AN INTRODUCTION TO C-CTHERAPY®: a Unified, Cross-Cultural Psychotherapy

NOTE: This article is meant for the practicing psychotherapist who wishes to apply the C-CTherapy® format. Understanding its contents, however, will not supply the mode of application. Instruction at the Center is the only means available to practise in C- CTherapy®.

ABSTRACT

Disease-model, cognitive theory is not employed, or indeed, is it related to a non- counselling C-CTherapy® treatment design; nor are any of the therapies based upon an "understanding why" -- study, diagnosis, treatment -- approach. As a cross-cultural psychotherapy, C-CTherapy® engages aberrant human behaviour. The treatment goal of this non-counselling format is to provide the patient with his own way of neutralizing his production of negative emotional material. This material originates from the non-volitional division of the patient's functioning mentality. It is from this division of functioning mentality, with its illogical thought material, that mental/emotional turmoil arises.

INTRODUCTION

The C-CTherapy® approach to functioning mentality addresses how a patient behaves, not theories on why he is behaving in this way. It diverges radically from cognitive, counselling therapies for they rely upon medical-psychological hypotheses. Relying upon these hypotheses -- rather than relying upon each patient's actual mentation as does C-CTherapy® -- guides the counselling therapist's diagnosis and treatment. Consequently, the counselling therapist acts as the "expert" on a patient's mental turmoil when in fact he is merely an expert on theories.

Counselling therapies are specific to a patient population, Western and European, and bound to those particular socio-economic traditions. In contrast, the patient-population open to the C-CTherapy® non-counselling format is the universe of human mental functioning. As a direct result of its unique treatment

design, the C-CTherapy® cross- cultural methodology is available to any human being needing relief from mental upset.

The methodology presented here has been developed and perfected in the author's field of aberrant human behaviour since 1967. The conclusions result from the universe of practice in the mental health field.

ROLE OF THE C-CTHERAPY® CLINICIAN

The C-CTherapy® clinician's reason for intervening in the patient's mental turmoil is not to correct the patient's immoral behaviour -- a counselling objective -- instead, the therapist's purpose is to move the patient, as expeditiously as possible, from mental pain to less mental pain.

During the opening session, the C-CTherapy® clinician asks the patient: "What do you want to talk about?" The patient's answer gives the therapist enough material to begin the treatment project. From the patient's answer, the clinician introduces the treatment goal, tying it to the patient's current mental upset. One patient, for instance, said: "My boyfriend gets mad at me and I don't know what to do." For this patient, the issue is: "Human beings don't like other humans being mad at them". That sentiment is universal, for we all want people to like us. In this first session, the therapist begins identifying how the patient's thinking creates her mental upset. The therapist views the patient's problem as an example of how the patient's emotional/illogical pattern operates.

For instance, this patient increases her anxiety level by trying to convince someone (the boy-friend) not to be mad at her. "If my boyfriend gets mad at me, that means he doesn't like me. I try to convince him not to be mad at me, but he doesn't listen." When her boyfriend gets annoyed, she interprets his negative emotion as meaning that he is leaving the relationship even though she has no real information to support her suspicion. It is this brand of thinking which produces her anxiety and to which the therapist must introduce her. To that end during another session, the therapist points out an illogical demand.

> Patient: I'm critical of him for not fulfilling my stupid dream and I feel let down.
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> Therapist: What is that stupid dream?
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> Patient: That he is tall, dark and handsome and never gets mad and always comforts me.
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> Therapist: So he's not measuring up to your illogical demand.
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> Patient: But he can't. He can't be six feet tall because he's five foot four inches and he loses his patience every once in a while. So why can't I just accept this real situation?

Although my patient realizes the absurdity of her behaviour, she has invested her emotional energy in convincing her boy-friend to change -- a losing project. She is experiencing that illogical patterns are mentally powerful and drive her behaviour.

The beginning of this process is the patient's learning to detect "what your mental activity is doing". Here is an example:

Patient: I heard my thoughts say; Oh Oh, he's going to leave me!

Therapist: That's a good example of the thought-voices that generate emotional behaviour creating your anxiety.

The patient discovers that thought-voices are a feature of her illogical, non-volitional division. After all, one cannot NOT think! My patient's thought-voices uniquely fit her behaviour pattern because every mental pattern is a unique product of that individual. The C-CTherapy® clinician emphasizes to the patient the constant need to monitor her thought-voices. In this way, the team works together -- the coach highlights the character and content of her mental pattern.

Because illogical, non-volitional patterns are habit-based activity, it is difficult for the patient to detect their operation. Detection, however, is precisely what the therapist is emphasizing. My patient notices the rapidity of her mental action this way: "My emotional pattern is running me before I know what I'm doing". That emotional action is reactive and instantaneous and, precisely, what the therapist is acquainting her with.

The thought-voice activity is habit-based. It is like a spinning bicycle wheel, the mental spokes invisible until the wheel slows down. At this point the blurring spokes become apparent. Same thing with mental action, it must be slowed down. This is the therapist's job otherwise the mental action poses a detection problem for the patient. Unless one can detect one's mental action, one remains at the mercy of one's own illogical pattern. The therapist uses the sessions to advance the patient's detection ability.

Therapist Directs the Session

In the C-CTherapy® design, the role of the clinician changes from that of counselling EXPERT on the patient to that of COACH . A coach outlines the learning exercises the patient will practise to attain his new skill of emotional self-management. The duties of coach diverge from those of a philosopher/counsellor imparting the "right way to think and behave". The duties of coach are the same as in any skill-acquisition program. For instance, in learning how to drive a car -- a skill-acquisition task -- the job is to practise braking, steering and parking, not philosophizing upon the existence of cars or reading stories about chauffeurs and race car drivers.

The therapist and patient combine their work into a team effort, but the therapist-coach directs the effort. Attaining emotional self-management dictates that the C-CTherapy® clinician be actively involved in the whole of each session. There is no sitting back to listen while the patient tells "stories". Thus, the role of the C-CTherapy® clinician is markedly different.

Another dramatic change occurs. While the therapist is not the expert on the patient's mentation, the therapist is the expert on the building of an alternative procedure. Creation of an alternative mental pathway enables the patient to counteract chronic emotional pain production. An acquired skill, therefore, supplies the patient with the ability needed to neutralize the illogical thought-voices of his operant mentality. For, it is from this non-volitional mental division that the patient's emotional pain originates.

The therapist's job, therefore, is to direct the building of an alternative coping mechanism for the patient who must construct that procedure from scratch. A building process is the only way the patient can deal with the "logic" of his illogical non- volitional pattern. In any process of building -- a skill, a house, or whatever -- one

follows a blueprint or a "building" plan.

The therapist outlines the building plan which he and the patient will take to neutralize the patient's state of turmoil. A mental relief plan is introduced and the practitioner lays out the patient's role: the patient will tape-record his session and listen to his tape between weekly sessions. Listening to his tape serves as the patient's homework. The therapist directs the patient as if to memorize his taped session, for the taped session is the patient's learning tool. All C-CTherapy® clinicians follow this basic format.

For the patient, practising exercises assigned by the therapist is mandatory. By doing what the coach tells you to do, one eventually accumulates the elements which come together to form a skill. An emotional self-management skill is not hypothetical or academic, it is procedural. No disease-model treatment proceeds in this way, and thus, cannot teach the patient a skill for long-term application.

PARTNERSHIP

The therapist holds and reads the blueprint and instructs the patient in the building of the patient's mental health skill. In this way, the therapist and patient work as a team. The patient becomes a PARTNER, and as such, is integral to the treatment process and its successful outcome. The patient's first duty is to practise detecting the activity of his mental functioning. Neither he nor the clinician pay attention to the patient's emotions, for, emotion is the non-volitional product of the patient's mental functioning. The patient's familiarity with the elements of his mental functioning, rather than his "feelings" or personal philosophy, is the team's focus.

THE RATIONALE FOR THE PARTNERSHIP

In order to acquire a skill, one needs to be taught by a teacher of that particular skill. The teacher's job is to combine the efforts of teacher and pupil into the learning process. Without this teaching-learning structure, no skill-acquisition is possible. This is the basis for the team effort.

In C-CTherapy®, the patient meets with the therapist for one purpose -- to build a mental coping skill that allows the patient to move himself from mental self- victimization towards tranquility. Only the patient is capable of neutralizing the negative production of his non-volitional pattern.

Identifying the Negative Thought-Voices Which Pop into One's Head

The patient, ignorant of the origin of his mental pain, lacked the means of coping with it. To cope with his mentally produced turmoil, the patient must learn how to neutralize his negative thought-voices.

The contents of the patient's non-volitional pattern are that which the C-CTherapy® clinician calls `thought-voices'. These thought-voices constitute the patient's preoccupation. By practising at detecting the thoughts `popping into' his head, the patient gains familiarity with the characteristics of these thought-voices. By gaining familiarity, the patient discovers the disruptive properties of his non-volitional pattern and gradually acquires the ability to intercede.

Learning to detect thought-voices is the first step which, eventually, will lead to the patient's ability to sabotage his mental self-victimization. Neutralizing the influence of the illogical mentation is the treatment objective. After all, attack is the best defense -- as the expression goes.

THE THERAPIST'S ROLE IS TO TACKLE THE NON-VOLITIONAL SYSTEM.

What is the Non-Volitional System?

The non-volitional system is a division of FUNCTIONING MENTALITY, the one in which illogical and emotional material resides and where crazy thoughts originate. Characteristically, non-volitional activity is involuntary, illogical and emotionally reactive.

C-CTherapy® is the only psychotherapy which, for treatment reasons, differentiates between volitional and non-volitional sources of mentation. The interplay between these two divisions of the operant mind constitute functioning mentality. The volitional division operates from a mental stance of logic and reason. The non-volitional division, on the other hand, is emotional in function and illogical in content. Thus, the thought-voices configuring this division assume an obsessive manner.

How Do You Acquire a Non-Volitional Division of Functioning Mentality? (For a detailed discussion follow this direct link to the "Child Development" section or visit the Center's Website: http://www.c-ctherapy.org)

When you were little, you inadvertently copied the adults around you. Today, those copied ingredients form your own non-volitional pattern. They stem from the emotional and attitudinal contents displayed by the adults surrounding you as a developing child. For example, the therapist explains that the child's developing mentality absorbs this parental material during mental maturation. Simultaneously, the therapist calls on the patient's information bank to identify the copied items.

Here is an example:

> Therapist: Who did you mentally absorb this item from when you were a kid?
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> Patient: I don't know.
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> Therapist: Who talked like that?
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> Patient: It sounds like my Mom saying, `Don't get so excited, life isn't like that'. Therapist: So it was Mom's kind of talk?
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> Patient: Yah. She said, `Don't have such a good time because then you won't have such a bad time'.
>
> Therapist: There it is, the style and content of the thought-voice that you inadvertently copied when you were little.

Later in the session, the patient recalled more of how her mother behaved. That the patient's emotional system was absorbed by her early emotional environment becomes vivid to her.

Patient: I keep thinking about all the bad things that are going to happen. I get frantic and can't sleep.

Therapist: Who got frantic when you were little?

Patient: Mother used to rush and hurry us around.

Therapist: What kinds of things did she do?

Patient: I remember that she would get on our case about doing things quickly. Also, I remember her getting out of bed and cleaning things in the middle of the night.

Therapist: Great! Now you've got a handle on where `busy getting frantic' originated. You see, it's copied.

WHAT HAPPENS IF THE NON-VOLITIONAL DIVISION IS NOT TACKLED?

If the therapist's methodology does NOT tackle the non-volitional pattern where emotional difficulties reside, an unsatisfactory outcome is inevitable. It is inevitable because the origin of upset -- the non-volitional pattern -- is left intact. For example, all therapists have encountered the patient who begins to feel good and then mysteriously becomes depressed again. The patient returns to his depressive state again because the non-volitional pattern holds the emotional power. Thus, it always has the ability to resurrect its old function and return the patient to his former state of gloom and doom. When a depressive feels good, for instance, thought-voices "pop in" with commentary such as: "Don't count on it! Feeling good never lasts." Since feeling BAD is the patient's daily experience, the new sense of feeling good is out of synch with the patient's thought-voices. If the depressive, therefore, has no way of counteracting his chronic mental activity, he is stuck, mentally, in "Woe is me".

Although it is illogical to operate from feeling good is BAD, all depressives operate from this mental position. Again, our patient illustrates:

Patient: When I lived with my ex-husband, I just hated the farm. Realistically I know I don't want to go back to him, but when I hear about his new girlfriend I get so mad, it breaks me up. They seem so happy together and I want happiness.

Therapist: Confusing, isn't it?

Patient: Here I am better off than when I was married yet I'm envious of my Ex and his lady friend.

Therapist: Does that sound logical?

Patient: That sounds ridiculous!

Therapist: Sounds like you can't stand feeling good.

Patient: It's like when I've cooked a delicious dinner and all my guests compliment me, but the voice inside my head says, `You could've done better'.

Therapist: And perhaps there is another voice which says you're not supposed to enjoy the compliments?

Patient: Yah, I hear that voice too. Sometimes when I'm feeling good and everything is going smoothly, I hear a doubting voice and I get afraid.

Therapist: That's the old business of `feeling good is bad'. Can you hear the thought-voice messing up your good feeling?

Patient: Yah.

Therapist: That's the habit. The habit is to get scared when you don't hear the usual thought-voice response.

If the therapist doesn't tackle this non-volitionally derived commentary -- in this case `feeling good is bad' -- the patient will be governed by these negative sentiments, and be so governed, for the remainder of her life.

NATURE OF THE THERAPIST-PATIENT INTERACTION

The skill-acquisition project, changes the role of the therapist; the C-CTherapy® clinician assumes the role of a "traffic director" or coach. The coach facilitates the patient's task of steering himself through his mental "minefield". The clinician keeps the patient's effort focused on the treatment goal of emotional self-management. This is the clinician's mandate and its success demands the therapist's active involvement.

The patient's commentary provides the C-CTherapy® clinician with an insight into those victimizing thought-voices operating in the patient's functioning mentality. Next, the therapist highlights those thought-voices for the patient. Here's the question the therapist asks:

Therapist: "What thoughts or words do you hear popping into your head, again and again?"

Patient: "I keep hearing thoughts like `be nice' and thoughts like I `ought to do what they wish'."
Therapist: "That's good, that's what we call thought-voices."

The therapist continues to listen for variations on the theme presented by his patient. Some common ones are: "get rid of bad things" or "you must behave right" or "this is what you must think". These parental declarations originate from early mental development because they are basic to parent-child interaction and are absorbed by the patient from the family setting. For instance, here is how the C-CTherapy® clinician interacts with the patient on the issue of early mental development.

Patient: I was told not to make negative statements.

Therapist: Who talked like that when you were a kid?

Patient: Both my parents. They said; `think before you speak'. `If you can't say something nice, say nothing at all'.

Therapist: This tells you who you inadvertently copied.

Patient: Yeah...are these thoughts normal?

Therapist: Yes, you could not have done differently. When you were little -- when you were mentally developing -- you absorbed this commentary. Now, as an adult, it is in your non-volitional pattern. You could not have avoided absorbing these kinds of attitudinal items. These inadvertently copied items produce the foundation for your original pattern of reacting. Our job now is to get a clear picture of who you copied and how you put yourself together from the time you were little.

Patient: You mean it's OK?

Therapist: Not only am I saying it's OK, it is humanly impossible to not have mental habits from early times.

Patient: Good habits, right?

Therapist: No! Mental habits don't fit into good or bad. C-CTherapy® assumes that habits are habits are habits. We focus only on neutralizing the habits which victimize us.

The therapist draws the patient's attention to the words in the thought-voices and identifies their themes. Throughout one's life the themes remain the same, only the contents change.

Therapist: "That's a good sample of `get it right', or, `there is an absolutely right way to behave'."

Patient: "Yes, now the voice is saying that `I shouldn't think like that'."

Therapist: "That's good, become familiar with that voice. You'll hear it frequently because we just discovered that it is one of your thought-voices."

The challenge is for the patient to perform this identification exercise outside the office and without the therapist's help. By consistently alerting himself to the repetitive mental rumination, the patient eventually learns to handle this mental material in a new way. He begins to appreciate that this mental material is simply habit-based and only representative of past mental conditioning. In short, repetitive mental rumination has no occult or mystical or pathological origin. By its very nature, a mental preoccupation keeps the patient's thought processes moving in a repetitive and circular fashion. The patient, therefore, is victimized by the constant barrage of repetitive mental ponderings, jam-packed with negative subject material. The patient experiences that these thought-voices result simply from the workings of the patient's non-volitional pattern. This recognition demystifies the patient's mental turmoil and in itself gives relief.

The Therapist-Coach Acts as a Mental Traffic Director

The C-CTherapy® clinician, by identifying each of the patient's mental items as they emerge, performs the role of a "mental traffic director". The therapist-coach assumes the posture of neutrality, regarding the patient's thought-voices as merely an example of mental functioning. It is the therapist-coach's mandate to have the patient view thought-voices, also, as only mental functioning. The object here is to get the patient to view the thought-voice habit in a neutral fashion. While the therapist-coach identifies, the patient imitates him so that, eventually, he becomes his own mental traffic director!

C-CTherapy® Treatment Does Not Apply to Groups

By practicing C-CTherapy® exercises supervised by the clinician, the patient builds his own skill of emotional self-management. The skill is customized for each person because each person's reactive system is unique. For, it is the uniqueness of one's reaction system that makes sisters different from sisters and brothers different from brothers. It is this feature of uniqueness which makes it impossible to customize a skill in a group setting. The skill is not transferable. For instance, my tennis playing brother cannot transfer his tennis playing ability to me without teaching me the game of tennis. A skill is not osmotically absorbed from the group.

The Patient Discovers the Power of the Non-volitional Pattern

The patient must discover for himself the weakness of the volitional division compared with the power of the non-volitional division. To do so, the C-CTherapy® clinician challenges the patient during the session: Can you promise me you'll never get mad again in your life? The patient, of course, realizes that he cannot comply. It becomes clear to him that no human being can satisfy the terms of that challenge. In this stark fashion, the patient learns about his own mental capabilities. He discovers that he cannot turn off, at will, the workings of his non-volitional pattern. The patient faces the futility of telling himself: "Stop reacting!" His participation in such experiments help him detect and activate real information and provides a taste of how he will mentally apply himself once he's built a mental alternative.

Indeed, the patient learns what the Center's research has uncovered; the non- volitional division of mental functioning is the source of illogical and aberrant behaviour. One's volitional division of functioning mentality -- that is, logic and reason -- does not produce emotional upset.

The patient's discovery that logic and reason has no impact on the illogical emotional pattern is a revelation to him. That there exists such an ability of shifting one's mental stance so that one can oppose negative thought-voices is another revelation. This discovery precedes the patient's ability to interrupt the obsessive demands of the repetitive thought-voices. This procedure of shifting away from the thought-voices inaugurates a countering routine with its accompanying methodology. It is this process which creates a mental alternative to the negative items in the patient's non- volitional pattern.

A Sampling of What the Patient Brings to the Session

(1.) The counselling-voice

The counselling-voice is the thought-voice that patients confuse with logical reasoning. The counselling-voice is the one which tells us how to behave. It is the same voice the patient heard as a child listening to parent instructions saying `Don't take candy from strangers', `Don't fight amongst yourselves', and `Don't burn yourself on the hot- plate'. In short, these are the parental admonitions which protect the growing child and

ensure his or her survival. (The reader has his or her own personal examples of these parental directives.)

The therapist orients the patient with regard to the composition and style of the patient's counselling-voice. The therapist points out to the patient that the counselling- voice resembles reasonable thinking in that it preoccupies the patient's thoughts with "figuring out the right way to behave".

The patient brings to the skill-acquisition process the mentally conditioned reflex of figuring out human behaviour -- his and others. By consistently identifying the counselling-voice, the patient begins to associate it with a function. He gains familiarity with what was, previously, an unknown automatic activity. For example:

> Patient: I don't understand.
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> Therapist: Ah Hah, your counselling voice says you don't understand. What does that conditioned part of you want me to do?
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> Patient: My counselling voice wants you to explain yourself so I can figure out whether or not I agree or disagree with you.
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> Therapist: Your counselling voice belongs to your mental functioning. You will hear it throughout your life. It is a normal activity -- not right or wrong. Mental functioning is neutral. Since I have more practice than you at detecting thought- voice activity, I will alert you to them, so you can begin to detect them for yourself. Patient: OK.
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> Therapist: Currently, you can't detect your mental functioning all by yourself because you are living the action in your head. That's why it is difficult to get a handle on the functioning which dictates your behaviour. When you leave the office and go back into the community you are immersed in your old pattern. That's why we use our sessions to practice detection.
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> Patient: Yes, my counseling voice tells me to catch and remember what you're saying.
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> Therapist: I agree that you're listening very hard for the formula of right behaving.
>
> Patient: Yah. Give me a gold star.

(2.) External Solutions to Mental Turmoil

Another indicator of the thought-voice habit is the push to solve one's upset with an external solution. In the following illustration, the external solution is the purchase of a house, but it could easily be the purchase of a new car, a new boat, new clothes. The Center calls this mental maneuver, buying things for the purpose of lifting one's mood, the BURMUDA SYNDROME. Finding a solution, externally, so the myth goes, will permanently improve one's mental state.

> Therapist: So you're looking for something out there to do it for you?
>
> Patient: Yah! Buying a house will make me feel better.

Therapist: Will this solution get rid of your upset forever?

Patient: Well, it will make me feel like I've got something that's mine.

Therapist: We've got a myth working -- that there is a solution to your problems, all you have to do is locate that solution.

Patient: That doesn't make sense.

Therapist: You are right, because it's a fiction.

Patient: Here, I was looking for a quick-fix solution!

Therapist: Good! Now, you can hear the workings of the Bermuda syndrome as if your new house will guarantee mental tranquility forever.

(3.) Thought-Voices Produce Behaviour

Most patient's don't realize that their behaviour comes from mental functioning. It is an important task in the therapist-patient treatment process for the patient to learn how thought-voices connect with behaviour. Here is an example of an angry patient who is out to teach her boss a lesson.

Therapist: Your attitude is what I call, `Piss on them!'

Patient: Yah. It makes me feel less bullied by them.

Therapist: Can you hear thought-voices motivating you?

Patient: I don't know, I guess I want to get back at them. In fact I even uncovered a bad mistake my boss made.

Therapist: Ah hah. You caught him out! Could you hear a voice commenting on your boss' stupidity?

Patient: Yeah, the voice says my boss is an idiot.

Therapist: Good, you heard the thought-voice.

Patient: I got back at him, but my boss wasn't there so he doesn't know that I made him pay for it. I slowed down and didn't do much work.

Therapist: You've just verbalized the voice telling you to teach him a lesson. Patient: Yeah. So what?

Therapist: Now you know the mechanism that causes you to give them "the finger."

(4.) Repetition of Thought-Voices

Repetition of thought is a characteristic of mental activity. The patient experiences how his mind repeats a menu of negative thoughts. This phenomenon of conditioning is further illustrated here.

Therapist: What thought-voices do you hear?

Patient: "You're screwing-up again and they're going to find out".

Therapist: This is how you make yourself miserable.

Patient: Yah. I hear that. I can feel the anger inside.

Therapist: Thinking back, how long have you heard this kind of thinking.

Patient: Now that you mention it, it seems that I've thought that way as long as I can remember.

What the Patient Discovers: The Outcome of the Therapist-patient Interaction.

The patient is working on several facets simultaneously. As the patient begins to recognize that neither his reasoning nor logic is capable of coping with his illogical non-volitional functioning, he is also discovering the style and character of his reactive pattern. Next, by practicing other exercises -- taught by the C-CTherapy® clinician at the Center -- the patient gradually dilutes the power of the victimizing thought-voices. Instead of routinely validating them, the patient now practices interrupting his old habit each time it is activated. This ability marks a significant change from his former obliviousness and inability to recognize mental habit-based activities.

For instance:

Discovery (1.) I had no idea how my reactive system worked or that it runs my behaviour.

"My mental busyness increases my emotional tension. I get anxious when I'm preoccupied with safety and survival. I want to guarantee that my relationship will last forever".

Discovery (2.) I'm getting used to what my head is doing.

"This detection exercise helps me to uncover my mental mysteries and lets me operate differently."

Discovery (3.) I ran around being manic because I was depressed

"I realize how my depression made me feel very high or very low.

Discovery (4.) I heard my thought-voice say: you can only count on bad things.

"So, my good feelings get squashed by my conditioning of `life is a disaster- zone'. I'm surprised that feeling good is possible and that it's OK."

Discovery (5.) I discovered an old emotion which I thought had gone away but is still around. "

My sad, mourning activity still pops-up once in a while. I don't get so upset, but I still have the traumatic memory. At least I am identifying the memory as a mental habit."

Before C-CTherapy®, the patient behaved reflexively in accordance with the demands of his thought-voices, unaware of their presence and unaware of their influence. In the past, the absence of a mental procedure left the patient with no alternative to turmoil. Therefore, he had no means of operating differently. But now, the patient recognizes immediately when his thought-voices are running him. At this stage, the patient has created a foundation and can now acquire a dependable and consistent coping mechanism.

SUMMARY.

(1.) C-CTherapy® is the first cross-cultural psychotherapy in that its treatment design incorporates human behaviour universals.

(2.) C-CTherapy® applies a unified non-cognitive, non-counselling treatment design to the patient's problem. The treatment goal is that of teaching the patient a personal mental health "skill". The patient will employ this skill each time he is beset by non- volitionally created mental turmoil.

(3.) Unlike counselling medical-model therapists, the C-CTherapy® clinician does not assume the role of EXPERT on the patient in respect to the workings of his functioning mentality.

(4.) In the C-CTherapy® treatment process, the therapist accepts the patient's verbalized commentary as factual. As well, the patient is an equal PARTNER in the non-counselling treatment process and so contributes equally. C-CTherapy®, is the first ever psychotherapy of this kind.

(5.) In each session the therapist introduces exercises which are tape-recorded by the patient for practise during the week.

(6.) The impact of the exercises taught by the C-CTherapy® practitioner accumulate to form a mental health skill which corresponds with the goal of emotional self- management. Thus, the patient acquires a dependable means of moving away from being chronically victimized by his own emotional mentality.

(7.) C-CTherapy® is the only treatment format to distinguish between behaviour produced by the VOLITIONAL division from that produced by the NON-VOLITIONAL division. As a result, C-CTherapy® directs the treatment effort at the division which has the operant capacity to victimize the patient -- the emotional, illogical NON- VOLITIONAL division.

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