

EDITOR’S NOTE 1: This case study (without a formal Guiding Conception and related sections) was originally written for Henriques’ *Psychology Today* blog to reach a large, lay audience (see <https://www.psychologytoday.com/us/blog/theory-knowledge/201706/maggies-story-the-many-reasons-why-not>); and the assessment and course of therapy sections contain many quotes from that blog entry. Thus the style in describing these sections is less formal than some of the other case studies in *PCSP*. However, the content and rigor of the case study are at a high level, which is why I have been eager to bring the case to *PCSP*’s readership.

EDITOR’S NOTE 2: For the interested reader, an outline of the structure of the case study of “Maggie” is shown in Appendix 1.

The Many Reasons Why Not to Commit Suicide: The Case of “Maggie”

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ABSTRACT

This case describes the treatment of Maggie, a first-year college student dealing with depression, trauma, and suicidal thoughts and behaviors. It illustrates a conceptualization and practice that takes place within a guiding conception positioned in the “unification pathway” to psychotherapy integration. Specifically, I have developed a foundational, meta-theoretical “big picture,” science-based “Unified Theory of Knowledge” (UTOK) that frames the work. It is a model of the evolution of energy, matter, mind, and culture within our universe’s history—that is, from the “big bang” to the multicultural, complex, human societies that dominate the earth today. Within the UTOK metapsychology (Henriques, 2022a), I have described where the discipline of psychology and the theory and practice of psychotherapy are positioned—allowing psychology and psychotherapy to be potentially grounded in a coherent naturalistic ontology that does not reduce to physicalism or overly rely on a natural science empirical epistemology.

UTOK shows how we can retranslate the standard biopsychosocial model into a model that defines the layers of existence in terms of life (the realm of living organisms), mind (the realm of minded animals), and culture (the realm of human persons). It uses this new big picture framework to reframe and realign the key insights from the four major approaches to individual

psychotherapy—behavioral, experiential/humanistic, psychodynamic, and cognitive—since each school of thought captures crucial aspects of human behavior and experience, both in its flourishing and its entrenchment in maladaptive patterns.

Because of the scope and complexity of UTOK, it is not possible to fully summarize it in the pages allotted to it in a *PCSP* case study. Rather, in the psychotherapy case study of Maggie below, the reader is offered a basic outline of UTOK's overall structure to provide a sense of what it is all about, together with plentiful references to learn more details about UTOK (e.g., Henriques, 2011, 2022a). This outline is then followed by psychotherapy-specific concepts and a central therapeutic technique—CALM-MO—that logically follow from UTOK and were central in Maggie's treatment, which is then presented in detail and discussed.

Key words: Unification; Integration; Depression; Suicide; Treatment; Case Study; Clinical Case Study

1. CASE CONTEXT AND METHOD

As has been well-documented in the literature (Henriques, 2014a; Haidt & Twenge, 2021), our society is facing a mental health crisis, and it is especially significant amongst our youth. The last decade has seen skyrocketing levels of anxiety and depression in children, adolescents, and young adults. Consistent with this is the fact that college student mental health has shown a precipitous decline in the past two decades, and likely worsened in the wake of the COVID pandemic. Perhaps most disconcertingly, suicidal thoughts and behaviors have also increased substantially in the last decade. For example, on Feb. 13, 2023, the U.S. Centers for Disease Control and prevention released a report documenting a dramatic increase between 2011 and 2021 in teen girls who reported they "persistently felt sad or hopeless," particularly from 36% in 2011 to 57% in 2021 (<https://www.cdc.gov/media/releases/2023/p0213-yrbs.html>). *Washington Post* newspaper articles following up the story had headlines such as "Teen girls 'engulfed' in violence and trauma, CDC finds" (<https://www.washingtonpost.com/education/2023/02/13/teen-girls-violence-trauma-pandemic-cdc/>), and "The crisis in American girlhood: Stark findings on the pervasive sadness, suicidal thoughts and sexual violence endured by teen girls have jolted parents and the wider public" (<https://www.washingtonpost.com/education/2023/02/17/teen-girls-mental-health-crisis/>).

This case study of "Maggie," whose name and identity have been disguised, presents an approach that includes several therapeutic frames that might be taken to help college students contemplating suicide. I am deeply thankful for Maggie's willingness to share her story. We do so with the hope is that it helps teens, parents, teachers, and therapists understand how and why serious depressive episodes develop and how effective therapy can work to transform the cycles of negative emotion and self-criticism into more virtuous cycles of adaptive growth.

2. THE CLIENT

Maggie is a white college freshman from a stable, two-parent family. At age 15 while in high school, Maggie had been hospitalized for depression after a suicide attempt. While she had seemed to recover to some degree, to the point where she didn't need rehospitalization, shortly after entering college her past depression and the stressors of being a freshman (e.g., demanding academic work, the need to make new friends, and the shattered hope that she would be free from her past) caught up with Maggie and she became suicidal again. This initiated an emergency visit and subsequent therapy with me in the Counseling and Psychological Services Center, a community mental health clinic run by James Madison University. This clinic homed many of the doctoral students in the Combined-Integrated program in Clinical and School Psychology, of which I was the program director at the time and remain as a core faculty member today.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

The Guiding Conception for Maggie's case is a foundational metatheory of psychology and psychotherapy I developed, called the Unified Theory of Knowledge (UTOK; Henriques 2022a). The UTOK is structured and offered as a metapsychology that enables a coherent alignment between natural science, subjective experience, and collective wisdom. It is most directly grounded in the science of psychology and the practice of psychotherapy, and functions to build a coherent landscape across the domains of human psychology and the schools of thought in psychotherapy. A full description of this theory is beyond the scope of this article, and my goal in this exposition is to provide the reader with enough to grip the basic features. To do so, I will describe it in two parts. First, I outline the broad span of UTOK to provide the reader an idea of how such a foundational metatheory can lay the groundwork for a wide-ranging integrative approach to psychotherapy. Second, I derive integrative, psychotherapy-specific concepts from the UTOK metatheory and describe their relevance for a case formulation and treatment plan for Maggie's therapy.

The Unified Theory of Knowledge (UTOK): An Outline

Psychotherapy Integration and Unification

The approach to psychotherapy taken here is located squarely within the psychotherapy integrative tradition. Consistent with an integrative approach, in working with Maggie I systematically drew from a wide variety of different perspectives. Some of the major perspectives that systematically inform my work include Paul Wachtel's (2014) cyclical psychodynamics, the interpersonal process approach as articulated by Teyber and Teyber (2016), emotion focused therapy as delineated by Greenberg (2015), and cognitive behavior therapy as

articulated by J. Beck (2011). In addition, the primary therapeutic tool that frames my general approach to psychotherapy, which I use with Maggie and is described below, is called "CALM-MO" (Henriques, 2022). It has significant connections and overlap with both ACT as articulated by Hayes et al. (2011) and interpersonal neurobiology, as described by Dan Siegel (2020).

Given the broad and diverse array of approaches that inform my work, a reasonable question emerges regarding how I frame the intersections between these different schools of thought. My overall approach to psychotherapy is found in what is called the "unification pathway" to psychotherapy integration (Marquis et al., 2021). This pathway has recently been recognized in the professional literature as the fifth major pathway to psychotherapy integration. As those familiar with psychotherapy integration know, there have historically been four major pathways to foster the exploration and the development of an integrative approach. They are: 1) common factors; 2) technical eclecticism; 3) assimilative integration; and 4) theoretical integration (see Norcross & Golfried, 2005 for a detailed description).

The defining feature of the unification pathway is that it adopts a meta-theoretical perspective that zooms out and attempts to frame the key insights of the major approaches into a coherent conceptual whole. As delineated by Marquis, et al. (2021), my unification approach (Henriques, 2003; 2022a) is one of the three major approaches that have been advanced that contribute to framing the unification pathway. I call my approach the Unified Theory of Knowledge (UTOK) model, for reasons described below and illustrated in Figure 1.

A crucial aspect of the UTOK model is that it explicitly concerns itself with metaphysics. Although when many hear the word metaphysics, they recoil, as they think it references abstract philosophical arguments or New Age woo, at the most general level, metaphysics refers to the concepts and categories one uses to map reality and how we know about it. Thus, it refers to our basic definitions, and how they connect via our ontology (i.e., beliefs about reality), our epistemology (i.e., how we know), and our overall cosmology (i.e., the worldview we operate from). Given how much trouble psychology and psychotherapy have had with defining their core concepts, like mind, behavior, cognition, consciousness, and the self, it is unfortunate that so little attention is given to metaphysics. However, a detailed analysis is beyond the scope of this article. For more on the topic of metaphysics in psychology and psychotherapy, see my recently released book, *A New Synthesis for Solving the Problem of Psychology: Addressing the Enlightenment Gap* (Henriques, 2022a). The book lays out the UTOK model, which provides a conceptual grammar that is up to the task of clarifying the right relation between matter and mind, that is between body and mind, a crucial aspect of psychology generally and psychotherapy specifically.

The Structure of the UTOK Model

Although UTOK was formally named after the treatment with Maggie occurred, the basic ideas that ground it have been in place for many years and were central in framing her case conceptualization and treatment. Central to UTOK is a descriptive metaphysical system called the Tree of Knowledge (ToK) System. This system was first described over two decades ago as a metatheoretical framework that could organize psychological science and assimilate and integrate the key insights of B. F. Skinner and Sigmund Freud (Henriques, 2003). Depicted in Figure 1, the ToK System offers a new map of what is sometimes called "Big History" (Henriques, et al. 2019), which offers a view of the universe from the Big Bang until the present on the dimensions of time and complexity. The ToK System maps the Big History of the universe as emerging out of "Energy" at the Big Bang and exploding into the dimensions of Matter then Life then Mind and then Culture. Matter corresponds to the behavior of *material objects*, Life corresponds to the behavior of *living organisms*, Mind corresponds to the behavior of *minded animals*, and Culture corresponds to the behavior of *human persons*. In addition to these four planes of existence, the ToK System also depicts science as a kind of justification system that emerges out of Culture and functions to create a kind of knowledge loop that maps these dimensions of complexification. In addition, frames physical sciences as being tasked with mapping the Matter dimension, the biological sciences as being tasked with mapping the Life dimension, the (basic) psychological sciences as being tasked with mapping the Mind dimension, and the social sciences (including human psychology), as being tasked with mapping the Culture dimension. As suggested by this description, the ToK System is a descriptive metaphysical system that maps both reality and our scientific knowledge of that reality.

In addition to the Tree of Knowledge System, UTOK also includes Behavioral Investment Theory, which provides a way to frame animal mindedness, Justification Systems Theory to frame the Culture Person dimension, and the Influence Matrix as a model that maps the human relationship system. Behavioral Investment Theory (BIT) frames the nervous system as an investment value system in a way that integrates evolutionary theory, neuroscience, behavioral science, cognitive science, and developmental systems theory. JUST frames the evolution of human persons and the Culture Person plane of existence by highlighting the complex feedback loop that arose with propositional language and question-answer dynamics to generate the justification systems that coordinate people. The Influence Matrix posits that at the core of human relationships is a barometer for social influence and relational value and that humans process changes in the self-other matrix on the dimensions of power, love, and freedom.

***Psychotherapy-Specific Concepts That Logically
Follow from the Larger UTOK Framework***

Character Adaptation Systems Theory (CAST): Integrating Particular Therapy Theories (Figure 2)

A New Unified Theory of Psychology (Henriques, 2011) details how these four ideas can assimilate and integrate major empirical findings and key insights from the primary schools of thought. This sets the stage for a human psychology that is conceptually up to the task for framing psychotherapy. This bridge is achieved via Character Adaptation Systems Theory (CAST; Henriques, 2017). Grounded in the metatheoretical structure afforded by UTOK, it provides a “new big five” for bridging personality theory and the major approaches to psychotherapy. The diagram that maps CAST is provided in Figure 2.

The Left Side of Figure 2: The Three Contexts of Development. Starting with the left side of the figure, there are three “vectors” that represent lines of development that are taking place on the three different planes of existence as framed by the ToK System. Specifically, there is the Life-Organism biophysiological line that starts at conception and ends at death (see “Life” in Figure 1). Then there is the Mind-Animal line that begins as birth, when the individual becomes a separate animal that operates on the Mind plane (see “Mind” in Figure 1). This is the line of learning and development. Then there is the Culture-Person plane, as CAST aligns it with Uri Bronfenbrenner’s socio-ecological model of macro, meso, and micro system levels (see “Culture” in Figure 1). The three vector lines in Figure 2 can be thought of as the biological, psychological, and social contexts of development.

The Center Circle in Figure 2: The Individual and the Five Systems of Character Adaptation. The circle in the middle of Figure 2 represents the individual. Coming out of the right of the circle are five systems of character adaptation. These are framed as the Habit, Experiential, Relationship, Defensive, and Justification Systems. These systems are identifiable patterns of neurocognitive activity that have different structural and functional organizations. They have evolved at different points in the history of mental evolution, and they create a hierarchical stack of mental adaptive processes that guide the way the individual navigates the agent-arena relationship (i.e., the relationship of an individual to the situation in which they are in). The far righthand side of the diagram represents the placeholder for the current and future stressors and affordances that the individual sees as potential paths of behavioral investment and adaptation. The different systems are described below.

Note that as systems of adaptation, the five can also be lenses through which we understand maladaptive patterns within psychotherapy. And, here, we can see that there is a clear and obvious alignment with the primary areas of focus for intervention from the major individual psychotherapy paradigms. Specifically, the Habit System relates to Behavior Therapy, as in

behavioral activation, contingency management, and skills training. The Experiential System relates to experiential therapy and many humanistic approaches, such as emotion-focused therapy. The relationship and defensive systems relate to psychodynamic therapy. And the Justification System relates to cognitive therapy, such as the version developed by Aaron Beck, as well as some approaches to narrative and existential therapy (i.e., therapies that focus on verbal meaning making). The five character adaptation systems are briefly described below.

The Habit System. This is the first and most basic system of character adaptation. It consists of sensorimotor patterns and reflexes, fixed action patterns, and procedural memories that can operate automatically and be produced without any conscious awareness.

The Experiential System with its Emotional Sweet Spot (Figure 3). This system includes the nonverbal perceptions, motives and drives, and emotions states that make up mental life. Examples of experiential phenomena include seeing red, being hungry, and feeling angry. According to UTOK, the experiential system is characterized by a perceptual-motivational-emotional control learning theory loop. This is the process by which exterior objects, events, stressors and affordances are categorized and made meaningful by perceptual processes (i.e., what is it, where is it) and are then referenced against motivational goal templates (i.e., drives to approach or avoid certain states), which then result in action orienting affective response tendencies (cf. La Cerra & Bingham, 2002) and finally behavioral strategies that either are rewarded or punished depending on their consequences.

Emotions, which can be framed as “energizing motion” driven by an affect system play a central role in organizing the experiential system. As integrating forces that generate perceptual response sets that inform the individual regarding what is good and bad, desirable and undesirable, emotions play a central role in psychotherapy. Indeed, many frame the core mechanism of changing in psychotherapy as a corrective emotional experience.

UTOK draws on the emotion-focused therapy tradition to frame how clients relate to their emotions. Specifically, it frames healthy emotional processing in terms of finding the “emotional sweet spot.” As shown in Figure 3 (more about CALM-MO below), this holding environment is characterized by the individual being aware and attuned to the feeling and having the capacity to accept it and bring it on to the stage of awareness to metabolize and integrate the message it is sending about one’s goals and state of being. At the same time, because emotions activate impulses, it is important to be able to adaptively regulate emotions and be able to effectively contain it from overwhelming the system. Thus, the sweet spot for healthy emotional processing is the capacity to be aware and attuned to the emotion, accept it and integrate it, but not be overwhelmed or decompensate. This aligns well with Greenberg’s (2015) emotion-focused approach.

The Relational System and the Influence Matrix (Figure 4). The Relational System is an extension of the Experiential System to the social world. The Relational System refers to the social motivations and feelings states, along with the internal working models and self-in-relation-to-other schema, that guide social mammals in general and humans in particular in their social exchanges and relationships.

The Relational System is specifically organized as an Influence Matrix, shown in Figure 4. It maps the key elements of the human relationship system. In *A New Synthesis for Solving the Problem of Psychology*, I show how we can think of the Influence Matrix as framing the human relationship system as a blend of both the attachment system as described by John Bowlby and the Interpersonal Circumplex as described by Timothy Leary (Henriques, 2022a). Specifically, as shown in Figure 4, the black line (relational value and social influence) and the green line (the autonomy-dependency freedom dimension) align with the key elements of attachment, whereas the blue line (the dominance-submissive power dimension) and the red line (the affiliation-hostility dimension) align with the key elements of the Interpersonal Circumplex. With its focus on the attachment system and relational drives like power, love, and freedom, the relational system aligns with the key focus of the psychodynamic tradition and related interpersonal approaches.

In UTOK, the central black line is framed as the “core psychosocial need.” That is, if there is one central, normative need that humans have as social primates, it is to be seen, known, and valued by important others, as well as to have social influence (the capacity to move others in accordance with one’s interests). As we will see below, the inability to meet this need was a strong factor in Maggie’s acute distress.

The Defensive System. This is the fourth system of character adaptation. It refers to the ways in which individuals manage their actions, feelings, and thoughts, and specifically the way individuals shift the focus of conscious attention to maintain a state of psychic equilibrium in times of threat or insecurity. The defensive system is the most diffuse of the character adaptation systems; however, it can nevertheless be specified by examining how images, impulses, cravings, and desires from the nonverbal systems (i.e., habit, experiential, relational) are integrated (or not) into the individual’s self-conscious justifications for being (for a review of psychological defense consistent with the current formulation, see Hart, 2014). As with the Relational System, the Defense system aligns with the psychodynamic tradition.

The Justification System. The Justification System is the seat of verbally mediated thought and symbolic reasoning. It is organized into language-based systems of beliefs and values that an individual uses to determine which actions and claims are legitimate and which are not, to give reasons for one’s behavior, and ultimately to develop a meaningful worldview. Although individuals can learn how to engage in analytic reasoning via the justification system,

the formulation provided by the UTOK model is that the justification system is first and foremost a motivated reasoning system (Kunda, 1990), one that is guided by (although not necessarily dictated by) nonverbal drives, goals, and intuitive frames, and is functionally organized as a reason giving system, rather than a purely analytical reasoning system.

With its focus on how humans engage in self-talk and make attributions, interpretations, and then explain why things happen the way they do, including the development of a sense of self-efficacy and self-esteem, the justification system aligns well with the primary focus of cognitive behavior therapy (Beck, 2011). In psychodynamic terms, the system is the home of the superego, and, for many, an inner CRITIC can form as a way of attempting to judge and blame oneself in a misguided attempt to prevent failure and rejection from others. At higher levels of abstraction involving considerations of one's worldview and sense of meaning making, the justification system also corresponds to the primary focus of both existential and narrative psychotherapy perspectives.

Summary of Character Adaptation Systems Theory. In sum, Figure 2 shows the connections between (a) a wide-ranging view of Life, Mind, and Culture (as shown in Figure 1) and (b) character adaptation systems theory, which captures the entrenched maladaptive patterns in acting, feeling, relating, and thinking that underlie the major individual psychotherapy paradigms—including the approaches behavioral, experiential, psychodynamic, and cognitive therapy (Henriques, 2022c). In addition, Behavior Investment Theory frame the habit and experiential systems, the Influence Matrix frames the human relationship system, and Justification Systems Theory frames the defensive and justification systems. It is in this way that UTOK provides a systematic framework for the integration of major therapy models. More specifically, the reader will see below how in my treatment of Maggie I employ concepts and methods from all four psychotherapy traditions.

Neurotic Loops: The Core of the Internalizing Conditions (Figure 5)

In plain language, psychotherapy is about developing healthier processes of thinking, feeling, acting, and relating. People come to psychotherapy because they have entrenched maladaptive patterns in these domains. The UTOK metapsychology posits that there is a core dynamic process underlying the emergence and maintenance of the maladaptive patterns that characterize the internalizing conditions (i.e., depression and anxiety and related conditions), and names it as a "*triple negative neurotic loop*" (see Figure 05). For ease of communication, this is sometimes shortened to "neurotic loop" (Henriques, 2022b) but the full name is useful as it highlights that the loop is formed by three negatives. First, there is a negative situation. This usually is an event, although it can also be an idea or an image. This negative situation then elicits a primary negative feeling. In the first two cases, the term negative refers simply to

valence. That is, something bad has happened and the individual understandably has negative feelings about it. Such processes do not form a loop.

The problematic loop is formed when there is a secondary set of negative reactions to the negative situation or negative feeling trigger. Negative here refers to a reaction that is counterproductive and maladaptive. This closes the loop because it means that the negative reaction makes the initial negative feeling-negative situation connection worse. Thus, a triple negative neurotic loop is when a negative situation causes a negative feeling that is then responded to with a maladaptive secondary reaction, thus generating more negative situations and negative feelings. UTOK frames this process as the core to entrenched maladaptive patterns, and the primary focus of the work of psychotherapy with adolescents and adults.

Factors That Exacerbate Neurotic Loops

There are several factors that contribute to a person's vulnerability to developing maladaptive neurotic loops. The most general factor is the degree of stress and the absence of "psychological nourishment" in the psychosocial environment. That is, the more negative situations there are and the more negative feelings, the more vulnerable one is to develop negative reactive processes. Of course, the converse is also true. This fact highlights why the relational environment is so central to the development of neurotic loops. In contrast to a safe, supportive, loving environment that encourages the growth of competence, an impoverished relational environment, or one characterized by abuse and neglect will result in chronic triggers.

Although there are many ways a person might maladaptively react to a negative situation that elicits negative feelings, it is helpful to divide such responses into three broad categories: 1) avoidance of situations or feelings; 2) blaming of self or others; 3) control that is rigid or misguided. UTOK frames these as "the ABCs" of neurotic loops (Henriques, 2022b). To be sure, avoidance, blame, and control might be adaptive in some cases. For example, they might result in distancing from an aversive stimulus, restoring a sense of justice, or giving the person a sense of power. Nevertheless, despite having logic or being something that might be useful in the short-term, they are also often strategies that end up making things worse. Avoidance means that there are places or images that the person cannot accept or approach, which makes them more and more defensive and needing to build up more and more character armor. Blaming others often makes them defensive and results in retaliatory hostilities, whereas self-blame undermines the person's confidence and self-acceptance and engenders shame. Control is often focused on ineffective solutions and the wishful belief that one could live in a world devoid of negative situations or negative feelings. A useful analogy is that the ABCs of neurotic loops are like bringing water to a grease fire. It makes sense to want to put out a fire. However, sometimes the consequence of negative reactivity is much worse than doing nothing at all.

Finally, there are aspects of development and character adaptation that make some individuals especially prone to developing neurotic loops. The four factors below—the inner “CRITIC,” high trait neuroticism, relational insecurity, and trauma—are prominent features in Maggie’s history that exacerbated her depression. These are described below in general terms, and their role in Maggie’s case will be considered later in the description of her therapy.

The Inner “CRITIC” (Figure 6). When one lacks resources to deal adaptively with a negative feeling (e.g., emotion regulation strategies and adaptive interpretive frameworks), one’s inner narrator may engage in a secondary reaction that inadvertently inflates the negative valence of the situation and/or the primary feelings. In the neurotic loop framework, the acronym CRITIC (see Figure 05) characterizes this typical maladaptive reaction as critical and closed to new information, resistant and rejecting of the situation, irritable, tense, insistent, and can’t cope and thinks the situation is hopeless. The structure of the inner CRITIC is formed when there is an inability to adaptively relate to negative situations and the negative feelings they naturally elicit. This difficulty in tolerating distress gives rise to a defensive, hyper-critical and judgmental egoic structure. The inner CRITICAL voice is often at the core of neurotic loops. Indeed, as we will see in the case below, Maggie had a very loud CRITIC.

Trait Neuroticism. Given the above formulation, we can wonder who is vulnerable to neurotic loops and why. Congruent with the CAST model introduced earlier, one’s characterological structure is influenced by the biological, learning and developmental, and sociocultural contexts alike. Various factors in each may place an individual on a path toward or away from recurrent neurotic loops that may give rise to internalizing conditions. For example, high trait neuroticism is an individual difference variable that plays a significant role in the development of internalizing conditions. High trait neuroticism means that the individual’s negative affect system is sensitive and that it is easily activated, spikes at more intense levels, and takes longer to return to baseline. Thus, one’s vulnerability for engaging in neurotic loops and developing internalizing conditions is increased for people high on trait neuroticism, especially in the absence of resources for understanding and processing one’s emotions in a secure relational context. Further, highly stressful situations and traumatic events may also lower the threshold for the development of neurotic loops, especially in the context of high trait neuroticism.

Relational Insecurity. Another crucial factor in whether someone is vulnerable to developing neurotic loops can be examined via considering the structure of the relationship system as mapped by the Influence Matrix (Figure 4) and the past and current relational environment in which the person resides. In CAST, the relationship system is one of the systems of character adaptation and key aspects of it are mapped by the Influence Matrix. The Matrix identifies two core attractor states, one in the upper right, marked by the experience of high

relational value and high social influence, and one in the lower left, marked by low relational value and low social influence. The Matrix is aligned with attachment theory, and we can frame the upper right as a place of *security, safety, competence, and love*, and the lower left as the reverse. That is, the lower left quadrant represents a sense of *incompetence, unlovability, rejection, and dejection*. This felt sense of vulnerability heightens the sense of threat and makes negative situations like traumas and negative feelings much more intense. In addition, the Matrix maps the key process dimensions of power (dominance-submission), love (affiliation-hostility), and freedom (autonomy-freedom) which further frames the relationships between social motives and emotions.

Trauma. In addition, trauma and adverse childhood events play a significant role. Traumas are, of course, intensely negative situations that elicit strong negative feelings. As such, they are often extremely difficult to hold in the emotional sweet spot. In addition, traumas potentially become ingrained in the embodied way of being in the world, such that situations that are associated with the trauma can pull forth a trauma response. This means that individuals are likely to respond with fight, flight, freeze or fawning in a way that is extreme and potentially maladaptive to the current situation.

Depression as a State of Behavioral Shutdown Perpetuated by Neurotic Loops

One of the first concepts that was analyzed via the lens provided by the Unified Theory was depression. In several papers (e.g., Henriques, 2000; 2018a), I have explicated why and how depression can be viewed as a state of behavioral shutdown. The basic logic derives from the idea that the nervous system is an investment value system that directs work effort to effect change in the desired direction. To the extent that an individual experiences their efforts to grow or escape from pain or get their needs met as being ineffective, frustrating, or futile, then the system will start to "shutdown" and shift from active pleasure seeking into a state characterized by passive avoidance and distress. Note that the first two diagnostic criteria of Major Depressive Disorder in the DSM-5 (APA, 2017) are negative affectivity, "e.g., feels sad, empty, hopeless;" and anhedonia, i.e., shows "diminished interest or pleasure in all, or almost all, activities [most of the time] (p. 160).

Within UTOK theory I have conceptualized a variety of types of depression based on the behavioral shutdown model. For example, it readily allows us to discriminate between depressive reactions, depressive disorders, and depressive diseases. Depressive reactions refer to understandable states of shutdown that emerge as a function of major environmental constraints or losses, such as being in an abusive relationship or experiencing the death of a child. A depressive disorder emerges via maladaptive patterns of adjusting to difficulty and stress, such that a vicious cycle of shutdown takes place. Finally, a depressive disease refers to depressive

modes and moods that emerge from malfunctioning biophysiological processes, such as hypothyroidism.

Shame-Based Depression (Figure 7)

Depressive disorders emerge when individuals develop ways of responding to the environment that unfortunately result in greater shutdown. Very often depressive disorders can be framed as a feedback loop that emerges in folks with high trait neuroticism, have trauma, limited relational security, and develop an inner CRITIC. This was the case with Maggie, which I framed to her in what I called a "shame-based depression." In general, shame is an emotional response to feelings of inferiority and defeat. Shame-based reactions may stem from a diversity of psychosocial processes, such as low tolerance of the distress associated with negative feelings; a presupposition that negative feelings are inherently problematic and that one is thus to blame for experiencing them; and/or as well as frustration with one's own tendency toward self-criticism, which leads one to turn against oneself even further and develop a strong inner CRITIC.

Whatever its cause, the shame creates negative feedback loops, which in turn create the behavioral shutdown associated with depression. This process is illustrated in Figure 7, in which a critical, avoidant mindset about emotion leads to two unhealthy extremes: avoidance and control, pushing emotions out of awareness so that can't be processed in a healthy way; or being flooded and overwhelmed by the emotions.

Reversing Neurotic Loops with "CALM-MO" (Figure 6)

In addition to offering a conceptual framework for understanding internalizing conditions through the manifestation of neurotic loops, UTOK proposes an integrative intervention tool to reverse such maladaptive processes. As I described in my Presidential address to the 38th Annual Society for the Exploration of Psychotherapy Integration, which was titled, *Toward a common core: The problems, mechanisms, processes, and principles at the center of psychotherapy*, CALM-MO is a psychological mindfulness tool aimed at reorienting the manner with which one relates to negative situations and subsequent negative feelings (Henriques, 2022c). As shown in Figure 6, "CALM" stands for curiosity, aceptance, loving compassion, and motivation toward valued states, and "MO" stands for metacognitive observer. This section offers a brief outline of the intervention, which was used in the work with Maggie. (For a more detailed description and account of the clinical utility of CALM-MO, see Miller, 2022).

As a psychological mindfulness tool, CALM-MO differs from meditative mindfulness interventions, which focus primarily on mindful awareness of embodied experience. In contrast, CALM-MO involves the activation of a metacognitive position to better understand the workings of the self and ways to cultivate more optimal responses to distress. The metacognitive observer

(MO) can be framed as a perspective or viewpoint that is deidentified from the egoic structure of the private self. That is, the MO is a decentralized point of view that holds the key aspects of one's conscious awareness as the object of analysis. As such, the MO is a reflective, rather than a reactive viewpoint on one's reality, feeling states, and ideational content. The MO also stands for *modus operandi*, which reflects the aim of the intervention of characterizing the client's manner of relating to negative situations over time, becoming a default strategy to cope with problems and negative feelings. A defining feature of a neurotic loop is its reactive nature. Alternatively, the MO standpoint seeks to hold emotions in the emotional sweet spot and then move from their toward valued states of being (see Figure 3).

Upon decentering from the egoic point of view to the more distanced, deidentified perspective of the MO, one can apply the principles of CALM. The goal, which is explicitly shared with clients in therapy, is to cultivate a "sage mode" that brings a "CALM" attitude to relating to the self and situation (Henriques & Gralha, 2022a). The sage mode enables the client to be oriented toward the question "What would a wise person say or do?" It also attempts to engender the presence of a safe, caring alternative perspective or imagined other. In addition, the word CALM is offered to represent a contrast to a neurotic, anxious, reactive stance. This is the starting point. The concept deepens when we unpack the meaning of the CALM acronym.

The "C" in CALM. The "C" stands for *curiosity*, and related concepts, like wonder, openness, and awe. I not infrequently share with clients my belief and value that it is a miracle that we experience the world the way we do. Indeed, I remain in awe of the fact that I am conscious of anything. The question: "How is it, exactly, that the water of my brain turns into the wine of conscious experience?" remains an awe-some question for me. This stance of wonder and awe serves as a background to orient the mode of curiosity. I teach clients to start with notions like: "Isn't it interesting that I am feeling X?" or "Where are my feelings coming from and why and what are they trying to get me to do?" The goal is to work toward creating an open space to be aware and attuned to the feelings one has.

As suggested by this analysis and shown in Figure 3, I often frame the CALM-MO tool as a flashlight that is shining the light of understanding on the individual's experience. As delineated by Henriques & Gralha (2022b), the following are common questions that clients are encouraged to ask:

1. *What are the facts?* The first step in curious exploration is gaining awareness of the reality of the problem without imprinting biased judgments or beliefs on it.

2. *What is your experience as a primate?* To do this, the client is encouraged to identify their primary negative reactions to the problem at hand. These are the "raw" emotions that come up immediately after a negative event. Labeling the emotion can be a helpful exercise: Does the

person feel sad? Angry? Guilty? Ashamed? The Influence Matrix (Figure 4) can be a helpful guide in connecting shifts in relational process to likely feeling states. Getting attuned to the primary reaction allows the person to accept it as part of their primary process and wonder about what it is trying to communicate.

3. *What is your experience as a person?* The person refers to the self-conscious actor who can explicitly self-reflect and voluntarily generate ideas about how they want to be. This "healthy ego" is the portion that is connected to the Metacognitive Observer (MO). At the same time, as I have noted, there is often an internalized critic, which can often usefully be labeled the critical parent voice. This is the voice of how the person should be, the voice that blames, that wants to control outcomes and achieve. Getting curious about the nature of this voice, where it comes from, what it wants, and how the person might relate to it is also a key aspect of shining the MO light of curiosity on the inner world.

4. *What is likely to be the experience of others?* Another angle that can be helpful is to have the person reflect on what the experience of those around them may be. As shown below, one session in Maggie's therapy a session involved helping her to empathize with her Dad via activating a sense of curiosity about his thoughts, feelings and desires.

The "A" in CALM. The "A" in CALM stands for *acceptance*. There is a famous formulation in Buddhism that suffering is pain times resistance. Resistance can be framed as attempting to avoid, blame, or control the negative situations and negative feelings in our lives. Acceptance involves both being able to see and be present with the world without having to react, blame or control. As developed within Dialectical Behavioral Therapy (Linehan, 2015), acceptance can be framed via distress tolerance and mindfulness exercises. In addition, Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011) offers much guidance on developing modes of acceptance. Acceptance can also be framed in relationship to behavioral principles of exposure, such that one can work to help clients gain contact with painful images and emotions, without having to avoid. If that is done in an adaptive way, then the person can learn to desensitize and habituate to the feeling, such that it does not trigger the system with nearly the same power.

The "L" in CALM. The "L" stands for *loving compassion*. The following description is given of "L" in the form of an imaginal exercise I often walk my clients through. Take a minute and imagine the following scenes. First, you are sitting at a restaurant and, at the table next to you, are a crying child and their parent. The angry parent says to the small, submissive child: "What is wrong with you? You never do anything right! Stop crying, you are making everything worse!" Now, imagine walking down the park and witnessing a group of teenagers bullying a saddened, shy-looking peer. Finally, picture a scene where a close friend is crying on your shoulder after finding out their spouse has been cheating for years.

I would posit that in each case, it is highly likely that you felt a sense of care. That is, you valued the worth of the hurt child, the bullied teen, or your betrayed friend. And you felt their injuries were not fair or warranted. Thus, out of care and a sense of their core dignity and worth, you wished that the world had treated them better and that their suffering would be alleviated. This is the essence of the loving compassionate attitude. And CALM-MO orients us to develop and hold that attitude for both self and others.

The "M" in CALM. Finally, the "M" stands for *motivated* toward valued states of being in the short and long term. One way to think of this is that it is about cultivating the right orientation toward the future. How is this achieved? First, CALM-MO orients us to be in right relation to the present via cultivating awareness and acceptance and a loving compassionate attitude for the miracle of conscious experience itself. Although cultivating a way of being in the present is crucial, it is also the case that we need to be effectively oriented toward doing and becoming. This raises the question: What is the right relationship between being, doing, and becoming? As suggested by the framing of M, to get this correct, we can divide our orientation into short-term and long-term outcomes.

Short-term outcomes can be framed in terms of a solution-focused mindset. Specifically, the M orients the individual to ask: Given this situation, what is the outcome that I desire? And given that, what is the best thing(s) I can do that maximize the likelihood of me achieving that outcome? These questions are also related to the Beckian approach (Beck, 2011) that orients people to wonder if their thinking is both accurate and helpful. Here the focus is on *helpful*, which can be concretely framed as oriented to valued outcomes and states of being. The "C" in ACT refers to commitment, and it orients individuals to consider their goals and ACT in a way that moves them in that direction. Indeed, the "A" and "M" in CALM-MO are essentially identical to the "A" and "C" in ACT. As such, we can draw on all the excellent research done by ACT scholars and practitioners to develop ways to clarify one's values and work toward desirable outcomes.

Connecting CAST to Goldfried's Core Change Principles in Therapy (Table 1)

Through CAST (Figure 2), UTOK aligns with Goldfried's (1982, 2019) work on developing a set of psychotherapeutic change principles that range across different theoretical orientations that can be consensually agreed upon. These are framed "at the middle level of abstraction between the theoretical explanations of different approaches to therapy and their specific clinical techniques to find commonalities that appear to underlie different approaches to therapy" (2019, p. 488). Below are these common principles of change along with an indication of the CAST systems to which they are particularly connected.

- 1) Fostering the patient's hope, positive expectations, and motivation to change (connected particularly to the Experiential and Cognitive Systems).
- 2) Facilitating the therapeutic alliance, involving a good bond and the agreement on goals and methods (connect particularly to the Relationship System).
- 3) Increasing patients' awareness of why they are having difficulties (connected particularly to the Cognitive and Psychodynamic Systems).
- 4) Encouraging corrective experiences, where risks are taken to improve functioning (connected particularly to the Behavioral and Experiential Systems). .
- 5) Emphasizing ongoing reality testing, involving a synergy between risk-taking and increasing awareness (connected particularly to the Behavioral and Cognitive Systems) (Goldfried, 2019, p. 488).

In the therapy with Maggie described below, the reader will see instantiations of all of Goldfried's five principles.

Another framework that Goldfried developed that I find enormously useful in helping clients understand the process of change is the "staircase model." I became aware of this framework after working with Maggie (Henriques, Goldfried, & Smith, 2021). At the time, my primary frame for helping clients (and clinicians) understand the work of therapy was that it was structured to cultivate awareness, acceptance, and active change, often in a nonlinear way that is oriented to more adaptive living and fulfilment and less neurotic looping. Goldfried's staircase model aligns with this but provides some added structure that I have found useful in sharing with clients and would have shared with Maggie at various times.

The model posits that clients come into therapy in a state of unconscious incompetence. This means they are both unaware of exactly what the source and patterns of the difficulties are and are lacking in both understanding and in skills to adjust. Then, with some assessment and feedback via a process of exploration, clients gain some insight and move to conscious incompetence. This is a state of much greater awareness of the entrenched maladaptive patterns, but limited skills in how to enact a more adaptive way of being. Then the client begins to explore some new ways of responding and develops modes of conscious competence. In these instances, the client can enact the insights and new learning in the relevant contexts, realize the benefits, and begin to develop the skills and sense of self-efficacy for adaptive living. Finally, the client internalizes these ways of being as a natural part of their living, so that they become unconsciously competent. Figure 8 depicts Goldfried's staircase framework, connected to the process by which clients obtain an increased awareness of their situation, come reframe their experiences and emotions in a more accepting and adaptive way (i.e., corrective emotional

experiences) and learn to internalize different and more adaptive ways of responding to the world going forward.

Summary of CAST, Neurotic Loops, and CALM-MO as a Framework for Psychotherapy

UTOK is a new metapsychology that provides a zoomed-out view of human psychological science and provides frameworks that can assimilate and integrate the key insights and empirical findings into a coherent picture that is up to the task of framing the human condition and the work of psychotherapy. It gives rise to a way to map character adaptation patterns via the five systems of habit, experience, relationships, defense, and justification (CAST). These five systems of adaptation have a clear and direct correspondence with the major schools of psychotherapy today. That is, the behavioral perspective aligns with the habit system, emotion focused perspectives align with the experiential system, the psychodynamic perspective aligns with the relationship and defensive systems, and the cognitive approaches align with the justification system. In addition, because they are framed as systems of character adaptation, they enable us to orient toward the major focus of psychotherapy, which is on problems that stem from entrenched maladaptive patterns. Finally, because UTOK and CAST theory incorporate the major schools of psychology today, they provide an opportunity for a psychotherapy approach that is enriched by these different schools, each of which has captured different aspects of human behavior and experience that are essential for a full understanding the ingredients for best and effective practice in psychotherapy.

The UTOK metapsychology helps us to identify the common core of psychotherapy and does so in part by identifying the primary focus of psychotherapy as being on alleviating entrenched maladaptive patterns. The UTOK lens allows us to map entrenched maladaptive patterns as a triple negative neurotic loop, where negative situations trigger negative feelings which in turn trigger negative secondary reactions. It is the third step that completes the loop and is a primary area of focus in UTOK's approach to treating the internalizing conditions. It orients to help people see why negative reactions, especially those driven by an inner CRITIC or characterized by avoidance, blame, or (misguided) control end up creating more problems than they solve. Shame-based depression is one example of how such maladaptive patterns can become manifest. In it, shame acts like an inner critic about negative feelings and one's general character and competence, inhibiting proper processing of those feelings and propelling the poles of the individual towards self-blame, excessive avoidance, and control or being flooded and overwhelmed (Figure 7).

To shift this maladaptive process, UTOK orients toward training folks to develop an inner CALM-MO flashlight that replaces the CRITIC mindset and shines an attitude of curiosity, acceptance, loving compassion, and motivation toward valued states (Figures 3 and 6). This process is framed both explicitly via training clients and implicitly via the process of therapy,

such that the therapist models a CALM way of being that fosters awareness, acceptance, and loving compassion that is oriented toward adaptive living. With this conceptual background in hand, we can now turn to see how these ideas were applied to help turn Maggie's life around.

4, 5, 6, & 7. ASSESSMENT, FORMULATION & TREATMENT PLAN, COURSE OF THERAPY, AND TREATMENT MONITORING

Note 1. These three aspects of the case are intertwined in the description of the therapy process below. The formulation and treatment plan are presented as emerging during the therapy process. A formal case formulation and treatment plan are presented at the end of the Course of Therapy description below.

Note 2. In the description below, I have placed in italics sections focusing on quotes from the interactions between Maggie and myself, and on my understanding of Maggie's inner experience. I have placed in brackets and italics my thinking about the case formulation and treatment plan.

Presenting Problem

One afternoon, as a member of the university graduate psychology faculty and a therapist and a supervisor in the university's Counseling and Psychological Services Clinic, I received a call about Maggie from Chad, one my first-year doctoral students. He was on duty in the Clinic and was conducting his second-ever intake interview.

He said:

"I need a clinical consult. I have just started an intake with a girl, um, she said she almost jumped off a bridge last night. She said that her roommate walked in on her while she was cutting on herself. Then she 'freaked out' and left her dorm and was getting ready to jump off a bridge. But two of her friends had followed her and talked her out of it and then they brought her over to us this morning. She said she does not want to be here. Her friends insisted she come in."

I replied, "I will be right over. Has she tried to kill herself before?" And the student responded, "Yes, three times, including an attempted hanging."

"Give her some of our symptom forms to fill out. I will be there in ten."

I told the seminar group I was leading that I needed to run and grabbed my stuff and headed over to CAPS.

Based upon my initial and later contact with Maggie and my clinical background in the psychology of suicide, below is my recreation of Maggie's state just before I first saw her in the emergency clinical consult mentioned above. She has confirmed this is an accurate rendition of her experience.

She sat on the edge of the bed, her hand pressed against her wrist. She felt nothing. She felt everything. Then she felt the small trickle of blood seep through her fingers. She had been cutting herself when her roommate walked in and had seen it. So now her roommate knows. And, for Maggie, that meant everyone would know. Everyone would know she is a freak who is experiencing so much craziness inside that she cuts on herself. And she knew that was only a part of her craziness. Deep inside, a black hole of despair had been growing for more than four years. Maybe even before that. Maybe she had always known that deep inside she is broken and crazy. She had tried desperately to hide it, tried to live a normal life. But she could not. It erupted when she was fourteen. It had hardened and turned even blacker after "the incident" with her boyfriend at 15. Shortly afterward she tried to hang herself and then was sent to a psych ward, which did not help. Her sophomore and junior years were pure hell. She thought that maybe it had started to soften, that maybe she had a shot at a somewhat normal life when she had moved to a different school for her senior year and made some new friends and was able to forget about the blackness.

But now, here, during her first year of college, the blackness was returning with a vengeance. The emotional isolation had started almost immediately. And now, eight weeks into her freshman year it was turning into a full boil. She was cutting almost every day now. And she was drinking and having meaningless sex and was feeling more and more distant. More and more despondent. And now her roommate knows. Yes, her roommate knew she was moody and had found her crying. But cutting? Now she would be known as a freak. Now everyone would see she was crazy and she would be even more isolated. And so what would happen? Her roommate would tell her RA, her RA would tell her parents. She winced at the thought of them. Having them know would be intolerable. Then what? Would they force her to drop out? Would she have to be locked up in a hospital again? Her life was a mess. It would always be a mess. There was no escaping that mess. That is, except for one way. There was only one way out. And this time she would make sure she got it right. There would be no aftermath, no facing her parents' confused and disapproving looks, no lockdown in a mental ward. She was done with this life.

***Phase 1 of Treatment, Sessions 1 to 4:
Hope That There Might Be a Map Out of the Darkness***

When I arrived at the Clinic and entered the office where Maggie was, she said she did not want to be there and that she was "fine." She even began to get up out of her chair.

I said, "Actually, Maggie, we are going to need to chat for a bit. If you bolt now, that will suck for both of us. The reason is because my professional obligation will be to call the cops and that can get ugly. I know that chatting with me might not be the most fun way to spend a day, but it probably will be better than dealing with the cops."



Our first session together. Source: Gregg Henriques

And so, our journey started. During that first two hours, I gathered more about her history. I learned that she was always a bit sensitive and easily stressed. I learned how her levels of anxiety and depression began to get noticeably worse at 13.

She talked about hating both her negative feelings and herself for having them and how she tried hiding them from everyone. She said things got worse and worse until 15, when she tried to hang herself, after which she was hospitalized. She felt horrible through much of her sophomore and junior years. She switched schools her senior year and, thankfully, things improved. She had hoped that her depression would be behind her, but that hope came crashing down during her first four weeks at college. She quickly became overwhelmed with the work, the new people, and the freedom to do whatever. Others seemed to adjust so easily, while she was anxious, self-conscious, and confused.

As she got increasingly stressed, her depressed mindset returned. This wave of emotional shutdown came with a voice that told her she was a horrible person, that if anyone really knew the real Maggie, they would abandon her. The voice that told her she was ugly, undeserving of love, and was a basket case of nerves who would never amount to anything. As that voice got louder, she shut down more and more. And then the cutting returned in full force. Three or four times a week. As the depression sank in, she realized that she would never be free from it. She was condemned to a miserable life.

“You have what I call a ‘shame-based’ depression,” I told her. [*See my formal description of this concept in the 3. Guiding Conception section above.*]

“What is that?” she asked.

"It is my term for describing folks who are in depressive shutdowns in part because they have 'turned against themselves'. It often starts in puberty, when an individual's identity is being formed. The situation is this: An individual has a sensitive or 'neurotic' temperament, which means they are easily upset or stressed and are difficult to sooth after a trigger. Such individuals, especially if they are low in extraversion and high in agreeableness, often begin to develop a war within themselves as their identity develops in adolescence. The identity is the part of a person that reflects on who one is and why and how one wishes to be. If an identity forms where the individual is very upset with their negative feelings and is not taught how to process them and they just want to be seen by others as kind, easy-going, and happy, they will attack themselves for their feelings. Of course, this does not make them feel better, but only charges their emotional system further. So, they create an internal feedback loop of negative feelings and critical self-talk. When this loop "closes" (meaning the criticism drives the feelings and the feelings drive the criticism), the system enters a depressive shutdown. Does that make sense?"

"Yes," Maggie said, in a neutral tone. "I just have never heard it explained that way before".

"How has it been explained to you?"

"It really hasn't. When I was hospitalized in the past, I was just told I had severe Major Depression and needed to be put on meds. They had me talk to a counselor who asked me about my feelings, but I did not like talking with her. It just made it worse. Then we just switched schools."

"Okay, to really get through this thing, we need for you to understand it, understand what drives it, and work through the unfinished emotional business that gave rise to it. Are you willing to work with me and give this a chance?"

"I guess."

And so began the first phase of our treatment, the whole of which would last approximately 15 months and have several watershed moments in it. In retelling it here, I divide the treatment into phases. The first phase involved getting Maggie to begin to wonder if therapy was possible (see Table 1, the core principle of Fostering hope). My detailed and intellectualized description of her problem helped her to realize I knew what I was talking about, gave her a map of her feelings and conflicts, and worked to down-regulate her emotions a bit, as she was quite dysregulated and overwhelmed.

The end of the first phase emerged as we settled into uncovering her inner world and some of the things that had happened to her. It was clear to me early on she had experienced some sort of unpleasant sexual encounter. I suspected it because she reported having emotionless hook-ups with several guys in succession. Her muted affect told me that she was

dissociating from something. I probed a bit and uncovered that there was "an event" that she would tell me about when she was ready.

***Phase 2 of Treatment, Sessions 5 to 9:
Working Toward and Then Through the Trauma Via Exposure***

Four weeks into our work, Maggie was doing better, and we were about to dive in deeper, when life gave her a nudge. She was still cutting on herself occasionally, and we were working on a plan for that. One day she used a new razor and really sliced herself, such that she needed to see a physician. She ended up going home to see her family doctor, who, in the course of exploring her emotional health, asked directly if she had been raped or sexually assaulted.

"Yes," she told me she heard herself say to him. It was the following Monday, and we were meeting as she had just returned from a weekend home and was feeling out of sorts.

"It was clear something had happened to you. Are you ready to talk about it?"

"It is just so awful to think about."

"I know, Maggie" I said. "But that is part of the healing process. I have known since the first time we met that something happened to you, and that you did everything you could to try not to think about it."

"Oh God," she wept.

"It is ok. We can get through this."

"It was when I was fifteen. My boyfriend at the time. He got me to sneak out and go to this house down the street where they were having a party. And we all got drunk. He coaxed me upstairs. We were fooling around. It was like 2 a.m. No one else was in the room....". Her voice trailed off.

"And then he started to try to take my clothes off." Tears were streaming down her face. "I tried to tell him no, that I did not want to. Then he pushed me on the bed. I kept saying I did not want to." She sobbed.

"I am so sorry, Maggie. That was not right."

"Then it was over. Just like that. And I was a virgin." She cried some more. "I barely even remember getting my stuff and walking home. I snuck back into my house. Then I just tried to go to sleep. And then got up the next morning and pretended nothing happened."

"You did not tell anyone?"

"Who could I tell? I snuck out. I drank. My parents would be super pissed at me. And I was drunk, and everything was a haze. And I hung out with mostly his friends. I only told my best friend three weeks later, and I made her swear she would never tell anyone."

"And what happened with him?" I asked.

"I basically started avoiding him. We never had sex again or anything. I avoided him and the relationship faded".

"And so you have been dealing with this trauma for years on your own. Part of our work is going to be about working through this event and processing its impact on you."

"Oh god," she cried. "I just want to forget about it."

"I know. But that won't happen. The memory is in you. And you have not processed the feelings associated with this trauma. And it is tearing you up inside."

And so we started processing her rape. And, as sometimes happens when people begin to dive into traumas they don't want to think about, she started to decompensate. It was just too much at first. Indeed, that was why I did not go right at it from the beginning. She was too fragile and lacked enough coping resources to manage the working through process.

And a huge part of Maggie's problem was that she could not allow herself to share anything with her parents. I began to explore this element of her life.

"No, I just cannot tell them. At all. Ever. They will hate me."

"Even your mother?"

"Especially my mother. You don't know her."

"Well, will you let me talk to her? At least so that I can understand who your mother is. I won't mention this, but I need to understand where your mother is coming from on this. You think you know her, but I am telling you that you might not really be able to understand where your mother is coming from. You are so afraid of others' reactions that you often distort where they are coming from. Can I talk with her, and see?"

"I don't know. Not yet."

A couple of weeks later, I received a message on my phone:

"I am not doing well. The nightmares are back in full force. And I started cutting again yesterday. I am starting to feel suicidal."

When I got in touch with her, she was in a full panic. "I am losing it. This is hell. I need this to stop."

"I understand. We need to get you to the hospital."

"Oh God, I don't want to go back there. I hate hospitals."

"This time I think it will be different. I will guide you," I said. "Trust me."

She called her friend who escorted her over to the emergency room. I met up with her 30 minutes later. When I arrived, she was rocking back and forth in her hospital bed, sobbing. Her friend stared up at me with a bewildered look on her face.

"It is ok," I said. "I know you are overwhelmed right now. But we can process these feelings through. Have your parents been notified?"

"Yes," she cried some more. "My mom is on her way and will be here in two hours."

"Good," I said. "And you will let me talk to her?"

She nodded.

"Listen, Maggie. I know you are in your blackest place right now. Right now, all you feel is the pain of everything you try to block and hide and deny. And, believe me, when the flood gates open up to these kinds of feelings, it sucks. And I am sorry you are feeling it. But we are safe. And if we listen to your feelings and if we relate to them in the right way, this will be healing."

For the next two hours, Maggie, her best friend and I went back and forth between tears, pain, joking around, and dazed exhaustion. Then her mother arrived. We had already talked through our game plan. Her mother would touch in with Maggie, and then I would touch in with her mother, then I would touch in with Maggie.

I waited outside as Maggie first spoke with her mother. Ten minutes passed. And then her mother came out to see me. She approached me and said, "Maggie said that you had been working with her and that it had helped some and that you wanted to talk with me."

"Thank you. And yes, I do want to speak with you."

We found a conference room and for the next half an hour we talked. My goal was to assess Maggie's mother, her love for Maggie, and to develop an understanding of why there was such a boundary between them. The news was very good after this encounter. My assessment was that Maggie's mother deeply loved Maggie. She was just confused in how to deal with Maggie. She was not fully to blame for this. Our culture is not helpful in guiding folks in this way. Consider that she received no guidance in all the previous hospitalizations and suicide attempts. And Maggie was so sensitive and cutoff at times that her mother just did not know what to say.

"I don't know what it is," Maggie's mother told me. "But it is like the life went out of her eyes at some point."

"About when?" I asked.

"Three years ago, maybe. Just before the suicide attempts started."

"Can I share that with Maggie?"

"Yes, absolutely," she said.

I was back in the room with Maggie, as her mother waited outside.

"Maggie," I said. "I have good news. Your mother loves you. Deeply. She just does not know how to connect with you, because she does not know what is going on with you."

She told me she feels like ‘a light went out’ in your eyes. She wants to know why.” Maggie stared at the wall, thoughtfully digesting what I was telling her.

It was getting late in the evening. I told Maggie I needed to head out. But I would be back. I would check in with her at lunch and then come back for visiting hours.

I returned at noon the next day, finding Maggie sitting in hospital room eating lunch. She looked in a much different place.

“How has the morning been?”

“Actually, pretty good. I told the psychiatric nurse all about my rape,” she said, both somewhat triumphantly and surprisingly calmly. “They think I have PTSD. And I think I want to tell my mom.”

“Wow. That is pretty big news. Do you want me to be here for that?”

“Yes.”

And so I came back to the hospital four hours later. Her mother was with Maggie when I arrived. We agreed I would speak to Maggie alone for a brief time.

“I told her I had something to tell her,” she said, as her mother closed the door behind her.

“What did she say?”

“She said she wanted to know whatever I wanted to tell her. And that she loved me.”

“I am really proud of how brave you are being. I know how scary this is.”

“Yeah, well, I just think it is time.”

We brought Maggie’s mother back in, and the story unfolded from Maggie fairly quickly. She reminded her mother about the boy she was dating when she was fifteen. Then she told her about the party, told her she snuck out and got drunk. She started crying.

“He took me upstairs. He started taking off my clothes. I told him ‘no’, but he did not stop.” Tears were streaming down her face when she said to her mother, “I am so sorry I snuck out and got drunk.”

“Oh honey,” her tearful mother said. “I am so sorry this happened to you. I knew something had happened to you. But I did not know what. I am just so sorry I was not there to protect you.”

They cried and hugged.

The healing impact that the next two hours would have on Maggie’s psychological system is hard to overstate. It was a prototypical, major corrective emotional experience. It can be understood in terms of the following case formulation and treatment plan. Prior to the rape,

Maggie had been depressed and had started process of “closing the loop,” which is the term I use for an individual who has strong negative feelings and then gets very self-critical about those feelings. This creates a vicious intrapsychic cycle of negativity. (This was described above in the 3. Guiding Conception section—as the triple negative neurotic loop model that results in entrenched maladaptive patterns.)

Then there was the trauma of the rape, which means that Maggie was devalued and disrespected at her core. On the heels of this, she was not protected or respected and justice was not served. Instead, she had imagined her parents would blame her, that her friends would blame her, and, indeed, she had basically blamed herself. So, her sense of worth and value were completely shattered by the fact that the rape could not be processed and there were no consequences. Thus, her sense of relational value and security was extremely low.

Now, finally, she was giving voice to this experience with her mother, her most important attachment figure. And instead of getting what she feared (punishment, rejection and disapproval), she received love and validation of her experience. In other words, she was getting love and validation for who she was as a person, which is something she had come to fundamentally believe she did not deserve and would never get. Being known and valued by important others is the core psychosocial need (Henriques, 2014b). It is the foundation upon which our psychosocial systems operate. This was a fundamentally transformative moment for Maggie. And this fact showed clearly in the weeks that followed.

Maggie stayed in the hospital two more days. Her mood settled down dramatically. The next month saw a fairly radical transformation, both in her mood and her relationship with her mother. In fact, she would never again become dangerously suicidal. And the tone and tenor of her relationship with her mother was qualitatively different from that moment onward. They finally could talk to each other about what was really going on. She could finally be seen and known and feel valued in that light.

I explained to both of them how Maggie had a fairly distorted view of her mom as a function of all the inner battles that she engaged in. I explained to them both how Maggie had a “neurotic temperament,” which simply meant that she had a sensitive and reactive negative affect system. I explained how she had turned against herself and then that created all sorts of private-to-public filtering and that she hid her “true self.” And I taught them both how to talk to one another. First, giving a few lessons in the hospital, and then as I worked with Maggie in outpatient individual therapy during the following weeks.

***Phase 3 and Treatment, Sessions 10 to 16:
Learning CALM-MO to Deal with Conflict and Distress***

The revelation of the rape to her mother and the healing that followed was transformative. She had stopped cutting, stopped being suicidal, and had started having positive experiences. However, Maggie still had a way to go to find mental health. She was still anxious

and frequently caught in self-critical loops. She was very reactive (regularly "freaking out" in her words), and she was not happy much of the time.

There was also the fact that her father knew something had happened but did not know what. Maggie finally disclosed to him what had happened during the Christmas break. The exchange went fine but was not quite as healing as the exchange with her mother. I made the mistake of not coaching and preparing Maggie for how her dad would likely react. Not infrequently, fathers react a bit differently. They get more activated regarding justice and retribution and making things right, which is what happened here. Her father began to talk seriously about bringing legal charges, which was something that just was not an option for several reasons, the most significant being that it was not where Maggie was at all.

Our therapy was focused on improving her emotional health by finding her emotional sweet spot. The emotional sweet spot is the "space" between being aware and attuned to her emotions on the one hand and adaptively regulating them on the other. My primary strategy for training folks in finding the emotional sweet spot is to coach them on cultivating a CALM MO.

Cultivating a CALM MO is an approach to psychological mindfulness I developed that has lots in common with ACT and Dan Siegel's interpersonal neurobiology. I teach folks that when they experience a negative event, what Susan Heiter (2016) calls a "bump," they need to activate a CALM MO perspective to help adaptively process the feelings, thoughts, and actions that follow. It is an acronym. M. O. stands for two things, one being "Modus Operandi" (mode of operating), and "Meta-cognitive Observer." CALM refers to the attitude of the meta-cognitive observer. Instead of being critical and controlling (which is how many get when they feel a bump), the goal is to become Curious, Accepting, Loving/Compassionate toward self and others, and Motivated to learn and grow toward adaptive outcomes, in the short and long term.

Maggie was working on developing a CALM MO capacity when an event with her dad would really teach her how to employ it. She was home, and her family was touring another college, as she had wondered in the fall if JMU was right for her. Her dad had been in a grumpy mood all day, which made her feel very tense. After the tour, her plan was to go see a concert with a male friend. And she was planning on spending the night in a hotel in D.C. with him as a friend. After they got home from the tour, she told her dad about her plan.

"No way," he said. "Just not happening."

"Dad, I know this guy well. It is fine. Nothing is going to happen."

"Nothing is going to happen because you are not going," he proclaimed.

"Dad, I have really been looking forward to this."

"You want to go? You are 18. Actually, that is old enough to make decisions. So go. By the way, it also means you are old enough to pay for your own college. So, you go, you pay your own way in college—from here on out!"

It was a harsh exchange and completely unsettled her. A short time later she was alone in her room, crying and feeling completely overwhelmed. She had told her friend she was not going, and he was pretty upset. So now she felt completely trapped. How could her father do this to her? Everything sucked.

Her mom came up into her room an hour later or so. "I know you are pretty upset, dear. I understand."

"Mom, it is just not fair," Maggie proclaimed.

"Sometimes life is not fair. What would Dr. Henriques tell you?"

"He would tell me to activate my CALM MO." It was the first time she had really thought about it as she was in a panic.

"That sounds interesting, what is that?" her mother asked.

"It says when you get stressed, take a perspective that is curious about what is happening, accepting of negative emotion, loving and compassionate toward self and others, and motivated to get the best outcome."

"Ok," her mother said. "Can we apply that here?"

And so they did. And it immediately began to transform how she was experiencing the event. One major shift was that she turned her "curious" attention to her father. She asked herself, with a curious attitude, what he was feeling and why. She quickly recalled he had been grumpy all day. It started when they had gotten lost, and the family was late to the tour. Her dad hates getting lost. And he was not happy about the transfer; he loved JMU and was really hoping she would graduate from there. And, of course, there was the rape incident that hung between them. Clearly, her going to a city and spending a night in a hotel with a boy activated that thought. What was he really trying to do? She asked herself. And a little voice told her that he was just trying to protect her.

This awareness immediately led to another insight. She had unacknowledged fears about what the rape would mean for her life. Would she always need to be looked after? Would she always be seen as vulnerable? Would others try to control her? Would she be judged as not being able to make good decisions? Yes. These thoughts resonated. This was why his reaction was so upsetting to her. It meant all these things she secretly had feared.

With a much deeper understanding available, the other pieces fell into place. She was in a much better place to accept her feelings. Yes, this sucked, but it was hardly torture. And both her father's feelings and her own made perfect sense. So, she could hold a loving attitude toward

both in the midst of the conflict. And the path forward seemed clear. Make the best out of the night and find a time to process this event with her father going forward. A half an hour later she and her mother were making popcorn and getting ready to watch a movie. Just before the movie started, her mother commented, "That CALM-MO thing really works, huh?" and they both chuckled and sank comfortably into the couch.

Gaining mastery in moments of intense emotional activation are the crucial learning events that lead to lasting change. And indeed, this event allowed Maggie a profound sense of mastery of her intrapsychic and interpersonal world. And it set the stage for two months of continued growth. She got a job. She altered her appearance, such that she starting leaning in to her physical attractiveness rather than trying to hide it. (Importantly, she now started to actually believe she was physically attractive). She also made many new friends and was really starting to flourish. Her improvement was so significant that I thought we were basically ready to move to a more maintenance phase. However, real life isn't about riding off into the sunset.

Phase 4 of Treatment, Sessions 17 to 23: The Vicious Return of PTSD Nightmares

In the back half of the spring semester, Maggie was really starting to feel confident that the majority of her troubles were behind her. She heard about a sexual assault awareness event on campus and decided to go over and give a show of support. So, without much forethought, she went.

She was alone. The event was taking place in a large room. A primary activity was that folks were making T-shirts representing the assault in some way. She walked into a large room. She saw hundreds of T-shirts. The lights were bright. There were so many T-shirts. The room started to spin. She lost her breath. Images flashed. She felt a pain in her gut. She valiantly tried to activate a CALM-MO perspective, but it was overloaded. She made her way to a counselor at the table and tried to say something, but nothing came out. She almost fainted. Then she saw a classmate she had talked to once or twice. She was also alone. The classmate said hi. She said hello back and they started talking. They spent two hours together sharing their stories.

She felt much calmer as she left. However, that night her nightmares returned. With a vengeance. The next day she was in a bit of a haze. She maintained her perspective and carried on. However, the following night, the same thing. And again on the third night. She called me and we moved our appointment up.

The next three weeks were tough. Nightmares every night. Exhaustion during the day. My frame was that we got a little over-confident, given how much progress she made. The nightmares were telling us there was still unfinished emotional business related to the rape. We talked more about what it could be. We hung in there. It was hard because it seemed her conscious self was largely at peace with it. But her subconscious self was not.

Eventually, the nightmares subsided. She was brave and strong and courageous and her system began to settle back down. But a problem had emerged that would give Maggie one additional lesson in working to adaptively regulate her feelings.

***Phase 5 of Treatment, Sessions 24 to 28:
Learning Effective Self-Talk in the Moment***

During the period in the spring semester when Maggie had been growing emotionally, she had been spending less time on her classes. Indeed, if there had been a positive point of focus for Maggie in the fall, it was her studies. The one positive attribute about herself she could (sort of) acknowledge was that she was smart. And so, she would focus on her studies in times of stress to prove to herself that she could get good grades. In the middle of the spring, with a much more active social life, she had started to fall behind on her studies. She figured that she could cram during the final month and really bring her grades up. And then she was bulldozed by the return of her nightmares and other PTSD symptoms. This had thrown her off her academics, as she was chronically fatigued and easily distracted. As her PTSD symptoms finally started to abate, it began to dawn on her she was seriously behind. She knew she was not going to do as well as she would like. In fact, she was so behind in chemistry that realized she might fail.

Her intelligence and good grades had been her anchor. When she was in her dark places, it was the one hook she could hang some pride on. As she came down from the PTSD resurgence, she awoke to the realization that the spring semester might bring a truly poor performance in her grades. This created a brutally strong negative wave of emotion.

The final phase of our treatment would be to teach her how to direct her cognitive system of justification toward effective self-talk.

"I am freaking out," she told me. "I have no idea what I am doing in chemistry. The final is today. I am going to fail. My parents are going to kill me. I can't function. What am I going to do?" Sobbing followed.

The Beckian cognitive approach teaches folks to separate the known, empirical facts from one's interpretations and expectations. We went through what we knew factually of Maggie's situation. The basic fact was that she did not understand several relevant concepts in chemistry and that her final was that day. That was the situation. But that was not really what Maggie was responding to emotionally. What was causing her to panic was the way she was interpreting and narrating her situation. She inferred that her difficulty understanding chemistry concepts meant that she would fail the final. And then, if she failed the final, she would fail the course. From that, she then came to believe that she would be "killed" by her parents. This image was horrible and intolerable because she believed that she would then be a failure as a person because she would have greatly disappointed the people that she loved. In other words, Maggie

was in a panic because she had made a string of interpretations that led to a catastrophic expectation for the future.

I encouraged her to come in for a special session. We spent two hours together, in which she was taught in the moment how to understand and gain insight into the vicious cycle of panic, how to identify her pattern of catastrophic and how to replace those extremely negative interpretations with more realistic narratives about her situation.

The first thing I did to help Maggie was to identify how she wanted to be. That is, what was her valued state of being, given her capacities and situation? The current situation was that she was not understanding chemistry, that she was three hours away from taking her final and was fearful that if she failed chemistry bad things would happen. I basically narrated for Maggie two options. Option one was that we could focus on the worse possible outcome, blame her and the school for the unfairness of it all, and crawl up into a little ball, and weep like a baby. Option two was that we can see the difficult situation for what it was currently, understand what it might (or might not) mean for the future, and try to adapt to it in a way that minimized bad outcomes and, in the process, learn how to cope more effectively with stress.

Framed with the options, Maggie said, "Obviously, I want option two. But I don't know how!"

To which I replied, "Exactly. You don't know how. So we will teach you. Let's get to work. Whatever your final grade is in chemistry, we can turn this into a growth experience because you don't know how to cope with **stressful** life events without decompensating. But it is one of the most important things to learn living life as an adult."

So Maggie came on down to my office, and I told her that we would start by doing what she would normally do. I had her bring in her chemistry book and so I told her to go ahead and proceed to study the part she wanted to learn about. She opened the book to the page, and within 30 seconds tears were running down her face. She uttered:

"I don't know this. I missed two classes when I went home, remember? And besides, he sucks as an instructor. I barely understand it when I am there. I don't know what I am doing. I am definitely going to fail this course."

"See what happened, there?" I ask. "Looking at chemistry problems you don't know gets you into a catastrophic narrative. Remember what I have taught you about thinking about your thinking. When you find yourself in a narrative like this, what are you supposed to ask yourself?"

Taking a deep breath she replied, "I am supposed to ask myself, 'Is my thought accurate?' and 'Is it helpful?'"

"So, is thinking that you are guaranteed to fail this course an accurate statement?"

"Well, I think so!" Then she chuckled through her tears, knowing what I would say. "I guess I don't know for a fact I will fail. And, you are right, it does not help me to think I am going to fail. It only makes me panic."

"Actually, it is appropriate for you to be concerned that it might happen, because it might. There is a grain of possible truth here. But focusing on it now and claiming it is certainly going to happen is neither fully accurate nor helpful. Given your situation, what would be most helpful?"

"I don't know." A pause. "I guess, based on what you've said, I need to focus on doing what I can to take the test with the best mindset I can and then try to cope with whatever happens."

"Exactly. So, what can we do to get you into a better mindset?"

"I have no clue."

"Well, is your final cumulative?"

"Yes."

"Did you understand any of it?"

"Well the stuff on covalent bonding was pretty straight forward. I also did well on that stuff on entropy and thermodynamics."

"Teach me some of that stuff." So, for the next 15 minutes she reviews stuff she knows. Her mood shifts.

"What are you thinking and feeling now?" I ask.

"I don't know, I guess I feel a little better. I know some of this stuff pretty well and it will be on the final."

"Do they ever curve the grades?" I ask.

"Yes, they curve the grades."

"Listen, I have no idea what you are going to get on your chemistry final or for your final grade. But what I do know is that focusing on what you don't know, and catastrophizing future outcomes makes you miserable and puts you in no position to take the exam in an effective way. Remember what we talked about in earlier sessions regarding arousal and performance. Extreme anxiety is horrible for effective performance. Keep that in mind. Ok, let's look at another section." Maggie turns to a different chapter that is difficult for her. Again the tears begin to flow.

"Ok," I ask. "What are the tears about?"

"My being smart is one of my good features. Looking at this tells me I am not smart. If that is true, then what do I have? Nothing!"

"Here again, notice how you frame your interpretations. Whereas before the negative focus was on your future and disapproval from your parents, now you are focusing on something fundamental about your character. Let's test out this conclusion you have reached, namely that if someone can't understand this section of your book, they are not fundamentally smart. Here, pass me the book."

She hands it to me and I stare at the complicated chemical formula on the page. "I have no idea what this means. I guess I am an idiot, then."

"No, of course, not" she says.

"But why not?"

"Because you are a professor of psychology."

"But you're a student who has blown off several classes for lots of different reasons and stopped paying attention to developing your chemistry skills. No one can learn this stuff who doesn't try to learn it. As we both know, for a host of reasons you have not really been focused on your studies the last two months. The point here, Maggie, is that you are engaging in what I call a 'character assassination', which is that because you are in a less than ideal spot, you see yourself as fundamentally bad or unworthy in some way. A different and I believe more adaptive frame is that the situation is not ideal, and we will learn from it. But that doesn't mean you are fundamentally worthless or incompetent."

"I know that at one level. But that just makes me feel like a loser. Why am I this way? Why can't I just think like a normal person?"

"Good question. And we have done lots of work together that I think helps you answer that question. You turned against yourself when you were 13 and developed a very strong inner CRITIC. Because of your unique learning history, you build justification narratives for what is happening that tend to be pessimistic, catastrophizing, and self-blaming. There are lots of reasons for this. It keeps you somewhat submissive in conflict, it often drives you to perfection in ways that are associated with past success, and it has become a bit of a habit. But regardless of why you have learned to be this way, now the key point is that when you think this way, you feel like shit and when you feel like shit, your thoughts shift more toward thinking this way, so it is a cycle. The main issue that I want to help you see is that your narrator is a key part of your mental health. I want to help you see its connections between your feelings and your actions and how they are all interrelated. I want to help you see how those interrelations get you in maladaptive spaces. Through awareness of your thoughts, acceptance of where you are and who you are, and the idea of what is a realistically adaptive way of being that will move you toward your goals in the future, we can learn new pathways of dealing with stress."

Maggie and I spent the next few hours together, practicing distraction (i.e., going for a walk), the CALM MO acceptance of her thoughts and feelings in the moment, the cognitive

intervention of replacing extreme negative interpretations with more helpful ones, and going over the most adaptive game plan for the test (i.e., focus on the questions she knew, emphasize the thought that she can tolerate whatever the outcome might be, and stay with the test for as long as she can tolerate it, and hand it in before she decompensates into a full blown panic). Just before the test, she described herself as being in a "pretty good" mindset.

Maggie later returned to my office just to let me know she stayed fairly regulated during the exam. She felt like she probably failed it, but at least she was doing okay. The next day she wrote to tell me that she told her parents she probably failed chemistry, but actually was doing ok with it because she was training herself on how to cope. She said her parents were surprisingly cool with it.

A couple of days later, she returned home for the summer. A week later she wrote and told me she "somehow" ended up with a C in the course and was having a great summer. To which I wrote her the note: "I guess you did not 'know' you were going to fail after all. :o)."

Phase 6 of Treatment, Sessions 28 to 40: Termination & Transfer to Chad

When Maggie came back in the fall we met for a few sessions. She had had a good summer. There had been a few bumps in the road with some family stressors, but nothing she had a difficult time managing. She had realized that because she does have a "sensitive" system, she will often have strong initial reactions, but everything changes when she relates to these feelings in the manner in which she had learned. And she was free of PTSD symptoms. Given how well she was doing, we decided to transfer her over to Chad, the doctoral student she first encountered. Maggie's therapy with me is reflected in her sessions with Chad in the Outcome section below.

Summary of the Final Case Formulation and the Plan of the Treatment Offered

The Formulation and Treatment Plan below, which draw on UTOK concepts presented in the Guiding Conception section above, emerged during the process of therapy described above in the Course of Therapy section.

Formulation

A few years after my work with Maggie, I developed the "Well-Being Screen and Check-up System" (WBCU) to achieve a comprehensive formulation for clients. The assessment system includes a semi-structured interview, self-report, and clinician evaluative measure that yield a picture of character functioning and adaptation (Henriques, XX; available upon request). Although the formal system was not yet developed, it nonetheless was operative as the system

that emerged was reflective of my clinical work at this time. When individuals are given the WBCU they are instructed as follows:

The Well-Being Check-Up (WBCU) is a systematic assessment process designed to help you get a better understanding of your psychological health and functioning. The goal of this assessment is to enable you to achieve: (a) a better understanding of your overall level of psychological health and well-being; as well as more specific domains of functioning, such as (b) your habits and lifestyle; (c) your emotions; (d) your relationships; (e) your coping skills; and (f) your identity (your sense of who you are and how you view yourself).

In addition to assessing these elements, this assessment works to place your adaptive functioning in a biological, developmental, and social context to enable you to understand why you are functioning the way you are. If you are having difficulties achieving optimal functioning or if you are struggling with some distressing symptoms, then you will also be provided with recommendations that will potentially improve your psychological health and well-being.

The WBCU results in a case conceptualization that covers five different domains as follows: 1) Overall psychological health and functioning; 2) habits and lifestyle; 3) emotions and emotional functioning; 4) relationships and interpersonal style; and 5) identity and coping. It also generates a developmental narrative and treatment recommendations. Appendix 2 describes each of these domains. Although we did not do a formal WBCU evaluation with Maggie, I was using the basic structure to understand my clients at that time and I will offer a formulation based on this framework. There are two ways the formulation can be written. One is to share with the client. The other is for therapists and thus is written in a more clinical style. I will offer the formulation in the latter format, based on her initial presentation.

Overall Psychological Functioning

When Maggie initially came to the clinic, her overall psychological functioning and well-being was in the very poor range. She was actively suicidal, highly reactive, and overwhelmed. Her problem solving was poor, negative affect extremely high, and she was behaving in dangerous and impulsive ways. Characterologically, if we apply the dimensional analysis that ranges from healthy-robust to healthy neurotic to neurotic to troubled neurotic to borderline to psychotic, she was functioning at the borderline level, and demonstrated disturbances in identity, relationships, and affective processing.

Habits, Health, and Lifestyle

Maggie's physical health was satisfactory. Her eating patterns were adequate, and her sleep was somewhat disturbed. She was consuming alcohol in a problematic way and was

engaging in indiscriminate sexual encounters that likely were not fulfilling. She lived in a college dorm but was largely isolated. She did not exercise regularly, nor have many fulfilling hobbies or avenues for play, growth or exploration that she found meaningful.

Emotions and Emotional Functioning

Her emotional valence was highly negative. She regularly experienced negative, reactive emotions, and had a general distressed mood, that was mixture of anxious arousal and depressive defeat. She experienced a limited range of positive emotions and saw few affordances and many stressors in her environment. In addition, her emotional functioning was poor. She had many secondary negative emotional reactions and harsh judgments about her feelings, and she had a fear of negative feelings that was chronically active. As such, she was constantly attempting to avoid and control her feelings, and then would be overwhelmed by them. Times when she could hold her emotions in the emotional sweet spot were limited. Dispositionally, she likely is high to very high on trait neuroticism and low on extraversion.

Relations and Interpersonal Style

Maggie had an impoverished relational world and experienced a high level of relational insecurity. She had a few friends at college, but none that she felt she could trust or knew her well. She was alienated from her parents and did not have good relationships with her siblings. She was not strongly affiliated with JMU, and her close friends from high school seemed distant. In addition, she experienced much self-criticism and shame.

Her relational style was agreeable and avoidant, characterized by anxiety and a desire to avoid blame, conflict, or embarrassment. She "put on a face" to be nice, but felt like an imposter. And she could experience brief hostile feelings, but these would quickly be turned against the self.

Identity and Coping

Maggie demonstrated much identity confusion. She did not demonstrate a strong sense of self, nor have a deep feeling for how to participate in the world effectively. Instead, her identity was characterized by vulnerability, threat, and fragile reactivity. Her primary domain of strength was her intelligence and academic achievement, which was high. However, even here she did not feel comfortable, but felt driven to succeed to ward off feelings of inferiority. She generally coped via defensive avoidance, misguided efforts to control, and self-blame.

Developmental Narrative

Maggie described herself while growing up as always somewhat sensitive and easily stressed, with her levels of anxiety and depression beginning to get noticeably worse at age 13. In terms of the concepts of the neurotic loop (Figure 5) and the internal CRITIC (Figure 6),

Maggie was hating both her negative feelings and herself for having them and tried hiding them from everyone. These feelings were heightened by Maggie's genetics, which seemed to have included trait neuroticism.

Maggie said things got worse and worse until age 15, when she made a suicide attempt and needed to be hospitalized. But it was unclear to me as the therapist as to why this had happened. As over the course of therapy Maggie developed a trusting relationship with me, she became able to describe the particular conditions that led to this worsening. Specifically, she described how at this time she experienced a trauma as she was raped and was too ashamed to tell anyone, including her parents, alienating her from her friends and parents. This deprived her of her "core psychological need," as she did not feel seen, known, nor valued by others in terms of her position on the Influence Matrix (Figure 4). Specifically, she was in the lower lefthand quadrant of the Matrix, involving low relative value, associated with an intense sense of incompetence, unlovability, rejection, and dejection. Moreover, she had internalized a strong critical introject, that is, an inner CRITIC (see Figure 6). Maggie's intense negative, shame-based, PTSD-based reaction to the rape prevented her from having the tools or the outside emotional support to find her emotional sweet spot (Figure 3). Rather her PTSD-based reaction to the rape set in motion ongoing neurotic loops (Figure 5).

Shortly after entering college, in the context of her longstanding past problems dealing with heightened negative affects as exacerbated by her rape, the stressors of college life—demanding academics, needing to find new friends, living independently from home without parental structure—caught up with Maggie and she became suicidal again. This initiated an emergency visit and subsequent therapy with me in the Counseling and Psychological Services center, a community mental health clinic run by James Madison University.

Treatment Plan

My primary focus in treatment is to cultivate a sound working alliance, whereby, following Bordin (1979), the key ingredients include: (a) establishing a high quality relationship, that includes trust, safety and good therapeutic flow in the clinic room; (b) quickly develop a shared conceptualization of the work of therapy that generates both some insight and affords the client and therapist an effective "self-world" grip on who they are, the situation they are in and why, and a way to understand both their symptoms and their options for change relative to acceptance; (c) a path for exploring those options and seeing what might afford growth, with a particular focus on how to be differently in a way that lessens the feedback loop of entrenched maladaptive patterns by reducing the ABC's of the CRITIC and replacing them with CALM-MO responses and attitudes. I then monitor the therapy for adaptive outcomes that seem reasonable given the formulation (i.e., I expect more rapid, positive changes working with a college student who is experiencing an adjustment disorder than a long term psychiatric patient who has been

struggling with severe symptoms for decades). These principles and processes for guiding treatment were reflective in Maggie's case.

Of course, because Maggie presented with a high risk of suicidal behavior, my first treatment goal was a risk assessment into a therapeutic plan that reduce risk and was oriented toward responding to such impulses with care. As such, my first goal was to establish a shared goal to not kill herself. To do that, I needed to instill hope and trust. Although Maggie's suicidality was a crucial factor to attend to, we can nevertheless align this with the consensus change principles developed by Goldfried (see Table 1). These involved creating hope (#1) in Maggie by establishing a close, supportive working therapeutic relationship (#2) and providing her an explanation of her distress that held promise for change (#3). Maggie was then provided with new corrective, experientially based ways to more adaptively address and handle her PTSD-based feelings and to be able to better reality test (#4 and #5).

In the context of these general principles, I employed three, more UTOK-specific approaches to help Maggie out of her PTSD-based way of thinking, feeling, and behaving.

First, to reverse the neurotic loops in Maggie's thinking and reactions, she was specifically taught to both understand her CRITIC and why it was problematic and to replace it with the CALM-MO tool (Figure 6).

Second, to deal with Maggie's lack of social support, specifically her alienation from her mother, I intervened by meeting with Maggie and her mother to help them start to communicate with each other about the realities of Maggie's experience. Once Maggie was assured of the possibility of her mother's supporting her in terms of the rape instead of rejecting her, Maggie started to move to the upper righthand quadrant of the Influence Matrix where she felt seen, known, nor valued by others. With having her mother's support and my guidance as the therapist, Maggie was able to handle the challenging task of telling her father about the rape and handling his upsetting reactions.

Third, after CALM-MO was not sufficient to deal with Maggie's intense concerns about her academic performance, I employed techniques developed by Beck in cognitive therapy to engage in effective self-talk and reality testing in the moment. These techniques were particularly applied to a crisis event in a few hours before Maggie's upcoming, very important chemistry test, for which she felt completely unprepared. Similar to her success in employing CALM-MO, her success in employing Beckian cognitive techniques enabled her to engage in active restructuring of her interpretive process.

Finally, the entire treatment process can be framed by my guiding principles to enhance adaptive living via shifting from the ABC's of neurotic loops and CRITICAL reactivity to a co-

created relational environment that is curious, accepting, loving-compassionate, and motivated toward valued states of being.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Work with Chad After Termination with Me

Maggie's work with Chad encompassed 13 sessions and largely involved retelling the stories of the previous year and the lessons she learned from them. She also would use the space to develop new notions about herself and who she could be. She was really coming into her own as a computer programmer. She had experienced some sexist encounters, as computer programming is a very male dominated field. She worked with Chad on some of those issues and on basically building a sense of self on a very different foundation than she had during her early teenage years.

One day she came in with a big announcement. She had Chad keep it a secret and swung by my office.

"I am going to NASA for an internship next semester!" She was heading down to Florida in the next couple of months, where she would train with them in advanced computer engineering. Over the next few years, Maggie would continue to check in and update me on her latest. Her trajectory had changed.

Termination with Chad and My Follow-Up Interview with Maggie

After terminating with Chad, Maggie had a follow-up interview with me. Based on the interview, I concluded that Maggie had re-written her narrative. Her relationships were different. Her emotions were different. Her core self was different.

I asked Maggie if I could tell her story in the above case study.

"Absolutely," she said. "If it can give one person hope that there is something on the other side, I would be thrilled."

"Pretty remarkable", I said in a way that she knew honored her character. "Recall that at first, we could not even tell your mother."

She chuckled. "Yeah, well, a lot has changed."

I also spoke briefly with Maggie about her view of the teen drama about suicide called, *13 Reasons Why* (https://en.wikipedia.org/wiki/13_Reasons_Why). "I hate that show," she said. I then asked Maggie to offer a summary of her experience as a way of reaching out to all those suffering individuals who are boxed in and feel like they have every reason to kill themselves. Here is what she said:

The treatment that I received from Dr. Gregg Henriques was lifesaving. This is not an exaggeration—I would not be here today if I had never met Gregg. After dealing with severe depression and the aftermath of a sexual assault, I wanted to kill myself. Indeed, I had tried several times previously and was convinced this time I would succeed. I came to Dr. Henriques in October of 2014, as I started to spiral out of control into another suicidal crisis—one I thought would be my last. The effects of this therapy were already visible by December, when I was hospitalized. Had I not been in treatment with Gregg, I would have killed myself then, but instead I checked myself into an inpatient treatment center because some hope had started to emerge deep inside of me.

While it has not been an easy battle, I have since made a huge recovery. Years later I am not only glad that I did not end my life, but I am very happy to be living the life I am, as I am feeling hopeful and fulfilled in a way that I would have never guessed possible when I entered therapy. I know many college students are suffering with profound emotional problems and I hope that my story can help raise awareness and get them the help they need.

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Table 1: The Consensus Change Principles Developed by Goldfried.(1980, 2019),
and Connections to the CAST Systems in UTOK

- 1) Fostering the patient's hope, positive expectations, and motivation to change (connected particularly to the Experiential and Cognitive Systems).
- 2) Facilitating the therapeutic alliance, involving a good bond and the agreement on goals and methods (connected particularly to the Relationship System).
- 3) Increasing patients' awareness of why they are having difficulties (connected particularly to the Cognitive and Psychodynamic Systems).
- 4) Encouraging corrective experiences, where risks are taken to improve functioning (connected particularly to the Behavioral and Experiential Systems).
- 5) Emphasizing ongoing reality testing, involving a synergy between risk-taking and increasing awareness (connected particularly to the Behavioral and Cognitive Systems).

Figure 1. The Tree of Knowledge System

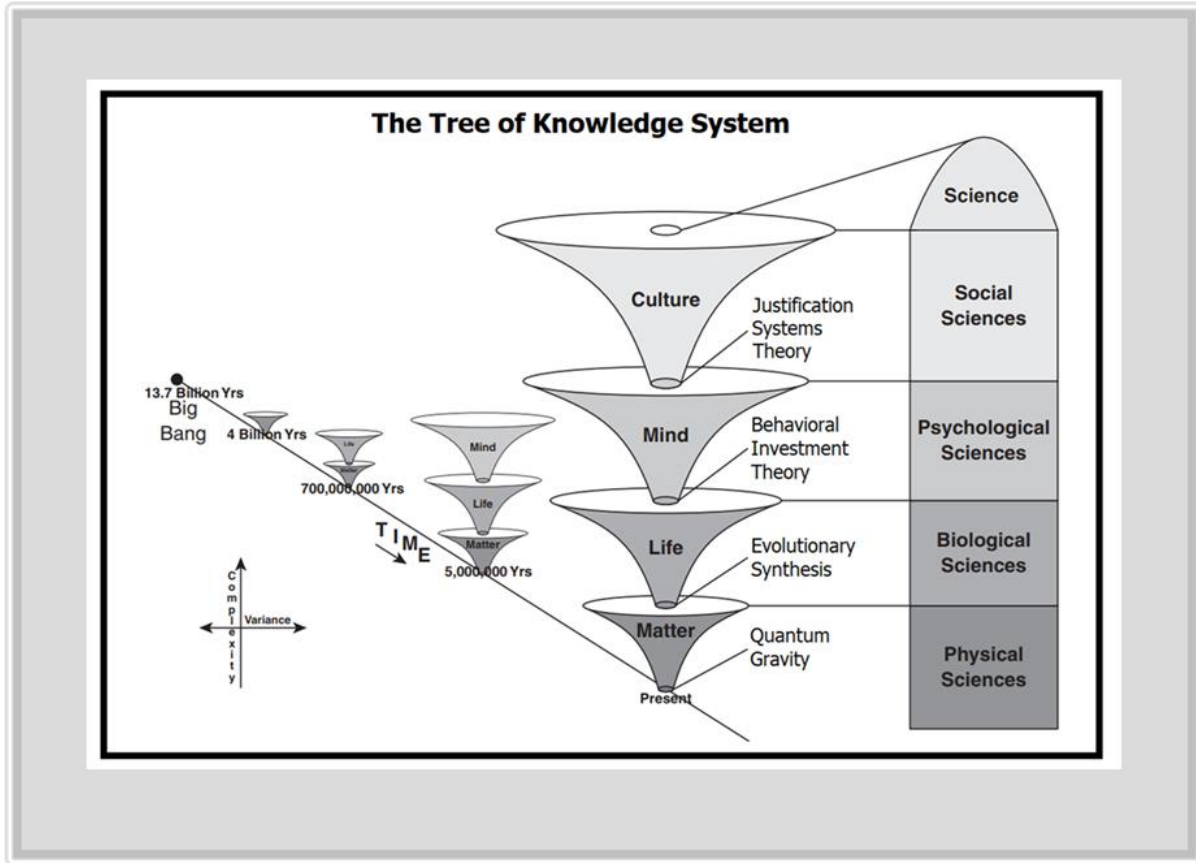


Figure 2. The Connection between the Unified Theory and the Major Approaches as mapped by Character Adaptation Systems Theory

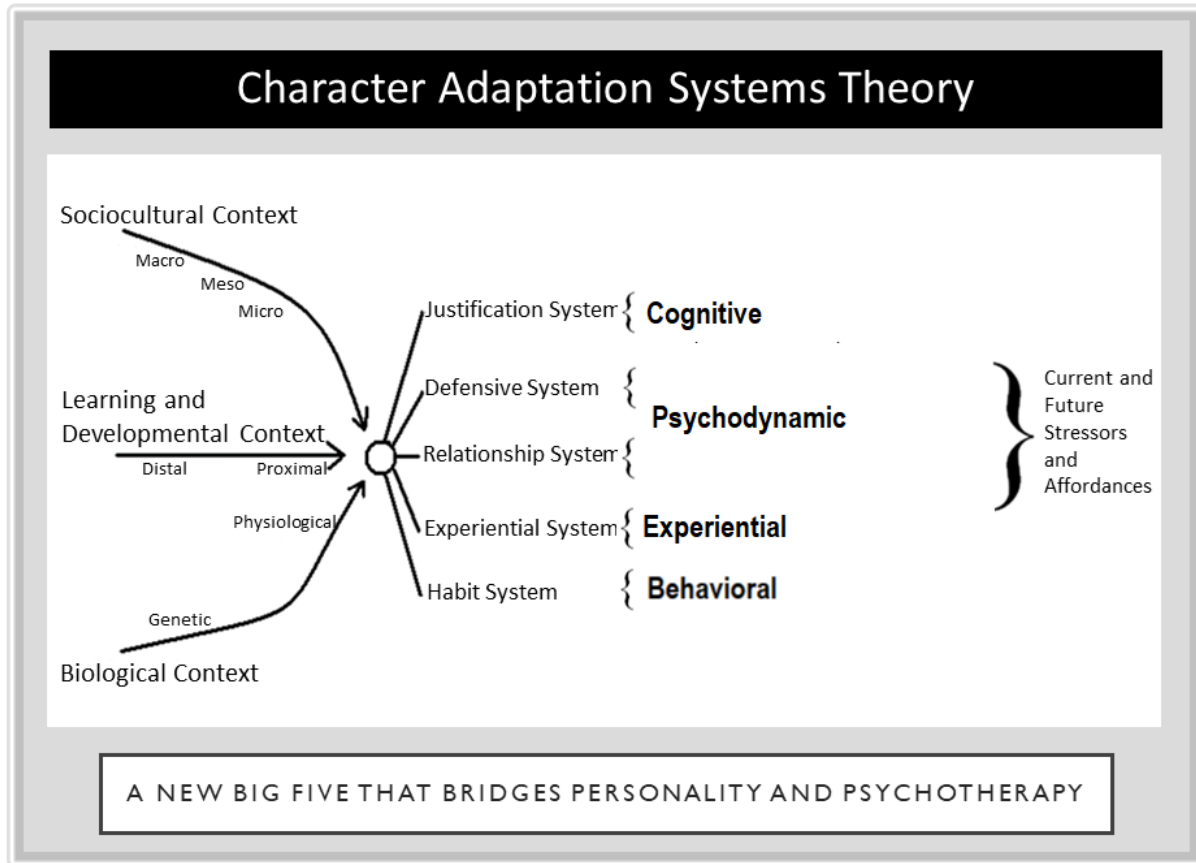


Figure 3. The Emotional Sweet Spot

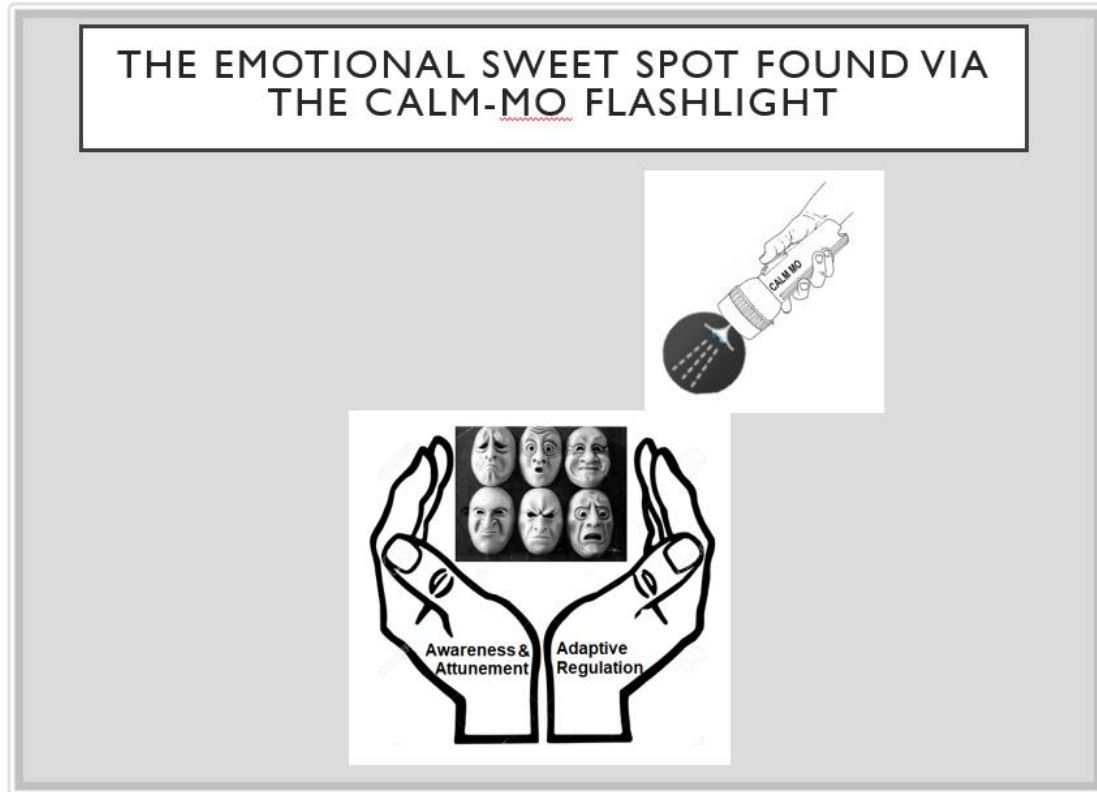


Figure 4. The Influence Matrix

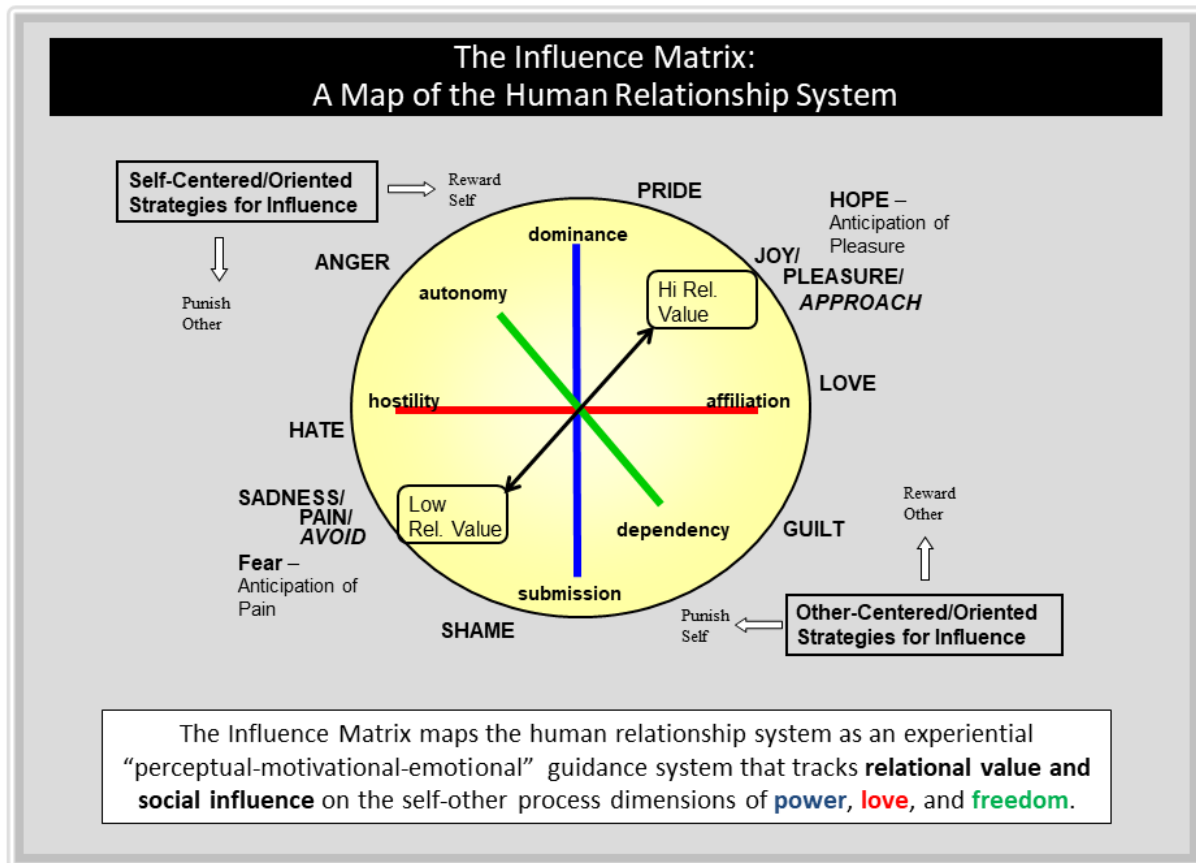


Figure 5. Triple Negative Neurotic Loops

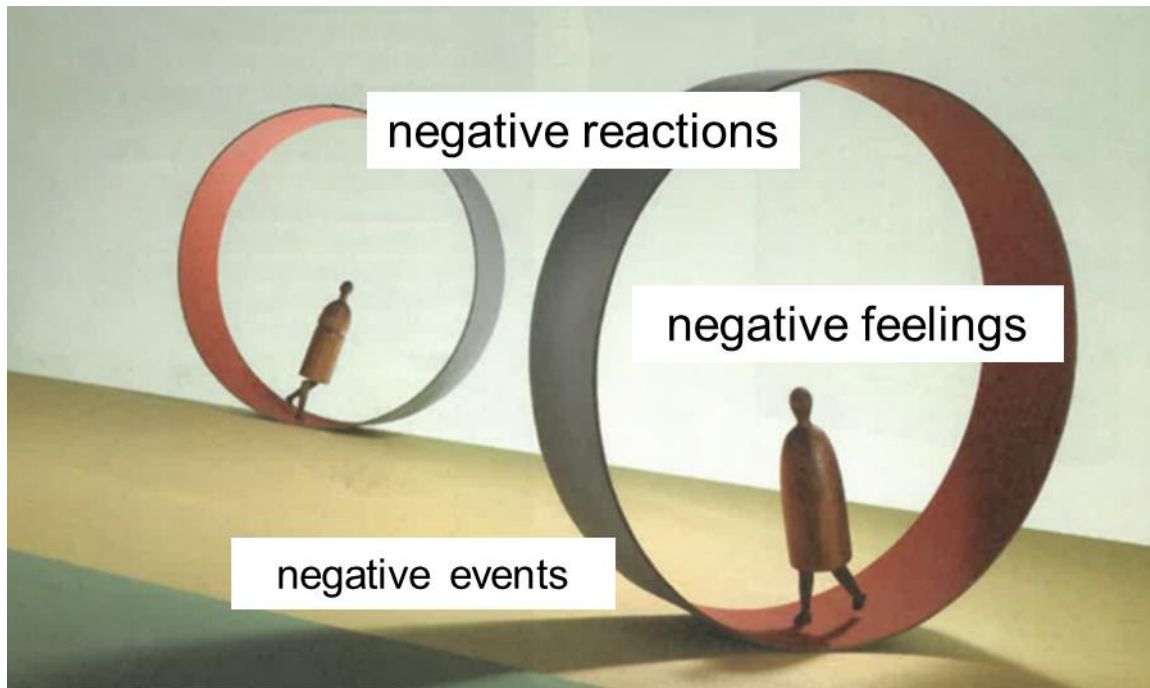


Figure 6. Moving from CRITIC to CALM

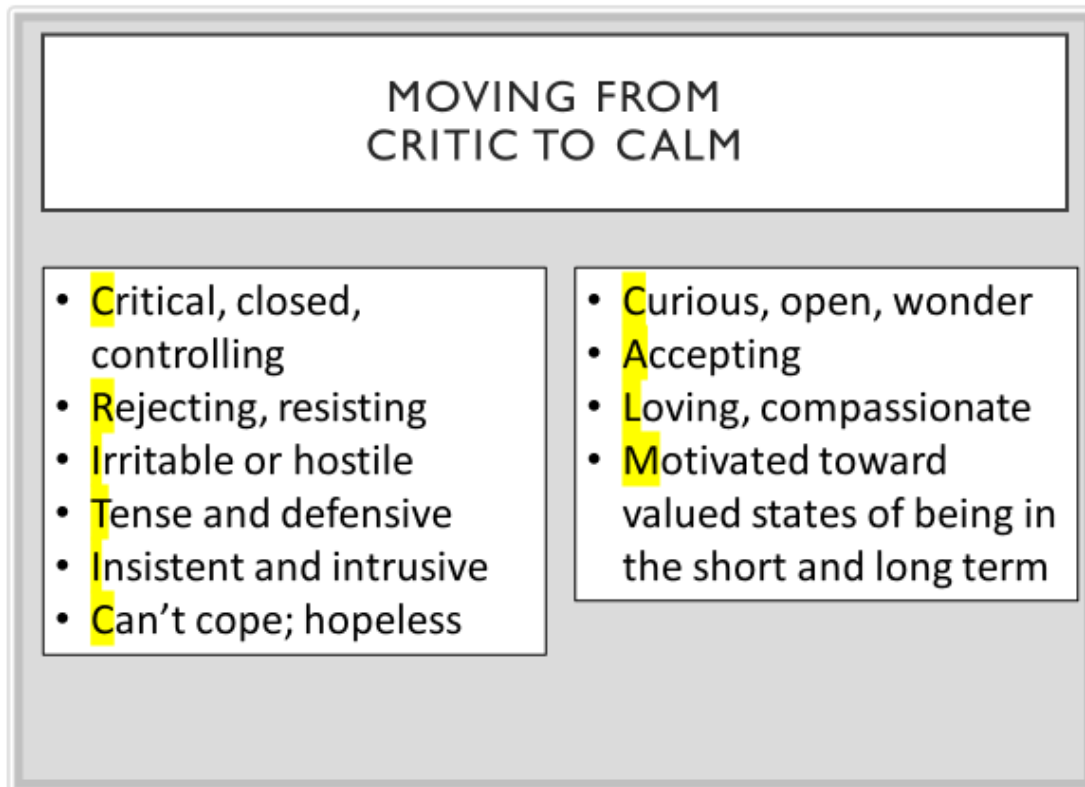


Figure 7. A Critical, Avoidance Mindset About Emotion

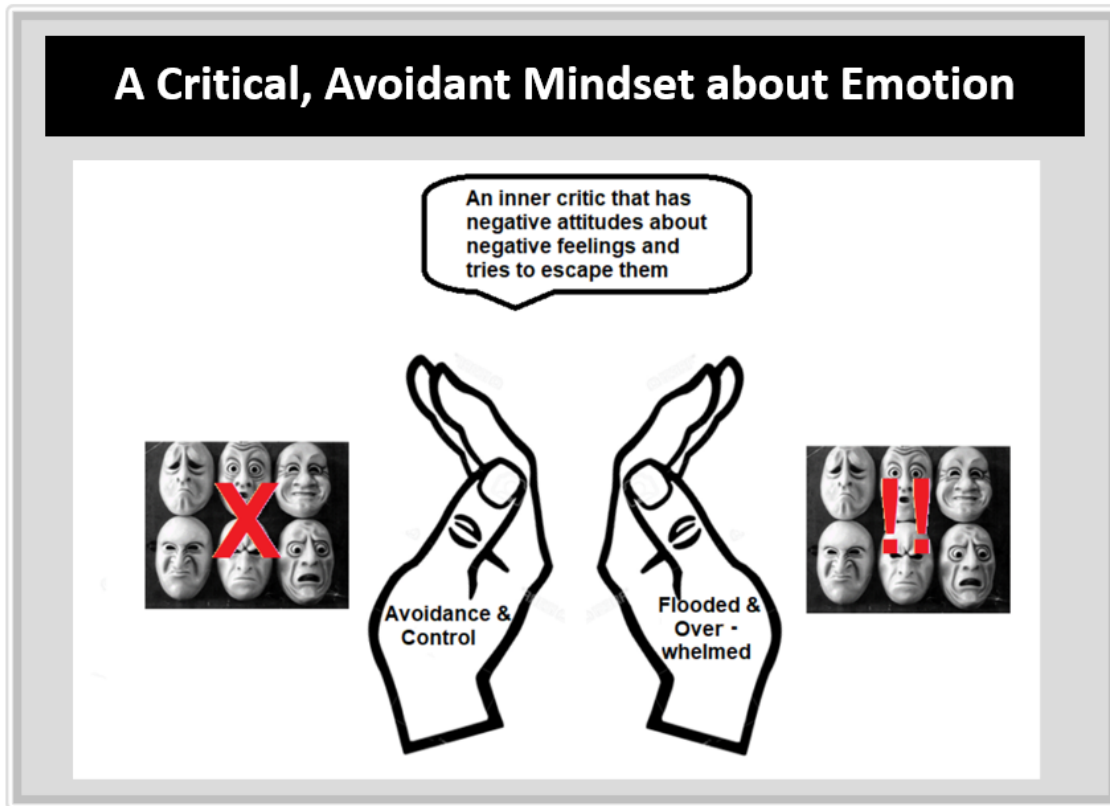
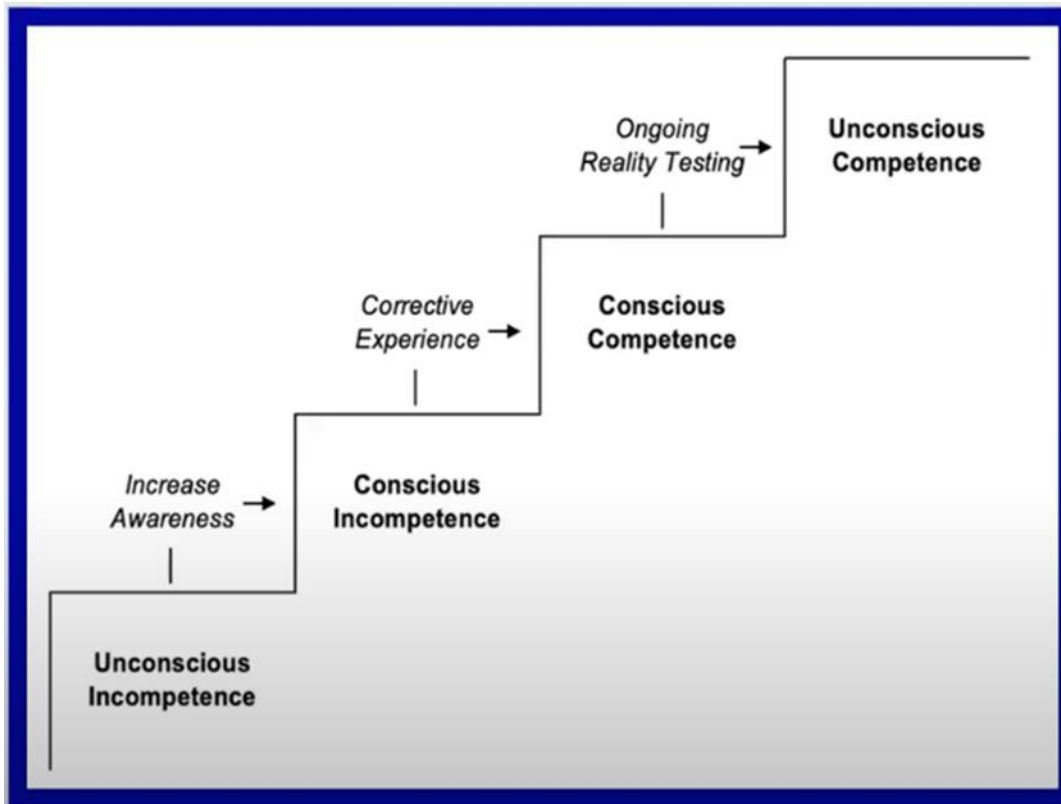


Figure 8. Goldfried's Staircase Model of Therapeutic Change



APPENDIX 1: OUTLINE OF THE CASE OF "MAGGIE"

1. CASE CONTEXT AND METHOD

2. THE CLIENT

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

The Unified Theory of Knowledge (UTOK): An Outline

Psychotherapy Integration and Unification

The Structure of the UTOK Model (Figure 1)

Psychotherapy-Specific Concepts That Logically Follow From the Larger UTOK Framework

Character Adaptation Systems Theory (CAST): Integrating Particular Therapy Theories (Fig. 2)

The Left Side of Figure 2: The Three Contexts of Development.

The Center Circle in Figure 2: The Individual

The Right Side of Figure 2: The Five Systems of Character Adaptation

The Habit System

The Experiential System with its Emotional Sweet Spot (Figure 3)

The Relational System and the Influence Matrix (Figure 4)

The Defensive System

The Justification System

Summary of Character Adaptation Systems Theory

Neurotic Loops: The Core of the Internalizing Conditions (Figure 5)

Factors That Exacerbate Neurotic Loops

The Inner "CRITIC" (Figure 6)

Trait Neuroticism

Trauma

Depression as a State of Behavioral Shutdown Perpetuated by Neurotic Loops

Shame-Based Depression (Figure 7)

Reversing Neurotic Loops with CALM-MO (Figure 6)

The "C" in CALM.

The "A" in CALM

The "L" in CALM

The "M" in CALM

Connecting CAST to Goldfried's "Common Core," Change Principles in Therapy (Table 1)

Summary of CAST, Neurotic Loops, and CALM-MO as a Framework for Psychotherapy

CAST

Neurotic Loops

CALM-MO

APPENDIX 1: OUTLINE OF THE CASE OF "MAGGIE" (continued)

4, 5, 6, & 7. ASSESSMENT, FORMULATION & TREATMENT PLAN, COURSE OF THERAPY, AND THERAPY MONITORING

Presenting Problem

Phase 1 of Treatment, Sessions 1 to 4: Hope That There Might Be a Map Out of the Darkness

Phase 2 of Treatment, Sessions 5 to 9: Working Toward & Then Through the Trauma Via Exposure

Phase 3 of Treatment, Sessions 10 to 16: Learning CALM-MO to Deal with Conflict and Distress

Phase 4 of Treatment, Sessions 17 to 23: The Vicious Return of PTSD Nightmares

Phase 5 of Treatment, Sessions 24 to 28: Learning Effective Self-Talk in the Moment

Phase 6 of Treatment, Sessions 28 to 40: Termination & Transfer to Chad

Summary of the Final Case Formulation and the Plan of the Treatment Offered

Formulation

Overall Psychological Functioning

Habits, Health, and Lifestyle

Emotions and Emotional Functioning

Relations and Interpersonal Style

Identity and Coping

Treatment Plan

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Work with Chad After Termination with Me

Termination with Chad and My Follow-Up Interview with Maggie

Appendix 2

Summary of the Well-Being Check-Up Domains

The purpose of this evaluation was to conduct a psychological “check-up”, which is designed to offer you an assessment of your psychological well-being, personality traits, identity, and adaptive tendencies. We have gathered information through surveys and an in-person interview and share with you the major findings with you below.

Section I:

Domains of Functioning

Major Domain/Findings #1: Overall Psychological Well-being

Psychological well-being refers to the extent to which one: 1) is satisfied with their life and its various domains; 2) generally experiences interest, joy and contentment (versus disengagement, depression and anxiety); 3) is functioning well psychologically, and 4) is living in an environment that meets core needs and offers opportunities and challenges for growth 5) in accordance with foundational human values.

Major Domain/Finding #2: Habits and Lifestyle

Habits and lifestyles refer to the day-to-day patterns of living that the individual is engaged in. This assessment explicitly considers five habit domains: 1) Sleeping; 2) Eating; 3) Exercise; 4) Substance use; and 5) Sexual activities (the acronym SEESS). Lifestyle refers to day-to-day living, standards of living, general rhythm and patterns, general levels of ecological stress and constraint.

Major Domain/Finding #3: Emotions and Emotional Functioning

Emotions are assessed on valence (positive to negative), key emotional states, levels of depression, anxiety and positive mood. In addition, traits of Neuroticism and Extraversion, which are considered the “set points” at which the negative and positive affect systems idle. Ideally, the ratio of positive to negative affect activation is between 2:1 and 3:2. Even levels of activation or higher negative to positive ratios are indicative of emotional distress.

Emotional Functioning is examined via “the emotional sweet spot formulation. Healthy emotional functioning resides in the sweet spot between the poles of being aware and attuned to one’s feelings and being able to regulate strong (negative) emotional experiences in accordance with one’s long-term values. In contrast, poor emotional functioning is characterized by being either over-regulated, lacking awareness, being cutoff and/or critical or being under-regulated, overly expressive

and experiencing chronically activating feelings that dominate the system and lead to impulsive acting out.

Major Domain/Finding #4: Relational Value and Interpersonal Style

Relational value refers to the extent to which an individual feels known and valued. It is assessed in 1) Family of Origin; 2) Peers; 3) Romantic Partners; 4) Group/Community; 5) Self. Core attachment history and current experience of relational value/security is considered. Ideally, one has a history of secure attachment and currently feels known and valued across the five domains.

Interpersonal style refers to one's preferred way of interacting, and way of managing relational process elements. It is assessed overall in terms of trait Agreeableness and self-other tendencies, attachment styles and issues and conflicts of power and love, freedom and dependency are explored. In particular, drives for power and achievement, approval and intimacy are assessed, as is the extent to which an individual maintains a healthy autonomous-interdependent balance versus a hyper-dependent or counter-dependent stance.

Major Domain/Finding #5: Identity, Coping, and Problem Solving

Identity refers to the structure and functioning of the private narrator. In general, a well-developed self is complex, thematically consistent but also flexible, and has good awareness of both experiential drives and emotions and long-term purposes for the valued life. Key areas to assess or consider are: 1) Degree of verbal intelligence; 2) Degree of psychological mindedness and insight (i.e., socio-emotional intelligence); 3) Degree of moral development; 4) Degree of empathy with important others; 5) Degree of conscientiousness and self-directedness (versus impulsivity and disorganization); and 6) Degree of openness, curiosity and exploration (versus closed-off rigidity and defensiveness).

Coping is assessed in terms of approach versus avoidance and the ways the individual processes negative emotion and is effective or not in sorting out and focusing on solutions as opposed to negative feelings. In addition, issues of blame (self or other) or misguided control should be considered in exploring problematic patterns of coping. In contrast, mature coping is generally found in taking perspective, being clear about values, self and other awareness, and the capacity to be in "right relation" to both what is the case and ought to be the case, even under duress. When evaluating coping, this can be thought of in terms of the "defensive system" and psychodynamic defense mechanisms should be considered. Ideally, an individual is oriented toward accepting their emotions as information about goals and can focus on and be committed to achieving valued outcomes.

Note: Other domains to consider that are not explicitly included in the Psychological Well-Being Checkup are: a) biological health and functioning (an evaluation conducted by a physician); b) traditional diagnostic categories of psychopathology (e.g., mood, personality, and substance use

disorders); c) systematic analysis of values and virtues; and d) systematic analysis of abilities and talents (such as intellect, music, and athleticism).

Section II:

A Brief Developmental Narrative

The developmental narrative should create an evolving, dynamic picture of the individual's systems of character adaptation across time. It should consider that there are critical developmental periods in a person's life that provide the foundation for growth. The first is the attachment period, then early childhood, then adolescence, then young adulthood, then middle adulthood, then into old age. Focus should be on the development of identity and purpose; relationships over time; turning points, conflicts and traumas. Erik Erikson's psychosocial developmental stages can be very useful for organizing key themes. Another helpful frame to use in developing the narrative is Luborsky's Core Conflictual Relational Theme method, which describes the relationship pattern or conflict in terms of three components: (a) wishes, needs, or intentions expressed by the subject (wishes); (b) expected or actual responses from others (ROs); and (c) responses of self (RSs); i.e., the patient's own emotional, behavioral, or symptomatic responses to others' responses. The narrative should end with a picture of the areas of less than optimal functioning, areas of strength, an understanding of how they evolved in a way that points to how more optimal functioning can be achieved in the next stages of life.

Section III:

Recommendations for Enhancing Adaptive Living in the Future

The "adaptive living formulation" provides the structure for approaching recommendations. Adaptive living as the process by which one realistically maximizes their valued states of being, given who they are and the situation they are in. Thus, given who they are, their current and likely future stressors and affordances, what pathways are likely to enhance adaptive living. Specifically, consider what might foster and enhance: 1) good habits and lifestyles; 2) the capacity to process emotions in the emotional sweet spot; 3) healthy and appropriate relationships and relationship processes; 4) effective coping and problem solving; 5) accurate and helpful interpretative schemes; and 6) the capacity for developing a CALM MO for moving toward valued states of being.

Therapeutically, there should be, at a minimum, attention to cultivating the working therapeutic alliance and fostering the common core of (a) fostering hope; (b) increasing insight and self-awareness; (c) enabling corrective emotional experiences; (d) exploring avenues for change; and (e) monitoring outcomes.