C-CTherapy®, The Canadian Psychotherapy, is practiced exclusively at the Center For Counter-Conditioning Therapy®.

THE GENESIS OF A UNIFIED, NON-COGNITIVE PSYCHOTHERAPY: an introduction to "C-CTherapy®"

ABSTRACT.

As a non-disease-based psychotherapy, C-CTherapy® is designed to engage aberrant human behaviour. This non-cognitive therapy provides the patient with a mental health skill for neutralizing his inadvertent production of negative emotional material, all of which originates from the non-volitional division of functioning mentality. It is from this division of functioning mentality, with its illogical thought material, that emotional turmoil arises. Both in structure and in its treatment goal, C-CTherapy® satisfies A.T. Beck's definition of a "system of psychotherapy" described in his 1976 book Cognitive Therapy and the Emotional Disorders. As a NON-COGNITIVE psychotherapy, C-CTherapy® employs a skill-building "blue-print" which systematically engages the patient's current experiences, and enables the patient to achieve the treatment goal of emotional self-management. Its methodology uses material from the patient's past, only, when that material advances the contemporary treatment process. For instance, in depressive cases, the patient consistently reports thoughts expressing attitudes such as, "nothing works" and "however hard I try, it's never good enough". While these chronic depressive themes were acquired in childhood, they now drive the patient's emotional turmoil. The patient, while a product of his history, lives in the NOW, and it is this matter of struggling in the NOW with negative items from the past which receives C-CTherapy®'s attention. Selected elements of this NON-COGNITIVE treatment design will be presented.

A SAMPLING OF C-CTHERAPY® OPERATING PRECEPTS.

You cannot NOT react to behaviour that you observe, no matter how illogical that behaviour appears. In short, you cannot ignore and thus successfully evade responding to the behaviour of others. Your early cognitive conditioning guarantees that your mind will force you to pay attention to (validate) cognitive mental functioning. The mental habit -- one cannot not react -- is easily demonstrated in the common activities of judging the behaviour of others, scapegoating, and moralizing about the right way to live.

One cannot NOT react because emotional reacting is not a volitional mental activity. Emotional reacting belongs to a non-volitional mental system, although non-volitional and illogical, emotional reacting is not haphazard. In short, one does not plan the behaviour. A mental system is not plucked out of the air, it develops during childhood through the normal maturation process of the child.

No Man can be psychologically or mentally victimized without his own inadvertent participation.

Just as one cannot NOT react to one's surroundings, one cannot NOT be influenced by the presence of another human being. The human capacity to intervene in another's behaviour, however, is limited to that of influence, not POWER. People usually spend the majority of their lives directly or indirectly interacting with each other. Each of us interacts (Eric Berne would say "transacts") within human behaviour boundaries. Legislated rules, social regulations and cultural mores dictate the questions confronted by each of us. Each person acknowledges these social structures with his or her own mental response, ranging from acceptance to rejection. *It is one's capacity for emotional response which is at issue here, not the form which the response takes*. The real information is, one cannot avoid responding to one's immediate environment. Responding to one's surroundings is universally what people do. Let me expand upon the character of influence. You may find yourself inadvertently involved in someone else's emotional behaviour and unexpectedly become victimized by your ill-timed presence. For instance, a friend walking beside you communicates his upset through words or actions. Your reaction system switches on without your intervention because you cannot NOT react. Your friend has not caused you to behave, you are there beside him. It is impossible to ignore the goings-on around you.

While the physical environment cannot "DO it to you", it does nevertheless provide the arena for mental response. Historically, mankind's interaction with other human beings dates back to the first knowledge of mankind. Controversy exists among anthropologists, ethnologists, and even semanticists, as to whether mankind's mental/ emotional development equals his cognitive/technological development. Although recognized as important, the subjects of human interaction and aberrant human behaviour have not been the foundation of a "system of psychotherapy" until the advent of C-CTherapy®, for, the emphasis in mental health has always been on disease.

NON-COGNITIVE; THE TEACHER

C-CTherapy® treatment concentrates on mental health skill-building as mandated by the non-cognitive system of psychotherapy. The therapist and patient together add to the patient's abilities rather than divesting the patient of previous talents. Unlike cognitive therapy, the C-CTherapy® practitioner does not meddle with the patient's old style of mental functioning. The role of the non-cognitive therapist is one of teacher, not of counselor or of adviser. The non-cognitive therapist is teaching the patient how to handle his own emotional system. The therapist teaches the patient a mental "tool", thus enhancing the patient's capacity to intervene in his own upset.

To satisfy the skill-building mandate, the therapist -- teacher -- teaches procedures so that the patient can work with his own illogical mentation. For, it is his non-volitional division of functioning mentality which perpetuates his mental upset. Therefore, all C-CTherapy® procedures introduced by the therapist help the patient build a mental alternative for himself -- a mental coping mechanism. Once acquired, this coping procedure lets the patient neutralize his own production of non-volitional negative material without ignoring or repressing his emotions. Under the direction of the therapist-teacher the patient acquires the means to CHOOSE the quality and the degree of his participation in any interaction. The patient can now circumvent VICTIMIZING himself.

UNIVERSAL CHARACTERISTICS EMPLOYED BY C-CTHERAPY®

Before proceeding, let me call attention to some characteristics of human behaviour which are featured in this unified, non-cognitive psychotherapy.

Human beings are innately gregarious.

Every culture legislates against excessive and unsolicited sociability so that gregariousness does not disrupt the smooth workings of the community. We see this culturally dictated legislation in laws and rules governing one-to-one civility in public. Body-language studies have shown us that the comfortable talking distance of the "Latin" is threatening to the "Northerner"; rats become neurotic in over-crowded conditions, and so do many humans. The "rules" regulating gregariousness are captured live by the "Zoom-lens" photo of people-filled sidewalks. Here we witness a quick, instinctive courtesy by the preoccupied pedestrians; the tolerable space allowed each pedestrian varies from Tokyo to Riyadh to New York.

If the matter of proximity and common interests automatically influence the nature of our sociability, so too, does selectivity. We select our friends and they in turn select us. The selection process is, for the most part, based upon what we have absorbed from the social, interactive atmosphere of our early childhood. For example, a person raised in affluence does not usually gravitate, socially, towards those raised in poverty. Although exceptions do occur for political or philosophical reasons or from the dictates of early conditioning, persons -- such as missionaries and social engineers -- must be emotionally motivated to overrule non-volitional conditioning which dictates that you stay with your own kind.

Humans instinctively move from mental pain to less mental pain. They do not deliberately go from pain to more pain.

Human beings, loath to disobey a cultural mandate, go to much trouble to conform. Disobeying has consquences, and therefore, is a painful behaviour. Take for instance the emotional reaction of some American middle class and affluent parents over the issue, "Parents should value and provide for their children's education". T.V. news and radio talk-shows report parents diligently searching for the "right" school for their child so that they can satisfy the cultural mandate. They mortgage the house or drive their child many miles from home in order for the child to attend private school. The cultural mandate that the child MUST attend college or attend the "right" school overwhelms the common sense of the parent.

In this instance, disobeying the cultural mandate is complicated by another feature namely "what will people think" which compels the parent to obey although no legal penalty would be incurred by ignoring it. That is, the parent will not be "zapped" or "melt" if he disobeys. But, disobeying the cultural mores inherent in one's mental conditioning creates emotional stress. Consequently, humans obey their conditioning even to their detriment. The need to reduce their pain creates more pain for these parents as they go broke -- that makes no sense. One's conditioned habit to obey cultural mores is in charge rather than logic and reason.

While the education example applies to only a small portion of the population of Western, industrialized countries, nervousness and anxiety apply to a larger segment. The Center's research indicates an abundance of anxious people in industrialized countries function from a chronic state of anxiety, now ingrained in their mentality. Unaware of their state of elevated anxiety, they are also unaware that they live in a chronic state of distress. As this chronic state is not of human choosing, deliberation is not its cause. In their attempt to reduce the distress, these populations ingest abundant amounts of psychotropics and attend to the teachings and abide by the nostrums of a variety of "gurus".

Perfection is not a human attribute.

Our conditioning regarding social obligation urges us to credit the difference between "what is" and "what should be". When we become emotional about our inability to comply with a social demand, we suffer! Ironically or tragically, the more we, as human beings, discover our incapacity for achieving perfection, the more disappointed we become. We act as though behaving in a perfect fashion is within the bounds of the human condition. In short, we surrender to the habit of resenting the state of our imperfection. It is totally illogical that HUMAN BEINGS resent being human.

CULTURAL MORES AND THE FITTING GAME: MORAL PRONOUNCEMENTS DO NOT EQUAL CLINICAL TREATMENT.

Now, we move from the parenting example to the general arena of cultural mores. Conditioned since our birth, we are emotionally sensitized to issues and matters pointed out to us by our parents. To these emotional items, we respond as if they were truths rather than parental biases. So far, cognitive disease-model psychotherapies are without a treatment design which provides the mental health field with a methodology that actively distinguishes between absolute truth and parental bias. After all, parental commentary is in sum merely the anecdotal musings gleaned from others, but as children we pay immediate attention to parental anecdote. It is in this way that parental comments become mentally converted into truths by the off-spring and then are later served up in the mental conditioning of those off-spring. As a consequence of this phenomenon, the attitudes of one generation become the model for the next.

As children, we respond to our parents as if their commentary equals absolute truth. This copying from our parents initiates a bad habit -- recasting negative commentary into "the truth". There is nothing other-worldly about mental conditioning, as its content is man-made. This childhood habit of listening to negative commentary from others, coupled with the tendency to VALIDATE the negative commentary heard, causes mental health patients to perpetuate their emotional turmoil. It is these "windows of perception" developed in childhood through which the patient interprets his surroundings. In effect, patients contribute to their own suffering by reliving upsetting experiences from their past through a process of mentally regurgitating these experiences. The expression, "adding insult to injury" is symptomatic of how "people do it to themselves".

Consequently, people in pain, inadvertently perpetuate their pain by practising the habit of negative recall. Cognitive therapy practitioners are constantly confouded when they witness patients increasing their mental pain beyond what is warranted; for instance, by the breaking of a social rule. At the same time, cognitive practitioners unknowingly contribute to the turmoil of their patients by paying attention to, and thus validating, their patients' negative preoccupation.

12-Step and Recovery Movement programs, products of Western-European culture and training, have joined with society in adopting a moralistic view of mental upset. The attitude adopted by the 12-Step and Recovery Movement programs differs little from the centuries old morally-charged dogma preached by clergy. When clinicians put on the "cloak of morality", they become inadvertent participants in a kind of clinical "fitting game". When Fritz Perls -- the father of Gestalt Therapy -- mentions the "fitting game" in his book, Gestalt Therapy Verbatim, he is referring to the practise of "fitting" the patient into a diagnostic category, subjecting him to a "how to think differently" regimen, and then, releasing him back into the community when his cognitive practitioner deems him "fitting" the social mold.

The "fitting game" and theories about "correct" human behaving foster morally driven therapies which lack any vestige of mental health treatment. The result is that cognitive therapies introduce treatment maneuvers based upon theories which simply amount to moral judgements on human behaving. In short, a therapy which treats SINNING does not belong in the category of mental health treatment.

GET RID OF IT -- THE COGNITIVE THERAPY MODEL

Up to now, all psychotherapies employed a COGNITIVE disease-model, medical design. No matter the title of that therapy, their clinical directives belong to a format premised upon the theory that people can "choose" appropriate behaviour. The theory posits that it is possible to renovate, and thus reformulate, one's behaviour. According to cognitive therapy the requisite for change amounts simply to the introduction of REASONING. In short, all one

needs is the WILL to follow good sense.

This reasoning approach is the framework for a "get rid of it" medical-model treatment program. Resembling, when for instance, the surgeon, by removing the patient's tumor, rids the patient of his problem. Because of its design, cognitive therapy is organized around the treatment enterprise of disallowing mental elements of the patient's old self. The therapist is supposed to help the patient get rid of his current manner of acting and thinking. Without exception, the goal of cognitive therapy is to get the patient to adopt a BETTER, more socially acceptable attitude. Naturally, the BETTER attitude relates to the patient's adoption of thoughts and actions which conform to those of the COGNITIVE therapist whose theory is wrapped-up in his treatment approach, namely that, the patient's behaviour was BAD so the patient must now CHOOSE a more socially correct one.

A Cognitive Therapy spokesman, A.T.Beck, M.D., in his book Cognitive Therapy and the Emotional Disorders, puts it this way:

"Cognitive therapists formulate the process of improvement in terms of the modification of conceptual systems, that is, changes in attitudes, beliefs, or modes of thinking. Most behavior therapists conceptualize the disorders of behavior and the procedures for their amelioration within a theoretical framework borrowed from the field of psychological learning theory, especially the concepts of classical and operant conditioning." (Beck page 322)

In fact, COGNITIVE therapy is mainly a negative treatment therapy, negative because the patient is confronted with a personal dilemma: The patient is assigned an impossible task -- to rid himself of a portion of his functioning mentality. According to the Center's recent research, it is NOT possible to replace a removed portion of functioning mentality with a morally and philosophically correct portion. Thus, cognitive therapy inflicts upon the patient the task of instituting a fiction. Unfortunately, cognitive therapy treats the fiction as clinical truth. The fiction is that the patient possesses the means to inaugurate, through mental choice, a renovation of his functioning mentality. That is, by assertion of personal resolve, he can raze his non-volitional pattern and build a new one. Cognitive therapies are out of touch with human capabilities. That is why this author created a "one to one" mental health treatment format clear of the flawed cognitive, disease-model thesis.

DIFFERENCES BETWEEN COGNITIVE THERAPIES AND NON-COGNITIVE C-CTHERAPY®

Beck distinguishes between a "system of psychotherapy" and "a simple cluster of techniques". Most cognitive therapies fit the latter definition and in the field are called ECLECTIC.

C-CTherapy® which meets Beck's definition of a system of psychotherapy, on the other hand, views the patient as central to the correction of his own state of turmoil. C-CTherapy®'s operational stance is that the patient is the owner of a mental catalogue of personal experiences and the currently relevant items will be involved in the treatment process. The non-cognitive treatment mandate requires that the patient eventually be able to neutralize these producers of his upset, on his own.

C-CTherapy® is not a philosophy of life, it is a skill acquisition format which follows progressive procedural steps. The treatment approach is one by which the patient gains proficiency through the application of therapist-directed exercises. The therapist's role concentrates, only, upon teaching C-CTherapy® exercises to the patient in his pursuit of a personal mental health skill.

This teaching approach is worlds apart from COGNITIVE therapy methodology. As a "philosophy of life" modality, cognitive therapies blend religious issues with questions such as, "what is the RIGHT way to be a human being?" Cognitive therapy, consequently, is preoccupied with moral matters such as right or wrong, good or bad behaviour.

The cognitive therapist focuses his efforts on resolving matters of moral or personal conscience, traditionally the domain of the clergy. In pursuit of understanding the patient's emotions, the cognitive therapist labours at responding in a sympathetic, emotionally supportive manner. The supposed result from this approach -- according to cognitive theory -- is the emergence of a human condition called BONDING. As a hypothetical state, bonding is supposed to "marry" the patient with the therapist into a posture of recovery. Their relationship, built upon understanding human behaviour, is supposed to CURE the patient. This is what the Center calls "laying on of hands", or, "relationships cure you".

Cognitive therapies fixate the therapist on the thesis that empathy and "understanding" will reveal a curative route out of the patient's mental turmoil. Therefore, the pursuit of "why" the patient sought therapy is relevant to cognitive theories. Thus, the cognitive therapist considers the patient's presenting problem as significant, and the fact that it is so considered provides grounds for cognitive therapy attention.

A non-cognitive psychotherapy, however, is not fixated on discovering the mystery behind human behaving. There is NO need to UNDERSTAND the patient because there exists NO mystery. The patient, carrying the instrument of upset which is his mental functioning, sits before the C-CTherapy® practitioner. In the non-cognitive treatment setting, only the current data matters. In order for the patient to sit in the office and provide what is commonly termed the "presenting problem", that patient must have survived whatever ordeal he or she previously encountered. At the Center, the only issue of relevance is the patient's physical survival. From this starting place, C-CTherapy® regards the cognitive therapy procedure of "rehashing" all past negative events as IRRELEVANT.

This non-cognitive approach adopts the treatment stance that "mental regurgitation" - as a potent force in the reduction of mental turmoil - is nothing but a meaningless exercise in negative recall. For C-CTherapy®, rehashing negative experience does nothing to enhance or push forward the treatment process. In point of fact, the Center's research finding is that a cognitive therapy design retards patient recovery. Cognitive therapy contributes to this outcome by focusing the patient's attention on his negative past. Recalling negative experiences from the past, however, contributes nothing to the patient's abilities for coping with future turmoil.

From cognitive to non-cognitive, the design change, produces a structural, operational change in both the therapist's task and the patient's role in the therapy process. The C-CTherapy® clinician is not the "boss". Both the therapist and the patient are of equal importance in the treatment process, establishing the clinical tone of this unique therapist-patient relationship. Even a minor point such as how the therapist begins the initial session is different. For instance, the non-cognitive therapist begins by asking the patient: "What do you want to talk about"?, or, "What upsetting thoughts are constantly on your mind?"

THE PATIENT'S EXPERIENTIAL LENS AND THE C-CTHERAPY® METHODOLOGY

Since 1967, the author has observed that patients come to the office for a variety of mental health reasons, such as:

(a.) The patient has come to learn from the therapist how he can steer people in a direction, whereby, they will do what he wants them to do, that is, "obey him".

(b.) The patient comes to find the "right way" to think.

(c.) The patient comes because his chronic state of mental pain is wearing him down and he hopes that the therapist will get rid of his upset.

But the C-CTherapy® practitioner assumes nothing about the patient, and therefore, takes nothing about his patient

for granted. Instead, the C-CTherapy® non-cognitive therapist operates from:

(1.) "I have the capacity to teach the patient a mental health skill which allows the patient to add on another ability to his bank of skills."

(2.) "As an expert on C-CTherapy®, I, as the non-cognitive practitioner, direct the patient to follow and practise procedures which lead to mental self-management. .

The therapist's clinical attitude is all important in the treatment process. As noted above, "why" the patient came to the office is considered irrelevant by the C-CTherapy® therapist. Because people carry their mental style with them wherever they go, the therapist will discover, in short order, what is "bugging" the patient. The patient sitting before the therapist, therefore, is the only spokesman capable of imparting information about his mental condition and the only person for the therapist to talk with.

For all patients, specific items in their emotional, non-volitional division of functioning mentality are the cause of mental pain production. The Center's non-cognitive therapy battles directly with this producer of mental pain. By teaching the patient how to neutralize these producers of mental pain, the patient builds an operational foundation from which he can consistently oppose pain production.

The clinical plan -- teaching the patient a personal mental health skill -- is introduced to the patient during the intial session. The C-CTherapy® practitioner underlines the reason for meeting in the office. The office, like a music-room, limits distraction so that the patient-student can concentrate on the project at hand -- learning skills. (As an aside, while the office serves the function of a therapy classroom, it is not necessary for the patient to ever attend an office session. Because of C-CTherapy®'s unique treatment design, the patient can receive mental health treatment over the telephone. The treatment program, acquisition of a mental health skill, remains constant regardless of the setting.) The therapist-teacher's job is to maintain the curative direction of the treatment program. The patient's job is to learn what is being taught. By concentrating on this skill acquisition task, the patient learns to neutralize the negative items in his reactive system, for, it was these items in the past which victimized him.

By learning to regard previously obeyed thought-voices as just a mental function instead of a truth, the patient and the therapist achieve the therapy goal of immobilizing the negative source of the patient's mental upset. The key, here, is that a change in treatment design provides the patient with a treatment strategy. By acquiring mental "tools", the patient obtains a specific methodology for mentally coping -- neutralizing illogical negative items. In sum, the therapist and the patient hold sessions in order for the therapist to TEACH, and for the patient to LEARN. The patient, therefore, is a PARTNER in the treatment process. For example, mental activity such as "judging" the behaviour of others -- a common mental habit -- receives early attention by the C-CTherapy® practitioner. This habit, copied from one's parents, is automatic in nature. Patients routinely judge both themselves and those around them. It is important that both therapist and patient familiarize themselves with the negative reinforcement rendered by judging when it appears, for it is this "judging human behaviour" which is one of the habits fostering patient self-victimization.

Because a treatment objective is for the patient to learn how to consistently move out of his chronic self-victimization habit, the patient must become adept at discovering his habit -- in this case judging -- when it starts up. By discovering how judging works and the role it plays in his mental, non-volitional pattern, he learns that not only does he judge the behaviour of others, but he judges his own behaviour as well. Through practise, the patient comes to identify an item, such as judging behaviour, and the negative role it occupies as a functioning mentality example. Directed by the C-CTherapy® practitioner, the patient steers clear of discussing good and bad behaviour as a pathway to relieving mental upset. Wrestling with his mental pattern in this manner enables the patient to turn this project of personal revelation and discovery into one of immense learning.

The patient learns to treat his thoughts as just so much mental function. Thus, he is able to introduce a totally different response to his mental activity, such as the COUNTERING exercise. The patient learns when its application is appropriate. Routine detection of an item like judging is crucial. It is crucial, also, that the patient experience the frequency of his mental indulgence in negative activity because all such activity is produced by the patient's non-volitional pattern.

This is a demanding project for the patient. The patient is used to living the behaviour which his functioning mentality creates. Mental activity of this genre needs to be drawn to the patient's attention by the therapist because, initially, the patient is unable to detect this reactive mental activity on his own. If this kind of mental activity went unattended, and therefore unchallenged, the C-CTherapy® "skill-acquisition mandate" would not be met. The "discovery and detection" exercise is a key project for the patient when his goal is working with his own emotional, non-volitional pattern. .

Discovery and detection is integral to the patient's skill-building process. The patient must become adept at detecting when this emotional material becomes mentally active, for instance, in "being scared", or, "feeling attacked". When the patient detects the beginning of the activity, his chances of intervening are good. He applies the appropriate procedure, designed to neutralize the early stages of negative activity, before the sequential reflex action begins.

Besides the on-going "discovery and detection", the patient pursues a concurrent activity involving another C-CTherapy® procedure called "contemporization". Contemporization -- the deliberate application of real information -- competes with the chronic, illogical thought activity (thought-voices). With this particular procedure, the patient learns to operate from up-to-date information, necessary for living in the real world.

The goal here is to render obsolescent the power of negative aspects of the old habit pattern. Let it be emphasized that a change in operation does not rid the patient of old mental habits. By practising at skill-building, the patient comes to discover that he, himself, has created inadvertently his own non-volitional pattern. Therefore, it is his job to put together, in a deliberate way, his own mental alternative to his old habit pattern.

C-CTherapy®, by orienting the patient to building a skill, instead of destroying his old style, shifts the therapeutic project to one of building a mental alternative. By repeatedly engaging in the therapist-directed clinical procedure, the patient systematically diminishes the negative cast of his behaviour. He, thus, reduces the power of his chronic emotional pain. That the patient learns to operate from an unique stance of personal deliberation is the crux of the Center's non-cognitive psychotherapy format.

To put a further crimp in the patient's validation of illogical thoughts, the C-CTherapy® practitioner teaches the patient an exercise called CHECKING-OUT ILLOGICAL THOUGHTS. The therapist instructs the patient to ask himself, whenever he feels anxious for no obvious reason, these ordinary questions: "Who is attacking me?" and "What is threatening me?" These questions are not a cognitive, volitional effort to convince the patient to think differently; the non-cognitive purpose is to get real information working.

The patient gets real information working by repeating these questions to himself and treating this action as a routine. This procedure -- repetition of C-CTherapy® exercises -- is applied because the mental nature of the patient's non-volitional pattern and its habit-based negative material is more powerful than an intellectual wish. An intellectual wish, such as convincing, is a volitional mental act. But, habit-based emotional, non-volitional action is involuntary. As the item in the non-volitional pattern is involuntary and driven by emotional habit, the likelihood exists that the patient will persist in following the established mental pathway. That is, it is highly likely that the patient will give in to the dictates of his negative thought-voices. The C-CTherapy® design takes this phenomenon for granted: The chronic habit of thought validation, because of its developmental head start, has usurped patient behaviour and, if left alone, would continue to produce illogical behaviour for the patient.

A C-CTherapy® procedure is applied by the patient each time he suspects the onset of mental turmoil. He comes to experience that repeated application of a counter to his chronic activity reduces his tension level. By experiencing this, he proves that he is (a.) capable of applying C-CTherapy® exercises and (b.) that the application of a countering exercise will always neutralize the onset of turmoil. It is because of this newly-found capability that he gets enjoyment out of his ability to sabotage the negative production of his non-volitional pattern. He is able to accomplish this change in function because he can, at long last, deliberately activate "evidentiary information" -- that is, contemporary information. This reliable procedure extinguishes negative activity which then proceeds to wipe out the emotional clamp formerly held by the non-volitional pattern.

When applied consistently for a few months, these non-cognitive exercises yield a personal mental health skill for the patient. Through this process -- the therapist teaching and the patient learning -- a personal methodology is established. The patient is then in possession of a method of coping with future episodes of negative mentation.

THE PATIENT GAINS A NEW PERSPECTIVE

"The proof of the pudding is in the eating", is how the patient demonstrates to himself that the exercises work. His own personal experience is reinforced by the Center's three decades of research. Proving to himself that this skill-building approach benefits him, the patient is rewarded with another mental feature -- a new-found perspective, totally unlike the operant character of his old mentality with its crazy reactive system.

Also, he finally discovers why his cognitive efforts left him so dissatisfied. In the past, everytime he worked at convincing himself that he shouldn't feel scared or he should not feel attacked, his emotional suffering increased. This was NOT the result he anticipated. Through repeated attempts to "think right", he now concludes that it is a waste of emotional effort to convince himself to think differently. He has discovered, through his own experience, that volitional (logic and reason) intentions are not capable of overpowering the negative production of the non-volitional pattern. He has solved the puzzle at last about why cognitive, disease-model therapies do not work. Emotional, non-volitionally derived mental activity is simply too strong.

This new-found perspective allows him to distinguish between logical and illogical mentation and the behaviour produced by each. No longer does he suffer from the delusion that the illogical thoughts of his non-volitional pattern WERE EVER logical. Always in the past, the patient's inadvertent validation of negative thoughts guaranteed a negative result. Through his work at the Center with C-CTherapy®, the patient has shifted from validating negative thought-voices to making the contemporary connection that his illogical thought-voices are solely a function of his mental pattern.

SUMMARY.

For the therapist:

(1.) The therapist cannot cure the patient, only the patient can cure the patient.

(2.) The therapist is NOT obliged to make the patient "think" right.

(3.) The therapist IS obliged to teach the patient a personal mental health skill.

(4.) The treatment goal aims to neutralize aberrant mental activity.

For the patient:

(1.) The patient's duty is to tape-record each therapy session and practise C-CTherapy® exercises throughout the week, all under the direction of the therapist. (2.) The patient learns to work with his mental self. Getting rid of his mental self is not the road to an absence of turmoil.

(3.) The patient must eventually come to terms with the reality that every human being has his own emotional style. Because there exists a style for each human being, there are as many styles of emotional reacting as there exist human beings.

(4.) Through patient acquisition of a personal mental health skill, he is eventually able to operate from: he is not GOD, and therefore, isn't in charge of the world, and, he utters OPINIONS not TRUTHS.

HISTORY OF METHODOLOGY

C-CTherapy®, a "system of psychotherapy", has been developed and employed since 1967 by its founder, the author. For three decades, the author and his colleagues have applied this non-cognitive psychotherapy format over the total spectrum of mental health cases.

A deferential note to the sceptics who populate the Medical-Psychological mental health industry: There exists no aberration in human behaviour which is not amenable to the treatment design of C-CTherapy®.

SUPPORTING DOCUMENTATION

Breggin, Peter, Toxic Psychiatry, St Martin's Press, 1991.

Fingarette, Herbert, Heavy Drinking: The Myth of Alcoholism as a Disease, University of California Press, 1988.

Kaminer, Wendy, I'm Dysfunctional, You're Dysfunctional: The Recovery Movement and Other Self-Help Fashions, Addison-Wesley, 1992.

Scull, Andrew, The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900, Yale University Press, 1993.