortion, which may include disturbances in physical/self (e.g., feeling of depersonalization), body image distortions, poor impulse control resulting in aggression toward themselves and others, and a lack of ability to enter into trusting intimate social relationships (Rosenstein & Horowitz, 1996). *see Sheperis et al. paper for citation* As such, resistance to conventional therapies based on a reciprocal relationship of trust (especially disinhibited subtypes) is very common. (Reber, 1996).

Additional barriers to traditional (psychotherapeutic or cognitive) interventions might include an inability to profit from experience, a minimal desire to change, little or no regard for authority, and poor impulse control.
I’ve chosen to collate my thoughts from a Christian worldview at this juncture, as I believe Christian counsellors, in particular, would do best to view diagnosis and assessment and the subsequent therapeutic interventions all through a more integralist “lense”.

According to Miller et al. (2004, 40) quoting three other research studies state that “diagnosis as most recently codified in the DSM-IV-TR has long had a problematic relationship with the practice and outcome of psychotherapy … despite widespread use of the DSM, the diagnosis a person receives at the outset of treatment bears little or no relationship to the outcome of that care.” The DSM is a political/philosophical document and the worldview represented changes with time, research, cultural influences, etc. and therefore needs to be adjusted for epidemiological issues and linguistics. Furthermore, the DSM-IV implements a multi-axial categorical system for classification. But categorical systems depend on criteria, which are very different from a dimensional system; putting people into “boxes”, in my opinion, doesn’t work so well with mental processes. A truly objective diagnostic system appears difficult at best – because we’re all on a continuum of health. If everyone is somewhere along a continuum, as counsellors then, we need only decide where along the continuum our client is at present.

The DSM-IV, based entirely on this systematic medical model, defines “disorder” using clinical reasoning: “The definition of mental disorder in … the DSM-IV requires that there be clinically significant impairment or distress. Assessing whether this criterion is met, especially in terms of role function, is an inherently difficult clinical judgement.” (APA, 2000, 8) Concomitantly, too often following a diagnostic criteria, the DSM stresses: “The judgement of deficiency or absence is made by the clinician…” or “The clinician may need to assess…” (APA, 2000, 539, 41). Where is the client and their personal resources in all of this, I ponder?

Ivy and Ivy (2003, 308) rightly point out that most theories agree on the need for extensive client involvement, and that counsellors who dwell less on the diagnoses and more on “Joining & Journeying” with the client will more often see true healing occur.
In client-centred therapy, it is the client who seeks new meaning to his/her situation. Carl Rogers (1951) believed that “in every human being there is an active force towards growth, freedom and self-actualization. Smith, quoting Rogers (1961), explains:

“… fully functioning persons do not hide behind masks or adopt artificial roles. They feel a sense of inner freedom, self determination, and choice in their direction of growth. They have no fear... and can accept inner and outer experiences as they are, without modifying them to suit a rigid self-concept or the expectations of others.” (Smith, 1993, 448)

Inclining toward an integralist paradigm, like Olthius (1999, 151) I too perceive the best therapy is “integrally and thoroughly spiritual (not clinical), concerned with making and remaking healing connections with ourselves, others and God. Not: Have I mastered therapeutic assessment? But: has the client been seen, heard, and blessed? Not: How brilliant was my diagnosis? But: have I helped the person to face their inner demons? Not: How successful was the intervention? But: have we in our work together being ushered into the presence of God?”

From a Christian worldview, the DSM-IV is a useful diagnostic tool only if it doesn’t supersede the basic components of a client directed approach to counselling. I concur with Miller (2004, 50): “Put bluntly, almost everything written by and for clinicians gives the mistaken impression that we are in the therapy business rather than client satisfaction and change…” May I never lose sight of the truth that we, as Christian counsellors, are truly privileged – “joining with God to assist some in finding that glorious way.” (Townsend, 2003, 16)
REFERENCES


