Non-Drugs Therapy of An Anxious Teenager
by

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ABSTRACT: A physician-diagnosed case treated by a non-medical, systems-based model illustrates the differences between the medical, symptom-based model and the human behavior model in the treatment of mental health cases.

Recently, in the morning paper, a youngster described her situation. As a therapist, I was struck by the similarity of her case to that of the young girl presented in this monograph.
'I am 13...I have depression and suffer from an obsessive-compulsive disorder called trichotillomania (hair pulling). I have considered suicide, and I am in therapy...'[1]

While this youngster treated by the medical model is labeled with a disease, the diagnostic format widely applied in mental health cases, the Center for Counter-Conditioning Therapy® avoids medical labels and treats tension and anxiety cases from a human behavior perspective. This clinical monograph presents that human behavior model.

INTRODUCTION

LaToya walks with dignity across the high school auditorium stage, her long dark hair accenting the sheen of her commencement robe. She accepts her diploma, shakes the provost's hand and walks into the arms of her proud mother, uncle and grandmother.

What is the background to this successful scene? Three years earlier, unable to concentrate on her studies, LaToya was failing in school. Afraid to face her mother with a report card full of Ds and Fs, she forged her grades to read Bs and Cs. In her distress, she had pulled out large patches of hair, leaving bald spots.

When her mother first contacted the Center for Counter-Conditioning Therapy® about her 14-year old daughter, she said, 'I've done my best, but nothing has worked. My daughter has seen two counselors and now she's under a psychiatrist's care. He's given her medication, but she's worse than ever. She won't look me in the eye; she just tugs and tugs. I find tufts of hair all over the house. The psychiatrist diagnosed her illness as trichotillomania and said she had other anxiety and tension related disorders. She's been taking medication for

nine months and it should help, but she is getting worse. I've lost my girl, Ã«cause now she's a zombie.'

Mother blamed herself. She was sure she had been a bad parent, and had done something to mentally cripple her child. One counselor had told her that she was too strict. Another told her she was too soft. All implied that she was not parenting right, that Mother was the cause of her daughter's ailments. But Mother could not figure out what she had done wrong.

'I've made huge personal sacrifices for LaToya,' she said, ' paying for private schooling, tutors, counselors and the psychiatrist. I even moved us out of our hometown to get her away from the dangerous neighborhood. School officials are going to kick her out if she does not improve. I tell her, Ã«LaToya, if you're going to fail, you can fail in public school. I'm not paying private tuition for you to screw up your life.' I've done everything I know to do, but I've messed up. Now I'm giving up. I'm ready to send her to her father. Maybe a father's hand will do some good. What should I do? Can you help?'

That is when I, as the C-CTherapy® practitioner accepted LaToya, age 14, into the Center's short-term program of six sessions. My purposes were several: take the mystery out of LaToya's strange behavior and provide immediate relief from her mental turmoil. The Center's field research and clinical design has found that demystifying the patient's turmoil, in and of itself, goes a long way toward changing the mental atmosphere under which any person functions. At the end of those sessions we (the three of us) would assess whether the short-term program had been sufficient. Here are the questions I would pose during the assessment: Had we clarified and taken the mystery out of LaToya's puzzling behavior? Did we think she would benefit from proceeding into long-term therapy? The purpose of long term-therapy, I explained, is for me to instruct LaToya in emotional self-management training. For the patient to build an emotional self management skill and mentally operate more effectively. That is why the program is long-term.

SHORT-TERM PROGRAM

LaToya's short-term program began when she arrived in my office for the first of six sessions. About 5'7", she weighed about 280 pounds, her long hair arranged to camouflage bald patches on her scalp and hairline. She watched me carefully through hooded eyelids, her brown eyes veiled with tension and medicated stupor.

LaToya speaks: I am 14 years old, I am adopted. My father left when I was three years old. My mother has raised me on her own. There is something wrong with me, but I don't know what it is. I try to do my studies but I always screw up. At school I'm on probation. They'll probably kick me out. Anyway, the dean says that if my grades don't improve I can't play sports. Basketball is my game and I would be very sad if they kicked me off the team.'

'Tell me why you think we are meeting together,' I asked.
'I worry about my friends a lot,' she said. 'I get mad at my girlfriends for starving themselves and scaring me. They always talk to me about their problems so I don't get my homework done. I altered my grades. I didn't want Mom to get mad at me. I didn't want to disappoint her. Mother threatens to send me to live with my father. I hate him. I haven't talked to him in three years. He lied to Mother and me about his girlfriend. I'll never forgive him. Anyway, he doesn't care about us and I don't want to leave my mother.'

With this introduction, we set to work immediately. I asked her to draw a circle on a piece of paper and divide the circle in half. Then I explained the concept of thought-voices, thoughts that pop into her head.

'You can be walking along the street minding your own business when suddenly a thought pops in. These

thoughts are different from those thoughts you set out to think.'
Immediately, LaToya knew what I was talking about because she had heard herself thinking this way. For instance, the thought that kept popping into her head was *Where's my mother*?
'Do you mean uh-oh, is Mother okay?' I asked.
'Yes. I'm scared that something bad will happen to her,' she said.
'What sorts of bad things do the voices say will happen to Mother?' I wanted to get her scenarios out into the open.
'She's going to die in a car accident, going to get beat up and robbed, going to...,' she said.
'Good,' I said, 'There's an un-oh thought-voice. Can you tell me how that thought makes you act?'
'Scared,' she said.
'Does knowing where Mother is make you feel safe?'
She nodded her head.
'So you must watch her and check up on her? Is that right,' I asked.
La Toya nodded.
'That must make it hard for you to leave her side, like sleeping over at a girlfriend's house,' I said.
La Toya looked at me -- a look of registration Ã± someone finally understood what she was struggling with.
I asked her how loud were the voices.
'Very loud, they talk all the time and I don't know what to do.' She thought maybe she was crazy. 'I guess I'm stupid, messed up. I don't mean to be bad.'

We discovered more examples of her current thought-voices. For instance in subsequent meetings, she reported that on her way to our session, she heard her scare-voice: *Uh-oh, what's going to happen? What will I talk about?*

Also, during each session she'd report the voices asking, *Where's my mother?* We identified this as her 'uh-oh' voice that constantly signaled disaster and danger. When I asked her who talked 'uh-oh' talk in the household when she was growing up, LaToya thought a moment and said, 'Grandma. We used to live with her in a dangerous neighborhood.' When LaToya and her mother moved to a hilly neighborhood, Grandma worried that their cliff-side house would slip into the gully below. LaToya refused to drive across the bridge, take public transportation, or go anywhere alone, her anxiety level shot up too high. LaToya was absorbing Grandma's fears. She was on her way to becoming a phobic.

'What's wrong with me?' she asked. 'Am I crazy or, worse, am I in the clutch of the devil?' 'Do I have a disease?'
'No, none of those things applies to you,' I told her. She was not a bad seed in the clutch of the devil. What she was hearing in her head were merely thinkings. These thinkings were hers and hers alone. 'No, You do not have a disease or bad genes. The reason the doctor gave you medication was that he didn't know how else to help you. That was his failing, not yours.'

Here I explained how all human beings acquire mental conditioning and thought-voices. From birth we absorb osmotically the attitudes, mannerisms, emotional and mental postures and reactions from people around us. 'Like an ink blotter,' I said, 'we soak up impressions of the grown-up people talking and behaving who surround us.' This osmotic mental absorption is the normal process by which every sentient human being who survives to adulthood acquires mental conditioning. As I presented this perspective about her confusing behavior, LaToya's mental fog began to clear.

I also introduced the fact that all people think. Every person on the planet has thoughts. Thinking is a universal

human characteristic. In fact, people can hear their thinkings if alerted to do so. 'Right now you don't know how to handle those loud voices talking in your head,' I told her, 'because no one has taught you how to view and deal with them. I am going to teach you how to cope with all that mental noise.'

All the while, LaToya had to struggle to hear me through the haze of medication clouding her mental functioning. From our first session onward, she tape recorded our sessions, a C-CTherapy® requirement for all patients. Each week she listened to her tape several times. That was her homework and it would help her unclutter her mental turmoil and organize her busy head.

Mental Exercise: 'The Check-List'

During the short-term program I would teach LaToya several mental exercises. The first was one the Center calls 'The Check-List.' I chose this particular one because she needed a way to quickly interfere with her anxiety. This exercise is designed for that purpose. Further, I wanted to introduce her to the novel notion that she had the capacity to work with herself. All she had to do was learn how.

'Ask and answer these questions,' I told her. 'What's my name? What is the address here? What is today's date? Who is attacking me? What is threatening me? I want you to run through this checklist many times. I know you intellectually know the answers. But intellectual knowing is not why you're posing these questions to yourself. You're asking them because you are building a mental platform. This platform and the accompanying exercises interrupt the scare voice,' I told LaToya. There was more to give her about the purpose and practice of this exercise, but this information was enough for starters.

The following session she returned to tell me of her success. While she took an English test, she practiced the checklist. She was able to interrupt her thought-voices long enough to concentrate and finish her exam without tugging her hair. Later, she used the exercise during another momentous occasion. She feared school retreats. But now, armed with her check-list, she had a framework from which to appease her negative thought-voices so that she could tolerate the school sleep-over. She reported happily that her checklist worked while she played tag with her classmates in a darkened room.

These successes were important for LaToya, as they proved to her that she could make this new approach work. She now had a way to manage her hair tugging and nervousness. She wanted more. She had a baby-sitting job each Saturday night. She liked reading to and playing games with the little boy and girl. But she dreaded their going to sleep because then the house was quiet and she was all alone with her thought-voices that said bad things were about to happen: burglars might come or fire might ignite. I asked how she had managed before coming to the Center and learning the check-list. She had turned on the computer and had listened to her radio. Why did she do this? Those activities had distracted her from the negative content of her loud thought-voices. I congratulated her on being creative in coming up with such distractions. Unfortunately such tactics do not work when one is trying to sleep. That is why LaToya and I were going to identify the tactics she had developed and use them deliberately.

We settled upon a two-part strategy to deal with her baby-sitting fear. The first, her check-list with which she already had practice, compelled her to obtain current information from her surroundings. The second gave her a solution. I instructed her to take with her to the babysitting job a flashlight and her cell phone. When she heard her 'uh-oh voice,' she was to investigate the house with her flashlight in one hand, her phone programed to 911 in the other. She could confidently check for danger because she had a plan, she knew what to do if, in fact, there were a threat. These strategies put up opposition to the fear-mongering voices, rather than succumbing to her victimizing habit. But following this new approach meant challenging her uh-oh voice. A scary action in itself.

But she did it and got away with it Ã± I congratulated her. In fact, she had survived the exercise of getting contemporary information to work for her. She took great pride in this large accomplishment.

Mental Exercise: 'Countering'

Another exercise I taught her during a subsequent session was called 'Countering.' I told her we were going to practice with a new perspective - that the uh-oh voice is a thought-voice based on habit, mental nonsense, so to speak. Each time she heard 'uh oh' she was to put up opposition to her scare-mongering habit by practicing her new exercise. 'In your head repeat *garbage*, *garbage*, *garbage* over and over again.[2] When you drift off of it, don't worry, just start up the repetition again when you next detect the Ã«uh-oh voice',' I said. I explained that countering is used as a mental grinding device. It repetitively interrupts mental traffic and, over time, wears down obedience to long established mental habits. This procedure also yields immediate results. The benefit of the mental exercises lays in the deliberate interruption of long-term negative mental habits.

EVALUATION OF SHORT-TERM PROGRAM: HOW THE HUMAN BEHAVIOR-SYSTEM DESIGN DIFFERS FROM THE MEDICAL-SYMPTOM MODEL

At the sixth session, the three of us I evaluated our strategy. Mother's questions centered around two concerns, moral and medical. The moral concern emerged in this question: 'Was LaToya lazy?' All the professionals, the teachers, psychologists, tutors and pediatricians remarked on LaToya's intelligence. She could do anything she wanted to, they said, 'if she would just apply herself.' If that were so, Mother concluded, then LaToya's problems lay in her character. She must have a character flaw.

In my view, laziness is not a disease, therefore, it is not a medical problem. LaToya was not slothful or shiftless. LaToya's behavior had nothing to do with morality or motivation. Instead, she was distracted by a busy head caught up in mental turmoil. The voices demanded so much attention that it would be difficult to listen to her teachers or her tutors, much less study on her own.

'If my daughter is not lazy and her moral character carries no flaw, then she must suffer from a disease or genetic defect,' Mother voiced her second concern. After all, she concluded, LaToya's biological history was unknown because she was an adopted child.

I informed Mother of how medicine had combined with morality to form behavioral diseases.[3] Since before Freud, I told her, the premise and design of physical medicine has been misapplied to emotional behavior.[4] Mother, as with most Westerners, comes from a long history of relying on the medical industry for answers to all problems, including mental, emotional and behavioral difficulties. That indoctrination included the following elements: That there was a disease underlying her daughter's odd behavior, that the psychiatrist or mental health practitioner would investigate the symptom, taking a history and delivering a diagnosis. Then this logical process of explanation and understanding would alleviate her daughter's turmoil.

The differences, I explained, between the medical-symptom model and the human behavior-system design, are profound. The medical model presumes that human emotional behavior and mental agitation come from ill-health and disease; that a pathogen or genetic defect is the sole or primary determinant of emotional behavior; that the doctor looks for and treats the patient's symptoms. The human behavior model, on the other hand, conforms to the fact that all human beings behave and think. Behavior and thinking are universal human characteristics, the contents varying from culture to culture and from person to person. Each of the many billions

of us who populate this planet carry individual variations; that is, as many variations as there are people.[5] Instead of seeking out the pathogen that is supposed to cause a patient's emotional behavior, the system design look to that individual's mental conditioning. Mental conditioning includes the absorbed impressions collected from infancy onwards, forming the mental reservoir of thought-voices. Mental conditioning drives one's functioning mentality, the interplay between the two divisions of mentation, the logical and the illogical.[6] As we discover the ingredients of the patient's mental conditioning, we teach that person how to cope with those few features in his or her mental system that constantly victimize him or her.

While the medical model assumes the doctor to be an expert on the patient and his disease, the human behavior model presumes the patient to be the expert on himself and, therefore, is the only one who can implement emotional change and relief. That is why the human behavior-system model replaces the doctor-patient structure with that of the teacher-student team. (See graph in summary.)

Most importantly, each person's mental conditioning combined with his innate sensitivities, his intelligence and his creativity, emerges as a discrete personality with particular behavioral patterns each sharply distinguished from the next person. The counseling formula does not allow for these unique differences. That is why a counseling formula and medical template had been useless for her daughter. LaToya's mental functioning and conditioning in its unique configuration belonged to LaToya, to her alone. She was the only one who could intercede with her mental functioning. That is why LaToya would be building during a long-term program a mental option for herself. She would be putting together a way to work with the source of her anxiety and hair tugging.

Mother had counted on the psychiatrist's diagnosis and his prescription of psychotropic drugs to rid her daughter of her symptoms. But the medical approach had failed. Although Mother recognized that failure, she was still suspicious of non-medical treatment. After all, doctors convey the mystique that they are the experts on all facets of human life. It is true, they are experts on the physical body. They are not, however, experts on mental conditioning, mental functioning or upon human behavior. Mother's indoctrination -- her belief in her doctor as the expert on LaToya Ã± had grown over Mother's thirty-five years of living.

Mother asked me if her rules interfered with what I was doing. She had heard 'so many different comments' from LaToya's past counselors that Mother thought she had to parent a 'right way' or she would 'undo' the counselor's work. Should she be parenting differently?

I told her that the counselors spoke only from an hypothesis, not from a God-given, absolute right way to parent. In other words, counselors were speculating about human behavior. Unfortunately, the barrage of psychological analysis has left parents confused as to their roles and responsibilities. I told her that she was not the sole influence of her daughter's development. Her daughter would absorb items of mental conditioning from many sources including her extended family of grandparents, uncles, aunts and even from the broader society of teachers, church, media and so forth. If there were such a thing as right parenting, Mother would have the ability to control how LaToya interpreted all her young impressions. In short, she would have absolute power over LaToya.

'How will you control LaToya's mental processes from birth onwards?' I asked her.
She thought a moment and said, 'I guess I can't.'
'That's right,' I said. 'You are not in charge of that process. Each of us unknowingly puts ourselves together through the process of acquiring mental conditioning and mental maturation. You are doing your parenting job of influence by providing food, shelter, and guidance. You don't, however, receive in return a robot-child. Each child absorbs bits and pieces uniquely and singularly. Each puts these bits together in an unique configuration.

That's why siblings, though reared under similar circumstances, develop different personalities and emotional reaction systems.'[7], [8] And there are as many configurations as there are people; namely, many billions.

I introduced a distinction to Mother. I am teaching LaToya how to deal with LaToya. Mother's domain, different from mine, includes running her household with rules, consequences, routines and such. Her job is to create an environment of consistency; that is, coherent household rules and penalties for disobeying those rules, reliable and uniform enforcement regardless of Mother's mood or energy. In other words, creating a mentally predictable family atmosphere. My job is teaching LaToya how to operate more effectively as a human being in any atmosphere.

Although Mother committed her energy, time and financial resources to LaToya's well-being, she viewed LaToya through her own mental conditioning, and that was one of negativity. She looked continuously for what was wrong with LaToya, rather than at her daughter's progress. It would be necessary for me to whittle away, over time, Mother's habit of doubt. Despite LaToya's accomplishments which Mother witnessed for herself, Mother's conditioning kept her clinging to her habit of skepticism. Although she would question the Center's approach for some time to come, she agreed for LaToya to move into the long-term program.

LONG-TERM PROGRAM

Goals of the long-term program differ from those of the short-term program. The short-term program aims to take the mystery out of the patient's mental turmoil. For instance, illustrating the composition of LaToya's thinking processes, both illogical and logical, served to demystify her puzzling behavior for her. LaToya recognized that, finally, someone knew what she was talking about and could help her through her mental fog. She felt as though, maybe, she were on the right track. But, as she had only participated in the short-term program, she had not yet accomplished anything substantial, substantial enough to sustain her through her lifetime. A lifetime's ability is the goal of the long-term program.

During the long-term process of building a platform from which to operate more effectively, LaToya and I would address many clinical issues including: discovering the range of content in her thought voices including the ever-present habit of self-sabotage; ambient anxiety and the production of trauma; and, dealing with Mother. We would also address medication and Telepsychotherapy. Each session would follow the by-now familiar format of LaToya recording her session, carrying out her weekly homework assignment of listening to her tape and practicing the exercises therein described.

Our sessions now turn to detecting on-going thought-voice activity. Familiarized now with the uh-oh thought-voice, LaToya could expand her range of detection. I told her that whenever she felt upset, scared or tense to check into her head and discover what the thought-voices were saying.
'Get used to identifying those repetitive thinkings,' I told her.
'Sometimes I don't hear anything,' she said.
'Do you notice when you're upset?' I asked. 'When you're sad, unhappy or angry?'
'Sure,' she said. 'My other counselor taught me about my feelings.'
'Yes,' I said. 'You're used to noticing your emotions. But you're not used to noticing the thinking that goes on inside your head that produces your emotions. Those are the workings of your thought-voices. We want to advance, so now you are training yourself to detect thought-voices in your head because they determine how you mentally operate.'
She looked at me. This was heavy stuff for a young teen.
' Also, right now your thinkings Ã± we can call them mental traffic Ã± are so fast that you don't catch them. Don't worry. Detection will get easier and you'll discover what is running you.'

Through my description she came to recognize thought-voices she had already encountered. For instance, *I'm a failure. I can't. I'm stupid, bad, lazy. Why bother (studying, playing basketball) , it won't work.* These messages interchanged with the scare voice - *What's going to happen in the session? Where's my mother?*

It was at this time, I suggested to LaToya that she tell her mother about the thought-voices, giving LaToya practice in reporting information about herself, another step in interfering with her mental traffic. This assignment in and of itself demanded courage from LaToya. She had to go against those thought-voices we later identified as sabotage-voices that said *Keep quiet, don't let anyone in on your secret, don't let them know how crazy you are.*

One afternoon LaToya plucked up her courage and told Mother about her thought-voices. Mother was relieved that LaToya was getting a handle on the mystery that had plagued them both. LaToya was surprised when the disasters that her sabotage voices predicted did not occur Ã± her mother did not disown her, love her any less, think she was crazy, bad or sinful.

This exercise was informative for Mother also, as it opened the topic of LaToya's emotional sensitivity, partly a result of being born with crack cocaine in her blood. Those of us who, for whatever reason, whether it be crack cocaine or constitutional hypersensitivity, react more forcefully to our surroundings.[9] Add to this characteristic that of high intelligence and we have got a busy head. This busy head, though normal, can also drive us to distraction. Thus, I further clarified the task ahead of LaToya and myself. I would teach her how to operate more effectively given her heightened sensitivity.

LaToya could hear for herself all kinds of thought-voices resounding in her own head now; after all, her head is where she lives. She was starting to get a handle on this human phenomenon and the fact that everyone thinks all the time. Thought-voices in the form of thinking become the basis for behavior production. Her discoveries that thought-voices were merely thinkings and not absolute truths released her further from the myth that she had no input or control over how she functioned. She felt better.

As we moved along, she gained proof that the voices were not destroying her. She grew braver. I wanted her to recognize that the thought-voices she was accustomed to hearing belonged to her, and were hers alone. Those voices represented her to herself. I reminded her that we were not at war with her thought-voices. 'We are not in the renovation business,' I told her. 'We are in the operating more effectively business. Therefore, mentally battling with yourself is not our purpose.'

I clarified for LaToya that people cannot avoid thinking their inadvertent and habitual thoughts. LaToya said she had never considered the voices as so much habit. It was a strange possibility, but a hopeful look into the future. For now, when she heard the victimizing thought-voices she had exercises to practice called 'Countering' and 'The Check-List.'

Mother recognized that LaToya was feeling better. LaToya, herself, told Mother she was benefitting, but she was still very anxious. I guessed at the source of her agitation, a reaction to medication her psychiatrist had prescribed almost a year before and which she was still taking. Unfortunately, the physical toxicity generated by the chemicals were not only making LaToya constitutionally anxious, the toxicity was contributing to her preoccupation with negative thinking: Grandma's plane would crash. Cousin would die at war. Mother would find a new husband and abandon LaToya.

I told Mother, 'Get her off those drugs.' I anticipated reluctance to do so by the psychiatrist. 'If the prescribing psychiatrist will not guide her off with reduced dosage, find a physician who will. 'Because,' I said, 'the

literature, testimonials, and anecdotal evidence all report withdrawal from these drugs can have severe side effects.'

Sure enough. The psychiatrist instructed Mother to halve LaToya's dosage every week and, having no other solution, abruptly dismissed this case. As Mother halved the dosage, LaToya felt light headed and mildly nauseous, dizzy and off balance. Several times she fell down. The most serious incident was on the basketball court where she broke her leg. She could not walk and could not come to the office. That is when the convenience of the Center's Telepsychotherapy program served her well. The program allows for the comfort and privacy of holding sessions in the patient's own home or office, without traveling anywhere.

At first, Mother's medical indoctrination caused her to question the efficacy of this approach. She was so accustomed to meeting with doctors, counselors and psychiatrists in person that she viewed Telepsychotherapy as less potent than face-to-face meetings.

'Naturally,' she said, 'telephone appointments will just be temporary Ã«cause it's not as good as LaToya seeing you in the office.'

'Actually, Telepsychotherapy is even more efficient than office visits,' I said, 'because the patient, in the comfort of familiar surroundings, confronts less distractions. She's not examining the office decorations or checking me out to see what I'm wearing and whether or not I'm smiling. The patient's attention is fully concentrated upon her therapy program. Her project is to discover how her head is working. Her project is not to figure out how the therapist's head is working.'

TELEPSYCHOTHERAPY

At the Center we make a distinction between friendly visiting and acquiring the skill of Emotional Self-Management. When LaToya met with her counselors, their method was to bond with LaToya and develop a relationship. Because of their 'friendly visiting' and the therapist/patient bond, LaToya would get better so went their belief. Relationship therapy would act as the change agent, their relationship the curative. Likewise the psychiatrist's diagnosis and treatment required in-office face-to-face visits. The psychiatrist, however, expected the pills he prescribed for LaToya to act as the change agent and cure LaToya.

The Center's method of Emotional Self-Management Training instructs LaToya as she builds for herself a mental option, a mental platform from which to operate more effectively. That she and I get along and like each other is not the change agent that will improve her functioning. After all, I'm not there with her at all times. Instead, the process of building her ability to cope with her turmoil each and every time she is in trouble with herself or other people is what improves her mental functioning. Consequently, I do not need to meet with LaToya face -to-face to instruct her. She does not need to see me to follow my directions. She needs to hear me and to tape record our session just as she did when she came to the office. She now does all of that by telephone. Then, of course, she needs to listen to herself on the tape and practice her homework during the week. In fact, she could have begun her long-term program with telepsychotherapy, never coming into the office in the first place. But accustomed to the friendly visiting format of traditional counseling programs, she began with in-office sessions until circumstances demanded a more convenient arrangement.

'Wow, Telepsychotherapy is great!' Mother said. 'But how do you know it works as well as in-office appointments?'

‘We know from decades of research findings at the Center that relationship therapy does not work,’ I said. ‘We know that the Center’s Telepsychotherapy works because our patients report the before and after differences in their functioning. Also we’ve been collecting clinical experience and field research since 1975.’

Here is a Telepsychotherapy vignette. LaToya calls me at the appointed time.

‘What thought-voices are you picking up on?’ I asked.
‘I deserve this broken leg Ã«cause I messed up,’ LaToya said.
‘You mean you were chosen to break your leg?’ I said.
‘Yes,’ she said.
‘So who or what did the choosing?’ I asked.
‘I’m being punished for something,’
‘By whom?’
‘I don’t know.’
‘I sense this accident was a result of bad timing. I suspect your bad timing was the result of withdrawal from medication.’[10]
Silence on LaToya’s end of the phone.
‘What thought-voices are you hearing?’ I asked.
‘Prof. Ilana is wrong! Don’t listen to her. I’m a failure. Breaking my ankle was meant to happen.’
‘ I hear negative thought-voices at work. Do you?’
‘Yes but, I was supposed to play at tomorrow’s game. I’ll never be able to play again.’
‘Is that what the voices are saying?’
‘Yes.’
‘Sounds like the voices are saying, Ã«Don’t count on good things. Count only on nothing going right.’ See how thought-voices work? When you listen to the tape, you’ll be able to pick up on the negative thought-voices. There’s your homework.’

Telepsychotherapy demands the same participation from patient and therapist as in-office visits. The patient must listen to her tape between sessions and practice the exercises it outlines. Through this process the patient builds the mental platform affording greater mental and emotional efficiency. Listening to the tape, in itself, is more of a challenge than the patient initially anticipates. Patients often look to the tape for instructions of how to think, behave, and emote just as if they were in counseling. In other words, they look to the tape for quick-fix answers. They soon find out, however, that the tape holds no instant solutions. Instead, the tape serves as the foundation for the building process; it serves as a discovery bank, a reservoir of the patients thought-voice pattern, how it sounds and how it gets her behaving.

In LaToya’s case, she found herself listening for the answer of how to get her friends to like her; how to think about the behavior of herself and other people; in short, how to keep other people from bugging her and how to control Mother. Disappointment imploded when she found no answers on the tape. Listening to the tape became a chore.

We had to overcome this obstacle because it interfered with her building process. We had to move her mentally from listening for answers to listening for learning. The goal was for her to begin practicing listening to the tape as simply homework. The object was to perform the task regularly whether or not she wanted to, just like practicing her algebra equations so she could learn algebra. She was learning that homework was easier to fulfill as routine activity than doing it as a truth-seeking big deal. The tape became an instructional aid that a) reinforced her weekly practice exercises and b) helped her hear what her thought-voices were saying and how that activity converted into behavior.

LA TOYA'S STRUGGLE WITH HER OWN SABOTAGE ACTIVITY

Sabotage thought-voices take many forms. The Center's research indicates that thought-voices are constant, and that people do not ever get rid of that habit-based activity. Instead of the patient trying to eliminate sabotaging thought-voices, the Center's methodology takes a realistic route and teaches patients how not to mentally validate their spoiling messages. By repeatedly interrupting the habit, we grind down its strength and reduce its power to that of background noise.

This accomplishment, however, results from a process requiring practice over time. The practitioner and, eventually the patient, needs to become accustomed to its presence and self-critical nature. Here follows a vignette of La Toya discovering her sabotage routine.

During the weeks in which LaToya studied for important tests in Spanish, biology and history, I asked her what her thought-voices were saying.

'Ã«You can't do it, you're going to fail. You're going to mess up. Don't want to take the test. Why bother?'' she said.
'Did you study?' I asked.
'Yes, with flash cards and I knew my vocabulary backwards and forwards,' she said.
'Sounds like the voice saying, Ã«You don't know what you know,'' I said.
'Yes,' she said.
'Does that make sense to you?' I asked.
'Not really,' she said.
'Me, neither,' I said. 'That sounds like the sabotaging habit to me.'
'I hear that kind of talk all the time,' she said.
'Good. Let's put your discovery to work,' I said. 'When you hear that kind of commentary, identify it as Ã«habit' and then interject your countering exercise.'

Practice opportunities went beyond studying for tests. For LaToya speaking in a group was frightening, so her teacher's requirement that students participate in class discussions caught her in a bind. When she wanted to raise her hand and answer her teacher's question or contribute to class discussion, her negative thought-voices railed. *You're wrong. They'll all see how stupid you are. They'll laugh at you. Don't answer.* It took her some time to relegate those thought-voices to the 'nonsense' category. Eventually, when less intimidated by them, she took the tack that during class discussion, her comments were a contribution, not the perfect answer. In fact, she reminded herself repeatedly, there are many billions of ways of talking right, so I can't talk wrong.' Reducing the influence of sabotage and applying a new perspective allowed her to engage in class with greater confidence and less tension. Her grades, of course, reflected her improvement.

But an irony appeared. Even when she excelled, getting an A on an exam, for example, she heard negative thought-voices declaring, *Don't feel good Ã«cause you don't deserve the A. You're not special.* Likewise, when she spoke up in class and received her teacher's attention, she heard the negative thought-voices again, *Don't stand out or excel Ã«cause people will notice you.* She worried that she would not fit in with her crowd, many of whom merely complained and chided her for trying so hard. The voice said, *If I feel good while my friend feels bad, I'm selfish.*

She had run into what the Center calls 'Feeling good is bad; feeling bad is good' or 'Feeling good is scary.' That translates into 'The only feeling that is not scary is feeling awful.' While operating outside of the old, feel-bad

structure allowed LaToya to feel better, this new sensation did not ring true to the intimidated and disorganized LaToya whom knew as herself. Dealing with sabotaging negative thought-voices would take more than identification and countering at this juncture. Her challenge was getting used to the novel notion that she could operate more effectively and, thus feel better. This is the goal of the building process.

When emotional change for the better occurs, people Ã± in their old way --often react negatively. Their usual critical, discontented selves have gone missing; they do not recognize themselves as beginning to feel good in their new shift of mental operation. So strange is this sensation that they must gradually and incrementally develop tolerance for their less anguished self. This is an accumulative process. The medical-symptom model has no way to accommodate the patient's reaction to his move from emotional turmoil to less turmoil because the Medical Model maintains that the therapist is the expert on the patient, i.e. medical therapist holds sway over the patient's well-being.[11]

The human behavior model eases the patient through this transition over time. This achievement does not come about by the therapist attacking the patient's old style of 'It's scary to not feel awful.' Instead, the therapist steers the patient toward taking for granted that he will feel more comfortable with his old, suffering self than with his newly-acquired sense of well-being. Eventually, through the combined efforts of therapist and patient, the power of the patient's 'it's scary to feel good' feature evaporates. This process not only takes time, but requires a therapeutic design able to accomplish this goal.

SECOND VIGNETTE OF LATOYA'S SABOTAGE VOICE

LaToya's building process occurred in many settings. For example at home, LaToya sat at her computer to begin an essay for history class. She looked at her notes and began typing. After a few paragraphs, she heard thought-voices with phrases such as: *Those words are wrong . What makes you think you can write on this topic? You don't know what you know.* Then she stopped. *You can do it*, she told herself. *You've done the research. Yes, you can*. So she could hear two kinds of voices. The battle attracted her attention, for it signified that she was hooked into her sabotage habit. Again, she attempted to write, but sabotage was still strong. She stared at the screen, all the while convincing herself that she could complete her assignment, but her hands were not typing. *The teacher won't like it. Mother will be angry.* After two hours she had only two paragraphs.

When Mother arrived home after a 10-hour work day, she checked LaToya's homework. 'This is terrible. What's wrong with you?' she demanded. 'Do it again, you can get it right.' LaToya heard Mother saying words similar to those she had heard in her own head, both criticizing and encouraging. At the end of her tiring day, Mother's outlook was less than positive; she could not believe that La Toya was even trying to learn her lessons. This does not mean that Mother was against LaToya, or that she was the cause of LaToya's turmoil. It merely demonstrates that Mother's conditioning and LaToya's conditioning carry similar messages, both encouraging and discouraging. Nevertheless, LaToya felt she could never measure up to Mother's standards. LaToya struggled against her own thought-voices and Mother's negativity.

It would appear that the sabotage voice had won, but this would be a superficial and incorrect interpretation. LaToya was learning to apply her exercises during these kinds of challenges. By routinely interfering with the sabotage voice, she had robbed it of some of its power, for it is the accumulative practice that builds for her a mental option. Hearing positive thought-voices signified that our efforts were going in the right direction. LaToya was on the road to counteracting the strength of her sabotage habit. And it showed, the essay she wrote that night won her an A+.

LATOYA'S CREATIVE SABOTAGE VOICE Ã± HER LALA VOICE

It took some work to detect another form of the sabotage routine. One day I asked LaToya what happened when she heard her mother, her uncle or teachers haranguing her about chores, homework or other behaviors. 'Oh, I pretend to listen, but I just hum la, la, la, la in my head while they're talking. I block them out,' she said. LaToya's answer gave me a clue about distracting voices.

'How loud are the voices today,' I asked.
'Very loud,' she said.
'Good, what are they saying?'
'I'm not sure, but I can hear *La, la, la, don't listen to Prof. Ilana, listen to me.'*
'Beautiful,' I said. Do you know what you have just discovered?' I asked.
'What?' she asked, her expression quizzical.
'You've just discovered the sabotage voice trying to block me out. That's a wonderful discovery.'

This discovery harkened a huge step. Discovering the La La voice broke into her conditioning and gave LaToya a view into her mental struggle. While our clinical mandate aimed at getting LaToya to help herself, her system blocked our goal. This breakthrough led her to hear the words of the command, *Don't listen to Prof Ilana. Listen only to me [the voices]. Prof. Ilana talks bad talk, the devil's talk. She's wrong. La la la.* The LaLa voice with its compelling noise cut out current, real information. LaToya was getting in her own way. Her mental conditioning was interfering with her building project.

Over and over we challenged the credibility of the sabotage voice.
'Who talked like this? Whose voice does this LaLa voice sound like?' I asked her.
'I don't know,' she said.
'That's okay,' I said. 'Eventually the mystery will clear up.'
Gradually LaToya countered the LaLa voice with a different twist. She countered with *Prof. Ilana is just trying to help*. This new step of going, bit by bit, against her mental conditioning took courage.

In short, the La La voice could have high-jacked our clinical efforts, forever sabotaging LaToya's building process. If the therapist knows nothing about the patient's La La voice, and the patient does not recognize it herself, or even if she does, but does not tell the therapist, the therapist's efforts will go for naught. Hence, the failure of the medical/counseling model. Dealing with sabotage starkly illustrates a major difference between the medical-symptom design and the human behavior-system design.

COUNSELING DOES NOT WORK = CONVINCING

LaToya was imbued with her previous counselors' advice. They had maintained that if they could convince LaToya to like herself, to be confident in her abilities, they could persuade her to change her behavior and improve her self-esteem. Their approach, they claimed, would renovate LaToya's unseemly behavior. They explained to her why she should not get scared, pointing to her intelligence and abilities. They gave her workbooks and showed her films to enhance her self-worth. They referred her to a psychologist so he could measure her self-esteem. They recommended an array of eclectic affirmations such as 'I can, I will, I must.'

The harder she tried to renovate herself according to her counselor's instructions, the more insistent grew her uh-oh-you-screwed-up voice. In fact, the counselor's admonitions reinforced LaToya's negativity, for she had converted the counselor's directions into an harangue similar to her own thought-voices. The familiar uh-oh voice conveyed the chronic message that she had failed. And, according to her interpretation of her counselor's

words, she had. She had failed at getting rid of those scary thoughts. She had failed at eliminating her anger with herself. Whenever she promised herself to do better, and convinced herself that she would try harder, a feeling of failure and disappointment followed. In fact, she had failed to get rid of her mental conditioning. But LaToya did not know what was happening. And her counselors could not tell her because they did not know themselves.

Mental health counseling relies on the tradition of philosophy Ã± the study of human morals, character, behavior and the pursuit of right thinking. Psychiatrists, psychologists and mental health practitioners believe that from this information comes mental balance, calmness and composure. Counseling Ã±the dispensing of information Ã ± appeals to the logic and reason division of patients' functioning mentality. In this way practitioners attempt to convince and persuade patients to change their illogical thinking and actions.

LaToya's counselors did not know that their logic and reason approach differs from that of building a mental platform. Building a mental platform is a step-by-step accumulation of a patient's practicing assigned exercises under the direction of a C-CTherapy® practitioner. This accumulation occurs as it does for a student learning mathematics; for instance, she must practice mathematical exercises or she will not gain a facility with math. Skill proficiency results from practicing her exercises whether they be for mathematics, tennis or chess. Similarly in C-CTherapy®, the learner builds her ability.

As we have seen, LaToya had no problem with logic. The problem was that her emotional reactions come from the illogical mental division of her functioning mentality. Duplicating her counselor's approach of talking away illogical behavior leaves LaToya without an operational instrument, without a consistent and reliable way to tackle her emotional turmoil. Sabotaged by her own thought-voices, she defeated her good intentions to try harder and suffered a loser's self-fulfilling prophesy.

The problem, of course, was that she was caught in an impossible quest, as no sentient human gets rid of thinking, ever, for our thinkings are our thought-voices. This was for LaToya, as for everyone else, a difficult realization.

'Can you convince yourself never, ever to get angry again,' I asked LaToya.
'No,' she said, laughing at the absurdity of my question.
'Why not?' I asked rhetorically. 'Logic has no impact upon the illogical,' I continued. I wanted to remind her that information alone does not derail emotional material. This is why not one of the many billions of us can avoid reacting to our surroundings. I could talk this way to this bright teen now, as she was growing accustomed to the Center's description of how our heads work.

LaToya offered an example of her convincing voice.
'Coach had to find me in the computer lab to tell me it was time to go to basketball. My thought-voices kicked up: *Uh-oh, I'm late. I screwed up. What are they going to think?* I was so embarrassed. I kept promising to myself not to make that mistake again. *You can do it. Yes you can. I'll show them*. But I also heard, *No you can't.'*

'It's a real struggle, isn't it?' I said. 'Now you can hear yourself working to convince yourself to behave differently. Remember we are not trying to get rid of talking ourselves out of anything. We are going to take for granted that we will hear this back and forth mental struggle for awhile. It is the nature of our building process. So don't worry that you're not moving fast enough. You're doing just fine.'

We could hear her progress. Her exercises never failed her. 'I interrupted the uh-oh voice on the court,' she said. 'I kept all my attention on the ball.' Through the process of accumulation her efficiency strengthened, as did her

confidence. Eventually, she relied more upon her exercises and developing her mental platform than upon her old mental style of trying to persuade herself to act differently. She grew accustomed to her new operational position of ‘humans cannot NOT react.’ That is, a shift had begun, moving her away from philosophizing to skill acquisition.

By this time we had achieved the following:
Ã¯ LaToya was no longer immobilized by her negative thought-voices.
Ã¯ She no longer relied upon convincing herself to think differently as her emotional solution and her means of coping. Instead, she was interrupting her mental flow with Center-directed exercises.
Ã¯ She was beginning to experience a mental shift in her emotional operation which is the Center’s goal.

TENSION, ANGER AND THE PUNCHING BAG

In the past, doctors had medicated LaToya to calm her agitation exhibited by tugging her hair. She would have had to rely on this intervention of medication for life, as the medical-symptom model did not teach her how to cope with the source of her tension production. Now released from the toxicity of her medication, her chemically-induced anxiety faded and she could learn to deal with her mental and emotional self.

While withdrawing from the medication LaToya’s light-headedness gradually subsided, her balance returned. Then after six months of physical therapy for her broken leg caused by the side effects of her medicated state, she was again running and training for the next basketball season. Sports were more than fun and games for LaToya. As her Mother said, ‘She plays with such determination, vengeance and fearlessness.’

The physical exertion of sport helped to vent her chronic level of tension. But sports were not distractive enough to interfere with the negative thought-voices. She could never do it right enough, never meet all the different requirements of all the different authorities in her life. After all, the criteria for right behavior changes from person to person around the world, never mind from teacher to teacher, friend to friend, parent to parent substitute. Her efforts to obey her conflicting thought-voices inevitably generated mental confusion which created anxiety and produced physical tension.

That is why now that she was clear-headed and free of medical side-effects we set about to build a more efficient way for her to let off steam. Once accomplished, she would play ball for the joy of the activity, less for the release of pent-up anger. We would take a two-pronged program; first deliberately venting, and second, interfering with her tension-making mental habit. This approach would enhance her timing, increase her responsiveness and flexibility regarding action on the court, but more importantly, it would build the foundation for her life-long coping ability.

‘Up til now you’ve played basketball and other sports as a way of letting off steam,’ I told her. ‘Now we’re going to separate letting off steam from playing ball. We’re going to progress beyond anger-venting and move to playing ball because you like the game and because basketball is an activity you do.’

Here is an example of our program.
‘First we need to build signals,’ I said. ‘For instance, how do you know when you’re tense?’
‘It’s hard for me to sit still,’ she said. ‘I have to get up and walk around, sometimes I jiggle my foot.’
‘Good, those are excellent signals. Any others?’
‘I think that’s when I tug my hair.’
‘Excellent connection. Now, for the next few weeks, I want you to practice a new exercise. When you notice these physical actions, I want you to identify to yourself Ã«tension signal’.’

After LaToya had practiced that connection for a few weeks, we moved forward to using her newly-discovered signal.

'When you need to let off steam,' I said. 'I want you to go to the punching bag and beat it up.'
'That's kind of silly,' she said.
'Good. Is that what your sabotage voice is saying?'
'I guess so. What would people think if they saw me?'
'It's hard to try something different, isn't it? The thought-voices want you to handle tension in the same old way, fidgeting and tugging. Is that what you want?'
'Not really.'

As LaToya used the punching bag method, she could feel the difference between tau- tight-ready-to-pounce muscles and just-walking-along-the-street muscles. Slowly, consistently, she could feel the release and reduction in her tension. She learned to recognize this difference and eventually refine her gauge. When her tension built, she acknowledged the signal and went to the punching bag.

On the surface that action seems a simple matter -- the patient practices the exercise of intentionally beating up her mattress or the gymnasium bag as a way of reducing the visceral collection of anger. In fact, letting off steam on the punching bag is more than venting. This tool sets the stage for the patient's following accomplishments:
Ã¯ recognition of her tension/anger level;
Ã¯ capitalizing on her tension as a signal;
Ã¯ application of the appropriate mental and physical exercise indicated by the signal.

LaToya was accomplishing a transition to a mental ability where anger was released on her punching bag routinely at home, and sports were played for sport. She was learning to use her tension deliberately.

AMBIENT ANXIETY

Oral presentations gave LaToya another discovery arena. LaToya and her classmates worried and fretted whenever they had to give a speech. One girl cried during her biology presentation. The girl's emotion triggered LaToya's own worry. *Something is going to go wrong*, railed her thought-voice. *The test will be hard. I don't know the answers*. Her sabotage habit kicked in. She was off on an emotional run.

'You ran into something we call ambient anxiety,' I said. 'Remember you cannot NOT react to your surroundings. Those of us who are intelligent and sensitive pick up the emotional environment surrounding us. We suck in that atmosphere and react to it.'

'It's like my ears open up,' LaToya said. 'And I hear all the comments around me.' LaToya was experiencing the fact that wherever there are people, they bring their emotions with them.
'You can feel their emotion, can't you?' I asked.
'Yes,' she said.
'You're learning how emotion catches your attention. Like a magnet you're compelled to latch on. These speeches give us a terrific chance for you to work with yourself. Your job in this learning atmosphere is to pay attention to your own reactive system. When those around you are getting tense and anxious, discover what your thought-voices are saying.'
'How do I do that?' LaToya said.

‘When you feel yourself swept up by the emotional atmosphere, pay attention to your own head. Can you identify the mental action so we can turn it into a signal? Eventually you will connect your reaction to the ambient emotion around you and use that signal to focus upon yourself and begin your countering. Thus, you’ll have gotten a handle on one of the mental mechanisms from which you automatically operate, activated by your sensitivity.’

LaToya used sports as another learning opportunity in which to practice her exercises. Before each game, the coach, eager for a win, pulled aside the full team for a pep talk. ‘Go out and show them what you can do. It’s up to you to prove you’re the best.’ The girls exuded tense excitement, their eyes riveted on the coach as one girl jiggled her foot, another tucked away a lucky charm, another bit her nails. During one of these talks, LaToya noticed herself getting agitated. She checked into her head. What were her thought-voices saying? Surprised, she heard the same message as the coach’s, *prove yourself.* She interrupted the thought-voices with her countering exercise. She also, unobtrusively, separated herself from the huddle for a few minutes alone. In other words, she created for herself an emotional space. Those moments of interruption gave her enough of a mental break in which to redirect her attention.

‘I didn’t fall for my uh-oh-do-it- right voice,’ she said. ‘And I played really well. It felt great.
‘Terrific,’ I said. ‘You’re getting good at using your countering in sports. Now let’s expand our learning horizon. Whenever you notice yourself picking up tension around you, make the connection Ã«It’s their style’. You’re getting used to the fact that there are many billions of people, each with his or her own style of behaving and operating.’

She was able to pull off this new mental practice on a trip with classmates to visit college campuses. (For her to venture away from her mother for a few days was unusual and marked substantial progress.) A busload of teen-age girls rife with enthusiasm, cliques, complaints and a full complement of emotions proved a terrific practice arena.

‘They sure complain a lot,’ she said upon her return.‘Even though everyone was pretty tense, I stayed calm.’ It was quite an accomplishment to keep herself level when those around her were getting frantic. Her accomplishment, operating differently, stunned her.
‘It was strange,’ she said, as if she should not have her own feelings but should mimic theirs. ‘Good,’ I said. ‘Now you’re discovering that you’re capable of operating differently.’

DEALING WITH TRAUMA

From the above discussion of clinical issues including LaToya’s range of thought-voices, self-sabotage and ambient anxiety, one would anticipate that the Center’s treatment of trauma would also differ dramatically from the conventional medical-symptom model.

On September 11, 2001, American students watched TV coverage replaying the devastation caused by the attack on the New York World Trade Center, as did much of the world. Horrific scenes played again and again, mesmerizing and traumatizing young and old alike. Class discussions and homework centered around the unfolding drama. By the end of the school day, students reported feeling agitated and exhausted. No wonder. They had had no mental break from the onslaught of horror images, self-examination or media analysis of ‘Who, what, when, where, and why.’

Counselors and teachers followed the medical-symptom protocol of debriefing after trauma; that is, relive again and again the event by regurgitating ‘what you saw, heard and felt.’[12,13] Also relive others’ experiences by

listening to their tragic stories. This medical-symptom model follows a popular 'debriefing' format adapted from military methods for gathering intelligence about the enemy's actions. The armed forces' debriefing model is a misapplication to mental health treatment, as debriefing was not designed as a vehicle for emotional support during mental and emotional trauma. Its purpose was solely intelligence gathering. The medical-symptom model took the term and combined it with the 12-step pietist tradition for alcohol recovery to form the medical/ psychological PTSD format.[14] In the PTSD format, reliving the event was supposed to prevent post-traumatic stress disorder and is still prescribed for every trauma sufferer.

As one might expect, the trauma of 9/11 activated LaToya's uh-oh disaster voice. Hers took its usual form of *Where's Mom? Is she okay?* Concern about loved ones was a common response of Americans during those days. By this time in treatment LaToya had had enough practice at working with her reactive system to dilute her old usual response. Although she could not extricate herself from the traumatized atmosphere during school hours, she elected to do something different than her friends were doing after school. Her friends hung out together until it was time to return to their respective homes, reinforcing each others' hysteria. Instead, LaToya removed herself from the emotionally-laden atmosphere. She went to her quiet home and the safety of her room, where there were no friends, no TV, no Mother or other imposed stimulation. She read a novel, distracting herself from the prevalent preoccupation with disaster. In other words, she gave her head a mental respite from the onslaught of ambient hysteria.

Some would say that distracting herself was denying reality. But the Center maintains that emotional shock is a common, ordinary reaction to horrific events. There are, however, as many reactions as there are people who view and or experience those events. The Center's research finds that reliving the event obstructs one's natural healing process by exacerbating and prolonging the individual's preoccupation with disaster. The Center's research finds that for a swift recovery from reaction to trauma, mental respite is necessary.[15], [16]

SUMMARY:
LaToya's story illustrates how the Center deals with what the physicians call a medical problem and what we at the Center call a human behavior issue. The difference between the two is profound. The depth of these differences can be measured by contrasting the Center's cure rate with the medical-symptom approach of maintaining the patient through drugs and counseling. These differences are outlined in the graph below.

EPILOGUE: No longer was LaToya the anxious teen pulling out her hair. Instead she went on to attend a prestigious university where she excelled.

Medical Model	**C-CTherapy® Human Behavior Model**
Doctor/counselor takes an historic perspective so as to understand symptoms. The counselor investigates the patient's history to understand the cause of the patient's problem; e.g., LaToya's counselors investigated Mother's parenting style, consulted with teachers and school personnel.	C-CTherapy® practitioner deals with the mental system of the patient's mental turmoil. Following the systems format, the practitioner asks the patient, 'What is stressing you out?' For LaToya, the answer was pulling out her hair, her poor concentration and her worry about her friends and mother.

In accordance with the symptoms format, the psychiatrist seeks to understand why LaToya is pulling out her hair so he can arrive at a diagnoses of her disease.	In accordance with the systems format, the C-CTherapy® practitioner, together with the patient, discovers what thought-voices are currently upsetting the patient.
From history-taking and consultation with other medical practitioners, the psychiatrist--as self-appointed expert on the patient's symptom and disease--prescribes medication for the patient.	The C-CTherapy® practitioner's role is as a teacher focusing upon universal human behavior characteristics. The teacher/ therapist assigns exercises. The patient tape records every session. Standard homework for every patient is to listen to that week's tape and practice exercises therein described.
The patient subjugates herself to the psychiatrist/counselor who emphasizes the counselor's own analysis of the patient and her symptom. LaToya's doctors and counselors 'befriended her' and engaged her in 'relationship therapy.' They attempted to figure out her symptoms -- why she pulled her hair, why she got nervous, and why she gained weight.	The C-CTherapy® view is that the patient is expert on herself. She is the treatment partner with the teacher/therapist and actively participates as she listens to her tape and practices her mental exercises.
Doctor/counselor views the patient through the disease model; i.e, human behavior and misbehavior is caused by an illness Ã± a disease and/or genes.	The C-CTherapy® practitioner treats all patients through the universal human behavior perspective. The therapist recognizes that all human beings react to their surroundings. All human beings behave. In the therapist's view disease is not germane to mental health treatment.
Cognitive	Non-Cognitive
Culture-Specific (Western European and North American)	Cross-Cultural
Psychiatrist/counselor relies on drugs therapy for maintenance.	C-CTherapy® does not maintain the patient through his suffering; C-CTherapy® cures the patient of that suffering. Under the direction of C-CTherapy® practitioner, LaToya concentrates on building a mental platform that allows her increasingly to move herself from pain to less pain.
Goal of long-term therapy is to socialize the patient.	Rather than renovate the patient, the goal of C-CTherapy® is to teach the patient to operate more effectively.
The psychiatrist/counselor meets in his office face-to-face with the patient so he can read body language and develop a relationship with the patient.	C-CTherapy® practices Telepsychotherapy, whereby the patient never comes to the office. The patient participates in Telepsychotherapy via telephone and tape recorder in his own office or home.
Doctor-patient relationship acts as change agent.	Change agent is the patient's acquisition and proficiency of the skill of emotional self-management.
Study and diagnosis, required in order to begin treatment, consumes the initial six to eight sessions.	Short-term therapy occurs in six sessions which are designed to take the mystery out of the patient's upset.

ENDNOTES:

1. ‘Dear Abby’ in San Francisco Chronicle, August 7, 2003.

2. I give patients a choice in their countering exercise between ‘garbage, garbage, garbage’ and ‘I am a worthwhile human being; I cannot fail at anything I do.’ One phrase is not better than another; each phrase takes up a different amount of mental space and time. Patients choose according to personal preference. No significance is attached to their choice.

3. ‘The Trauma Industry’ at www.c-ctherapy.org/trauma.htm.

4. Singer, Ilana, Emotional Recovery After Natural Disasters: How To Get Back to Normal Life, Idyll Arbor, Inc, Ravensdale, 2001.

5. Malinowski, Bronislaw, Sex and Repression in Savage Society, Meridian Books, New York, 1955.

6. C-CTherapy® glossary at www.c-ctherapy.org/glossary.html.

7. Gillies, Norman A. and Ilana Singer, ‘Child Development: A 21st Century View Through C-CTherapy®,’ 1999, www.c-ctherapy.org/child2.htm.

8. Gillies, Norman A. and Ilana Singer, ‘Mental Development of a Human Being as Viewed by ‘Counter-Conditioning Therapy®’, 1993, www.c-ctherapy.org/child1.htm.

9. Singer, Ilana, ‘Sensitivity and Intelligence: A Clinical Consideration in Mental Health Treatment of Women,’ 2001, www.c-ctherapy.org/women.html.

10. Breggin, Peter R., Toxic Psychiatry, St. Martin’s Press, New York, 1991.

11. Gillies, Norman A., ‘Combating the Tyranny of Thought-Voices: A C-CTherapy Perspective®,’ 2003, www.c-ctherapy.org/tyranny.htm.

12. Singer, Ilana, Emotional Recovery After Natural Disasters: How To Get Back To Normal Life, Idyll Arbor, Ravensdale, 2001.

13. Singer, Ilana, ‘The Trauma Industry,’ 2001, www.c-ctherapy.org/trauma.htm.

14. For further discussion of this point, see Singer, Ilana, ‘The Trauma Industry,’ 2001, www.c-ctherapy.org/trauma.htm.

15. Singer, Ilana, Emotional Recovery After Natural Disasters: How To Get Back To Normal Life, Idyll Arbor, Inc., Ravensdale, 2001.

16. Singer, Ilana, ‘The Trauma Industry,’ 2001, www.c-ctherapy.org/trauma.htm.